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HEALTH PERSPECTIVES ACCORDING TO YUKONERS:
QUALITATIVE ANALYSIS OF SEVENTY-SEVEN IN-DEPTH INTERVIEWS

by

Jane Fry, B.A.

A thesis submitted to
the Faculty of Graduate Studies and Research
in partial fulfilment of
the requirements for the degree of

Master of Arts

Department of Sociology/Anthropology

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"Health Perspectives According to Yukoners:
Qualitative Analysis of Seventy-Seven In-Depth Interviews"

submitted by Jane Fry, B.A.

in partial fulfillment of the requirements for
the degree of Master of Arts

Thesis Supervisor

Chair, Department of Sociology/Anthropology

Carleton University

August 29, 1995

ABSTRACT

This qualitative research used grounded theory methodology to analyze interviews conducted with 77 Yukon residents. The main question in the interview was "What does being well/well-being mean to you?" This research was part of a larger project carried out by the Yukon Bureau of Statistics in keeping with the Yukon Health Act.

The results showed three groups of respondents who were divided according to priorities in their lives: multi-dimensional group; family-centred group; and self-centred group. The common denominator for all these respondents was that health was not merely a biological entity. It also encompassed the mental, spiritual and/or social health components. The most notable result for the majority of respondents was that if they were healthy, then they were happy.

Dedication

Dedicated to Norm, Alison, Paul and Lindsay.

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CHAPTER I

INTRODUCTION

This analysis will examine the health perspectives of people living in the Yukon Territory. In 1990, the Yukon Health Act was developed to address a new direction for health care policy in the Yukon. In response to this Act, a qualitative study was conducted in the Yukon in the summer of 1991. Seventy-seven respondents were asked the following questions: "What does being well/ well-being mean to you? What do you need to be well? What do you do to feel good/ stay healthy? Could you describe your health to me? Do you have a few words that would describe what health means to you?"¹ When the data were coded, three separate perspectives of health emerged: multi-dimensional health perspective; family-centred health perspective; and self-centred health perspective. The names of these groups reflect the priorities and main influences in the respondents' lives.

This chapter will first specify the research question, followed by a brief explanation of what health is and what this research will accomplish. This will be followed by a description of some of the Yukon's distinctive characteristics, as well as the importance of health promotion. Finally, there is a brief explanation of the

¹ See Appendix A for the complete questionnaire.

organization of this thesis.

The Research Question

The research question states "What does the word 'health' mean to people living in the Yukon?" There are various parts to this: individual health perspectives; health definitions, conceptualizations and influences; importance of health for Yukoners; variations in health definitions throughout the Yukon; demographic analysis of the respondents; the validity of different definitions; and the influence which an individual's definition of health has on his/her lifestyle.

This thesis will attempt to address all of these key areas of inquiry in order to develop an overall understanding of health perspectives of Yukoners. Before examining the key components of the thesis, it is necessary to conceptualize a definition of health, taking account of its complexity.

What Is Health?

"A conclusive definition of "what health is" seems to be impossible. The best answer is that "it depends"; it depends on who is defining health, whose health it is, and how the definition will be applied." (Yukon Bureau of Statistics, 1992, p.5). "Health means different things to different people in different places and at different times in their lives." (Yukon Bureau of Statistics, 1994, p.5).

Health appears to be a nebulous entity, but it is not.

Health is a definite entity on the individual level, which also varies between individuals. There are many factors which affect health. One factor is stage of life. For example, upon having children, a previously-held, self-centred view of health may become a family-centred view of health. There are also demographic differences (eg., income, education, marital status, gender) associated with health perspectives (Yukon Bureau of Statistics, 1994).²

Purpose of this Research

There are many factors exacerbating certain health problems and creating pressure for a new kind of social support. Rapid and irreversible social change, shifting family structure, an aging population and a wider participation by women in the paid work force are some of the factors. To continue to improve the health of Canadians, we have to move forward with new policies and solutions (Epp, 1986).

The pursuit of better health is a legitimate objective for governmental policy in the economic field. In many countries of the industrialized world, policies are pursued that are harmful to health and are legitimized by the claim that they promote other ends (Smith, 1983).

There are

"three major challenges which are not

² The literature review will illustrate the many definitions of health in more detail and the difficulty in arriving at an agreed upon definition.

being adequately addressed by the current health policies and practices: the disadvantaged groups have a significantly lower life expectancy, poorer health and a higher prevalence of disability than the average Canadian; various forms of preventable diseases and injuries continue to undermine the health and quality of life of many Canadians; many thousands of Canadians suffer from chronic disease, disability, or various forms of emotional stress, and lack adequate community support to help them cope and live meaningful, productive and dignified lives." (Epp, 1986, p.396)

This research is part of a larger research project initiated, conducted and analyzed by the Yukon Bureau of Statistics. Living in the Yukon is different from living anywhere south of the Yukon.³ Since there is a paucity of research that fully explores the health of Yukoners, qualitative research is necessary to provide a definition and to develop specific hypotheses about health (Grady and Wallston, 1988).

In the summer of 1991, after the interviews were conducted, my use of the data was approved by the Yukon Bureau of Statistics and the Yukon Deputy Minister, Department of Health and Social Services. The proposal stated that results of the research would be useful for the department in the area of policy recommendation, in relation to programs which are currently existing or which may be implemented. Health and Social Services will be better

³ This difference will be explained in a later section.

able to determine the needs of their different clients through a consideration of their conceptions of health. If groups at risk for ill health can be identified, then ways could be devised to help them.

This research was conducted solely in the Yukon, therefore a description of distinctive characteristics relevant to this research is in order.

The Yukon Territory

In 1990 (the year before this survey was conducted), there were just under 30,000 people living in the Yukon,⁴ about 25% of whom are First Nations peoples.⁵ Almost two thirds of the population live in Whitehorse, the Territorial capital. The remainder live in communities of less than 2,000, ranging from 20 to 1700 people (Yukon: Bureau of Statistics, 1990a). Discovering health perspectives of Yukoners is a relevant research issue because of differences in living conditions between northern and more southern communities in Canada (Imrie and Warren, 1988) which can and do influence a person's health.

Nutrition is highly influenced by variation and availability of food (Imrie and Warren, 1988). The cost of purchasing marketed food in northern communities is high because of the long distance of transport by truck or air.

⁴ For a more detailed description of characteristics of the Yukon, see Appendix B.

⁵ There are seven First Nations groups in the Yukon.

The variety may be limited, and perishable foods quickly deteriorate. In one of the communities, Old Crow, the only access is by air. As such, non-indigenous food must be flown in. Further, the amount of space available on the airplane is limited, as is storage space in the stores. Traditional food sources (wildlife, fish, vegetation) remain important (Wein, 1994).

Exercise has a different connotation for people who live in the Yukon than for many people who live in southern urban areas (Imrie and Warren, 1988). Some Yukoners need to haul their own water, chop their own wood, hunt and/or trap. A person needs to be in a certain physical condition to partake in these activities, but they are not considered to be exercise by Northerners because they are an integral part of everyday life, a necessity for survival (Imrie and Warren, 1988).

Hours of sunlight differ from those in the South. In summertime, the daily amount of daylight can be as much as twenty hours and in the winter it can be as little as six hours. This affects the mental health of some Northerners (Seasonal Affective Disorder). The cold weather may also prevent people from spending much time outside and may result in cabin fever, that is, too much time spent indoors (Yukon News, 1992).

A difference between the age of the population⁶ in the Yukon and the rest of Canada is noted. "The Yukon has a relatively young population compared to Canada as a whole." (Yukon Bureau of Statistics, 1991). Differences are principally in the 25-34 age group (28% in Yukon versus 23% in Canada), the 35-44 age group (26% in Yukon versus 20% in Canada), and the over 55 age group (12% in Yukon versus 25% in Canada). Also, there is a difference in the proportion of men to women, that is, the Yukon population has 53% males to 47% females. Canada's population has a proportion of 51% females to 49% males (Yukon Bureau of Statistics, 1991).

In the past, the unemployment rate has been significantly higher in the Yukon than in the rest of Canada. This contributes to poverty, social and psychological stress, and the loss of self-esteem. These factors may be hidden behind symptoms such as substance abuse, family violence or risk-taking behaviour (Brunton, 1990).

The Yukon Health Act was developed to address the distinctiveness of the benefits and detriments this environment has on health.

The Yukon Health Act (1990), defines health as

"the physical, emotional, social, mental, and spiritual well-being of residents of the Yukon in harmony with their physical, social, economic, and

⁶ This includes only those people over fifteen years of age.

cultural environments;' (Yukon Bureau of Statistics, 1990b, p.1).

The Act outlined a new direction for health care policy in the Yukon. It stated that future health care policies should include the following: a preventive approach to health care; the integration of health care and social service; health care which is accessible to everyone; cultural sensitivity; a partnership between individuals, groups, communities and the government; and accountability of the planners and providers of the health care programs and services. The Health Act was designed to help "identify appropriate indicators of health and social well-being" (Yukon Bureau of Statistics, 1990b, p.5). It is based on a socio-ecological perspective of health and extends beyond the bio-medical model of health (Yukon Bureau of Statistics, 1990b).

Health care may have a very broad definition. One of the parts of this definition is a preventive approach which states that improvements in health may best be effected through the practice of proactive health care, instead of the current reactive, or "after-the-fact" medicine (Edginton, 1989). The Health Act states that

"people can achieve and improve their well-being through prevention of illness and injury, promotion of health, and collective action against the social, environmental, and occupational causes of illness and injury;" (Yukon Bureau of Statistics, 1990b, p.1).

In examining health care, it is seen that some individuals use health care services and others do not. Two types of beliefs motivate people to take proactive health care measures (Hayes and Ross, 1987). Understanding what motivates people to undertake preventive health care will aid in developing health promotion programs. Readiness to take action is the first belief. The individual is concerned with health and this provides the main motivator to take on proactive health behaviours. The second belief has modifying factors that help or hinder action. The action taken depends on the perceived effectiveness of the action and the cost of the action (Hayes and Ross, 1987). A concern with these beliefs is how to measure preventive health care behaviour.

Health Promotion

The Ottawa Chapter for Health Promotion describes the fundamentals for health as "peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity." (Engel, 1994, p.7). It also states that "health is a means rather than an end in itself - not the object of living. ... Although physical fitness ... is a prerequisite for well-being, fitness alone does not guarantee good health." (Engel, 1994, p.7). But, how practical is this definition, and how may it be applied to the general population?

Preventive health care may be accomplished through

health promotion in the following ways. There are three mechanisms which are intrinsic to health promotion. The first is self care, that is encouraging healthy choices, and the decisions and actions individuals take in the interest of their own health (Epp, 1986). Most individuals do not worry about their health until they lose it. The prevention of disease may mean forsaking habits many people enjoy, such as overeating, smoking, or excessive consumption of alcohol.

The second mechanism intrinsic to health promotion is mutual aid, that is, actions people take to help each other cope. It is frequently referred to as social support, eg., self help movements (Epp, 1986). Today, disease prevention and health promotion are the motto for health care. Prevention can be hard to sell because it takes both personal and community action. Studies show that even a few words from health professionals can help prevent disease by motivating people to modify their lifestyle (Engel, 1994). The Yukon Health Act states that

"improvements in health and social services require the cooperative partnership of governments, professionals, voluntary organizations, aboriginal groups, communities, and individual;" (Yukon Bureau of Statistics, 1990b, p.1).

A third mechanism intrinsic to health promotion is healthy environments, that is, the creation of conditions and surroundings which are conducive to health. They should help preserve and enhance our health (Epp, 1986) and not

affect it negatively.

In sum, research on health in the Yukon is necessary for two main reasons. The first is the distinctiveness of living in the Yukon as compared to the provinces. There are enough differences which affects the health of Yukoners to warrant separate research.

The second reason for the necessity of research on health in the Yukon concerns the Yukon Health Act. The main goals of the Health Act are to promote and protect health. The Health Act emphasizes the socio-ecological perspective on health, which includes asking people directly about their perspectives on health. Results of this research will be useful for Health and Social Services in the area of policy recommendation.

Overview of Thesis

Following the introduction is a review of the literature surrounding health. Methodology of the research will be examined in chapter III, followed by results in Chapter IV. Discussion will be followed by the conclusion of the thesis in the Chapter V.

CHAPTER II

THEORETICAL FRAMEWORK

An exhaustive definition of health⁷ would be difficult to achieve because there is so much literature on the subject. Some research gives the subject of health a positive definition, while other research defines health as what it is not, that is, health is defined as the absence of both disease and illness - a negative definition in which disease and illness are defined instead of health. Health is also defined as a resource, a means to an end, that is, a way to have a happier, longer life.

This literature review begins by examining definitions and concepts of health. It will be suggested that health can be divided into three spheres: personal; biomedical; and alternative. Then there will be a brief examination of the literature on gender and health, and the chapter will end with a section on the ways in which health conditions have changed over the years.

What is Health?

A concept which is referred to constantly in definitions of health is wholeness or soundness. The following table illustrates how this concept has been constant through the ages (Lee, 1983, p.23):

⁷ In most literature on health, well-being is equated with health. In this research, it will also be equated with health unless otherwise stated.

TABLE 1
Health - the word and the concept

(Indo-European)	kailo	whole, intact, uninjured
(Old English)	hal	whole, sound, hale
	haelan	to heal
	haelth	health
(Middle English)	helthe	health
(Greek)	hygienos	healthy, sound, wholesome
(Latin)	sanitos	health, soundness
(Hebrew)	shalem	healthy, whole

There are many other concepts of health, as the following table illustrates (Lee, 1983, p.24):

TABLE 2
Concepts of Health

1.	absence of disease
2.	adaptation
3.	a balance
4.	a condition of soundness: freedom from disease, ailment, pain
5.	a flourishing condition
6.	a general condition
7.	a level
8.	a process of man-environment interaction
9.	a purchasable commodity (a good or commodity)
10.	a right
11.	a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity
12.	an equilibrium
13.	an undisturbed rhythm
14.	continuing, perfect adjustment of an organism to its environment
15.	freedom from disease, dysfunction, disability
16.	optimal fitness
17.	soundness
18.	wholeness

There is no universally agreed upon definition of health (Engel, 1994). In fact, there is a lack of clarity in definitions of health in research, because health is not

something that can be narrowly defined (Edginton, 1989; Engel, 1994; Smith, 1983; Smith, 1988). One factor common in all definitions is that health is the absence of disease (Edginton, 1989; Engel, 1994; Maykovich, 1980; Smith, 1983) or a state of well-being or 'feeling okay'. One cannot think about health without the reality or possibility of disease (Stacey, 1988).

Health is not easily measured. People in good health have no diagnosable diseases, are energetic, satisfied with life and in control. However, even those with diagnosable diseases (eg., colitis, diabetes) may also feel well most of the time (Edginton, 1989). There are also degrees of feeling healthy, that is, people can have a cold and still perform their regular activities, or they can have cancer and still feel healthy. As well, good health for an eighty-year old person may be different from that of a twenty-year old. Thus, definitions of health are complicated by issues of relativity (Edginton, 1989; Smith, 1983).

Strong consensus among professionals and laypersons exists that health, illness, and disease involve, in varying degrees, biomedical, personal and socio-cultural dimensions (Gochman, 1988). Edginton (1989) states that health is a complex formed by the relation between larger issues of health and illness, the medical system, the environment and our personal experience with illness. It is a social, not an individual problem, thus individuals cannot be held

totally responsible for their own health (Edginton, 1989).

Health may also be defined in relation to healing and therefore illness. There are three spheres in which healing occurs: popular (home and community); folk (non-medicalized specialists such as herbalists and faith healers); and professional (biomedicine, and professionalised healing traditions such as Indian and Chinese medicines). The last sphere is the dominant one of the three (Litva and Eyles, 1994).

Grant and colleagues (1992) have noted that "... Health is a normative, value-laden and socially constructed term." (p.2). Concepts of health set boundaries for individuals to relate to their own health. They are a framework for professionals and policy makers to interpret their roles and approaches to health care. They define what is or is not health, and what knowledge is legitimate or silent. These concepts also define what health practices are funded or not funded (Grant et al., 1992).

Differences of opinion about disease and health exist not only in the general population but also in the medical profession (Edginton, 1989). The definition of health is complex and difficult for a number of reasons. The first reason is the simultaneous existence of lay and professional /scientific definitions which overlap appreciably. Professional definitions are more formal than lay definitions but they are nonetheless different and these

differences have implications for research. The second reason for complexity in definitions of health is the existence of multiple professional or scientific definitions. Medical and psychological definitions illustrate this, with the former emphasizing the presence or absence of pathology, and the latter emphasizing perceptions, feelings of well-being, and equilibrium (Gochman, 1988).

The complexity of health is also explained by the existence of plural definitions within each profession or science which depend on theoretical or ideological commitments. The structural-functional perspective in sociology views health in terms of equilibrium of society. Therefore, disease is dysfunctional because it disrupts social equilibrium by impairing expected performance of the individual (Gochman, 1988). On the other hand, the conflict theory states that health and illness are related to unequal social arrangements (Clarke, 1990). That is, some social groups have higher rates of mortality and morbidity, not because of their genetic or biological makeup, but because of their social position (Edginton, 1989).

