CONCEPTIONS OF HEALTH:
A CROSS-CULTURAL COMPARISON

by

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Abstract
The purpose of this study was to investigate the health views of Anglophones and Francophones of European ancestry as well as First Nations individuals living in an urban setting. A total of 60 participants were individually interviewed. The first objective of the research was to understand how the interviewees defined health. They provided a multidimensional definition of health that departs from the biomedical model, arguing that health is more than the absence of illness and that it encompasses the whole person, not only the body. The second objective of the study was to gain a better understanding of the participants’ health practices. Many argued that one needs to be proactive in order to be healthy and explained that health practices should be tailored in accordance with one’s particular needs. They especially emphasized the importance of having a healthy lifestyle. The third objective of the research was to investigate cultural differences in health definitions and practices. While Anglophones and Francophones talked about health from an individual perspective, First Nations interviewees provided a definition of health that expands beyond the boundaries of the individual self. They also emphasized spiritual and developmental health, while Anglophones and Francophones placed more importance on physical health. Francophones and First Nations interviewees reported promoting their health by maintaining their traditions and culture. The fourth objective of the study was to explore the extent to which definitions of health are related to health practices. The findings indicated that some of the health definitions could significantly predict the participants’ health practices. The research findings suggest that culture should be taken into consideration in order to provide culturally appropriate health care and to develop health policies and programs that reflect the concerns of members of various cultures. The present study advances knowledge by (a)
proposing a new health definition that expands beyond the self, (b) providing new evidence
to show that culture influences health conceptions, (c) highlighting both qualitative and
quantitative variations in health conceptions as a function of culture, and (d) showing that
health practices partly flow from one’s health definitions.

*Keywords:* health conception, health practice, culture
# TABLE OF CONTENTS

Abstract ii  
Table of Contents iv  
List of Tables vii  
List of Figures viii  
Acknowledgement ix  

**INTRODUCTION** 1  
Health Status of Aboriginal Peoples in Canada 2  
Health Status of Minority French-Speaking Canadians 4  
Culture and Health Disparities 5  

**LITERATURE ON HEALTH CONCEPTIONS** 8  
Health as a Personal Construct 8  
Theory of personal construct 8  
Multidimensional Health Models 13  
Health Conception Determinants 18  
Culture 18  
*Health as a cultural construct* 18  
*Acculturation* 33  
Other determinant factors 38  
The Relationship Between Health Definitions and Health Practices 43  
The Present Study 44  

**METHOD** 47  
Context 47  
Participants 50
Measures
Procedure

RESULTS: QUALITATIVE ANALYSIS

Data Analysis Procedure
Definitions of Health: Research Question 1

Negative health

Positive health
State: Being healthy
Process: Moving towards health
Structures
Physical health
Mental health
Social health
Spiritual health

Beyond individual health

Health Practices: Research Question 2

Individual health practices
Being proactive
Understanding one’s health needs
Lifestyle
Managing mental health
Maintaining good relationships
Medical practices
Spiritual-religious practices
Maintaining traditions/culture

Beyond individual health practices

Cross-Cultural and Cross-Gender Comparison: Research Question 3

RESULTS: QUANTITATIVE ANALYSIS

Scoring Procedure
Preliminary Analyses
Reliability and validity
LIST OF TABLES

Table 1 – Summary of Frequencies, Means, and Standard Deviations for Scores on the Demographic Variables as a Function of Culture and Gender

Table 2 – Chi-Square Tests of Homogeneity of Sample

Table 3 – Pearson Correlations among Health Definition Dimensions

Table 4 – Pearson Correlations among Health Practice Dimensions

Table 5 – Summary of Means (and Standard Deviations) for Scores on the Health Definition and Health Practice Dimensions as a Function of Culture and Gender

Table 6 – Effect of Culture on Individual Health Definition Dimensions

Table 7 – Effect of Culture on Individual Health Practice Dimensions

Table 8 – Regression Coefficients [and 95% Confidence Intervals] of Being Proactive, Understanding Health Needs, Lifestyle, Balanced Life, and Managing Stress on Health Definition Dimensions

Table 9 – Regression Coefficients [and 95% Confidence Intervals] of Maintaining Relations, Medical Practices, Religious Practices, and Logarithm of Maintaining Traditions and of Beyond Individual Health Practices on Health Definition Dimensions
LIST OF FIGURES

Figure 1 – Definitions of Health across Cultural and Gender Groups 65
Figure 2 – Health Practices across Cultural and Gender Groups 83
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Introduction


Despite its prevalence in the fields of health, the biomedical model has been the target of increasing criticism (Brannon & Feist, 2004). One major objection lies in its reductionist nature (Alonso, 2004; Engel, 1977; Tripp-Reimer, 1984). By focusing exclusively on the absence of disease, it fails to represent the general population’s perspectives on health (Goins, Spencer, & Williams, 2011; Hufford, 1992; Laffrey, 1986a; Mansour, 1994). Indeed, ample evidence has shown that people tend to define health in a more complex way (e.g., Froman, 1995; Goins et al., 2011; Mansour, 1994; Rubenstein, O’Connor, Nieman, & Gracely, 1992; Woodgate & Leach, 2010). Moreover, studies addressing health conceptions have found important interindividual variations in the way people perceive health (Kenney, 1992; Long, 1993; Mansour, 1994; Morse, 1987; Wang, 2004). These findings point to a constructivist view of health.

In reaction to the constructivist literature and to the criticism directed against the biomedical health perspective, multidimensional health models, which capture a variability of health conceptions, have been developed (Baumann, 1961; Pender, 1990; Saylor, 2004;
Schlenger, 1976; Smith, 1981; WHO, 1948). Although these models offer a more comprehensive view of health, they are based on studies conducted predominantly with Caucasian, English-speaking populations (Ailinger & Causey, 1995). As a result, they may not reflect cultural minorities' views on health.

Therefore, in order to learn about alternative views on health, the present study seeks to investigate variations in health conceptions as a function of culture. More specifically, the objectives of the study are (a) to provide in-depth descriptions of the health definitions held by English-speaking Canadians living in an urban setting as well as minority French-speaking and First Nations Canadians, whose historical experiences of contact with the majority group present some parallels; (b) to gain a better understanding of the health practices they engage in to promote their health; (c) to investigate cultural differences in health definitions and health practices; and (d) to explore the extent to which definitions of health are related to health practices.

By addressing these objectives, the present study aims at finding ways to improve access to quality care and, in turn, to promote the health of First Nations Peoples and French-speaking Canadians. Recent statistics have indicated that individuals within these two cultural groups are in relatively poor health compared to the English-speaking population.

Health Status of Aboriginal Peoples in Canada

In 1996, the Royal Commission on Aboriginal Peoples found that on many indicators of health, including life expectancy, infant mortality, and the prevalence rate of physical and mental illness, Aboriginal communities were in poorer health in comparison with the general population (Canada, 1996).
In 2005, the Health Council of Canada reported that Aboriginals’ health was poorer than the health of the general Canadian population. First Nations and Inuit had higher mortality rates, lower birth weight, as well as shorter life expectancy compared to the rest of Canadians. Specifically, the tuberculosis infection rate was 6 times higher among First Nations and 17 times higher among Inuit than among other Canadians. Diabetes was rising among Aboriginal populations and was especially prevalent among First Nations and Métis (Health Council of Canada, 2005).

More recently, Health Canada (2009) reported that tuberculosis, human immunodeficiency virus, hepatitis C, and sexually transmitted diseases were 2 to 6 times more prevalent among Aboriginals than among non-Aboriginal individuals. First Nations adults living on reserves reported poorer health and higher rates of suicide contemplation and attempts compared to the general Canadian population. Cardiovascular conditions, diabetes, asthma, chronic bronchitis, and tuberculosis disproportionately affected First Nations individuals living on reserves.

Two recently published reports by Statistics Canada (Tjepkema, Wilkins, Pennock, & Goedhuis, 2011; Tjepkema, Wilkins, Senécal, Guimond, & Penney, 2011) compared the potential years of life lost between the ages of 25 and 74 among Status Indians, non-Status Indians, Métis, and non-Aboriginal adults. The results revealed that Aboriginals had higher rates of premature deaths compared to non-Aboriginal adults. The vast majority of premature deaths among Aboriginals were caused by injuries and noncommunicable diseases, including malignant neoplasms, diabetes, cardiovascular diseases, respiratory diseases, and digestive diseases.
Health Status of Minority French-Speaking Canadians

Based on the data from the National Population Health Survey, a group of researchers (Kopec, Williams, To, & Austin, 2001) compared the health status of Canadian-born Anglophones, Francophones, and bilingual individuals as well as English-speaking and non-English-speaking immigrants. In comparison with the other groups, the Canadian-born Francophones had the highest rates of chronic diseases and chronic pain, whereas the Canadian-born Anglophones enjoyed the highest health status.

Other studies have revealed that health disparities between Anglophones and Francophones are not consistent across Canadian provinces. In Québec and New Brunswick, where the proportion of Francophones is relatively large, French-speaking Canadians seem to be as healthy as their English-speaking counterparts. For instance, the results of a study conducted by Desjardins (2003) in New Brunswick showed that the health disparities that affected Francophones in the past have virtually disappeared. The author believes that the health status of Francophones improved as a result of the numerous health reforms that took place since the 1980s aimed at increasing access to health services in French.

However, in provinces where the Francophone population is smaller in proportion, French-speaking Canadians are in poorer health compared to Anglophones. For instance, in 2002, a survey conducted in Ontario revealed that on many health measures, the Francophone population had poorer health outcomes compared to the English-speaking Ontario population, having higher rates of chronic cardiovascular diseases, chronic bronchitis, emphysema, arthritis, asthma, and migraines (Bouchard, Roy, Lemyre, & Gilbert, 2002). More recently, a group of researchers (Bouchard, Gaboury, Chomienne, Gilbert, &
Dubois, 2009) found that Francophones living in minority settings had lower self-reported health compared to their English-speaking counterparts.

**Culture and Health Disparities**

Health disparities are the result of a combination of complex factors—such as environmental, social, and political—which are often beyond the control of individuals (Berry, 1998; Brannon & Feist, 2004; Dunn & Dyck, 2000; Duran & Duran, 1995; Garcia, 2006). Ethnicity and culture are related to factors that affect the health of minority members, including socioeconomic status, education, and discrimination (Berry, 1998; Brannon & Feist, 2004; Duran & Duran, 1995; Garcia, 2006). However, researchers have found that even when controlling for socioeconomic differences, members of ethnic and linguistic minority groups remain in poorer health in comparison with the general population (Bouchard et al., 2009). For instance, Bouchard et al. (2009) found that when socioeconomic and lifestyle factors were taken into account, the health status of Francophone men living in minority settings remained significantly lower compared to that of Anglophone men. The authors attributed these health disparities to poor access to quality care for Francophones living in minority settings.

In fact, the issue of access to quality care for ethnic and linguistic minority patients is well documented (Berry, 1998; Brannon & Feist, 2004; Elliott & Gillie, 1998; Johnson & Smith, 2002; Pavlish, Noor, & Brandt, 2010; Ravenell, Johnson, & Whitaker, 2006). Some studies have shown that minority patients underutilize health-care services (Elliot & Gillie, 1998; Li & Browne, 2000; Newbold, 2009); others have shown that those who access mainstream health-care facilities often report being dissatisfied with the quality of care, especially with respect to the way health professionals interact with them (Browne, 2007;
Browne & Fiske, 2001; Pavlish et al., 2010). Indeed, empirical evidence has shown that doctors and their ethnic and linguistic minority patients often face relational and communication difficulties (Johnson & Smith, 2002; Schouten & Meeuwesen, 2006; Somnath, 2006; Towle, Godolphin, & Alexander, 2006).

These difficulties can have important implications for the patients given that the quality of the doctor-patient relationship has been linked to positive health outcomes in patients (Fuertes et al., 2007; Harmsen, Bernsen, Meeuwesen, Pinto, & Bruijnzeels, 2004; Mead & Bower, 2002; Schouten & Meeuwesen, 2006). For instance, it has been shown that a positive relationship between doctors and patients contributes to patients' satisfaction with health care services (Fuertes et al., 2007; Mead & Bower, 2002), which in turn influences patients' health practices, including health-seeking behaviours and adherence to doctors' recommendations (De Ridder, Theunissen, & Van Dulmen, 2007; Kerse et al., 2004).

Moreover, a positive doctor-patient alliance promotes open communication channels through which both parties could gain a better understanding of each other's perspectives on symptoms and reach a better agreement on treatment goals (Fuertes et al., 2007). Consequently, relational and communication difficulties between doctors and their cultural minority patients create disparities in access to quality care for these patients, which can partly explain their relatively poor health in comparison with the general population.

Some authors have argued that relational difficulties during cross-cultural medical encounters result from cultural differences between doctors and their minority patients, especially with respect to their perceptions of health, illness, and treatment plans (Cass et al., 2002; Pachter, 1994; Pavlish et al., 2010; Reiff, Zakut, & Weingarten, 1999; Schouten & Meeuwesen, 2006). For instance, past studies have shown that, due to divergent health
perspectives, cultural minority patients often report not feeling understood by their doctors (Hilfinger Messias, 2002; Pavlish et al., 2010; Reiff et al., 1999). Other studies have demonstrated that cultural differences in the views of doctors and patients can result in misunderstandings (Armstrong & Swartzman, 2001; Laffrey, 1986a; Pavlish et al., 2010; Tripp-Reimer, 1984) and lead to patients' lack of trust in their doctors (Pavlish et al., 2010; Rubenstein et al., 1992; Schomann & Schmitke, 2007). Finally, a lack of concordance in the perspectives of doctors and patients has been linked to low adherence to doctors’ recommendations (Kerse et al., 2004; Phillips, 1990) and low access to mainstream health-care services among members of cultural minority groups (Belliard & Ramírez-Johnson, 2005), which in turn can lead to poor health outcomes.

Therefore, to improve the quality of health care for members of cultural minority groups and, in turn, to promote their health it is essential for their perspectives on health to be known, not only to health-care providers, but also to policy makers and researchers. It is the goal of this research to gain insight on the health conceptions and health practices of First Nations and French-speaking Canadians living in a minority setting, whose historical experiences of contact with the majority groups are somewhat similar, as well as those of English-speaking Canadians, the latter mainly serving as a reference group.

In the next chapter, representative literature on health conceptions and health practices across various cultural groups is reviewed, followed by the four research questions addressed by the present study.
Literature on Health Conceptions

Health as a Personal Construct

Constructivism represents a philosophical paradigm stipulating that people do not have direct access to reality (Fransella & Neimeyer, 2003; Rowe, 1996). It is assumed that individuals actively create their own interpretations and representations of the nature of people, objects, and events in order to give meaning to their universe (Bannister, 2003). Since humans are capable of creating multiple meanings, constructivism embraces the idea of multiple realities (Ratnor, 2006).

Theory of personal construct. One of the only constructivist theories found in the field of psychology is Kelly's theory of personal construct (Chiari & Nuzzo, 1996; Rowe, 1996). Although Kelly’s theory was received by a limited audience when it was first published in 1955, it has since gained increasing popularity in psychology and other fields of the humanities (Blowers & O’Connor, 1996; Rowe, 1996). It has been used to address an expanding range of issues and concepts (Adams-Webber, 2003), including the study of how people construct their representations of themselves and others (Feixas, Erazo-Caicedo, Harter, & Bach, 2008), of abnormality (Stanley & Raskin, 2002), of disorders (McNamee, 2002), and of disability (Dixon & Johnston, 2008). In a similar vein, the theory of personal construct offers a theoretical framework that can explain why people develop different conceptions of health.

Two fundamental postulates are found at the heart of Kelly’s theory of personal construct, namely, constructive alternativism and human the scientist (Blowers & O’Connor, 1996). The constructive-alternativism postulate assumes that people are not merely reacting to their environment, but are actively constructing their own representations of their
surrounding world (Chiari & Nuzzo, 1996). These constructs are then organized into a system, which Kelly referred to as a personal construct system. At any given moment, the universe is open to many alternative interpretations, giving rise to a multitude of constructions (Blowers & O’Connor, 1996; Kelly, 1970/2003).

According to the human-the-scientist postulate, these constructions are open to continual revisions (Blowers & O’Connor, 1996). Kelly (1963) compared the construction process to the work of scientists. Scientists develop theories in order to explain phenomena, based on which hypotheses are generated. Studies are then conducted in order to test these hypotheses. According to the research findings, the original theories are supported, revised, or rejected. In a similar vein, Kelly perceived personal construct systems as organized theories that allow people to anticipate and predict future events. These predictions and anticipations can be seen as hypotheses that people put to test. Based on their subsequent experiences of events, people evaluate their personal constructs to see if they really have predictive power. If they do, they are consolidated, if not, they have to be changed or adjusted in order to increase one’s ability to anticipate events (Bannister, 2003; Blowers & O’Connor, 1996; Fransella & Neiyemer, 2003; Kelly, 1963, 1970/2003; Rowe, 1996). However, the universe is not a static entity; it is constantly changing. Consequently, no one can ever reach a representation or construction system that would predict future events perfectly. Personal constructs are always changing and evolving as new experiences are incorporated into our representation system (Blowers & O’Connor, 1996; Kelly, 1963).

Kelly further elaborated these two fundamental postulates into eleven corollaries. Some of these corollaries are especially relevant to the issue of health conceptions. According to the individuality corollary, everyone has a unique set of personal constructs
(Kelly, 1963, 1970/2003). Personal constructs originate from personal experiences and since people have different and unique experiences, it is very unlikely that two individuals will come to create identical construct systems (Bannister, 1962; Kelly, 1970/2003; Rowe, 1996).

Therefore, following the rationale of the individuality corollary, people should construct their own perspectives on what being healthy means and on how health can be promoted, based on their personal health and illness experiences. Numerous researchers studying health conceptions have emphasized the role of personal experiences in the way people come to think about health (Angel & Thoits, 1987; Chan, Cheung, Mok, Cheung, & Tong, 2006; Dorvil, 1985; Goins et al., 2011; Harmsen et al., 2004; Pender, 1990; Strandmark, 2007). It has been argued that though there is an objective clinical reality to health phenomena, from the patients' perspectives, health remains a subjective experience (Dorvil, 1985; Noack, 1991; Strandmark, 2007; Tripp-Reimer, 1984). Since the health experiences of people are highly variable, it is not surprising that many researchers have found interindividual variability in health views (Baumann, 1961; Buck & Ryan-Wenger, 2003; Häggman-Laitila, 1997; Kushner, 2007; Laffrey, 1986a; Morse, 1987; Polakoff & Gregory, 2002; Smith, 1981; Woods et al., 1988).

According to the organization corollary, personal construct systems are hierarchically organized with the more general constructs, called superordinate constructs, encompassing subordinate constructs (Bannister, 1962; Blowers & O’Connor, 1996; Kelly, 1963, 1970/2003). With respect to health conceptions, past studies have shown that health represents a multidimensional concept. In contrast to the biomedical perspective, members of the general population tend to define health in a more complex way, identifying other dimensions of health aside from the mere absence of disease (Froman, 1995; Goins et al.,
2011; Kenney, 1992; Laffrey 1986a; Mansour, 1994; Morse, 1987; Rubenstein et al., 1992; Tripp-Reimer, 1984; Woodgate & Leach, 2010). These results suggest that for members of the general population, health probably represents a superordinate construct that comprises a number of dimensions subsumed under the general health construct.

