'PLACING' LAY PERCEPTIONS OF HEALTH AND ILLNESS

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ABSTRACT

This thesis contributes to a little researched topic in health geography, that of lay perceptions of health and illness and their relationship to space. Informed by a symbolic interactionist perspective, the qualitative method of in depth interviewing is used to access and explore how 53 informants, living in relatively remote towns in Ontario, conceptualize health and illness. In this study, two notions of place are used. Place is used in both its geographic and experiential senses. Place-in-life, defined in the study largely by age, appears to have an influences on how people perceive health and illness. It is speculated that the differences found between the sites are linked to the presence of a papermill as well as the large number of Native Canadians living in Papermill Town. This study used the theory of symbolic interactionism to uncover the meanings that people held about health and illness. Although a relatively new theory to health geography, it was particularly useful for exploring how these meanings impact upon the physical and social bodies interaction with the world and how they contribute to and maintain a person's place-in-the-world.

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I wish to dedicate this work to mother, Beatrix Litva.

TABLE OF CONTENTS

Chapter 1

Introduction

1.1 Context

Traditionally spatial analysis has been concerned with the locational and spatial variations of human phenomena (Haggett 1986). This has resulted in place being relegated as simply a container for human phenomena (Eyles 1993). Increasingly, however, the importance of place as more than a container of things is recognized within human geography through the influential works of Tuan (1974) and Eyles (1985). Tuan developed the sense-of-place notion that describes the consciousness people have of places holding a special significance for them. Eyles extended this sense of place idea to include people's tangible experiences of places and their place-in-the-world (social context). Thus place is seen as both the centre of lived meaning and social position (Eyles 1985). This 're-thinking' of place involves a greater interest in the context of an experienced place rather than its catalogued characteristics, as practised in spatial analysis (Kearns 1993).

Within the sub-discipline of medical geography, there has been a call to make place matter. The interest in making place matter has also resulted in a call for greater theoretical exploration (Jones and Moon 1993; Kearns and Joseph 1993; Kearns 1993; Eyles 1993) in particular, taking into account the structure/agency debates (Giddens, 1979). It is felt that the use of theory-driven approaches results in a broader idea of place emerging, where:

> A setting is not just a spatial parameter, and physical environment in which interactions 'occur'...it is these elements mobilised as part of interaction. Features of the setting of interaction, including its spatial and physical aspects...are routinely drawn upon by social actors in the sustaining of communication (Giddens 1979).

Thus place, or a locale as Giddens (1984) calls it, refers to the setting of interaction that is essential for specifying the contextuality of that interaction. Consequently, place can be viewed as both the centre of lived meaning and social position (Eyles 1985) and a container of things, involving both the local and the global (Massey 1991).

A theoretically informed notion of place has played a small part in medical geographic work. This has prompted geographers to question whether medical geography is "an unnecessarily placeless endeavour"(Kearns 1993:145). One reason for this 'unnecessarily placelessness' is the fact that the theoretical underpinnings of much medical geographic work have been limited (Jones and Moon 1993). Thus, geographers have called for re-focussing medical geography to make place matter by incorporating theories of society (Eyles 1993: Kearns and Joseph 1993; Kearns 1993; Jones and Moon 1987, 1993). In particular Kearns (1993) has advocated reconsidering aspects of social theory, in particular the structure/agency debate. Of particular relevance are the ways in which people perceive their environments (contexts), and how these environments affect their perceptions and behaviours.

Research done in the United Kingdom has hinted at the significance of place as a possible factor in influencing lay perceptions of health and illness. Variations in

perceptions among white working class populations living in different cities prompted Eyles and Donovan (1990) to conclude that "there are some subcultural and locational differences [in lay perceptions] these being largely based on the material circumstances..." (1990: 116). Most of the research on lay perceptions of health and illness has been carried out in the United Kingdom (Blaxter and Paterson 1982; Pill and Stott 1982; Cornwell 1984; Donovan 1986; Calnan 1987; Eyles and Donovan 1990), with some in France (Herzlich 1973) and the United States (Crawford 1984)and Canada (Walters 1993; Litva 1993).

In most of these studies, except Eyles and Donovan, a situated view of place was never part of the context of the inquiry. In a previous study of lay perceptions of health and illness (Litva 1993), it was noted that an individual's place-in-the-world affected how the concept of health was perceived (Litva and Eyles 1994). But because that research was only done on one site, it was difficult to determine the extent to which physical place influenced people's perceptions of health and illness. Yet others (Evans-Pritchard 1937; Fabrega, 1974; Kleinman 1980) have asserted that ideas about what health is vary from place to place as well as at different times in history (Ehrenreich and English 1973). Therefore, this study of lay perceptions has been devised to take into account the recent call for a theory- informed study which takes into account a situated view of place in the context of inquiry and recent debates within the geography of health.

1.2 The Nature of Lay Perceptions

In the social and health sciences, there is a growing interest in finding out what 'ordinary' people think about a variety of health issues (Furnham 1988; Pierret 1993). The term lay perception usually refers to the feelings, ideas and attitudes of nonprofessionals (Freidson 1970). The main distinction between lay knowledge and professional knowledge is that lay knowledge is most often experiential (Stacey 1994).

In an attempt to make sense of the social and physical world, to be able to see it as stable, orderly, predictable and understandable, people develop theories or explanations for the things that are relevant to their lives (Furnham 1988). Through observation, exposure to others, the media, and personal experiences, people develop ideas about how things work (Sarbin *et al* 1960). Perceptions are the particular ideas we have that allow us to experience and give meaning to the world in which we exist. Perceptions are, therefore, people's personal and individualistic interpretations of their own reality (Litva, 1993).

Lay perceptions are different from the 'scientific' theories in that they fulfill different functions. Yet lay theories do overlap with scientific theories in that they function in similar ways. Lay theories, like scientific theories, can be explicit, coherent and falsifiable (Furnham 1988). Hewstone (1983) suggested three functions of lay theories: the control function, the self-esteem function, and the self-presentation function. The control function is such that the individual can achieve

some control through understanding cause and effect in the social and physical worlds. The self-esteem function serves to protect, validate and enhance feeling of personal worth and effectiveness. Finally, the self-presentation function allows for the gain of public approval for avoiding acts of embarrassment.

It is in light of individual circumstances and attributes (Cornwell 1984; Blaxter 1990), as well as previous experiences, that lay people socially construct meanings of health, illness, and disease. Lay beliefs serve to make the world a stable, orderly and predictable place. A suggested function of lay beliefs is to establish a cause-and-effect relationship between phenomena, which in turn enables lay people to designate blame, praise or responsibility (Furnham 1988).

1.3 Research Objectives

There are three objectives to this research project. The first objective is to explore the nature of lay perceptions at two sites, which share some similar geographical and social characteristics, in order to determine the extent to which place influences lay perceptions of health and illness. Instead of comparing perceptions between social classes, as most lay perceptions research has done, we will use age groups to define a person's place-in-the-world (see section 2.4). The second objective is to discover whether there are differences between the two sites and if variations occur between age groups at each site. Attention to age variations extends our knowledge of the impact of a persons place-in-the world upon lay perceptions. In order to address the structure/agency debate which is presently taking place within

health geography (cf. Kearns 1993; Jones and Moon 1993; Eyles 1993; Kearns and Joseph 1993) as well as do a theoretically informed study, the third objective is to assess the usefulness of a preferred theoretical framework (symbolic interactionism) for making sense of lay perceptions of health and illness.

1.4 Substantive and Scholarly Significance

One of the areas where lay beliefs have very significant impact is in the area of health. Most people have theories about what health is, what to do to stay healthy, how illness is caused and what to do when ill. Based upon these perceptions, people decide how to act. Therefore like attitudes, lay perceptions have definite consequences for the development of further perceptions as well as behaviours (Furnham 1988).

Models of health beliefs (cf. Becker 1974), used by psychologists, sociologists, and geographers, have attempted to understand how lay people process ideas about their health, which leads them to act or not to act. These models attempt to describe the salient factors of relevance and then explore possible causal chains though these variables from beliefs/perceptions to behaviour (Becker 1974). Yet one of the major criticisms of this method for approaching lay beliefs of health is that it does not take into account people's social environments. Beliefs about health are rooted in wider cultural contexts and lifestyles are inseparable from the socio-economic structures in which individuals live (Nettleton 1995). Therefore in order to understand lay perceptions of health and illness, it is necessary to pursue more

contextually sensitive approaches. Thus we can learn the extent to which an individual's context- their structural location, cultural context, personal biography, social identity - influences how health and illness are perceived and perhaps shed light on why people do the things they do.

One of the more practical implications of understanding lay beliefs is that it can inform public policy (Eyles and Woods 1983; Eyles 1992). As we become more aware that health is a product of social and behavioural factors, an in-depth understanding of the effects of these factors upon perceptions may provide insight for public policy which has been attempting to encourage people to modify their lifestyles and adopt more healthy ways of living (Epp 1986). However, health promotion has been accused of emphasizing lifestyle factors in isolation from their social context thus it is often at odds with the ways in which lay people think, feel and act in relation to health ((Noble Tesh 1988; Davison and Smith 1995). Behaviours which may affect health invariably carry social meaning other than those which pertain to health. Understanding people's ideas about health and illness management is valuable for developing effective health education programmes. Lay perception research can also demonstrate if there are significant 'gaps' between health promotion priorities and popular culture.

At the scholarly level, there are several ways in which this research contributes to the development of health geography. First, it begins from a theoretically informed position - symbolic interactionism - instead of a policy informed one. It thus

contributes to the growing body of theoretically informed health geography. This research will explore existing explanations around how lay perceptions of health and illness are constructed and determine if and how inclusion of geographic concepts such as place can increase the theoretical power of such explanations. At a more general level, it contributes to the small body of research on lay perceptions of health and represents one of a few formal studies of its kind in Canada.

1.5 Chapter Outlines

This dissertation contains nine chapters. In chapter two, we look at lay perceptions research in order to set the context for this research within the body of literature on lay perceptions. We will also outline what this study contributes to this research. Chapter three discusses the theoretical framework which is informing this study - symbolic interactionism, as well as its relevance for studying lay perceptions of health and illness. Chapter four explains the methodology used in this study. Chapter five is the first of the empirical chapters and it focuses on how health is defined in the self and how health is defined in general. In the next chapter, chapter six, we look at how people manage their health. Chapter seven deals with illness and how the informants conceptualize illness and what they perceive to cause illness. In Chapter eight, we explore how the informants manage illness in the self and view others who are sick. In the final chapter, we address the objectives of this study and suggest other research questions which arise from doing this research.

Chapter 2

Literature Review

2.1 Introduction

The concept of place is "one of the most multi-layered and multi-purpose words in our language" (Harvey 1993: 4). One of the greatest challenges facing the health geographer who wishes to make place matter is the lack of clear explanation of anything other than geographic place and how these broader notions are to be utilized. Eyles and Donovan (1990: 412) give us a clue when they state that a place-orientation to geographic health research demands "learning first-hand about people, observing and analysing 'real life'." It is interesting that while all lay perceptions studies are conducted *in places*, none of them explicitly attempt to link the physical environment to health and illness perceptions. Further, what is also found is that while these studies have a great deal to say about the influence of culture, social class, and gender on lay perceptions, the literature on the impacts of age upon lay perceptions is unsatisfactory in light of the fact that it tells us very little on how lay perceptions vary between age groups.

This study analyses 'real life' in places at two levels: first at a geographic level and second, at an experiential level. The literature demonstrates that comparative studies, looking at how perceptions vary between two similar places, have not been done to any great extent. Dyck (1996) suggests that class, 'race', sexuality, gender, and age all are positionings within sets of social relations of places. As there is a gap

in the literature around age variations in lay perceptions, this study focuses on age as a way to explore how people in different age groups perceive of health and illness.

In this chapter, the lay perception of health and illness literature is explored. Only those studies conducted on societies whose dominant health care system is biomedical are included in this review. First we look at what studies focusing on culture, social class and gender have found. Then we move on to look at geographical studies of lay perceptions. While there is only one study which explicitly claims to attempt a regional comparison, we also include those studies done by geographers which make implicit statements about the impacts of more experiential notions of place on lay perceptions of health and illness. Also in that section, we explore studies which explore age differences in lay perceptions. Ultimately we find that place and age are components of lay perceptions which have not been explored very well.

Much of the early research on lay concepts of health and illness was concerned with how well lay perceptions coincided with what biomedicine taught as appropriate health behaviours (Rosenstock 1974; Becker 1974), patient compliance (Zbrowski 1952; Zola 1966), and lay help seeking behaviour (Wadsworth *et al.* 1971; Hannay 1979). When lay ideas did not coincide with biomedical views, they were often seen as being ignorant, outmoded, and even dangerous (Stacey 1988). At that time, medical knowledge was viewed as universal, generalizable, and a logical 'science', while lay perceptions were seen as 'unscientific', illogical and ideologically suspect

(Eyles and Donovan 1990). Yet much of this research has been criticized on the ground that it fails to incorporate the socio-stuctural basis upon which lay perceptions are founded and where social action takes place (Bunton *et al.* 1991).

Research on lay perceptions has shifted away from focusing on lay behaviour to focus more upon social attitudes and actions addressing such questions as: what is health? How do lay people maintain their health? Consequently lay ideas are recognized to be logical and valid in their own right (Stacey 1988). Cornwell (1984) states that lay perceptions can be seen as being perfectly reasonable when we put these understandings in the context of people's lives. Researchers, many of whom are drawing upon the interpretative sociological tradition, are now focusing on what people think about their health and how they make sense of illness. The reasoning behind understanding lay perceptions is that while lay concepts may indeed be 'less informed' or 'expert' than those of biomedicine, in many ways - because health is a subjective experience - they provide a different type of information (see Williams 1983). As Calnan states:

> The value of adopting the interpretive approach.... is that emphasis is placed on understanding lay people's actions in terms of the meaning that they place on these actions. The meaning is itself derived from their own complex body of knowledge and beliefs, which is closely linked with the social context in which they live their daily lives. Thus, rather than treating beliefs about health as idiosyncratic, this approach emphasizes their logic and integrity (1987: 8).

Lay perceptions are part of the commonsense ideas passed on and used by others, including biomedicine (see Helman 1978). Because of this, lay perceptions offer a

starting point for studying both the genesis of social ideas and the conceptual basis of medicine (Williams 1983). Lay ideas are complex and consist of many different factors (Eyles and Donovan 1990). In fact, Blaxter (1982) and Pill and Stott (1982) were impressed by the complex, multifactorial responses that their respondents frequently used when explaining what illness is of which they develop in order to account for individual material, social, and bodily circumstances.

2.2 Dimensions of Lay Perceptions: Culture, Social Class, Gender

Lay perception research has tended to concentrate on certain dimensions of social life and these are explored in this section. There is an extensive body of anthropological literature which focuses on how different societies think about health (Evans-Pritchard 1937; Fabrega, 1974; Kleinman 1980) but mainly in countries where the biomedical model is not the predominant model for health care. Cultural studies in countries in which health care systems are biomedically based are relatively sparse.

Crawford's (1984) study, in Chicago, found that talking about health was like talking about U.S. cultural notions of well-being or quality of life. Both were consonant with the American ethics of self-reliance and individualism. Health clearly represented a socially recognizable and admired status which was an important part of the identities of the informants. Health was seen as both discipline and release. To achieve and maintain health required disciplined work. A similarity was perceived between occupational work discipline and health work discipline; the body was seen as the body of a worker. At the same time, health was also thought of requiring

'release' involving pleasure seeking behaviour and satisfaction of desires (cf. d'Houtard and Field, 1984). Crawford related this apparent contradiction (health as discipline and release) to American culture where capitalism regularly uses health to further its own positions and consequently the contradictions in capitalism are experienced in the bodies and minds of individuals.

Donovan (1986) studied the perceptions of people living in London, England who were of Afro-Caribbean or Asian descent. Between the two groups, Donovan found that there were differences in how health, illness and disease were conceptualized. Amongst the Afro-Caribbean informants, health was seen as a residual state - the presence or absence of illness or disease. The informants believed that perfect health could include 'everyday' illnesses such as colds or 'flu. Illnesses were described in very general terms but they were differentiated according to whether they were 'real' or 'heavy' illnesses (something which actually stopped them from working). Diseases, on the other hand, were described using specific biomedical language. The Asian informants saw health as a state of perfection and defined by the absence of ill-health. Unlike the Afro-Caribbean informants, none of the Asian informants felt that perfect health was possible to achieve. Their concepts of illness were informed by their traditional theory of the importance of balance of the 'hot' and 'cold' forces in the body. Consequently, illnesses were perceived to be the result of disturbances in this natural balance. Unlike the Afro-Caribbean informants, the Asians did not differentiate between illness and disease unless they were assimilated

into Western culture.

Stainton-Rogers (1991) working in England focused on the diversity of accounts for explaining health and illness. Exploring the broader cultural contexts and explanatory frameworks within which people construct explanations of health and illness resulted in eight different accounts: body as machine, body under siege, inequality of access, cultural critique, health promotion, robust individualism, God's will, willpower. The accounts are not all mutually compatible and there are numerous contradictions between them yet Stainton-Rogers argues that this does not prove lay people lack rationality and instead should be regarded as complementary.

Herzlich's (1973) research, one of the earliest lay perceptions studies, studied middle class people living in Paris and Normandy. She found that health and illness were perceived as the outcome of a struggle between an individual and their way of life. The informants felt responsible for their health because they felt that they were defined by it. Consequently people felt guilty, not for becoming ill, but for having lost their health. Popular concepts of the causes of illness and disease were variations on the themes also found in medical theories. Illness is seen as exogenous - caused by the way of life of each person whereas disease is seen as endogenous - represented by the individual and their part in the genesis of their condition. Herzlich felt that it was not so much that lay knowledge followed medical knowledge but that both draw upon a common stock of knowledge.

Like Herzlich, Helman (1978) found that folk models of illness and the

biomedical model are mutually reinforcing. Helman discusses lay and biomedical concepts of illness which are based upon his experiences as a family doctor in an English suburban community. He concluded that biomedical treatments and concepts, particularly germ theory, actually reinforce 'folk' models instead of oppose them.

Blaxter and Patterson's (1982) study of three generations of Scottish working class women revealed that health was perceived in functional terms particularly that of being able to work. The ability to work had great symbolic importance for these women. If one could work or was not forced to stay off work, then one must have good health. Subsequently health was either the absence of the symptoms of illness or the refusal to admit their existence in order to carry on. The women's concepts of illness and disease held many moral connotations. They perceived it to be necessary to reject the sick role as long as possible, even in the presence of illness or disease. Illness was not so much the experience of symptoms as much as it was the reaction to symptoms. "Illness was weakness, 'lying down to it' being functionally unfit, giving in to disease" (Blaxter 1983: 60) Some illnesses were seen as 'normal' or as 'part of being a woman' and therefore were also not to be given into easily. There was also a tendency for these women to normalize chronic or 'female' conditions. They also had clear models of disease which were part of their conception of illness. The names they used for disease were, for the most part, ones also used by biomedicine.

Because of the strong stigma associated with illness and disease, finding a

cause outside of the individual appears to be important for people (Blaxter 1983; Pill and Stott 1982). Blaxter (1983) found that some of the most commonly cited causes of illness were infection followed by heredity, environmental hazards, the secondary effects of other disease, stress, childbearing and menopause, trauma and surgery. Pill and Stott's (1982) study of working-class women also found that their informants saw the major cause of illness to be germs followed by life-style, heredity, and stress

d'Houtard and Field (1984) studied how health was conceived amongst three social classes in Lorraine, France. The intention of this study was to uncover any differences in how health was conceptualized by manual, non-manual, and professional/managerial workers. The way health was conceptualized varied according to socio-economic status. The higher income groups had more holistic, wider concepts of health where health was positively conceived and carried with it the notion of personal responsibility and control. Lower income groups had definitions which were strongly influenced by the biomedical model, and were negatively related to a lack of perceived responsibility or control.

Calnan and Johnson's (1985) study also found this clear social class difference in how health is conceptualized. The study focused on women from four social classes (social class V and IV being lower income and classes II and I being higher income) living in England. When speaking of health in the abstract, women from social classes IV and V tended to use uni-dimensional definitions whereas the women from social classes I and II tended to incorporate a wider range of elements which

included being fit, active and the absence of illness. However, when the women were asked to speak of health in themselves, no social class difference was evident. Both groups of women tended to rely on negative definitions of health.

It appears from these previous studies that health is very much related to how people think about work. Cornwell's (1984) study of working class men and women living in East London confirms this conclusion. Cornwell states that the way in which the informants of her study thought about their health was very similar to the way in which they thought about their work. In this case, like the women in Blaxter and Paterson's (1982) study, the informants were preoccupied with its moral aspects, in particular hard work. They felt that as far as health and illness are concerned, people should be able to deal with it with cheerful stoicism and demonstrate this by refusing to openly worry or complain. Good health is perceived to be a morally worthy state and illness is discreditable. Diseases are anything recognized by the doctor, whereas illnesses are dictated by the natural inequalities which are found in the basic make-up of different individuals. However, Cornwell found that this perception, which comprised the 'public accounts' given by people, changed upon closer examination and deeper probing. Individual 'private accounts' revealed that health is much more pragmatic and practical and is thought of in terms of being able to perform day-to-day activities. Like Calnan and Johnson (1985), Cornwell demonstrates that health in the abstract is thought of differently than health in the self.

Eyles and Donovan (1990) studied working class perceptions amongst black

and white samples living in metropolitan areas of England. While health was found by the informants to be very difficult to describe, it was generally seen in residual terms; of not being ill and being able to function or carry on with day to day activities. This finding is not surprising and confirms the findings of previous studies of working class people (Blaxter and Paterson 1982; D'Houtard and Field 1984; Calnan and Johnson 1985; Cornwell 1984). Also, like Cornwell (1984), Eyles and Donovan found the people feared the loss of functional capacity or of not being able to work. This represented some sort of stigma associated with being ill. All people wanted to be healthy and this involved some negotiation especially for those who were not (ie. those who had chronic conditions). What emerged was the distinction between 'ordinary' illnesses, which are to be tolerated because they are an inevitable part of life, and 'serious' illnesses which necessitate seeking professional help. Diseases, on the other hand, are medically defined, acute dysfunctions which can be life threatening and almost always require medical attention. It is only when an illness is considered to be life-threatening or is interrupting normal life that the label 'serious' is assigned and accepted. In a study done in southern Ontario, Litva and Eyles (1994) found that going to the doctor allowed for the temporary legitimation of sickness and prevented the individual from being seen as deviant.

In general, all of these studies looking at social class perceptions of health demonstrate that within the limits set by individual experiences, health concepts tend to vary according to the immediate material circumstances in which people live and

by which they are constrained. The extent to which people are dependent on their own physical labour, the extent to which they control their own lives and the lives of others, influences how people think of health, illness, and disease (Pill and Stott, 1982).

Lay perceptions research looking at gender has tended to focus upon how women from different social groups conceptualize the causes of disease. Walters (1993) found that women from higher social classes tended to view stress as one of the major causes of illness. Women from lower social classes tended to see the major cause of illness to be depression. Saltonstall's (1993) study focused upon comparing the perceptions of middle class men and women between the ages of 35 and 55. In this study, health was found to be grounded in a sense of self and sense of body, both of which are tied to conceptions of past and future health activities. The respondents cited different bodily symbols of health for males and females, differentiating between male and female bodies, their needs and 'appropriate' health activities. For example, men often spoke of their bodies 'belonging' to them while women generally did not use ownership language. When speaking about diet, men usually spoke of the nutrient quality while women also emphasized the caloric quality. While health may be a universal fact as well as a constituted social reality, the healthy body was rarely referenced in universal, non-gendered terms. Health activities were viewed as a form of practice which constructs a 'gendered' person in the same way as other social and cultural activities.

2.3 Place, Age and Lay Perceptions

While lay perceptions research has tended to focus upon gender, social class and culture, it has not adequately explored the role of physical place and age (place-in-life) on lay perceptions. Thus this study has set the objective to try to address this gap in the literature. Within this body of literature on lay perceptions, there is only one study which explicitly states that its purpose is to explore the impact of place on lay perceptions of health. Research by Donovan(1986) and Cornwell(1984), while situated in places and seeking to make the link between people's experience of places and their perceptions, fails to make the role of place explicit and leaves the reader wondering what place is and how it matters.

Eyles and Donovan's (1990) study of three communities in metropolitan areas of England explicitly states the intention of examining region variations in lay perceptions of health and in the utilisation of health services. What they found was that " regional [sic] consciousnesses with respect to health and illness do not exist. But it is not as straightforward as that"(Eyles and Donovan 1990: 116). While we can expect a shared view of the world, there are exceptions. They found that racism imposed on black and Asian people creates particular disadvantages which affect their quality of life. As well, different cultural heritages provide different ways of seeing and acting in the world. Essentially political, social and communication structures in particular places may affect how people think and act thus contributing to a 'regional consciousness'. Ultimately they conclude that subcultural and locational differences

are largely based upon the material circumstances of the particular subcultures and localities.

Central to Donovan's (1986) research involving Afro-Caribbeans and Asians living in the north and east parts of London, England is the understanding of the meanings and experience of health and ill-health, particularly focusing upon the context of everyday events, the effects of social forces and relations and each individual's personal and cultural inheritance. It is recognized that age, class, race and gender are all positions within the social relations of places: in essence contributing to people's sense of place. Donovan mentions the effects of the physical environment, in terms of pollution, coldness and dampness as well as personal safety, on the informant's perceptions. Yet while there are many interesting discoveries about race relations and how they affect each group of informants thus contributing to a sort of 'regional or local consciousness', Donovan fails to define or discuss the experiential components of place and its possible influence on lay perceptions of health.

Another study done by Cornwell(1984) describes the account of health and illness found amongst informants living in East London. This study of a particular locale tells us how people living in a working class area perceive health and illness. In her study, Cornwell uncovers the distinction between private and public accounts of health and illness as well as the power relations that are entailed in the institutionalization of medical care. While the relationship between insider and

outsider accounts are suggested to be components of the concept of experiential place (cf. Jackson 1986), we are still left wondering how these contribute to the experience of living in East London and how it affects people's perceptions. Ultimately, Cornwell's study tells us more about lay perceptions and social class, which is arguably central to their sense of place.

As previously stated, one aspect of the social relations of places is age (cf. Dyck 1996). While there have been some studies which seek to explain how age impacts lay perceptions, there are few which look at and compare how perceptions vary between age groups. Williams (1983),explored conceptions of health among 60 year old Aberdonians. It was revealed that health is generally conceived in three ways. Health was viewed in three different ways: the relative absence of disease, as a reserve, or as being 'fit' or 'able to work'. Unfortunately we do not know how this compares with Aberdonians of other ages.

Blaxter's (1990) lifestyle survey provides us with some clues as to the ways in which health is conceived over the life course. This large scale survey done in the United Kingdom found that amongst older people, in particular men, health was thought of in terms of functions or the ability to do things, mental well-being, and the absence of disease. Older respondents had a different expectation of health in that they considered a much higher level of pain and discomfort to be 'normal'. Amongst the middle aged, concepts of health became more complex with emphasis being put on total mental and physical well-being. Blaxter's intent was to study age differences

in perceptions, and she did find that younger men tend to think of health in terms of positive physical fitness, while younger women also incorporated ideas of energy vitality and the ability to cope. This study, while giving us insights into the fact that lay perceptions do vary by age, does not tell us much about the context because of the large scale survey instrument used to extract these perceptions.

In earlier studies, Blaxter (1983) and Cornwell (1984) also found intergenerational differences in perceptions of the causes of disease and illness. Older people attached more significance to moral fibre whereas younger people tended to place more emphasis on germs, viruses and social stress as the causes of illness and disease. But intergenerational categories are very general and fail to tell us how perceptions vary within these broad generational categories.