Another reason that health definitions are complex is that there are at least three dimensions to be considered: 1) the biomedical dimension which subsumes a host of biological, biochemical, and physiological processes where health is the absence of symptoms or signs of illness;

2) the personal dimension which has a variety of affective, perceptual, behavioural and other psychological components wherein health is a sense or feeling of well-being; and 3) the socio-cultural dimension which is made up of many performance, interactional, social structural and cultural components where health is the capacity to perform (Gochman, 1988).

The World Health Organization (WHO) attempted to go beyond the conventional disease model of health and defined health as the "state of complete physical, mental and social well-being, encompassing the ability to achieve full potential, deal with crises and meet environmental challenges." (Engel, 1994, p.7). This definition is used by many researchers in their search for a definition of health.

Wellness has become a trendy term for health. It is the "capacity to undertake physical effort, to live within one's own potential and carry out tasks with vigour and alertness, leaving enough energy for unforeseen emergencies." (Engel, 1994, p.7). This positive definition equates health with a quality of life as a goal, which is translated into individual terms and seen as a basis for personal potential (Chambers, 1991; Litva and Eyles, 1994; Stacey, 1988).

The WHO definition allows for the multifaceted nature of health by stating that health involves the physical, mental, and social components. Although health and disease

may have some link, health has a reality that is independent of disease (Gochman, 1988).

The WHO definition focuses more on the physical and mental quality of people's lives than on rates of diagnosed illnesses. Well-being is on a continuum (Chambers, 1991; Ross et al., 1990), at one end is tiredness, sickness, many short-term illnesses (cold/flu), and/or ongoing problems like arthritis, depression or anxiousness. At the other end of the continuum is healthiness, energy, happiness and hopefulness. Physical and mental health are directly related, they share common causes, affect each other and signs of one are often signs of the other (Ross et al., 1990).

While the WHO definition goes beyond historical definitions, which tended to be more restrictive and based solely on a medical model, this definition does not say exactly what health is and it does not say what is meant by well-being (Gochman, 1988). It also lacks indicators of health. All the indicators given are of diseases (Stacey, 1988). As well, it is an idealistic abstraction and has an unrealistic expectation for everyone to be healthy by the year 2000 (White, 1982). This broad definition is far-reaching and encompasses every facet of our lives - economic, political and social. Very few people and very few populations are healthy according to this definition (Edginton, 1989).

The WHO definition has also been judged inadequate by reports focusing on health promotion activities. That is, even if morbidity and longevity are unaffected, health promotion may enhance health by increasing energy, stamina, and feelings of well-being, resilience and productivity (Chambers, 1991).

In sum, the confusions in health definitions exist primarily in relation to the relative importance of each of the dimensions mentioned in the above definitions (Gochman, 1988). The next section will detail the symbolic interactionist point of view in the sociology of health and illness.

Sociology of Health and Illness

The sociology of health and illness has followed medicine in defining illness and disease over the years, rather than health (Stacey, 1988). For the last twenty years, the sociology of health and illness has sought:

"to describe and explain the social causes and consequences of illness, disease, disability, and death; to show the ways lay people and professionals alike constitute or construct their categories of disease and illness; and to portray the ways that illness affects social interaction among various people." (Clarke, 1990, p.15).

The sociology of health and illness studies how social and cultural factors influence people's health, people's perceptions of health and healing, and healing methods in different societies.

The sociology of health and illness also examines how the fate of individuals is linked to the workings of the social body. Illness, death, health, and well-being are socially produced in large part. Social groups and shared cultures can shape members' bodies in different ways: stays and corsets worn by middle class women in the nineteenth century; the wearing of high heels and earpiercing; working bent over in a mine shaft for years; or sitting at a desk all day. Illness is not just a physical, but also a social experience (Freund and McGuire, 1991).

In this discipline, Symbolic Interactionist theory looks at meanings, changes, and interactions in relation to health and illness (Clarke, 1990). Attributions of disease are dependent upon social construction, and social interactions and social labelling are important in determining what disease is (Gochman, 1988). Impact of disease and diagnosis on the individual's self and on his/her relationship with others is described (Clarke, 1990). Abstractions used do not relate to individuals alone, but to individuals in interaction (Stacey, 1988) and meanings are constructed out of social interactions in specific social, political, economic and historical contexts. As well, meanings reflect a person's position in the social structure, and that person's personal relationships and experiences (Clarke, 1990).

The socio-ecological model of health, which includes

the biomedical model, is "dynamic and emphasizes interrelatedness between individuals, his or her health, and social, economic, and physical environments." (Grant et al., 1992, p.4-5). "The inextricable links between people and their environment constitute the basis for a socio-ecological approach to health." (WHO et al., 1986, p.426). This model emphasizes the complexity and interrelatedness of our societies. It also encourages reciprocal maintenance - taking care of each other, our communities and our natural environment. As well, it also shows that changing patterns of life, work, and leisure have a significant impact on health (WHO et al., 1986).

In sum, the sociology of health and illness shows how social and cultural factors influence people's health. These factors are dependent upon the time and place in which the individual lives.

Health Concepts - The Personal Sphere

The personal sphere of health concerns individual definitions of health. When respondents in one survey (Litva and Eyles, 1994) were asked their definitions of health, views differed. Some individuals drew upon the context of their own experiences to define health. Their definitions were tied in with the quality of their lives and were often explained in psychological terms as the ability to feel happy, enjoy life and feel good about the self. Definitions also included an individualistic sense of well-

being which was linked to a psychological, not a physical state. Other respondents found it difficult to define health and some could only speak in general terms so their definitions were very abstract. Health was largely described in negative terms, that is, being without illness or debilitating disease. Health was also viewed in terms of physical wellness (Litva and Eyles, 1994).

"Ordinary people ... develop explanatory theories to account for their material, social and bodily circumstances. These they apply to themselves as individuals, but in developing them they draw on all sorts of knowledge and wisdom, some of it derived from their own experience, some of it handed on by word of mouth, other parts of it derived from highly trained practioners." (Stacey, 1988, p.142).

Individual concepts of health vary systematically with health experiences. Lay concepts may be seen as social representations expressing values of the society, and also as expressions of societal conflict. Aspects of lay concepts vary from one social class to another in ways that appear to relate to the material differences between the classes (Stacey, 1988).

The definition of health encompasses internal and external, visible and invisible, and physical and metaphysical dimensions of the respondent. Judging oneself as healthy involves taking stock of one's health inventory which fluctuates with time and action. "In sum, the sense of being healthy involves both a sense of self and a sense of

body (a body self), both of which were tied to a conception of past and future actions." (Saltonstall, 1993, p.9). The body and self, in this context, are described as reflexive aspects of one wholeness, one 'being', and neither is complete without the other (Saltonstall, 1993).

Healthiness is considered to be a product of a personal and particular self and body. Selfhood, embodiment, and health are intertwined. "Health is not a universal fact, but is a constituted social reality, constructed through the medium of the body using the raw materials of social meaning and symbol." (Saltonstall, 1993, p.12). Health is a creation of those selves.

"People appear to believe that the causes of health, illness and recovery are related quite specifically to factors like: psychological temperament and well-being; the quality, quantity and type of conventional medical treatment made available; work and home general environmental factors; life style habits; societal or cultural issues; fate and religious factors. " (Furnham, 1994, p.723).

These factors are fairly robust across domains of beliefs with respect to health and illness. Some factors, such as gender, education, and marital status, significantly predict health beliefs. Another important factor is the strength, rather than loyalty, of religious beliefs which tends to predict fatalistic or supernatural health-related beliefs (Furnham, 1994).

Political beliefs and age predict a number of health

factors. The more liberal the person is, and the older they are, the more they emphasize external environmental and sociological causes and cures for illness. There is also a direct relationship between belief in alternative medicine and belief in controllable or internal causes of health, illness, and recovery (Furnham, 1994).

Health Components

There are five components discussed in defining health: physical; mental; emotional; spiritual; and social. Physical well-being is "feeling fit and able, unrestricted by discomfort or disability." (Ross et al., 1990, p. 1060). Good physical health improves psychological well-being and may decrease concurrent depression. It appears to be mediated by processes within the person, not by interactions with others (Hayes and Ross, 1986). Physical distress includes feeling unhealthy, tired, having headaches and pain. It is indicated by self-reported symptoms, dysfunction, and sick days. It is not always indicated by the number of visits to the doctor (Ross et al., 1990).

"A cursory glance at the mass media shows the concern Americans have for appearance and attractiveness." (Hayes and Ross, 1987, p.122). Our society places demands on the individual to be concerned with appearance. And concern with appearance may be a motivating factor in preventive health behaviours rather than a concern with health. For the average person, concern with appearance has as much

effect on eating habits as does concern with health (Hayes and Ross, 1987).

The mental health component includes: psychological and social harmony and integration; quality of life and general well-being; self-actualization and growth; effective personal adaptation; and mutual influences of the individual, the group and the environment (Caldwell and Gilbert, 1990). The mind and body are interrelated and mental problems are not utterly separate from physical problems (Freund and McGuire, 1991). Health can be effected by the experience and management of stress, which involves normal and expected parts of life. Individuals are responsible for managing their own stress, therefore inability to manage stress is an individual weakness. Stress potentially threatens the body's ability to resist illness (Litva and Eyles, 1994).

Emotional health, or psychological well-being, "consists of feeling happy, hopeful, and energetic, with a zest for life." (Ross et al., 1990, p.1060). The sense of self is our experience of ourselves as unique and distinct persons. Self concept includes our thoughts and feelings, both positive and negative, about ourselves as individuals. It depends very much on both the extent to which various social interactions validate or affirm our sense of self and our social position (Freund and McGuire, 1991). Our health is affected by our sense of self or self-preservation. An

empowered self, a self which experiences a sense of coherence, can produce health. But a dispirited self, a poor sense of self and the feeling of being overwhelmed by events, has been linked to depression and anxiety (Freund and McGuire, 1991).

Psychological distress includes moods of depression or anxiety, and physiological symptoms are associated with these moods. Depression and anxiety correlate highly with each other. They also correlate with other problems such as anger, paranoia and substance abuse (Ross et al., 1990).

In examining the spiritual health component, researchers remain far from a consensus on which specific dimensions of spirituality contribute to psychological well-being and subjective perceptions of life quality. Religion may enhance various aspects of well-being through: social integration and support (Ellison, 1991); the establishment of personal relationships with a divine other (Ellison, 1991; Pollner, 1989); the provision of systems of meaning and existential coherence; and the promotion of more specific patterns of religious organization and personal lifestyle. The previous relationships are not mutually exclusive (Ellison, 1991).

Persons who enjoy a greater sense of coherence and order in their lives have better physical and psychological health than other people. And it has been suggested that strong religious beliefs and experiences may deepen this

sense of meaning and comprehensibility. Firm religious beliefs significantly enhance both cognitive and affective perceptions of life quality. Religious faith buffers the negative effects of trauma on well-being and strong religious faith makes traumatic events easier to bear. Persons with liberal, non-traditional and nondenominational Protestant ties report significantly greater life satisfaction than unaffiliated individuals (Ellison, 1991).

The social health component includes social support, a general term for the many different resources that aid persons in times of crisis and helps them cope with life. There is much literature on social support and health that makes associations between social isolation and poor health (Freund and McGuire, 1991).

Marital status has been associated with negative health behaviour, that is, behaviour which is detrimental to health. Married people have the lowest rates of negative health behaviour, and divorced people have the highest rates of negative health behaviour. The unmarried state is more detrimental to men than women. And the presence of children in the home has deterrent effects on health-compromising behaviour (Umberson, 1987). In other words, children have a positive effect on health.

There are limitations in the social support and health literature. It assumes that social support should be treated as a stable, constant factor. In fact, levels of

support do not remain the same over time. Another limitation is that stressful events and social support are not independent factors, but rather interact with each other. The literature also focuses only on beneficial aspects of social support. And, lastly, the research fails to consider the larger contexts of the power in which social support takes place, that is, people in economic need may have difficulties with their social network (Freund and McGuire, 1991).

In sum, health can be divided into five components: physical; mental; emotional; spiritual; and social. These components affect people's health in differing ways depending on the importance each individual places on each component.

Health Determinants

There are four health determinants into which most models of health may be fitted: biological; behavioural; socio-cultural; and environmental (Lee, 1983). These determinants are not uniform across all research. Some researchers link the categories together, some researchers only define two categories and still other researchers keep them separate.

The personal sphere of health encompasses the behavioural and socio-cultural determinants of health. The behavioural health determinant includes behaviour (Chambers, 1991; Lee, 1983; Litva and Eyles, 1994), lifestyle

(Chambers, 1991: Lee, 1983: Smith, 1983), emotional reactions and states, and psychological status (Lee, 1983).

Lifestyle is an aggregate of individual health habits, such as, exercise, diet, smoking, substance use, and sexual habits (Engel, 1994; Lalonde, 1977; Mustard, 1983). Both treatment and prevention of illness require a change in lifestyles (Clarke, 1990).

Health is "a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities." (WHO et al., 1986 p.426). The basic prerequisites for health are "peace, shelter, education, food, income, stable eco-system, sustainable resources, social justice and equity." (WHO et al., 1986, p.426). Good health is a "major resource for social, economic and personal development and an important dimension of quality of life." (WHO et al., 1986, p.426). Some factors which can harm or favour health are political, economic, social, cultural, environmental, behavioural and biological (WHO et al., 1986).

Health is seen as a reserve, energy, fitness, and social support (Litva and Eyles, 1994). Health can be seen as a crucial resource for the individual to have because it insures that daily life can go on. It is important to the individual's sense of self-worth and becomes personal. Often illness or physical disability will be dismissed,

denied or renegotiated so that if illness is experienced, it is part of being healthy, such as the cold or the influenza. To be healthy, people will sometimes deny that their illness exists or that illness interferes with their normal functioning because this is a comment on their 'worthiness'.

Health for others means fitness, the ability to work and perform normal roles and 'not being ill'. Health is an abstract state of being (Litva and Eyles, 1994).

"Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow it attainment of health by all its members." (WHO et al., 1986, p.427).

The idea of health as a resource has merit because it increases our awareness that health is something we should promote, protect and conserve (White, 1986). Health and its maintenance is a major social investment and challenge. To achieve good health the importance of an enlightened and involved community is the preferred approach. There is a need for people to be involved in making decisions about their own health (White, 1986).

Using health as a resource, a means to an end, has some problems. The definitions are idealistic and hard to apply to everyday life. As well, when health is a resource, does this mean that people cannot function if they are not

healthy? And are those people who are functioning even though they are not biomedically healthy, functioning to their fullest capacity?

The socio-cultural determinant includes the social structure or social organization (the relatively stable, ongoing pattern of social interaction) and cultural patterns (beliefs, values, actions and material objects shared by people) within the human community (Freund and McGuire, 1991; Lee, 1983; Smith, 1988). It also includes shared belief systems, family structures and social contracts (Lee, 1983). This recognition of nonmedical factors of health is not new. The socio-cultural factors of health and illness are now seen more and more in the context of social science as well as biomedical science. Health care can no longer be confined to the clinical model of health (Smith, 1988).

"Health is a social construction wholly dependent on its social context:" (Grant et al., 1992, p.7). Social norms influence our definition of health which varies between different social classes and ethnic groups. Health may depend on a person's ability to perform the tasks of day-to-day life as defined by the society they live in. There is no state of absolute health (Edginton, 1989).

Certain social practices contribute to the production of a healthy body, others lead to its destruction. The very condition of our bodies, whether we are healthy or sick, whether we live or die, depends not on luck but on social

circumstances. Sociopolitical factors and culture construct our physical environments and hence our bodies (Freund and McGuire, 1991).

Historical and cross-cultural studies show that the definitions of health are culture-bound (Edginton, 1989; Litva and Eyles, 1994; Stacey, 1988). There is a code which significantly shapes health attitudes and health behaviours and helps to define our place in the world (Litva and Eyles, 1994). The standards of health in any culture reflect that culture's core values, for example, strength, fertility, spirituality, fatness, thinness, or youthfulness (Freund and McGuire, 1991). Health is looked at similarly across culture in many ways. Cross-cultural agreement is that health is characterized as "good", "potent", and "active". But the meanings of these adjectives vary from one culture to another (Gochman, 1988).

In our society, health is the absence of organic disease. In other societies the definition of health is wider - the suffering of the body is not distinguished from suffering of the mind, nor is suffering of a group different from individual suffering (Stacey, 1988).

In sum, the personal health sphere states that health is dependent on the person's characteristics, ascribed or otherwise, and on the social and economic circumstances of the individual. This sphere is affected by behavioural and socio-cultural determinants and can be divided into five

components - physical, mental, emotional, spiritual, and social.

Health Concepts - The Biomedical Sphere

Another sphere into which health concepts can be placed is in the biomedical sphere.