Another corollary that has direct applicability to the issue of health conceptions is the dichotomy corollary. According to Kelly, constructs are always represented into dichotomous or polarized dimensions such as black and white or good and bad (Bannister, 1962; Blowers & O'Connor, 1996; Kelly, 1963, 1970/2003). Indeed, one can perceive and thus develop a conception of something when that something has some sort of contrast (Rowe, 1996). A construct serves to group, under one pole, elements that are perceived as similar and to distinguish them from contrasting elements represented at the other end of the construct (Blowers & O’Connor, 1996).

The biomedical representation of health in terms of a health-illness continuum appears to make sense in light of the dichotomy corollary. However, many studies have shown that from the perspective of the general population, illness is not seen as the opposite of health (e.g., Emami, Benner, Lipson, & Ekman, 2000; Laffrey & Crabtree, 1988; Millstein & Irwin, 1987). In fact, it has been shown that people can continue to describe themselves as healthy despite the presence of illness (Kushner, 2007; Laffrey, 1986b; Mansour, 1994; Pender, 1990; Woods et al., 1988). For instance, Laffrey and Crabtree (1988) compared the self-reported health status of adults with cardiovascular diseases and adults without any health problems. With the exception of the presence or absence of disease dimension, on which the participants with cardiovascular diseases scored lower, the latter reported being as healthy as the participants who had no health problems with respect to the other dimensions...
of health. Therefore, it seems that the opposite pole of health is not defined merely as sick, but as not healthy. As indicated earlier, this health-nonhealth construct includes many dimensions. Following the organization and the dichotomy corollaries, it appears that people represent health as a superordinate construct that subsumes subordinate constructs, including the presence or absence of disease along with other dimensions.

Finally, one of the elements of the theory of personal construct most emphasized by Kelly is the sociality corollary (Kelly, 1970/2003). It specifies that in order for people to build relationships with others and to communicate effectively, they must share or at least strive to gain an understanding of their interactant’s personal constructs (Adams-Webber, 2003; Bannister, 1962; Kelly, 1963, 1970/2003). Making inferences about the constructions of other individuals is key to explaining and predicting the behaviours of others. Thus, Kelly hypothesized that the development, maintenance, and quality of relationships are functions of the commonalities in the content, the structure, and the complexity of the construct systems of individuals (Adams-Webber, 2003).

Research has shown that the health conceptions of lay people tend to differ from the biomedical health view held by health professionals, especially physicians (Baumann, 1961; Froman, 1995; Goins et al., 2011; Kenney, 1992; Laffrey 1986a; Laffrey & Crabtree, 1988; Mansour, 1994; Morse, 1987; Rubenstein et al., 1992; Tripp-Reimer, 1984; Woodgate & Leach, 2010). These differences in the health conceptions of health professionals and patients can have serious implications for the doctor-patient working alliance (Jovchelovitch & Gervais, 1999). In a study conducted with Ethiopian immigrants, Reiff et al. (1999) found disparities in the meaning of illness and in treatment beliefs of doctors and patients. While patients talked about their illness in a more holistic way, sometimes referring to culture-
specific complaints, doctors focused almost exclusively on the biomedically meaningful complaints. As a consequence, patients did not feel understood by their doctors and they reported being dissatisfied with the quality of care they received. Another group of researchers found that when doctors and patients disagree about the nature of the patients' problems and possible treatments, patients adhere less to their doctors' recommendations (Kerse et al., 2004). Schlomann and Schmitke (2007) reported that a lack of concordance between the beliefs of health professionals and patients with respect to hypertension was related to patients' lack of trust in their doctors.

**Multidimensional Health Models**

In reaction to the criticisms voiced against the reductionist view of the biomedical model and to the constructivist literature suggesting that people construct their own conceptions of health, multidimensional health models have been developed (Baumann, 1961; Engel, 1977; Laffrey, 1986a; Schlenger, 1976; Smith, 1981). Instead of conceptualizing health on a single health-illness bipolar continuum, health has been represented on more than one dimension.

Conceptualizing health as a multidimensional phenomenon allows for a more comprehensive or holistic view of health (Larson, 1999), which takes into consideration that people attach different meanings to health. Some individuals may give more weight to certain dimensions, while others focus on other aspects. By representing health on more than one dimension, theorists hope to encompass the different health perspectives found among members of the general population (Alonso, 2004; Engel, 1977; Smith, 1981).

The use of multidimensional health models also allows for a conceptualization of health that is independent of illness. This reflects the results of studies showing that people
do not view health and illness as two opposite ends of the same continuum (Emami et al., 2000; Kushner, 2007; Laffrey & Crabtree, 1988; Millstein & Irwin, 1987). Health and illness can coexist independently from one another, suggesting that people can continue to experience health despite the presence of a disease (Laffrey, 1986b; Larson, 1999; Mansour, 1994; Pender, 1990; Woods et al., 1988). Although the absence of disease may represent an important aspect of what being healthy means, it is not sufficient for people to fully experience health (Engel, 1977). Overall, according to the perspective of multidimensional health models, health departs from illness not only in terms of degree, but also with respect to other characteristics that are qualitatively different from illness (Schlenger, 1976). This conceptualization of health, focusing on what health is rather than what it is not, has been referred to as positive health (Mezzich, 2005; Strandmark, 2007; Woods et al., 1988).

The biopsychosocial model proposed by the World Health Organization (WHO, 1948) and advocated by Engel (1977) represents an alternative paradigm to the biomedical model, extending the definition of health by incorporating aspects of physical, social, and psychological well-being. Indeed, according to the WHO, health is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (p. 1).

Baumann (1961) proposed a three-dimensional model inspired by the results of a study in which she interviewed patients and medical students in order to understand their perspectives on health. Responses were grouped into three major orientations: feeling-state orientation, symptom orientation, and performance orientation. With respect to the feeling-state orientation, some participants talked about health by referring to feelings of well-being, such as being in good spirits, alert, energetic, good humoured, and satisfied. Others
mentioned the absence of disease as an important aspect of what it means to be healthy, which falls under the symptom orientation. Finally, responses in the performance orientation dealt with one’s ability to perform daily tasks, which was considered another characteristic of a healthy person.

Schlenger (1976) proposed another multidimensional health model characterized by two major processes. The first process, which he called the negative feedback process, includes what has been referred to as negative health and is defined in terms of the absence of disease. The positive feedback process reflects the concept of positive health, which he defined as developmental growth in the direction of the actualization of one’s potential.

Smith (1981) conducted a comprehensive review of the health conception literature and she proposed a model similar to Baumann’s. Four dimensions were identified: clinical, role performance, adaptative, and eudemonistic. The eudemonistic, clinical, and role performance dimensions are closely related to the feeling-state orientation, symptom orientation, and performance orientation proposed by Baumann. However, Smith expanded the eudemonistic dimension by including the process of self-actualization. In that respect, health is not seen as an end state, but as a process towards growth and development. Smith identified an additional dimension, which she called the adaptative orientation, according to which being healthy means being able to adapt to changing circumstances. Smith considered these four health conceptions as organized hierarchically, with the lower orientations encompassed by the eudemonistic orientation.

Pender (1990) defined health as a life-long developmental process in which individuals interact with their environment in order to achieve a sense of balance or harmony. She described health in terms of five dimensions: affect, attitude, activity, aspiration, and
accomplishment. The affect dimension emphasizes the subjective experience of being healthy. It refers to a feeling of well-being, which includes a sense of tranquility or serenity as well as a sense of vitality and energy. The dimension of attitude denotes a positive outlook at oneself and the world in general. The third dimension—activity—suggests that healthy individuals should engage in activities that are beneficial to their own health and well-being. By aspiration, Pender emphasized the developmental process towards positive growth and the actualization of the self that characterizes healthy individuals. Aspiration also includes an active participation in the development of one's community. According to Pender, healthy individuals engage in activities that contribute not only to their own well-being, but also to the enhancement of their society. Finally, the dimension of accomplishment refers to the end result of an active and healthy lifestyle. It is characterized by a sense of achievement and of harmony with one's environment.

Saylor (2004) proposed a model of health that emphasizes wholeness. She described health in terms of three dimensions: optimal function, well-being, and quality of life. Saylor stressed an integrative perspective on health. She viewed the physical, mental, social, and spiritual aspects as interconnected. Therefore, in order to enjoy good health, the whole person must experience optimal function, well-being, and quality of life. This state of health can be attained by actively engaging in a continual cycle of activity-performance and renewal-recovery.

Past studies provide support for these multidimensional health models. Across research sites, participants have consistently emphasized the idea of health as the ability to function, to perform daily activities, and to be independent (e.g., Bishop & Yardley, 2010; Crawford Shearer, Fleury, & Reed, 2009; Fagerlind, Ring, Brülde, Feltelius, & Lindblad,
2010; Kenney, 1992; Mansour, 1994). Although it has been suggested in many studies that the absence of illness represents one dimension of health, other studies have shown that people consider that one can still be healthy despite an illness as long as one can still function (Laffrey & Crabtree, 1988; Kushner, 2007). Well-being and the ability to adapt to changing circumstances represent two definitions of health that have been frequently reported in previous studies (e.g., Buck & Ryan-Wenger, 2003; Fitzgibbon, Cross, & Ruskin, 1992; Häggman-Laitila, 1997; Millstein & Irwin, 1987; Woods et al., 1988), while a health definition in terms of a developmental process has been reported in only a few studies (Häggman-Laitila, 1997; Polakoff & Gregory, 2002; Woods et al., 1988).

It has been argued that health encompasses different aspects of the self, with the physical and mental aspects being the most frequently identified (e.g., Buck & Ryan-Wenger, 2003; Fitzgibbon et al., 1992; Kenney, 1992; Millstein & Irwin, 1987), followed by social health and spiritual health (Goins et al., 2011; Kushner, 2007; Polakoff & Gregory, 2002; Woods et al., 1988). Finally, a few studies have revealed a concept of health defined as having a sense of wholeness or balance among different aspects of health (Kushner, 2007; Polakoff & Gregory, 2002; Woods et al., 1988). These conceptions of health in terms of wholeness, balance, and harmony have been found primarily in studies conducted with women or studies involving members of diverse cultural backgrounds.

Past studies have also revealed that people are generally of the opinion that the best way to promote health is by adopting healthy behaviours and avoiding unhealthy behaviours (e.g., Buck & Ryan-Wenger, 2003; Fagerlind et al., 2010; Fitzgibbon et al., 1992; Millstein & Irwin, 1987; Woods et al., 1988). Other health practices include keeping track of one's current state of health, using health-care services, maintaining good relationships, engaging
in pleasant activities, managing stress, and engaging in spiritual practices (Crawford Shearer et al., 2009; Goins et al., 2011; Kushner, 2007).

**Health Conception Determinants**

As explained earlier, scholars in the health conception literature have posited that health and illness experiences influence how people come to represent what being healthy means (Angel & Thoits, 1987; Dorvil, 1985; Harmsen et al., 2004; Pender, 1990; Strandmark, 2007). Because individuals have unique experiences, they adopt different ideas on health. Despite these interindivudual differences in health conceptions, important commonalities have been found among certain groups of people (Jobanputra & Furnham, 2005; Pender, 1990). Therefore, in addition to personal experiences, other sociocultural factors appear to play a role in the way people perceive and define health (Chan et al., 2006; Goins et al., 2011; Hufford, 1992).

**Culture.** Many researchers and theorists have recognized that culture probably influences individuals’ perceptions and definitions of health as well as their beliefs about how to maintain or promote their health (Hufford, 1992; Jobanputra & Furnham, 2005; Jovchelovitch & Gervais, 1999; O’Connor, 1998; Torsch & Ma, 2000). Studies examining health conceptions across cultures have found differences in the meaning people of different cultures ascribe to health (e.g., Felton, Parsons, Misener, & Oldaker, 1997; Hakim & Wegmann, 2002; Hjelm, Bard, Nyberg, & Apelqvist, 2005; Jobanputra & Furnham, 2005; Torsch & Ma, 2000). As a result, these researchers have argued that health represents a cultural construct.

**Health as a cultural construct.** At first glance, Kelly’s theory of personal construct appears to be exclusively concerned with the psychology of individuals. The use of the word
personal certainly denotes a notion of individuals as independent construers of their own universe (Davidson & Reser, 1996). However, this emphasis on individuals should not be understood as evidence that Kelly refuted the idea of shared meanings and understanding (Bannister, 2003; Davidson & Reser, 1996).

Kelly was in fact the first researcher to conduct cross-cultural research from a personal construct theoretical perspective. In “Europe’s Matrix of Decision” (Kelly, 1962), he reported the findings of months of research aimed at mapping the decision-making process of Europeans across more than thirty countries. Harry Triandis, a leading figure in the field of cross-cultural psychology, declared in 1964 that Kelly’s theory is one of the most promising approaches to conducting research across cultures (Davidson & Reser, 1996). Contemporary personal construct psychologists also believe that the theory of personal construct lends itself to the study of cultural and cross-cultural construction of knowledge (Davidson & Reser, 1996; Scheer, 2003).

According to the commonality corollary of Kelly’s theory, groups of people, including those of the same cultural or subcultural denomination, share certain constructs. Because they have similar experiences and life circumstances, they come to represent their surrounding world in a comparable way (Bannister, 2003; Kelly, 1963, 1970/2003; Scheer, 2003). In fact, Kelly (1963) defined culture in terms of a set of shared constructs. “People belong to the same cultural group, . . . because they construe their experience in the same way” (p. 94). In a study conducted by Bannister (1962) aimed at exploring interindividual and intercultural variations in the way people construct their representations of others, the author found that although no participants represented others in exactly the same way, those who belonged to the same culture tended to have similar construction patterns. Therefore,
personal construct psychologists have acknowledged the existence of both personal and shared social and cultural constructs (Davidson & Reser, 1996).

In turn, these constructs shared by members of a given cultural group make them experience and give meaning to events in a similar way (Bannister, 1962; Kelly, 1963). In the same line of reasoning, scholars in the health conception literature have suggested that culture gives meaning to personal experiences of health and illness, thus giving rise to culturally shared conceptions of health and illness. They have posited that health and illness experiences are explained and understood through the lens of one’s cultural knowledge (Angel & Thoits, 1987; Dorvil, 1985; Jobanputra & Furnham, 2005; Jovchelovitch & Gervais, 1999; Kleinman, 1978).

But how does cultural knowledge, based on which people’s experiences of health and illness are understood, come to be acquired by groups of individuals? According to Moscovici (1984), sociocultural representations and knowledge are transmitted by socialization and enculturation processes through interpersonal relations, daily practices, and the use of language. With respect to relationships, the sociality corollary discussed earlier highlights the role of interpersonal relations in the way people construct their representations of events. According to this corollary, people must strive to look at situations from the vantage point of others in order to relate to them and to communicate effectively (Adams-Webber, 2003; Kelly, 1963, 1970/2003). The sociability corollary thus suggests that people have the potential to learn from the perspectives of others. Personal constructs are communicated, shared, and traded through interpersonal exchanges (Bannister, 2003).

In a study conducted with Chinese adults living in Hong Kong, the authors (Chan et al., 2006) reported that the participants conceptualized health as a resource that allows them
to fulfill their social roles. Health was seen not only as a resource that enables them to function on a personal level, but also as an obligation or a responsibility towards others, including their employers and family members. The participants also recognized the connection between the mind and the body; they defined health as a balance between these elements. These conceptions of health reflect the cultural influences these participants have been exposed to, including Confucian teachings about social responsibilities and roles, Taoism's emphasis on unity and balance, and the strong work culture of Hong Kong. But what the authors really wanted to understand was how these participants learned and acquired these conceptions of health. What emerged from these participants' narratives is the role their own experiences with health, illness, and the health-care system played in the way they looked at health. In addition to their personal experiences, they talked about the influence of their family on how they view health. The authors concluded that families represent important socializing agents through which cultural health beliefs are transmitted.

In addition to interpersonal relations, Moscovici (1984) suggested that sociocultural representations shared by groups of individuals are learned through the practices of daily life. Much of our cultural knowledge is learned not from explicit formal teaching, but is learned through the enactment of daily living (Jovchelovitch & Gervais, 1999). According to Berry and colleagues (Berry, Poortinga, Segall, & Dasen, 2002), the former process refers to socialization whereas the latter represents the process of enculturation. By observing and engaging in daily practices, people come to internalize certain cultural knowledge without necessarily realizing that learning is taking place. Learning through enculturation explains why people are often unaware of divergent views and perspectives on health (Angel & Thoits, 1987). Unless they are exposed to different ways of thinking about health, their
perspectives are often taken for granted and objectified as the natural way of defining health (Jovchelovitch & Gervais, 1999).

Jovchelovitch and Gervais (1999) studied the health and illness representations of Chinese immigrants living in England. The participants defined a healthy individual as someone who has a good flow and distribution of vital energy, called ch'i. Health was also defined in terms of balance and harmony between elements within the person as well as between the person and the social, natural, and supernatural world. They believed in the importance of regulating and balancing opposite forces, including hot-cold, wet-dry, and yin-yang. Again, the authors were especially interested in learning how these health beliefs were acquired. What was apparent from the participants’ accounts is that much of what is known about health, illness, and health-promoting strategies is learned around the family table. Daily practices concerning the way food is prepared as well as the type of food that should be consumed at certain periods and for certain purposes clearly impacted these participants’ perceptions of health.

In addition to food, the authors also pointed to the role of language as a carrier of health and illness beliefs (Jovchelovitch & Gervais, 1999). Personal construct psychologists have suggested that language represents a powerful force that shapes the way people perceive and conceptualize their internal and external realities (Rowe, 1996; Scheer, 2003). Personal construct psychologist Dorothy Rowe (1996) suggested that “the language we speak created the reality in which we live” (p. 11). Scholars studying illness and health conceptions across cultures have also recognized the role of language in the transmission of cultural health and illness knowledge (Hjelm et al., 2005). For instance, Fadiman (1997) reported that for
Hmongs, the concept of chronic illness is difficult to grasp since there is no word in their language that translates to chronic.

However, it is important to keep in mind that according to the theory of personal construct, people play an active role in the construction and representation of their realities (Kelly, 1963). They do not passively assimilate the cultural knowledge of their groups. Cultural information provides a foundation to the personal construction process, but this information is actively manipulated, evaluated, compared, and personalized by individuals before it becomes integrated into their construct systems (Bannister, 1962; Chiari & Nuzzo, 1996; Fransella & Neimeyer, 2003). Therefore, within any given culture, idiosyncrasies will always be found amidst shared cultural constructs (Scheer, 2003). Although Kelly recognized the existence of shared social and cultural constructs, as a psychologist, he developed a theory that is first and foremost a theory of individuals in the sense that the construction of knowledge, including cultural knowledge, is done by individuals (Davidson & Reser, 1996).

Since culture influences the way people conceptualize health, it is important that health models guiding medical and nursing practices reflect cultural variations in health conceptions. Although the multidimensional health models described earlier offer a more comprehensive view of health, most of these models have been developed or tested in studies conducted primarily with Caucasian, English-speaking populations (Ailinger & Causey, 1995). The few studies that have included participants from diverse cultural backgrounds have analyzed the data as a whole and have not provided a description of the health conceptions held by members of each cultural group (Polakoff & Gregory, 2002; Woods et al., 1988). As a result, these models might not be representative of ethnic minorities’ health conceptions.
Some scholars have argued that many health models rest on certain Western values (Kleinman, Eisenberg, & Good, 1978). Others have suggested that they are especially congruent with middle class, American values (McMullin, 2005; O’Connor, 1998; Somnath, 2006; Stein, 1990) and with masculine cultural idioms (Stein, 1990). These values include individualism, mastery over nature, future orientation, performance, productivity, independence, and self-reliance or self-control (McMullin, 2005; O’Connor, 1998; Stein, 1990). For instance, McMullin (2005) argued that the concept of health defined in terms of the body without disease and the ability to function stems from fundamental Western values, such as independence, performance, and productivity. A person who is not incapacitated by illness represents a productive citizen, who in turn exemplifies a core value of Western society. Health models as well as past studies have also emphasized individual behaviours, including diet and exercise, as the prime method of promoting health, thus reflecting Western values such as self-reliance and control (Chan et al., 2006). It is believed that through self-discipline, anyone can achieve health (McMullin, 2005).