2.4 Conclusions

In general, what has been found from this body of literature is that most of the research has been carried out on specific groups: usually women, particular age-groups or the working classes (Pierret 1993). From the body of research exploring culture and social class implications on lay perceptions of health, we can be fairly confident that culture as well as material circumstances influence how health and illness are understood. The study on gender variations has tended to be focused upon women's perceptions. However, Saltonstall's study which is the only comparative study, suggesting that gender impacts upon how the body is perceived as well as how to take care of the body.

With the exception of Eyles and Donovan's (1990) study, no lay perceptions research has attempted to explicitly explore the role of place, in its geographical sense, upon lay perceptions of health and illness. While it may be argued that Donovan's (1986) and Cornwell's (1984) studies are about the experience of living in places, because their focus was not explicitly upon the impacts of experiential place, we are forced to speculate a great deal. In terms of studies exploring age variations, Blaxter's (1990) cross-sectional study, while revealing age differences in how health is understood does not allow us to separate the effects of changes over the life-course of individuals from effects due to differences between the generations (Curtis and Taket 1996). Nonetheless, Blaxter's research indicates that life-cycle variations do exist but we still need further understanding of how and why they exist. Thus this study focuses upon addressing two gaps in the literature: the impacts of place and the impacts of age (place-in-life) upon lay perceptions of health and illness. Before we move on to look at how place impacts upon lay perceptions, in the next chapter, we shall examine the methods used for carrying out this research.

Chapter 3

Theoretical Approach

3.1 Introduction

All research in the social sciences is theory laden (Sayer 1992). The theoretical framework which guides the research process informs what is to be studied and what is not, as well as how it will be studied. This theory-method linkage means that the approach taken to study the world 'frames' what will be learned (Glaser and Strauss, 1967). It is therefore important to acknowledge openly the theoretical criteria which shape our search for and classification of observable phenomena as well as the relationships between them (Litva and Eyles, 1995). In this chapter, we will discuss the preferred theoretical framework which informs this study, symbolic interactionism, and demonstrate why it was chosen.

Symbolic interactionism is rooted in pragmatism (Ritzer 1992; Hewitt 1991). Essentially this means that symbolic interactionism does not believe in the existence of an objective reality but only the existence of a socially constructed one. However, unlike other social constructionist theories, symbolic interactionism does not assume that social and cultural patterns by themselves explain conduct. Human beings are not treated as passive in or to their environment. Human beings, while being shaped by culture and society, are also actively engaged in shaping or constructing them.

3.2 Society as Constructed through Conversation

Symbolic interactionism views the social world as a social product, the

meanings of which are constituted in and through social interaction, particularly through conversation. The roots of symbolic interactionism lie in philosophical pragmatism and psychological behaviourism. From this confluence developed the symbolic interactionism practised at the University of Chicago in the 1920s. This theory stood in contrast to the psychological reductionism of behaviourism and the determinism of structural functionalism through its distinctive orientation toward the mental capacities of actors and their relationship to action and interaction.

The founding thinker behind symbolic interactionism is George Herbert Mead (1934). All modern discussions around symbolic interactionism give him a central place. Yet a number of symbolic interactionists (Blumer 1969; Manis and Meltzer, 1978; Rose 1962) have tried to enumerate the basic principles of this theory. The most concise formulation of the principles of interactionism comes from Blumer (1969), set out as a series of assumptions. The first is that people will act towards things based upon the meaning that they have attached to them. The second is that meanings are attached to things as a result of social interactions with other people. The third of symbolic interactionism is that meanings are altered and negotiated through an interpretive process used by individuals in dealing with things that they encounter.

The symbolic interactionist approach states that the meanings that are attached to the things are central in their own right; meanings that people hold about things are important to study (Blumer 1969). They are not regarded as being intrinsic to the

make-up of a thing nor are seen as emerging through a combination of psychological elements in the person. But to ignore meanings and focus upon such factors as patterns or habits which are said to produce particular behaviours, is to neglect the role that meaning plays in the formation of certain behaviours. Meanings arise through the process of interaction between people. The meaning of a thing for a person evolves out of the ways in which other persons act toward the person with regard to the thing (ie. Cooley's (1964) 'looking glass self', Mead's 'objective-subjective self').

Symbolic interactionism sees human society as people engaged in living. People are involved in a process of ongoing activity in which they are constantly forming lines of action to suit the many life situations they encounter. As Mead states:

> Individuals in human society were not seen as units that are motivated by external or internal forces beyond their control, or within the confines of a more or less fixed structure. Rather, they were viewed as reflective or interacting units which comprise the societal entity.(1934)

They are also involved in a process of interaction in which each person develops actions which must fit everyone else's. The ability to think enables people to act reflectively rather than just responding to stimuli. People construct and guide what they do, rather than unconsciously just doing it. Consequently, interaction involves indicating to others what to do while at the same time interpreting indications made by others (Blumer 1985).

The principal architect of symbolic interactionism is often thought to be

George Herbert Mead, a pragmatist philosopher, who is best known for his theory of the mind. Mead's theory of the mind attempts to record the origins and development of human intelligence by linking it to the process of evolution, by viewing the mind and behaviour as inseparable and by showing that the origins of the human mind lie in society. Mead did not treat the mind as a separate entity. He sought to avoid the dualistic view of mind and body that had plagued philosophy, a view which led people to separate the physical body from the mind. For Mead, mind, body and conduct are inseparable aspects of a process of evolution that has produced a uniquely human life form. Mead referred to his theory as social psychology and it was his student, Blumer, who coined the phrase symbolic interactionism.

Mead's starting point is language or the 'significant symbol' and the implications of this on human action and interaction. Significant symbols are shared meanings. People learn symbols as well as meanings through social interaction. They are developed in the course of interaction, which itself is a matter of people seeking to achieve practical results in co-operation with each other. Most individual acts are a part of more complex, socially coordinated activity. For example, shaking hands is a socially coordinated act in which the past experiences and future hopes of two individuals, as well as established social conventions, are important. Social interactions produce meaning and meanings make up our world. We create our world by giving meaning to it.

So far we have been discussing 'external conversations' - the process by

which we create our shared world which explain the first two principles of symbolic interactionism. Mead felt that humans have the distinctive capacity to carry on an inner conversation with themselves. All mental processes, therefore, are viewed by Mead as being lodged in the social process. The internal interpretative process is an internal conversation between two different parts of the self; the 'me' and the 'I'. The internal conversation provides a channel through which all the external conversations must pass. Socialization occurs through the internal conversation.

The self has the ability to treat oneself as an object. The self arises within the social process. Society is the ongoing social process that precedes and shapes the self. The general mechanism of the self is the ability of people to put themselves in the place of others, to act as they act and to see themselves as others see them; otherwise referred to as the generalized other. The self is essential to the emergence of the self as well as of organized group activities because the significant symbol brings out similar reactions in everybody.

As one part of a process within the larger process of the self, the 'me' allows us to look at ourselves as others view us. It is the organized set of attitudes of others assumed by the actor. Social control is manifested through the 'me'. The other part of the self is the 'I' which is the part that looks at ourselves. It unpredictable and the source of originality, creativity and spontaneity. It is the key source of novelty in the social process, it is where our personality is located. The 'me' allows the individual to live in the social world, while the 'I' makes social change possible. Thus the 'I'

and the 'me' are part of the whole social process allowing both individuals and society to function effectively.

3.3 Relevance of Symbolic Interactionism

There are three significant reasons why symbolic interactionism has been chosen to inform this study and why it is the most appropriate theory to do so. First, symbolic interactionism does not treat the agent as passive to social forces. Second, it does not treat the mind as a separate entity from the body and acknowledges internal forces (internal conversations with the self) as well as external forces (conversations with others) as having an impact. Finally, it appears that for studying the impact of place on lay perceptions of health and illness, symbolic interactionism, with its notion that people both make and are influenced by their context, resonates with recent thinking about the concept of place and its impacts in humanistic geography.

Symbolic interactionism seeks to explain the actual formation of conduct from social interaction, and not to assume that social and cultural patterns by themselves explain conduct as theories such as structural functionalism and conflict tend to do. Human beings are not only shaped by culture and society, but they are also actively involved in shaping them. Functionalist and conflict theories both tend to assume that people's understandings are constructed *for* them and imposed *upon* them as the product of social forces. Essentially, people are treated as puppets (Dingwall 1976). Symbolic interactionism, while acknowledging the impacts of social forces, does not

treat people as passive recipients but as active agents engage in the shaping of the social forces which in turn shape them (Stainton-Rogers 1991).

Lay perception research has demonstrated that there is a relationship between the mind and the body (Crawford 1980; Saltonstall 1993; Litva and Eyles 1994). Consequently, the nature of this relationship means that in order to study lay perceptions of health and illness, the theory used must be able to take this fact into account. Mead, in developing symbolic interactionism , sought to avoid the dualistic view of mind and body that had plagued philosophy, a view which led people to separate the physical body from the mind. For Mead, mind, body and conduct are inseparable aspects of a process of evolution that has produced a uniquely human life form. It is this emphasis which makes this theory particularly useful for exploring lay perceptions of health and illness. Within the biomedical model, the body is generally treated as a dualism where there is no interaction between the mind and the physical body so that these two realms can be addressed separately. Yet symbolic interactionism does not separate the two and even asserts that one constructs the other. This very much ties in with Giddens (1991) who argues that the body is no longer an "intrinsic 'given' functioning outside the internally referential systems of modernity, but becomes itself reflexively mobilized" (1991: 218).

A final reason for using this theory is that Ley (1981) has argued that a major focus of humanistic geography is the recovery of 'the relationship between landscape and identity.' Central to his argument is the notion of 'place is a negotiated reality,

a social construction by a purposeful set of actors. But the relationship is mutual, for places in turn develop and reinforce the identity of the social group that claims them" (Ley 1981: 219). Duncan (1978) also asserted that the self is 'dependent upon one's relations to a place and the persons associated with that place'. It is therefore useful for this place (physical place and place-in-the-world) sensitive study of lay perceptions to use a theory, like symbolic interactionism, where physical and social context are treated as having an active role in the formation of perceptions as well as being created by the perceptions themselves.

3.4 Conclusions

In this section the nature of symbolic interactionism has been discussed, specifically focusing on how symbolic interactionism perceives the role of internal and external conversations for influencing how things are perceived and how they are responded to. We then moved to demonstrate why such a theory appears to be appropriate for exploring lay perceptions of health. Such a theory, which views meaning as a topic of study and social relations as constantly under construction, requires a method which allows the researcher to be able to access these perceptions as well as the interpretative system underlying the discourses. This method would have to allow people to be able to freely express their feelings as they talk about their lives and practices. In the next chapter, the methodological aspects of this research, particularly the use of in-depth interviewing as a way of accessing the meanings that people attach to health and illness, will be explored.

Chapter 4

Research Design and Methods

4.1 Introduction

The research is located within the interpretive paradigm which is concerned with the understanding and analysis of meanings within specific contexts (Eyles 1988; Eyles and Donovan 1990). This thesis seeks to explore the differences in how people living in two different sites make sense of health and illness. In addition, it seeks to explore how perceptions vary between age groups in order to get an idea of how a person's place-in-life influences perceptions. It is recognized, however, that realities are multiple and flexible and it is understood *a priori* that there is no way to distinguish between 'causes' and 'effects' in this type of study (Baxter and Eyles, 1996). Instead, the information provided by the informants is set against theoretical concepts and ideas in order to enhance our understanding of their worlds. So the methods used in this study take into account the fact that we cannot create generalizable statements about these people's worlds. Instead the study seeks to *explore* and attempts to *represent* these people's worlds as well as possible.

In the previous chapter, the preferred theoretical framework of symbolic interactionism was explored. Interactionism, as discussed, is concerned with the creations and change of symbolic orders via social interaction; essentially it is concerned with the meanings people hold about things. The concern with meanings has an important implication for how interactionists view methodology (Silverman,

1993) for meanings are not readily available for observation (Mead 1934). Subsequently, the method used must be one which is sensitive enough to allow the researcher to be able to get at these meanings but also to understand them from the informants' perspective or point of view (Blumer 1969). In light of this, the qualitative method of semi-structured in-depth interviewing was chosen as the method for this study.

Doing good qualitative research is a task which is often downplayed, misunderstood and not carefully explained. Credibility is one of the most important principles for guiding qualitative studies. Credibility can be understood as the degree to which the description of human experience is accurate enough so that those having the experience would recognize it and those outside of the experience can relate to or understand it (Lincoln and Guba, 1985). What is sought is that those having the experience would recognize it immediately (Eyles 1988; McDowell 1992). Hence the goal of a researcher is to represent as well as possible the realities of a group in a way that the scientific community understands the reconstruction as do the people who constructed the reality in the first place (Baxter and Eyles, 1996). Consequently, as part of doing qualitative research, a 'thick description' (Geertz 1973) of the processes involved in how the data was obtained, analyzed and presented is provided to give the reader as clear a story line as possible to follow.

4.2 Site and Site Selection

In qualitative research, site selection is often both theoretically and practically

driven. An earlier study (cf. Litva 1993) on a town located next to a large city initially caused me to question the extent to which place influenced peoples perceptions of health. Therefore two communities were chosen which were relatively similar in order to be able to determine if lay perceptions varied between two similar places. Both of the communities are small towns which are located in quite remote parts of Ontario. Farming Town (site B) is at least one hour drive to the largest urban centre, and is service centre to the surrounding farming community. Papermill Town (site C) is locate three hours drive from a major urban centre and acts as a small service centre for a large section of Ontario's north-western corner. According to 1991 census data, both towns have a population under 10,000 people. The residents in both towns are predominantly English speaking, of British decent and Protestant backgrounds. Papermill Town does, however, differ in that it has a large native population living in and around the community on reservations. The communities are both largely comprised of single, detached owner-occupied homes.

According to the 1991 Census data, Farming Town has an unemployment rate for people 25 years and older of 7.2% while Papermill Town's is slightly lower at 5.3%. The major source of employment in Farming town for men is white collar employment and construction trades while for women it is clerical work. In Papermill town, the major source of employment for men are service occupations and construction, while women are largely employed in services. Another difference between the communities is the fact that Farming Town is surrounding by agricultural

land use while Papermill Town has a large pulp and paper industry. Each community has been trying to build up its tourism trade to supplement local industry and to provide more jobs. Farming town has an average family income of $59,906 which is higher than Papermill Town's $51,818.

Another influence on the choice of communities was the fact that the research focus would be upon the meanings held by people. However, in order to be able to access the informants worlds, it is essential that the researcher have ways in which to be able to establish links and build rapport. In the case of Farming Town, I had lived for a while within the community and had a number of key informants on whom I could draw to help me find people to interview. In the case of Papermill Town, there was a key informant known to us who had lived there all his life and who was willing to help establish linkages in the community.

4.3 The Informants and Informant Selection Procedures

One of the objectives of this research is to compare how people in different age groups between two sites perceive issues around health and illness. In addition to this, based on the literature on lay perceptions of health and illness, I adopted other criteria which influenced whom I would include in my sample. While difficult to control for all variables, the literature suggests that economic status and ethnicity are particularly influential variables upon lay perceptions of health (See Chapter 2). Therefore, before going into the field, I knew that I wanted to interview people who

were of working age, were Canadian[1], were non-professionals, as well as not native. Also, in keeping with the goals of the research, I wanted to get as equal numbers as possible of men and women for each of the three age categories (young, middle, older) which I had constructed for this study. The informants in the young group included all those who were 39 years and under. The middle group would be comprised of informants who were between the ages of 40 and 59 years. The older group would include all of those who were 60 years and older. Each site had three age groups which was compared to the other site's equivalent age category. This allowed age variations to be identified (if they existed) and explored.

With these criteria in mind, two types of sampling were employed. The decision to use these two particular sampling strategies was influenced by the fact that I was not able to spend long periods of time in each town. The first type was snowball, or chain, sampling. This involves using certain key informants in each community to help identify and gain access to information-rich informants. By using a person who is well situated in the community, the researcher is able to gain access quickly to information rich informants, who are those able to talk easily with you, with whom you can quickly and easily establish a rapport, and who are comfortable talking freely with the researcher. Each key informant was told about the types of people we wanted to interview in terms of age and ethnic status. They were then

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[1]In this case, 'Canadians' were defined simply as people born in Canada who were not native Canadian.

asked if they knew of family or friends who might be good interview subjects. Afterwards, I would ask each informant if they could refer me to other informants. In this way, I did not have to rely on one key informant and I was not restricted to drawing all my informants from one person's social network.

Snowball sampling proved to be indispensable tool for gaining access to different types of people like millworkers at PaperMill Town (site C) and farmers at Farm Town (site B). Before I began interviewing, I was not aware of difficulties with accessing the millworkers because I did not know the shifts that they worked. I therefore needed help finding people who were on the 'right' shift so that I could interview them. The key informants proved to be very useful. Also, I had timed my research at site B to coincide with hay season. This is a particularly important time for farmers as they must get their haying done in a short period of time. Consequently they work very long hours and this made it difficult to get them to commit to an interview. Having someone who understood and knew the informant's lifestyles was therefore invaluable tool.

The second type of sampling used was convenience or opportunistic sampling. Fieldwork can often involve on-the-spot decisions about sampling in order to take advantage of unforseen opportunities which arise while in the field. It is not possible to capture everything while in the field and therefore decisions sometimes have to be made about which people to interview *in situ*. This type of sampling reflects the flexibility of qualitative research design as it allows the researcher to follow new leads

and to take advantage of whatever unfolds as it unfolds (Kuzel 1992). This sampling strategy would be flexible enough to allow me to take advantage of opportunities for getting interviews with people. I asked everybody I came in contact with such a waiters or cab drivers to participate in an interview. I also found that by watching the community television channel I could find out where various events were taking place such as Weight Watcher Meetings or Euchre Nights. I would show up at these events and try to solicit interviews. This proved to be very successful and I suspect it is because the people who participate in these events are likely to be relatively out-going. I also found that the various resource centers in the communities were good places to solicit interviews. At PaperMill Town (site C), I used the legal aid office, the senior center and the women's resource center as sites for soliciting interviews. Donut shops also turned out to be great places to find interviewees.

Recruitment of the informants usually occurs until no new themes or constructs emerge from the informants. In this study, this was one of the reasons for stopping the interviewing when I did. The total number of interviews I completed was 53. The data collection for Farming Town (site B) was conducted during a one week period in August of 1992 and a four day period in August of 1993. The total number of interviews from Farming town was 27. While at Papermill Town (site C), I only had a total of seven days to solicit and conduct the interviews. In the one week that I was in Papermill Town in August of 1993, I was able to do a total of 26 interviews. All the interviews were tape recorded and each informant was given a

fictitious name.

Appendix A lists the fictitious names of the informants interviewed at each site as well as descriptive information. Appendix B shows how the informants were categorized for the analysis. From each site, the informants were divided into one of three age categories; young, middle or older. I did attempt to interview an equal number of men and women in each age category but was only moderately successful. Hence the unequal numbers in some age categories.

4.4 Interviewing Practices

As my time in the field was limited, I decided to use a semi-structured interview approach, using a set of previously identified themes (see Appendix C). The use of a checklist enabled me to focus the interview only on the relevant (health) issues as well as ensure that all the themes were discussed which all the informants. The themes were not always presented in exactly the same order or the same way for each informant as the goal was to conduct the interviews in a conversation-like manner (ie. no set order to the themes). The themes used initially were derived from my Master's degree (Litva 1993) as well as from similar research by my supervisor in the United Kingdom (Eyles and Donovan 1990). As part of the interviewing process, I kept a detailed journal in which I recorded as much about the setting as I could. I also kept track of new themes which emerged from each interview. I followed up on these new themes (potentially negative cases) with subsequent informants in order to determine if they were particular to the individual or if they

represented a part of the collective reality which I had previously encountered. It was in this way that the list of themes evolved throughout the interviews (Glaser and Strauss 1967). The length of time each interview took varied between one hour and three hours. It is interesting to note that what changed the most throughout the course of the interviews was not so much the list of key words but how they are conceptualized, treated and linked together. Thus I feel the research design remained grounded within the empirical world.

Keeping track of these emerging themes is also part of determining when the interviewing stopped in each site. When no new themes emerged from the interviews and all negative cases (situations where an informant said something which did not confirm what had been previously stated by informants) had been explored, I felt that I had gathered sufficient data to represent these informants lived realities.

In order to protect identities, thus encouraging open and free discussion, all the informants were guaranteed anonymity and have been given a fictitious name. Each informant was asked if the interview could be taped. As it turned out, none of the people in the study objected to my using a tape recorder in the interview. I always tried to treat the tape recorder casually so that if the informants were uncomfortable with it, it was not magnified by my trying to pretend it was not there. Taping is a preferred way to increase dependability in the data as none of the data retrieval is dependent upon memory. The tapes are all transcribed verbatim later on with every cough, laugh and 'um' included. When interpreting the data, if I became uncertain

about the intended meaning or context in which something was said, I often returned to these tapes. These, with my field notes can usually bring back the setting, mood and sounds of a particular interview.

In qualitative research, the researcher is the instrument. This means that the research is dependent upon the interviewer's skill at developing a rapport with respondents and his/her ability to use this to develop information-rich conversations. One of the things which I felt was very important was to conduct the interviews in a place where the informant would feel comfortable and I would feel safe. Thus the study is conducted in a naturalistic or 'real world' situation (Wilms and Johnson 1993). At times this can put the researcher in awkward situations which require a great deal of self-control. One such incident occurred when I wanted to interview a very busy farmer. Unfortunately my only opportunity to do so was at 8:00 am in the morning while he was artificially inseminating a cow. One time at site C, I was interviewing a women who had very serious eczema which resulted in a dusting of flakes of skin covering much of the furniture in the house. Needless to say, this caused me a great deal of discomfort and I had to fight with myself to control my voice as well as my facial expressions.

When conducting the interviews, there are concerns over power relations and related to this the presentation of the self in interview. Age, gender, ethnicity and physical appearance can potentially affect how respondents react in the interview (Pile 1991). I therefore make it a practice to try to address these issues prior to entering

the research setting and adjusting myself as the research proceeds. One of the things which I do pay attention to is how I look. Very quickly into the interviewing process I realized I looked far too much like a graduate student. I attempted to change the way I dressed which involved trading in my Birkenstock shoes for a pair of running shoes.

The practice of being sensitive to one's own ethnocentrism and biases is called disciplined subjectivity by Erickson (1973) or is better known as bracketing (Lincoln and Guba, 1985) or researcher reflexivity (Brody 1992). In most qualitative research, the researcher must attempt to bracket his/her own values and assumptions about the problem. This may involve explicitly stating them, often in the form of an auto-biographic account so that the readers might see why certain results were find or why certain explanations were offered. (Eyles and Donovan, 1990; Willms and Johnson 1993). The researcher does not remain objectively removed from the research subject thus avoiding bias as he/she does in quantitative research. Instead these biases are accepted but not as unproblematic. There must be an open disclosure about the preconceptions held by the investigator which may influence data collection and processing. Thus, these preconceptions become part of the conduct of the inquiry (Willms and Johnson 1993). It is therefore important to make this information clear to the reader (Patton 1990). For these reasons, I provide a brief auto-biographical account.

I am from a mixed Dutch and Russian heritage although I am Canadian born.

I am the fourth child in a family of five children. I was raised as a Roman Catholic although I no longer practice this faith. The majority of my life was spent living in a small rural community with which I still strongly identify as it has left many of its imprints upon me. I still speak with a slight accent which is associated with this particular part of Ontario and as soon as I arrive back in the place I think of as 'home' I immediately slip back into the local vernacular. I left this town when my father came to work for McMaster University where he is presently employed as a professor. My mother, at this time, works in the home and has done so for the majority of my childhood.

There are other strategies for bracketing the effects of social relations on the findings during the interview process. Among these are prolonged engagement, persistent observation, and triangulation (Lincoln and Guba 1985). Prolonged engagement involves spending enough time in the field in order to build trust and rapport with the respondents. Another strategy for conducting credible analysis is to use persistent observation. This involves being able to focus on the 'things which count' in terms of the research questions being asked. As I was born and raised in Ontario, I did not feel that prolonged engagement nor persistent observation was as important as it would be if I were studying a group of people outside of my culture. I felt that since I was part of this culture, I had a good grasp on how things worked and on the major issues with regards to perceptions of health and illness. In the next section, I discuss in detail how I used triangulation to reduce the effects of any

personal bias upon the interpretation of the data.

4.5 Analysis

When doing qualitative research it is difficult to define the precise moment at which data collection ends and analysis begins. While gathering the data, patterns, themes, and categories of analysis were recorded in field notes as they emerged in order to document each step of the research process (thick description), as well as to keep track of emerging themes (Glaser and Strauss 1967), to ensure follow-up on any negative cases (Patton 1990: Gilchrist 1992), and to determine the point of redundancy (when no new themes emerge). The tapes were all transcribed verbatim by two transcribers in order to provide the text for analysis. In addition to the tapes, field notes were kept to record information which could help in the analysis of the transcript as well as provide a description of the context, moods and atmosphere of each interview. These field notes and audio recordings include verbatim accounts and narratives of behaviours, activities and events. Sometimes referred to as low-inference descriptors, they are one way in which to ensure the dependability of data (Pelto and Pelto 1978; Schatzman and Strauss 1973; Patton 1990).

Triangulation is a strategy for ensuring that the findings are not an artifact of a single method or of a single investigator's bias. There are essentially four types of triangulation. They are the use of multiple sources, methods, investigators and theories (Patton 1992; Eyles and Smith, 1988). While it would be ideal that the research use all four types, it is often logistically (and financially!) impossible.

Therefore, assessments of qualitative research findings are not based upon whether or not all methods of triangulation have been used but upon how many have been used and how well they have been used. This study used source and investigator triangulation. Source triangulation refers to the use of more than one report from a data set to corroborate a construct. One of the most common ways to do this is to use quotations from several different respondents. During my analysis, I focused a great deal of time and attention on ensuring that more than one person corroborated an idea.

Investigator triangulation involves using more than one person who is familiar with the research to look at the data independently and see if we arrived a similar results. Before coding began, I asked Jamie Baxter, a qualitative researcher and Ph.D. student, and John Eyles, my supervisor, to read and code a randomly selected set of transcripts. I coded the same set of transcripts as well. After they had been coded, I compared the coding schemes, discussed it with my supervisor John Eyles and along with my original list of themes, ideas from my field notes, as well as constructs from the literature, I developed a coding scheme with which to analyze the data. I used WordPerfect to search and sort the transcripts. Essentially I created a file for each general code word (which I call first level codes) such as 'health', 'lifestyle', and 'illness'. As the analysis progressed, I created new files with code words which emerged from the first level codes. For example, from the code 'illness', I constructed and created what I call second level code files based on words such as

'blame' or 'management' and simply cut and pasted the quotes from each informant's interview into that file. Sometimes I found that first level code words had to be expanded as they were more complex than I initially thought. So the word health had to be split into two first level codes: health-abstract and health-self. Afterwards, I had a print-out of the quotes for each first-level and second-level code word. This method also allowed me to cross-code the same line of data. I then re-coded each file in order to document the variety contained within one single second level code. When I had completed half of my analysis, I had Jamie Baxter look at it to examine my interpretations and identify possible sources of misinterpretation.

4.6 Presentation of Findings

Quotations are important for revealing how meanings are expressed in the respondents' own words rather than the words of the researcher. Yet the researcher must provide a discussion of why particular voices are heard and others silenced through the selection of quotes (Bryman 1988; Silverman 1993). During the entire research process, I kept a journal in which I recorded themes, hunches, interpretations and ideas as I read and re-read the data. After all of the data had been analyzed and coded and re-coded, I looked at each file and began to develop a story line informed by theoretical constructs which have emerged from the informants stories. I feel that there must be several quotes to support a construct before I consider it to exist or represent the informants realities. However, sometimes when deciding which quotes to use, I find that one quote may have this theme in it but illustrate another theme

much better. I prefer not to include a quote more than once as it makes reading repetitious. When I present the quotes, they are verbatim. I do not 'clean' up my data as I feel the hesitancy and the repetition demonstrate that these ideas about commonplace concepts such as health, illness or disease are sometimes very difficult to articulate.