"Disease is an objectively measurable pathology of the physical body, which is the result of the malfunctioning of parts of the body. Cure is through chemo-therapeutic, surgical, or other "heroic" means. Hospitals, as places for the practice of high-tech medicine, are of primary importance." (Clarke, 1990, p.225).

The biomedical model, which states that the body is a biomedical organism (Stacey, 1988), dominates the treatment of illness in Canada (Clarke, 1990; Edginton, 1989). The absence of disease is central to the biomedical model. Once the disease is identified (diagnosed), it can be treated, removed, and health is restored (Clarke, 1990; Grant et al., 1992; Litva and Eyles, 1994). The primary focus of medical research is on the particular genetic or hereditary characteristics of the individual, rather than on the social ecology of a particular group (Edginton, 1989).

The biomedical sphere is legitimized through legislation. The medical profession in Canada has control over the definition of health and illness, and benefits monetarily from its monopoly (Edginton, 1989).

There are two different determinants of health in the biomedical sphere. The biological health determinant states

that health takes place within the body (Lalonde, 1977; Lee, 1983) and includes genetics (Engel, 1994; Lee, 1983), aging (Lee, 1983), heredity (Smith, 1983), and biomedical risk factors (Chambers, 1991). The patient is restored to health when there is relief from pain and no more signs or symptoms of disease (Smith, 1988). There are material (that is, physical) sources of health and illness. One source is food - its availability and individual eating patterns (Freund and McGuire, 1991). Another source is smoking which may be positively and negatively associated with healthiness. It is seen by some people as a reasonable risk to undertake to deal with more serious threats to health, such as, stress or being overweight (Litva and Eyles, 1994). A third material source of health and illness is alcohol, which if consumed in small quantities may be beneficial to health, but when consumed in excessive quantities is dangerous to health (Litva and Eyles, 1994).

The second health determinant in the biomedical sphere lies outside the individual's body. This determinant concerns the interactions between the individual and the physical, chemical, biological (Chambers, 1991; Gochman, 1988; Lalonde, 1977; Lee, 1983; Mustard, 1983; Smith, 1983) and social environments that relate to health (Lalonde, 1977; Lee, 1983). The quality of the physical environment affects our health (Freund and McGuire, 1991) so a health promoting environment, including clean air and water, is

important (Engel, 1994).

The main critique of the biomedical sphere is that only the body itself is considered when there is illness or disease. This model focuses more on curing than preventing illness (Engel, 1994), and separates the physical from the psychological or emotional problems (Engel, 1994; Freund and McGuire, 1991).

There are other criticisms of the biomedical model. Biomedicine takes responsibility from the patients' hands and gives it to the doctors (Edginton, 1989, Stacey, 1988), thus the individual is not directly responsible for his/her own health. Physical reductionism assumes that illness can be reduced to disordered bodily functions and the social conditions contributing to illness or promoting healing are ignored. Specific etiology assumes that each disease is caused by a specific, potentially identifiable agent but a complete account of the causation of disease is not provided (Freund and McGuire, 1991).

In sum, the biomedical sphere of health is the dominant sphere in health concepts in our society. It examines health from a biomedical perspective and encompasses the biological and environmental health determinants.

Health Concepts - The Alternative Sphere

The third sphere into which health concepts may be placed is the alternative sphere. Alternative methods of health care state that an holistic perspective of health is

necessary. There is a need to go beyond the rigid separations of concepts about the body, mind and society, and to stress the importance of interactions between mind, body, and society (Freund and McGuire, 1991). Alternative healing methods are sometimes used in conjunction with biomedicine, often without the knowledge of the patient's medical doctor (Freund and McGuire, 1991).

A definition of holistic health is the biopsychosocial model - an image of "well-being for body, spirit and mind." (Engel, 1994, p.7). The mind and body are intertwined into one unit and people should be treated as whole persons with other factors being taken into account, such as economic, social, psychological (Clarke, 1990; Engel, 1994), cultural and/or historical contexts (Freund and McGuire, 1991).

Some researchers state that alternative health care methods are being used and developed in reaction to the biomedical model of health care, which treats the patient as an object (Edginton, 1989). Holistic health care givers seek an egalitarian, as opposed to a dominating or authoritarian, relationship with clients and co-workers (Goldstein et al., 1987). The alternative sphere is being seen increasingly as more attractive because modern medicine is seen to be relatively ineffective for chronic and lifestyle illnesses (Edginton, 1989).

Some synonyms for alternative health care are: "traditional", 'holistic', 'unorthodox', 'unofficial', or

'fringe'". (Grant et al., 1992, p.5). Some alternative methods are: herbalism; osteopathy; chiropractic; homeopathy; massage therapy; hypnotherapy (Grant et al., 1992); naturopathy; and hydrotherapy. As well, there are Oriental medical practices such as accupressure, acupuncture, and Oriental herbal medicine (Freund and McGuire, 1991; Maykovich, 1980; Stacey, 1988). Other alternative healing methods encompass spiritual elements, such as spiritual healing, psychic surgery (Grant et al., 1992), and Christian Science (Clarke, 1990; Maykovich, 1980; Stacey, 1988).

Another alternative health care method is indigenous healing, or folk medicine - an underlying belief system (aboriginal) that is used for health or healing (Freund and McGuire, 1991; Maykovich, 1980). This type of alternative medicine tends to be practised by people who are separated from mainstream society for reasons, such as geographical distance, cultural differences, or poverty (Maykovich, 1980). First Nations people hold holistic health ideas believing that health is within the individual, social and kinship group, the environment, and past and future generations, as well as the present generation (Brunton, 1990).

One critique of alternative health care methods is in the broadness of its definition and the practicality of it. Holistic health is loosely defined by both practioners and

commentators. In defining it:

"frequently cited attributes include a definition of health as a positive state, not merely as the absence of disease; an acceptance of both a psychological and a spiritual component in the etiology and treatment of disease; a concern for the individual's own responsibility for illness and health through behavioral, attitudinal, and spiritual change; an emphasis on health education, self-help, and self healing; a relationship between the physician and other health-care providers that is relatively open, equal and reciprocal; concern with how the individual's health reflects the familial, social, and cultural environment; an openness toward using natural "low-technology", and non-Western techniques whenever possible; an emphasis on physical and/or emotional contact between practitioner and client; and an acceptance of the notion that successful healing transforms the practitioner as well as the patient." (Goldstein et al., 1987 p. 103-104).

This definition is reminiscent of the WHO definition of health which states much about health but can be difficult to apply.

Another critique involves certain assumptions about the human body held by alternative health care givers. Firstly, our health is determined by a balanced state of well-being (Edginton, 1989) but this balanced state of well-being is not defined. The second assumption is that our bodies have the ability to heal themselves (Edginton, 1989) but this does not account for chronic diseases from which people still suffer. The third assumption is that interactions

with people can affect our well-being (Edginton, 1989) but this can happen in a positive, as well as, a negative way.

In sum, the use of alternative health care methods is on the rise due to a dissatisfaction with the biomedical method of healing. Alternative health care methods take into account the mind, body and spirit. Many alternative methods stress healing rather than cure, where healing is seen as care of the individual throughout the illness and after the cure, and the cure is seen as the elimination of the disease (Edginton, 1989).

Gender and Health

An important issue today is the relationship between gender and health. There are many similarities and differences apparent when examining some of the issues surrounding gender and health: body maintenance; work; friends and family; rest, exercise and food; and illness. Women and men share similar ideas of health. The idea of health is closely associated with the idea of well-being. Contemporary men's and women's ideas of health have become synonymous with a particular condition or state of life itself. Men and women define health comprehensively, referring to it as a state or condition of being which is often related to capacity, performance and function (Saltonstall, 1993).

There are biological and physiological needs of the body for rest, exercise, and food. These three items are

staples in the commonsense understanding of healthiness. In order of importance in their lives, men and women differ with regard to these three items. Men rated exercise as the most important followed by sleep and food (for nutrition). Women stated that food was most important followed by exercise and rest. Women regularly linked healthiness, eating, exercise and being thin when questioned about healthiness (Saltonstall, 1993).

Body maintenance is important for both genders. For men, sports and outdoor activities are followed in importance by eating well and brushing their teeth. Women stated that exercise is important, followed by diet, and caring for their skin and hair. Men are concerned with the body as the medium of action. Women are concerned with maintaining function and capacity, and keeping their bodies in a 'presentable' condition. Women stated that the inner body is more important than the outer body, whereas men stated that the inner and outer body are equally important (Saltonstall, 1993). And women are more concerned with appearance than men (Hayes and Ross, 1987).

Men often mention a conflict between work and health activities, such as, time conflicts and the unhealthiness of work-related practices (travel, restaurants). Work demands usually take precedence over health demands for them (Saltonstall, 1993). When questioned about the importance of friends and family, women frequently allude to friends or

family in their definition of health while men rarely did so (Saltonstall, 1993).

Women tend to suffer more from frequent illness and disability, though the problems are typically not serious or life-threatening. On the other hand, men suffer from more life-threatening diseases which cause more permanent disability and earlier death. Men and women suffer the same types of problems, but the frequency of problems and the pace of death is different (Verbrugge, 1985).

There are five hypotheses on the differences in health for men and women. Firstly are the biological risks of disease, that is, there is a difference in the genes, therefore there are different risks of morbidity. Secondly, men and women have different acquired risks of illness and injury. They experience different risks which they encounter at work, leisure, and life style. The psychosocial aspects of symptoms and care, such as illness behaviour, are different. There is a greater awareness of physical symptoms among women, and earlier and more persistent care. When health reporting behaviour is examined, women are more complete and detailed in their description. Lastly, women are more attentive when it comes to health care and, therefore, benefit more (Verbrugge, 1985).

In sum, differences between men and women in regard to health are apparent, and are a subject for further research

and discussion.

Changes in Health Conditions Over the Years

Health status and conditions have changed over the years. The conditions of human health have moved through three major eras over the years. The past was an era of acute, usually infectious diseases. These problems yielded to medical and social advances in the first half of the century. The second era, the present, is characterized by chronic illnesses with particular characteristics. The health indices associated with these illnesses are, in the most important areas, either beginning to improve or are projected to improve. The future era predicts the elimination of disease and the control of chronic illnesses which will allow health to be defined in positive social, psychological and physical terms rather than in the negative medical sense of absence of disease (Fries and Crapo, 1983), a complete turnaround from the past era.

A person's definition of health and illness is influenced by time and place (Edginton, 1989; Stacey, 1988). Health is a social ideal that varies widely from culture to culture, or from one historical period to another (Freund and McGuire, 1991). In the sixteenth and seventeenth centuries, there was a plethora of healing modes. Public health was taken over by medicine near the end of the nineteenth century (Stacey, 1988).

Health used to be defined in terms of absence of

disease because infectious diseases were the predominant cause of illness and death (Fries and Crapo, 1983). In the United States, the number one killer in 1900 was tuberculosis. There were 194 deaths per 100,000. In 1930, this was reduced to 70 deaths per 100,000. In 1980, there was slightly less than 1 death per 100,000 - a decline of more than 99.5%. This decline occurred largely for social and economic, as opposed to strictly medical, reasons. Other major acute diseases showed similar declines in the century for the same reason as tuberculosis - diphtheria, typhoid fever, syphilis, measles, whooping cough, and smallpox (Fries and Crapo, 1983).

By the mid 1900s the incidence of many of these infectious diseases was reduced and health became more than simply not being ill (Epp, 1986). Deaths from infectious diseases declined dramatically, mainly because of improved water supply, sanitation, adequate food supply, birth control, and immunization (Clarke, 1990; Stacey, 1988). The epidemics of infectious diseases which killed or maimed large numbers of the population appeared to be a phenomena of the past in the third quarter of the twentieth century (Stacey, 1988).

In Canada, there have been considerable changes in morbidity and mortality patterns over the years. One noticeable trend is the aging of the population. Over the past 150 years, there has been a dramatic shift in life

expectancy rates in Canada and other developed nations (Clarke, 1990). Life expectancy from birth has increased from 47 to 73 years in this century alone (Fries and Crapo, 1983). Another trend is the relative increase in the amount of chronic versus acute illness (Clarke, 1990) such as: atherosclerosis; cancer; osteoarthritis; emphysema; cirrhosis; and violent deaths (Clarke, 1990; Edginton, 1989; Fries and Crapo, 1983). These are called diseases of civilization and affluence as they are typical of developed nations. Causes of death are related to lifestyle, the environment, and work (Clarke, 1990; Edginton, 1989). And there are self-imposed contributions to mortality - smoking, drug abuse, excessive alcohol consumption, poor diet, lack of exercise, overwork, reckless driving and unsafe sex (Clarke, 1990). The main problems to be dealt with in health care now are chronic diseases, disabilities, and mental illness (Stacey, 1988).

Another change in health over the years is the shift toward emphasis on individual responsibility for health care. We are being told that we should take responsibility for our own health by committing ourselves to a healthy lifestyle, or to wellness by the government and doctors through health promotion campaigns. But we have less control over the potential social causes of ill health. There is an assumption that individuals control their lives independently of their social context. This leads to

blaming the victims for their misfortunes, so we must look to social, as well as individual, prevention (Edginton, 1989). In the future, many of the changes in health care will be dictated by economic forces. We may be forced to adopt low technology solutions and to place greater emphasis on prevention than crisis management (Young, 1988).

Recently, new epidemics have emerged including Legionnaire's disease, AIDS (Edginton, 1989; Stacey, 1988) and the flesh-eating disease.

"Although neither so far has killed in the quantities of the old epidemics, and AIDS not with the speed, they have come as something of a shock to many people who thought the scourge of uncontrollable epidemics was a thing of the past." (Stacey, 1988, p.136).

More recent research mentions AIDS but older research does not simply because twenty years ago it was not even a concept. This example shows the changes that can take place in health conditions and concerns over the years and illustrates why it is so important to continually be conducting research on health issues.

Summary

Health is a basic and dynamic force in our lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments (Epp, 1986). Most researchers realize that health is not one-dimensional. It encompasses biological, behavioural, cultural and environmental issues. On a more individual

level, health is made up of physical, mental, emotional, spiritual, and social components.

Symbolic interaction was used as a theoretical framework because it looks at meanings, changes, and interactions, and is derived from a social interaction or social systems point of view. The abstractions do not relate to individuals alone, but to individuals in interaction. And the socio-ecological model of health emphasizes the relationships between individuals, their health and their social, economic and physical environments. This model is necessary because of the interrelatedness of health and other aspects of our societies. This research will show the relationships between health and other spheres of peoples' lives, such as personal, work, and leisure.

The next chapter will discuss the methodology, sample, and analytical methods used in this research.

CHAPTER III

METHODOLOGY

This chapter will present the methodology employed in this research and describe; the research team used for the initial stage of this research; the sampling method and the actual sample used; the interviews; the questionnaire package; and a description of the data analysis.

Introduction

My research objective was to discover the different perspectives of health held by Yukon residents and factors associated with perspectives. There were five different components of health to be considered: physical; mental; emotional; spiritual; and social. No firmer hypothesis was set as the results I was expecting were still unclear until data analysis was begun. This is in keeping with the grounded theory methodology.

Qualitative research methods are the primary methods used in this research. The principal qualitative methodology used is grounded theory which designs a general theory that reflects the respondents' substantive experiences. The emphasis here is on theory construction, rather than theory testing (Glaser and Strauss, 1967; Taylor and Bogdan, 1984).

This research began with a research question which identified the phenomenon to be studied (Glaser, 1992) - health - and issues relevant to health were allowed to

emerge. The theory was inductively derived from the study of the phenomenon it represented (Glaser, 1992; Taylor and Bogdan, 1984). Theory, concepts, hypotheses and propositions were discovered directly from the data, rather than from a priori assumptions, other research or existing theoretical formulas (Glaser, 1992; Taylor and Bogdan, 1984).

Grounded theory was developed through a constant comparative method which simultaneously coded and analyzed the data to develop concepts (Glaser, 1992; Taylor and Bogdan, 1984). I did not start with any concepts before coding the data. Patterns were established with similar incidents and were given conceptual names. Then the concepts were refined, their properties identified, and their relationships with each other explored. Concepts and categories were integrated into a coherent theory (Taylor and Bogdan, 1984) which accounted for as much variation in behaviour with as few categories and properties as possible (Glaser, 1992). The theory fits the data (Glaser and Strauss, 1967) because it has been built by making comparisons in the data (Neumann, 1991).

It was important to keep a written record of everything that was done and all the decisions that are made. Memos were essential because they contained ideas as they emerged (Glaser, 1992).

There was no need to review all the literature

beforehand in the substantive area under study because it could have impeded the analysis and formation of the categories. Once core variables and categories were established, the literature was reviewed and related to the research. A story line was developed that united and integrated the major themes in the data (Taylor and Bogdan, 1984).

There were three levels of analysis. The first order interpretation established the reasons and motives for the behaviour. The second order interpretation elicited a sense of meaning in the data, that is, the actions were put into a context to understand their significance. And the third order interpretation generalized or linked the second order interpretation to the general theory (Neumann, 1991).