Studies investigating cultural conceptions of health are of two kinds, namely, cultural or cross-cultural. Cultural studies focus on the health conceptions found among members of a given cultural group. Comparing the results of these studies provides preliminary evidence of the cultural variations in health conceptions. However, since there is no way to ensure that the data were collected in a similar fashion across research sites, it is impossible to draw conclusions about the influence of culture on the way people conceptualize health. The differences observed may be the results of different data collection methods. In contrast, cross-cultural studies are conducted with two or more cultural groups with the objective of highlighting similarities and differences in the health conceptions of members of different
cultural backgrounds. These studies provide more compelling evidence of the cultural construction of health.

Within the cultural tradition, Ailinger and Causey (1995) conducted open-ended interviews with older Hispanic immigrants living in the United States in order to understand what being healthy means to them and how they maintain their health. The participants defined health in terms of the absence of disease or pain and in terms of well-being. Feelings of well-being must transcend the whole person, namely, the physical, mental, and spiritual self. They also defined a healthy person as being independent and able to function. Finally, a few participants mentioned appearance or a good body image as a characteristic of a healthy person. The participants believed they could maintain their health by exercising, eating well, and taking their medications. Maintaining good relationships with others, especially with family members, was also recognized as an important avenue to promote health.

More recently, Ailinger, Gonzalez, and Zamora (2007) studied the concept of a healthy adult and a healthy baby from the perspective of Nicaraguan women. A healthy individual was described as someone who is able to function and to perform daily activities, who feels well emotionally, and who has a good appearance or body image, including nice skin colour. When asked about ways to maintain good health, participants reported that it is important to maintain proper hygiene and sanitation, to eat well, and to seek health care when needed.

A group of researchers (Van Uchelen, Davidson, Quessette, Brasfield, & Demerais, 1997) conducted a study with 31 First Nations individuals living in Vancouver. The researchers did not focus on health per se, but asked the participants to talk about their views on wellness. The participants described wellness in terms of having a sense of community,
having positive relationships with others, and contributing to one's community. They also talked about the importance of having a strong cultural identity as First Nations individuals as well as knowing and practicing cultural traditions. Wellness was described as having a spiritual and a balanced life. Finally, participants talked about the need to come to terms with the negative aspects of the past in order to achieve wellness.

Elliott and Gillie (1998) investigated the meaning of health held by South Asian, Fijian women in British Columbia. These women adopted an integrative view of health arguing that health includes the whole person, namely, the body, the mind, and the spirit. Health was defined as a general sense of well-being. They also defined health in terms of balance or harmony between elements within the body and between the physical, mental, and spiritual aspects of the self. They placed much emphasis on functionality and performance as important indictors of health. Thus, health was seen as a resource that allows them to function and to fulfill their roles, especially as caregivers. Indeed, they considered it their responsibility to take care of their family. Family was such a central theme in these women's narratives that they even included their family members in their definitions of health. For them, being healthy meant that their family was also healthy. Meadows, Thurston, and Melton (2001) found similar results with a group of immigrant women in Alberta. In terms of health practices, the participants in Elliott's and Gillie's study recognized the importance of eating well and exercising. They reported that having support from their close ones and in turn helping them could contribute to health. Finally, they reported maintaining their health by using traditional and mainstream health services.

Jan and Smith (1998) interviewed Pakistani families living in the United States about their perspectives on health. These immigrants defined health as a process towards achieving
a sense of wholeness. For them, wholeness involves a sense of physical, psychological, moral, and spiritual well-being and balance. They emphasized spiritual peace as a fundamental aspect of being healthy. They believed they could stay healthy by maintaining good relationships with family members and neighbours and by participating in their community. They also promoted their health by maintaining their traditional practices and their former ways of living.

A group of researchers (Emami et al., 2000) investigated the meaning of health held by Iranian elderly immigrants in Sweden. They perceived health as having a sense of continuity in life. Health was also defined in terms of a general feeling of well-being that can exist despite the presence of a disease. They emphasized the notion of balance when talking about their views on health. Being healthy meant maintaining a sense of balance within themselves, especially between the body and the mind, and also between themselves and others around them. They viewed health as one of the most important goals in life.

Wang (2004) conducted a study with university students in China. When asked what being healthy means to them, some of the participants reported that being healthy means not being sick. However, he observed that in general Chinese students adopted a more holistic view of health. The participants defined health in terms of a general sense of mental and physical well-being and the ability to adapt to changing circumstances. For some students, the concept of health also extended to the intellectual and the moral domains. They stated that being healthy means having pure and moral thoughts. With respect to health practices, the participants identified the importance of exercising, eating well, and trying to avoid or reduce stress. Maintaining good relationships was also seen as a way to keep themselves
healthy. Finally, a few participants mentioned trying to maintain their health by engaging in challenging intellectual activities.

In a study addressing the health conceptions of African-American men, the authors (Ravenell et al., 2006) reported that although the absence of disease was cited as a characteristic of a healthy person, the participants’ definitions of health included other dimensions. A general sense of well-being, especially at the physical and mental levels, was particularly stressed during the interviews. Economic stability and having a sense of spirituality were also part of these African-Americans’ conceptions of health. Finally, being able to function was mentioned by almost all of the participants, but for different reasons. While the younger men emphasized their ability to fulfill their social roles, older men talked about the importance of being able to take care of themselves and being independent. Health-maintaining strategies identified by the participants include engaging in healthy behaviours, such as eating well and exercising; avoiding unhealthy behaviours, such as consuming tobacco, drugs, and alcohol; and managing stress. The use of prayers and other spiritual practices were mentioned by some of the participants. Other health-promoting strategies identified included seeking health care when needed, getting support from family and friends, and self-empowerment, especially by educating themselves about health-related matters.

Hartweg and Isabelli-Garcia (2007) conducted a study with low-income Latino women who immigrated to the United States. They were asked to talk about their perceptions of health and health-promoting practices. The authors identified 15 themes in total. With respect to health definitions, the themes identified fell into the following categories: absence of illness and pain, emotional well-being, physical well-being, taking care of one’s self-image or appearance, and having a spiritual life. With regard to health-promoting practices,
the participants identified having good nutrition and exercising, while avoiding harmful behaviours, such as smoking, drinking, or doing drugs. They also mentioned seeking medical care when needed and keeping informed by their doctors about health-related issues.

Labun and Emblen (2007) investigated the concept of health from the perspective of the Stó:lō-Coast Salish First Nation People in British Columbia’s lower mainland. The participants defined health as a general sense of balance and continuity through times of change. In order for an individual to be healthy, they considered that every aspect of the individual, namely, the body, the mind, and the spirit, must be balanced. Some of the participants argued that health is not only a personal matter. It also means that one’s family and one’s community experience good health. In order to promote their health, many reported engaging in traditional and spiritual practices. Others explained that in order to be healthy, they need to believe or have faith in something. Finally, social support from family, friends, elders, and healers was recognized as an essential health-promoting strategy.

A group of researchers (Capstick, Norris, Sopoaga, & Tobata, 2009) conducted a review of the literature on health and culture in Polynesia. They reported that Polynesian islanders’ conceptions of health tend to expand outside the limits of the individual self. For them, being in good health also implies having healthy relationships with others, with nature, and with the spiritual world. The authors explained this relational conception of health in terms of an interdependent self-construal. Indeed, in many collectivist cultures, including those in the Pacific islands, the self is not represented as closed or bounded. Instead, people tend to see the self as being connected with the social world.

Within the cross-cultural research tradition, Torsch and Ma (2000) conducted a qualitative study with two groups of elders: a group of Chinese elders living in the United
States and a group of Chamorros living on Guam Island. Two common themes were found in the health perspectives of these two groups of elders. Members of both groups defined health in terms of wholeness, indicating that health involves every aspect of the self, including the body, the mind, and the spirit. They also believed that these elements are interconnected. The second theme mentioned by these elders refers to a sense of orientation towards others. Being healthy means having harmonious interpersonal relationships. Despite the increasing prevalence of chronic illness in later life, they believed they could continue to be healthy.

The authors also highlighted differences in the health conceptions of the Chinese and the Chamorro participants. The Chinese participants defined health in terms of a balance between opposite elements in the body, including yin and yang, while the Chamorros placed more importance on functional capability.

Hakim and Wegmann (2002) interviewed elders who belonged to four different cultural groups on their perceptions of health. The sample included Americans of African, Latin, Vietnamese, and First Nations descent. Health was defined in terms of one’s ability to function, to be active, and to be independent. They also defined health in terms of some kind of balance. The Vietnamese-Americans emphasized the notion of balance between elements within the body, such as yin and yang; the others talked about a balance between the body and other aspects of health, including mental, social, and spiritual health. Except for the Native Americans, all the participants included being free of pain in their definitions of health. Only the African-Americans defined a healthy person in comparison to other less healthy people. For them, health was seen as a relative concept. With respect to health practices, participants in all four groups mentioned the use of prayers and spiritual practices. The First Nations participants reported seeking health care from traditional medicine, which
includes sweat lodges, tribal healers, and the use of herbs. Only if these practices do not work would they seek health care from Western medicine. Participants in the other groups tended to rely more on the use of mainstream health institutions. With the exception of First Nations, all the participants mentioned exercising, eating right, and seeing their doctor on a regular basis as ways of maintaining their health.

A group of Swedish researchers (Hjelm et al., 2005) conducted a qualitative study on the health and illness beliefs of Arab, Yugoslavian, and Swedish men with diabetes. Important differences emerged among these men. The authors reported that Swedes and Arabs adopted a negative conception of health, arguing that health means being free of illness. Yugoslavians defined health in terms of a resource or wealth that allows them to function in life. Arabs also mentioned functional capability, but emphasized the ability to perform their social roles. Arabs and Yugoslavians discussed sexual functioning when defining what being healthy means. Finally, Swedish participants included the well-being of their family in their definitions of health. In terms of health practices, Swedish men emphasized the importance of engaging in healthy behaviours, such as eating well and exercising. Non-Swedish participants talked about managing stress and relying on the use of health services; Swedish participants reported using self-care measures. Arab and Swedish men mentioned that social support is a contributing factor to health.

A group of researchers (McCarthy, Ruiz, Gale, Karam, & Moore, 2004) investigated the meaning of health held by older Anglophone and Hispanophone women living in the United States. Anglophone women adopted a view of health reflecting individualist cultural values. These women defined health in terms of the absence of disease, physical well-being, and the ability to function and to be independent. To promote their health, they relied on self-
care measures and the use of professional health services. They said they do not like to encumber family members with their health problems. In contrast, the Hispanophone women’s conceptions of health were more in line with an interdependent concept of self. They acknowledged the interdependence between their own health and the health of their close ones. They described a healthy person as someone who has close relationships with their family and a spiritual connection with god. They reported distrusting physicians and other health-care professionals. They tried to promote their health by maintaining good relationships and by engaging in spiritual practices.

Felton et al. (1997) reported the results of a quantitative study conducted with college women on their health definitions and health-promoting behaviours. The sample included 62 pairs of Caucasian and African-American students who were compatible with respect to age, body mass index, and socioeconomic status. The participants completed the Laffrey Health Conception Scale (Laffrey, 1986a) and the Health-Promoting Lifestyle Profile (Walker, Sechrist, & Pender, 1987). The results of t tests revealed no differences in the health definitions held by the women from the two ethnic groups. However, differences were found in the health-promoting behaviours. It was shown that Caucasian women practiced healthy nutrition behaviours and used interpersonal support to a greater extent than the African-American participants.

Another quantitative study conducted in Great Britain examined the health beliefs of Gujarati-Indian immigrants and British Caucasians (Jobanputra & Furnham, 2005). The participants were asked to complete a questionnaire measuring the extent to which they agreed with six health-promoting factors. Between-subjects analyses of covariance (ANCOVAs) were performed, controlling for demographic differences between the
participants. The results indicated that in comparison to British Caucasians, Gujarati Indians agreed more with explanations of health in terms of supernatural factors and older Indians believed that chance-related factors are important contributors of health.

Acculturation. Canada is considered a pluralist society where a number of different cultural groups reside in close proximity and interact on a daily basis (Berry et al., 2002). Given that culture appears to play a role in the way people conceptualize health, the potential influence of cross-cultural contacts on health conceptions cannot be ignored (Jobanputra & Furnham, 2005). According to the acculturation and adaptation model, acculturation consists of a process of change in the primary culture as a result of cross-cultural contact (Berry, 1980, 2005; Berry & Sam, 1997; Berry et al., 2002). Although it has been recognized that changes or consolidation of cultural values and conceptions can occur within the dominant culture when people interact with members of cultural minority groups, most studies on acculturation have examined the impact of the dominant culture on cultural minorities (Berry et al., 2002).

With respect to minority groups, acculturation to the dominant culture is influenced by a number of factors. The degree of contact and proximity with the dominant culture, the proportion of individuals in the minority group in comparison to the majority group, the geographical dispersion of minority members, the minority group's attitude towards the cultural values of the majority group, and the nature of the relationship between the minority and majority groups all play a role in the extent to which members of cultural minorities acculturate to the dominant cultural values (Berry et al., 2002; Gudykunst, 2004; Phillips, 2005).
Health conception studies conducted with immigrants have provided evidence of the influence of acculturation on conceptions of health and illness. For instance, DeSantis (1993) investigated the conceptions of health of Haitian immigrants in the United States in relation to the process of acculturation. A large number of participants indicated that a person’s health could only be evaluated through the use of diagnostic tests performed by physicians. The author reported that reliance on physicians’ verification of health does not represent a traditional health-seeking behaviour among Haitians. She concluded that increasing contacts with biomedical institutions as well as acculturation to the biomedical culture impacted the health conceptions of these Haitian immigrants.

Grieshop (1997) investigated the impact of immigration on the health beliefs of a group of Mixtec immigrants who moved from Mexico to California. The average time since immigration was about three years. The author was especially interested in the participants’ beliefs about explanatory factors of health and illness, including omens or beliefs about supernatural causes of health and illness, which are widespread in Mexican culture. The health beliefs of Mixtec immigrants were compared to those of a group of Mixtecs residing in Mexico City. The findings showed that Mixtec immigrants reported fewer traditional health beliefs that involve omens or supernatural factors compared to Mixtecs in Mexico City.

Reiff et al. (1999) investigated the illness and treatment perceptions of Ethiopian immigrants and their doctors to assess the effect of time since immigration on the level of concordance in the health perspectives of doctors and patients. They found discrepancies in the illness and treatment beliefs of doctors and their patients who immigrated only two years before the study was conducted; patients who immigrated seven years before the study
reported illness beliefs that were more similar to the perspectives of the doctors. The authors also noticed that during medical interactions, the former group of immigrants were more likely to report culture-specific complaints, while the second group of immigrants reported more complaints that fit into biomedically meaningful categories.

Comparing cancer-related beliefs of Japanese, Japanese-Americans, and Euro-Americans, the researchers (Cook Gotay et al., 2004) found that the Japanese and the Euro-Americans held very different beliefs, especially with respect to the consequences of cancer and the controllability or curability of cancer. The Japanese participants had a more fatalistic view of cancer, arguing that cancer is not curable, whereas the Euro-American participants were more optimistic. They found that the illness beliefs of the Japanese-Americans, who had been living in the United States for three generations or more, were more similar to the beliefs of the Euro-Americans compared to the Japanese participants. They concluded that these similarities in the illness beliefs of Euro-Americans and Japanese-Americans resulted from a high degree of acculturation of Japanese-Americans to American cultural values.

Phillips (2005) compared pregnancy-related beliefs and practices among three groups of African-Americans who had different acculturation experiences with Western culture. She found that Americans of African descent who immigrated to the United States in recent years as well as African-Americans who lived in communities that are geographically isolated from the dominant cultural groups retained more traditional beliefs and practices compared to those who lived in close proximity with American Caucasians.

Contact with the dominant culture does not necessarily lead to the adoption of mainstream cultural values at the cost of the traditional culture. With a greater acceptance of cultural diversity in North America and policies that support multiculturalism (Berry et al.,
research findings have shown a mix of traditional and dominant cultural health beliefs among cultural minority groups (Castro, Furth, & Karlow, 1984; Cook Gotay et al., 2004; DeSantis, 1993; Grieshop, 1997; Jobanputra & Furnham, 2005; Phillips, 2005; Reiff et al., 1999), suggesting an integration acculturation strategy (Berry, 2005).

However, it is important to keep in mind that Canadian society has not always embraced the value of multiculturalism (Berry et al., 2002). Even today, the predominant egalitarian discourse hides deep-rooted institutionalized and ambivalent discriminatory practices (Dovidio & Gaertner, 1998; Tang & Browne, 2008). Before 1971, Canadian immigration policies were more in line with the idea of a melting pot, which is geared towards maintaining a common cultural identity (Berry et al., 2002).

Long-established cultural minorities have been the targets of assimilationist policies. In Manitoba for instance, the Official Language Act of 1890 declared that English was the only official language in Manitoba and from 1916 to 1970, education in French was forbidden in Manitoban schools, the intention being to assimilate Francophones (Bédard, 2002). Although some of them came to abandon their mother tongue through generations, a significant proportion of Franco-Manitobans managed to maintain their language and to survive as a distinct cultural group in Manitoba (Stebbins, 2000).

Starting in 1874, residential schools for Aboriginal Canadians were established across Canada by the federal government in partnership with various religious organizations. These institutions were based on coercive and assimilationist policies aimed at eradicating Aboriginal cultural knowledge and traditions (Indian and Northern Affairs Canada, 2003). The effect of colonialism on individuals' identification with their Aboriginal culture varies greatly within Aboriginal communities (Morrissette, McKenzie, & Morrissette, 1993).
Morrissette et al. (1993) depicted the degree of assimilation of Aboriginal individuals on a continuum that goes from identification to non-identification with traditional culture, with neo-traditional—defined as a blend of traditional values and beliefs with those of the dominant society—in between. Although the residential school period affected Aboriginal Peoples in Canada in different ways, it did not succeed in completely eradicating their cultures (James, 2001). In fact, according to Fanon (1965), cultural oppression may result in counterassimilation, a process where the oppressed group resists the domination of the majority group and retains its cultural roots (Phillips, 2005). Movements to revitalize Aboriginal practices, including Native languages and health practices, at the international level attest to a backlash to cultural oppression among Aboriginal communities (Hunter, Logan, Barton, & Goulet, 2004; Smith, 1999). It has been argued that the maintenance of traditional cultural beliefs, knowledge, and practices, including cultural conceptions of health, is tied to a struggle to reclaim Native cultural identities (Hunter et al., 2004; McMullin, 2005; Morrissette et al., 1993).