There are several things to consider when deciding which quotes to include in the write-up. For instance, some people are naturally far more articulate than others and subsequently their voices will be heard more often. Another issue is how well the quote confirms the theoretical construct being explored without undue explanation on my part. The reality is that some people say the same thing but only in a series of short responses such as "uh-huh", "maybe" or "I think so". I pay particular attention to how much of a voice each informant is given compared with the rest of the informants. Sometimes this is difficult because the interviewing process does not always go well with everybody. And while their ideas confirm or resonate with another person's meanings, you do not always get really "rich"or insightful answers. I do, however, feel it important to include everyone's 'voice' in this thesis. Therefore, if there are two quotes essentially supporting the same construct, I will give preference to the person from whom we have not heard as much in other parts of the analysis.

In my write-up I use as many quotes as possible. My decision to include the quote is determined by how well it captures the essence and meaning of the construct,

how understandable it is without a great deal of build up or explanation, and whether it contributes to the telling of the story. This means that I often use as large a 'chunk' of the conversation to support the construct as possible. I do include the voices of informants whose ideas or experiences do not fit with the rest of the informants. For example, while discussing concepts of health (chapter 5), I included a relatively large section about Nat (a negative case) who, because of his context, had a different understanding of the concept of healthiness. This was juxtaposed with Patricia who also suffered from a chronic illness yet had a concept of health in the self which was similar to the group.

It is also my personal preference to use a large number of quotes for which relatively little interpretation is required. The parts which I coded to be related to a particular theme are in bold. In this way, the reader is able to assess the accuracy of my interpretation as well as to hear the informants express their meaning in their own words. After writing up the findings, I had John Eyles check my written interpretations to triangulate my final and written interpretations.

4.7 Conclusions

In this section we explored the interpretive methods used to used to try and gain access to and explore the worlds of 53 people. Coming from a symbolic interactionist perspective with its focus on meanings meant that in-depth interviews were the most useful tool for gathering information about health and illness. The approaches taken for selecting the sites for study and the informants were also

outlined. A detailed description of how the analysis was conducted provides insights into how the final documentation of the research was reached.

The degree to which a researcher can access a person's world is highly contentious. As a qualitative researcher, there are techniques to use but how successful one is in representing another person's reality remains open for debate. While I make not claims to be able to provide 'facts' about how people perceive health and illness, I do feel that this research has been able to capture the essence of their realities. As Eyles and Donovan state "for all its partiality, incompleteness and evocation, an ethnographic account helps reconstruct reality" (1990: 126)

In retrospect there are some things which I would have done differently. I would have liked to have another researcher involved in the interviewing process and more time to spend gathering people's perceptions. However, at the time I felt that, under specific conditions, I was making the best choices possible and my intent was upon doing good qualitative research. Despite this intent, the reality is that we are often operating under time and budget constraints and must simply do the best we can. The experience I have gained, however, has provided an invaluable skill for coping with the messy, frustrating, and unpredictable nature of qualitative research and for trying to produce meaningful storylines. We now move on to document the storylines of these informants about health and illness.

Chapter 5

Explaining Health

5.1 Introduction

There exists a long tradition of research in medical sociology which seeks to understand illness and its related behaviours within their social contexts , yet very little lay perceptions research has been done regarding the concept of health (Backett 1992). This is partly because illness is often a problematic event, disruptive of daily life and therefore easier to identify and analyse. It is therefore more 'practical' to examine and understand. The study of health and its related behaviours has tended to be less well developed. Attempts to specify what health is have tended to equate it with life itself (cf. Seedhouse 1986).

Lay ideas around the concept of health draw upon a wide and diverse sets of sources (Fitzpatrick 1984). Yet lay ideas are incredibly pragmatic in that they allow us to be able to cope with a complexity of health issues and to make sense of our lives. Many lay beliefs about health have their starting-point in the wholeness of the self (Aggleton 1990). People will often consider themselves to be healthy despite being badly diseased or very ill. What seems to matter is the wholeness or the integrity of the individual, their ability to cope, and their inner strength. As long as these are intact, healthiness remains. This perception has been found repeatedly in lay perception research (Litva and Eyles 1994; Eyles and Donovan 1990; Williams 1983; Blaxter and Paterson 1982; Herzlich 1973).

Ideas about what health is have varied from place to place (Evans-Pritchard 1937; Fabrega, 1974; Kleinman 1980) as well as at different times (Ehrenreich and English 1973). Lay concepts and logic are not usually those of science or medicine and yet quite often ideas are 'borrowed', accurately or inaccurately, from these formal systems of knowledge (Freund and McGuire, 1995).

In this chapter, we focus on two particular perceptions. First we explore whether the informants see themselves as healthy and why. Secondly we look at how they define the concept of health. The reason the question "Are you healthy?" was asked prior to asking "What is health?" was so that the subjective experiences imbedded in the self (being healthy) could be compared to a more 'objective' view of health (Saltonstall 1993). There appears to be a difference between how health is perceived between the age groups with some variations between places. There also appears to be a discrepancy between how the (physical) body and the social body are conceptualized and treated(Fox 1994).

5.2 Explaining Health in the Self

At the beginning of every interview, all of the informants were asked how their health was at the time of the interview. The goal was to explore how informants constructed their own health, what aspects were involved in this construction, and to see if where they lived influenced how a person perceived the self. The youngest group from Farming Town were the most likely to describe health in their self as being very good to excellent. The same age group from Papermill Town tended to

see their own health as 'good' or 'fine'.

> Zane (B young) - Well , in all modesty **excellent health** (laugh) I always **have a physical every year** and the doctor always does that actually.....lots of energy. Lot's of strength, I never.... never get sick. No I....I might actually, probably in the last 15 years, I probably had flu twice, so I should retract "never'. The flu twice and maybe cold once or twice, that's about it.
>
> Barb (B young) - My present health...uh..would be, I guess, **very good to excellent** with, I guess, the only downturn being...um...side effects of pregnancy.
>
> Cameron (C young) - **Good, excellent, perfect.**.... well, not really.
> A - No?
> Cameron - Hum...**lousy, some time but other than that it's fine. Sinus headaches**, and that's all.
>
> Sandy (C young) - Fine, **I haven't had any real problems with it...say good**.
>
> Scott (C young) - **I seem to be fine.**
>
> Trista (C young) - **Other than a cold, I'm okay** (laugh).
> A - Do you have good health or bad health then?
> Trista - I'd say that I'm average.
> A - How do you know that you are average?
> Trista - Well, because **whenever I have a cold or anything, a lot of people around me have the same thing.** Like when I'm feeling good, you know, it's no problem but if I have a cold a lot of the people that I work with or a lot of the people that I hang out with have the same thing.

Trista's and Cameron's words reflect how flexible an individuals definition of health can be. Despite the presence of an 'illness' namely a cold, they still see themselves as having their health. Trista shows how illnesses such as colds or flu are incorporated into an individual's definition because others are seen to experience them as well. They are therefore 'normal' and not beyond the realm of the expected range of things

that a healthy person is likely to experience. Therefore, the self is not experiencing an illness which might make them appear as 'deviant' by others and their good health status is not threatened.

When the informants in the youngest group were asked how they knew that they were healthy, they often said that it was either that they had just had a physical and their doctor told them they were or because they were presently free of illness and rarely experienced such things as colds or the flu. They often combined their 'feelings' with the fact that they had seen their doctor for a physical check-up and nothing was wrong.

> Dennis (B young) - Yeah, yeah **it's very seldom that I have ever....**
> A- So you don't get sick very often?
> Dennis - No, not at all.
> A - Is that...?
> Dennis - You know **I bare....I rarely get a cold.**

> Iris (B young) - The **last physical I had was a year ago**. So I would say **I'm healthy**. I **haven't been majorly sick** with colds or anything for probably over a year and my arm is probably the only reason I'd say.

> A - How would you describe your health right now?
> Frank (B young) - **Very good**.
> A - And how do you know that?
> Frank - Uh, well I've had a, **a physical within the last six months** and everything was fine and **I certainly don't have any complaints**.
> A - So you feel good and the doctor told you were good?
> Frank - That's right.

> A - How do you know that you are healthy?
> Scott (C young) - How do I know that? Ah...(pause) well, **nothing seems to be wrong...nothing hurts**...feels wrong. Ah..... I seem to **have a fair amount of energy.**

Cheryl (C young) - Hum....my health is good, now.
A - Okay. How do you know this?
Cheryl - Well I just **had my annual check up** a couple of weeks ago actually.

While the youngest informants saw themselves as being healthy, they sometimes spoke of the potential to be more healthy if they paid more attention to particular health behaviours. Health appears to be a 'reserve' which can be also be 'stored' or 'increased' (cf. Blaxter 1990). In particular, this group of informants referred to those behaviours which tended to relate to their appearance. Their words reflect that they feel a certain amount of control over this issue. While it is their own choice not to engage in certain lifestyle behaviours, they do feel guilty about their lack of motivation or control.

Geraldine (B young) - Generally **I'm fairly healthy but.... I could use more exercise (laugh)** ... I guess. I would say....yeah. I'd say exercise and eating well.....well, I exercise, not.... I don't have like 2 hours a day or, like...or like...like I don't have a regular basis of anything....so that's why I won't say in great health (laugh).

Dennis (B young) - Well I don't ....I...e'exactly. I won't say I feel unhealthy, **I don't feel as healthy. (laugh) I don't feel as...as fit**, okay, yeah sure, that's a better word. But I wouldn't... I wouldn't ....It's such a relative thing, 'cause you know, **I'm healthier than your average person**, I would say in general. **And I've just been more fit. I've been in better shape that I am now, but I'm still in pretty good health.**

A - (laughs) Are you in good health right now?
Tim (B young) - I, **I'd say very, but, I'm probably overweight, but**...
A -How do you know you're in good health?
Tim - I...I'd say very, but, I'm probably overweight, but...um, I just pa-, well, I just had a physical a little while ago for disability..uh...insurance, like in case I got hurt for work.

April (B young) - **I think I'm healthy, but of course I'm carrying too**

much weight and that's not healthy, you know. And...I have trouble with arms sleep..... going down when I go to sleep...and a... so I...I know that I **have t'....to lose the weight**...and that's important, but other than that I....**I feel I guess I'm healthy.**
A - ...So you see part of this weight as being unhealthy?
April - Well, I....I...don't think the weight was the baby. I had the weight before her. Actually I am about five pounds less now then when I got pregnant. So I was very careful during the pregnancy, because I knew I could have trouble...I ....I...only gained 13. So.. I.. I... did very well with that... but it... like as I say it's ... a lot of it's....you know, that.

Trista (C young) - Well, **I feel I'm average, but I still don't feel that I'm really healthy**. Like **I could go out and I can exercise and do stuff to make myself feel better about myself,** but....but I don't know (laugh). Okay, like.... I feel average, **but I feel that I could be more healthy than I am.**

Geraldine's words demonstrate how she feels her healthiness is 'limited' by her lack of attention to exercise. Tim is reluctant to say he has very good health because of his weight. April feels healthy but feels she should lose some weight. Trista speaks of having only 'average' health because she does not do enough exercise to feel better about herself.

For these informants, health was something they did not fully think of unless it was absent. As Scott (C young) says; "I mean it's not something I think about constantly, but... I'm still aware of it." Yet health, even if it tends to be taken for granted by this particular age group, is still very important. As Sandy (C young) states " I don't like being sick. It...it cramps my life style..." People spoke of health being important primarily so that they could meet day to day obligations and do the things they like to do. Illness was something which got in the way of life. The

importance of health appears to be very much tied in with their present social roles and obligations at this stage in their lives.

> Barb (B young) - **If I didn't have my health, I wouldn't be able to do much else.** Um...right now I feel that's probably it. Later on, I'd say if I didn't have my health and I was ill all the time, you'd wonder if you'd be able to take proper care of your children, be able to do things with them as well as look after them daily. Um...even go...um, go to my parent's house for dinner or um....generally though, I guess it would be children and work that you....that would be your concern.
>
> Tim (B young) - **The only reason you....that I can see why you'd want to stay healthy is to work** ...is to make things better for yourself....
>
> A - Is your health important to you?
> Sherry (C young) - Yes, it is because **I have a family to take care of and if my health is bad then everybody suffers.**

Because of the responsibilities that these individuals have in their lives, they see health as something of which they must be aware. They see taking care of their health in terms of not getting sick because it might prevent them from performing their duties or roles. At times it comes across as a rather egocentric way of thinking in that some of the informants felt that their sickness would seriously impact the well being of their family. We see this notion of self as being central in the case of Frank.

> Frank (B young) - I've got a family and everything and yeah, you know, that's one of my greatest fears that **if I ever got sick, you know, it makes it much tougher on the family**...I don't know....uh...I guess I feel pretty good about myself and stuff and **I think my family need me so I feel that if I wasn't around that ....that would be a problem** and when...uh...especially for the kids.
>
> Greg (B young) - Nobody wants to get sick, but some people sort of don't care or.....everybody doesn't want to get sick at this level but maybe farmers really don't want to get sick.

If someone should let their health suffer and get sick, we find that the informants feel that, in some ways, they have not only let themselves down but they have let society down as well. They spoke of their health as being their own responsibility but it also appears that perhaps health is a societal obligation. Yet to some extent it is also an obligation to the self, which as Tim states, has an impact on society.

> Tim (B young) - **Maybe it is an obligation, but it's an obligation to yourself** and if I'm going to be miserable or whatever to other people the... I'm going to get that back and in turn that's going to make my life. So I, if I don't... if I'm not nice to other people and etc.....I'm not going to get these things back and my life's not going to be getting any good. So it's....**it's an obligation to the self.**

> Geraldine (B young) -I think...like, it's up to anybody, **it's up to themselves to keep, you know, to keep themselves healthy and to keep themselves... fit.**

> Barb (B young)- Um...I guess the sense is that m-...is it...to me **it's showing a sense of no responsibility**. IF you undertake to do something..um be it going to work or showing up for a lunch date or uh....being a volunteer somewhere and you suddenly call last minute and say, "oh, I'm really sick" or whatever, and then you knew that it was whatever, I just think that's sort of **a sign of unreliability**.

Informants from the middle age group at site B and site C were likely to see their own health as being good to very good. Fidel's words in particular demonstrate that defining health in the self is age-relative at this stage in life as many of the informants do not expect to be physically in the same shape as they were when they were younger. Yet they do not see their health status as greatly limited by their age. They are also more likely to be experiencing certain limitations on their health, yet despite them they still see themselves as being healthy. So, in Fox's (1994) terms

while the physical body is suffering a disorder or 'malfunction', it does not affect the social body which remains intact.

Carl (B middle)- Great. I just had a medical. I feel great. But I've always had good health. I'm fortunate. **I think I am perfectly healthy.**

Fidel (B middle) -**I think it's pretty good**. Yeah. Hum...**I guess when you get to be older you start to be more concerned with certain things, but I think my health is pretty good**.... I've had an arm problem here for awhile, so, as far as being in 100 percent health, I'm not. I've got an arm problem.

Liz (C middle) - I don't ... **I think it's pretty good, I mean.... it's not optimal but it's certainly ... very manageable and functional,** so.

Nowella (C middle) - I think...**by my standard, I say good**.
A - What do you mean by your standards?
Nowella - Well, I'm not really sure why I would say that. But I don't know, I feel...I feel health, you know. I probably feel better than I ever have.

Max (C middle) - **Generally, good.** I... you know, **I've got a little touch of arthritis now and again.** (laugh) But I mean, generally, I'm in good health. I have the type of job that requires good health, and maintains it when you have it too.

A - How is your health right now?
Greg (C middle) - **Good. My back's sore.**
A - Your back is sore?
Greg - I've got back problems.

Patricia (C middle) - Well... **I've got arthritis that I've had and psoriasis, that I've had for a long time.... hum .... I guess other than that, okay.**
A - So you've got these problems and you've had them for a long time but you see that your health is okay?
Patricia - Yeah .. I..I've pretty well been told that by my doctor. In fact, just before this surgery, I had to get a lot of tests done and there were no problems.

Ned - (C middle) **Not too bad a shape. I feel alright. I get trouble with my ...with one of [my] hands** and it's sort of on again, off again. Just from... I just think it has a lot to do with power tools and things like that and, you

know, the trade that I'm in.

Like the younger informants, health in the physical body includes certain 'normal' or 'expected' illnesses. For example, Greg above describes his health as good. Later on he admits that he is suffering from a cold and sore throat.

> Carl (B middle) - **I get a few sniffles**. I have a day or two where I feel a little under the weather, but I just um...pop a lot of Vitamin C and get a lot of rest.
>
> Paula (B middle) - Not very often, but (laughs), yeah, **I'm not sick very often.**
>
> Greg (C middle) - Me, **I'm very ... very seldom I'm sick**. Like I've had this **sore throat** and that for a week now. I'm.... like I'm really shocked that I even got this. Like I don't .... **I don't get sick too often, maybe once a year.**
>
> Nowella (C middle) - **I get an occasional flu bug.**
> A - Are these abnormal things?
> Nowella - I don't think so. You know like... like most people I usually seem to pick up, you know, in the winter time, I might pick up a bug or something and it lasts a week, it's gone.
>
> Nat (C middle) - You know **sometimes I have upset stomach**, you know, like ... like anybody else. **Standard... maladies,** whatever you want to call it.
>
> Ned (C middle) - **I get colds and stuff like that but I've never .... never had any real serious hospitalizing illnesses** or anything.

At site C Nat, an informant in the middle age group, was the only informant who spoke of not having good health. At the time of the interview, Nat was trying new medications to help him stop having epileptic seizures. At the same time, he spoke extensively of personal problems he was going through with his family.

> Nat (C middle) - Well, I have.. another each, once a month, seizures.
> A - Epileptic seizures?

Nat - Yeah.
A - Okay. And you're on medication everyday for that?
Nat: Yup. Three times a day.
A - Do you have health, right now?
Nat - Ah.. no really.
A - No?
Nat - No.
A - You don't feel good?
Nat - No, because if you taking medication, eh..**Unless it's.. an artificial health. I stay well as much..l as much as I can. (laugh)**

It is interesting to compare Nat's perception of his healthiness with Patricia's. Both were suffering from chronic illnesses yet Patricia, as seen in her statement above, certainly sees herself as being healthy. When this was probed more deeply, it was revealed that Patricia had other things in her life which balanced out the problems from her health state, namely good luck.

A - Do you feel particularly unlucky?

Patricia (C middle) - Not really. Well, I mean, it's not nice when it flares up or something like that, or if I get sick or..you know have to have surgery. But everybody has problems in life and you know I see a lot of things in other people's lives that I wouldn't want to have to deal with or experience. Maybe in..if I think about it, **I might think I was unlucky as far as my health and my physical condition goes but, as far as my life as a whole, no I don't.**

Nat's difficulties may result from his type of illness. Epilepsy is one of the more stigmatized or 'illegitimate' illnesses (Freidson 1970; Schneider and Conrad 1980; Scambler 1984). He appears to be negotiating with his physician with different medications being tried to help him manage his illness. Yet that point of management had not yet been achieved and therefore he only has an "artificial" health. Because of his need for medications, Nat is still constructing and assessing health in the self based

on his concepts of health which he held prior to his diagnosis. As Nat lives with his illness, he may incorporate it into his notion of health in the self. Nat is also going through familial problems because of a recent divorce. He is also accused by his daughter of sexual abuse. Consequently, Nat does not appear to have much of a support system. Possibly, because so many parts of his life are out of balance, this impedes the negotiation of his illness as a 'normal' part of being healthy. Thus he is faced with dealing with his illness on his own as well as with the fact that society perceives him as an 'imperfect being' and the medication is a constant reminder of his 'spoiled social identity' (Goffman 1968).

When the informants in the middle age group were asked how they knew that they were healthy, they cited being careful and watching certain lifestyle behaviours as having a role in maintaining their health status. They also justified their definition by the fact that they had seen their family physician and had been told that they were healthy.

> A - So how do you know you're in good health?
> Fidel (B middle)- **Regular medical appointments, good eating habits, sleeping habits, work habits and exercise**. I've had nothing that disturbs me, let's put it that way.
>
> Carl (B middle) - Well, I've uh, **I go for regular checkups** and uh, **I keep very active.** I'm a member of a bicycle club and I cycle a lot and the whole family cycles. Um, so, I'm involved in a racing program and that kind of thing, so **I'm very aware of nutrition and fitness** and that kind of thing.
>
> A - How is your health right now?
> Carol-Ann (C middle) - Good.
> A - How do you know that?

Carol-Ann - **I have a medical every year**. And there's nothing wrong. I have arthritis, but other than that.....

Like the younger informants, we find that the middle informants feel that they are limiting their ability to be healthier by practising certain lifestyle behaviours such as smoking or not watching their weight.

Charlotte (C middle) - Oh, just pretty good, you know. **I'm fairly healthy despite the fact that I'm you know, pushing 60 and a smoker.**
A - Oh, okay. So as a smoker you think you're unhealthy?
Charlotte - Well, **I think I'd be healthier if I didn't smoke.**

Howard (C middle) - **I think it's fair. I'm a bit overweight,** so I would.... like I'm... I feel good and everything else, but I also realize that I'm a bit overweight and I should lose weight, you know, this sort of thing.... because I'm approaching that age where heart attacks are...if you smoke and drink too much coffee and this sort of thing you're .... you're in that warning ....warning area.

Health is stated as being important to this group because it allows them to do the things they have to do and to be able to do the things that they like to do. In particular, informants from this group saw health as important so that they could work.

Hank (B middle) -Oh, [health is] very important, very important. **Because I want to be able to do the things I want to do whenever I want to do them and uh, if you don't have your health it's really hard to do that**.

Carol Ann - (C middle) - Well, certainly. **If you don't have health, how can you work? How can you do anything?**

James (C middle) - Well, **I want to live 'till I'm 70 anyway**. I want 15 years of my pension.

Similar to the feeling expressed by some of the informants in the younger group,

Fidel feels that it is an individual's responsibility to stay healthy. Hank feels that we have a moral obligation to stay healthy We must try to help others recognize this because, as Howard states, everybody has a responsibility not to get sick even if they have been sick.

> Fidel (B middle) - If you don't watch out for yourself.....(sighs).
>
> Hank (B middle) - I think we should be looking after what we have and we should be helping others too.....to stay healthy. Sure, **I think we have an ob-, a moral obligation.**
>
> Howard (C middle) - Get healthy? Yeah, your disease is in remission and be able to keep it there. **And it's wholly....your responsibility**. Uh huh. That's right, **he has a choice**.

There is a sense with the middle aged informants that they have some control over the physical body and they extend this thinking to others.

The informants in the older group are more likely to speak of having existing health problems. Yet most of them still saw themselves as healthy. Unlike the other groups, their definition of their own healthiness is determined by how well they are coping with these disabilities or illnesses, as well as their general attitude towards life.

> Laura (B older) - Well, **I haven't been sick as such** uh, **I've been very healthy. I've had a hip surgery done**, and uh, a hip replacement and in that respect, if you can call that sick, although it's not sick - I was laid up and so....."
>
> A - How is your health right now?
> Evelyn (C older) - Oh, **my health is pretty good right now**. **I did have surgery in June, I had a gall bladder operation,** but, I've gotten over it pretty well.
> A - Have you? No problems since then?
> Evelyn - No, no.

A - So your health is good?
Evelyn - Oh, yeah it's good, sure.

A - So how... how would you describe your health right now?
Jem (C older) - **Ah, good.** Ah, **right now I'm goin' through a skin... ailments for three weeks** and then take another test and see if they're negative or positive, right along here (shows me the skin ailment).

A - How would you describe your health right now?
Stu (B older) - **Good.**
A - It's good.
Stu - Oh, yes.
A - How do you know that?
Stu - **Because I feel healthy.** Uh, you know, it, **I think this question of health is to a great extent in the mind anyway**....um.

Laura has recently had her hip replaced and prior to the surgery suffered great pain. Yet after successful surgery, she sees herself as healthy. She even questions if her surgery can be classified as something which threatens her health state. The conversations with Evelyn and Jem also demonstrate how people in this group tended to define themselves as being healthy despite having had or presently experiencing difficulties. This process of negotiation within the self over the important self-defining characteristics of health amongst this group may be linked to the fact that they see healthiness as being age-relative. They did not expect to be 'problem - free' and saw certain limitations or experiences as being expected. There appears to be a point of balance where people learn to cope with life changes. One result is having 'good health'.

Vince, for example, has had to make major lifestyle changes due to his Crones disease and heart problems, yet he feels he is in good health taking all things

into consideration. As Don's words show constructing the self as healthy seems to be important for people to continue meeting day to day obligations or being able to still do things that are enjoyable to them. Evelyn's words summarize the general attitude of this group which is that you do not *expect* to be problem free as you get older which is very different perception from the young group of informants who do expect to be healthy. Joseph, a very active 76 year old, is still able to do the haying and therefore is in good health.

> A - Okay, how would you describe your health right now?
> Vince (B older) - (pause) **I would say, uh, all things being considered, and considering my age and everything else, I would, I would say that you know, I, me, I', in good health.** That's what the doctor tells me.
>
> A - How is your health?
> Don (B older) - Uh, **pretty good actually for my age, you know**.
> A - What does that mean?
> Don - Well, it means that if you are 75, you don't expect to be the same as when you were 25. Although, sometimes that's very frustrating for us because you want to do a lot of things and sometimes you just aren't, aren't able to do it, you see. You get a bit uh, tight through the chest or something like that and you say, "Well gosh, you know, I'd better be careful." Because uh, you have to feel you have become fragile.
>
> Evelyn (C older) - Well...how would you put it...**...you begin to have medical problems as you get up in age.**
>
> A - So are you healthy now?
> Joseph (B older) - Oh, yeah.
> A - How do you know that? Did you go to the doctor or something?
> Joseph - No, I haven't. I didn't think I had to go, you know.
> A - So how do you know you're in good health?
> Joseph - Well, **I figure that I must have been. There was one, one Sunday here, on Sunday here at the haying, of course, un, un, we had hay, we had the hay in stooks and so the wagon holds 200 bales, 150 to 200 bales, so I, I put on a load myself on Sunday**. The journey, the journey would

take um, very often take a part on each side of it to, if we were loading by hand, like you know. I generally always had the, had the forks on the loader like you see, but we didn't happen to have them on, we didn't happen to have them on, and so, I loaded them on and um, so the worker would um, set them on the wagon, put them on the wagon and uh, **so I, it didn't uh, it didn't bother me at all, like.....**

Ed was one of the older informants who described himself as definitely not being healthy, having respiratory problems, and immune system problems. And yet, because Ed has family obligations that he feels he must meet and because he can still go out fishing once in a while, he has at least some of his 'health'.

A - So would you describe yourself as healthy?
Ed (C older) - **No, not now I'm not, definitely not.** No, no I have a hard time to exercise or anything, you know, because ....of my lung capacity. **I'm a respiratory cripple** you might say.
A - .....(?)
Ed - I'd like to see my grandchildren get a good education, and if I can help them then. But...and **if I'm not gonna have half decent health well then what's the point in being around eh?**
A - So you think of yourself as having half decent health?
Ed - Yeah.
A - You say you're not healthy but ...you're have decent?
Ed - Yeah, **like I can still do a few things that I want to do**. I can still get out on the boat and do some fishing and stuff like that.
A - So you're still enjoying life?
Ed - Oh yeah, yeah.
A - So health is enjoying life?
Ed - I would think so, yup. **If you don't have your health, you haven't go anything.**
A - Hm.
Ed - Yeah, **you gotta have your health**.

This logic demonstrates how the social body and the physical body are mutually dependent. From Ed we find that what he is able to do for his family and how he can interact on a day-to-day basis helps him deal with the limitations imposed

by his physical body. He could 'give into' his illness and adopt the role of an ill person but it is through his 'self', his need to maintain his social identity, that he resists the pull of this role. Thus by acting as normal as possible in his condition, he will reap the social benefit by avoiding stigma (Goffman 1968). We also find this mind-body duality reflected by Lily whose concepts of healthiness show that in lay perceptions, the social body is often used to define or at least deal with the physical body.