The initial part of my analysis (the forming of the core categories and concepts) was completed, followed by a more comprehensive literature review. In this way, the literature did not influence the forming of my categories or my results.

The Research Team

This research was part of a larger research project being carried out by the Yukon Bureau of Statistics. A research team, of which I was an integral member, was formed to carry out the initial part of this research. There were

ten people who were part of this research team,⁸ with one person in charge. Qualitative research was a new entity to the majority of the members on the research team so there was one "seasoned veteran", with extensive experience in the field, who was able to guide the others. Two members of the team had previous experience in this type of research and were considered to be the senior interviewers.⁹ Two other members soon gained enough experience to be considered proficient interviewers. The project manager and three other researchers in the Yukon Bureau of Statistics were brought into the process to take part in the interviews when other research members were not available. Research team meetings were held on a regular basis to ensure that all team members were kept up to date with daily occurrences.¹⁰

There are many advantages in conducting a research project on a team basis. Time is always an important research consideration and it was possible to collect all the data within two months utilizing the team. As well, there was constant discussion among the members concerning different issues. This allowed our knowledge base to be the

⁸ Not all the researchers participated in this research process on a full-time basis.

⁹ I was one of the senior interviewers.

¹⁰ At times, there appeared to be repetition in the meetings. However, when this occurred, it meant that one or more of the team members were unclear about a specific point and it was important to clear up the issue before proceeding any further.

sum of the research team's knowledge. Another advantage is that, usually, a researcher only had to conduct one interview a day. If s/he participated in another interview, it was in the role of observer. This allowed the researcher to be at his/her optimum as an interviewer for all interviews.

One of the disadvantages of working on a research team arises if a member(s) differs from the rest of the team on key issues, ideology and/or interview techniques. As well, if one team member is not fulfilling his/her obligations or following the standards which have been set out, this can create tension on the team. This may, in turn, affect the interview process. Not only would problems be created, but it would also be hard to ensure consistency in the results if not all team members were following the same guidelines. On occasion, one member of our team did choose to ignore the established guidelines, which created some problems. These problems, however were overcome as they occurred. The advantages of this arrangement far outweighed the disadvantages in this particular research project.

The Sample

The sampling methods chosen to ensure good data collection were important. The key for the makeup of the sample was variety, that is, not too many people from the same walk of life. Purposeful (in search for variety) and representative (of the population) sampling techniques were

used in our research. Some of our sampling was done randomly at the beginning. After a number of interviews had been completed, the sampling was done on a quota basis.¹¹

The snowball sampling method was also used when there was a certain type of respondent required for the survey. For example, we were looking for respondents who practised alternative health care methods so we enquired of one of the alternative health care givers and were supplied, readily, with a long list of names.

Some members of the research team knew people in the communities (Dawson City, Faro, Mayo, Watson Lake) and contacted them. If they were not able to be interviewed they were asked for names of other possible respondents. The accidental sampling method was sometimes used in the communities when we did not have any contacts to furnish us with possible names. We would walk around and randomly choose respondents based on the requirements of the survey.

There was a total of 77 respondents from all walks of life - professionals, business people, health practionners, homemakers, artists, miners, and other blue collar, as well as white collar, workers. There was also a variety of age groups, from as young as 18 years of age to people in their seventies.

¹¹ For example, a matrix detailing the basic demographics of our respondents was constructed part way through the interviewing process. It showed that very few males had been interviewed. After this, only males were interviewed until the ratios were more even between the sexes.

TABLE 3
RESPONDENT CHARACTERISTICS

Category	Characteristic	N	Percentage %	Total
Sex	Male	33	43	77
	Female	44	57	
Age (Years)	Under 30	18	23	77
	30 to 60	42	55	
	Over 60	17	22	
Ethnicity	Aboriginal	17	22	77
	Non-Aboriginal	60	78	
Occupation	Employed	59	77	77
	Other ¹²	18	23	
Employment ¹³	White Collar	48	81	59
	Blue Collar	11	19	
Residence	Whitehorse	48	62	77
	Other	29	38	
Living Alone ¹⁴	No	62	81	77
	Yes	15	19	
Disability ¹⁵	Yes	5	7	77
	No	72	93	

There was almost an even mix of male and female respondents. As well, the percentage of aboriginals included was representative of the Yukon population, that is, roughly twenty-two percent. The majority of the population in Yukon

¹² This category includes students, homemakers, retirees, and unemployed people.

- ¹³ This category only includes respondents who are employed.

¹⁴ These respondents could be living with/ without a family member(s) or a significant other, sharing accommodations with a friend(s), or in an institution.

¹⁵ This category includes respondents with a chronic disease, a terminal illness and/or a mental health problem.

lives in Whitehorse (two-thirds), so thirty-eight percent of the respondents were from most of the other communities in Yukon. There were two respondents who lived in institutions¹⁶ -- an old age home, and a drug and alcohol rehabilitation centre.

The sample included respondents in different states of health. Overall, the majority of the sample appeared to be in good health. Some respondents, however, were not as mobile as others and a few had chronic health problems. One respondent had a terminal illness.

There was a total of seventy-eight possible interviews and only one was not completed. On occasion a respondent would forget about the interview. When this occurred in the communities we would randomly select another respondent. When this happened in Whitehorse, the respondent was contacted at a later time and another interview time was set up.

Respondents reacted to the interviews in a positive manner. Some respondents had already heard about the survey, before they were asked to participate, and asked to be interviewed.

¹⁶ To obtain respondents in the institutions, the director of the institute was called, the process was explained, and they were asked if they could give us the name of one of their residents.

The Interview

Pretests of the interview were conducted to iron out any preliminary problems.¹⁷ The interviews were initially conducted on other members of the research team, then on some of the other staff of Yukon Bureau of Statistics. These initial interviews allowed the research team to become familiar and comfortable with the interviews using respondents who would be forgiving when mistakes were made. It was essential that the interviewer and the observer remain value-neutral and non-judgmental throughout the interview. It was a listening process for us, not a conversation.

Before the interview began, the respondents were asked if they had any objections to the tape recording of the interview.¹⁸ Only one respondent refused to be recorded but still agreed to be interviewed. One other respondent requested that only the interviewer and the observer listen to the tape recording after the interview was over.¹⁹ The wishes of the respondent were important to us so after that

¹⁷ These results were not included in the final analysis.

¹⁸ Fifteen interviews were transcribed. These were chosen by the interviewer or the observer if it was thought that there were good quotations in it for the written reports. The cost of transcribing all the interviews was prohibitive.

¹⁹ The respondent did not want there to be a chance that some of the comments made would be taken out of context. As well, the respondent stated that his/her thoughts and emotions were captured on the tape as was his/her spirit. And s/he did not want these to be mistaken.

particular interview was concluded I transcribed the interview and the tape was destroyed.

At the end of the interview, once the tape recorder was turned off, the respondent was asked what they thought of the whole process. This acted as a debriefing period for the respondent and was an important period because some questions were of a highly personal nature and we did not want the respondent to walk away feeling like a "guinea pig". This also helped to relax the respondent. In some interviews this final part lasted only a few minutes, in others it lasted longer. It all depended on the respondent and their frame of mind after the actual interview was over.

The interviews were conducted in person and were a combination of survey research and participant observation. An interviewer and observer were present at each interview and the differing roles of the two researchers was explained to respondents at the beginning of the process.

The role of the interviewer²⁰ was to engage in active listening, that is, s/he listened with great care, and to be responsible for directing the interview. If the direction of the interview needed to be changed, if prompts were needed or if certain questions were unnecessary, it was the role of the interviewer to effect these changes.

The interviewer/ respondent relationship was important. The physical presentation of the interviewer influenced the

²⁰ I was the interviewer for twenty-two interviews.

respondent's thoughts about the interview. So, the interviewer had to come across as non-intimidating to the respondent.

The observer²¹ had a passive role throughout most of the interview, to record the interview and take field notes. These notes included general observations of the interview process and specific notes of the interview. They were used as backup if the tape recording was faulty. As well, these notes served as a quick check as to the content of the interview so the research team would not have to actually go back to the tape recording and listen to it. In some interviews, the interviewer would return to the tape to obtain an accurate picture of the interview.

The observer was to be as unobtrusive as possible. Where possible, s/he would sit outside the vision range of the respondent. This was to emphasize the non-interactive role of the observer. The observer's position freed up the interviewer to concentrate on the questions and responses.²²

After the interviewer was finished asking questions, the observer would be brought back into the process by the interviewer. S/he was asked if there were any areas or

²¹ I was the observer for nineteen interviews.

²² We had much discussion before the interviews began concerning the need for an observer in the interviews. In the end, it was decided that the quality of the interviews was more important than the quantity.

issues the respondent had mentioned which needed to be clarified, or if there were any issues about which the interviewer had forgotten to inquire.²³

Initially, contact was made with respondents by one member of the research team²⁴ to ensure consistency in the initial contacts. If the interview time was set up more than a few days in advance, the potential respondent was usually contacted the day before, or the day of, the interview to confirm the time. This ensured that the respondent was able to be there and eliminated a waste of time on our part if a respondent forgot about the interview. If a potential respondent was known to one of the team members, this member would make the initial contact, explain the process and set up an interview time.

The actual time of the interview was made amenable to the respondent. The earliest interview was conducted at 8:00 am, the latest interview started at 7:00 pm. The actual length of the interviews ranged from as short as twenty minutes to as long as three hours. The average

²³ This additional question came about quite naturally in one of the interviews when the observer realized that the interviewer had missed a question. The flow was so smooth in the transition between the interviewer and the observer asking questions, that this question was built into the questionnaire.

²⁴ We changed the word from "interview" to "meeting" when contacting the respondents. This change occurred because of a comment from one respondent who felt it was not really like an interview, more like a conversation because of the open-ended questions.

length was forty-five minutes to one hour.

The interview schedule was developed based on the physical proximity of the respondents. When the communities were surveyed, the interviews were scheduled to accommodate our travelling time.

It was important that the data sites were appropriate (Lofland and Lofland, 1984) and the interview context was in a place where the respondent was comfortable and there were few interruptions (Neumann, 1991). When possible, interviews in Whitehorse were conducted in the Director's office at Yukon Bureau of Statistics. Confidentiality was very important to our process so we ensured that the place where the interview was held was private. For those unable to come to our offices, we went to their offices, after explaining how important it was to have a private place to talk.

In the communities²⁵, some of the interviews were held in respondents' homes. This appeared to be easier for them for a number of reasons. When we were travelling to the communities it was difficult to give an estimated time of arrival for the research team. Our arrival time was dependent on road conditions and it was not always possible to know these in advance. As well, the respondent was in a

²⁵ Descriptions, or walk-about, were conducted of the communities by the research team. These were written up as field notes to remind us of the description and atmosphere of the communities. These have not been included because the population in the Yukon is too small for anonymity.

comfortable setting and this would help to ease some of the tension that would be created by partaking in the interview.

The place of business of the respondent was also used as an interview site. Various other places were used as circumstances dictated - our hotel room, a picnic table in a quiet park, the front steps of an Indian Band Office, the home of one of the interviewers and a hotel bar.

Each interview had a file number.²⁶ Any mention of the name of the respondent was deleted from the file. To ensure confidentiality of the respondents, a master list of the interviews, the names of the respondents and the interviewing team were kept by one of the members of the research team, myself. When various interviews were referred to, the file numbers were used.

Most procedures in the interview process were flexible except: 1) there were two researchers present at each interview; and 2) confidentiality of the information was of utmost importance. It was important to maintain the anonymity of the respondent.²⁷

²⁶ Only one interview was not completed. The respondent did not appear to understand the seriousness of the questions and constantly referred to drinking in one of the local taverns. The interview was terminated, on a friendly note, after a few minutes.

²⁷ The confidentiality of the respondent was especially important because many of the communities were small in size, from 30 to 1500 people.

The Questionnaire Package

The questionnaire package²⁸ contained a number of different forms.²⁹ One form was the interviewer's guide. This was a pre-interview check list which contained the purpose of the interview, points to remember in the interview, general hints about asking questions and probes. This form was to be reviewed by the interviewer before each interview. The observer also had a guide to be reviewed before each interview.³⁰ This guide contained pointers about: tape operations; interview rapport; observer form; and interview debriefing.

The questionnaire was included in the package. For the initial draft, a qualitative questionnaire previously developed by Yukon Bureau of Statistics was utilized. The questions were tailored to suit our purposes. This process, an emergent methodology, was subject to revision at any time. The main questions were as follows. "What does being well/ well-being mean to you? What do you need to be well? What do you do to feel good/ stay healthy? Could you describe your health to me?"

²⁸ See Appendix A for copies of all the forms.

²⁹ I designed the layout of the forms and wrote the purpose of the interview on the bottom of every page of the questionnaire to remind us constantly, so we did not stray to another topic.

³⁰ Two different colours of paper were used for the interviewer and the observer forms to easily distinguish between them.

Our actual questionnaire started with an introduction to the whole research process. Most respondents were already aware of the purpose and objectives but this was repeated to reinforce them and to clarify any questions the respondent might have before the actual interview began. The introduction was important because it set the tone for the entire interview. A carefully thought out explanation or account of the research was developed which was brief, straightforward and appropriate (Lofland and Lofland, 1984).

The actual questions were tailored to specific people and situations. The interviewer showed interest in the responses and encouraged elaboration. Instead of being similar to a question and answer period, it corresponded to a friendly, conversational exchange (Neumann, 1991). Respondents were encouraged to tell the story in their own terms.

The order in which the questions were asked was flexible, depending on the respondents (Lofland and Lofland, 1984). If the order did not seem to be working, the interviewer would change around the order to try to suit the respondent.³¹ Not all the questions in the questionnaire were asked of all the respondents. The questions were reviewed on a regular basis to determine if any problems existed. This was also to ensure that all areas of health

³¹ This was done for respondents with physical diseases or mental handicaps.

were being covered. The respondents were not asked any direct demographic questions but we assessed their basic characteristics indirectly from some of their answers and from our observations. At the end of the interview, the respondents were asked if they had anything to add to their previous answers. This gave them a chance for their own input if there was some area which they thought had been missed.

The observer had a form which asked for basic details of the location and time of the interview, and basic characteristics of the respondents. There were two copies of the first order analysis form in the questionnaire package. Both the interviewer and the observer had to fill out this form independently. It summarized the main themes, impressions and comments of the interview. The final form in the package was a sign-off sheet. This was to ensure that all pieces of paperwork were completed by the interviewer and the observer. Each interview had a separate questionnaire package.³²

The post-interview reports, as well as any field notes, were written up as soon as possible after the interview (Lofland and Lofland, 1984; Schatzman and Strauss, 1973).

³² I was responsible for ensuring that these packages were complete and the changes which had been discussed at the meetings were implemented. This was to ensure consistency in making all changes and in keeping the packages together and complete. It was also my responsibility to ensure that all forms were filled out by the various team members after the interview was completed.

This was important because two interviews were often scheduled in one day and if the notes were not written up as soon as possible, there would be a chance that the results from the two different interviews could be mixed up. Additions, if necessary, were added to the notes later on.

After the interview was completed the final package for each interview contained the following pieces of documentation: field notes from the observer; two first order analysis forms - one from the observer and one from the interviewer; a summary form of the location of the interview and a summary form of respondent characteristics; and a second order analysis. There were other documentations which were optional in the files: field notes by the interviewer; and a graphic diagram of the respondent and their concepts, correlates and priorities of health.

Access to the Data

I was hired as a researcher for this project in the summer of 1991. The director of the Yukon Bureau of Statistics, Dr. Glenn Grant, approved my use of the data, pending approval by the Yukon Deputy of Health and Social Services, Gaye Hanson. At a meeting attended by the above two people and myself, in August 1991, I presented a research proposal. It included a description of my research, the benefits to the Department of Health and Social Services, the implications of the research, my use of the data and guarantees which I, as the researcher, required.

This proposal was accepted under certain conditions. After the initial conditions were met, the data was released to me in October 1991. I was given the raw data and conducted primary research on the data.

Data Analysis

In our research project, the first order analysis form contained the initial analysis of the interview. No in-depth analysis was done at this stage. The two different first order analyses were done separately by the observer and the interviewer. Then, the two researchers would meet and compare their analyses and the interviewer would compose a second order analysis, which would be a combination of the two first order analyses. These second order analyses were very important because they allowed the researchers to determine if they understood the interviews. If there were any discrepancies, these were discussed and resolved at this stage.

After the interviews were completed, another level of analysis was conducted and a Core Summary Document was made for each interview. This document was in each file and it compiled all the separate pieces of paper in the file. The third level of analysis was conducted here, that is, the answers of the respondents were placed in the different categories of the components of health.

Qualitative data is analyzed inductively. The data was interpreted by finding out how the people being studied saw

the world, how they defined situations and what the situations meant to them. Analysis began early in the project while the data were being collected. Data were organized into categories on the basis of themes, concepts or familiar features. Then new concepts were developed and new conceptual definitions were made (Neumann, 1991).