McMullin (2005) asked 35 Native Hawaiians what it meant to be a healthy Hawaiian. The participants depicted a picture of health in terms of the healthy ancestor. Although they mentioned the absence of illness as a characteristic of the healthy ancestor, they believed that being healthy is more than being free of disease. Being healthy also meant having physical vitality and strength, being energetic, and active. They said that being healthy meant having a positive state of mind, which taps into the mental aspect of health. In addition to physical and mental well-being, they talked about the importance of having a spiritual life and gaining a balance between work, family, spirituality, and play. This balanced view of life leads to a sense of unity and harmony. To achieve this state of health, they believed that Native
Hawaiians must know and practice their traditional culture, which includes maintaining a traditional Hawaiian diet, establishing community gardens, and sharing food. They believed these practices lead to positive relationships with others and a strong sense of community. Connecting with traditional lands was also mentioned as a means of promoting health, especially spiritual well-being. However, they discussed how, historically, access to lands and to healthy food has been denied, which has contributed to the deterioration of their health. The author concluded that Native Hawaiians’ conceptions of health in terms of the healthy ancestor is linked to an effort to reassert their native cultural identity. Access to land and to traditional food was seen not only as a means to promote health, but also as a way of reasserting one’s cultural identity. The struggles to reclaim their cultural identity and to reclaim their health are interconnected, as revitalizing their culture could contribute to their health.

Investigating the transmission of cultural health knowledge through daily practices among Chinese immigrants in England, Jovchelovitch and Gervais (1999) found that the maintenance of traditional health beliefs fulfills identity needs. They reported that “representations of health and illness are not just about being healthy and avoiding illness; they are first, and perhaps foremost, about being Chinese” (p. 258).

Other determinant factors. Another body of research on health conceptions has shown that in addition to culture and personal experiences, other factors could play a role in how people conceptualize health and how they promote their health. These include gender, age, socioeconomic standing, place of residence, education level, health status, and marital status.
Past studies have shown a link between health conceptions and gender. For instance, Kenney (1992) noticed that when defining health, women placed more emphasis on social well-being and harmony compared to men. Mansour (1994) noted that women had a more comprehensive view of health including many more dimensions in comparison to the health conceptions of men. Dorvil (1985) explained these differences by suggesting that women are generally more attentive and concerned about their health than men. As a result, they come to represent health in a more complex way. Bishop and Yardley (2010) reported that the women who took part in their study placed more importance on well-being and functionality compared to men. However, Wang (2004), who investigated conceptions of health among Chinese students, found that more men included mental health in their health definitions compared to women. Other researchers observed no differences in the health conceptions of men and women (Bagwell & Bush, 1999; Buck & Ryan-Wenger, 2003; DeSantis, 1993).

With respect to health-promoting strategies, a study conducted with blue-collar workers showed that women relied more on interpersonal support to promote their health in comparison to men (Bagwell & Bush, 1999). This study also indicated that women believed they were responsible for the health of their close ones to a greater extent than men.

Wang (2004) noticed a developmental trend towards the inclusion of mental health in students' perceptions of health as they grew older. Millstein and Irwin (1987) observed that older students' concepts of health were less focused on the mere absence of disease and included a variety of themes, such as mental well-being. Another study conducted with adolescents showed that their health conceptions became more complex as they grew older (Buck & Ryan-Wenger, 2003). Differences were also observed in studies conducted with adult participants. Baumann (1961) found that within her patient sample, younger
participants tended to define health in terms of the absence of disease, while older patients were more concerned with functionality and performance. Laffrey and Crabtree (1988) reported age differences in health conceptions with older participants placing a higher value on health and defining health with more depth. Using the Laffrey Health Conception Scale, Woods et al. (1988) found that older women adhered less to the eudemonistic dimension of health compared to younger women, but defined health more in terms of role performance and adaptive orientation. Mansour (1994) reported that older participants agreed more with the belief that health means having a sense of harmony with the universe. However, Laffrey et al. (1985) as well as Kenney (1992) did not find a relationship between age and health conceptions.

With regard to health-promoting strategies, Mansour (1994) observed that older participants considered having enough money an important contributor to health. In another study, it was shown that older participants tended to promote their health by having good nutrition, while the younger participants relied more on exercise (Bagwell & Bush, 1999). A gender and age interaction effect was also observed in that study with younger women and older men adhering to the health dimensions measured by the Laffrey Health Conception Scale to a greater extent than older women and younger men.

Other studies have shown that socioeconomic conditions and place of residence, namely, rural or urban, could contribute to people’s conceptions of health. For instance, Long (1993) found that blue-collar workers living in rural areas defined health in terms of their level of functionality, whereas urban dwellers tended to focus on appearance and well-being. The author posited that because of the socioeconomic circumstances prevailing in rural communities, the ability to perform one’s job is highly valued and considered indispensable,
which in turn influences how people define health. Goins et al. (2011) found that older adults living in rural Appalachia regarded health as a valuable commodity as it allows them to fulfill their roles, whereas the absence of health would significantly impact their daily functioning. Stein (1990) also observed that people from farming families in the United States held an instrumental perception of health. Similar results were reported by Noack (1991), who suggested that the health status of members of the working class is predominantly evaluated in terms of their level of functionality. Other researchers (Laffrey et al., 1985; Woods et al., 1988) observed that women with a higher family income tended to define health by using more dimensions than those with a lower income. The former also adhered to a eudemonistic definition of health to a greater extent than those in lower income brackets (Woods et al., 1988). More recently, Provencher (2003) explored the health conceptions of older Francophone women living in an urban setting in the province of New Brunswick. Although they defined health in a similar way, women in different social classes attributed health and illness to different factors. Those in the lower class perceived health as being somewhat out of their personal control. They attributed health to destiny and luck. Women in the middle class believed that health is a personal responsibility and that through healthy behaviours they could promote their health.

Closely related to socioeconomic standing is educational level, which has also been shown to be an important health conception determinant. Laffrey and Crabtree (1988) as well as Kenney (1992) found that participants with higher education placed more importance on functionality when defining health. Baumann (1961) reported that participants with more education tended to define health in terms of the absence of disease to a greater extent than those with less education. Conversely, appearance and body image (Kenney, 1992) as well as
feeling-state (Baumann, 1961) appeared to be important aspects of the health conceptions held by people with lower educational levels. Woods et al. (1988) noted that women who had more education defined health using more dimensions compared to those of less education. They also found that women with more education adhered more to a eudemonistic definition of health and less to a role-performance conception of health. Mansour (1994) also demonstrated that level of education is related to health conceptions, with less-educated participants agreeing more with a definition of health in terms of a feeling of harmony and a connection with god.

A few studies have also indicated that current health status can have an impact on health conceptions, although results are not consistent. Baumann (1961) found that chronically ill patients placed more importance on performance, whereas healthy medical students emphasized the absence of disease to a greater extent when defining health. Bishop and Yardley (2010) reported similar results. Morse (1987) noticed a different trend. Participants who suffered from chronic or acute diseases tended to define health in terms of the absence of disease, whereas participants who were in good health placed more importance on psychological well-being. Mansour (1994) found that people who had health problems conceptualized health with more depth. They had a view of health that went beyond the mere absence of disease, thus contradicting Morse's results. Laffrey (1986b) compared overweight and normal weight patients and found that these two groups had very similar health conceptions. Laffrey and Crabtree (1988) found no differences in the way healthy people and people with chronic cardiovascular diseases defined health. The health-promoting strategies used by these two groups of participants were also very similar. However, recreation was identified by healthy participants but not by those who had chronic
diseases, while the latter mentioned the use of medications as a way to promote their health, which was not identified by healthy participants.

Finally, Mansour (1994) reported that marital status is related to health conceptions. The author noticed that widowers and divorcees placed more importance on harmony compared to married people. No other researchers observed the influence of marital status on health conceptions.

The Relationship between Health Definitions and Health Practices

Few studies have examined the relationship between beliefs about health or illness and health practices. However, these studies have lent support for the role of health and illness conceptions on health behaviours. Laffrey et al. (1985) proposed a taxonomy of health practices. They recognized three categories of health practices that vary along a continuum from negative to positive health. Illness-preventing practices are aimed at reducing the risks of contracting an illness or disease. Health-maintaining practices seek to maintain or preserve one’s current health status. Finally, health-promoting practices seek to achieve better health. On the one hand, the authors reported that participants who adhered to the perception of health in terms of the absence of disease relied primarily on practices aimed at preventing diseases. On the other hand, those who embraced a eudemonistic view of health reported engaging in behaviours that seek to promote health.

Cook (1991) conducted a study on illness beliefs among Chinese-, Indian-, and Anglo-Celtic-Canadians. He identified three categories of illness beliefs, namely, biomedical, psychosocial, and phenomenological. He found a significant difference among the three groups with respect to illness beliefs, with Chinese- and Indian-Canadians adhering to psychosocial and phenomenological illness beliefs to a greater extent than Anglo-Celtic-
Canadians. The author also examined whether illness beliefs would predict health-seeking behaviours. He found that those who reported more biomedical illness beliefs used mainstream health institutions to a greater extent, while those who adhered to psychosocial and phenomenological illness beliefs relied more on their social networks and folk health sectors.

Bagwell and Bush (1999) investigated the health conceptions and health-promoting practices of blue-collar workers. They found that participants who had higher scores on the Laffrey Health Conception Scale, which indicates that their conceptions of health include all four dimensions of clinical, role-performance, adaptive, and eudemonistic health, engaged in significantly more health-promoting behaviours compared to those who adhered to a conception of health only in terms of the absence of disease. These health practices include interpersonal support, nutrition, exercise, stress management, self-actualization, and health responsibility.

Phillips (2005) compared pregnancy-related beliefs and practices of three groups of Americans of African decent. She found that mothers who defined health in terms of a balance between hot and cold elements in the body reported engaging in health-promoting behaviours that are consistent with this traditional health belief. These mothers described at length the practices they used during and after their pregnancy in order to maintain a balance between hot and cold. Nutrition was especially important for them. Indeed, they selected food in accordance with their hot and cold properties.

**The Present Study**

Despite previous studies aimed at identifying health conceptions in culturally diverse groups, these studies have several limitations. First, many studies have focused on one
cultural group at a time; the comparative approach has seldom been used in health conception research, thus failing to grasp the role culture plays in health conceptions. Second, researchers conducting comparative studies on health conceptions have rarely controlled for other influential factors such as socioeconomic standing. The only two studies taking these factors into account were quantitative studies using standardized health conception and health belief measures (Felton et al., 1997; Jobanputra & Furnham, 2005). Although these studies allowed for quantitative comparisons between participants of different cultural backgrounds, they could not assert whether participants would define health using characteristics that are qualitatively different. Third, no researchers have yet investigated health conceptions across cultures using both qualitative and quantitative research methods simultaneously. Finally, research on health conceptions has focused mostly on immigrant populations. Long-established minority groups living in Canada, including First Nations Peoples and French-speaking Caucasians, have been virtually absent from the health conception literature, especially in urban settings. Consequently, knowledge of cultural differences in health conceptions among members of minority groups who have a long history of contact with the dominant culture is lacking.

The present study addresses a gap in the literature on health conceptions of long-established minority groups. The aim of this research project is to address the following questions:

1. What are the health conceptions of English-speaking Canadians living in an urban setting and of minority French-speaking and First Nations Canadians, whose historical experiences of contact with the majority group present some parallels?
2. What are the health practices English-speaking, French-speaking, and First Nations Canadians engage in to promote their health?

3. Are there cultural differences in health definitions and health practices across the three groups?

4. Are health definitions related to the health practices people engage in to promote their health?
Method

Context

The present study was conducted with members of three cultural groups living in Winnipeg, the capital of Manitoba: English-speaking Caucasians, French-speaking Caucasians, and First Nations Peoples. As of the 2006 census, Winnipeg had a population of 633,451 inhabitants and the population of the metropolitan area reached 694,668. In a province of 1,148,401 people, it appears that over half of Manitoba’s population lives in the capital city (Statistics Canada, 2007a).

The composition of Winnipeg’s population is quite diverse, both from an ethnic and a linguistic perspective. Aboriginal Peoples and immigrants populated the province of Manitoba (Haque, 1996; Kaye, 1996). The first few waves of immigration, starting in the early 1800s, brought newcomers from other parts of North America and Europe (Haque, 1996; Kaye, 1996). However, in the 1970s, Canada opened its immigration policies to immigrants from Africa, Asia, the Middle East, and from Central and South America (Hyman, 2004). The 2006 census revealed that of the total population of Winnipeg, 16% reported being members of a visible minority, 19% reported being first-generation immigrants, and 22% declared their mother tongue as neither of the two official languages (Statistics Canada, 2007a).

Approximately 73% of Winnipeggers are of European ancestry, the vast majority having English as their maternal language (Statistics Canada, 2007a). The ancestors of today’s English-speaking Caucasians living in Winnipeg have immigrated from eastern regions of the North American Continent and from Europe (Blay, 1986, 2010; Haque, 1996; Kaye, 1996). After Manitoba’s entry into the confederation in 1870, the government
organized major campaigns to attract immigrants from Ontario, Québec, and the United States. Fearing the prospect of being surrounded by two francophone provinces and attracted by the perspective of having access to free fertile agricultural lands, Ontarians responded to the call. In addition to immigrants from Ontario and the United States, the early twentieth century also brought a large number of immigrants from European countries, including Britain, Ireland, Scotland, Germany, Switzerland, Italy, Poland, Russia, Ukraine, and Iceland. Although a few of these groups have managed to maintain their languages, most of them, through generations, have come to adopt English as their mother tongue. The descendants of these immigrants make up most of Winnipeg's current English-speaking population of European ancestry (Blay, 1986, 2010; Haque, 1996; Kaye, 1996).

The Franco-Manitobans are a group of people who have fought to conserve their maternal language (Stebbins, 2000). Although they now represent a small minority, Francophones were in fact the first settlers of Rupert's Land—part of which is now Manitoba—arriving as early as the 1700s. Their population continued to grow and remained relatively large in proportion to the total population until 1870. The first Manitoban census conducted in 1870 revealed that about 50% of the population was Francophone. However, Francophones were quickly outnumbered by a massive wave of immigrants coming from Ontario, the United States, and later directly from Europe. In 1891, the Francophone population, which represented about half of Manitoba's population only 21 years earlier, fell to 7.3% (Blay, 1986, 2010; Manitoba Library Consortium, 2005). Ever since that period, Francophones living in Manitoba have remained a small minority. The ancestors of Winnipeg's French-speaking Caucasians were immigrants arriving directly from the province of Québec or Quebecers who temporarily settled in the United States before coming to
Manitoba as well as immigrants from European countries, mostly France, Belgium, and Switzerland (Blay, 1986, 2010; Manitoba Library Consortium, 2005). Today, Franco-Manitobans make up about 4% of Winnipeg’s population, accounting for about 57% of the Francophone population of Manitoba (Statistics Canada, 2007a). Franco-Manitobans in Winnipeg are located in a few districts and represent the largest concentration of Francophones in Western Canada (Stebbins, 2000).

For thousands of years prior to the arrival of Europeans, First Nations Peoples have occupied the territory that is now known as Manitoba (Corrigan & Annis, 1996). Cohabitation and intermarriage among First Nations individuals and Westerners also gave rise to a new nation known as the Métis nation. The first Manitoba census conducted in 1870 revealed that 80% of Manitobans were of mixed European and First Nations ancestry (Kaye, 1996). As of the 2006 census, 10% of Winnipeg’s population reported being Aboriginal, making Winnipeg the Canadian city with the largest Aboriginal population (Statistics Canada, 2007a). Between 2001 and 2006, Winnipeg’s Aboriginal population grew by 22%, with the Métis representing the fastest growing group. In 2006, they accounted for 60% of Winnipeg’s Aboriginal population, while the First Nations represented 38% (Statistics Canada, 2010b). While Aboriginal Peoples in Canada form three distinct groups—First Nations, Inuit, and Métis—only First Nations individuals were the focus of the study. First Nations Peoples, also referred to as Status and non-Status Indians, represent the descendants of the first inhabitants of the North American continent who are neither Inuit nor Métis (Aboriginal Affairs and Northern Development Canada, 2011). A number of Nations make up Manitoba’s First Nations, the five principal being the Cree, the Ojibway (Anishnaabe), the
Dakota, the Ojibway-Cree, and the Dene Nations. Together, they form three linguistic families: Athapaskan, Siouan, and Algonquian (Corrigan & Annis, 1996; Rust, 2007).

The present study sought to investigate health conceptions among members of these three cultural groups. For the purpose of this research, the English-speaking Caucasians mainly served as a reference group. French-speaking Caucasians and First Nations individuals were considered within the same study because their historical experiences of contact with the English-speaking population in Manitoba are similar in some ways, which provides a basis for comparison. First, they are both long-established cultural groups who were present during the foundation of Manitoba (Blay, 1986, 2010; Corrigan & Annis, 1996; Kaye, 1996; Manitoba Library Consortium, 2005), thus having a long history of contact with the majority group. Second, they were subjected to assimilationist policies aimed at eradicating their cultural heritage and/or language (Bédard, 2002; Indian and Northern Affairs Canada, 2003). Third, although these assimilationist practices affected people in a variety of ways, many individuals within these two groups managed to maintain their traditions to some degree, thus evolving as distinct cultural groups within the Manitoban cultural mosaic (Allan, 1997; James, 2001; Morrissette et al., 1993; Parker, 1983).

Participants

A total of 60 individuals took part in this study: 20 English-speaking Caucasians, 20 French-speaking Caucasians—who will respectively be referred to as Anglophones and Francophones—and 20 First Nations individuals. Each group was comprised of 10 men and 10 women. The characteristics of the participants are presented in Table 1. Descriptive analyses were conducted on perceived health, education, marital status, employment status, income, and age.
Table 1

Summary of Frequencies, Means, and Standard Deviations for Scores on the Demographic Variables as a Function of Culture and Gender

<table>
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<th>Variable</th>
<th>Francophone</th>
<th></th>
<th>Anglophone</th>
<th></th>
<th>First Nations</th>
<th></th>
<th>Total (N=60)</th>
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<td>Man (n=10)</td>
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<td>Man (n=10)</td>
<td>Woman (n=10)</td>
<td>Man (n=10)</td>
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<td>28</td>
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In order to determine whether the sample was homogeneous with respect to the demographic variables that have been shown to be related to conceptions of health, chi-square analyses and an analysis of variance (ANOVA) were conducted. The results of the chi-square analyses are presented in Table 2. At first glance the three cultural groups and the six cultural by gender groups differed with respect to their level of education ($p < .05$). However, since multiple comparisons were performed, the probability of committing a type I error increased. In this case, an alpha correction was used. With 18 comparisons and using a Šidak correction, the alpha level was adjusted to .003. Using this criterion, none of the chi-square coefficients were significant.

A $2 \times 3$ (Culture [Anglophone, Francophone, First Nations] $\times$ Gender [Man, Woman]) between-subjects ANOVA was also conducted in order to examine whether the sample was homogeneous in terms of the age of the participants. The main effects of culture, $F(2, 57) = 0.64, p = .530, \eta^2_p = .02$, and gender, $F(1, 58) = 0.09, p = .765, \eta^2_p < .01$, on age were not significant nor was the Culture $\times$ Gender interaction effect, $F(2, 54) = 0.49, p = .616, \eta^2_p = .02$. It was concluded that the sample was homogeneous with respect to these demographic variables.