> A - How is your health right now?
> Lily (C older) - At... **at one point I developed histoplasmosis** , which is a parasite. See I used to walk around that soccer field and the pigeons...there 8 million sea gulls and pigeons, and I got histoplasmosis which is a parasite and I got...**I had pneumonia** and I had it... I got it in my lungs .....this is the best I have felt in about 3 years. But I can't, on a day like today, I can't go up and down stairs. **But on the other hand mentally I... I... think like a very healthy person.**
> A - How is that?
> Lily- **I think that I can go out and do 400 things in a month and actually I can only do 20.** I think that I'm going to do... like I'm planning to stain my deck before winter sets in. I don't know if I'll get ... I'm thinking of building a ... I have a child with special needs and I've got to fix the back door. **I think healthy. I think I'm going to o it and sometimes do.** I knit and crochet. I'm a craft person. However, I praise and thank God that I'm alive 'cause I've got children.
> A - So although you don't have your physical health, are you saying you have very poor physical health but very good mental health?
> Lily - Most of the time. Most of the time.

The older informants spoke of health as being important primarily so that they would be able to do the things they enjoy but also because some of them felt that their families depended on them and needed them to be well. In some cases, the informants spoke of their illnesses as being a great burden on the family, a burden they did not

wish to inflict very often despite their advancing ages.

> Laura (B older) - I don't know why. Because I feel, I suppose, that **I'm important to me, so therefore my health has to be important to me**. And, and not only that, **but for my family. It's important to them that I be healthy. Otherwise, it would be, well they'd be upset, they'd be depressed**. They would have to run to help poor Mom and I don't want to lay that burden on them.

> Ed (C older) - **I'd like to see my grandchildren get a good education,** and if I can help them then.....but....and **if I'm not gonna have half decent health then what's the point in being around,** eh?

> A - Is your health important to you?
> Mel (C older) - **Very important. I got 5 grandchildren**.
> A - So it's important because of your children?
> Mel - **And it's important for me. 'Cause I'm an outdoor person.** And it's only now, in this last week that I've been fishing once in the last 2 years because I was burning so bad. I couldn't do anything. I couldn't ride my snow machine.

The perceived sense of control over health found in the other two age groups seems to extend to this group as well. Don speaks of maintaining health as being an individual responsibility necessary for yourself and for your family. Emmy reflects this perception stating that we have to take responsibility for ourselves. Stu brings forth the idea that sickness is a burden on society and therefore as we have to pay attention to our health and not do things which might harm it. Overall, we get a sense of how the self is very much embedded in the social.

> Don (B older) - I think a..the effort to...**to remain relatively health...so un, to keep yourself in the state that you can operate, that you can work, that you can do what is fun to work, what you enjoy** - well, **that is your own responsibility.** There is a pressure because you feel that **you have a responsibility to yourself and to your family and that you ...stay healthy**.....because there is one thing for sure, nobody's autonomous. You

know, you are not your own boss....not from your own body and the idea that you can do with your body what you want is absurd.

Emmy (B older) - Because the **people themselves have got to take some responsibility...for their own lives.**

Stu (B older) - I think **we owe it to our society as a whole to stay healthy,** because it's too high a price to pay to, to let health go and just to uh...to not pay any attention to our health...I mean, we can't afford it. The health care system, um...can't afford to, to support people who, who don't care anything about their health, but society generally without considering the costs, we can't afford this sort of thing, to let people just ignore their health, because it's...it's...**it's too depressing.....we can't afford to have that sort of a festering, festering sore,** if you like, in society.

5.3 Defining Health

All informants were asked if they could define or explain health. The intention was to see how people defined health, to see if definitions of health varied between age groups and between places, and to see how definitions differed from the informants' explanations of health in the self. The question 'How would you define/explain what health is?', proved to be very challenging and in some cases such as with Chris and Greg, almost annoying.

Chris (C young) - What - is - health? What kind of question is that?

Greg (C middle) - That you're living, I guess. I don't know... what is health? I don't know what you mean by that.

For many of the informants in the younger group, concept of health encompasses both physical and emotional aspects of well-being. However, the physical aspects of well-being were more likely to be mentioned before the emotional/spiritual aspects. None of the informants made the relationship between

the physical and emotional aspects explicit. Yet for this age group the self and the body are still intertwined in their definitions.

> Sandy (C young) - Hum... well I think, I think first of all when I think of health, **I think of the physical... and being physically okay,** and not having anything major wrong with you. **I think being happy has a lot to do with being healthy.** Being happy with your.... your over-all life in general, I think. If you're not that can cause a lot of health problems.
>
> A - What is health?
> Barb (B young) - Um, **a felling of well-being, both physically and mentally,** um....
> A - What do you mean about physical well - being?
> Barb - Uh, physical well, being I guess...um....in terms of your body, **nothing is wrong with your body.** Your, **you don't have a broken leg or you don't have cancer or things like that, so you feel, you feel healthy and emotionally**...I guess....would be to do with, with you life. Your everyday life. Um, be it your, your husband, in my case with my husband, feeling good about the relationship and feeling that it's healthy and stress-free.
>
> Cheryl (C young) - Well, health is when I don't feel sick (laugh). Which is... well, **health to me is partly the physical health which is not feeling sick, not...my body not really complaining about anything,** or really feeling a reasonable amount of energy. Hm... and then **in terms of emotional health hum....for me that is the ability to be able to relax and let go of things and..... not sort of abscess about things, not have a lot of feelings of anxiety.**
>
> Iris(B young) - Oh, God. (laughter) **Feeling good,** um, with no major complaints. **Physically and mentally.**

When emotional well-being was emphasized, it was usually because the informants saw some aspect of their physical well-being as not being present. These physical aspects seemed to be very much tied into the issue of self-esteem or how good a person felt about themselves. This issue emerged amongst individuals who through the course of the interview revealed that they were experiencing some self-

esteem problems. Tim, for example, is struggling with his alcoholism as well as the physical shape of his body after that abuse. Iris, after just having her second child, is experiencing pressure from her husband to have a certain body size and shape. Ann is experiencing the trauma and stigmatization associated with having a STD. Trista is struggling with all the body image problems that many young women in our society face today.

> Tim (B young) - Health, I think is just, **a lot of it's feeling good about yourself and your body and being able to do normal activities of a normal person.**
> A - So health can be mental and physical.....
> Tim - Yeah, I think a lot, in a lot of ways they're intertwined. Like, uh, I mean, and **I think a lot of it, to have a healthy body you have to have a healthy mind.** Like you feel good about yourself and then, like you know, a lot of us think, not just physiological...psychologically as well.
>
> April (B young) - What do I think of health? **I guess just in good shape,** probably.....and feeling good about...**Self esteem has to come in there to a certain degree I suppose.**
>
> Ann (B young) - Because **your health has to do with your emotional stability too**....Because if, if you're not, if, if you're, like having problems and you're depressed and, and **you're stressed out from something that's happening in your life, it's going to have a physical effect on you.....**
>
> Trista (C young) - I'd say being in condition, **not being too overweight, not being too underweight,** just... I...I...I...don't even know what average is but personally I think I'm pretty average.

In some cases the informants were likely to emphasize the physical aspects of health in that health was either not being sick or being physically in shape and able to perform day to day functions. Health is life itself or the self in context of everyday living.

Zane (B young)- Well, probably the best definition is **not being sick.** Being..... being able to do what you have to do...**without being impeded** by something that makes you unhealthy.

Dennis (B young)- I think for your average person it's **just lack of...of obvious illness.**

Geraldine (B young) - Basically if... like when you keep your... to me it's your body... **to keep your body in shape... like in working... better working condition,** I guess, I'd have to say.

Cameron (C young) - What - is - health? What question is that? Hum... I'd say health is ah... ah... **It's the ability I guess to a... to function comfortably** and that so.

Mike (C young) - Ah...**able bodied, satisfied....**

Scott (C young) - Ah... (pause), mainly **I guess a general well-being**...a number of things: personal hygiene, I guess, sleeping habits, and how you feed...how well you eat, I guess.

When the informants from this group were asked what is the opposite of health, they usually spoke of it as being physically ill and never of being emotionally ill as they did in their definitions of healthiness. The only exception was Tim who initially had a more holistic definition of health than some of the others in his age group. He saw the opposite of health as not being able to enjoy life.

A - Okay, so what is the opposite of health?
Tim (B young) - Um, **not being able to enjoy life,** um and its activities. I mean if you're bedridden or something like that, I don't think that's life. I mean, like, if some of these people are convalescing or whatever in these old age homes they're, they're awake and they're funct- their heart's functioning, and maybe not their brain even.

Greg (B young) - The opposite of health? I guess that would be **being sick.**

Iris (B young) - (pause) **Being sick,** obviously, being in poor physical

condition.

Frank (B young) - **Uh, diseased**. Which means uh... (clears throat) that un, just not feeling well.

Zane (B young) - Well, unhealthy I would say. I think it.. if I think of it superficially it's be uncomfortable, not... like, **not being able to do what you have to... want to do.** Again, being impeded by something, you know, and it could obviously be degrees vary from having simple sniffles to a ... not being able to control your body temper.....

Above all, the informants recognized that their concepts of health were unique to them and their situation and could not necessarily be applied to others. Zane had previously given a negative definition of health as not being sick or physically limited. When his definition was challenged, he explained that what is health to him is not necessarily health to another person. Dennis' quote also reinforces the fact that lay people see their definition as being relative to the self and its context.

A - What about people with chronic disabilities. Are they unhealthy?
Zane (B young) - You know, **if you use my definition, well, I guess you'd have to say they are**. And...now obviously that definition is my own personal definition and... some... **some people in those situations might consider themselves healthy** also....free of disease maybe... you know they would consider. **If it was me I would say I was unhealthy in that case.** If I had ... like if I was in a wheel chair for example, I mean the most obvious disability, visual disability, anyways, I'd say I was unhealthy.....

Dennis (B young) - ....**It's such a relative thing, 'cause you know, I'm healthier than your average person,** I would say in general. And I've just been more fit. I've been in better shape than I am in now, but I'm still in pretty good health.

Within the middle age group, we find the mental/emotional aspects of well-being begin to be much more obvious in the informants' concepts of health. There

also seems to be a stronger tendency to link the mind or social body with the physical body. Paula speaks of health as being well in both mind and body. It appears that being able to perform functions/do the things you want to do is a prominent link between mental and physical health. Carl sees health as having energy to do all the things you want to do. Hank describes health as the ability to get up in the morning, to feel good and to do the things you want.

> Paula (B middle) - I think if, **if you're healthy, in both mind and body, both mind and body as well and you're happy.**
>
> Carl (B middle) - **Physical well-being, mental well-being.** Having...um...the energy to do all the things you want to do ...
>
> Hank (B middle) - Uh, **health is uh, getting up in the morning, you feel good and uh.....just getting up in the morning** (laughs)....being able to do whatever it is I want to do and you... Just to be able to get up in the morning and go out about your day's... uh....**work and feel good about yourself and good about your family.**

Within this age group, people's concepts of health become, as Max describes it, a relative state of being. He uses his father to demonstrate how if the mind is healthy, it does not matter what the physical body is doing. It is through the social body that health is achieved. Fidel speaks of health as being in good mental and physical shape according to your age. James, who works in a paper mill at site C, see health as whatever he can achieve under his particular circumstances.

> Max (C middle) - Health. Well, let's see now. **There's a state of being I suppose, a measure of state of being. Generally you have mental and physical, but I think there are points common to each.** I guess it's as much perception too.... as an actual measurable quantity. I have an 84 year old father who has a heart murmur and he has arthritis and he also walks to

church every morning...(laughs).... goes out on meals on wheels to give to those old people... you see. So it's, you know, **that's a state of mind as much as anything.**. So ... you know I mean, **it's... it's a relative thing.**

Fidel (B middle) - I suppose the body....**the body being in the best physical and mental shape, that's possible according to your age and circumstances.**

A - What is health to you?
James (C middle) - Whatever you got...that's it you know. How do you know what health is, I mean. Look at yourself, **the best you can,** but how do you do that. I smoke and I work in an environment with lots of chemicals and it's just work... **you gotta work you know.....**

Mental well-being is usually perceived to precede physical well-being within this age group. Informants often referred to stress or depression as having a negative impact on physical well-being. Paula speaks of how such feelings take away energy from the body and can impact your health.

Paula (B middle) - If you're .... if you're worrying about something, you know, or if you're , yeah, angry at somebody or, you know, it uses up a lot of energy doing that. **Negative things use up a lot of energy from your body** and , so I think, you know, **positive and happy is uh...you're healthy then.**

Unique to site C was the emphasis of the spiritual as well as emotional and physical well-being. In many ways these ideas coincide with native ideas around health even though none of them was native. The middle aged informants at site C definitions reflected the World Health Organization's definition of health as physical, mental and spiritual well-being except from these informants' words it is not a general idealized state but is once again a state specific to the individual.

Nowella (C middle) - Well, you know, **I think it goes far beyond just physical health , for me anyway.** It .... **it involves like a mental, spiritual**

component as well. Just a feeling good, you know, looking forward to life.

Howard (C middle) - What is health? Well... (clears throat)...**to be in a good physically, mentally, spiritual condition.** That's what I would consider a healthy person.

Liz (C middle) - Hum... it's **I have a holistic view of it. So it's ... a physical, spiritual, all the aspects put in together of well-being**... a feeling of well-being and relational.....community wise that way too.

It is interesting that when this same group were asked what is the opposite of health in the abstract, they used a definition which was asymmetrical with their definition. So while health is physical and mental well-being, the opposite of health is being physically sick. This was also found in the definitions from the younger age group.

A - What is the opposite of health?
Hank (B middle) **I guess sickness**. If somebody like...uh.... somebody that is laid up in bed or in the hospital.....

Fidel (B middle) - The opposite of health? Something you would define as not being health. How can you say.... **I mean sickness would obviously be the word that most people would think of.**

It is logical to say that this emphasis on the physical may simply be that the most obvious sign of not having your health are physical symptoms such as aches, pains or fevers. Illness reminds us that we have a physical body, while emotional and spiritual ill-health are far less concrete and far more negotiable. Therefore they appear not to be readily considered by lay people as the opposite of health.

The older informants overwhelmingly defined health as having a certain quality of life relative to one's circumstances. This relativity means being able to do the things that you would want to be able to do at their age, of feeling contented with

their life and self, not feeling too much pain, and being able to control any present illness. We see from the following quotes that health is still a difficult concept. However, it appears that, when compared to other age groups, this group's age and experience helped them to be more clear in what health is to them. Interesting in this context is the notion of knowing what the illness is and being able to manage it, as Emmy describes. This theme emerged several times when the informants of this group spoke of being ill when they and their doctor did not know what was wrong with them. Clinical diagnosis, however, appears to gives them the key to beginning to be healthy even if it is a chronic disease. The body is no longer out-of-control and the self can once again becomes central. As Ellen states the illness "just becomes part of you and you go on". Then health becomes an attitude or way of living one's life and the biological reality is downplayed.

> Calvin (B older) - (pause and laugh) Well, just.... well, health, I guess is **feeling good and feeling...not feeling pain,** or you know, **just feeling connected with yourself** and your... the way your body feels and ever.....

> Emmy (B older) - Oh... health. Well, I suppose.. **being well enough and able enough to carry on the things you want to do in life** and.. But then again that... is a bit constraining **because you could only have one leg and still be in quite good health....**(laugh).
> A - What about diabetics. Can they reach a point of good health?
> Emmy - Well, it would be my feeling that if you have diabetics [sic] you know what it is and therefore... **you have a means of controlling.. controlling it and dealing with it** and.. **then it just becomes part of you and you go on.** Yeah, I mean... (pause) don't have to have perfect health but you have good health.. I mean you can still get along with your life.

> Laura (B older) - How would I..... well, **health is well-being.** Health is uh, **both mental and physical. Um, reasonably happy with your set of**

circumstances.

A- What is your definition of health?
Stu (B older) - Oh...(pause)...i-it's a little hard to day. Uh, I guess it's a...huh...broadly speaking it's the um... **lack of ill health** (laughs). That's kind of funny way to put it perhaps.....
A - So health is the absence of illness?
Stu - No, it's more than that. I , I mean I...**I think it's a feeling of well-being. Um, the, to a point where you can enjoy life**... you can enjoy the things you want to do, **you feel motivated to do things, to keep going and so on.....**

A - How would you define health?
Vince (B older) - I think health is a... I think you'd find that health is a ....**an attitude toward the obligations that you have**. If you're healthy, you're have.. **you have a zeal for doing them** and if you're not healthy, you don't have that zest for doing things.

A - How would you define health? What is health?
Evelyn (C older) - Well, if you're... **it's the quality of life** I think means a lot if your life is good to yourself. But, if your health is so bad that you don't enjoy life then it's really a problem I think, you know? **There's a lot of people that are not well and yet they're able to cope with it** and **they do have a fairly good life.**
A - So they have their health?
Evelyn - Yes. It's even.. well it's ... **some people can take it and some can't**. Like some will have problems and... it really gets them down and others can sort of rise above, you mights say, you know.

When this group of informants were asked what was the opposite of health their answers were far more congruent with their definitions of health than the previous two groups. As Vince states above, not to have your health is not to have a zest for life. So the opposite of health was usually seen as not feeling physically well and/or not feeling emotionally well or in Don's case, of giving up.

Calvin (B older) - Well, I think **when you're just feel down, miserable and not the way you know you should feel, or you could feel perhaps.**

Don (B older) - (pause) That's a good question. **They've given up....giving up.** Yeah, giving up, it's... you know...**health is a very relative state - nobody is every completely healthy** and I certainly, myself, wasn't.

5.4 Findings

Amongst the younger group, there are subtle differences between places in how people defined their health. The younger informants from Farming Town (site B) were more likely to describe their health as being very good to excellent while the younger informants at Papermill Town (site C) who tended to see their own health as 'good' or 'fine'. This may be linked to several factors. One factor may be the fact that Farming Town is a farming community and the informants saw this as supporting a healthy life. The informants at Papermill Town , however, are dominated by a large paper mill which has been seen as an environmental hazard. In the next chapter, we explore this difference more thoroughly. This place difference may also be linked to the type of job that these young people had and this influence is also explored more completely in Chapter 6.

While there did not appear to be any place differences, the informants from the middle age group saw their own health as being good to very good. The older informants spoke of their health as being limited by their age and spoke of having existing health problems. Yet they still saw themselves as being healthy. We also found that individual definitions of health often include such things as colds and so-called 'normal' illnesses. Amongst the older people, health was age-related. They did not expect to be without some problems.

There appears to be a point of balance where people learn to accept and cope with life and health changes. The result is that relative to virtually all others in their age group, they see themselves as having good health. This balance or negotiation point is greatly influenced by people's ability to continue meeting day to day obligations or being able to still do things that are enjoyable to them. This reasoning illustrates how lay people divide health into two realms, the social and the physical body, which are mutually dependent but one sometimes plays a more significant role than the other. As we grow older, the physical body wears down and we lose some control over whether our physical body can be well or not. Perhaps to compensate, we create our healthiness primarily through the mind for as we shall see in Chapter 8, a healthy mind can compensate for an unhealthy body. Thus in a way we have a certain amount of 'control' over how we are perceived and how we perceive ourselves. Thus we maintain our notion of social worth through self-esteem and positive definitions of the self and our place-in-the-world or position in our society.

There were differences between the age groups in how people knew that they were healthy but there were not obvious differences between places. The younger informants often combined their own feelings with a doctor's opinion to justify their definition of their own health-state. It seems likely that doctors' opinions may influence their definition of the body, which in turn will influence how the self is constructed. Illness is stigmatizing (Goffman 1968). By being diagnosed as healthy by a physician, we have an obvious sign that the physical body is free of illness and

is not 'spoiled' (Fabrega and Manning 1972). Thus our 'normal' social identities are intact (Freidson 1970). Usually the informants spoke of the doctor's opinion as a justification of their own. Similar to the younger informants, the middle age group described themselves as being 'healthy' primarily because they felt that they were careful and vigilant about certain lifestyle behaviours which they felt had a role in keeping them well. They also justified their self-definition by the fact that they had seen their family physician and had been told that they were healthy.

Interestingly, although much more likely to be seeing a doctor on a regular basis, the older informants were not greatly influenced by what their doctor says, but more by how well they coped with these disabilities or illnesses, and by their general attitude towards life. This may be because, by medical definition, many of the informants in the age group do not have their health. Many of them suffer from various medically recognizable and diagnosed diseases. Therefore, in order to have their health, these informants focused more on their 'feelings' and how they compared with others in their age group. The self seems to become more predominant and maybe more important as one ages.

The youngest and middle age groups of informants suggested that they did not usually think about health and tended to take it for granted. Yet at the same time, they also spoke of health as being very important for being able to fulfil their roles in society, in particular to be able to work. Crawford (1984) and d'Houtaud (1984) found that people often perceive the importance of a healthy body for work; the body

is seen as the body of a worker. The older informants did not take health for granted seeing it as an essential tool for enjoying all the other aspects of their lives. As Vince, one of the older informants at Farming Town states: "Is it important? It's number one on the list. It's very important to be healthy. Everything else hinges on your health, almost everything."

The informants were asked to define what health is. This proved to be difficult, especially for the first two groups as they were more likely to not have to think about their health on a day to day basis. What was revealed was that it is more difficult to define health in the abstract than it is to describe how one feels. It also appears that concepts of health tend to depend on whether the person is speaking about health in themselves or health in the abstract (cf. Calnan and Johnson 1985; Blaxter 1990; Litva and Eyles 1994).

The younger informants, at both sites, saw health as encompassing components of the physical and the emotional. However this linkage was not made explicit in their definitions. There was the tendency to see health first as a lack of obvious illness and this became particularly clear when the informants were asked what the opposite of health was. There is a conspicuous difference between concepts of health in the self which initially included certain 'normal' ailments and limitations such as colds, and how these informants see health in the abstract.

The middle age group responded to this question by emphasizing the emotional aspects of well-being becoming more obviously linked with the physical.

One distinct difference which emerged between the places was that at Papermill Town, included in the idea of physical and emotional well-being as part of health were notions of the spiritual well-being. This may be a result of interactions with the large native population in their area influencing how they construct health (cf. Young, 1984). Interestingly, when these informants were asked what was the opposite of health, their answers were incongruent with how they had defined health. They saw the opposite of health as simply involving the physical body; as being ill or physically limited in some way.

In the older group, we find health defined as having a certain quality of life relative to one's circumstances. There is less 'space' between how this group defines health in the self and health in abstract. Indeed, this is substantiated when they were asked what is the opposite of health. Their answers centred around not feeling physically and/or emotionally well; of not being able to cope well with one's circumstances.

Blaxter's (1990) lifestyle survey in the U.K. also found differences in how health is conceived in the self over the life course. In younger informants, health was perceived as positive fitness with emphasis on energy and the ability to cope. Middle aged informants had more complex definitions of health which included mental and physical well-being. Older informants thought of health in term of function or the ability to do things as well as through ideas of contentment, happiness, state of mind even in the presence of disease or disability.

Overall, the importance of health in people's lives shows that people do not see themselves as autonomous or isolated, but as part of a group to which they have a certain amount of responsibility. So while health appears to be of individual concern, good health appears to be crucial to being able to meet social and moral obligations (Cornwell 1984; Litva and Eyles 1994). The informants from all three age groups at both sites did agree that we have to take care of our health so as to be able to be part of society and not a burden to significant others or to society.

In general we found that a person's place-in-life (age) does result in differences in how health is perceived. While the differences between places were not as numerous as the age differences, place does appear to have some impact on how health is defined. For example, the younger informants at Papermill Town had a less positive view of their health than the informants at Farming Town and this may be because of the physical environment in which they live and the type of occupations they hold. In chapter 6, we explore the informant's perceptions of the role of particular behaviours (ie. drinking alcohol and smoking), as well as the physical environment. It is there that we gain a stronger insight as to how where they live affects their health. We will find that things like the type of jobs they perform influence their decisions to smoke, as well as the stress they experience. We also find that there is a general concern of the effect of the environment upon their health.

5.5 Discussion - "You gotta have your health."

Healthiness appears to be a very flexible concept. As Crawford states:

> Talking about health becomes a means by which we participate in secular ritual. We affirm ourselves and each other, as well as allocate responsibility for failure or misfortune, through these shared images of well-being. The 'health' of the physical body - at the same time a social body- validates conventional understandings (Crawford 1984: 78).

At the same time, the judgements we make, particularly concerning our own health must, to a certain extent, be uniform and universal. None of the respondents would think of themselves as healthy if they had typhoid, but they did when they had a broken arm or the 'flu. Therefore, health and healthiness obviously have meaning through participation in a network of associated meanings and implied relationships (Wright 1994).

We have seen that health is an evaluative term in the context of judging health of the self as well as of others. It has obvious moral implications as expressed by the use of such terms as "good" and "bad" when evaluating health. This has been found in other studies of lay perceptions of health (Crawford, 1984; Blaxter 1983; Backett 1992, Saltonstall 1993). Backett states that such evaluations of health easily spill over into assessments of individuals. A healthy person is a person who possesses positive social attributes; a person who has an intact 'actual social identity' (Goffman 1968; Freidson 1970).

Moral values act as guides for human actions. For example, in the next chapter we shall explore how the ability to make conscious lifestyle choices is analogous to making moral choices. The recognition of moral responsibility and obligations is the essence of human action and relations and underpins much of social

order and social life. Health assessment tells us about the degree of control that a person has over their life, not only as a conscious moral actor (the self) but also in the sense of being able to choose the course of their future. Health is a judgement of the full potential of human life. When applied to an individual, it is a judgement about their ability to live fully moral and social lives (Wright 1994). In other words, it is a judgement of their worth. Hence so much of self-esteem is embodied in 'healthiness'.

Yet the concepts of health and being healthy are not used interchangeably but are defined by the ways in which they are used. The concept of health implies some abstract level of functioning or some inscription on the surface of the anatomical body (Fox 1994). It is often physical as health is often seen as the lack of disease and therefore by implication, the presence of healthy organs.

The concept of healthiness, on the other hand, is only meaningful in terms of a set of social and moral relationships. When we judge ourselves to be healthy, we are commenting on the ability of the self to function in a variety of normal social situations. Being healthy does imply some level of physical functioning but being able to function physically does not ensure 'healthiness'. Healthiness rests primarily upon our active participation and compliance with social norms. An individual must be able to function within the frame of reference that society forges in order to maintain a sense of order and solid seeming social reality (Berger and Luckman 1967). Sometimes this involves a person with an illness of physical disability to carry on with

day to day life and interact with people in a way that does not become problematic. Goffman has termed this a 'moral career' arguing that by pretending to not be ill - and subsequently accept stigma label - an individual is highly 'rewarded' by society by being treated as 'normal' (Goffman 1968). So in place of the physical body, the social body (or the self) is the surface upon which social reality is constructed and inscribed with social meaning and symbol (Fox 1994, Lupton 1994).

People who are healthy are recognized as having a basic responsibility for their ideas and actions. This in turn demonstrates their worth. These attributions of personal responsibility and worth are conditions for the judgement of good health as well as self and societal esteem. Judgements around health become reinforcing - linking the self to society and the body to the self. We never see people or ourselves as just physical bodies: we also 'see' the social self. Therefore when we are commenting on our health and other people's health, we are never doing so strictly in terms of physical well-being. Given these important judgements, how individuals manage health and the appearance of healthiness are central to social functioning - they hold symbolic meanings. We turn to these issues in the next chapter.