From this point on in the analysis, the research team was not used, this was now my research. The first step in coding was the development and coding of categories. All the data had to be coded which involved making comparisons and asking questions. When the category was being named, a label was chosen which was graphic enough to remind the researcher quickly of the contents. When codes were being labelled, "in vivo" labels were the best, that is words and phrases used by the respondents themselves. The data was then sorted into coding categories and analysis was refined. This is where any propositions that did not fit were discarded. As well, the negative cases were analyzed to deepen understanding of the research.

The main concepts emerged as the interviews were coded. There were a number of reasons and criteria for including and excluding certain categories: only a small number of respondents mentioned it; it was based on my sense of importance of that subcategory; and the relevance of that subcategory to the current research issue.

The cases were coded according to categories³³ which were developed based on the central focus, or priorities, of the individuals lives as derived from the content of the interviews. That is, what is the central focus in their life and how does this focus affect their perspective on health. The decision to base the categories on the central foci was arrived at after the initial coding of the interviews. The one outstanding feature of all the interviews was that the central focus in an individuals' life affected the majority of the decisions concerning that person's life. Therefore, this central focus (foci) would affect the individual's perspective of health.

Some respondents only had one main focus in their lives, some had two and others had more than two foci in their lives. For example, some respondents regarded their job as the most important aspect of their lives and the majority of their life decisions were based on the effect that particular decision would have on their job. Other respondents had three foci which were influential in their decisions - work, family and selves. And, before any major decisions were made, the effect these decisions would have on the three major foci in their life were considered.

The original method of categorizing the respondents was

³³ The categories developed are subjective and have been made according to my interpretation of the interviews. There is consistency in the categorization of the respondents because I was the only one classifying them.

to draw a matrix for each respondent using concentric circles. The central focus(i) in their lives was placed in the middle circle. In the next circle were the items which were of secondary importance in the individual's life, and so on with the other circles. After all the matrices were drawn, a list was made of the different categories mentioned. There were three categories into which the respondents were classified. For the initial analysis of the respondents, there were three major groups and ten minor groups of respondents. These minor groups held about one-third of the respondents so the categories were re-evaluated. The criteria for the categories were based solely on the respondents' answers. There were no previously established categories into which the respondents were placed.

When the groups were first composed, there were many respondents who did not fit into any of the three groups. So the restrictions for classifying the respondents were made a bit broader. Respondents in the multi-dimensional group initially contained only respondents who gave equal importance to their work, their families and themselves. In re-examining the groups which were left over, I realized that many of the responses of respondents in the work and family group were similar to responses from those in the work, family and self group. The only element missing in the former group was the self. However, most other

responses were similar so these respondents were put with those in the multi-dimensional group. This regrouping merely emphasizes that some respondents (almost one-third in this survey) were concerned about more than one area in their life and these priorities influenced their health and the answers given when queried about their health.

When respondents in the family-centred group were initialled coded, there were a number of respondents (eleven) not in this group. However, on re-examining these respondents, it was discovered that their answers were similar to those of respondents in the family-centred group. The respondents who were reclassified were in three groups originally: family and self; spirituality and family; and spirituality, family and self. The common thread in the three smaller groups that were reclassified is in the family element. These respondents, like those in the family-centred group, concerned themselves with people in their immediate circle. This differs from respondents who were in the work and family group. They were not classified into the family-centred group because their circle of influence extended beyond the home to the work arena.

The self-centred group had thirteen respondents added to the original group. These respondents were originally classified into the following groups: work and self; God and self; work-centred; work, spirituality and self; God-centred; and Alcoholics Anonymous tenets centred. Even

though these respondents have more than one priority in their lives, or even though the priority in their lives is not directly themselves, indirectly, the priority in their lives is themselves. Respondents who have work as a priority in their lives are self-centred, because many of them are fulfilling themselves through their jobs.³⁴ Some of the respondents were in mining, business, or real estate. Other respondents held political office. Ostensibly, these respondents are in their jobs to help people. However, these particular respondents talked about the importance of their career in their life, not the importance of people. People are important to them, but in a secondary way and this analysis is concerned with the primary foci in peoples' lives. Respondents who have God, or a higher power (Alcoholics Anonymous), in their life are concerned with their relationship with God. Spirituality is linked closely with the self because it affects the self and what the self does and is. So these respondents all have in common themselves, even though this is manifested in different ways - through their work, or their spirituality.

Once the categories were specified, cases were analyzed according to basic demographic characteristics to examine

³⁴ This researcher realizes that some people are in certain careers because they want to help people and that is their prime concern, eg., doctor, social worker. However, in this survey, none of the respondents in this particular group were in this position.

similarities and differences among them.³⁵ Some of these characteristics were ascertained by simply looking at the respondent and not by asking them directly, such as age and general state of health. Various hints were given during the interviews which helped us formulate the answers to other basic questions, for example, marital status, occupation, and with whom the respondent resided. Occasionally it was discovered, at a later date, that one of the basic demographics had been assessed incorrectly. When this occurred, an amendment was made to the original answer sheets. For example, one respondent did not mention the existence of a significant other person in his/her life during the interview, however, in a discussion at a later date, it was mentioned that s/he was living with a partner. This suggested that this partner may not have been a critical influence in his/her life or in many of the decisions which s/he made.

It should be remembered that the responses given were moment-specific. The respondents may not, and probably would not, give the same answers at different points in their lives. For example, one respondent was looking for employment when s/he was interviewed. His/her main concern was financial matters because s/he was unemployed and living alone. But once s/he obtained employment, this concern

³⁵ No in-depth analysis was conducted using the demographics because the numbers were too small but preliminary results suggest areas of future inquiry.

would disappear.

Most of the analysis was completed before reviewing the literature, in the method of grounded theory. A number of tables based on the respondents' answers were made. One table illustrated the different concepts each respondent discussed. Next, the reasons for engaging in the different concepts was examined. Some respondents mentioned the consequences to them if they failed to engage in a certain activity. As well, the importance of the different concepts was tabled.

The Core Summary Documents were reviewed to ensure that all the responses were in the correct health components (physical, mental, emotional, spiritual, social). After the documents were re-organized, all the responses were written on separate lines, cut up, separated into the five components of health and then the pieces of paper with similar answers were grouped together. This was quite time consuming, but it helped to clearly see the connections between many categories.

The next chapter of the thesis will detail the results of the research.

CHAPTER IV

RESULTS

The initial analysis indicated three categories of respondents. Thus the results are divided into three sections: family and health; self and health; and multi-dimensional views and health. Individuals in the family and health category stated that the most important aspect of their life was their family. If their family was healthy and happy, then the respondents were happy. The family could include the spouse, the children and/or the significant other.

Respondents in the self and health category stated that there was nothing more important in their lives than themselves:

"I am a product of myself";
the most important thing is "taking care
of myself";
"only self will make you happy"; and
"I am the most important thing in my
whole life".

Respondents in the multi-dimensional category had a balance in their lives between the different areas of their life. If their family was healthy, if work was going well and they were healthy, they were happy. If anything was wrong in any of these three areas, the respondents would not be happy. All the cases were checked repeatedly to satisfy the analyst about category assignment.

The results are based upon an assumption of a direct

relationship between a person's life priorities and his/her perspectives upon health. Thus, knowledge of the priorities and perspectives can inform a multi-dimensional, culturally sensitive, health policy.

Each of the next three sections starts with a description of the group of respondents, followed by the definitions of health held for the different components of health and the different synonyms given. Not much comparison of results within the group are made because the numbers are too small for meaningful analysis. Instead, the group is examined as a whole.³⁶ After the results have been discussed, there is a comparison between the groups highlighting relevant similarities and differences.

Multi-Dimensional Health View

The multi-dimensional (or family/work/self) view of health has almost one third of the respondents (twenty-four of seventy-seven): nine of the thirty male non-aboriginals; eleven of the thirty female non-aboriginals; two of the three male aboriginals; and two of the fourteen female aboriginals. It is interesting to note that one third of all female respondents are in this category. For these respondents, work, family, and themselves have equal importance in their lives. If one of these three elements

³⁶ I realize there are probably many differences between the genders, and the aboriginal and non-aboriginal respondents, but these analyses will have to be explored with a larger sample.

is not functioning well, this affects the respondent in the other two important areas of their lives (see Table 4).

TABLE 4
MULTI-DIMENSIONAL HEALTH VIEW
RESPONDENT CHARACTERISTICS

Category	Characteristics	N	Total
Sex	Male	11	24
	Female	13	
Age (Years)	Under 30	3	24
	30 - 60	16	
	Over 60	5	
Ethnicity	Aboriginal	4	24
	Non-Aboriginal	20	
Occupation	Employed	20	24
	Other	4	
Employment	White Collar	17	20
	Blue Collar	3	
Residence	Whitehorse	14	24
	Other	10	
Living Alone	No	22	24
	Yes	2	

Two thirds of the respondents in this category are in the middle age group, with only three of twenty-four in the younger age group, and five of twenty-four in the older age group. The majority of the respondents, except for four, are employed outside the home and only three of the employed are in a blue collar occupation. The remainder are in white collar occupations. Fourteen of the respondents in this category live in Whitehorse and ten live in a rural area. The majority of the respondents (twenty-two of twenty-four) live with at least one other person. Only two (of twenty-

four) live on their own.

Components of Health

When different components of health were examined, it was found that all the respondents discussed the physical, mental and social components, the majority believed in the spiritual, and slightly less in the emotional component. Few of the respondents ranked all five of the health components as being equal in importance. The majority of the respondents gave prominence to the physical component, followed by the mental one. The most common reason given to partake in physical activity was overwhelmingly because it was an essential and necessary part of life. This reason was followed by those people who engaged in physical activity because they enjoyed it. There were others who enjoyed being alone and were able to do this with some form of physical exercise. Just under half of the respondents took part in physical activities for the social aspect, that is, to interact with other people, whether it be competitively on a one-to-one basis or as a member of a team.

There was diversity in the comments given surrounding the physical component of health. The majority, however, stated that their "diet was important", that is, "eating the right food". A number of individuals also stated that the

physical environment and exercise were important.³⁷ There were other reasons given for the importance of the physical aspect of health, such as: "it affects the rest of your being; knowing your body; it gives a person energy; and to relieve stress". It was also important for some respondents to be able to use alternative methods of health care, such as, massage therapy, accupressure and herbology.

"I really feel that it is important for me to get some kind of physical exercise regularly and I find if I don't do that then I don't feel as well as when I exercise regularly. And I also think that diet is very important, making sure that I, that I eat from all the food groups and keep a balanced diet." (M1)

"Nutrition is very important, proper nutrition is important, that proper weight control is important, ... balancing exercise, because I'm not an exercise freak..." (M2)

"I'm feeling healthy when I have the energy to do things that I want to do. ...I, I'd have to say that when I really feel healthy, I am physically active. I can feel pretty unhealthy if I go for a week without doing any exercise if that's what my lifestyle gives me for that week. ... If I'm not eating properly I notice that right away, I don't feel as well if I'm not eating a balanced diet or skipping my meals or not taking care of my nutritional health." (M3)

"I pay attention to my diet, to what I'm eating and I try to eat as healthy foods as I possibly can or what I believe are healthy for me, ... Exercise definitely, I have to incorporate that into my daily

³⁷ The type and duration of exercise was not always defined.

activity." (M4)

"Basically stay active, being active and exercise in a way, although it is not really planned exercise ... but I think that for us it is being active and being involved in things, and the physical activity as well is a real plus as far as our feeling good." (M5)

There were a number of reasons given for the importance of the mental health component. The categories which contained more respondents were: "being positive; achieving goals; and the necessity of a challenge in life". Other reasons were given, such as: "education and learning; independence; financial stability; feeling good about yourself; being busy; and being in control".

"... if I've completed a task or a project that I've been working on for some time that makes me feel good that I've accomplished something." (M1)

"I feel healthy when I get through a day and feel like I have accomplished the things that I want to do, ... I've coped with the barriers that have come up during the day." (M3)

"I think you set goals, short term and long term goals for yourself and your family ... family, business and that does affect you, even gets right down to affecting you physically, if you're under stress or you're worried or you're upset, or you're whatever, it can upset you physically." (M5)

The emotional aspect of health was often linked, if not made synonymous with the mental aspect of health. There were few reasons given here by respondents for the importance of emotional health. The main reason was "to be

happy". There were other reasons given such as:
 "contentment; needing a positive work environment; and
 loving yourself".

"I guess I'm feeling healthy when I'm
 happy, when I'm content with the way
 things are going." (M3)

"I know when I'm feeling healthy because
 I'm usually feeling happy." (M4)

"There are all kinds of downs, but we
 just carry on and there is a happy one
 coming along right behind it generally
 ... it doesn't help to dig a hole and
 bury yourself, but some days the best
 thing is a good cry and then carry on,
 so there is ups and downs to it, but
 there is no getting away from it and
 you might as well make it positive ...
 anyway, we all like to be happy." (M5)

Few respondents gave reasons for believing in
 spirituality. One reason, though, was that it was an
 essential part of their lives. There were some people who
 believed in aboriginal spirituality. Other reasons given
 for the importance of spiritual health were: "being
 spiritually aware; defining moral beliefs; being nice to
 people; being tolerant of other's beliefs; and having daily
 prayer or a daily ritual". Some respondents stated that
 spirituality was not important for them because it was in
 the background and it was nothing formal.

"I honestly believe that there is some
 sort of being but an inner being that we
 all need, an inner faith that we all
 need. I firmly believe that each person
 needs a specific faith in something and
 if they use the word God or Buddha or a
 religious being that's fair enough."
 (M2)

"I don't have a specific religion but I think that I have sort of moral beliefs and thoughts ... I think that you should know your spirituality in terms of whatever is, whether it is religion or belief in a higher being or just your moral concepts of what's right and what's wrong." (M3)

"to me religion is, are the religions of the earth ... they are a more structured approach, whereas spirituality you don't necessarily be anywhere at a particular time of day you want, it's something between you and your creator, and I'm not saying that religious people are not spiritual people. Ah, so for me it's a, my own personal connection with the creator, with the divine I like." (M4)

"I think that as long as you mean it in your day-to-day life, it doesn't matter how many times you run through a church door or whatever it may be ... but I think first and foremost it is practising in your everyday, day-to-day life." (M5)

These respondents tended to emphasize the social aspect of health. It gave them support, and most of them enjoyed it. The majority of the respondents stated that their family was "very important". A smaller number of people said that good friends were important. Only a few stated that the community was important. Other reasons given for the importance of the social health component were: "communication; sharing knowledge; support groups; and making contacts". A minority of the respondents engaged in the social aspect of health for the purpose of giving or receiving information or knowledge.

"spending time with my children makes me happy ... doing things with my friends

makes me happy ... my friends are really supportive." (M1)

"I think I'm a people person and I don't like to be locked away, on the other hand I realize that there is always a point in time that I needed some time to myself to sort of just lay back ..."
(M3)

"I enjoy life when I'm feeling healthy, I enjoy being around people. ... Well, friends are important sure, because that's an aspect in enjoying life and sharing who you are and learning, learning about who you are too and that helps us emotionally mature and grow."
(M4)

"... my family, my husband and kids, knowing that they are okay ... and friends are very important, you do an awful lot of visiting with friends and stuff around the community ... the times that we have with each other, etc., you know, that is the one thing for us."
(M5)

Synonyms of Health

When asked for synonyms of health, the main ones given by this group were: balance ("completeness and balance", "mind, body and soul", "state of well-being involving a psychological, spiritual, emotional, physical balance"); energy ("when the body has energy and vitality"); happiness ("happiness equals wellness", be happy, that's it, be happy"); feeling good ("... to feel good about myself and who I am", "feeling good"); well-being ("a state of well-being"); and ability ("the ability to do things, to think well and with clarity", "function at the best of my abilities with no restraints - physically or mentally", the

ability to do what I want everyday and to complete it",
 "being able to do what I want physically and mentally").

"My relationship with my spouse and with my children is, both of those things is important to me. Being able to self actualize through my career and profession is very important to me, feeling as though I've attained goals that I've set for myself. Being acknowledged for the accomplishments that I've achieved has been important to me in the past once I've set a goal for myself and been able to achieve that particular end has been important to me. It's a combination of things that are really important to me. But that gets back to my sense of what well-being is."
 (M1)

(What are the most important things in your life?)

"Enjoying the family, ... those relationships. A job well done, I enjoy work....the personal satisfaction from working, those things make me very happy." (M2)

(How do you know when you're feeling healthy?)

"I guess when I don't feel like I've been run over by a truck. I guess that when I'm feeling fine, I've got energy and the drive and you know, the ambition to, you know, get up and go do things. No aches and pains any place." (M5)

The respondents of this group look at health as being positive (happiness, feeling good, well-being), active (energy and ability), and multi-dimensional (balance). Health is an integral part of life for this group, or as one respondent stated "life is health".