**Measures**

Open-ended individual interviews were conducted by a research assistant to gather information on how the participants conceptualize health. Interviews followed a structured format, using a predefined set of questions (Appendix A). The questions were adapted from interview questions that have been used in previous studies (Ailinger & Causey, 1995; Ailinger et al., 2007; Hakim & Wegmann, 2002; McMullin, 2005) and were translated in French by an independent translator.
Table 2

*Chi-Square Tests of Homogeneity of Sample*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Culture</th>
<th>Gender</th>
<th>Culture × Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\chi^2$</td>
<td>$p$</td>
<td>$\chi^2$</td>
</tr>
<tr>
<td>Perceived health</td>
<td>1.89</td>
<td>.756</td>
<td>0.30</td>
</tr>
<tr>
<td>Education</td>
<td>18.63</td>
<td>.017</td>
<td>4.01</td>
</tr>
<tr>
<td>Marital status</td>
<td>8.00</td>
<td>.434</td>
<td>2.43</td>
</tr>
<tr>
<td>Employment</td>
<td>2.50</td>
<td>.287</td>
<td>0.42</td>
</tr>
<tr>
<td>Student</td>
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<td>.622</td>
<td>0.27</td>
</tr>
<tr>
<td>Income</td>
<td>7.06</td>
<td>.315</td>
<td>0.23</td>
</tr>
</tbody>
</table>

*Note. N = 60.*
During the interviews, the participants were asked to talk about their perceptions and definitions of health and about the health practices they engage in to promote their health. The research assistant also used probing techniques to explore important leads that came up during the interviews, which included requesting that the participants provide details and examples to elaborate on their conceptions of health and asking for clarifications. At the end of the interviews, the participants were also asked to complete a short questionnaire (Appendix B) measuring a few demographic variables that have been shown to be related to health conceptions: age, education level, employment status, income, marital status, and perceived health status (e.g., Goins et al., 2011; Kenney, 1992; Laffrey & Crabtree, 1988; Mansour, 1994; Woods et al., 1988).

Procedure

After the approval was granted by the research ethics boards of the University of Northern British Columbia and the Collège universitaire de Saint-Boniface, participants were recruited within the City of Winnipeg with the use of convenience, snowballing, and criterion sampling strategies (Miles & Huberman, 1994). A call for participation (Appendix C), inviting those who were interested in the study to contact the researcher or her research assistant, was posted in local community centers and local newspapers. The call for participation also circulated by emails through local community agencies and their networks, with the approval of the directors of these agencies. In addition to the call for participation, interviewees were asked, at the end of the interview, to inform friends and relatives about the research project and to provide those who showed an interest in the study with the researcher’s or the research assistant’s contact information.
The recruitment process with First Nations individuals proved to be a challenge at first. It required that the researcher create a relation of trust with gatekeepers or key members within the First Nations community of Winnipeg, who would put her in contact with volunteers. However, to make sure that the participants would not feel pressured to take part in the study and that their participation would remain confidential, the key individuals were asked to inform members of the First Nations community about the research project and to ask volunteers to contact the researcher or the research assistant directly.

Criteria for inclusion required that the participants (a) were born in Winnipeg or have attended school in Winnipeg; (b) were still residing in the City of Winnipeg; (c) self-identified as being members of one of the three cultural groups, namely, English-speaking Caucasians, French-Speaking Caucasians, or First Nations; and (d) had an annual income above the poverty line, which in 2006 was evaluated at $21,202 before taxes for cities of the size of Winnipeg (Statistics Canada, 2007b) and below the upper end of the middle class, which was fixed at $100,000. There was one exception to the last criterion. For those who reported being students and who were not working at the time of the interview, but were living with a spouse or a parent as dependents, the poverty line was adjusted according to the total household income and the number of people included in the household. For instance, using Statistics Canada (2007b) cut-off scores, the poverty line was evaluated at $26,396 for a household of two individuals as of 2006. The number of students who reported being dependents was distributed relatively equally among the three cultural groups.

As one of the objectives of this study was to isolate the role culture plays in the way people conceptualize health, it was imperative that the interviews be conducted in a similar way with participants in all three cultural groups. Therefore, it was decided that a research
assistant would conduct all the interviews to reduce the potential influence the researcher could exert on the participants because of her knowledge on the subject. The use of a research assistant also served as a means of reducing the power imbalance between the participants and the interviewer (Richards & Schwartz, 2002) in such a way that the participants would feel free to take part in the study and that they would not feel compelled to discuss certain information they are not comfortable sharing.

However, the use of a research assistant posed ethical considerations that needed to be addressed by the researcher. Because of the exploratory nature of the interview process, some participants shared sensitive information that led to negative feelings. The researcher was aware of her ethical obligations towards the participants and towards the research assistant. It was important to ensure that the participants were not experiencing unnecessary harm and continuous distress following the interviews and that the research assistant was not experiencing distress as well by being the recipient of these negative feelings. Therefore, the researcher and the research assistant held weekly debriefing sessions during which the research assistant was invited to talk about the interviews with the researcher and to discuss the concerns she had with regard to how the interviews went.

Prior to conducting the interviews, the researcher and the research assistant engaged in the process of bracketing, which involved making explicit their own conceptions of the topic at hand (Creswell, 2007). Researchers working from a phenomenological approach have argued that by making their views explicit, researchers can consciously set aside or bracket out their preconceptions, which in turn allows them to refrain from exerting an influence on the participants during the interviews and to minimize bias during data analyses (Creswell, 2007; Moustakas, 1994).
Moreover, the research assistant received training in qualitative interviewing. During the training session, the interview questions were reviewed to make sure that the researcher and the research assistant had a common understanding of each question. Probing techniques were taught. The research assistant was asked to conduct three trial interviews, based on which the researcher provided concrete feedback to improve interviewing skills. After conducting these trial interviews, one practical consideration in preparing for the interviews that became evident was the necessity to give the participants some time to reflect on the questions before the interview. They found it difficult to provide immediate answers to those questions, explaining that they never thought about the meaning of health before. Based on their suggestions, it was decided that the participants would receive the questions the day before the interview was scheduled.

The interviews were conducted with the volunteers at an agreed-upon time and place. Prior to the interview, participants were asked to read and sign a consent form (Appendix D), which was available in French and English. The participants were also given the choice to be interviewed in English or French. The interviews lasted on average between 40 and 45 minutes and were audio recorded with the written consent of the participants. At the end of the interview, participants were asked whether they wanted their contribution to be recognized by having their names mentioned if direct quotations drawn from their interviews were to be presented or whether they wanted to remain anonymous. Therefore, when excerpts from interviews are presented in the Results section, the names of those who wished to be recognized are mentioned, while those who wanted to remain anonymous are only identified by their gender and cultural affiliation. Finally, the participants were asked to complete a short questionnaire measuring demographic variables, which took approximately
five minutes. As a sign of gratitude, the interviewees received a $10 gift certificate for participation. The interviews were then transcribed verbatim by two research assistants and an independent translator translated the French interviews into English.

Two interviews were replaced. One was conducted with one of the first participants who took part in the study. This participant provided very short answers and had difficulty elaborating on her conceptions of health. As a result, the research assistant reacted by asking leading questions, thus invalidating the data. Another interview had to be replaced because it was found only after the interview was completed that the participant did not meet one of the inclusion criteria. The participant, who was a single mother, had an annual income below the poverty line.

Before engaging in the process of analyzing the data, the participants were asked to review their interview transcripts to verify their accuracy. They were invited to remove inaccurate information, add additional information, and provide clarifications or changes if needed.
Results: Qualitative Analysis

In line with the first and the second objectives of this study, open-ended responses to interview questions were analyzed for recurring themes, thereby providing rich qualitative descriptions of the way the participants define health and of the practices they engage in to promote their health. During this process, thematic units were identified in the interview transcripts and were assigned to categories developed inductively (Krippendorff, 2004; Weber, 1990).

The qualitative analysis also partly addressed the third objective of this study, which was to identify similarities and differences in health definitions and health practices among the three cultural groups. Therefore, after the health definition and health practice themes were identified, the cultural groups were compared in order to highlight qualitative variations in their conceptions of health. Indeed, certain health definitions and health practices appeared to be unique to certain groups.

As is customary in health conception research, gender groups were also compared to uncover possible gender variations in health conceptions. Moreover, investigating gender differences within each cultural group allows for the exploration of a possible Culture × Gender interact effect. Studies examining gender variations in health conceptions in Western societies reported that women have a more complex view of health (Bishop & Yardley, 2010; Kenney, 1992; Mansour, 1994), while a study conducted with Chinese participants found the opposite trend (Want, 2004), suggesting that gender differences may vary across cultural groups. The qualitative analysis procedure is outlined in greater details below.
Data Analysis Procedure

The qualitative data were analyzed with the use of NVivo 8 software. NVivo is a powerful tool that allows researchers to organize qualitative data, to sort data into codes or themes, to discover patterns of relationships and connections between themes, to make comparisons among participants or groups of participants according to a given attribute, and to build models (Bazeley, 2007). A phenomenological approach to qualitative inquiry was used as a guide to data analysis. This approach requires that the researcher focus on the participants’ personal experiences with the phenomenon under study in order to capture the meaning they ascribe to the phenomenon (Bazeley, 2007; Creswell, 2007; Moustakas, 1994). In the present study, statements that referred to the way health was experienced by the participants were analyzed, as these experiences are believed to provide the foundation for their definitions of health and their health practices.

The first phase of the qualitative analysis was to code each interview individually. While working on a given interview, the researcher started by immersing herself in the data by reading the interview transcript several times in order to get a general sense of the participant’s responses as a whole (Creswell, 2007; Patton, 2002). Afterwards, the researcher engaged in an initial phase of sorting the data into general categories. Interview responses were first divided into what appeared to be irrelevant information and significant statements (Patton, 2002). Afterwards, the significant statements were sorted again according to whether they referred to definitions of health or to health practices.

The content of these two broad categories was further coded according to emerging themes. Thus, the next step consisted of decomposing the text into thematic units and grouping these units into categories developed inductively (Krippendorff, 2004; Weber,
In a phenomenological approach, coding usually progresses from the specific to the general (Bazeley, 2007). Therefore, narrow categories were first created, a process that Creswell (2007) referred to as horizontalization of the data. During this phase, an inductive approach to coding was used, in which the researcher let the thematic codes arise from the data instead of using theoretically guided thematic codes (Krippendorff, 2004; Weber, 1990).

It has been suggested that using an inductive approach to coding allows the researcher to remain open to a variety of perspectives emerging from the data, which is especially important when conducting research in a cross-cultural setting (Bazeley, 2007; Creswell, 2007; Patton, 2002). Indeed, theoretical codes derived a priori may reflect the views of members of certain cultures, but members of other cultures may not share these views. Therefore, when existing theories or models are not adapted to reflect the particularities of a given population, it has been recommended that an inductive approach be used (Berry et al., 2002). Since only a few studies have examined the health conceptions of First Nations Peoples and Francophones living as minority groups in an urban setting, there was a lack of knowledge from which predefined thematic codes could be theoretically derived. The inductive method was thus appropriate given the exploratory nature of the present study.

However, other researchers have argued that when working from an inductive standpoint, the researcher could involuntarily project his or her own perspective on the data, leading to results that are not objective (Berry et al., 2002). Therefore, various measures were taken to ensure the validity of the results, which included the use of bracketing, having the participants review their interview transcripts to verify their accuracy, and computing an intercoder reliability coefficient.
The initial detailed coding phase led to the creation of a large number of narrow or specific categories. These specific codes were then grouped into larger meaning units or overarching categories (Bazeley, 2007; Cresswell, 2007). According to Bazeley (2007), the last level of abstraction, the most general classification system, should be comprised of approximately five to 10 general themes. During this phase, the researcher moved from an individual level analysis to a group level analysis. Indeed, once the researcher acquired a good sense of the specific themes found across individual interviews, she compared the themes in order to identify commonalities and structures of relationships between them. The codes were organized hierarchically with the general themes encompassing a number of specific themes (Cresswell, 2007; Krippendorff, 2004; Weber, 1990). The results of the content analysis reported in this section are thus organized according to these more general themes. For each of the general themes, a definition is provided along with its related subthemes.

As suggested by Patton (2002), after the themes were identified through inductive thinking and organized structurally into various levels of abstraction, the researcher engaged in a phase of deductive thinking in order to test the appropriateness of the classification system. The objective was to determine whether the categories were exhaustive and thus encompassed all the significant statements (Krippendorff, 2004; Weber, 1990). Moreover, in this phase, the researcher paid attention to the passages that did not fit in any category and she examined information initially identified as irrelevant to the research questions. She worked back and forth between the raw data and her classification system, making adjustments when needed (Patton, 2002).
Definitions of Health: Research Question 1

Throughout the interviews, a few common health definitions clearly emerged. Responses either fell into a negative or a positive definition of health. Within the positive health view, the majority of the participants focused on their individual health, while a few talked about health as expanding beyond themselves. Individual health was discussed in terms of states, processes, and structures. Some participants defined health as an end state that can be achieved, which includes the ability to function, a general sense of well-being, and financial security. Others suggested that health is a life-long process that involves moving in the right direction, namely, aging well, developing one’s potential, and balancing the different aspects of the self. Finally, the participants believed that the state of being healthy or the process of moving towards health encompasses many aspects of the individual self, including the physical, mental, social, and spiritual self. In relation to these structural aspects of the self, many emphasized the notion of wholeness. These general themes and their related subthemes are presented in Figure 1.

Negative health. For as many as 44 of the 60 participants, the meaning of health was expressed in negative terms by referring to what health is not. For them, the absence of certain characteristics was seen as important in order to consider themselves healthy. This negative view of health is well illustrated in the following expression used by a few participants: “You know you’re healthy when you don’t think about it”, as opposed to when you are sick, injured, or in pain.

The most common subtheme that fell into this negative health definition is the absence of disease. While some participants talked about the absence of disease in general, others specifically mentioned certain types of diseases, including physical and mental illness.
Figure 1. Definitions of health across cultural and gender groups
Other participants mentioned that a benign illness would not interfere with their health and only serious or chronic diseases would prevent them from being healthy. As demonstrated by the following example given by an Anglophone woman, some participants distinguished between a condition and a lifestyle illness, considering only the latter counterproductive to good health:

I look at Type 1 diabetes as someone who has a little flaw in terms of how they . . . in terms of how they, umm . . . in how they process insulin. So I’m not even sure I’d call that person sick . . . I would say they have a condition. Type 2 diabetes is entirely different. To me that’s something that you can control and that’s affected by . . . that’s determined by lifestyle, that’s determined by the nutritional choices you make, that’s determined by exercise and that’s controllable. So I consider someone who has diabetes 2, umm . . . sick.

In addition to the absence of disease, health was defined as the absence of pain and disability. A few interviewees went as far as saying that in order to be considered healthy, a person must not only be free of illness, pain, or disability in the present time, but this person should not be prone to illness and injury in general and if he or she ever becomes sick or injured, this person should be able to recover quickly.

Despite the view of health as being the absence of disease, pain, and disability, many participants recognized exceptions to these criteria of good health. In other words, they considered that one can still be healthy in spite of an illness, pain, or a disability, as long as the health condition is under control or as long as one can still function. A Francophone man stated:
For example... someone could be in a wheelchair and be healthy and active. You know, according to one's capabilities... like not going running... so, for example, I think of my grandmother who has difficulty walking because she hurt herself one day, but she goes on being healthy because it doesn’t stop her from being active [translated from French].

**Positive health.** For the 44 participants who provided a negative definition of health, this negative view of health represents only one dimension of their health definitions. In fact, every participant talked about certain characteristics that should be present in a healthy individual, providing a positive description of health. As an Anglophone woman explained, the absence of illness, pain, or disability merely represents a prerequisite for good health, but other characteristics should be present for a person to be considered healthy:

> I guess some people are technically not ill, nothing’s been diagnosed in them, they have no known disease... but they don’t necessarily exude well-being... umm... so I think wellness is beyond, umm, not being ill it’s, umm... it’s that one step beyond where you actually have, umm... an exuberance of health.

**State: Being healthy.** Many interviewees defined health as an end state that is possible to achieve. This state of health includes the ability to function and to perform in daily life, a sense of general well-being, and financial security.

The ability to function in one’s daily life and to be able to achieve a certain level of performance is one of the most common definitions of health provided by the participants. This theme even appeared in the negative definition of health described above, as many participants argued that one could still be healthy despite an illness, pain, or a disability, as long as this person can continue to function relatively normally. The ability to function and to
perform was highlighted again by a total of 44 participants when they talked about health in positive terms.

Within the functionality or performance theme, a few subthemes were identified. For example, some participants argued that being healthy means leading an active life by engaging in a variety of activities that are leisure or work related, as explained by a Francophone woman:

You're able to hang on and put your fullest in your day's work. You're not exhausted, you have enough energy, you're physically healthy to . . . . You exercise, umm, and then you can be socially active. You can look after your house, your house is clean, you have food in the fridge, you cook your meals, you take care of your family if you have one [translated from French].

Others believed that to be considered healthy, one must function without difficulty or major impediments and without having to rely on medications. Finally, a few participants emphasized their social roles by suggesting that being healthy means being able to take care of others, especially their family. In this regard, a First Nations woman opined:

I'm a mother so I think if I'm physically healthy, I can look after my children and look after my family . . . . Same with emotional, like if I'm not, umm, healthy emotionally, then I won't help anybody or myself.

In addition to one's ability to function and to perform optimally in one's daily life, the state of being healthy was also defined in terms of a general sense of well-being. Indeed, in the presence of health, one feels good, alive, and invigorated and the "spirit is elevated". This theme was mentioned by a total of 34 interviewees. The idea of health as a sense of well-being was discussed by some of the participants in relation to the mental, physical, and
spiritual aspects of health. For them, being healthy means feeling good physically, mentally, and spiritually. These subthemes will be discussed in greater details in the section where the four structures of health—physical, mental, social, and spiritual—are presented.

A few interviewees elaborated on the idea of health as a general sense of well-being by suggesting that when they are healthy, they feel like they are at the right place and that everything is going well in their life, as explained by Thomas, a First Nations man:

I’m just sitting there and everything just feels right. Everything is done, I had a good day, and I’m feeling good. Umm, then I know I’m healthy . . . . Those are indicators when you feel right. You know you are where you need to be.

The third theme that fell into the definitions of health in terms of an end state is financial health, which was mentioned by a total of eight participants. Financial health was defined by the majority of these participants as being financially secure, which allows them to meet the basic necessities of life, such as having access to nutritional food and shelter. They argued that in order to be healthy it is important they be financially secure as this can have an impact on the other aspects of health, such as physical health or even mental health, as discussed by a Francophone woman:

Financially . . . I find that it’s . . . I’ve been in a situation where I wasn’t able to pay my bills. And now I find it super important because when I have money, I’m less anxious, less worried. And that’s related to my . . . my mental health. When I don’t need to worry, I can, let’s say, concentrate on other things, umm . . . with my family, or calling a friend or something like that . . . . If my finances are in good shape, I don’t need to worry [translated from French].
*Process: Moving towards health.* As opposed to those who defined health as an achievable end state, a total of 36 participants argued that health is a process that continues throughout life and that has no end state. They defined health as a constant movement towards the positive pole of health and as long as one is moving in the right direction one is considered healthy, as explained by Kayla, an Anglophone woman:

I don’t know if, if there’s per se an end goal in being healthy. Like I don’t know if there’s, there’s a be-all-end-all location. Maybe it’s more so that you always just strive to make your improvements. Like, you can always . . . maybe add something to your life to be healthier, or take something away from your life to be healthier. And it’s travelling in the right direction, towards being more healthy, as opposed to . . . going the opposite direction on a continuum.

Definitions of health in terms of a process fell into three subthemes: balancing the different aspects or structures of the self, developing one’s potential, and aging well.