Chapter 6

Managing Health

6.1 Introduction

Like concepts of health, ideas about health-related behaviours are embedded and expressed in daily life. Negotiating one's way through the plethora of health information available can appear to be a daunting task for the individual. It is particularly problematic as health education has created a public awareness of the risks associated with certain 'lifestyle' choices. Lifestyle is a sociocultural phenomenon which has arisen from interactions between patterns of behaviour and life situations (Blaxter 1990). Health behaviours are shaped by values and beliefs learned in social settings, as well as by the opportunities and constraints defined by particular economic and social settings (Dean *et al* 1995). The emphasis in health promotion upon lifestyle behaviours has focused upon shifting the responsibility of avoiding health risks onto the individual for their own sake as well as for the greater good of society (Lupton 1993). Subsequently embedded in lay perceptions of health behaviours, we also find social and moral evaluations. Yet despite this, people appear to be very capable of making sense of it all and negotiating their health behaviours (Backett 1992).

Within this chapter, we explore how the informants manage or negotiate their own health. The topic was introduced at an appropriate time in the conversation with a question such as, "How do you take care of your health?"or "How do you stay

healthy?". Because each interview is unique in its own right and each informant is unique, the exact phrasing of the question varies from interview to interview. However, the intention was to find out what people do or do not do in order to maintain health and therefore describe themselves as healthy people. As behaviours were mentioned they were probed more deeply in order to find out more about how people perceive them.

6.2 Diet and Exercise

When the informants were asked about what types of things they did to stay healthy or manage their health, the informants from both sites and all three age groups mentioned that they watched their diet, tried to exercise and get plenty of rest.

> Iris (B young) - I try and **eat healthy** and...and **keep my weight down**. Um....I try and just, **get enough rest**.

> Sandy (C young) - I do... **some form of aerobic activity every day**...hum...I **try to be active everyday**....**generally low fat, fruits and vegetables every day**, and I think the exercise combined with that really makes me feel better.

> Carl (B middle) - Well, I've uh...**I go for regular checkups** and uh, **I keep very active.** I'm a member of a bicycle club and I cycle a lot and the whole family cycles. Um, so I'm involved in a racing program and that kind of thing, so **I'm very aware of nutrition and fitness** and that kind of thing.

> Charlotte (C middle) - I.. you know, **I watch what I eat. I watch my weight**. I I'm physical. I...you know, **I keep active and physical** and.....

> Calvin (B older) - Well I like to feel that **if you eat properly** and do some ex'... I feel a lot better if **I exercise and , regularly**. It... it doesn't help me any if it's scheduled exercise but as long as you're doing something that ...you know, your body's active, it...it help a lot. And I think **good nutrition is very important**.

Earnie (C older) - I think I... **probably exercise a little bit. I don't drink or smoke.**

While many of these 'behaviours' coincide with present day thinking and health promotion around what a healthy lifestyle is, the informants were quick to point out that extremes in these behaviours were very undesirable. The informants saw themselves as being in no way 'fanatic' about any of these behaviours and did not wish to be perceived as so. In fact, they often referred to people who are very involved in these behaviours as being 'fanatic'.

A - Is diet something that you're aware of or conscientious of?
April (B young) - Oh yes, obviously especially being married to the man I am. (laugh) Yeah...(laugh) yeah. It is ...it's always there, always in our lives and it's... it's ... can be almost a problem in some ways, you know, **because he's so health conscious it's almost to the point of fanaticism.**

Ned (C middle) - Actually, I don't do a whole lot (laugh) you know? **I'm a little bit careful about what I eat,** you know. **I'm not fanatical about it or anything like that.** I don't eat a lot of junk food and stuff like that, so that's about it. I don't exercise or any of that sort of stuff.

The goal, it seems, is to maintain a sort of balance and to not be overly concerned with unhealthy or healthy behaviours - to be moderate. To exercise too much can be as bad as not exercising at all. It is important to eat well and watch what you eat but to not be too controlled or rigid. Dennis (B young) states: "Don't have too many carrots". Eating too much of the wrong things, however, can also be bad. It is therefore more important to be perceived as moderate where both extremes are seen as undesirable or even health threatening. It is important to note that none of the informants in this sample felt that they practised any particular health behaviours in

excess except for the self defined problem drinkers. They did, however, know of or speak of other people who did.

> Sandy (C young) - But hum....but **I think everything in moderation.** I mean not.. when you want to be.. when you think of a healthy lifestyle, that could mean you can... **a chocolate fudge sundae once in a while.** But you shouldn't be having it every day or even 3 or 4 times a week. So I think things in moderation.

> Nowella (C middle)- Well, in about the last year or so, I've been really trying to watch my diet. I've lost some weight. I started to exercise. But you... you can ... **you can be too careful with your diet, or you can exercise too much which tends to lead to illness,** or disease as well.

> Stu (B older) - **We don't do our power walk** or our jogging and so on, um...but uh, it..you know, **I don't think we're, we're not, I, I would say, health conscious in that sense.** Now...um...I think if, if we were eating steak all the time...you know, if we, if I insisted on having steak and, you know, lots of um...butter and so on, all that then I think this probably would not be a good thing. It's, **it's so much of this thing is everything, everything in moderation. People who go into excess on things, I think are headed for trouble.** It's the same thing with smoking, drinking, eating... um....even exercise. I think they, **if...if they do it in excess, I think is, it can be troublesome.** Exercise or lack of, you know, we have the, the couch potatoes who like to sit in front of the TV all the time. We watch TV but uh..uh..it's not on, not on all the time.

6.3 Smoking and Alcohol

It is not uncommon to have informants view 'life-enhancing' behaviours as those which some might not see as being particularly 'health enhancing'. The following quotes from these informants from Papermill Town indicate that the self is treated differently than the body. For example, they talk of drinking as being primarily bad for the body but helpful for emotional well-being.

> Cameron (C young) - How do I stay healthy? I've never really thought it. I

just do. **I eat well and drink well** (shows me his beer).

Carol (C young) - Actually what I think what everybody needs is what we have, is **we sit down with a bottle of vodka every second Thursday, and play cards.**

Sherry (C young) - It's [alcohol] probably not very good for your health....I don't... if you really think about it, it's probably not very good but maybe **...for your mental health it is okay.**

However, the notion of moderation found in the previous section was also extended to these lifestyle choices which are not usually viewed to be healthy ones. The informants certainly saw smoking to be a possible cause of illnesses such as cancer or heart disease in other people. However, it seemed that this only occurred if smoking was done 'in excess' and then the person became 'addicted'. Smoking was no longer something you did for the self, it was something you *had to do* for the body. Scott says it depends on how much you smoke and Fidel agrees with him. Fidel also states that these are the people who needs the cigarettes. Mark, also a smoker, says that the people who get sick from smoking are the ones who do not know how to smoke.

Scott (C young) - I guess I'd actually have to see the research to find out. Like it does. **I'm sure it causes cancer in the long run, but I guess it depends on how much you smoke.**

Fidel (B middle) - I have seen people who smoke cigarettes and they go through a pack a day. That's a hell of a lot of tobacco ...on ...on cigarettes. But cigarettes **I've know more people who smoked cigarettes because they need them, not because they're enjoying them....if you have to have it, that's not healthy any more....**

Mark (B older) - Yeah because a, **an awful lot of people don't know how**

to smoke. They'll smoke three or four packs of cigarettes a day and they expect to be healthy. I smoke uh, well, two and a half a week. Oh, I don't think there's any question about it. Tobacco and lung cancer being, uh, connected.
A - And yet you smoke?
Mark - **Because it's the way that people smoke.**

All of the above informants smoked yet did not see themselves as being excessive smokers or of losing control over their smoking. Dennis tells us that he only smokes on weekends when he drinks. Mike is an infrequent smoker and feels he can quit at any point as the self is still in control of the body. Stu smokes but it is 'only' a pipe which he has 'only' twice a day.

Dennis (B young) - **If I have a cigarette a week, or, like a couple with a couple of drinks, or on the weekend,** or whatever, you know, a social thing. **I don't think it's a big health threat.**

Mike (C young) - Ah...**I smoke off and on. I'll smoke for a couple of months and then I'll quit for a year** and then I'll smoke for up to a year. So, I don't personally see that as a... for me personally anyway, a health challenge.....**I smoke very little, maybe 4 or 5 cigarettes a day** on a ....**if I smoke at all, that's not going to be the cause of illness for me.**

Stu (B older) - I guess it's the evidence is too much to deny and I can say that because I, I smoke a pipe...(laughs)
A - And that doesn't worry you?
Stu - No, it doesn't because I, **I will have a I'll probably have two pipes a day.** Um, I'll have one with my second cup of coffee in the morning and I'll have another one in the evening, but, but it doesn't bother me. I, **I do it because I just enjoy having a pipe. I find I can sit and relax.**

Essentially, none of these smokers saw their smoking as a potential health threat because they did it in moderation, and they felt that they were not addicted to it. There were smokers who did admit that they were addicted to smoking and that it

could be a potential health threat. They sometimes experienced guilt because of their smoking and because of how society views them. But at this time, the difficulties faced with quitting were not as great as the different problems many of them were facing in their day to day lives.

> Trista (C young) - **I shouldn't be doing it and I know I shouldn't be doing it,** but 'cause everybody says to me, you know, like.. a lot of the thing is... when I go to the doctor and I have a problem with me, they might go say "You smoke don't you?" and they say "Well, you should cut down or you should quit".
>
> A - Do you worry about how smoking affects your health?
> Carol-Ann (C middle) - **You betcha. It's hard to quit though.**
> A - Is it?
> Carol -Ann - Oh, yeah. **Stress is what happens to me. I quit and then I got into a situation where I couldn't handle it.** And somebody was sitting there smoking and I picked one up and started again.
> A - So it helps you manage stress.
> Carol-Ann - Yeah.
>
> A - Why do you smoke?
> Charlotte (C middle) - **'Cause I'm addicted to the damn thing,** you know. I know it's an addiction.
> A - So stop.
> Charlotte - (laugh) That is easier said than done, easier said than done.
> A - So how do you rationalize it?
> Charlotte - **I don't try. I just accept it.**

In section 6.5, we explore one of the major reasons why people smoke -namely stress. It appears that stress is perceived as a greater threat to the self than worrying about the effects of smoking on the body.

With alcohol, we find this notion of moderation again. Informants who did not define themselves as alcoholics or problem-drinkers see alcohol as being harmless

in small amounts like one or two drinks. It is not surprising that some of these informants consume alcohol in health-threatening amounts. Yet they were very aware of the problems related to drinking alcohol in excessive amounts. As Ellen aptly states, alcohol has its place. It seems that people feel that as long as they keep alcohol in its place, in that they do not let it take over the body in the form of an 'addiction', they have not gone beyond what society deems acceptable.

> Dennis (B young) - Like alcohol in excess, I don't think alcohol...and that's also the big, you know, **"One beer a day is good and 8 a day is probably bad." But so it's the same would be for carrots**. If you had like... 100 carrots, it's probably bad too. So **I think anything in moderate your body can handle but anything in excess you body can't.**
>
> Iris (B young) - **Red wine - the thing to drink**. Yeah, and beer. You know, **a beer can be very good for nursing mothers**. It's a good thing to have, be-one a day. Yes, it's a nice excuse (laugh). But any, you know, with everything **I think if, if you overdo it, it's bad**.
>
> Scott (C young) - Oh, I would say so.....hum...**again taken in moderation, it won't affect you overly.** But **when you get down in terms of alcoholism or black outs, like obviously you're losing brain cells**...that's not overly wonderful.
>
> Nowella (C middle) - I really think it can... negatively. Again, it's the sort of thing that **I think having 1 or 2 drinks probably doesn't harm you at all. But if it's over-use.....**
>
> Ellen (B older) - Um, I think um, again of course the ....**I hear the word alcoholism, think about the abuse of it, but I think there are, there is a place for everything in, in moderation** that sometimes it, some **alcohol is very nice, very good even**. But **if you abuse it, then you're really asking for trouble in many ways, mentally, physically.**

In section 6.5 we explore one of the places where alcohol is acceptable. Alcohol, if used to relax and combat stress, is seen as being socially acceptable in people's lives.

There were three people who defined themselves as problem drinkers - Tim (B young) Cameron (C young) and James (C middle). It was during his interview that Tim first said he described himself to someone else as an alcoholic. He was presently seeking treatment for his addiction and when I revisited site B the next year, he wanted to see his transcript. He was the only informant who wanted to see his transcript. From speaking with Tim, I found that an alcoholic faces a great deal of isolation. His following statement illustrates how he sees people who are moderate drinkers as being 'normal' people doing 'normal' things.

> Tim (B young) - So **I won't be able to go out drinking on my stag tour**. You know, I won't be able to drink when they have a stag for me....uh...you know what I mean? Like, **things that normal people can do and I won't be able to do them.**

It appears that people who have become 'addicted' and are recovering from this addiction are separated, maybe even 'ostracized', from both people who are heavy drinkers and those who are moderate drinkers.

6.4 Regular Check-ups

The role of the family doctor in maintaining one's health came up in some interviews, particularly in the middle and older group. Very few of the younger informants, especially those from Papermill Town, had a regular family doctor and none of them saw seeing the doctor as part of maintaining their health.

> A - Okay, okay. So....do you have a regular doctor?
> Trista (C young) - **Not really** (laugh).
> A - No?
> Trista - No I don't.

A - Do you go for regular check-ups and stuff like that?
Trista - **I might go to the doctor once a year but I don't really have a doctor, no, I don't.**

Frank (B young) - Uh. No, I've never really had a, a liking for any of the doctors. **I've gone to different doctors uh, you know, I've never sort of stuck with one.** I wouldn't say I had a, a personal doctor or a family doctor.
A - You don't?
Frank- No. My kids do and my wife do. They go to the same one all the time, but I go to whoever is handy, yeah.

Informants in the middle group from both sites usually had a family doctor whom they were more likely to see as part of maintaining their own health. Informants in the older group from both sites were very likely to see their doctors regularly and to view them as part of maintaining or managing their health. It was common to hear them speak of making lifestyle changes because they were under a doctor's supervision for particular health problems.

Carl (B middle) - Well, I've...uh..**I go for regular check-ups** and uh, I keep very active...

James (C middle) - What do I do to stay healthy? I don't know, **I might...I might use a doctor....**

Bev (B older) - **I watch my diet**. I have been on medication but I have been...I've had reaction from most medication, so it's not worth the risk. The doc'...**even my doctor feels it's not worth the risk of having the...complications that I have with the medication.** So it's mainly diet right now....

Kelly (B older) - What do I do? Well, **eat healthy, and rest** and uh, I don't walk enough really....I should go up and park at the, up at the, either the corner of the subdivisions and walk down the ninth line or walk in around the subdivision there. That's what I'm planning on doing that, **'cuz uh Dr. XXXX, that's my doctor, says 'You should walk more**. Keep down the weight.'

6.5 Mental Well -Being

Taking care of one's mental health was a common theme for all the informants from both places and all age groups when they were asked what they do to stay healthy. The ways in which they did this varied from informant to informant but some common themes emerged. Having good mental health seems to begin with having a good attitude. The informants often brought up managing one's attitude or view of life as a way to stay or be healthy. They spoke of feeling good about oneself or having healthy self-esteem as a way of preventing illness or dealing with health problems.

> Frank (B young) - Uh, well I really believe that uh...(clears throat) **a person who feels good about themselves is mentally alert and uh...positive.** Uh, **I think your body uh...can put up with a lot more stress,** a lot more uh, **even you know, physical things - bacteria, viruses, and....and can fight them off better. I even think people can cure themselves of some kinds of cancer** just because uh,...and just being very active.

> Mike (C young) - For people who are ...maybe overweight or smoking or things like that, that are health challenges...**dealing with those challenges starts with the mental attitude you start towards them**. So it's ... I think **it's a big factor in a lot of it....to just assume that things are always going to work out and you're not going to be sick** and, you know, everything will be fine and that usually things turn our the way you see them turning out.

> Hank (B middle) - I think that's **an awful lot of, of your getting well if you're getting good support and people are caring about you and coming and giving you support** and everything else, **you tend to feel better about yourself, how fortunate you are, and I think just...you get better if you're well mentally, you tend to get better physically....**

> Stan (B older)- **I feel healthy. Uh, you know, it...I think this question of health is to a great extent in the mind anyway, um.....**

A - Uh-hum. So you feel the mind can control the body?

Stu - Oh, yes. Oh, yes, to a great extent. Maybe, I know if you, **I think uh, if you want to feel well, you'll feel well. Um, if you don't want to, then you could be perpetually sick.** Um, and I'm sure there are people that enjoy being - they, as, I, who was it? Um. Mark Twain said that he's enjoying ill health?

From the informants' words, we get the idea that it is almost more important to take care of the mind or the self first because if the self is healthy, the health of the body will follow. This perception of attitude being linked with maintaining health was probed more fully during the interviews. The results from all groups and both sites illustrate that the informants perceive a significant connection between attitude-thinking positively - and being healthy. They have examples of how their positive attitude affects them and how they know it affects others. They also demonstrate some strong ideas around what happens when someone does not have a positive attitude or if they do not even try to have a good attitude.

Zane (B young) Well.. that's debatable, also.. ..I'll say.... **the mind is probably the most powerful thing** that there is on this earth in my mind. Okay.. again in my mind, yeah. But.. I've known people.. that.. this.. the doctor said, "There's physical ability you can walk again, that's.. that's it." A couple of years later, they're walking. You know, and it's all.. **I know it's because of their positive attitude, because I know these people.**

Greg (B young) - **I've been trying to push that attitude toward me** and uh, it doesn't happen over night. It's a, it takes a long time to, like uh, **I've always had a, a positive attitude, a positive goal and uh, like I don't get sick hardly at all.** Uh, they just said Grandpa, that's the first time he's been sick and he's 80.

Fidel (B middle) - **Mind over matter, if you will.** Definitely, definitely. I've

seen people my own age, I'm 42 now, I just turned 42.. I've seen people my own age, I just.. I can't believe the way, to me, they just.. look.. less healthy than me. I feel, oh, they've put on a lot of poundage and their hair is going grey.. now of course a lot of that's genetics, of course.

Ellen (B older) - Some-sometimes I wake up in the morning and I don't feel good. I say, "Darn it. **Today I ha-, don't have time to be sick. I have to do this and this and that.**" So then you set yourself to it and **sometimes it is almost like mind over matter**. That you can say, "It is nonsense. I'm not sick." So just putter along. **So if you give in then and say to someone, "I feel so lousy."** Then they maybe start to, "Sit down and, or lay down."

Stu (B older) - You know, there are the people obviously who simply, **it doesn't matter what they try, they would not have good health because it's a, it's a physical thing, but, so much of poor health is a, a matter of, of attitudes or state of mind** and if, if they allow that to continue and don't do anything about trying to, to correct it, then you're right, **I think that's immoral.**

Evlyn (C older) - 'Cause **some of them really have bad problems and they seem to overcome it, some.. you know, they still make a life for themselves, you know**

There is a definite sense that the mind can make you healthy and prevent illness. In Chapter 8, we explore this same notion of attitude and its relationship to illness and the illness experience.

Stress was regularly cited as a major threat to the informants' mental well-being. They saw stress as something which can have a direct effect upon people's physical health, as Geraldine and Stu point out. The threat of stress on mental well-being and having to cope with it were shared in all the age groups at both sites. The impacts it had on their lives and how they dealt with it, however, did vary by age group and by site. We see from the following quotes that the informants feel that

stress, although not 'organic' or rooted in the 'biological', has identifiable 'symptoms' or physical effects on a person.

> Geraldine (B young) - I think **if you're too stressed out or whatever, you get achy and sick and that sort of thing.**
>
> Stu (B older) - They become so, so involved, **I guess with their stress that... uh..um...they become ill and as far as the individual is concerned, he is physically ill....**
>
> Osmund (B older) - **You can worry uh...you can worry yourself sick. You can worry yourself sick.** Yeah, and uh...I don't know why I took the...the heart attack unless - I, yeah, I do know. Um. I was smoking and I was playing in a country band and, and I was not uh....uh..I was not rested. I never was rested.

The young informants spoke of their own experiences of how having too much stress in their lives which had caused them to be seriously ill (see also chapter 7). Greg speaks of the point where he could no longer work on his farm because he was too physically and emotionally worn out. Barb speaks of some of the symptoms she had as a result of work stress that resulted in her hospitalization. Cheryl speaks of a major job change and how the stress of this change impacted her body. Sandy talks about how stress makes the body more vulnerable to 'things which are out there.'

> Greg (B young) - **Before I was going a little harder, like I could do more physical work and more faster paced and uh...I was just crashing.** Like, I'd be walking across the yard and I literally would fight to either finish or I'd stop in the middle of the yard and get...go...just go to the next chair.
> A - What was happening?
> Greg - Oh, I was bad, I guess. **I was crabby all the time**....But I was, I knew I was getting - **little things were buggin' me a little too much** and, and I, **I was tired all the time**, but not from...not from sick, I was tired.
>
> Barb (B young)- Well, the first time I was in the hospital was last April..

um...it was interesting, I guess. It was uh...job related. **It was, like I was just burnt out. Uh, fatigued, had lost more weight and I guess my blood pressure dropped too dramatically and my pulse was erratic** and so they decided that bed rest was the best thing. It wasn't anything in particular.

Cheryl (C young) - I like to believe there's always a reason if things kind of come in clumps like that and **I think it's probably stress related.** I mean for me, **if I'm under some sort of major significant like change or stress, you know, I can usually feel it in my body in one way or another.**...Like I remember, the first time I got bronchitis was right around a major job change time period, you know, like I had just gotten' a new job, I got bronchitis for the very first time in my life and I got laryngitis associated with that and I had to stay home and couldn't talk for 3 or 4 days....I was really overloaded. So I have no trouble believing that was definitely stress related, you know. I was sick, like I had 3 colds in 4 months and that's really unusual.

Sandy (C young) - **I think it can probably make you more prone. Like if you're exposed to that virus, if you're tired or something, or you've been working too hard and you've got a lot of extra stress, you could probably caught the cold that much easier if you're exposed to it.** I wouldn't say that it's going to cause a cold you know....somewhat more susceptible to it.

The notion of stress as a cause of illness demonstrates a 'connectedness' of the self and the body. It appears that in this case the self (mind) affects the body and makes the body more susceptible to illness. When illness happens, the physical body becomes more obvious. As Cheryl stated, when she is under a great deal of stress, she feels it in her body.

While the informants from the other two age groups did speak of the effects stress had *directly* on their body, many of them also said that they had, over time, learned to deal with it. In the case of Fidel and Howard, they now deal better with stress than they used to by just not thinking about it. James, on the other hand, verbalizes a sad reality faced by the papermill workers at Papermill Town. He sees

the effects of this work on his peers and the choices they make to deal with that stress.

> Fidel (B middle) - **I think we have to learn how to just avoid stress. I've been in plenty of stressful situations and I just said "Ah...to hell with them"**. And that's, **you know, forget it.** You have to solve problems, very often, yes. But having to start to worry about them, I mean, and.. I get a lot of customers that give me g'....but the ones that five the grief are the ones that really bother me. And I don't like any customer to give me grief.

> Howard (C middle) - In the earlier part of life, yes, it did. **Stress did affect me because I didn't know how to handle it.** I didn't know how to deal with stress before. So I didn't know how to... you know, **I lay awake at night, many a nights, tossing and turning, worrying about this, worrying about that,** all different issues which now **today I can look back at it....and I know how to deal with these things and it's not that important,** you know. I should never have been doing that. But I lost a lot of sleep.

> James (C middle) - I don't know what the hell it is. There's been lots, shit, on some shifts.....well, **some shifts I get on I might have 6 AAs [Alcoholic Anonymous members] with me and that are 6 druggies and 6 divorcees.** There's lots of that goes on here. I don't know why.
> A - Is there a lot of stress associated with your job?
> James - Uh huh. **Mental stress, not physical stress but mental stress. It's a very hard job on the mind, very hard job**. Like we're production workers, eh, and to beat a machine which is full of technology, it's pretty damn hard, very hard.

The middle aged informants were creative in the ways they dealt with stress or reduced its internalization. Carol speaks of her card night where she and her friends drink alcohol and talk. Carl uses his bike to help him combat stress. Charlotte likes to plant a large garden.

> Carol (C young) - **You do need to talk stuff off. If you've got pressures at home and stuff like that,** you've got kids are causing a little trouble and... and... or just wondering "Is my kid normal with what he's doing as compared to the other kids." **You need to talk.**

Carl (B middle) - Yes, well a healthy lifestyle being uh...trying to um...maintain a..a clean environment in the home....Um **trying to reduce stress in your life through a variety of methods, there are all sorts of different ways of doing it and for me, cycling is one of them. It's a great stress reliever.** If I do start to feel stress, I go out and try and blast away on the bicycle and I come back and I'm too exhausted after that to be, to be stressed, so it works really well.

Charlotte (C middle) - There's all kinds of ways. **I garden. I love to garden.** I just planted a huge, big perennial bed this year,...so..I've got all kinds of ways that I..you know. **Things that I really like to do and that..that...that..compensate, I think for, say the things that working in a place like this or even just being aware of what the hell the world is like, that I can get rid of the stuff when I do the other, you know.**

Yet the reality is that many of the informants use alcohol and cigarettes as ways of combatting stress. In many cases, people recognized that, in this context, alcohol and cigarettes have a socially legitimate place. People are trying to take care of the self. Carol-Ann recognizes her husband's need to have a drink after work. In Tim's case, smoking is a method to deal with the stress of recently quitting drinking. Fidel uses his cigars as a means of taking a break while James' and Greg's words show how smoking cigarettes used to be able to cope with his workplace stress.

Carol-Ann (C middle) - **Some people use it [alcohol] to relieve stress, I know my husband does.** He has a bottle of beer or a drink every night, **he finds it very relaxing.**

Tim (B young) - Right now I've just - I don't know, well, I might as well admit it. I'm going to AA [Alcoholic's Anonymous] and I'm smoking more than I normally do, because uh, well I.... you know, sometimes I get tense and whatever and I'm f -, **I find it as a release valve...**
A - So smoking helps you deal with the tension you having right now?
Tim - Yeah. **Though it may in the long term cause more tension or whatever, but right now I find, I do find I'm smoking more than I used to....**

Fidel (B middle) - Hum....**going off and smoking when I'm driving or when... I'm just relaxing outside, going for a stole [?] outside, or sitting outside,** I'll smoke them outside...but to me it's more of a ...it's not something I need, it's just something that.....I don't know what it is.

A - So what things do you do to deal with this [work] stress?
James (C middle) - Me? **Probably smoke.**
A - Smoking helps you deal with it?
James - Well, yeah, **it takes my mind off the job, I smoke. So I smoke lots. I would just smoke for years,** so...well nowadays, well it don't bother me that much any more. **Stress is probably the biggest trouble over here in the mill, stress for people. That's harder on you than smokin'.....**

Greg (C middle) - I've checked with him [family doctor], there's nothing ....he says nerves. **I gotta get a smoke. It's just nerves. The only way you're going to get rid of stress is quit your job.**

6.6 Findings

Many of the behaviours professed to be part of maintaining one's health reflected present day thinking around what a healthy lifestyle is. However, it is important to recognize that the informants perceived any extremes in any lifestyle behaviours, either doing too little or too much, as undesirable. We heard the informants state such things as too much exercise was as bad as too little. The goal, it seems, is to maintain a sort of balance and to appear to be not overly concerned with unhealthy or healthy behaviours. Thus to be healthy is not only to negotiate circumstances into what it means to be healthy as we found in the previous chapter, but also to find a socially acceptable balance in lifestyle behaviours (Backett 1992).

This notion of moderation also extended to these lifestyle choices which are not usually viewed to be healthy ones. In fact, it was not uncommon to have

informants speak of behaviours which were likely to be perceived as being more 'life-enhancing' than 'health enhancing' behaviours. For instance, most of the informants certainly saw smoking to be a possible cause of illnesses such as cancer or heart disease in other people. However, it seemed that this only occurred if smoking was done 'in excess' and then the person became 'addicted'. As long as a person saw themselves as keeping their smoking at a certain level, their health was not really threatened. Yet they were likely to see others as being 'addicted' to their smoking and therefore damaging their health.