"... it's a feeling as though I personally am able to manage my affairs and manage myself physically to get around. There is also a sense of well

being that comes with financial security that is something that I think of when I think of well being, an independence I guess, an ability to function myself and an ability to care for my family." (M1)

"I really think of well-being as more than physical well-being or a physical thing, I think there are many components of well-being." ... (Health) "is an overall sense of well-being ... a sense of personal well-being, so that you have a balance in your life of work and pleasure and a safe home environment, of good relationships ... Health ... it's your home, it's your relationships, it's your faith, your family and community, it's a whole circle of things ... and if all are in balance then you are in a state of well-being." (M2)

"What health means to me ... I would say total well-being but that's sort of, I think health is the ability to do what I want to do in a day and complete it and I think that its sort of much of what I said, it's my ability to function to the best of my ability without any restraints, whether those are physical, mental, social." (M3)

"Well-being is to me when I am feeling balanced physically, mentally, emotionally and spiritually. And it's when I'm feeling that particular state of well-being my body is free of pain, disease, my mind is clear and feeling peaceful, I'm in tune with myself. I'm feeling centred and good. Feeling positive. ... To maintain my well-being, ... it's just to continue eating well, having rest, proper rest and exercise, good friends. ... What health means to me?... it's more or less, it's a state wherein the body has the energy and the vitality to do the things that you want to do in your life..." (M4)

(Health is) "being emotionally content and physically well." (M5)

In sum, respondents in the multi-dimensional health

group regard the physical component as necessary, with nutrition and balance being important. Regarding the mental component, they prefer a positive attitude, challenge and achievement, having control of their lives and their independence. Happiness is also important. Spirituality does not play a primary role in their lives. However, the social component, consisting of family and support, is important.

Family-Centred Health View

The family and health (or family-centred) view contains just over one-third of the respondents (twenty-seven of seventy-seven): three of the thirty male non-aboriginals; fifteen of the thirty female non-aboriginals; and nine of the fourteen female aboriginals. It is noteworthy that half of the female non-aboriginals and over half of the female aboriginals are in this group, and there are only three males in this group. For these respondents, everything revolves around their family and that is the most important aspect of their life. The family must be well for the respondents to be well.

The age group of these respondents is divided into the middle and older age groups, with seven in the younger age group. Of those employed outside the home, only two respondents are in a blue collar job, with the rest in white collar jobs. Over half of the respondents (sixteen of twenty-seven) live in Whitehorse and the rest in rural

areas. And the majority (twenty-two of twenty-seven) live with at least one other person (see Table 5).

TABLE 5
FAMILY-CENTRED HEALTH VIEW
RESPONDENT CHARACTERISTICS

Category	Characteristic	N	Total
Sex	Male	3	27
	Female	24	
Age	Under 30	7	27
	30 - 60	12	
	Over 60	8	
Ethnicity	Aboriginal	9	27
	Non-Aboriginal	18	
Occupation	Employed	18	27
	Other	9	
Employment	White Collar	16	18
	Blue Collar	2	
Residence	Whitehorse	16	27
	Other	11	
Living Alone	No	22	27
	Yes	5	

Components of Health

All the respondents stated that the physical component of health was important for them. When the reason for partaking in physical activities was probed, the majority reason was that it was an essential part of the respondents' lives. Other reasons given for doing physical activities were: "to be alone; for enjoyment; and for the social aspect". The main comment given about the physical component was the importance of nutrition. Other comments

were: "the importance of the physical environment; exercise; sleep; and keeping busy or active".

"Well, no aches or pains, no headaches, no colds ... I like physical, not exercises, I hate doing exercises. But, like the physical activity of swimming or walking, and ya, I think I feel healthy after a couple of weeks where I've been really faithful to my routine, either one of those. ... So I usually do as much walking as I can and generally keeping active. ... Other than when I don't get proper rest, proper sleep, that certainly affects my health and certainly the way I feel each day." (F2)

Almost all the respondents stated that the mental health component was important for their overall health. "Being positive, and the importance of alone time" were mentioned as reasons for the importance of mental health. Other reasons mentioned were: "peace of mind; independence; the need for respect; having control; and no financial worries".

"I think you need to have a positive attitude, someone says that, a positive attitude, ..." (F2)

"You need time and quiet and thinking."
(F3)

Less than half of the respondents stated that the emotional component of health was important. The main reason mentioned for the importance of emotional health was "the need to be happy".

(Is there any other kinds of things that make you happy?)

"Well, I'm glad when we get what we're after trying to get. I feel good about it, I know where to put it and how to

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PM-1 3 1/2" x 4" PHOTOGRAPHIC MICROCOPY TARGET
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keep it and everything like that and then I know I won't go hungry ... I'm happy where I am, I'm satisfied, got enough to eat and everything like." (F1)

"when there is no turmoil and everything is sort of no frictions within the family and things are going smoothly. I might say listening to music makes me feel happy, I suppose again the time that I feel more content which I suppose is happiness, as well, I am out walking." (F2)

The majority of respondents stated that some aspect of spiritual health was a part of their overall health. When asked the reason, those who replied all stated that it was "an essential part of their lives". A number of the respondents stated that "spirituality is not the same as religion". Other respondents stated: "it helped them to cope; their belief in God; and the importance of being a good person".

"I think so, ya, I think that there is a lot of comfort or what is the correct word, ya, I think I look to the church itself for sort of support ..." (F2)

"one of the things I do to get myself in balance is pray. Prayer is very important in my own life ... and channelling that energy, spiritual energy into myself, to be able to understand everything around me ... I realized that this is what I needed, that I needed the spiritual and physical love that includes everybody in my family. And I feel that I have peace anywhere in the world and the greatest element, I feel that helps is if we maintain ... the Bahai. " (F3)

"It is basically based on fundamental respect for what you live with and what is provided for you." (F4)

All the respondents stated that the social aspect was integral to their health. The majority needed social support, some stated that social input was essential to them and over half stated that they enjoyed being sociable. The majority of respondents in this category stated the importance of family to them. Other respondents stated the importance of community and extended family. Another reason given for the importance of the social aspect of health was the importance of friends. Few of the respondents partook of the social aspect of health for the purpose of gaining information or knowledge.

"Learning begins at home, when to go to bed, when to get up, when to do different things. ... Well sure, we have to trust one another in order to make a go of it, we have to be," ... (Does that [grandchildren] make you feel happy?)
 "It does, you know when they come in like that and ask me, it's simple and everything like that ... I'm still wanted and I'm still needed and these I guess are the things that really keeps maybe a person wanting to live." (F1)

(What is the most important thing in your life?)

"My family."

(Your kids?)

"And grandkids." (F2)

Synonyms of Health

When a synonym for health was queried for this group the most common one given was family. Happiness was also mentioned ("If you're healthy, you're happy"), as was balance and being able to do what they wanted to do when they wanted to do it.

"Well, I'm thankful that I am well and I can say I'm well because I look at a younger person and I've told them many times that I would like to see them grow as old as I am" (F1)

"Well-being is when, when you're so happy and everything is good in your little world and what you're doing... Well-being is more a physical thing I think, it's that you don't have too many problems that day and things are going well. ... Just off the top of my head, it just means feeling good and being able to be mobile and do the things you want." (F2)

"I feel that health begins with yourself and then it moves out into your family, how you teach your children to be positive." (F3)

In sum, respondents in the family-centred group consider the physical component to be essential and nutrition is important. The mental aspect is very important for them - being positive, having control over their lives and independence. Spirituality does not play a primary role for them. And in the social component, family and support from family and friends are of utmost importance.

"Health would mean to live in peace with each other and not to be easily influenced by other people but basically to take care of each other, your relatives, your land, first of all your land, your relatives, each other, community and then your nation." (F4)

Self-Centred Health View

The self and health (or self-centred) view contains twenty-six of the seventy-seven respondents: eighteen of the thirty male non-aboriginals; five of the thirty female non-

aboriginals; one of the three male aboriginals; and two of the fourteen female aboriginals. It is interesting to note that there are three times as many males in this category as females. For these respondents, they are the centre of their own lives. They, themselves, are more important than work, family or anything else in their lives (see Table 6).

TABLE 6
SELF-CENTRED HEALTH VIEW
RESPONDENT CHARACTERISTICS

Category	Characteristic	N	Total
Sex	Male	19	26
	Female	7	
Age (Years)	Under 30	9	26
	30 - 60	13	
	Over 60	4	
Ethnicity	Aboriginal	4	26
	Non-Aboriginal	22	
Occupation	Employed	20	26
	Other	6	
Employment	White Collar	14	20
	Blue Collar	6	
Residence	Whitehorse	18	26
	Other	8	
Living Alone	No	18	26
	Yes	8	

Half of the respondents are in the middle age category. Of those respondents who are employed outside the home, just over two thirds were in white collar occupations and the rest in blue collar occupations. Eighteen of the twenty-six respondents live in Whitehorse, with just under a third living in a rural area. And two thirds of the respondents

live with at least one other person.

Components of Health

All respondents stated that the physical component of health was important to them and almost all ranked it as being of primary importance. One third partake in the physical health component to be alone and/or because they enjoy it. The majority of respondents stated that it was essential for their health and only a few stated that it was important for social reasons. There was a great diversity of correlates given in this category: "eating right; sleeping right; enjoying the outdoors; their independence; exercise; and the physical environment".

(Is there anything you need to do each day to make yourself feel healthy?)

"Yes, I have to be physically active and I have to do my spiritual regime. ... I find that eating is an important issue, one's diet ... Just being confident that your body will be able to do whatever chores or demands that you place upon it, whether it be lifting things or running, ..." (S1)

"Whenever I'm doing physical, I have to feel creative about it." (S3)

"The physical plane is what we eat and how we exercise and how we use our body and certainly by not putting a bunch of garbage in it, whether it's alcohol or smoke or additives or chemicals ... the balance in vitamins and minerals are important." (S4)

"I guess I would like to be physically fit ... it just physically feels good to have your body in shape ... nutrition is really important ... not eating properly, boy, it makes a world of difference on how you feel and the

amount of energy you have throughout the day ...if I lost the ability to be physically fit I would just, that would kill me ... I couldn't imagine my life without being healthy and fit because it just makes me so happy ... it is probably true that how you look on the outside is reflecting how you look on the inside ... sleep is important actually, I feel really crummy when I don't get a full night's sleep." (S5)

There were many different reasons given concerning mental health. The most popular one was the importance of a positive outlook. Other reasons were: "the need for a challenge; the importance of education; self-improvement; and creativity".

"I believe in living life and responding to life. And being free enough to go in whichever direction that path takes me. ... I'm not sure how you evaluate what is best but it's going in a direction that I feel positive about." (S1)

"Being relaxed, you know, at most times and like I said before, just being able to see things in perspective and always bearing some degree of humour in mind. ... Even now, I really enjoy learning new and different things, whether it be at school or travelling places and that." (S2)

"In that state of peace, you know, in heart and spirit, then what one does execute in the body is naturally healthier, we think better, interact better, more creative." (S3)

"On the mental planes I think a healthy stimulus and the mental challenges comes from what you read, what you watch ... I have a very active mind and I try to talk to stimulating people on the mental plane and I am fairly selective on where I allow my mind to be ... with the mind you can make your self sick or

well." (S4)

"It all goes back to accomplishing things, like I really like to finish a product ... time alone is really important for me and I spend a lot of time alone." (S5)

There was no one particular reason given for the importance of emotional health. The one common thread, however, was the importance of happiness.

"I'll say this, discovery makes me feel happy, discovering new things. There are lots of things that make me feel happy ... When I perform better than what I expected myself to perform no matter what it is, whether work, a dance, if it's music or sports, if it's things of a spiritual nature, meditation, insights, reading from different holy scriptures from the various world religions and so forth, and discovering things, and that makes me happy." (S1)

"I also take pride in taking some of the things I've learned and when I've done them well that makes me feel happy. ... I'm quite happy just to spend a day or an afternoon by myself just doing a bit of reading, magazines or what not. I'm not really into books and that. But just enough quiet time to think things over and not to take life too seriously." (S2)

"Well, ultimately, it's to experience a loving state, the state of loving, that is, self love and the love I experience with others. That's all others, that's family love, spousal love, your friends' love, your, you and I kind of love, mankind. I mean, that's, that's to mean pretty close to the ideal state of being to be in." (S3)

"On the emotional planes I'm a meditator. I meditate on a fairly regular basis and I try and stay centred in my own energy. I don't get into other

people's energy. If somebody's upset I let them be upset but I don't get upset." (S4)

"I just think that it is really just important to live for the moment and be really happy for every day that you are here instead of wishing your life away."
(S5)

Few respondents stated that the spiritual aspect of health was essential to their life. A couple of respondents stated that they did not practise religion in a formal sense and two others stated that spirituality meant a peace in their soul and spirit. The other comments given were: "the destructiveness of religion; meditation; aboriginal spirituality; spiritual healing; and the Bahai faith".

"But, I suppose, I guess I could say, that is, there is an energy flow that is not perceptible to the eye, or to the sense, then I feel that I, I am somehow involved in that energy flow, ... Being honest is a spiritual act and it's predicated on spiritual qualities - being truthful, being honest, just, considerate, thoughtful, sincere and all these to me are spiritual qualities and so on." (S1)

"I see spirituality not so much as a religious, ... but, more than just a person's personal Zen, personal sense or resilience or pride. It is more of an intangible will, ... I do believe in a higher power but not necessarily that what the church preaches or any religious institute preaches so I don't really, I'm not a regular church goer, personally I just see the various religions as different interpretations on history, whereas no one religion has much more weight than the others. I really don't have very much respect for the institutes themselves, ... But as

far as my day to day life goes, it is irrelevant. ... Personal spirituality would be, as I said before, a sense of pride, intangible set of, I wouldn't use the word morals, but just a personal code and personal motivation to carry out your own wishes." (S2)

"... by spiritual I mean being and this is not, I don't mean spiritual in a formalized religious sense, context of the word but rather at peace with the universe, kind of broad philosophy, you know." (S3)

"On the spiritual planes, part of the spiritual balance as well as the emotional is the meditation." (S4)

"I guess I personally don't believe in going to church and that is not what I mean by being spiritual. I guess what I mean is being confident in myself, being comfortable with myself and having respect for nature." (S5)

Over half of the respondents enjoyed the social aspect of health and less than half stated that receiving social support was important for them. One third stated that it was essential and fewer said that gaining information or knowledge was important. Other comments about the social health component given by this group of people were: "the need for other people; the importance of friends; honesty; and being accepted for yourself".

"What do I need to be well? I need support of well-being environment and the primary elements in that environment are my kids and then my friends. ... I think among the best memories I have are those memories when my whole family, aunts, uncles, cousins, sisters, grandparents, we would all go on these summer bus rides and huge picnics and there would be music and kids would be

dancing and we would swim and play games with the old folks and we played games with the young folks." (S1)

"I enjoy visiting and just hanging out with a lot of my friends. Not just the quantity, but the more people I can relate to, I enjoy that quite a bit. ... I enjoy my privacy quite a bit. I've got to pretty much, that is one thing I will never take for granted again." (S2)

"If I have choices I don't hang around negative people because I don't want to be caught in their energy. Or I don't want to listen to their focus, which is usually focusing on the negative side of things ... I think everybody needs to be touched and to be loved." (S4)

"I really enjoy just being out there doing things ... you definitely have to talk all the time to people ... I still need that people interaction but it has to be different from the stuff I get at work. It just has to be fun. It has to be people I just want to be with and just go have fun with." (S5)

Synonyms of Health

When asked for their synonyms of health these respondents mentioned: happiness ("to be happy"); balance ("in balance", "holistic", "inner and outer being in harmony"); and energy ("radiant level", "vitality", "energy"). The most common thread in this group was the emphasis on the respondents' themselves and being responsible for themselves: "I am the most important thing in my life"; "Life is about making choices, you have to take command of your own lifestyle."; "I am a product of myself"; it is "futile to dwell on that which you can't change"; "if

you have enough self-respect, you'll find a way to take care of yourself"; "Life is all about making choices, you have to take command of your own lifestyle."; and "You can worry about things which you have no control over, which is pointless, or you can worry about things you have control over, which is again pointless. Control them and don't worry."