A total of 19 participants defined a healthy person as someone who is internally balanced, which means that all the aspects of an individual should be equally strong and in balance in relation to one another. These include the physical, mental, spiritual, and social aspects of the self. In other words, a healthy person is someone who attends to all these components with equal attention, as a First Nations man explained:

You have your emotions, you have like your psyche, like your mental, your intelligence, you have your spirituality, and then you have your physical self. So if you look at like a car, say if you’re putting all your energy into one tire, well there are four tires. The car’s gonna be funny, it’s gonna look funny. One tire that’s really inflated and the other ones are kinda deflated. So that’s not like a good balance, your
car's not gonna go nowhere right? So if you have all of them kinda blown up, together, equally, then you're gonna have a good smooth ride.

However, most of the participants who defined health as an internal balance recognized that no one is always perfectly balanced. Thus, they saw this balance as an ideal they aspire to attain. They argued that striving to achieve a balance is a life-long process that requires constant efforts and attention, as suggested by the same participant: “As long as you're conscious of it and you continue . . . to move towards that balance, even though you may never get it”.

Health was also defined in terms of a movement towards developing one’s potential. This theme was found in 14 interviews. These participants described a healthy person as someone who strives to be the best at what he or she does either at work, school, or in other activities and as someone who tries to improve as a person. Being healthy means continuing to grow as an individual and to learn so one can eventually actualize one’s talents and potentials. Again that was seen as a process that continues throughout life. A few participants stressed the importance of considering one’s potential in relation to one’s capabilities and limits. For instance, one Francophone man talked about his grandmother who, because of an injury, has difficulty walking. Even though she cannot do as much as she used to, he still considered her to be healthy: “She’s right up to her limits all the time. She pushes to be up to her limits” [translated from French]. For this reason, he saw her as a healthy person.

Finally, the process of moving towards good health also means aging well. This theme was discussed by a total of six participants. According to them, a healthy person should reach later stages of life and still enjoy good health. This person should continue to feel good, to be active, and to function at an optimal level. A Francophone man talked about
his 80-year-old parents as models of good health:

They’re 80. They still ride their bikes, they still walk, they garden, they travel, they still make their own bread. They eat simply and well and they live yeah . . . they live simply. I think that would be my ideal of health, someone who lives simply. Yeah, I think as you get older, and you can stay healthy, that would probably be a perfect example of good health [translated from French].

This participant went on to say that a person’s health can only be judged when this person has attained old age. He argued that oftentimes what people do to maintain their health when they are younger can in fact have detrimental effects in the long run. Even if these individuals are healthy when they are younger, they may become ill later in life. Thus, health cannot be inferred from a snapshot of one point in life. A truly healthy person is someone who can continue to maintain good health throughout his or her life.

Structures. While defining health, whether it is in terms of an end state or a life-long process, the interviewees also specified which aspects of the individual are encompassed by health. Thus, in addition to a state and a procedural perspective, a structural view of health also emerged from the interviews. These structures include the physical, mental, social, and spiritual aspects of the self. With the exception of two Anglophone men who focused singularly on physical health, all the participants discussed health in reference to at least two of these structures. Many emphasized the concept of wholeness, suggesting that health is not limited to the body but involves the whole person. A total of 44 interviewees explicitly mentioned that health is more than just the physical. The following excerpt taken from an interview conducted with a First Nations woman exemplifies this idea:
A lot of the time it’s seen in the appearance or in, umm, the physical stuff. And in a lot of cases that’s like . . . the person can be the most physically fit person in the world and yet they don’t have all of these other things. Maybe they don’t have family, maybe they don’t have a link to the community, and maybe they don’t believe in a higher power of some sort . . . . I really think that this person can be the most physical person in the world and the best at everything and they’re going to live forever. But that’s not really a healthy person to me.

The concept of wholeness, as defined by the participants, also implies that all the aspects of the self are interconnected and can influence one another. That is why people should pay attention to their health as a whole.

*Physical health.* Physical health is a theme that was discussed by every participant, in varying detail. They all agreed that health means, at least in part, being physically healthy. Physical health first involves being free of physical illness. However, in addition to the absence of illness, every participant also described physical health in positive terms, by referring to the presence of certain characteristics. Their descriptions of a physically healthy person were organized into four subthemes: physical appearance, physical well-being, good physical functioning, and physical strength.

A total of 48 participants described a healthy person in terms of physical appearance. As suggested by a First Nations man, appearance is a reflection of what is going on in the inside and therefore can be a good indicator of health:

Your shell of yourself, sometimes can be a reflection of the inside, you know. If you’re, you know, you’re not exercising, you’re not eating properly then in a way there’s something going on the inside that’s not healthy, right. And it’s showing
physically, it’s showing on the surface.

One of the aspects of a person’s appearance mentioned frequently is weight. A healthy person has to be a certain weight. However, for most participants, the span of what is considered a healthy weight is relatively broad. As long as a person is not obese or severely underweight, this person can be considered healthy. Besides weight, some of the interviewees said they can judge a person’s health by looking at the colour, tone, and complexion of the skin. A healthy person is glowing and has rosy cheeks. This person also has shiny hair and has a bright look in his or her eyes. A few participants also mentioned that good body posture is an indication of health. Finally, a healthy person was defined as someone who looks clean.

In addition to appearance, physical health includes feeling good physically, which was reported by a total of 44 participants. Physical well-being was defined by the participants as having lots of energy and feeling awake, invigorated, and well rested. This theme was often discussed in relation to the theme that pertains to one’s ability to function and perform on a daily basis. The interviewees explained that it is this physical energy and vitality that allows them to get through their day and accomplish their tasks.

A total of 29 participants defined physical health in terms of good physical functioning. By analogy to a machine, they argued that a healthy body is a body that has all its parts working properly. In a similar vein, a healthy individual was described as someone who has all his or her internal organs functioning normally and who has good mobility. Finally, a few participants thought that having a good appetite is an indicator that the body is functioning well.

The last theme that fell into physical health is physical strength. This theme was
discussed by a total of 25 participants. For these participants, being healthy means being physically fit and having strength and endurance, as illustrated by David, an Anglophone man who, because of his work, often has to lift heavy stones:

If I was unable to lift one of the stones that I wanted to work on, onto, umm, the bench . . . right, onto my workbench, then I would consider myself being unhealthy. I would either have to be injured or ill to not be able to do that.

Mental health. Mental health is the second most common aspect of a healthy individual identified by the participants; it was mentioned by 58 interviewees. From their descriptions of what mental health means, it appeared that mental health has an emotional and an intellectual component, the former surfacing more frequently during the interviews.

A total of 57 participants talked about mental health in terms of emotional health. Consistent with what was stated above regarding negative health, the participants included the absence of mental illness in their definitions of emotional health, identifying specifically the absence of depression, anxiety disorders, suicidal thoughts, addictions, and schizophrenia. However, as was the case with physical health, the absence of mental disorder is not sufficient to qualify for good emotional health. Other characteristics discussed with regard to emotional health are emotional well-being; adaptability-coping; and healthy thoughts, beliefs, and expectations.

In total, 54 participants stressed the importance of feeling good emotionally to considering themselves healthy. Emotional well-being was defined in many different ways, but for most of the interviewees, it means being happy. Moreover, “feeling good about myself” and “feeling good in my skin” are expressions that were frequently used during the interviews, suggesting that feeling confident and having good self-esteem are part of the
makeup of an emotionally healthy person. Another common subtheme that fell into emotional well-being is feeling satisfied with what life has to offer. For example, some interviewees argued that being healthy means being satisfied with one’s life, job and with one’s family and friends. Feeling motivated and feeling like engaging in different activities was also mentioned by many participants and is well illustrated by the following comment by a Francophone man:

Waking up in the morning and feeling that it’s fun to wake up that day because there are things to do and there are, umm, ... relationships that ... I can have ... I feel like doing things at the social level as much as for work or, umm, at the intellectual level. Like I feel like keeping myself busy, I feel like doing things, and keeping myself busy [translated from French].

Finally, two other subthemes highlighted by a few participants in relation to the concept of emotional well-being are having a sense of meaning in life and feeling like one has control over one’s life.

The second characteristic of an emotionally healthy individual is one’s ability to adapt and to cope with life’s demands, which was discussed by 35 interviewees. For them, adaptation and coping include the capacity to regulate their emotions when, for instance, a conflict arises or when they face a difficult situation. On the one hand, a majority of participants talked about the importance of being able to cope with stress in the context of the normal demands of modern life. They described a healthy person as someone who can manage the stress of work and/or family. On the other hand, a few participants talked about adaptation and coping in relation to extraordinary life circumstances. For them, being healthy means being able to overcome difficult situations they may have to face during the course of
their lives. For instance, one First Nations woman talked about how difficult it was to cope with the loss of her brother and how that impacted her health, especially her emotional health. Only later in her life, when she had the resources to start coping with her loss, was she able to embark again on the road leading to positive health.

Finally, 25 interviewees described emotional health as having healthy thoughts, beliefs, and expectations. Most of them insisted on the importance of being positive. Indeed, they defined a healthy person as someone who is optimistic and who has a positive outlook on life. For a few participants, being healthy means having realistic perceptions and expectations, as suggested by Lisa, an Anglophone woman:

They wouldn’t have, you know . . . really unrealistic expectations for themselves or really poor perceptions . . . . I don’t think anybody has perfectly accurate perceptions of the world, everybody’s perceptions are a little bit . . . coloured by their experience and their beliefs. But . . . sometimes it starts to cross that line where now you’re really kind of out there, now it doesn’t really seem to even match a reasonable perception of what most people would have.

In addition to emotional health, some 24 participants also included intellectual health in their descriptions of a mentally healthy individual. Intellectual health involves having one’s mental faculties functioning optimally. Some of the participants talked about their memory or their capacity to absorb new information as important indicators of health. The expressions “being sharp” or having a “quick mind” were frequently used while defining intellectual health. Finally, a few participants described an intellectually healthy person as someone who is perceptive and aware of what is going on in his or her surroundings.
Social health. The third aspect of an individual that was included in the participants’ definitions of health is the social self or what the participants referred to as “social health” or as “relational health”. This theme appeared in 39 interviews. One Francophone man mentioned that “a good indication is also seeing people in a context where they’re with their friends” [translated from French]. Thus, it appears that a healthy person presents some qualities that are brought to the forefront when this person is in relationships with others. These include having healthy relationships, socializing, and being altruistic.

A total of 30 participants defined a healthy individual as someone who has healthy relationships. One Francophone woman mentioned that when you are healthy “you get along with others, you can communicate with them” [translated from French]. When discussing this theme, most interviewees talked about having healthy relationships with their family members and friends, while others talked about their coworkers. A few participants also suggested that a healthy person should have good relationships with his or her community in general. Hanwakan, a First Nations man, who defined himself as very healthy, said that “I definitely have a sense of community . . . . So I guess I’m grounded in that sense with the community”.

Another subtheme under the social definition of health is the tendency to socialize more when healthy. A total of 20 participants mentioned that when they are healthy, they usually feel like going out and being around people, whereas when they are not healthy, they tend to isolate themselves. One Anglophone woman considered her disposition to socialize as a barometer of health:

I tend to be very much, umm, an introvert. And it takes a lot of energy out of me to be an extravert . . . . It’s a practiced skill for me to be an extravert, so, umm, the more
extraverted I am, tells me the more energy I have... and that’s coming from... health.

Finally, 18 participants described a healthy person as someone who is altruistic, meaning that this person tends to care about other people. They viewed a healthy individual as a “giving person”, as someone who is generous and willing to help others. A few interviewees also mentioned that contributing to one’s community represents a defining characteristic of health, as Leon, a First Nations man, commented:

Like a healthy person to me is someone who’s almost like a mentor. Like in some of the neighbourhood work I do, it’s often run by people who you realize are healthy. Like they are looking beyond just the... working, but do that extra volunteering. Umm... I think the characteristics of a healthy person like they tend to be giving back to the community more than... it’s not just an existence but they kind of move beyond their own existence by trying to help other people.

Spiritual health. A total of 36 participants included spiritual health in their definition of health. When asked to define what spiritual health means, the most common description, provided 25 interviewees, is a feeling of connection. These participants described healthy individuals as grounded and attentive or aware of what is happening inside themselves or in their surroundings. For some of these participants, being grounded or connected involves being in touch with one’s true inner self. Some mentioned being connected with the natural world and others indicated being connected to a higher being or power of some sort. This feeling of connection was described in the following terms by an Anglophone woman:

If I’m outside, I’m just looking around and really appreciating what’s around me. Yeah. Not being kind of in a blur and just noticing. Noticing and being aware...
don’t get bogged down by all the everyday kind of stuff and artificial stuff that we create. I know it’s kind of just being connected to what’s around me and appreciate what’s real and what’s there, umm . . . and what has been for as long as we know.

In addition to being grounded and connected, spiritual health was variably described as having faith in something and having a sense of guidance. Others talked about having a sense of peace, as feeling fulfilled, or as having a sense of purpose in life. Understanding one’s place in the universe was seen as a sign of good spiritual health by a few participants, exemplified by an Anglophone man who mentioned that “just realising . . . how we’re a very small piece of a puzzle of this world that we live in and . . . just realising where you fit into the big picture”.

For some of the interviewees, feeling connected, especially to one’s inner self, and being able to understand one’s place in the universe was achieved by embracing one’s culture. They defined spiritual health as having a strong cultural identity. When asked what spiritual health means for her, here is what Leigh, a First Nations woman, had to say:

Growing up, umm . . . I didn’t know that part of myself and I felt that was missing in my teenage years. Umm, I was always seeking that, I was always seeking that part of me. Umm, to find that, umm, that identity of who I am as . . . as a person and in this world . . . and once I started finding about my culture . . . is when I . . . felt that I found myself. And that was when I finally, you know, started to . . . have a place in the world. You know, I was starting to identify as becoming grounded.

**Beyond individual health.** For some 15 participants, health expands beyond the mere individual self to include other people in their life, their community, and even the environment. They discussed concepts such as a healthy family, a healthy community, and
environmental health, which means that health can be viewed from a systemic perspective. Most of these participants explained how their own health and that of others around them, of their community, and of the environment are intricately linked with one another, thus exerting a mutual influence.

Those who defined health by referring to the health of other people often mentioned their family members. Dean, a First Nations man, who defined health as striving to maintain a state of balance, explained how being balanced can affect his whole family by saying that “if we’re in balance as individuals, then the two of us living together as a couple and as a family, the family can be in balance”.

A few participants showed concerns for the state of health of their community. This theme was mostly discussed in relation to the impact of the residential school era and the plague of diabetes that “takes a toll” on Aboriginal communities. They explained how these community problems affect individual members, as mentioned by a First Nations woman:

He [father] was raised in the city and again was first-generation residential school, so there were a lot of things that he prevented in our family. He grew up with some of that stuff I think way back. Umm, but I think in the end with all the effects of the residential school on them going away to school and not being able to parent . . . I bet you can say almost 90% of the people have been affected by the residential school and stuff in one respect or another. Your grandfather, your mother, your father, your sister, your uncle, your brother, your cousin, or anybody. And it’s made a huge impact so I don’t think a lot of people give the impact to, umm, the actual . . . what it actually impacted. And it’s generations and generations down.
Finally, when asked what health means, a few interviewees also discussed the health of the environment, emphasizing the poor state of the environment and how it can affect people. Leigh, a First Nations woman made the following comment:

Because not honouring her [Mother Earth] anymore, she’s hurting. She provided for us, she gave us all these gifts to work with . . . to maintain life here on earth. And now that people are taking advantage and not giving back to her, she’s reacting with all these things . . . . You know, all these nasty disasters happening all over, she’s trying to say something.

Health Practices: Research Question 2

When asked what they do to promote their health, many interviewees emphasized that one has to be proactive in order to be healthy and has to be willing to put in the effort. However, some of the participants advised that before engaging in any health practices, it is important that one tries to understand one’s particular health needs and to tailor one’s practices accordingly. The health practices identified by the participants include, in order of frequency, having a healthy lifestyle, managing one’s mental health by maintaining a balanced life and by managing stress, maintaining good relationships with others, seeking medical care when needed, engaging in spiritual and religious practices, and maintaining traditions and culture. Finally, a few participants also discussed practices aimed at promoting the health of others and preserving the environment. The themes that pertain to health practices are presented in Figure 2.
Figure 2. Health practices across cultural and gender groups
Individual health practices.

*Being proactive.* A total of 40 participants argued that in order to be healthy, one must be proactive. They believed that health and illness do not affect people randomly, but are in great part the results of one’s actions or inactions. Thus, health is something that requires constant effort and attention and people have to attend diligently to their health in order to achieve or maintain good health.

In that respect, 15 interviewees talked about the role of prevention to ensure long-term health. Kayla, an Anglophone woman, mentioned that a “healthy person is concerned about prolonging their healthy state”. In order to maintain health, one needs to look beyond the present and think about the future. One has to assess the long-term effects of one’s present actions. Lisa, an Anglophone woman, referred to some people in these terms: “Even if they’re healthy now, their lifestyle is so unhealthy that I wouldn’t think of them being healthy in a year”. Overall, these participants reported engaging in health practices with the objective of preventing health problems in the future and maintaining long-term health. Some participants indicated they try to be proactive by seeking information about health-related matters. Health knowledge was seen as an important tool by 11 interviewees. One Anglophone man reported that knowledge is empowering and it allows him to take responsibility for his own health. Another participant mentioned having read many books on mental health when she was struggling with mental health issues. She wanted to educate herself in order to understand what she could do to promote her mental health.

Finally, a few interviewees talked about the importance of prioritizing their health. They argued that health is one of the most important things in life and therefore, it should be at the top of one’s list of priorities. One Francophone woman made the following comment:
Health is very, very important. It’s the most important thing, you know, being healthy . . . . That’s what I hear old people say. Old people, what they say the most often is when they lose their health, they lose their reason to live. Being sick takes everything away from them. And they say, “we took it for granted when we were healthy. And now that we aren’t, we’re unhappy” [translated from French].

**Understanding one’s health needs.** Understanding one’s particular health needs is a theme that was found in 38 interviews. These participants argued that everyone has different needs, which require different practices to fulfill those particular needs. Therefore, before engaging in practices aimed at promoting one’s health, one must try to understand one’s particular needs, as there is not one course of action that is applicable to everyone. One Anglophone woman argued:

> It’s not necessarily the behaviours that . . . that are defining your health. But for some people they might need to do certain things to stay healthy. A diabetic needs to take insulin to stay healthy . . . umm, a person who gains weight very easily may need to participate in fitness plans to stay healthy. And mentally I think people who are more prone to being emotional need to practice certain strategies to stay mentally healthy.

Some of the participants elaborated on the actual process they engage in as a means of understanding their health needs. This process involves three distinct steps: monitoring, analyzing, and tailoring.

Monitoring means being in touch with the different aspects of one’s self, including the body, the mind, and the spirit. Some interviewees believed in the importance of constantly being aware and conscious of their current health state in order for them to identify their strengths and weaknesses. Many of them discussed this process of monitoring
by referring to their physical self. As one First Nations man reported, "I'm the one that knows my body the best and I know when things are out of whack". Joanne, an Anglophone woman, talked about how she listens to her body in the following terms:

I think part of being healthy is being connected enough to your body to recognize what it's telling you. You know, just like, you know, if you eat something bad your stomach won't feel good. Well if your stress level is too high, for myself I know my body will tell me, and it's like oh that's why I had a headache yesterday, maybe I just need to calm down a little bit. Or maybe I just need to take a little more time in the evening and just . . . chill or whatever it might be.