When speaking about alcohol, we find this notion of moderation - in keeping with recent medical statements and advice - once again present. Informants who did not define themselves as alcoholics or problem-drinkers saw alcohol as being harmless in small amounts in accord with medical opinion. It seems that people hold an idea that as long as alcohol is kept in its place in their lives, and does not take control of their lives in the form of an addiction, it is not health threatening to drink. For instance, using alcohol to relax and combat stress is seen as one of its socially acceptable 'roles' in peoples lives.

The role of the family doctor in maintaining one's health was noted, particularly amongst the middle aged and older informants. Very few of the younger informants, and especially those from Papermill Town had a regular family doctor and none of them saw seeing the doctor as part of maintaining their health. The middle aged people from both sites usually had a family doctor whom they were more likely

to see as part of maintaining their own health. The older informants from both sites were very likely to see their doctors regularly and to view them as part of maintaining or managing their health. It was also common for the older informants to speak of making lifestyle changes because they were under a doctors' supervision for particular health problems.

Taking care of one's mental health was a familiar theme brought up by all the informants from all sites and age groups. The ways in which they did this varied from informant to informant but some common themes emerged. Having good mental health seems to begin with having a good attitude. The informants often brought up managing one's attitude or view of life as a way to stay or be healthy. They spoke of feeling good about oneself or having high self-esteem as a way of preventing illness or dealing with health problems. It is simply mind over matter; if you want to be well, you start by thinking that you are well. From the informants words, it seems almost more important to take care of the mind because the body will take its cue from the mind and then take care of itself. The informants in Calnan and Johnson's (1985) study felt that good health was strongly linked to having a positive attitude about life. People feel that they must be happy to be healthy. Furnham's (1994) survey in Britain showed that people feel that psychological factors such as positive emotions or positive thinking is a way of preserving or improving one's health.

This perception of attitude being linked with maintaining health was probed more fully during the interviews. The results from all groups and both sites illustrate

that the informants perceive a significant connection between attitude and being healthy. They have examples of how their positive attitude affects them and how they know it affects others. They also demonstrate some strong ideas around what happens when someone does not have a positive attitude or if they do not even try to have a good attitude.

Stress was regularly cited as a major threat to the informants' mental well-being. The informants saw stress as something which can have a direct effect upon a person's physical health. The younger informants spoke candidly about their experiences with what they felt were stress-related illnesses. While the informants from the other two age groups did speak of the effects stress can have on the body, many of them felt that over time they had learned to combat the effects of stress. They did this largely by taking care of the self and using alcohol and cigarettes as a way of making themselves feel good and feel relaxed. In many cases, people recognized that in this context, alcohol and cigarettes, have a socially legitimate place.

There seem to be two ways for the informants to cope with the vast array of information around health behaviours. One is to legitimize their behaviours in terms of their appropriate social contexts. Behaviours are then less likely to be evaluated as in themselves 'unhealthy'. There remain inappropriate social contexts in which to participate in such behaviours. The second way to cope with any confusion is to locate themselves within typical spectrums of behaviour. This involves comparing

oneself with others whose behaviours are perceived to be extremes. Excesses of behaviour which represent extremes of unhealthiness are often looked at disapprovingly. Interestingly, being a 'health freak' appears to be just as much of a taboo as regularly indulging in excessively unhealthy behaviours (Backett 1992). Often the informants were insistent that they were not in any way fanatical about any particular behaviour. Too great a preoccupation with healthy behaviours is seen as suspect and the informants imply that it is indicative of unpleasant personality characteristics. It also appears that 'life-enhancing' behaviours were sometimes seen as separate from 'health enhancing' behaviours. Overall it is very clear that achieving a sense of balance is very important to the informants when faced with the assortment of health information presently available.

While there did not appear to be significant differences between sites in how people managed their health, a person's age or place-in-life seems to influence how they take care of themselves and why they practise certain health behaviours more faithfully than others. For example family doctors were more likely to be viewed as part of managing one's health amongst the middle and older age groups. There also appears to be differences in how the younger informants perceive and deal with stress compared to the middle and older informants. While there were certain behavioural differences between the informants from each place, such as there were more smokers and heavy drinkers from Papermill Town as well as the younger informants from this site were less likely to have a family doctor, these differences did not seem to cause

divergence in perceptions. Therefore we can only gather that place does not seem to have a strong impact on perceptions around how health is managed.

6.7 Discussion- Negotiating The Moral Minefields of Health

Health partly appears be an 'achieved' state, where one needs to be somewhat 'vigilant' over the physical body. At the same time, it also appears to be a moral state, where the processes involved in determining what to do for one's health entails locating oneself within the realities of perceived social expectations around what is 'appropriate' health behaviour (Backett 1992). Therefore, managing ones health is an extremely flexible and practical accomplishment.

People's accounts of health incorporate both the need for self-control and the desirability of being able to 'let go' allowing them to rationalize the choices they make in the way they conduct their everyday lives (Crawford 1984; Lupton and Chapman 1995). Sometimes 'life enhancing' behaviours such as drinking alcohol and smoking were not compatible with those commonly thought of as 'health enhancing'. A dilemma exists for people when life enhancing behaviours are imbued with moral overtones. But as we found, the informants have mechanisms with which to cope with these contradictions. One mechanism is to see their own experiences as being 'balanced' or moderate and to demonstrate an avoidance of excess.

In this study we also found that lifestyle beliefs and practices are evaluated by locating them within appropriate social contexts and a spectrum of behaviour. This notion of moderation as defined by what is socially acceptable and the fact that people

are very concerned with being viewed as moderate suggests that ideas about health are very much constructed through interactions with the rest of society. Yet there is a difference between how health is actually managed and how people speak of health management in the abstract. While people may not practise certain health behaviours themselves, they are well aware of the 'typically' accepted lifestyle behaviours and rarely will speak against their value.

Having a 'healthy' physical body is a socially defined phenomenon in which health practices have both symbolic and practical meaning for the social and the physical body. For instance, it is evident that the production of health for the self involves management of the physical body. The self is partly dependent upon the physical body although not completely as we have seen from informants who suffer from chronic illness. So the physical 'needs of the body' for rest, exercise and food are included in people's definition of what makes them healthy. How these behaviours are actually carried out is very much determined by the need for the social body to 'fit' into societal norms and not to be seen as deviant by not practising them excessively or by being a 'health nut'. So how health is managed has symbolic value which can influence how an individual is perceived by the rest of society. Being perceived as normal is essential for social integration (Goffman 1969). This chapter has also revealed that while there are differences in how health is managed between the age groups the differences between geographical places were not as distinct. In the next chapter, we continue to explore the role of place in lay perceptions of health

and illness by focusing upon the illness experience in chapter 7 and how illness in managed in chapter 8.

Chapter 7

Defining Illness

7.1 Introduction

Just as people's notions of health are shaped by their own circumstances, so to are the ways that they make sense of illness. Lay perceptions of illness have been studied by others (Blaxter 1983; Donovan 1986; Eyles and Donovan 1990; Helman 1978; Herzlich 1973; Pill and Stott 1982; Litva and Eyles 1994) in order to find out how people define what illness is and how they determine what the causes of illness are. Fitzpatrick *et al* (1984) have stated that cultural factors influence the perception, labelling and explanation of illness. For example, people from Western countries tend to emphasize factors such as disease, environmental factors, stress and diet more so the people in non-western societies (cf. Herzlich 1979).

We explore similar themes in this chapter, asking such questions as 'what is an illness?' and 'what causes it?'. Like the concept of health, illness is also difficult for the informants to define as it is seen as being a very broad concept. The informants' words demonstrate that the interpretation of illness is an ongoing process; it is in almost constant negotiation. Illness can be the deterioration of the body or of losing balance or harmony. When we explore how illness differs from disease we learn more about the perceived characteristics of illness. It is also interesting to note that concepts of illness are difficult to separate from notions of causation and that people have a variety of general ideas about what causes illness. As they did when they

spoke of health, the respondents' conceptualizations of illness and its causes vary *in the abstract* from the ones they hold in the self. In this chapter, we focus upon these abstract notions by exploring how illness is defined and what the respondents perceive the causes of illness to be.

7.2 Defining Illness

When the informants were asked to explain what an illness is, they initially had some difficulty and had to be prompted. Dennis' words give us an idea as to why this question proves more difficult that initially thought when he states; "What's an illness? That's a pretty broad question". When we look at how this question was responded to, we find general answers and ones that relate to notions of causality. Illness usually begins with not feeling well. Something in the body does not feel as it usually does. It drags you down, and as Bev implies, something feels out of control. This is the stage when the physical body is making its presence known to the social body by providing symptoms. The informants from all sites and age groups spoke of illness as beginning with not feeling good or of feeling pain.

> Cameron (C young) - Ah...something that **drags you down.**
>
> Ned (C middle)- Well, **it's being sick** I guess.
>
> Bev (B older) -**You start aching** here and there. It's just the same as headache, the next thing you may be all stuffed up with a cold.
>
> Molly (C older) - Well, I guess it's **when you don't feel good** (laugh).

Sometimes illness is conceived by the informants as the 'deterioration' or

'degeneration' of the body. Illness is explained as a breakdown of the body or its parts which results in 'limitations' being put on an individual's ability to function 'normally' or at '100%'. With the younger group, there was a tendency to focus more on just physical limitations. We also find this idea but to a more limited extent in the middle and older groups.

> Dennis (B young) - Okay, what is an illness? Any....make a definition of illness. It's stuff...'cause there's all kinds isn't there...**any deterioration of normal bodily functions** I would say.
>
> Tim (B young) - Um. An illness is um...I...I... would describe it as some would, is, I can't think of the right word uh...uh...okay. An illness doesn't enable you to getting back to what, what is not the health. I think an illness uh...doesn't let you, enable you, **it doesn't enable you to uh...per- per- perform the activities of a normal person.**
>
> Iris (B young) - I don't know....**something that makes you not feel 100%.**
>
> Sandy (C young) - Something physically going wrong, speaking in physical terms, **something physical wrong with your body....you're interrupted because of it.** You probably don't feel well physically.
>
> Charlotte (C middle) - Well, an illness is...is..when our...some function of your body goes... you know, it's amiss...it's a malfunction...
>
> William (B older) - Well, let's see what would be..how would you define an illness? Well, I suppose **whenever your body is not functioning a 100%** you must have some'...something wrong with you, you know.
>
> Jem (C older) - Well, to me it's an illness is something **like a... malfunction of something. Same as a car, it's trying to tell you something, something's not working properly.**

Here we find the body is conceived as being a machine which can break down and no longer work the way it is expected to. Jem makes the analogy of the body as a car

which is trying to 'communicate' with you. Among some of the older informants, it is apparent that they perceive this breakdown as including physical or mental aspects.

> Hank (B middle) - What's an illness? Oh, somebody that's not, well it could be mental or it could be physical. But uh...either one I think is a big drawback.
>
> Vince (B older) - An illness? (pause) I think a.... I think an illness is some, is **some malfunction of your body or your mind over which you have, you have literally not much control**. Even the mind and, not much you can do about it....

The notion of illness as losing the balance in the body or as the failure to maintain harmony or equilibrium in the body (see also Herzlich 1973) only appear amongst the middle aged group of informants who lived at Papermill Town (site C). This perception did not appear in the younger or the older group of informants, nor did it emerge amongst the same aged informants at Farm Town (site B).

> Nowella (C middle) - Something...**something out of balance.** You know, whether...again it could be physical or...a mental...
>
> Patricia (C middle) - Well... I guess it's a... an un'...you know, an **unbalance...an upset of the homeostasis of the body**.
>
> Liz (C middle)- Hum let's see. (pause). I think it's sort of a...**the body comes to a saturation point of.. it can handle so much...imbalance.** See, I sort of have the debit-credit idea in my head. If you add on too may, you know, habits that are going to do you in....then eventually the body's gonna start giving a message that there's an imbalance there.

These findings are also discussed in Chapter 5, where at site C we found the middle groups's perceptions of health also included the spiritual realm. Here also we find these notions of imbalance and lack of harmony as being part of concepts of illness.

This place specific perception may be particular to Papermill Town (site C) because of the large native population in that area with which the informants would interact on a daily basis. These ideas are commonly associated with native ideas of health (Evans-Pritchard,1937; Young, 1984).

When the informants were asked if illness is different from disease we tend to learn more about the perceived characteristics of illness. Illness is perceived as being something far more common and far less serious than disease. We find that people perceive diseases as something which might require more than their own personal treatment or for which there may be no cure at all. Illness, on the other hand, is usually handled by the self and for which there usually is some sort of remedy.

> A - Are illness and disease the same?
> Scott (C young) - No, disease is, I guess, **a little bit more serious** to me than actual illness.
>
> April (B young) - When you're ill I guess you're in bed and taking your tylenol. But **a disease is something that has to maybe be treated in the hospital.**
>
> Cameron (C young) - What's the difference between an illness and a disease? Aren't they the same thing? Well, a disease is usually...ah....I would say so only **a disease sounds more serious**...a more serious illness, I guess.
>
> Stu (B older) - I think the **disease is probably, usually more severe** because there may not be uh....**there may not be any cure for it**...um.
>
> William (B older) - I suppose **the disease would be more of the serious thing which usually takes medical....medical treatment** to take care of a disease. Where an illness cold be a cold, or could be a flu.
>
> Molly (C older) - Well, I'd say the **disease is more serious.** Because you might be able to cure it and you might not.

Related to this notion of seriousness is the length of time illnesses last compared to diseases. Because illnesses are perceived as not being as serious, they are also perceived as not lasting as long as disease. In some cases, the only thing needed to get over an illness is time or 'waiting it out' and therefore it is not seen as really serious (cf. Eyles and Donovan 1990).

> Mike (C young) - I know ill might be....like you got a bug or a flu or something like that. To me anyways **if you're ill you're just... it's temporary.** Like "I'm ill today.... ill this morning." And then **a disease would be like a permanent,** if someone had a debilitating disease

> Sherry (C young) - A disease I would assume would be... something that isn't curable. Like **an illness they could..it could come and go.**

> Jem (Colder) - A **disease lingers and stays awhile and it could be fatal. Where an illness is not.**

Diseases are more likely to have a 'medical' name and to be diagnosed by a doctor. In that sense, they are seen as being more 'technical' or 'objective' than illnesses which are seen as lived experiences (cf. Kleinman 1988; Turner 1984). As Carol-Ann states, a disease is concrete because it has a name or a category. Illness is something where the symptoms are not always as consistent, generalizable, or recognizable.

> Barb (B young) - I'd say there's more people who have, um, **there's a lot of people today who are, have defined their disease**: what it is. That they have cancer; they have cancer. But there's a lot of other people who go around saying "Well I'm sick. I'm sick. I'm sick." They haven't defined it. Once, I guess, **they define it, then they, then they go from illness to disease.**

> Charlotte (C middle) I think of disease as being **something like**.. well you

know **cancer or heart disease or kidney disease.**

Howard (C middle) - Well, **if you have a disease,** if you have cancer as a disease, **it has a name and a category**...

Carol-Ann (C middle) - **Disease is something concrete.** Well, **they know what it is and you've got it.**

Also apparent from this comparison of illness with disease is the notion that if someone has a disease, they may 'be ill'. The inverse, is however, not true. Illnesses are not necessarily perceived as being diseased. From this we get a sense that diseases are a more physical or biological experience in that there is something wrong with the body that is diagnosable or has 'an aetiology'. Illness, however, seems to be what you feel and what you go through emotionally and mentally when you do not feel well (cf. Dingwall 1976; Kleinman 1988).

Geraldine (B young) - I think **all diseases are illness as well,** so that's why I think they are sort of related. **But not all illnesses are diseases.**

Iris (B young) -I think **you can be ill without having a disease.**

Tim (B young) - I think **a disease could be an illness, but illness isn't necessarily a disease.**

Hank (B middle) - Certainly you get disease you're going to be sick or ill. Um, I don't think all diseases uh...**if you have a disease, you're certainly sick. But you can be sick without having a disease.**

Molly (C older) - I mean **if you have a disease, you're ill too, but you can be ill and not have a disease.**

7.3 The Causes of Illness

Most of the informants perceived illness to be caused not by one but by

several things, some of which are within our control and some of which are not. Therefore, lay perceptions of the causes of illness can be divided into two categories: those the informants perceive they have control over preventing or avoiding, and those they perceive over which they have no control. Some illness are perceived not to be the 'fault' of the sick person. Others are perceived to be the victim's fault. It is perceived that the victim caused the illness and therefore they may bear a certain stigma for bringing the illness upon themselves.

One thing which people perceived to be completely beyond their control are illnesses which they attribute to be caused by or related to genetics. These are the illnesses which occur completely unexpectedly because of some 'inherent weakness' in a person's system. If an illness is perceived to be genetic in nature, people believe that there is nothing the individual can do to prevent this illness from happening. They are not to be blamed for it is simply bad luck or fate.

> Dennis (B young) - But at the same time **some people can't help it**, you know. Some people are **genetically prone**. And...and some people even **no matter what they do they're still going to become ill** or have these....well....I think that's true. **Some people have inherent weaknesses**, whether it be immune system weakness, whether it be genetic problems.
>
> Fidel (B middle) - Yeah **it's in your genes that are going to decide** if you're going to get this illness of that illness or whatever.
>
> Nat (C middle) - Oh (laugh)..it can ...hereditary...it can be hereditary, you know. If you are... **if you have a disease that is from your genes, well what you gonna do eh?**
>
> William (B older)- I think most illness are pretty well genetics. Well, you know, I mean it's again, **I think luck and genetics is playing a big part** in

there, you know.

Another factor, perceived by the informants to cause illness and yet be beyond a person's control, is the environment. When the informants spoke of the environment, the concept was used rather broadly to include work, home and the physical environment. Tim's words, for instance, show us that environment as a cause of illness is very general and to him it includes occupational and social/family environments. It was the informants from site C who expressed greatest concern about the environment and its effects on health. This may be due to reports in local newspapers and on community TV channels about the potential health hazards presented by the paper mill.

> Barb (B young) - I guess **environmental factors to some degree**. Um, I guess in terms of um...for instance the...**the UV factor is a certain thing. The sun, radiation, pollution, acid rain, things like that.** That type of stuff. Again that, that could be in terms of a lot of media hype as well. Who knows?
>
> Tim (B young)- I think there's a lot of different things that could ca-...cause illness. Uh, I think **in your work environment, to you home life to, what you eat and drink or what you're exposed to**.
>
> Sandy (C young) -I've heard of..**my husband works there** and I've heard a lot of men with..er.. with, you know, **dying quite young of cancer or related illness**.....Someone...another women who works here, she been in a few small towns like that, she said, **"Why do you think the cemetery's always next to the mill in a little town?"**
>
> Carl (B middle) - Mental attitude and mental health has a large part to play in health and in general health and uh...**a poor social situation or um, a very uncomfortable ambiance in a house or in a home or something like that can have a very detrimental affect as well**, cause it adds to the stress and the stress uh, helps create vulnerability to germs.

Charlotte (C middle) - Some of the other ...the causes of illness...**pollution I would say. Pollution is very ....is very heavy, air pollution,** which we have her in this community whether people want to recognize it or not. Yes, **our local paper mill is never met the environmental specifications.**

A - What do you mean by environmental causes?
Max (C middle) - Well....a **we have a building that we work in that I'm convinced is not healthy,** principally because I worked with... in it with the DPW [Department of Public Works] before I went to the post office and I.... you know, ah...**the sick building syndrome I think is a pretty good example of it.** I lived in the...in the..well, in fact I grew up..it was right by the paper mill and I go back there now and [he coughs]. You know and.. and I think, Christ, I grew up here and it never bothered us. **Cause there's a helluva pile of cancer in this area and I don't really understand why.** 'Cause basically it's a pretty healthy place to live, water's reasonable good...

Included in the notion of the environment as a cause of illness is the idea that some environments contain more germs than other environments and therefore pose a greater unavoidable risk to people. Illness is perceived as the body being invaded by unseen external forces such as germs or viruses. The result, of course, is that the ill person is limited in their ability to perform their day to day duties.

Greg (B young) - Um, an **illness is when you got some kind of disease or virus..**

Scott (C young) - I guess that illness would be **when your body doesn't work quite right through, either injury or through some kind of virus.**

Carl (B middle)- Um, some part of **the body that's not functioning properly perhaps because of infection or, um, a bug infection** or whatever, um, and that kind of thing.

Fidel (B middle) - An abnormal...body function, I suppose. **An invasion of the body of some kind or the other.**....Well, no, let's put it this way, an invasion of body you can have all sorts of things, hepatitis, diseases...malaria. **Things which attack us from the outside,** bacteria, viruses.....

Scott (C young) -Well, **anyone can actually get sick...like it depends on what kind of environment you're in.** I mean, **if you walk into, you know, a place that's got... some kind of communicable disease** or anything like that, **I'll bet you there's a chance you're gonna be picking it up.**

Kelly (B older) - Well I do really think very seriously **pollution is creating a lot of our illness.** I really do. **Our air is so polluted** not that uh, I think that's that. And it has the doctors baffled in a great many instances. For instance, now you take the...uh, as you say that uh, how...um..**TB is coming back and they haven't got anything now to, to cure it and uh, they have that um, that meningitis.**

The perception that germs were a cause of illness was one that could be found in all age groups. Yet it was more predominant amongst the older informants. They were far more likely to mention germs first of several perceived causes of illness.

Ellen (B older) - What causes illness, ooh..again you can...you can have so many, many answers. Of course, **you can have contagious diseases, so....germs.**

Emmy (B older) - Well, Lord be....well flu...or cold or anything that you can pick up along the way. I suppose AIDS when you come right down to it. Anything that's caused by a virus or germ....

Evelyn (C older) - It could be a bug.
A - Like germs of something?
Evelyn- Yeah, germs.

Yet the environment is one perceived cause of illness over which people feel they have very little control. In the case of Papermill Town, people feel helpless against the industry which provides jobs for a large number of people. If the industry were to disappear, Papermill Town (site C) would suffer greatly. They do not even feel that the government can protect them. Therefore a trade-off must occur between employment and the quality of the physical environment. This is reflected by Patricia

who feels that the environment is a problem everywhere; it is one from which you can not move away.

> James (C middle) - **The government lets these people get away with the shit,** it's not the workin' man. I mean, how am I ever gonna fight the company? **How you gonna fight 'em?** They let them... **they let them dump the chemical in the river,** not me. I don't let 'em do that. I'd a wished.. I wish they wouldn't dump the chemical in the river 'cause I eat that fish.

> Patricia (C middle) - Well, I suppose I though about it **but there's not much point in worrying about it 'cause we're here... it's there.** You can't really change that. I guess we could move but I don't want to move....I mean the environment is a problem everywhere.

There are factors which are perceived to cause illness which people believe are largely within their own control. One is how people live their lives and which health behaviours they choose to follow or ignore. These behaviours are largely seen as 'precautions' which individuals are expected to take to protect themselves from things such as viruses (cf. Eyles and Donovan 1990). If they do take care of themselves and still get sick, then it is not their fault because they did try to protect themselves. If they do not practise a healthy lifestyle, then any illness which follows is because of their own lack of responsibility. For example, Trista is well aware of the fact that she did not take care of herself and she accepts responsibility for her illness.

> Zane (B young) - I mean you don't feel right and...it's like you're not getting enough sleep, not getting enough exercise, your body's not getting the nutrients it needs. I mean if you put rotten gas in you car and the things going to run like crap. You know, **if you don't use the right oil, I mean it's going to wear out and it's going to die on you** and that's, you know, that's all there is to it. And your body's ...your body's just a machine basically, you know. It's the same type of idea. But...it does, **it lowers your resistance** to a point where any diseases that come along, **any viruses, bacteria and that are**

gonna take a foothold in your body a lot easier.

Trista (C young) - If you don't get the right needles or something. Or, if **you're not taking the right care of yourself...you're going to get an illness**....just like I have a cold, right? I didn't take the right precautions. I didn't ...you know, drink the right fluids and take the right vitamins so I have an illness.

April (B young) - I don't know...I do think that they are responsible. But I guess it's... it was just like it was weakness. It's probably in like...**they knew what they were doing was not good for them**....But I think, is it any worse than myself carrying the weight that I'm carrying. I know it's not healthy for me.

Bev (B older)- What causes illness? I..I think that **if you don't look after yourself, if you don't eat properly...**if you go beyond your limitations....if you push yourself beyond limitations you...can be ill.

Ellen (B older) - You know, um...say that you expose yourself knowingly to, to harmful things....say smoking for example. You know that's one of the things.... that you more or less know... and then you should know if you start smoking or have you ever smoked. **Don't expose yourself to the risks.**

Lifestyle did not emerge strongly as a perceived cause of illness amongst the informants in the middle aged group at both sites. It is difficult to ascertain why but one possible explanation may be that many of these informants perceived stress as a far greater cause of their own illnesses as opposed to alcohol, smoking or diet. There was also a difference between sites in that the informants from the younger and older groups who cited lifestyle issues as a cause of illness were mostly from Farm Town as reflected in the quotes above.

Yet even with lifestyle factors, fate still plays a role in people's perceptions. For example, we find that people perceive lifestyle, including such things as smoking

and diet, to cause illness. But luck, especially amongst the younger informants at both sites, is perceived to still play a role. A common example cited was someone who smoked all of their life and never became ill.

> Iris (B younger) - Well, I mean to certain extent [illness] is preventable. You can, you know, **if you eat well and you eat certain things and don't smoke, but um, some of it's fate.**
>
> Ann (B younger) - **You don't really control anything** (laughs). You know, I don't think so. Like as far as AIDS goes, you have control over whether or not you get it, but as far as cancer goes, there is no...you know...there's no...**you can't stop it from happening.** Like cancer of the bowels or something, you can't stop that from coming. You can't. **You just have to live from day to day and whatever you get, you deal with it.** Just something that I ...I think myself like, there's nothing you can do about anything.
>
> Scott (C younger)- There's **obviously 1 or 2 thing that just kind of show up anyway no matter how healthy you may be so....**
>
> Fidel (B middle) - There's always the case of [changes voice] **"oh my grandfather's been smoking for 90 years and he's healthy as a horse. You know. You know, he smokes 25 a day". Well, he's lucky!** And **then there's the other person who smokes and well...they get luck cancer at 30 years old.** Who knows?

Stress and worry are, however, perceived causes of illness which are also seen as within individual control. These are probably one of the most problematic causes because they are difficult to deal with and yet they are so prevalent in today's society. Stress is perceived to cause people's immune systems not to work as well thus making them more vulnerable to viruses and germs. By not dealing well with stress, an individual is seen as bringing the illness onto themselves.

> Mike (C young)- Well, a lot of **people I think, get wrapped up in their**

situations. Either with their jobs or their...and **they let the situation get in control of them**..instead of vice versa. And that's when....**that's when people start getting..having a problem with illness,** is when they start worrying to much about it.

Sandy (C young) - **If you're exposed** to a virus, if you're tired or something, or **you've been working too hard and you've got a lot of extra stress,** you could probably **caught the cold that much easier** if you're exposed to it.

Paula (B middle) - I think you're.....mental health...um, I guess that might of under stress, or you know. I guess stress - physically, mentally and emotionally. I think all three. **If you're worried** and worried about something, you're, you know, I think **your immune system is down and you're likely to get sick.**

Nat (C middle)- Well, I would say stress...well, **stress is one, is one of the principle things** and then...ah...work.
A- Work? What do you mean?
Nat - Well, when you work at 20 hours a day, you have no...your mind... **your faculty gets so weak, you know.**

A - What do you think causes illness?
Stu (B older) - Uh (laughs) to come out with, with today's hot one - **stress. That's the...the current one, I think.**
A - Do you think stress is a cause of illness?
Stu - Stress? Oh, yes. Yeah but I believe in stress, in the fact that there is stress. But I don't believe that stress necessarily leads to an illness. I don't think it has to. **I think people can handle stress if they're of a proper frame of mind.** We've all been through stress, you know. Your parents went through it, we went through it...um, you know. I think **we're all involved with stress at some point, but we have to learn to handle it.**

It is ironic that the informants see stress and worry as something which is within their own control yet many of the sources of stress and worry, such as work, family, money, are hazards beyond their control. What is controllable, as we see reflected in Stu's words above, is one's attitude or reactions to stress and worry. Having a positive attitude is a major component for being healthy and a bad attitude

is a perceived cause of illness. As Zane (B young) summarizes for us, "if we're going to get down to black and white, then at where your mind is, is really the answer. **You know, like it's the cure and the cause."**

Attitude works in several ways to cause or bring on illness. Having a bad attitude can, as Carl describes, make you less likely to take care of your body. In some cases the mind is seen as having the capacity to make a well person sick. A bad attitude also makes a person who is ill to 'give in' to it. This notion carries with it strong moral connotations about an individual.