"For me, well-being is more of a holistic notion that a person's life is in balance. ... I know when I'm feeling healthy because my routine, especially my spiritual discipline in my life is going well. That is interrupted when I'm not healthy and I know that. ... the refrain that keeps popping into my head is health is more than a physical thing. ... So health to me encompasses the total person, it has to be in my view, to use jargon today, holistic and accessible ... So for me health has to do with, oriented with well-being. And health has more to do with prevention than it has to do with the disease."
(S1)

"I suppose I could start out with the cliché - soul, mind and body but being well is just being as least stressed as possible and most confident in the body's ability to do things you want."
... (What is the most important thing in your life?) "Physically it would simply be a sound health and mentally it would be knowing that I'm free to look forward to being able to do almost anything I want to do. ... I am a product of myself, ... What health means to me, as I've said before, sort of a strong mind and strong body ... I guess it would also deal with having a mental confidence and understanding, to not worry about pursuing various things."
(S2)

"... being without disease, being well

is, when I think of being well I think of it in many spheres, I think of it not only in my body, feeling good in my body but not feeling ill at ease, pain, discomfort, limitations, handicaps but also being well in my heart, in my, in my mood or myself, my emotions. Being well also of course applies to the spiritual self, in my, at peace in my soul or spirit and basically I'm just covering the four elements of a holistic look, as well as includes my mind as well, you know I'm anxious free and I'm laughing ... But to me it is whole health in all four spheres, that they are in balance and in harmony, that's ideal. ... it's the will to be healthy, to want to live a long life." (S3)

"My health is balance, you know, and health is being in balance in the physical planes, emotional and mental and spiritual planes ... I have to be responsible for myself ... you have good energy ... my physical body does what I want it to do and my mind is clear and it functions well and I feel balanced on my emotional planes." (S4)

"... physically being fit as well as being mental and emotional well being like being happy are pretty important ... and I guess the other one would be, I don't know the word I want, it is not religious, but spiritual well being I guess ... you just feel clean and fit and healthy and alive and you have lots of energy all the time and it helps to make you feel happy ... this is my priority, this is my lifestyle and this is what I want to do with my life." (S5)

These respondents find it important to be in control of their lives and look at health as positive (happiness), and active (energy and responsibility). For these respondents "health is life".

Respondents in the self-centred group state that the

physical component is very important and an essential part of their life. The spirituality and social components do not have a primary role in the lives of the majority of the respondents.

Comparing the Groups

There are similarities and differences between the three different groups of respondents.

Similarities

Respondents were almost evenly split into three groups: family-centred had twenty-seven; multi-dimensional had twenty-four; and self-centred had twenty-six respondents. The respondents in all three groups agreed that nutrition and eating well were important and sleep was a requirement for good physical health. They also agreed on the importance of any type of physical activity, walking, biking, gardening, alone or with other people.

When the reasons for the importance of mental health were stated for the three groups, there were almost the same number of reasons given by respondents in all three groups, in other words, there exists a diversity of reasons for this category. Respondents in all three groups have few reasons for the importance of emotional health in their lives. This pattern could be indicative of the constant interchange between mental and emotional health by the respondents. An example of this interchange is evident in the "happy" dimension. It is given as a dimension of mental and

emotional health by different respondents. This could account for a lack of distinction by many respondents in the difference between mental and emotional health. Those respondents in all three groups who did give a reason for the importance of emotional health gave happiness as a dimension.

Respondents in all the groups mentioned wanting to have choices in life. They mentioned having a positive attitude toward life, being happy, and being well mentally. Everyone also mentioned the need for quiet time and time alone. All the respondents also mentioned that they are interested in and practice self-improvement.

When the correlates of spirituality were examined, there were about the same number and type of comments from respondents in the three groups: "being a good person but not having to go to church"; a "personal sense of spirituality"; "spirituality - an individual thing". In all three groups there were few respondents who made a differentiation between spirituality and religion.

When negative comments about spirituality were examined, respondents in the three groups had the same number and types of comments: "religion does not play a role"; "doesn't practice religion"; "views religion as destructive"; and "religion is the cause of a lot of destruction".

Respondents in all the groups mentioned friends as a

correlate of the social component of health: "being with friends who share holistic beliefs and practices"; "taking and doing things with friends"; "friends provide support"; and "values support a network of friends".

Differences

The difference which was most notable when listing the different dimensions of health components was the diversity in answers for the self-centred and the multi-dimensional categories in comparison with the family-centred category. It appears that those respondents who are family-centred have more in common with each other than simply the fact that their family is the centre of their lives. They also have similar thoughts in regard to the importance of physical health in their lives.

Respondents in the multi-dimensional group wanted to be in good enough physical shape to be able to do what they wanted to do. Having energy and being active were also important. For respondents in the self-centred group having energy and being in shape were important. And respondents in the family-centred group engaged in the physical component of health for the sake of exercise. The physical health component is not as important for this group as it is for the other two groups. The nutrition aspect was mentioned more by the family-centred group and the multi-dimensional group than the other group. However, when the priorities of health were mentioned, nutrition was mentioned

most by the multi-dimensional group.

Proportionately more respondents in the self-centred category live on their own than in the other two categories. But the numbers are not large in this sample so these figures are only indicative of potential research in this area and are not necessarily indicative of a trend. There were also more respondents who worked in blue collar occupations in the self-centred category than in either of the other two categories.

Respondents in the multi-dimensional group mentioned the use of reading and writing as ways to relax. Those in the family-centred group did not mention the necessity of a challenge in life as much as the other two groups. Global worries³⁸ did not concern respondents in the self-centred group very much, as they did the other two groups. The issue of stress was not mentioned by respondents in the family-centred group very much, but it was mentioned almost equally by those in the other two groups.

The importance of work was mentioned by the multi-dimensional group, but hardly by respondents in the other groups. When priorities of health were examined, those in the multi-dimensional group mentioned the need for self-improvement and accomplishments the most of the three groups: "attainment of goals"; sense of accomplishment"; and "growth, work and personal life".

38 Global worries concerned the nation and other countries.

The majority of respondents in the multi-dimensional and the family-centred groups tended to follow a formal, traditional religion. There is a similarity found in the importance of spirituality given by those in the other two groups. These respondents mention some basic Judeo-Christian morals: "being a good person; treating others with respect; having a moral standard to adhere to; the golden rule; being nice to people; and being tolerant of other's beliefs". There is also more mention of Christianity and a belief in God by respondents in these two groups. There are respondents in these two groups who also believe in other religions than Christianity. Those who are self-centred reflect little of the Judeo-Christian religion. Rather, they appear to be practising alternative religions, if any at all. They talk about spirituality being an individual matter, belief in a higher power - but not God - meditation, the Bahai faith and eastern religions.

When the issue of family was mentioned, it was predominantly by respondents in the multi-dimensional and family-centred groups. When friends were mentioned, it was usually by those in the self-centred and the multi-dimensional groups. When the importance of communication was discussed, it was principally by respondents in the self-centred and the multi-dimensional groups: "likes people and talking to them"; and "communication important". Few respondents in the self-centred group mentioned friends and

family as being important. Those in this group actually had the fewest reasons for this aspect of health and its importance.

Respondents in the multi-dimensional group had the most comments about balance in their lives between the different components of health and they linked different components together. When priorities in health were examined, those in the multi-dimensional group discussed balance, but respondents in the self-centred and family-centred group barely mentioned it.

Summary

In sum, the similarities and differences show the importance of different health components to respondents in the three groups. One major similarity was the importance of happiness to most respondents. The differences simply show the diversity of reasons given by a diversity of people. This shows the importance of focusing on a similarity in approaching people about their health because health promotion wants to promote health to all. So, this can be done by targeting the similarities among the groups and expanding on this theme.

CHAPTER V

HEALTH PERSPECTIVES OF YUKONERS

This chapter will link the previous results chapter³⁹ with the literature discussed earlier. The introduction will discuss the complexities and relativity of health definitions, followed by health concepts, determinants and components. Finally, suggestions and implications for future research will be offered.

What is Health?

When definitions of health were examined, it was seen that respondents in this survey held definitions of health similar to definitions in other research - that health is not something that can be narrowly defined (Engel, 1994; Edginton, 1989; Smith, 1988; Smith, 1983). One factor common in the respondents' definitions of health is that one is healthy when one feels "okay" (Stacey, 1988).

The reasons found in this research for the complexity in defining health are: differing backgrounds of respondents which influence their definitions (eg., cultural, educational, familial); different stages of life which the respondents are in (eg., young, married, children, unemployed); and different components of health which the respondents used to define health (eg, physical, mental,

39 Many respondents did not distinguish between the mental and emotional health components. Even though they are separate in the literature review, they will be combined in the discussion, as they were in the results.

spiritual, social).

Diversification in health definitions exists primarily in relation to the relative importance of each of the dimensions mentioned in the definitions (Engel, 1994; Gochman, 1988; Smith, 1983). This research found diversification in definitions, as is evidenced by: 1) the main criteria used in determining which health groups the respondents would be placed in - according to the priorities in their lives; and 2) the results previously analyzed.

The one notable factor which was apparent in the results is that, for these respondents, health is happiness. For respondents in the family-centred group, health, and therefore happiness, is achieved through the health of the family. Respondents in the self-centred group achieved happiness through themselves, by doing what they wanted to do, that is, by fulfilling their own potential. And respondents in the multi-dimensional group found health and happiness through satisfaction in those areas of life important to them, - work and family. Health determinants affect the respondents' health, both positively and negatively.

Health Determinants

There are two determinants to be considered when examining health: the lifestyle model; and health as a resource. Some respondents realized the effect of various

lifestyle decisions and tailored these decisions to influence their health, eg. they would try to have adequate nutrition and watch their weight. This agrees with previous research suggesting that to enjoy good health people should make healthy decisions in the following areas: exercise; stress; nutrition; smoking; and substance use and abuse (Clarke, 1990; Engel, 1994; Litva and Eyles, 1994; Mustard, 1983). Many respondents in the self-centred group stated that maintaining one's health does not only concern engaging in appropriate health behaviours. It also involves self-management (Litva and Eyles, 1994).

According to many respondents, health was an individual's responsibility. Individuals have choices and it is their responsibility to maintain their own health to the best of their ability. Few respondents blamed someone or something for their lack of good health. This finding disagreed with the literature which stated that health is a social, not an individual problem, and an individual cannot be held totally responsible for their own health (Edginton, 1989).

Respondents talked about the importance of being able to perform to the best of their ability. For many, being well meant performing to their fullest potential (Smith, 1983). Respondents in the multi-dimensional group stated that ability was a synonym for health.

The second determinant of health to be considered is

health as a resource necessary for everyday life, because it insures that daily life will continue for the individual. Health is seen in resource terms in this research, as a reserve, energy, fitness and social support (Litva and Eyles, 1994). One common thread in the self-centred and multi-dimensional groups was one of the synonyms used for health - energy. When these respondents felt healthy, they had an energy or a vitality about them. Respondents in the multi-dimensional and family-centred groups mentioned the necessity for social support in their life. And when they had this support, they felt healthy and happy.

This idea of health as a resource is an interesting one in light of health promotion activities because health is something to be promoted, protected and conserved. And if people are involved in making decisions about their own health (White, 1986) perhaps they will be more conscious of achieving and maintaining good health, and this would hopefully lessen the burden on the dollars spent on health care by the government.

Health Concepts

Respondents discussed the concept of wholeness or soundness in health (Lee, 1983). In all these groups, there were some respondents who also described health as balance. When they were asked to explain this word, they would explain that the balance was among different health components - physical, mental, spiritual and/or social, and

when there was a balance between the various components, they felt healthy. This definition is similar to the WHO definition of health, which emphasizes the physical, mental and social components of health.

Respondents in all groups used their life circumstances and experiences to define what health meant to them. And for the majority, being happy was the most important goal. They drew upon the context of their own experiences in order to explain what health meant to them (Litva and Eyles, 1994). Their definitions were very much tied in with the quality of their life, and were often explained in psychological terms as the ability to feel happy, enjoy life and feel good about the self. Unlike the results of Litva and Eyles (1994), who found that the individualistic sense of well-being was linked to the psychological, not the physical state, this research found that the individualistic sense of well-being was linked to the psychological, physical, spiritual and/or social component of health of the respondent. The end result of good health - being happy - was important to all respondents, but the sense of well-being was linked to all components of health, not just the mental one.

Respondents were asked to define well-being and they did so in positive terms: by what they had the ability and energy to do in the physical component; by their thoughts and feelings (being positive, in control, happy,

achievement) in the mental component; and by their connections with family and friends, and the activities they did together in the social component. Negative comments were used to describe the above health components, but these comments were in the minority, with the spiritual component having the most number of negative comments. Religion was described as destructive, unimportant, and not essential. These findings are different from those found by Litva and Eyles (1994) in that respondents in their survey found it difficult to define health and tended to do so in negative terms, that is, being without illness or debilitating disease. Perhaps the emphasis from the respondents, in this research, on the positive aspects of health is due to the wording used in the main question, that is "What is well-being to you?" This implies a positive answer and perhaps this question was "leading" the respondent to give a positive answer.

Health Components

Health is defined through concepts on a larger scale and on a smaller scale through health components. Respondents in the multi-dimensional group stated that health encompassed the physical, mental and social components of health, and well-being was the balance of these three components. According to these respondents, there was an equal importance of the physical, mental and social components of health for them. This is similar to

the WHO definition of health which states that health is a "state of complete physical, mental and social well-being, encompassing the ability to achieve full potential, deal with crises and meet environmental challenges." (Engel, 1994, p.7). There were respondents in all three groups who defined a relation between physical and mental health, with respondents in the self-centred category discussing this the most. They rarely mentioned the social component and when they did it was in a secondary manner.

Many of the respondents emphasized the effect of the different components of health on each other, for example, one respondent stated that if they did not look good, then they did not feel good and vice versa, if they did not feel good, then they did not look good. This illustrates the direct two-way relationship between the physical and mental components of health.

Physical

Respondents in the self-centred group mentioned the importance of exercise to help ease stress and tension (Hayes and Ross, 1986). These respondents also stated the importance of being active and positive, and this was accomplished by being physically fit and having energy. The physical component of health was very important to these respondents, and thus was an essential part of their lives. For some of these respondents, concern with appearance was a motivating factor in preventive health behaviours (Hayes and

Ross, 1987).

The majority of respondents in the multi-dimensional group ranked the physical component as being more important than the other components. They found it to be an essential and necessary part of their life. About half of the respondents engaged in physical activities for the social aspect, that is, getting together with people while participating in physical activities.

All respondents in the family-centred group stated that the physical component of health was important for them, that it was an essential part of their lives, as was keeping busy and active. Respondents in the self-centred group stated that the physical component was important to them and almost all of them ranked it as being of primary importance. Most stated that it was essential for their health, while some participated in physical activities to be alone and/or for the enjoyment of it.

Many respondents stated the importance of proper nutrition. Respondents in all three groups realized the importance of nutrition and some respondents emphasized the fact that they do try to get proper nutrition (Litva and Eyles, 1994). The majority of respondents in the multi-dimensional group stated that their diet was important, as did the respondents in the family-centred group.

In sum, all three groups of respondents agreed that nutrition and any type of physical activity were important.

There did not seem to be any respondents who stated that they did not enjoy physical exercise. Even those respondents who had physical disabilities which limited their physical activities, stated that they enjoyed physical activities to the best of their ability. This could be particular to the Yukon because in the south people talk about "couch potatoes", people who do not engage in physical activity except when necessary. The environment of the Yukon is conducive to participating in physical activities and perhaps there are more people who are prone to this who live in the Yukon. This would be an interesting area of future research.

Mental

Many respondents stated the importance of happiness in their life (Ross et al., 1990). They stated that when they were healthy and other priorities in their lives were going well, they were happy. Thus, their goal in life was to be happy and the way to achieve this was through good health. This theme was consistent in the three groups of respondents.

Mental health for multi-dimensional group respondents meant being positive, having challenge and achieving goals. Happiness was given by the respondents as a synonym for health. Feeling good was also another synonym given. It was also important to these respondents to have control of their life and their independence.

For respondents in the family-centred group, mental health meant being positive and having time alone. These factors were important for their overall health. It was also important for them to be independent and have control over their lives. Respondents in this group gave happiness and independence as synonyms for health. Respondents in the self-centred group stated the importance of a positive outlook, challenge, self-improvement and creativity. A synonym of health for them was happiness. Respondents in all three groups mentioned the importance of choice in their life, as well as having a positive attitude.

In sum, the mental health component was a part of these respondents' definitions of health, whether it was independence, happiness, being positive, having a challenge or improving themselves. It was not neglected by any respondents and it usually affected or was affected by the physical component.

Spiritual

The sample was too small for in-depth analysis of the relationship between health and spirituality but comments of the respondents do suggest a positive relationship (Ellison, 1991). Symbolic relations with a divine other are a significant correlate of well-being (Pollner, 1989). And strong religious beliefs can be associated with different religions, for example, Judeo-Christian, Bahai, or Aboriginal beliefs. The majority of respondents in the

multi-dimension group believed in the spiritual component. They stated that it was an essential part of their lives. Even though the respondents in the family-centred group did not give primary importance to the spiritual component, some did state that it was essential. In sum, in-depth research is needed in this area to determine the strength of the relationship between health and spirituality.

Social

The importance of the social component of health was mentioned primarily by respondents in the family-centred and multi-dimensional groups. Some respondents in the self-centred group mentioned it but it did not have primary importance for them. The support given by friends and family was mentioned often, as was also found by Freund and McGuire (1991), and the need for positive relationships.