Once they have identified that something is not working properly with respect to their health, some participants reported engaging in a second step, which involves analyzing the situation. Before taking any concrete steps to resolve the problem, they described how they try to understand or pinpoint what could have caused their health problems. Kayla, an Anglophone woman, reported that when she is not feeling right, she attempts to "construct a theory of how [she has] gotten to where [she] is". The participants reasoned that by understanding its underlying causes, they could more effectively address the issue.

Finally, after analyzing their current health state and identifying any health problems they may be struggling with as well as possible causes, the third step is to tailor their health practices in order to meet their particular health needs. The actual practices they mentioned will be discussed in the remainder of this chapter.

*Lifestyle.* The most common health practice identified by the participants is to adopt a healthy lifestyle. With the exception of one First Nations woman, all the participants discussed the importance of having a healthy lifestyle in order to promote their health. When
asked what a healthy lifestyle represented, it was variably defined in terms of engaging in healthy behaviours, avoiding unhealthy behaviours, practicing moderation, creating an environment conducive to good health, and returning to a more traditional way of living.

All participants who talked about lifestyle reported engaging in what they described as healthy behaviours. The two most common behaviours discussed by the interviewees are exercising and paying attention to one’s diet, which means eating nutritious food, while avoiding high-calorie diets and processed food. Some participants talked about the healing properties of sleep and they reported trying to get eight or nine hours of sleep every night. A few participants also mentioned trying to lose weight or having lost weight in the past, which was mostly discussed in relation to exercising and nutrition. Finally, some participants also considered maintaining good personal hygiene important to staying healthy.

Some interviewees reported avoiding behaviours that can negatively impact their health. This theme was found in 28 interviews. These harmful behaviours include consuming alcohol, smoking cigarettes, and taking drugs. Some participants reported avoiding prescription drugs unless they suffer from a health condition that absolutely requires medications.

A third theme pertaining to lifestyle that was often discussed in relation to engaging in healthy behaviours and avoiding unhealthy behaviours is practicing moderation. Moderation was mentioned by 29 interviewees. They considered that it is acceptable and even salutary to indulge in certain behaviours once in a while, such as consuming alcohol, as long as they are not abusing it. In a similar vein, they believed that being obsessed about one’s health and engaging in healthy behaviours excessively are not part of a healthy lifestyle either. As one First Nations man reported “too much of anything is not good for you”.

Overall, these participants believed in the value of moderation, as Bluma, an Anglophone woman, explained:

For example my brother, umm . . . we’re ten and a half months apart. And he . . . he works out every second day or daily and he feels all guilty if he eats a piece of cake. And we’ll go out and I’ll have the cake and he says “how can you eat that?” . . . So he probably considers himself healthy because he works out and he works hard to maintain this. And I look at him and I don’t see health . . . because there’s nothing wrong with being flexible . . . if you’re very rigid and unforgiving, that’s not healthy.

A total of nine participants also talked about the importance of creating an environment that is conducive to good health, especially in their own home. Some of them mentioned keeping their house clean. Other participants emphasized the importance of avoiding exposure to harmful agents that can be found in food, household products, or the environment. These include pollution, pesticides, hormones, and chemical products. For instance, one interviewee talked at length about avoiding products such as Febreze and Plug-ins in his house as he believes these chemicals can have long-lasting effects on health.

Finally, six participants described a healthy lifestyle by referring to a previous time, a time when people were not suffering from many of the health problems that emerged with modern life. They try to go back to what they consider a more traditional lifestyle, which involves eating food that comes “from the farm and from the land”, having their own garden and raising their own livestock. One First Nations man believed that Aboriginals could be healthier if they would change their diet to eat more traditional foods. One Francophone man described what he referred to as a “simple lifestyle” in the following terms:
There’s so much complexity in our world today. I don’t think complexity is necessary to live in a healthy way. I think people who have a simpler life probably have . . . they’re healthier just because their lives are simpler . . . . Eating locally can be less stressful sometimes . . . . You know, your diet is less varied so, it’s simpler. Maybe it’s not as exiting but, in the long run, I think it’s more . . . . I don’t have a car and I think it’s probably the most important thing obviously for your health. I walk and I ride my bike and it changes how I run errands, because then it becomes really a question of what I need to feed myself . . . . I make everything from scratch. Like my food is all homemade [translated from French].

Managing mental health. Besides lifestyle, the most common health practices described by the interviewees are aimed at promoting their mental health. With the exception of two Anglophone men, all the participants talked about how they manage their mental health, the most common approaches being maintaining a balanced life and managing stress.

Twenty-eight participants discussed the importance of having a balanced life in order for them to be healthy. Having a balanced life was defined as having variety in one’s life and engaging in different activities as opposed to focusing one’s energy on one area. As one Anglophone man suggested, “if you’re either working all the time or, you know, not working and socializing all the time, either one is not healthy”. Finding a balance between family and work and still having time for themselves was frequently discussed by many participants and proved to be a challenge for some of them. But they seem to understand the importance of finding that balance. Some of them reported trying not taking on too many responsibilities, especially at work. “I don’t think being a workaholic is necessarily really healthy”, argued one Anglophone woman. By dispersing their energy through different spheres of their lives,
problems that might arise in one area would not affect them as much, as a Francophone woman explained:

I work and I go to school but I try to make it so that I still have time to do things I like, so, umm, so that it's not just school and work. Umm, so, sometimes I'm a bit overloaded, but I try to do a little of everything, that way I have the balance I need to feel well . . . . So, little problems I have don't seem that bad because I still have things I like . . . . The things I like carry more weight than little everyday problems [translated from French].

Some participants went into detail about the kind of activities they engage in to maintain a balance in their lives. These responses were discussed around three subthemes: engaging in pleasant activities; engaging in stimulating, intellectual activities; and engaging in meaningful activities.

A total of 49 participants described activities they engage in to promote their health and that bring them pleasure, the most frequent one being spending time with family and friends. Others mentioned making time for themselves, which for some involves spending time alone to partake in activities they enjoy. Thomas, a First Nations man, described how he devotes the last hour of his day to do the things he feels like doing. He argued that “it’s not about other people, it’s about me during that last hour”. That is how he manages to find a balance with the many responsibilities he faces during the day. A few other interviewees also mentioned the importance of having a good sense of humour and laughing.

Twenty-one participants reported engaging in stimulating and intellectual activities as a means of promoting their emotional and intellectual health. The most frequently reported activity is continual learning. For example, one Anglophone man who retired shortly before
the interview reported that he was planning on learning to play the violin. He talked at length about the importance of keeping busy and of stimulating his mind. A few participants discussed how learning about other cultures is also stimulating for them.

Finally, for 17 participants, one way to achieve balance in life and to promote health is by engaging in meaningful activities. Some of them argued that finding meaning in their lives is achieved through work. Others reported engaging in volunteer work. A few interviewees explained that helping others and contributing to their community are meaningful activities that bring them satisfaction and pleasure.

In addition to maintaining balance in life, managing stress was frequently discussed as a means of promoting mental health. This theme was found in 27 interviews. Some of the participants talked about managing stress in relation to keeping a balanced life, especially between their professional and their personal lives, as for them, maintaining balance in life represents a way of reducing stress. In that respect, a few interviewees emphasized the importance of living at a slower pace as suggested by Alex, a First Nations man, who argued that “sometimes, you want things to slow down because everything is moving too fast”. A Francophone woman expressed a similar idea:

Today, the fact that we can do those things so quickly, people expect we do everything faster. So, it’s true that on the one hand, it could have its advantages. Like me, I can write an email, and I can expect a really quick answer... but now people expect that you do 50 times more because we’re 50 times faster, so we can do 50 times more. But I’m not so sure we’re meant to go that fast. I think generally society needs to take a step back. I think that would be good because there are so many people who are stressed [translated from French].
Others found that planning ahead of time and being organized help them deal with the stress that comes with their responsibilities at work, at school, or as parents. A few participants also suggested that managing their finances and making sure they have enough money saved are important to reduce stress. Finally, another strategy used by a few participants is to remove themselves from stress-inducing situations. For instance, one Anglophone man reported that his previous job was very stressful and he decided to switch to another less stressful job.

Besides maintaining a balanced life and managing stress, a few other themes emerged from the interviews as participants discussed practices they engage in to promote their mental and emotional health. Fifteen participants stressed the importance of learning to “let go”, finding ways to release negative emotions such as anger, sadness, and grief, as opposed to keeping them inside. Having some kind of outlet, such as writing, art, or music, was found to be helpful for releasing these emotions. Finally, cultivating a positive attitude and seeking counselling are two other themes found under managing mental health. Both these themes were mentioned by 14 interviewees.

**Maintaining good relationships.** Maintaining good relationships is a theme that was commonly found in the interviews. When asked what they do to promote their health, 39 interviewees mentioned trying to keep good relationships with their friends, their family members, their colleagues, and people in their community. This theme is different from the one described earlier under maintaining a balanced life, which involves spending time with family and friends. For those participants, spending time with their close relations was viewed as something that brings them pleasure and that helps them keep balance in life, whereas the participants who stressed the importance of having good relationships put more
emphasis on actually ensuring their relationships with their close ones are positive and healthy. Alex, a First Nations man, explained how conflicts can damage relationships and in turn how they can affect one’s health:

One thing I really want to touch on is like arguments . . . fights . . . they’re damaging to children, they’re damaging to yourself, to your soul. There’s no point to it but they happen and then of course there’s a time when you can say ok, I’m sorry, or you can take a reality check and you can be like ok, what do I gotta do better next time? You know. And maybe there’s like, umm, restitution you know, umm, how can I repair the situation? How can I . . . cause I can’t have the moment back. The moment already passed and now I got to live with that . . . I used to be very argumentative or whatever, I don’t know how to say that . . . but, umm . . . that, that can pull me down very much.

For some of the participants, having good relationships first means carefully choosing with whom they want to get involved. They try to surround themselves with positive people, while avoiding or setting boundaries with people who can “bring them down”. In pursuing relationships with people who are important in their lives, a few participants believe it is important to have open communication channels to make sure their relationships remain healthy.

Having positive relationships, especially with family and friends, allows one to build a strong network on which one can rely when facing difficult situations. A total of 31 interviewees reported having sought support from others in the past when they experienced difficulties, including health-related problems.

*Medical practices.* A total of 33 participants reported having sought medical care in
the past or seeking medical care on a regular basis in order to maintain their health. Most of them used Western medicine, while a few also reported using alternative or traditional medicine, either as their sole source of health care or in combination with Western medicine.

Among the interviewees who reported using Western medicine, 26 mentioned visiting health professionals on a regular basis or sporadically. Those who consult health professionals more regularly tend to do this as a preventive measure. They reported seeing their doctors, their dentists, or their optometrists on an annual basis. Among these participants, twelve also talked about the importance of having regular checkups and of doing screening tests to ensure early detection of any illness they may have. As mentioned earlier when discussing mental health practices, a few participants also disclosed having sought help from mental health professionals in the past. Eight participants reported taking medications or having taken medications in the past. One First Nations woman stressed the importance of complying with medication regimens prescribed by her doctor. Finally, one participant reported having used immunization measures to prevent illness.

Alternative medicine or traditional medicine was used by a total of 10 participants. A few of them argued that alternative medicine complements Western medicine. The most common sources of alternative medicine are massage therapists, chiropractors, naturalists, and herbalists. One First Nations participant also mentioned seeking care from elders or a medicine man.

**Spiritual-religious practices.** A total of 26 participants mentioned engaging in spiritual and religious practices in order to promote their health. These practices include going to church and praying to God or to the Creator. A few interviewees reported drawing their spiritual strength from nature. They explained how being outside, preferably outside of
the city, and being in touch with nature help them maintain their health, especially their spiritual health.

Another spiritual practice discussed is to take some time alone to reflect, to "check in", or "get in touch" with one's inner self and to reflect on one's life. Alex, a First Nations man, explained this process of reflecting:

You got to step back and . . . maybe you need some introspection, you need to look at yourself and who am I? Or what am I? Or what's going on in my life? Or maybe you might need to . . . retrospect on . . . the past, whether it be your life or someone else's life, because then you can obviously take from examples just be like, oh look what happened to that person when he did this . . . . Step back and say what am I here for? What am I going to do? What am I doing with my life? Where am I headed?

Some reported engaging in this process of reflecting through meditation and yoga. One Francophone man said that the practice of weaving allows him to take the time to reflect about himself and on his life.

**Maintaining traditions/culture.** Maintaining traditions and culture is the last individual health practice identified. A total of 22 participants emphasized the importance of keeping their culture alive as they draw strength from it, which in turn helps them promote their health. Culture and traditions are maintained by engaging in traditional practices, by maintaining ties with people of the same cultural background, and by speaking one's maternal language.

A total of 16 interviewees reported engaging in traditional cultural practices in order to promote their health. For the most part, these traditional practices involve taking part in ceremonies. These ceremonies include sweat lodge, smudging, sundance, fasting, feasts,
gatherings, sharing circles, pipe ceremonies, women ceremonies, full moon ceremonies, and drum ceremonies. The interviewees explained how these ceremonies allow them to release or to let go of stress and negative emotions. Here is what Leigh, a First Nations woman, had to say about ceremonies in general and about the use of the drum, which she described as a healing tool:

That's what affects our health, we just pile this stuff on, keep it inside of us. And you know, we just add on to it right. And it's still in there and yet you know you feel this heaviness. But you don't . . . might not know how to release it sometimes. And for me when I go [to ceremonies], I release all that and I feel so much better . . . . Last night, me and my granddaughter, we drummed and sang and you know, umm, I felt better, I felt so much better . . . . I felt the vibrations of the drum . . . like it was just knocking off all that stuff . . . all that negativity.

The use of traditional practices was often discussed in relation to spiritual practices as participants engage in these ceremonies for spiritual reasons.

For nine participants, maintaining ties with people of the same cultural background was seen as important. Mario explained how, as a Francophone, it is important for him to have a sense of belonging to the Francophone community. He reported that community gatherings represent "a link that holds us together, that unites us" [translated from French]. For some of the First Nations interviewees, talking to elders was described as a means of maintaining their culture and of promoting their health. Dale explained that maintaining ties with other First Nations individuals represents a way of building a network of support:

It could be a simple thing as, umm, a lot may go to powwows for strength and a connection with other First Nations Peoples. Umm, some may attend ceremonies,
share with elders, share with fellow First Nations persons what they are feeling.

Because a lot of us do feel, umm, tension that other cultures wouldn't feel, tensions from within. So we may struggle to sort of, umm, accept a lot of issues.

Finally, two participants mentioned that maintaining their maternal language was important for them. One Francophone woman described how she frequently speaks English since her partner and her colleagues are Anglophones, but when she is with other Francophones she feels more like herself: “I’m in my environment, I’m comfortable and at ease and then I’m happy” [translated from French].

**Beyond individual health practices.** In addition to the practices described above, which are aimed at promoting one’s individual health, some of the interviewees also explained what they do to promote the health of other individuals, of their community, or of the environment. Indeed, when asked what they do to keep themselves healthy, 18 participants discussed health practices that expand beyond their individual health.

While talking about ways to promote their health, a total of nine participants also included their family members, especially their children, in the discussion. They described what they do as parents to ensure the health of their children, which, among other things, includes making sure they get enough exercise, eat well, and go to ceremonies.

In addition to taking care of their family, eight interviewees reported devoting time to their community. They described the work they do in their community, often with children, in order to promote a healthy community. This theme was often discussed in conjunction with the theme pertaining to engaging in meaningful activities because this work in the community not only contributes to the community itself, but also to feelings of well-being,
meaning, and satisfaction within themselves. Eric, a First Nations man, described the work he did with adolescents in his community:

I was helping a lot of youth, umm, to try to stay away from gang life and it was very, umm . . . . I wanted them, to show them that there are other alternatives to a healthy lifestyle which I was trying to promote through gardening . . . umm, and learning about . . . umm . . . doing something that is positive around a community and building it.

Another First Nations woman explained how she is concerned with the health problems that affect Aboriginals. She is studying to become a nurse because she would like to help Aboriginal Peoples.

Finally, six interviewees talked about what they do in order to preserve the environment, which includes recycling, using alternative sources of energy, and commuting.

**Cross-Cultural and Cross-Gender Comparison**

As a means of addressing the third objective of this study, the health definitions and health practices were compared to identify differences among cultural and gender groups with regard to their views on health.

With respect to cultural variations, the theme that pertains to maintaining traditions and culture appeared in interviews conducted with First Nations and Francophone participants, while this theme was not discussed by Anglophones. A related subtheme, which fell under lifestyle—returning to a traditional lifestyle—was also discussed exclusively by Francophone and First Nations participants. Another subtheme—spiritual health, defined as having a strong cultural identity—was found only in interviews conducted with First Nations participants.
The concept of health as a developmental process, defined as balancing the different aspects of the self and developing one's potential, was found predominantly among First Nations and Francophone interviewees.

Two general themes were discussed almost exclusively by First Nations participants: beyond individual health and beyond individual health practices. A few related subthemes were also found predominantly among First Nations interviewees. Within the functionality theme, the great majority of participants who talked about the ability to take care of others, especially family members, were First Nations participants. Moreover, within the social health theme, two subthemes—having healthy relationships with the community and contributing to one's community—appeared more frequently among First Nations interviewees.

Within the First Nations group, gender variations emerged. Being able to take care of others, having healthy relationships with the community, and health practices aimed at promoting the health of family members are subthemes that were found predominantly among First Nations women. No other gender differences were observed.
Results: Quantitative Analysis

Scoring Procedure

Statistical analyses, using SPSS 18 software, were conducted on the data. A scoring sheet (Appendix E) was developed and was used by two research assistants who each scored half of the data according to the major themes identified during the content analysis. The interviews were randomly assigned to the two research assistants. They read the interview transcripts and classified passages of text according to the classification system developed during the qualitative analysis. Afterwards, they assigned scores to the participants with respect to each health definition and health practice dimension identified using a 0 to 3 point scale. Scores were assigned according to the importance interviewees ascribed to the dimensions, which was evaluated based on the frequency and the amount of details provided when discussing these dimensions. According to Bazeley (2007), ideas that are of significance for the participants tend to be repeated and elaborated in more detail. Thus, for any given dimension, a score of zero was assigned to participants who did not mention the dimension or did not express any idea related to this dimension. Interviewees who mentioned the dimension but provided no description or only a few details received a score of one. Those who mentioned the dimension and somewhat elaborated, explained, or described it were assigned a score of two. Finally, those who mentioned the dimension and elaborated at length by giving examples and emphasizing the importance of this dimension received a score of three.

Prior to engaging in the process of scoring the interviews, the researcher met with the research assistants and reviewed with them the list of dimensions for which each participant would receive scores. The researcher defined each dimension and the research assistants were
then asked to describe the dimensions in their own words. The researcher brought up a few clarifications when needed until the researcher and the research assistants reached a common understanding of the meaning of each dimension.

**Preliminary Analyses**

**Reliability and validity.** The researcher and the two research assistants independently scored 15% of the data, representing nine interviews. These nine interviews were selected randomly, three in each of the three cultural groups. Pearson correlation coefficients were computed as a means of providing a measure of reliability of the scoring procedure. Pearson correlations were used instead of other intercoder reliability measures, such as Cohen's Kappa or Fleiss' Kappa, as the latter are more appropriate when used with nominal data, whereas correlations take into account the ordering in the scale (Gwet, 2010). The interscorer reliability coefficients were .91 between the two research assistants, .91 between the researcher and one of the assistants, and .93 between the researcher and the other assistant. These coefficients are satisfactory. Thus, the scoring procedure used to quantify the data proved to be an appropriate measure to discriminate responses according to the major themes or dimensions identified during the content analysis.