> Carl (B middle) - I believe mental attitude a lot of the times, and lack of um, lack of care for the body. You know, a lack of understanding of the rest you need, the nutrition you need, the exercise and that kind of thing. **If you're run down, if you're sort of receptive to them [germs]**, then they can effect you. Receptive mentally I mean. If you're convinced that you know everyone around you is getting a cold and you're convinced you're going to get a cold, you'll have a cold within three days, four days or something like that.....The **mind I think can sort of create an environment that is um, welcoming to the germs** in effect. You know, it.. it's sort of , it's almost as if it's saying "Come on in!"
>
> Max (C middle) - There's **some people that can talk themselves into being sick....**
>
> Hank (B middle) - A lot of people **sit around feeling sorry for themselves** and just..uh...nothing really to occupy their mind or their body. I think mental is a lot of it. I think **the big majority of the illnesses are mental.**...I think **we bring on an awful lot of illnesses on ourselves,** both physically and uh..mentally.
>
> Vince (B older) - I think everybody gives in sometimes, but the **people who prolong the giving in, I think they make themselves sick.**

This notion of 'giving in' to illness has been found in several other lay perception

studies (cf. Calnan and Johnson 1985; Blaxter 1983; Williams 1990; Crawford 1977).

7.4 Findings

The informants in this study had a difficult time separating concepts of illness from notions of causation. Illness is conceived in three different ways. First illness can be thought of as the 'deterioration' or 'degeneration' of the body. There is a mechanical breakdown of the body or its parts which results in 'limitations' being put on a individual's ability to function 'normally' or at '100%'. Within the youngest group, there was a tendency to focus more on just physical breakdowns but the older informants also included the notion of mental breakdown. The second way that illness is perceived by the informants is as losing balance in the body. Illness is attributed to the failure to maintain harmony or equilibrium in the body(Herzlich 1973; d'Houtard and Field 1984) Lay perceptions research has also found this notion of illness as 'losing equilibrium' was present. Yet this perception did not appear in the youngest or the oldest group of informants. It also appeared to be more predominant amongst the middle aged group of informants from Papermill Town. The third way that illness was conceptualized was as something which is caused by an invasion of the body by unseen external forces such as germs or viruses. The result, of course, is that the ill person is limited in their ability to perform their day to day duties.

When the informants were asked if illnesses were different from disease we learn more about the meaning of illness. Illnesses are perceived to be far more common, to not last as long, and to be far less serious than disease. Illness can

usually handled by the self as there is usually some sort of remedy. Waiting to see if it passes, or using over-the-counter medications were possible responses to illness. Diseases, on the other hand, are perceived to be more concrete in that they are likely to be medically diagnosed and have a name. If someone is diseased, they may also 'be ill'. The inverse, is however, not true. If someone is ill, they are not necessarily diseased. Therefore, lay people perceive illness to be the subjective experience while disease is a far more objectively defined one (Blaxter and Paterson 1982; Cornwell 1984). As Kleinman (1980) explains it, disease refers the biophysical condition while illness refers to how the sick persons lives with and respond to symptoms. He asserts that because doctors of western medicine are trained to focus exclusively on disease, they often have difficulty in dealing with the illness experience.

Most of the informants perceived illness to be caused by several different things. The causes of illness can be broken into two general categories; those the informants perceive they have control over preventing or avoiding, and those they perceive over which they have little or no control. One thing which people perceived to be completely beyond an individuals control were illness caused by genes. Another is the environment. Particularly at Papermill Town (site C), the informants expressed a greater concern about the environment and it effects on health. As asserted earlier in the chapter, this may be due to community discourse taking place about the effect of the papermill upon their environment (and health). However, many at Papermill Town (site C) also saw the environmental impacts as something they had to put up

with or risk losing their source of income.

The factors perceived to be within an individual's own control are lifestyle choices, stress and attitude. How people lived their lives was seen as a choice. It was a choice they made to take care of themselves so that if they did get sick, it is not their fault because they did try to protect themselves. As Pill and Stott (1982) found in their study of middle-aged women living in South Wales, lifestyle choices contribute to an individual's ability to 'resist' or 'fight off' germs. The only group which did not mention lifestyle as a perceived cause of illness were the informants in the middle group from both sites Farming Town (site B) and Papermill Town (site C).

Stress and worry are perceived causes of illness which are within individual control. Stress is perceived to cause people's immune systems not to work as well thus making them more vulnerable to viruses and germs. By not dealing well with stress or by giving into worry, an individual is seen as bringing the illness onto themselves. In Blaxter and Paterson's (1982) study of working class Scottish women, the informants were very conscious of the mind-body link as psychological factors such as stress and strain were popular causes of illness.

In chapter 6 we found that people viewed having a positive attitude a major factor for managing health. A bad attitude is also a perceived cause of illness (cf. Furnham 1994). A bad attitude can make you less likely to take care of your body and therefore you are more likely to become ill. A bad attitude can also make a well person sick because they are likely to 'give in' to it or as Blaxter and Patersons'

informants put it "lying down to it".

There were several age or place-in-life differences found amongst the informants when speaking of the causes of illness. It appeared that the middle aged informants from both sites tended not to perceive lifestyle as a cause of illness. The younger informants tended to see luck as having a greater role in whether they got sick than the middle or older aged informants. There appear to be two place specific differences which emerged while speaking about illness. It seems that the middle aged informants from Papermill Town saw illness as a result of the failure to maintain equilibrium or harmony in their body. The informants from Papermill Town were also more likely to perceive the environment as a cause of illness. Unlike the informants from Farming Town, they saw their environment as hazardous to their health.

7.5 Discussion - "..illness...that's a pretty broad question"

When illness strikes, people seek to comprehend what has happened to them: What is the nature of their illness? What caused it? Interaction with physicians is one way in which western culture seeks to restore the disorder that illness causes. This is by means of naming it and giving it a culturally recognizable form (Freund and McGuire 1995). Naming the illness imposes order on a previously chaotic set of experiences, etiologies contribute to restoring a sense of order because they reflect important values of the social group, especially by identifying a causal relationship. In applying particular etiologies to a given illness episode, the medical process ritually re-affirms these values (Young 1976).

People employ their own conceptions to explain the nature and the causes of illness. While illness etiologies in Western medicine typically deal with proximate causes (eg. germs, genetic defects), lay ideas about the causes of illness are based upon the kinds of empirical evidence available to them through their own experiences as well as from interactions with friends, family and their family doctor.

Chrisman (1977) constructed a framework from a review of cross-cultural evidence of folk ideas of illness in which he identifies several lay 'logics' about the causes of illness. First there is the logic of degeneration in which illness follows the running down of the physical body. The informants in this study saw the physical body as having the potential to breakdown and thus limited and individual's ability to function 'normally'. The second logic is the mechanical logic in which illness is the outcome of damage or wearing down of body structures. These informants seemed to used this metaphor to suggests that the physical body is radically 'other' to the self (cf. Shilling, 1994) which can communicate with you (the self). The third logic, which was also found in this study, is one of balance where illness results from a disruption of the harmony in the body from external factors (eg. environment, stress) and involves both the physical body as well as the social body. The final logic is that of invasion where germs invade the physical body thus causing illness. This notion came out more strongly when the informants spoke of potential causes of illness rather than when they defined what illness was.

Lay understanding of the meaning of illness does not fully address the

experience of illness. Essentially, what we have done in this chapter is examine how illness is understood in the abstract. In the next chapter, we shall explore how illness is experienced in the self. Illness is a time when the self must be preserved (cf. Goffman 1969) for, as we shall see, illness is also the time when we are most critical of others.

Chapter 8

Managing Illness

8.1 Introduction

To be ill is not simply to be in a biologically altered state, but also potentially to be in a socially altered state (Field 1976). This is because an individual's illness experience is also affected by how other members of their family and their social network perceive, live with and respond to their symptoms and disability (Kleinman 1988). In this chapter we focus upon the experience of illness by the informants from Farming Town (site B) and Papermill Town(site C). While it is very clear that people interpret illness based on their own experiences with it, their interaction with society, and their interactions with health care professionals, in particular physicians, influence the shape of their illness experiences and how one responds to it.

Like concepts of illness in the abstract which we explored in the previous chapter, we find that notions of illness in self and in others are dominated by the moral aspect; whether the illness is legitimate and the response appropriate. The degree of 'spoilage' to identity (stigma) resulting from an illness becomes as a key variable in the social construction of illness and the illness experience (Field 1976). From the respondent's words we find that illness appears to be a time when the physical body must be 'managed' in certain ways or else the social body may be threatened with social reprisal usually in the form of stigma. Consequently, it appears that when we are ill, we are not only suffering from the physical disorder alone, but

the social experience of illness and the meanings attached to it (Freund and McGuire 1995).

8.2 Managing Illness in the Self

Part of being ill involves recognizing signs and symptoms. Many informants spoke of having a very 'close' relationship with their physical body and of being able to 'read' or 'hear' the signals that their body gives. They know when something is not 'normal' or 'usual' for their body. When these signals arise, informants spoke of watching these signals carefully and sometimes responding to them in various ways in the hopes to avoid illness.

> Dennis (B young) - **I know my body pretty well** just from training a lot and...experiencing different things and I, you know, most of the time when something's wrong I can tell.
>
> Fidel (B middle) - I'm convinced that there's **nobody that knows my body better than me**. I felt the...I...I know my head colds so well...that I've... that I can feel them coming on, I can feel the tickles. I say, "Oh, no. Here we go." And I just know them, you know.
>
> Paula (B middle) - I can, **I'm able to read body signals**, I guess you would call it. So that uh, I can feel, you know, if I'm getting a sore throat or whatever, I can feel that coming and I'll up the vitamins that I take, try and get a little more rest and I can usually head it off.
>
> Carl (B middle) - **I feel I'm in tune with , with my body** and with what's going on and uh, you know, and the type of illnesses that I get generally are minor and common.
>
> Jem (C older) - **The body tells you as signs** as you can't...you don't feel like gettin' up in the morning and that is very unusual for me (laughs).

What is normal for a person's body varies from person to person. But the

signs and symptoms that a person experiences when a 'usual' illness such as a cold or flu is coming up tend to be fairly generalizable across the whole group. People spoke of feeling unusually tired, or of having unusual pain such as a sore throat. What they of knew was that they felt 'different' from what they normally do. What is obvious is that people are very aware when something different is occurring in their body and this causes them to become alert or vigilant over these changes in their physical bodies. When the illness becomes recognizable, it become the flu or a cold, the informants had many method with which to deal with the illness.

These symptoms appear to be what Kleinman (1988) refers to as first-level meaning of symptoms where implicated in these symptoms are forms of knowledge about the body, the self, and their relationship to each other as well as to society. At the very core of these complaints is an integration between physiological, psychological, and social meaning (Kleinman 1986). For members of Western societies, Kleinman asserts, the body is a discrete entity, machinelike and objective, separate from thought and emotion.

For many people it is a difficult and embarrassing thing to admit that they are ill. Therefore they often decide to do nothing about their illness either because they feel there is no point as illness has to run its course, or because doing something might attract the attention of others.

Frank (B young) - What do you do? Uh, try and ignore it.

Ned (C middle) - Nothing usually...so let it run its course. There isn't

anything you can do most of the time. You can buy medicines and things but they don't do anything, you know. I mean if you're bad enough to go the doctor...maybe but I usually don't.

Kelly (B older) -I'm not that private,you know what I mean, but I think it's my business what way I feel, you know, and so on. And I figure that **"Oh why should I be telling you?"** Maybe I'm bogging you down with my anxieties, whereas you have enough of your own, you know what I mean? Well, that what I say. **You say to rest and so you can't rest except you stay quiet.**

Ellen (B older) - It came to a point a couple years ago when I, **I really couldn't hide it anymore,** you know. I couldn't go to church, I would faint. So I had to admit that I wasn't good enough to go to church which I found deathly embarrassing. You know, I really hated that and now still once in a while, like last summer, I got a real faint spell. I said "Oh God, I should really get up and go out." And I couldn't do it. I just could not do it, so **then people would, would say "Oh look there she's sick again."**

Particularly from Ellen's words, we get a sense of the potential embarrassment at being 'discovered' as being sick. The potential for her to faint in public is very embarrassing for her and fainting would provide the public with an obvious sign that Ellen is not well. The reactions of an individual to the initial variation or difference greatly influences the degree of stigmatization. If it is seen by both the individual manifesting it and by others who may notice it as merely a slight and acceptable modification of behaviour, then it will not lead to any substantial redefinition of the individual and the self remains intact.

The normalizing of illness as part of the illness experience is reminiscent of what Lemert (1967) refers to as primary deviance, those departures from the normal state that although present are dealt with as part of normal social activity. However, when a person's behaviour persistently fails to meet the expectations of others, a

search for an explanation of the unusual behaviour will be initiated. Illness represents a deviation from a 'normal' bodily state. Whether it will be treated as a primary deviance is dependent upon a persons response to the deviation. One of the most common responses to illness for the informants from the younger and middle groups at both sites, was to keep working. By demonstrating the ability to carry out normal everyday tasks and activities, people are not at risk of being labelled ill or deviant. Often they spoke of having to be very sick before they would stop working. In some cases work is seen as a remedy to sickness because some illnesses are viewed as originating in one's attitude and work can take the mind off of the signals.

> Barb (B young) - What do I do personally? I um, well I keep going unless, you know, it hit's me all of a sudden, whatever, the flu or whatever. I don't get sick often. My husband is the same way. I find that, it's only something good that would knock me out like if I was really, really flu-ish or whatever or fatigued that I would go home, but I think if you, if you don't have the time you won't make the time to be sick.
>
> Greg (B young) - I never think of being sick and then when I am sick, I uh, **I keep working anyways. I figure that's the best medicine** nine times out of ten to be.
>
> Scott (C young) - I don't like getting a lot for free. Like I like to work for what I'm doing..for what I get. Like there's been times where I've been, actually in my entire life **I think I've called into work 4 time sick. I can still work whether or not I have a cough.**..obviously you can't work quite as well, but you can still go in there and do whatever it is, you know. You don't have to be a peak efficiency every time you go and do some kind of a job.
>
> Hank (B middle)- **If you just go ahead and work, uh, it uh..you forget about it.** Your mind can only think of one thing at a time and a lot of pain is in your head. An awful lot of it, because if you actually concentrate on something else, you don't feel the pain.

Carol-Ann (C middle) - **A little bit sick is not enough..to warrant booking off work**. Like not enough to...if I'm sick enough to stay home, it means I'm sick and I'm in bed, flat out.

Max (C middle)- You know, you feel off colour, you know, everybody gets a little touch of the flu now and again, or anything. But you're going to feel as rotten at home as you do on the job so you might as well go out. I mean there's rarely that I really feel or I really, you know, don't feel right.

While illness is a potential source of embarrassment, working through illness can be a source of pride for some of the informants. Many liked to strengthen this point by speaking of how few workdays they have had to miss because of illness.

Max (C middle) - I haven't had an uncertified sick day, I would say, for 4 or 5 years.

Howard (C middle) - I can't remember, I've been on this job for, it'll be just about 3 years and I've never...I've gone home one afternoon because I wasn't feeling well.

Carl (B middle) - You can, you can look at the number of days that I've had to get a supply teacher and it's usually for something else other than being sick.

The most common approach to illness was to rest and to try and use over-the-counter medications such as cold remedies or aspirin. They only did so when they knew what was wrong with them or if they had specific symptoms (ie. pain) which they knew a specific remedy could help with. Vitamin C was also mentioned as something which can be taken as a precaution or when someone has a cold. None of the informants felt they used these medications unless absolutely necessary and then they did so sparingly.

Frank (B young) - I'd probably take and Anacin or something like that. If uh,

some kind of medication, yeah. And if uh, I don't know, if I were just feeling kind of lousy, I'd probably try and sleep at first, sleep it off.

Gregory (C middle) - I don't like taking pills at all. They're not good for you. Well, cough syrup maybe once in a while, not very often. I haven't taken it yet for my cold. Maybe the odd allergy pill though.

William (B older) - Usually it's, you know, it's vitamin C and an aspiring type of thing.

Molly (C older) - It's hard to say what you'd do. It depends on what you're sick with. You know, if you take... if you have a headache I don't bother taking an aspirin because it's going to pass. Unless it was to be a persistent headache and then I might go and take a coated aspirin.

Some people had home remedies which they liked to use when they experienced particular symptoms. They appear to be part of the 'private solution' to illness and were usually remedies which they had learned from someone else, usually a family member, and had found them to work in the past.

Barb (B young) - I usually drink um.... hot water with sugar and lemon or lemon and honey.

Evelyn (C older) - You know what I take is ginger and honey. It sound silly but water and ginger and honey.
A - For a cold?
Evelyn - Yes and it helps. I think it's from my Mother, maybe. I don't know. It's an old, old recipe. You take hot water with ginger and honey and I use to get the preserved ginger.

Going to the doctor is not an immediate response when illness is detected. The informants spoke of not going to the doctor unless they were 'really sick' and absolutely had to and only if they perceived it to be a 'legitimate' problem. As Barb says, going to the doctor is a last resort response which occurs only after you have

tried to solve the problem yourself.

> Barb (B young) - I'm the sort of person to see if it'll cure itself. Like for instance, I waited a week before I went to the doctors with this cold and I'll try everything, everything I can possibly do before I sort of have to go.
>
> Dennis (B young) - I'm not a hypochondriac. I go when I think there's a legitimate problem.
>
> Charlotte (C middle) - **I usually don't go to a doctor unless I'm really sick. I'll do everything else possible**, you know...to try to look after myself before I'll go to the doctor.
>
> Hank (B middle) - I don't very often go to a doctor. I **have to be really sick before I go to the doctor.**
>
> Bev (B older) - I'm afraid **they have to be good warning before I go to a doctor.** But I eventually do go to a doctor. And it really has to be bad before I'll give in to go.
>
> Evelyn (C older) - If I'm **really sick I'll go** to the doctor...

Going to the doctor occurs after the individual has determined several things. First they have to determine that they cannot solve or cope with the problem privately or by themselves. This is either because they do not have access to the necessary type of medication such as an antibiotic, or they do not know precisely what to do about the problem.

> Sandy (C young) - It has to be **something I think I'm not going to get better on my own.**
>
> Frank (B young) - I wouldn't go to the doctor personally until I felt that I **couldn't cope with it** and till I felt that I wasn't going to get better without medical care.

If the illness is seen as lasting too long, then people will decide to go to the doctor.

They go in order to get it 'checked' and to make sure that their 'diagnosis' is correct and they are doing everything that they should be doing. Thus the credibility of the self, in being able to handle the physical body, can remain intact.

> Geraldine (B young) - Like if I had **something that's prolonging**, you know, like if I have a sore throat, like I'll go. So I guess I wouldn't say right away to the doctor, but **if it keeps up I'd go** to the doctor.
>
> Iris (B young) - **If it's lasted for a week and a half.** Yeah, or if it's something that I, that just doesn't seem to be going away, then I'll go get that checked.
>
> Max (C middle) - I'm not really crazy about running to the doctor...but at the same time **if that what's advocations then I don't hesitate** in doing that. You know, if I was....**had an infection and it wasn't clearing up** I would take antibiotics, no problem. I mean I would go to the physician and say "I've got this" and he'd probably prescribe antibiotics and I'd take them.
>
> Jem (C older) - Well I would say aches and pains if..or you can still tell too it it's a break or a sprain, **about 3 days if it doesn't ease up. It's time to go and get some better advice.**
>
> Ann (B young) - I've got a sister that's a nurse and I've got another sister that likes to read a medical book for fun, so I figure she might know and one of them might know what possible might be wrong so I can go to the doctor with some idea of what I possibly have. That's what **I use a doctor for is to confirm what I have**, basically.

Amongst the older informants, some went to the doctor because other family members wanted them to. They often spoke of not wanting to go but of going only to appease their family. In this case, going to the doctor is more an obligation to the family than it is to the self.

> Don (B older) - I go there once in a while, but uh, you know, you sort of feel obliged to do that..
> A - Why is that?

Don - Well,uh because you know family insisting and things and you know there are certain things that the doctor could, uh you know, normal medicine or what do you call it, conventional medicine could detect in time and do something about it.

8.3 Illness in Others

We have seen from the above responses that the informants feel that they do not give in to illness very easy. And if they do so, they try to do it quietly without letting others know that they are sick. The goal appears to be to keep illness private as long a possible thus not risking any potential stigmatization by others. Control of health is one direct expression of control of the self (Crawford 1984). When others appear to 'give in' to illness, they are demonstrating a lack of control over the self and thus are dealt with rather harshly.

To begin, people who are sick a lot are often viewed as complainers and attention seekers by the informants. It was often suggested that the person who was sick was not really sick and maybe 'faking it.' It was very common for the informants to harshly judge others who were sick. What is interesting is that this view crossed all the age groups. Even those in the older group, who saw illness as an accepted part of being healthy in chapter 5, were very harsh on people who were sick a lot. It appears at times that the informants are accusing others who are sick of doing in intentionally in order to avoid responsibilities.

Greg (B young) - I never make up stories and **I hate people who whine** and uh, so I'm, **if you did a lot of whining and did a lot of this and you were a faker, well then it's easy to say "Oh, he's just faking it."**

Mike (C young) - it's like when I was working with these other guys and they.... they'd have colds and they..they'd just come into work and **they're just whining, moaning about it**. Like that's not going to help it any, so. **Even if I am a little bit under the weather, I never acknowledge it to anybody or...**make a big production about it.

Iris (B young) - "Yeah, always complaining about it. **You think "God, what's wrong with you?"**

Hank (B middle) - **There are people who do it for sympathy, will try and get attention.** They - to get attention because they're not getting attention other ways. **They feel they're not getting enough attention**. They were probably as children, **they were probably babied and uh, really pampered when they were sick** or when they weren't and uh, the least little scrape of knew or something like that and, you know their mother probably said "Oh my poor baby, my poor baby." Or if they felt even the least little bit of fever, you should rush them off to the hospital and get them checked and you know, um...I think that adds to it and then when they become adults they don't have that, that doting mother so they have to try and get attention somehow. And I know of a, number of people, a number of acquaintances that are actually like that.

Carol-Ann (C middle) - **People use it as a ploy**. People cry wolf so many times when they really do get sick you don't believe their sick....**A lot of people use health to get what they want.**
A - They use health?
Carol-Ann - Well they use it like "Oh, I'm not feeling well. Feel sorry for me, come and sit with me. Spend time with me. You see a lot of women use "Oh, I've got a headache, you do the dishes. You do the cooking, I'm going to lay down. But I'm o.k for bingo tonight."

Max (C middle) - I have a problem with **people who manipulate people with illness.**
A - Do you think there's people who would do that?
Max - Oh, yes there's unquestionable so. I know of a person at work who does...who attempts to do that, you know. And it's kind of pathetic in a way. But...but it's ....I..I have a problem with manipulative behaviour of any kind. **I resent it**.....

Calvin (B older) - You see **some older person who complains about this and that and the other thing,** you know, all the time and they're not very

healthy and...and maybe not the... maybe not that old either, but.... and you know they're not really looking after themselves and **they seem to enjoy it**, I don't know...

Laura (B older) - I do feel, I do feel that uh, people - well I don't know, if they're afraid of illness or something uh...magnify every little ache and pain in their mind or - I don't know.

Many of the informants spoke of knowing what to do when they are ill largely because they had learned from their families, they knew to consult various sources such as medical books to find solutions, and they were very 'connected' with their body and its needs. In this way, they knew how to distinguish what are 'real' illness. Other people who become sick don't know how to listen to their own body. In some cases this caused them to be irresponsible and to not be 'responsible' for their own health.

Fidel (B middle) - You know they're ignorant about what...what's going on with their body so I guess they become frightened..about what's going on, or they haven't had a proper education about it. **There's no discipline.** So and the same thing in...with the health care system. You know, when I grew up if we cut ourselves, we were told, "Don't come screaming in the house just 'cause you've got a bit of blood on it." We were **trained and we were just told what our body's like.**

Don (B older) - It would be very useful if people started get in touch with their own lives, their own body and listened carefully. You know, I think the biggest problem we have is that we don't listen to, to the natural world which, of which we are part.

Ellen (B older) - I think lots of people are not tunes in to their bodies at all. It's something you acquire, that you have to work on, to just, to listen to your body.

Calvin (B older) - I mean some people don't seem to think about it all and..they just eat as they... whatever they fancy at the time and don't think

about what's in the food or anything, it's just...want to eat.

One of the responses to people who are seen as 'giving in too easily' to illness is to label them as hypochondriac. Kleinman (1988) calls hypochondriasis 'the ironic disease' as it is a disease where there is no disease. In contemporary psychiatry, it is viewed as a chronic condition where an individual fears they have a disease when in fact there is no pathological evidence to support this fear. We see from the following quotes that the informants draw upon this biomedical idea about hypochondriasis and apply it to the illness experiences of others. Thus a person who is sick all the time, who seems to enjoy being sick, yet are not 'really ill' are hypochondriacs. There is no pathological basis for their reaction and they are highly stigmatized by being viewed as being deviant.

> Scott (C young) - **Someone who constantly believes they're ill** and like, as soon as something comes up, like if they wake up in the morning and they've got, you know, a little soreness here they've got tendinitis or anything like that. Obviously there's gonna be few of those as...like hypochondriacs....**they're kind of screwed up to begin with**. But anybody that's trying to , you know, get off work..well usually the same people that get with the UIC as well. They're generally, I guess **lazy, have no kind of work ethic.**
>
> Gregory (C middle) - People's minds.....sometimes **you're not even ill and you think your ill**
>
> Paula (B middle) - I think some people do have... I have, actually used to have, not a close friend but an acquaintance, and I think part of her was, you know, it was, and I don't think she did it on purpose, but she didn't have everything together and **she used to focus on every ache, pain and ailment that she had.**
>
> Carl (B middle) - He was convinced for years that he had cancer and it was

only in the last year that he was diagnosed as having it. But he tended to be **a little bit of a hypochondriac** and **the least little thing, he was convinced that it was really serious** and that kind of thing....

Kelly (B older) - Absolutely it's normal to be sick but then again, you can have a, you can have um....what should I call it? A...uh, claustrophobia [sic - hypochondria] about **you that can imagine you're sick...**

The idea of something being mentally wrong with other people who are sick is reflected in the following excerpts. We have several informants speaking of other people who are sick as really just having a bad attitude and giving in to their illness. Pollock (1993) found that the body and mind exert a reciprocal influence insofar as mental attitude is thought to influence both susceptibility to illness and its outcome. As we see here, the informants also believe that a sick physical body can be the result of a weak mind. The solution, of course, lies simply in others taking control of themselves and improving their attitude. In essence, the physical body is an expression of the strength or willpower of the self.

Zane (B young) - You know like we were going to **have a choice**, you know, one of the few animals on earth that is **given the power of choice.** Which means that **wherever you end up, again is your fault because of decisions you have made**.

Paula (C middle) - I think some people do have - I have a, actually used to have, not a close friend but an acquaintance and I, I think part of hers was, you know, it was she went, I don't think she was doing it on purpose, but **she didn't have everything together and she used to focus on every ache, pain and ailment she had**
A - Why did she do that?
Paula - Uh, oh things that were unresolved, not being able to go ahead and focus on positive things and do things and, you know, just enjoy, enjoy life...