Some respondents organized their life around this component of health. Respondents in the family-centred group stated the primary importance of the social component of health, that is, if their family was not well, then they were not well. Other respondents would combine the social with the physical component of health. That is, they would engage in physical exercise for the purpose of social interaction. Respondents in the family-centred group stated that the social component of health was integral to their health. The majority of them needed the support it offered. Some stated that it was essential for them and others said

that they enjoyed it. Friends, as well as family, were important to this group. Many respondents in this group gave the word family as a synonym for health.

Respondents in the multi-dimensional and the family-centred group stated the importance of social support to and from family and friends. When they were feeling down or depressed, many would go to their family or friends for support. This is reminiscent of the socio-ecological model which also encourages reciprocal maintenance, that is, taking care of each other (WHO et al., 1986). Respondents in the multi-dimensional group stated that the social aspect was essential in their lives because it gave them support and enjoyment.

Some of the respondents in the self-centred group enjoyed the social aspect of health and some stated that it gave them support. A few said that it was essential. But the ones that did talk about it mentioned the importance of friends and being accepted for yourself. When family was mentioned it was primarily by the family-centred and the multi-dimensional groups. When friends were mentioned, it was primarily by the multi-dimensional and the self-centred group. It would be interesting to determine the reason for this.

The detrimental effects of the social components were mentioned by some respondents, something which is not mentioned in much literature (Freund and McGuire, 1991).

Respondents would mention that they enjoyed associating with people who were positive, and they did not like being around people who were negative because this would influence the respondents themselves negatively.

Conclusion

In conclusion, this thesis started with a research question which asked "What is health to Yukoners?" Results showed that respondents tended to use some or all health components to define health - physical, mental, spiritual, social - and there is not one definition which is standard throughout the Yukon. The one common denominator is that health, as a biological or social entity, does not stand alone. The biological component influences that social one, which includes the cultural effects, and vice versa.

These results showed that people can be divided into groups which reflect their health perspectives, based upon the priorities they hold in their lives, and this in turn reflects their lifestyles. Three groups were defined in this research. The first group contained respondents who held a multi-dimensional view of health, that is, they had more than one priority in their lives, which were of equal value, eg., family, work, themselves. For these respondents to be healthy, everything had to be going well in each area. Members of this group combined the physical, mental and social components of health.

The family-centred group contained respondents who

prioritized their family in their lives. If everyone in their family was well, then these respondents would also be well. Members of this group talked about the social, mental, physical and spiritual components.

The third group of respondents had a viewpoint that they, themselves, were the most important aspect of their lives - the self-centred group. They discussed the physical and mental components over the spiritual and social ones. If spiritual health was important to them, it was not a Judeo-Christian religion that they followed.

There is a direct relationship between the definitions of health which Yukoners have and their lifestyles. Respondents in the family-centred group patterned their lives around their family. Decisions would be made in regard to how they would affect their family. And activities would be planned to involve the family.

The main factor common to respondents in all three groups was the reason they wanted to be healthy - to be happy. When the focus of the respondents' lives was going well, they would feel healthy and happy and have energy. In the multi-dimensional group, if work was not going well, this would affect their mental health, which would, in turn, affect their physical health and they would be unhappy. Respondents in all three groups pursued happiness as their goal, and the way to happiness was through good health. Similar to the importance of happiness, was the importance

of a positive outlook.

Respondents in the Yukon had a perspective of health which was similar to the WHO definition of health - that health is the absence of disease, and the physical and mental health components affect each other. These results also emphasized the social and cultural factors which influence people's health and these factors are dependent upon the time and place in which the individual lives.

The other issue mentioned in the research, which differed from the literature, was that the majority of respondents did feel responsible for their own health. They stated that they wanted to be involved in making decisions about their own health and they wanted to be responsible for it.

Research and Policy Implications

These results showed health used as a resource to achieve happiness. This is useful when examining health policy and health promotion. Health is discussed as a resource, as a means to an end, to achieve happiness, and when a person is healthy, they have energy and are happy. So this could be instilled in health promotion campaigns. As well, health promotion could emphasize the responsibility the individual has to look after their own health. This was mentioned in the Yukon and respondents are willing to look after their own health. Self care, that is encouraging healthy choices and the decisions individuals take in the

interest of their own health is a definite direction to be taken in health promotion.

Some individuals mentioned the importance of physical appearance and that, for them, it was a motivating factor in preventive health behaviour rather than a concern with health. This is another factor to be taken into account in health promotion programs. Also, balance was mentioned by most respondents in their perspectives on health, so health promotion campaigns should not only emphasize the physical component or only the mental component but all the health components. As well, the possible trends evidenced in this research between the genders could be used in health promotion. Men could be appealed to be in campaigns emphasizing the self and self-preservation. And women could be influenced by campaigns aimed towards family and friends.

An area of research to be explored is the effect of different demographics on a person's health, eg., age, marital status, occupation, gender. These results were not analyzed with respect to demographics because numbers were too small for analysis. Two differences in the makeup of the respondents in the groups was noted. The first concerns the family-centred group which had appreciably more females than males. Secondly is a difference in the self-centred group which had more males than females. These differences are two examples of what should be explored in a larger sample. As well, there are other gender differences which

could be explored. Do Yukon men and women exhibit differences in ranking the importance of rest, exercise, nutrition, body maintenance as their southern counterparts do?

Another area which needs research is the differences between health perspectives of aboriginals and non-aboriginals. With almost one quarter of the population in the Yukon being aboriginal, health promotion campaigns need to determine the differences and address these in the health promotion campaigns.

Results of this thesis showed the relativity of definitions of health - they varied depending on the respondents and their life circumstances. This is the reason it is important to acknowledge the main factor found in common in the definitions - that of happiness - and to use this to promote good health. Health promotion campaigns should emphasize that physical and mental health do have factors in common and affect each other.

The current state of knowledge concerning health perspectives of Yukoners is limited. The symbolic interactionist framework explored the interactions of individuals in relation to their perspectives on health. And it was shown that the different components of health - physical, mental, spiritual, social - do have an influence on each other and do not stand alone. So these different components must be studied together and not in isolation.

APPENDIX A**THE QUESTIONNAIRE PACKAGE**

Pre-Interview Check List

INTERVIEWERS' GUIDE

Purpose:

In the type of research we are undertaking the interviewer serves as the "instrument" in the collection and analysis of data, please remember:

- The purpose of interviewing is to allow the understanding of the other person's perspective.
- Responsibility of the interviewer is to provide the framework within which people can respond comfortably, accurately, and honestly to open-ended questions.
- The quality of the information collected is totally dependent upon your ability as an interviewer.
- It is the responsibility of the interviewer to ensure that each question is clear and that the participant understands the question.

Check Point:

The following are summary points adapted from Patton (Chapter five):

- ✓ Keep centered on our purpose in the interview
- ✓ Ensure that the interview provides an opportunity for the participant to tell their own story (in their terms).
- ✓ Be prepared for the interview - know what the purpose and goals of the interview are.
- ✓ Communicate clearly what information is required, what is important, and let the interviewee know when they are off track (time is valuable).
- ✓ Listen attentively and respond to the participant to let them know you are actively involved in what is said.
- ✓ Exhibit interest in the topic and the individual being interviewed.
- ✓ Maintain neutrality toward the content of responses (do not make judgements on the responses).
- ✓ Be fully observant while interviewing.
- ✓ Important: maintain control of the interview.
- ✓ Review and reflect immediately on the outcome of the interview (the content and the process).
- ✓ Enjoy the interview and exhibit this interest - be enthusiastic.

Questions:

In general any of your questions during the interview should reflect the following:

- Ask clear and understandable questions.
- Questions should be singular, avoiding multiple concepts.
- If you paraphrase the question, try to avoid WHY questions (they infer causal relationship that interfere with analysis or induction).
- Questions should be totally neutral to avoid suggesting appropriate responses. (do not lead the participant other than in the direction of interview).
- Consider transitional statements between the "grand tour" questions if there is a break in the logic of the interview (use a transition or a summary to break a logical block).

Probes:

While in the interview attempt to be flexible and vary your probes. Consider the following approaches:

- Detail probes "how", "what", "when", "where", and "who".
- Elaboration probes (*Please would you elaborate; could you explain what you mean; I would like to ask you to explain this to me again in detail appear slow if necessary; any other reason; what do you mean by that; could you tell me more; which would be closer to the way you feel.*)
- Clarification probes (*You used the term xxx, what do you mean by this word; I do not understand your meaning could you clarify this point.*)
- Repetition probes (*repeat the question if the response is not fully developed ,or as a variant repeat the respondent's reply.*)
- Silence, the expectant pause (*use the time for note taking thus deflecting the attention from the participant, it is not unusual to have silence in a conversation of 10 to 20 seconds*)
- Neutral Phrases (*use "I see," "Hmmm," "Yes?" "OK," and "go on" to encourage the respondent to continue.*)
- Contrast: use the respondents own terms as a means of contrasting apparently inconsistent statements (*earlier you said xxx, you now speak of xxx, what do you mean.*)
- Reflective Statements (*feed back the last comment with expectant pause.*)
- Non Verbal Clues (*facial gestures that suggest an anticipation of more information.*)

Pre-Interview Check List **OBSERVER'S GUIDE**

Tape Operations: The tape operations is essential to the success of the data collection process, please:

- Be responsible for the operations of the tape recording. Ensure extra batteries, tape recorder, and tapes are available.
- Ensure that tape is operative and recording before and throughout the interview. The tape recorder does not start recording the interview until after the interviewer has given the introduction and has received approval from the respondent to tape the interview. When the interviewer tells the respondent "Thank You, the interview is over", the tape recorder is turned off, even if the interviewer and the respondent continue talking for a few minutes.
- In the event of total tape failure be prepared to take notes during interview.
- Introduce the tape with description (time, meeting number, participants and place); sign off the tape with announcement of completion. Ensure the tape is fast forwarded to the end of that side so the tape is ready for use the next time.
- Ensure that both sides of the tape are labelled with appropriate code and given directly to the lead researcher.

Interview Rapport: As an observer it is essential that you remember that:

- Your role is to remain neutral throughout the interview. Specifically avoid being involved in the interview process. It is also important to be removed from the attention of the interviewee
- You are to ensure that the whole attention of the participant is centered on the interviewer. Avoid eye contact or non-essential movements that would attract the attention of the participant.

Observer Form: The observer summary form is the first step in the analysis process, please:

- While in the interview complete the **observer summary form** (general comments, summary information, major issues, and any implications for data analysis).
- Return **observer summary form** to lead researcher upon completion.

Interview Debriefing: The observer acts as the interviewer coordinator, please:

- Coordinate the debriefing of the interview. Ensure that all individuals required to participate do so and that the debriefing occurs immediately after interview.
- Submit the **interview debriefing form** and assembled information regarding the interview to lead researcher immediately after interview.

MEETING QUESTIONS

Respondent name: _____
 Interview Date: _____
 Interviewer: _____
 Observer: _____

Introduction:

I would like to start by thanking you for agreeing to talk to me today. Our purpose is to gain an understanding of your views about your health and personal well-being. (*for professionals only* - Your personal views, not necessarily those of your organization.)

This discussion is one of a select few being carried out all over the Yukon as part of a larger research program leading to a Health Promotion Survey which will be conducted in the Yukon next year. The interview will probably last just over an hour. This is an opportunity to be heard and share your insights and experiences. We are interested in hearing your opinions so there are no right or wrong answers. Please feel free to express yourself openly and be assured that all information provided will be kept anonymous and confidential. With your consent we would like to tape your comments to ensure that they are accurately recorded. If we have further questions, may we contact you in future to confirm our understanding of your ideas? XXX is here only to operate the tape recorder and to observe. S/he will not be participating in any other way in our discussion.

Do you have any questions before we begin?

Icebreakers:

How are you?

Beautiful day today, eh?

How was your day today?

I noticed that xxxxx was really nice here in your community.

Describe your community to me.

What do you like about living here?

Are there any drawbacks to living here?

*Our Purpose:

What is "health" to the individual Yukoner?

Question #1: What does being well/ well-being mean to you?

- ♻ Describe yourself at your peak.
- ♻ What's the favorite part of your day/ week?
- ♻ What makes you feel happy?
- ♻ How do you know when you're feeling healthy?
- ♻ Do you ever think about religion or spirituality?
- ♻ How do you know when you're not feeling healthy?
- ♻ When was the last time you weren't feeling good/ fine?
- ♻ When you are physically ill, do you go to a practioner or therapist of any type?
- ♻ Who do you usually go to for advice on issues about health?

Question #2: What do you need to be well?

- ♥ Is there anything you need to do each day to make yourself feel healthy?
- ♥ What's the most important thing in your life?
- ♥ When do you know your life is going the way you want it to?
- ♥ What do you look for in life?
- ♥ What do you hope for?
- ♥ What do you do to feel satisfied/ to enjoy yourself/ to relax/ for entertainment/ recreation?
- ♥ What makes you feel bad/ upsets you?
- ♥ If you worry, what do you worry about?
- ♥ What do you do to calm yourself down?
- ♥ Who do you turn to when you're feeling upset/ down?
- ♥ What affects your health?

*** Our Purpose:**

What is "health" to the individual Yukoner?

Question #3: What do you do to feel good/ stay healthy?

- ♣ How do you know when you're feeling good?
- ♣ How do you cope, when things are not going well?
- ♣ How could you be encouraged to continue your current health supporting activity?
- ♣ How did you come about understanding health as you do now?/ Who do you go to for your health information?
- ♣ Describe to me the choices you feel you have in regard to your health/ well-being.
- ♣ What's important for you to do to maintain your well-being?

Question #4:

- ✓ Could you describe your health to me?
- ✓ Do you have a few words that would describe what health means to you?

Question #5: Is there anything about health or well-being that you would like to tell me that I have forgotten to ask?

✓ *Check:* Have you covered physical/ spiritual/ emotional/ mental/ social?

Observer, (*insert name here*) are there any questions you would like to ask?

THANK YOU *Tape off*

*** Our Purpose:**

What is "health" to the individual Yukoner?

*** Do a short debriefing of the respondent - make the respondent feel like a person again and not just like a "guinea pig".**

1. Any comments about the meeting?
2. Is the respondent interested in obtaining a report of the findings, once this phase of the research is finished? If so, please fill in the following information:

Respondent's Name: _____

Full Address: _____

Phone Number: _____

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FIRST ORDER ANALYSIS

Respondent Name: _____ *Meeting Code:* _____
Observer: _____ *Interviewer:* _____

To be done independently by the interviewer and the observer.

Question 1: **MAIN THEMES, IMPRESSIONS, SUMMARY
STATEMENTS** about what went on during the
meeting.

Concepts:

Correlates:

Priorities:

Question 2: EXPLANATIONS, SPECULATIONS, HYPOTHESES about the content of the meeting.

Question 3: FOLLOW UP necessary as a result of this contact.
- elaboration necessary of any points?

Question 4: Overall impression of the meeting.

Implication for modification, revision, recording or analysis as a result of this meeting.
- what went right/ wrong?

- what questions worked/ did not work?

- should this tape be transcribed? Yes/ No

Question 5: ANY OTHER COMMENTS that may have been generated as a result of this contact.

SIGN OFF SHEET

Meeting Code # _____

Part A: To be filled in by the Interviewer.

1. Put this page in Observer's basket when field notes and first order analysis is done.

*Interviewer's initials*_____

2. When the observer returns this sheet, put it in the file with the rest of the notes from the meeting.

*Interviewer's initials*_____

Part B: To be filled in by the Observer.

Read over: a) the field notes,
b) the first order analysis,
c) the second order analysis.

If there are any additions, deletions or changes, please note them below.

If not, put this sheet in the Interviewer's basket when done.

*Observer's initials:*_____

*** Remember: The interviewer is responsible for ensuring that all the paperwork, tapes and files related to the interview s/he conducted are completed.**

24/06/91

APPENDIX B DESCRIPTION OF THE YUKON

The Yukon Territory is 483,450 square kilometres and is situated in the Canadian Cordillera, a mountainous belt stretching along the Pacific Coast. It is bounded on the south by British Columbia, on the east by the Northwest Territories, on the west by Alaska and on the north by the Beaufort Sea. It has the highest point in Canada, Mount Logan, at 5,971 metres. The Yukon River is the second longest river in Canada, 3,185 kilometres. Yukon also has the largest non-polar ice field in the world.

The climate in the Yukon is sub-arctic and there is relatively little precipitation year round. The average temperature rises above 10 Celsius for no more than four months each year. The average January temperature is -20 Celsius to -32 Celsius. The average July temperature is 14 Celsius. (Yukon Bureau of Statistics, 1990a). Since the Yukon has a very rugged environment, there are many activities for outdoor enthusiasts, such as fishing, hunting, whitewater rafting, hiking and mountain climbing.

The main industries in the Yukon are mining, tourism, forestry, trapping, agriculture and fishing. Mineral exploration and production form the basis of the economy. The other major economic sectors are government services and tourism (Yukon Bureau of Statistics, 1990a).

In houses which are situated outside of city or town limits, it is common for dwellings to have no running water

or telephones. All communities are accessible by road except Old Crow, a traditional First Nations community in northern Yukon (Yukon Bureau of Statistics, 1990a).

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