Ellen (B older) - Sometimes you say **"Come on, put your shoulder on it."**

You know, kind of thing. **"You would feel so much better if you forget about this now and try."** But it's hard to judge, you know.

If illness is suspected as not being legitimate or if an individual is suspected of exaggerating their response, people respond with suspicion and an lack of sympathy. Sympathy appears to be something which is contingent upon whether the person feels that the other individual is worthy of it. The other person demonstrates this worthiness by responding to illness in the appropriate ways which were outlined in the previous section. If the 'other' is seen not doing the right thing or giving into illness, then sympathy is seen as being 'wasted'. For example, Molly speaks of people who "cry wolf" and how she is reluctant to feel sorry for them.

> Stu (B older) - They annoy me more than anything. I'm afraid I have no real sympathy for them. Well, you know, there was the um, I don't know whether you say it in the, in the [paper] the other day, the day the government announced uh...uh that the number of drugs that were being taken off and, you know they talked about this women who was on 17 different medications. Oh, come on. Really. Who needs 17 different medications and who is it in the medical world that is prescribing or allowing this woman to be on 17 different medications?

> Molly (C older) - Some people cry wolf once too often, sort of thing. But they're really sick and you find out that they're aren't really sick that they, it's just a ploy they have, then you'd feel you wasted your sympathy because they weren't really sick anyways in the first place. I haven't met anybody like that. But I've heard about them.

8.4 Findings

When people are ill they receive signals from their bodies which are usually in the form of unusual pain or tiredness. People felt that they had a close relationship with their bodies, one which allowed them to 'listen' to their bodies and to 'hear' the

signals that their body gives. It appears as if the internal conversation goes beyond what Mead (1934) defined as the 'I' and the 'me' which are both aspects of the self. As part of the symbolic interaction, there also appears to be a conversation going on between the self and the physical body; in essence, between mind and matter. The body acts as an tangible symbol to society that the self has a strong will and is able to 'control' or 'manage' the physical body. Thus, the symbolic order is partly maintained through this internal conversation.

When the illness becomes distinctive, the informants had many methods with which to deal with the illness - waiting or ignoring, getting more rest, working it through, or using over the counter medications. Generally people normalize their symptoms based upon previous experience. They interpret the symptoms as within the range of 'okay' or at least understandable and manageable (Freund and McGuire 1995).

One of the most common responses to illness for the informants from the younger and middle groups at both sites, was to keep working. People are strongly committed to appearing to be in good health as we found in chapter 5 and are reluctant to give obvious signs when it is impaired. Often they spoke of having to be very sick before they would stop working. Cornwell (1984) in her study of working class people living in Bethnal Green, found that the informants were very preoccupied with the moral aspect of hard work. As illness was concerned, the moral approach to getting over it was to carry on with a cheerful stoicism, ignoring them so

that you can carry on (Eyles and Donovan 1986; Blaxter and Paterson 1982; Litva and Eyles 1994) thus they represent to society an intact physical body which means that people will not question the integrity of the self.

Going to the doctor is not an immediate response by the informants when illness is detected. The informants felt that they did not go to the doctor unless they were 'really sick' and absolutely had to and only if they perceived it to be a 'legitimate' problem (Eyles and Donovan 1990, Donovan 1986), if it lasted too long, or if family insisted. Zola (1993) looked at the reasons why people seek medical help in his study of 200 people at three medical clinics. These reasons included sanctioning by others, perceived interference with vocational or physical activities, and temporalizing of the symptoms.

We found that the informants had very strong views about other people who were sick. People who are sick a lot are often viewed as complainers and attention seekers by the informants; of 'crying wolf'. This perception was found in all the age groups. Even the oldest informants, who we would suspect to have had more experience with illness, tended to be very harsh on others who were sick a lot.

The informants often referred to others who are sick a lot as having a bad attitude. One of the most salient issues relating to physical illness is that the nature of the person who is ill, is often evaluated based upon his or here response to illness, and in particular, their strength of constitution and of mind (see also Blaxter and Paterson 1982; Crawford 1984; Cornwell 1984; Blaxter 1990) Illness potentially

spoils a persons identity and it is in this context that the ideas about attitude can be brought into play to offset this threat or even override it (Pollock 1993). As we have seen, many of the informants say the solution to others' illness to be to simply take control of themselves and improve their attitude. Thus it appears that it is ultimately the 'self' which must control illness.

People who give into illness or who lack the ability to 'fight' illness risk being perceived a hypochondriac. Being a hypochondriac is very much perceived to be a negative thing as these are people who overreact to any sign that their body gives them or lack control over their bodies. As the self appears to be the means by which one 'fights' illness, in the case of hypochondriacs, the self is flawed thus allowing the physical body to dominate.

Overall, while there were a few variations in perceptions between age groups, there did not appear to be any strong variations between the geographical places. This may be related to the fact that people's illness experiences appear to be much more influenced by interaction with peer groups and the health care system than by where one physically lives.

8.5 Discussion- "...keep working...that's the best medicine'

The onset of illness, especially if severe or chronic, constitutes a threat to the integrity of the body and self-identity. When pain and discomfort are not felt, the body remains relatively unobtrusive. It is often not until illness or pain is experienced that the body comes into constant conscious being. Illness may be thought of as the

body taking over, as an external environment separate to the self that requires a status change from a healthy person to an unhealthy person (Lupton, 1994). Most everyday illnesses which people experience are not very disruptive, but they do serve to remind us our bodies' limits. We find that, sometimes people do not want to make this role change and will ignore or downplay illness and keep working. Dysfunction of the body, represented by illness, appears to affect the harmony between the physical and the social and moral beings (Comaroff 1982). As we have seen from these people's accounts, being ill is far more than a biophysical event; it has social, emotional and moral implications.

The sick role changes according to the cultural meanings ascribed to illness. Some illnesses are not perceived as the 'fault' of the individual. They are perceived as 'innocent victims' of their fate. Other causes of illnesses emphasis the 'guilt' of the individual for not being vigilant of their health. Illness makes the individual's control over the body suspect (Kirmayer 1988). Such people are seen as 'deviant' because they allowed themselves to become ill: they ignored the moral prescriptions of society (Parsons 1951, Lupton 1994). This potential for blame can force people to either hide or ignore their illness and carry on with everyday life as if nothing is wrong. But 'others' who become ill are perceived as having caused their own illness and are often perceived as deserving it (Sontag 1989).

The body usually is the site at which illness is interpreted. The sick body provides a meaningful text. Signs and symptoms are a map for understanding what

is going on. Illness, as we found from the informant's words, is a time when your body is trying to communicate with you and much depends on how well the self can listen. It appears that while the informants knew how to 'listen' to their bodies, others are often unable to and this was perceived as part of their problem - a problem which relates to the moral basis or social cement of everyday life. Others, by succumbing to illness are seen as 'unglued' from the social fabric that is preserved as we continue to perform, in our own eyes, our duties. Illness if 'revelled in' is discursive and we condemn to bring people back.

The experience of illness, even if only temporary, reminds us of our limitations as well as our ultimate mortality. When ill, our bodies are telling us that they cannot always be counted on to be able to what we want them to do. Because our very sense of who we are and our important social relationships are intimately connected with our bodies and their routine functioning, being ill is seen as disruptive and disordering. Illness as a symbol acts to make moral distinction thus attempting to control the social disorder it threatens (Comaroff 1982).

Chapter 9

Conclusions

9.1 Introduction

This thesis has explored lay concepts of health and illness at two sites in Ontario, Canada. The first objective was to explore the nature of lay perceptions at two sites, which share some similar geographical and social characteristics, to find out the extent to which geographical place influenced lay perceptions of health and illness. The second objective was to discover whether there were differences between the two sites and if variations occurred between age groups at each site. In an attempt to take into account the structure/agency debate taking place within health geography (cf. Kearns 1993; Jones and Moon 1993; Eyles 1993; Kearns and Joseph 1993) and to do a theoretically informed study, the final objective was to assess the usefulness of symbolic interactionism for making sense of lay perceptions of health and illness. This thesis concludes by specifically addressing these objectives in this final chapter.

9.2 Geographical variations in lay perceptions

Does geographical place matter for lay perceptions of health and illness? The results from this study suggest that there was not a strong place consciousness as manifested in differences between places. There were some differences found between the two sites. For example, place appeared to have some impact on how health was defined. In Chapter five, the younger informants at Papermill Town had a less positive view of their health than the informants at Farming Town. This may

be because of the physical environment in which they live and the types of occupations they held. The middle aged informants from Papermill Town saw illness as a result of the failure to maintain equilibrium or harmony in their body. The informants from Papermill Town were also more likely to perceive the environment as a cause of illness while the informants from Farming Town perceived their environment as contributing to their health.

In general, I can only speculate as to whether place does or does not matter. Place remained elusive perhaps because of the theory and method chosen. My chosen theory and its limitations are discussed more explicitly in section 9.4. In terms of method, whilst most appropriate for studying health perceptions, it may not be the best way to study geographical place differences. The sample group from this study cannot be considered representative enough to conclude that physical place does not matter for how people perceive health and illness. In order to test whether physical place mattered, it may have been useful to have also done a quantitative study thereby producing a representative survey of people living in these sites. The results from a quantitative survey might have also been able to inform the list of themes used for the in depth interviews thus resulting in asking different questions.

Eyles and Donovan (1990) assert that place differences are not always straightforward or obvious. These differences can be subtle and might be based upon material circumstances. A previous study done of a middle class, urban community in Ontario(Litva 1993), shows that where one lives affects ones material

circumstances and this filters into perceptions of health and illness. The people living in Small Town Ontario were predominantly white collar workers who saw work as a potential threat to health like the informants from Papermill Town and Farming Town. They, however, perceived the threat to be the effects of work stress while the informants at both Papermill and Farming Town saw the physical conditions of their work environment as the potential threat to their own health.

This study also found that the physical environment can influence people's perceptions. Another aspect of physical place is that where we are situated can influence with whom we interact with and how we interact with them. In a sense, it is the point where place-in-life and geographical place coincide. As we saw with Papermill Town, the proximity of another distinct culture (Native Canadian) with different ideas about health and illness appeared to influence how people in the middle aged group thought about health and illness. There was also a certain level of community discourse around drinking and this appears to facilitate a higher tolerance for heavy drinking. This differed markedly with the sample from the study of Small Town Ontario (cf. Litva 1993; Litva and Eyles 1994). However, untangling the differential effects of place and class is difficult given the research design.

Nonetheless, while the evidence that place matters is complex, we may speculate about what causes similarities in how people perceive health and illness between two places in Ontario. If we look at other lay perception research in countries where the dominant health care system is biomedical, we find similar

perceptions (cf. Crawford 1984; Donovan 1986; Herzlich 1973; Pill and Stott 1982;Blaxter and Paterson 1982; Blaxter 1983; Calnan and Johnson 1985; Cornwell 1984; Eyles and Donovan 1990; Litva and Eyles 1994). Essentially, similarities in lay perceptions of health and illness between place may be attributed to two influences. First, interactions with the biomedical culture including health care practitioners has led to what has been called a 'medicalized culture' (Illich 1976). The dominance of the biomedical model means that to a certain degree there is, as Berger and Luckman (1967) describe, a shared 'symbolic universe'. This shared universe may contribute to similar perceptions between places.

This study has suggested another factor which may also contribute to a shared symbolic universe - namely religion. Most of the countries where lay perceptions research of this sort have been done are predominantly Christian. A finding of other lay perception studies, is that people tend to speak about health and illness, in moral forms (cf. Blaxter and Paterson 1982; Crawford 1984; Litva and Eyles 1994). Yet except for Williams (1990), religion as an influential factor in the creation of the social experience has tended to be overlooked in lay perceptions research. Religion was thought to have been replaced by the biomedical model in being the 'moral entrepreneur' in our society (cf. Becker 1963; Freidson 1970; Freund and McGuire 1995). But Williams states "any study of symbolic practice, sense of identity, moral beliefs or schemes of interpretation is, therefore, in the antechamber of religion (1993:72)". This leaves questions about the relationship between religion and

medicine as at least two forces which influence the nature of lay perceptions. If we are to understand the nature of lay perceptions, we need to research further the influence of religion combined with the biomedical model upon lay perceptions of health and illness.

There is a shared local world view which causes people from two different places to conceptualize health and illness similarly. But definitions about health and illness in the self can be influenced by the different 'contexts' because where we live influences with whom we interact and how we interact with them. This can ultimately affect our perceptions.

9.3 Place-in-life variations in lay perceptions

The second objective of this research was to learn whether there were differences in lay perceptions of health and illness between age groups. Over their lives, what people have experienced, with whom they have interacted, and with those they presently interact, contributes to age variations in perceptions of health and illness. In this study, there were many cases where people in the same age group but from different sites shared similar perceptions that were different from he other two age groups at the same site. In chapter five, we found that a person's age resulted in differences in how health in the self was perceived. There were also differences in how each age group knew that they were healthy. Chapter six showed that a person's age or place-in-life seemed to influence how they take care of themselves, the role the family doctor played in this management, as well as why some age groups practise

certain health behaviours more faithfully than others.

When exploring how illness was defined in chapter seven, several age or place-in-life differences arose amongst the informants when speaking of the causes of illness. In chapter eight, there are not many place-in-life differences between the two sites. The only obvious differences were that the informants from the younger and middle age groups at both sites felt that to keep working was an appropriate and preferred response to illness. They spoke of having to be very sick before they would stop working. This perception did not appear amongst the older informants and was likely due to the fact that they were usually retired and did not work in paid occupations. When discussion how illness is managed in the self and others, there were no differences noted between age groups.

These findings are largely conjectural and form the basis for future enquiry. Methodologically, although age groups were used, basing these upon chronological age to study the impact of experiential place on lay perceptions may not have been the best choice. While chronological age may be part of the sets of social relations which define place, it maybe an unsatisfactory indicator of people's perceptions and experiences. Perhaps the concept of lifecourse (Backett and Davison 1995), which encapsulates demographic, socio-cultural, psychological and economic processes would have been more successful in demonstrating how a person's place in relation to others impacts upon how health is perceived. It may also capture the essence of experiential place as expressed by geographers such as Dyck (1995) and Kearns and

Joseph(1993). That is for future research to uncover.

9.4 The utility of symbolic interactionism

The third objective of this study was to explore the usefulness of a symbolic interactionist approach for exploring lay perceptions of health and illness. While useful, it does have its limitations. Symbolic interactionism emphasizes the view that the management and control of bodies are dependent upon the actions of relatively autonomous social human agents (Shilling 1993). Lofland has asked: "What are the conditions of being able to perform and sustain a given official self? Stated in the reverse, what are the things that disrupt the maintenance of a given official self?" (Lofland 1980: 41). While never explicitly stated by the theory, because symbolic interactionism does not view the body as separate from the mind, there is a sense that the body is viewed as both a biological and social product. Fro instance, symbolic interactionism has theorized the internal conversation between the 'I' and the 'me'. It also brings forth the notion of the 'external conversation' which is that between the self and others. Implicit is that the physical body is what we present to the other. Others act based upon how they perceive our physical body along with our social body. It is the degree of convergence between the self (social body) and the physical body which leads others as well as ourselves to label us as 'healthy' or 'unhealthy'. If we look physically healthy but our social body contradicts how our physical body is presented, then the social identity of a person may be threatened. We have seen this in the way the informants respond to others who claim to be ill but do not look ill.

These people are often suspected of being hypochondriacs or of having a bad attitude. But people who are physically disabled or chronically ill are often able to present an intact and official (not deviant) self by the way in which the self speaks through or despite the physical body.

The notion of mind-body dualism within symbolic interactionism is also useful for explaining why some lifestyle choices are seen as 'bad' and others as 'good'. In this study we found that sometimes smoking or drinking alcohol were seen as 'okay' lifestyle choices. We also found that people perceive those who exercise or diet too much as lacking 'balance' or as 'deviant'. Thus it appears that certain acts upon the physical body must be seen as a balanced response to the physical and social body. If the needs of the physical body (through addiction) become excessive, then that behaviour may be perceived as unhealthy. We say this particularly when the informants perceived alcohol as appropriate in small amounts as it helped them to relax. In large amounts or in the case of addiction, they were adamant that it was bad. This view also extended to behaviours like exercise and dieting. Therefore, the social body and the physical body work together in the presentation of the self to society as well as in maintaining an individual's place in society.

Symbolic interactionism was also helpful in that this study was able to uncover differences in the meanings that people held about health and illness. In accepting that meaning influences behaviour, symbolic interactionism also holds that meaning is constantly being negotiated through interactions with others and the social and

physical environment. This view of the world does not see the agent as a mere pawn of structures around him/her. Thus people are not treated as passive agents to their environments but as also entering into their constructions (Saltonstall 1993; Lupton 1994). As Gerhardt asserts, when a symbolic interactionist studies health and illness "what matters is not the symptoms which an individual develops but rather, that it is perceived and categorized by the environment" (1989:82).

Perhaps in this way, it could be asserted that this theory addresses the dualism of structure and agency . For example, Meltzer, Petras, and Reynolds (1975) state that:

> the influence that stimuli have upon human behaviour is shaped by the context of symbolic meanings within which human behaviour occurs. These meanings emerge from the shared interaction of individuals in human society. Society itself is constructed out of the behavior of humans, who actively play a role in developing the social limits that will be placed upon their behaviour. Thus, human behavior is not a unilinear unfolding towards a predetermined end, but an active constructing process whereby humans endeavor to 'make sense' of their social and physical environments.

Methodologically, this theory was not useful for uncovering the dualism of structure and agency. While we certainly see the role of social norms and roles in how people perceive health and illness, the nature of these structures is not completely understood. Whilst the theory does acknowledge that the agent is actively engaged in interacting with the structures around him/her when constructing meanings, there still appears to be a tendency to put more emphasis upon the agent. This theory does not give us the analytical tools to understand or deal with the dualism of structure and

agency. This may be linked to the fact that the body (both is its physical and social forms) as a theoretical construct has tended to be under theorized and somewhat overlooked by symbolic interactionism. Too much is left unstated leaving much room for further exploration and theory development.

9.5 Contributions to knowledge

To begin, this study contributes to a little researched topic in health geography, that of lay perceptions of health and illness and their relationship to place. In attempting to take up current challenges in health geography to 'make place matter' (cf. Kearns 1993; Eyles 1993; Jones and Moon 1993; Kearns and Joseph 1993) two notions of place were explored. Although, because of the nature of the evidence, the conclusions are necessarily muted and I am unable to conclusively say whether geographical place matters, this study provides a basis for future place sensitive studies of lay perceptions of health and illness by raising questions about approach. In terms of contributions to the body of literature, this study is one of a few whose starting points are in geography (cf. Eyles and Donovan 1990; Donovan 1986; Cornwell 1984) and it also contributes to the small body of lay perception research which has been done in Canada (Walters 1993; Litva 1993; Litva and Eyles 1994).

While place may matter to lay perceptions of health and illness, it appeared that place-in-life or age differences were far more obvious and numerous than geographical place differences. In terms of experiential place, this study did demonstrate that age impacted upon a person's perceptions and subsequently these

helped to define their place-in-the-world. Previous lay perceptions research has not completely explored the role of age and thus this study has attempted to contribute information which may fill this gap. It would be helpful to carry out future lay perceptions research which follows a group of people, in a 'cohort' design, for a significant period to learn if these perceptions change as we age and why this is so.

Theoretically, this study demonstrate the utility of symbolic interactionism for looking at people's perceptions of health and illness. We begin to see how the physical and social bodies interact with the world and how they contribute to and maintain a persons place-in-the-world. So this study contributes to knowledge first by being one of a very few studies to use this perspective in health geography and second by shedding some light on the nature of human-environment interactions.

9.6 Conclusions

Wright (1994) has argued that if we are ever to understand the institutions and activities of our social life, we must have an understanding of the concepts we use to organize, structure and make sense of life. In chapter one, it was stated that in an attempt to make sense of the social and physical world, people develop theories or explanations for the things which are relevant to their lives (Furnham 1988) and such is the case with health and illness. The informants make sense of health and illness through exposure to and interaction with others, the health care system, literature, the media, as well as from personal experiences and from observing their bodies. Based upon the findings of this study, these influences as well as the impact they have is

contingent upon a persons place-in-life and possibly upon geographical place.

The findings from this study support Hewston's (1983) ideas about the functions that lay perceptions ultimately serve. In people's concepts of illness we found that they were very closely tied to notions of causation. This allows people to achieve some control through understanding of cause and effects in the social and physical worlds. Hewston states that the self-esteem function serves to protect, validate and enhance feelings of personal worth and effectiveness. This is very much reflected when people talk about their perceptions of health and illness in the self and health and illness in others. For example, they spoke of needing their health so that they can work or carry out day-to-day activities. This notion of work was also reflected in people's perceived responses to illness which was often to continue working. Work seems to be very much tied to people's notions of social value and personal worth and therefore appear in their perceptions of health and illness. Lastly, the self-presentation function is to gain public approval and avoid embarrassing oneself. For example, the informants were aware of the moral implications of doing certain things which can affect health. This is demonstrated by the health lifestyle language when people spoke of managing their health.

This thesis has explored the perceptions held by 53 people living in two different sites in relatively isolated parts of Ontario Canada. The lives and perceptions of these people helped uncover many new ides about how people think about health and illness and how this relates to society in general. However, as most studies do,

it raises as many questions as were answered. Nonetheless, what can be confidently said is that lay perceptions are very complex and are influenced by many factors, in the context in which they exist, they make perfect sense.

Appendices

Appendix A
Description of Informants at time of Interview

Farming Town

1. Ann - 18 yrs, unemployed, single, on assistance, suffers from asthma and pelvic inflammatory disease, smoker

2. Barb - 24 yrs, married, 30 weeks pregnant, restaurant owner, chronic eczema, non-smoker

3. Dennis - 25 yrs, single, unemployed, single, casual smoker

4. Frank - approx. 35-40 yrs, married, 3 children, teacher, non-smoker

5. Geraldine - 21 yrs, university student, non-smoker

6. Greg - 21 yrs, farmer, single, has Epstein-Barr virus, non-smoker

7. Iris - approx. 32-36 yrs, librarian, married, has children, non-smoker

8. Tim - 26 yrs, runs his own canteen, engaged, self-described alcoholic, smokes

9. Zane - approc. 35 yrs, free-lance computer programmer, previous military expereince, married to April, has 3 chidren, non-smoker

10. April - approx. 35 yrs, married to Zane, works in the home, has 3 children, non-smoker

11.Carl - 40 yrs, art teacher, married with 2 children, reformed smoker

12. Paula - 38-40 yrs, farmer, married with children

13. Fidel - 42 yrs, landscaper, not married lives with parents, smokes

14. Hank - mid 40's, part-time farmer, married with children

15. Bev - 60+ yrs, retired data processor, single

16. Calvin - 60+ yrs, retired aircraft mechanic, married, diagnosed with cancer

17. Don - 75 yrs, artisit, married to Ellen, has 8 children

18. Ellen - 71 yrs, married to Don, has 8 children, suffers from angina

19. Emmy - 64 yrs, retired school teacher, has seven children

20. Joseph - 86 yrs old, full-time farmer, married to Kelly

21. Kelly - early 70's, lives and works on farm, retired from cafeteria work, has had 7 children

22. Laura - late 60's, reitred postal worker, widowed with 5 children

23. Mark - 82 yrs old, farmer, retired school bus driver, married to Nancy, has 11 children

24. Nancy - late 70's, married to Mark, farmer

25. Stu - Late 60's, married, retired school teacher

26. Vince - mid 70's, retired school teacher, widowed

27. Osmund - 76 yrs, farmer, divorced, suffers from heart disease

Papermill Town

1.Cameron - 26 yrs old, works in pulp and paper mill, single, self-described heavy drinker, smokes.

2. Carol - approx 34 yrs old, secretary at paper mill, married with two children, non-smoker.

3. Cheryl - approx 30 yrs old, counsellor at sexual assault centre, single, non-smoker.

4. Mike - 28 yrs old, bartender, single, casual smoker.

5. Sandy - approx. 35 yrs, director of women's resource centre, married with 2 children, non-smoker.

6. Scott - 22 yrs old, waiter, single, occasional smoker.

7. Trista - 20 yrs old, waitress, single, smoker.

8. Sherry -approx. 30 yrs old, secretary at mill, married with 2 children, non-smoker.

9. Carol-Ann - mid50's, works at retirement home, married with children, smokes

10. Charlotte - late 50's, volunteer counsellor at sexual assault centre, divorced with children, smoker

11. Gregory - mid 40's, works for the town, sober alcoholic, married with children, smoker

12. Nowella - 45 yrs, self-employed, married

13. Nat - 52 yrs, on disability, divorced with 3 childrens, epileptic

14. Liz - 43 yrs, married, works in the home, two children

15. James - 52 yrs, works in papermill, married with children, smokes and drinks heavily

16. Max - 45 yrs, postal worker, unmarried

17. Patricia - 45 yrs, married with 1 child, suffers from several chronic illnesses

18. Ned - 42 yrs, carpenter, married with children

19. Howard - late 50's works at senior centre, married with children

20. Earnie - 65+ yrs, retured millworker, widowed

21. Ed - 65+ yrs, retired millwright, married with children, disabled due to lung disease

22. Jem - 66 yrs, retired hydro worker, married with children

23 Evelyn - 75 yrs. Retired, married with 8 children

24. Mel - 73 yrs, volunteer drug and alcohol counselor, sober alcoholic, 2 children

25. Lily - early 60's, divorced with children, physically disabled

26. Molly - mid 70's, widowed, has children

Appendix B
Description of Place-in-life groups
Younger Group

Farming Town (site B)	Papermill Town
Ann	Cameron
Barb	Carol
Dennis	Cheryl
Frank	Mike
Geraldine	Sandy
Greg	Scott
Iris	Trista
Tim	Sherry
Zane	
April	

Middle Age Group

Carl	Carol-Ann
Paula	Charlotte
Fidel	Gregory
Hank	Nowella
	Nat
	Liz
	James
	Max
	Patricia
	Ned
	Howard

Older Group

Bev	Earnie
Calvin	Ed
Don	Evelyn
Ellen	Jem
Joseph	Mel
Kelly	Lily
Laura	Molly
Mark	
Nancy	
Stu	
Vince	
Osmund	

Appendix C
List of Interview Themes

1. Definitions: health (self-described, importance of, meaning), illness, disease
2. Causes of illness
3. Health Determinants - exercise, diet, smoking, alcohol, environment
4. Coping with illness - signs and symptom, responses
5. Health and illness information - types, sources
6. Morality and illness - blame, guilt, responsibility
7. Health care - access, satisfaction, problems

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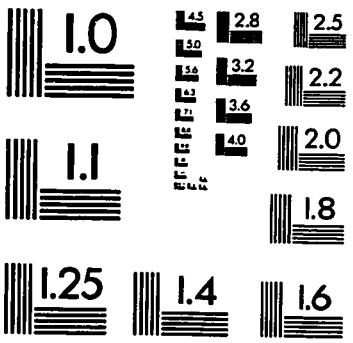

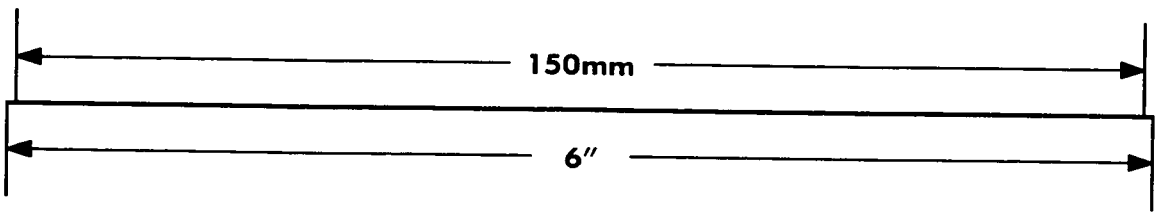

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