The convergent and divergent validity of the health definition and the health practice dimensions was evaluated through the inspection of the Pearson correlation matrices presented in Table 3 and Table 4. For the health definition dimensions, the strongest correlation appeared between spiritual health and physical health; with respect to health practices, the strongest correlation was found between maintaining traditions and beyond individual health practices.
<table>
<thead>
<tr>
<th>Dimension</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
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<td>2. Functionality</td>
<td></td>
<td>-21</td>
<td>-26*</td>
<td>.07</td>
<td>-0.4</td>
<td>-14</td>
<td>-41**</td>
<td>-11</td>
<td></td>
</tr>
<tr>
<td>3. Well-being</td>
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<td>-22</td>
<td>.26*</td>
<td>.19</td>
<td>.32*</td>
<td>.01</td>
<td></td>
<td></td>
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<td>4. Developmental health</td>
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<td>.07</td>
<td>.17</td>
<td>.34**</td>
<td>.47**</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Physical health</td>
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<td>.11</td>
<td>-28*</td>
<td>.55**</td>
<td>.34**</td>
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<td>6. Mental health</td>
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<td>.29*</td>
<td>.16</td>
<td>-0.08</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>7. Social health</td>
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<td>.14</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>8. Spiritual health</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td>9. Beyond individual health</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. N = 60.  
* p < .05. ** p < .01.
Table 4

*Pearson Correlations among Health Practice Dimensions*

<table>
<thead>
<tr>
<th>Dimension</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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</thead>
<tbody>
<tr>
<td>1. Proactive</td>
<td>—</td>
<td>.54**</td>
<td>-.04</td>
<td>.10</td>
<td>-.07</td>
<td>.05</td>
<td>.42**</td>
<td>-.06</td>
<td>-.23</td>
<td>-.11</td>
</tr>
<tr>
<td>2. Understand health needs</td>
<td>—</td>
<td>-.45**</td>
<td>.13</td>
<td>-.04</td>
<td>.35**</td>
<td>.03</td>
<td>-.08</td>
<td>.02</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>3. Lifestyle</td>
<td>—</td>
<td>-.21</td>
<td>.02</td>
<td>-.29*</td>
<td>-.16</td>
<td>-.21</td>
<td>-.36**</td>
<td>-.35**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Balanced life</td>
<td>—</td>
<td>.18</td>
<td>.27*</td>
<td>-.08</td>
<td>.23</td>
<td>-.06</td>
<td>.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Manage stress</td>
<td>—</td>
<td>.16</td>
<td>-.11</td>
<td>-.03</td>
<td>-.14</td>
<td>-.26*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Maintain relations</td>
<td>—</td>
<td>.00</td>
<td>.01</td>
<td>.04</td>
<td>.02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Medical practices</td>
<td>—</td>
<td>-.10</td>
<td>.08</td>
<td>.07</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Religious practices</td>
<td>—</td>
<td>.42**</td>
<td>.24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Maintain traditions</td>
<td>—</td>
<td>.61**</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Beyond individual health practices</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. N = 60.*

* p < .05. ** p < .01.
According to Tabachnick and Fidell (2001), correlation coefficients above .70 and below -.70 suggest a problem in terms of divergent validity. Although some of the dimensions were found to be significantly correlated with one another, which may suggest that they measure similar or overlapping constructs, no correlation coefficients exceeded these values, providing a measure of divergent validity. The dimensions appeared to measure distinct constructs and therefore, none of the dimensions were combined together for the main analyses.

Descriptive analysis. The results of descriptive analyses conducted on the health definition and health practice dimensions are presented in Table 5. For each of these dimensions, the mean scores and the standard deviations are provided for each of the six cultural by gender groups separately and for the sample as a whole.

Principal Analyses

Cultural and gender variations in health conceptions: Research question 3. In order to address the third objective of this study, two 2 × 3 (Culture [Anglophone, Francophone, First Nations] × Gender [Man, Woman]) between-subjects multivariate analyses of variances (MANOVAs) were performed. These analyses were conducted to examine quantitative variations with respect to health definitions and health practices as a function of culture and gender. The analyses were conducted separately for the health definition dimensions and the health practice dimensions and were conducted only on the dimensions that were shared by at least two cultural groups. Although it was found during the content analysis that some dimensions were discussed by participants in more than one cultural group, differences may still be found in terms of the importance they ascribed to these dimensions.
### Table 5

**Summary of Means (and Standard Deviations) for Scores on the Health Definition and Health Practice Dimensions as a Function of Culture and Gender**

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Francophone</th>
<th></th>
<th>Anglophone</th>
<th></th>
<th>First Nations</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Woman</td>
<td>Man</td>
<td>Woman</td>
<td>Man</td>
<td>Woman</td>
<td>Man</td>
<td></td>
</tr>
<tr>
<td></td>
<td>((n=10))</td>
<td>((n=10))</td>
<td>((n=10))</td>
<td>((n=10))</td>
<td>((n=10))</td>
<td>((n=10))</td>
<td>((N=60))</td>
</tr>
<tr>
<td>Negative health</td>
<td>1.0 (0.82)</td>
<td>0.8 (0.63)</td>
<td>1.3 (0.82)</td>
<td>1.5 (1.08)</td>
<td>1.1 (1.10)</td>
<td>0.5 (0.85)</td>
<td>1.0 (0.92)</td>
</tr>
<tr>
<td>Functionality</td>
<td>0.9 (0.99)</td>
<td>1.1 (0.99)</td>
<td>1.3 (0.95)</td>
<td>1.9 (0.88)</td>
<td>1.3 (1.06)</td>
<td>0.9 (0.88)</td>
<td>1.2 (0.98)</td>
</tr>
<tr>
<td>Well-being</td>
<td>2.1 (0.74)</td>
<td>2.1 (0.88)</td>
<td>2.1 (0.88)</td>
<td>0.8 (0.79)</td>
<td>2.0 (0.67)</td>
<td>1.7 (0.48)</td>
<td>1.8 (0.86)</td>
</tr>
<tr>
<td>Developmental health</td>
<td>1.0 (0.47)</td>
<td>1.4 (1.17)</td>
<td>0.8 (0.79)</td>
<td>0.2 (0.42)</td>
<td>1.3 (1.16)</td>
<td>1.8 (1.14)</td>
<td>1.1 (1.01)</td>
</tr>
<tr>
<td>Physical health</td>
<td>2.2 (0.42)</td>
<td>2.2 (0.42)</td>
<td>2.0 (0.00)</td>
<td>2.5 (0.71)</td>
<td>1.7 (0.67)</td>
<td>1.7 (0.48)</td>
<td>2.1 (0.57)</td>
</tr>
<tr>
<td>Mental health</td>
<td>2.4 (0.52)</td>
<td>2.4 (0.52)</td>
<td>2.1 (0.88)</td>
<td>1.7 (1.06)</td>
<td>2.3 (0.48)</td>
<td>2.2 (0.42)</td>
<td>2.2 (0.70)</td>
</tr>
<tr>
<td>Social health</td>
<td>1.5 (0.85)</td>
<td>1.5 (0.85)</td>
<td>1.2 (0.79)</td>
<td>0.7 (0.67)</td>
<td>1.2 (0.92)</td>
<td>1.5 (0.85)</td>
<td>1.3 (0.84)</td>
</tr>
<tr>
<td>Spiritual health</td>
<td>0.9 (0.99)</td>
<td>1.0 (1.15)</td>
<td>1.3 (1.25)</td>
<td>0.5 (1.08)</td>
<td>1.7 (1.25)</td>
<td>2.3 (0.67)</td>
<td>1.3 (1.19)</td>
</tr>
<tr>
<td>Beyond individual health</td>
<td>0.0 (0.00)</td>
<td>0.3 (0.67)</td>
<td>0.1 (0.32)</td>
<td>0.0 (0.00)</td>
<td>1.1 (1.10)</td>
<td>0.8 (0.62)</td>
<td>0.4 (0.72)</td>
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<tr>
<td>Proactive</td>
<td>2.1 (0.88)</td>
<td>1.8 (0.63)</td>
<td>2.2 (1.03)</td>
<td>1.8 (1.03)</td>
<td>1.7 (0.48)</td>
<td>1.4 (0.70)</td>
<td>1.8 (0.83)</td>
</tr>
<tr>
<td>Understand health needs</td>
<td>1.9 (1.10)</td>
<td>1.8 (0.79)</td>
<td>2.5 (0.71)</td>
<td>1.5 (0.97)</td>
<td>2.2 (0.92)</td>
<td>1.8 (1.14)</td>
<td>2.0 (0.96)</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>2.5 (0.53)</td>
<td>2.5 (0.53)</td>
<td>2.5 (0.53)</td>
<td>2.8 (0.42)</td>
<td>1.6 (0.84)</td>
<td>2.4 (0.70)</td>
<td>2.4 (0.69)</td>
</tr>
<tr>
<td>Dimension</td>
<td>Francophone</td>
<td></td>
<td>Anglophone</td>
<td></td>
<td>First Nations</td>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------</td>
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<td>------------</td>
<td>-------------------------</td>
<td>---------------</td>
<td>-------------------------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>Woman (n = 10)</td>
<td>Man (n = 10)</td>
<td>Woman (n = 10)</td>
<td>Man (n = 10)</td>
<td>Woman (n = 10)</td>
<td>Man (n = 10)</td>
<td>Total (N = 60)</td>
</tr>
<tr>
<td>Balanced life</td>
<td>1.7 (0.67)</td>
<td>1.5 (1.08)</td>
<td>1.3 (0.82)</td>
<td>1.1 (1.20)</td>
<td>1.2 (0.79)</td>
<td>1.3 (1.06)</td>
<td>1.4 (0.94)</td>
</tr>
<tr>
<td>Manage stress</td>
<td>1.5 (0.97)</td>
<td>0.7 (0.82)</td>
<td>0.5 (0.53)</td>
<td>0.7 (0.95)</td>
<td>0.5 (0.71)</td>
<td>0.4 (0.52)</td>
<td>0.7 (0.83)</td>
</tr>
<tr>
<td>Maintain relations</td>
<td>1.5 (1.08)</td>
<td>1.1 (0.74)</td>
<td>1.9 (0.99)</td>
<td>0.7 (0.82)</td>
<td>1.5 (1.18)</td>
<td>1.2 (0.63)</td>
<td>1.3 (0.97)</td>
</tr>
<tr>
<td>Medical practices</td>
<td>1.0 (1.05)</td>
<td>0.3 (0.67)</td>
<td>1.0 (0.94)</td>
<td>0.9 (0.88)</td>
<td>1.3 (0.82)</td>
<td>0.6 (0.52)</td>
<td>0.9 (0.86)</td>
</tr>
<tr>
<td>Religious practices</td>
<td>0.8 (1.03)</td>
<td>1.1 (1.20)</td>
<td>0.8 (1.14)</td>
<td>0.2 (0.63)</td>
<td>1.2 (1.14)</td>
<td>1.7 (0.95)</td>
<td>1.0 (1.09)</td>
</tr>
<tr>
<td>Maintain traditions</td>
<td>0.2 (0.42)</td>
<td>0.3 (0.48)</td>
<td>0.0 (0.00)</td>
<td>0.0 (0.00)</td>
<td>1.7 (1.16)</td>
<td>1.6 (0.70)</td>
<td>0.6 (0.94)</td>
</tr>
<tr>
<td>Beyond individual health practices</td>
<td>0.10 (0.32)</td>
<td>0.10 (0.32)</td>
<td>0.10 (0.32)</td>
<td>0.10 (0.32)</td>
<td>1.9 (0.74)</td>
<td>0.9 (0.88)</td>
<td>0.5 (0.85)</td>
</tr>
</tbody>
</table>
The objective of the statistical analyses was to uncover possible quantitative variations with regard to shared health definitions and health practices. As a result, two dimensions, namely, beyond individual health and beyond individual health practices, which were found in interviews conducted with First Nations participants, were not included in the analyses.

Prior to conducting the MANOVAs, the dependent variables were first examined for fit between their distributions of scores and the MANOVA's assumptions, which include univariate and multivariate normality, absence of univariate and multivariate outliers, linearity, homogeneity of variance-covariance matrices, and absence of multicollinearity (Tabachnick & Fidell, 2001). These assumptions were tested with grouped data, namely, with each of the six cultural by gender groups separately.

With the exception of univariate and multivariate normality, all the assumptions were deemed satisfactory. An inspection of the skewness and kurtosis coefficients and of the graphical representations of the distributions of scores of the dependent variables revealed the presence of non-normal distributions, especially when examined separately for each cultural by gender group. However, according to Tabachnick and Fidell (2001), MANOVA is relatively robust to violation of normality, as long as cell sizes are equal and non-normality is not caused by the presence of outliers, which was not the case here. Moreover, the Central Limit Theorem suggests that the sampling distribution of means approximates normality even when the distribution of scores is not normal, as long as sample cell sizes are relatively large: between 20 and 30 cases or more per cell (Tabachnick & Fidell, 2001). Therefore, violation of normality probably did not affect the results of the analyses examining for culture and gender main effects. However, for the interaction effect, where there were only
108

10 cases per cell, non-normality was potentially problematic. Therefore, it was decided that a transformation method be applied to the problematic variables and to perform the main analyses with the original variables and with the transformed variables. The analyses provided similar results. Therefore, it was decided that the results obtained from the analyses conducted with untransformed variables be presented.

Since two MANOVAs were conducted, one for the health definitions and one for the health practices, a Šidak correction was used to take into account the inflated type I error that results from performing multiple tests. The alpha level was thus adjusted to .025. With the use of the Wilks’ lambda criterion, it appeared that the combined health definition dimensions were significantly affected by culture, $F(16, 94) = 3.05, p < .001, \eta^2_p = .34$, but not by gender, $F(8, 47) = 1.94, p = .075, \eta^2_p = .25$, nor by the Culture × Gender interaction, $F(16, 94) = 1.02, p = .443, \eta^2_p = .15$.

To investigate the effect of culture on each individual health definition dimension, a series of one-way between-subjects ANOVAs were first performed. With eight comparisons being conducted and using a Šidak correction, an alpha level of .006 was selected. The results are presented in the ANOVA column in Table 6.

The results showed a significant effect of culture on developmental health. Post hoc Scheffé tests revealed that First Nations participants ($M = 1.55$) adhered to a developmental definition of health to a greater extent than Anglophones ($M = 0.50$), but Francophones ($M = 1.20$) did not differ from First Nations and Anglophone participants. A significant culture effect was also found on physical health. Post hoc comparisons using Scheffé tests showed that Francophones ($M = 2.20$) and Anglophones ($M = 2.25$) rated physical health as more important compared to First Nations participants ($M = 1.70$).
Table 6

*Effect of Culture on Individual Health Definition Dimensions*

<table>
<thead>
<tr>
<th>Dimension</th>
<th>ANOVA</th>
<th></th>
<th>ANCOVA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$F$</td>
<td>$p$</td>
<td>$F$</td>
<td>$p$</td>
</tr>
<tr>
<td>Physical health</td>
<td>6.96</td>
<td>.002</td>
<td>6.96</td>
<td>.002</td>
</tr>
<tr>
<td>Mental health</td>
<td>2.85</td>
<td>.066</td>
<td>3.37</td>
<td>.042</td>
</tr>
<tr>
<td>Functioning</td>
<td>2.40</td>
<td>.116</td>
<td>2.02</td>
<td>.143</td>
</tr>
<tr>
<td>Negative health</td>
<td>2.57</td>
<td>.085</td>
<td>0.51</td>
<td>.601</td>
</tr>
<tr>
<td>Social health</td>
<td>2.39</td>
<td>.100</td>
<td>1.29</td>
<td>.285</td>
</tr>
<tr>
<td>Developmental health</td>
<td>6.63</td>
<td>.003</td>
<td>2.49</td>
<td>.093</td>
</tr>
<tr>
<td>Well-being</td>
<td>3.12</td>
<td>.052</td>
<td>1.49</td>
<td>.235</td>
</tr>
<tr>
<td>Spiritual health</td>
<td>6.40</td>
<td>.003</td>
<td>3.07</td>
<td>.055</td>
</tr>
</tbody>
</table>

*Note.* $N = 60.$
Francophone and Anglophone participants did not differ from one another with respect to the importance they ascribed to physical health. Finally, the results revealed that culture is significantly related to spiritual health. Post hoc Scheffé tests indicated that First Nations participants ($M = 2.00$) ascribed more importance to spiritual health compared to Anglophones ($M = 0.90$) and Francophones ($M = 0.95$), while these two groups did not differ from one another.

The results of these ANOVAs should be interpreted with caution since these analyses do not take into account the interdependence between the dependent variables. Indeed, it is possible that the differences found between cultural groups with respect to their health definitions are not due to the effect of culture per se, but may be explained by these definitions being correlated with one another. Indeed, by looking at the Pearson correlation matrix presented in Table 3, it appeared that developmental health was negatively related to physical health and was positively related to spiritual health, while physical and spiritual health shared a strong negative correlation.

Therefore, as a means of taking into account the correlations between the dependent variables, the effect of culture on each health definition dimension was also investigated using a Roy-Bergmann stepdown procedure in a series of analyses of covariance (ANCOVAs). Each dependent variable was entered in the model in a given order with the highest priority variable tested with an ANOVA and treated as a covariate in the following analyses. All the other dependent variables were tested with an ANCOVA and were then added to the list of covariates as they enter into the model. The order of entry of the health definition dimensions was based on the frequency with which each dimension was discussed.
by the participants during the interviews: physical health, mental health, functioning, negative health, social health, developmental health, well-being, and spiritual health.

Roy-Bergmann stepdown analysis requires that, at each step, the regression between the dependent variable and the covariates is the same for all groups (Tabachnick & Fidell, 2001). At every step of the procedure, homogeneity of regression was achieved. The results of the Roy-Bergmann stepdown analysis are presented in the ANCOVA column in Table 6.

Since physical health was entered at step one in the model, the results are the same as the ones obtained with an ANOVA. However, it appeared that when the effect of culture on physical health, mental health, functioning, negative health, and social health was taken into account, the effect of culture on developmental health was no longer significant. Moreover, when taking into account the effect of culture on the aforementioned variables as well as on developmental health and well-being, the effect of culture on spiritual health was no longer significant.

A second 2 × 3 (Culture [Anglophone, Francophone, First Nations] × Gender [Man, Woman]) between-subjects MANOVA conducted on the health practice dimensions revealed a main effect of culture, $F(18, 92) = 4.44, p < .001, \eta^2_p = .47$, on the dependent variables taken together, using the Wilks’ lambda criterion. However, the results showed that the combined health practice dimensions were not significantly affected by gender, $F(9, 46) = 1.72, p = .112, \eta^2_p = .25$, nor by an interaction of culture and gender, $F(18, 94) = 1.24, p = .249, \eta^2_p = .19$.

The effect of culture on each individual health practice dimension was investigated using a series of one-way between-subjects ANOVAS. The results are presented in the ANOVA column in Table 7.
Table 7

**Effect of Culture on Individual Health Practice Dimensions**

<table>
<thead>
<tr>
<th>Dimension</th>
<th>ANOVA</th>
<th>ANCOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(F)</td>
<td>(p)</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>5.61</td>
<td>.006</td>
</tr>
<tr>
<td>Being proactive</td>
<td>1.83</td>
<td>.170</td>
</tr>
<tr>
<td>Maintain relations</td>
<td>0.02</td>
<td>.983</td>
</tr>
<tr>
<td>Understand needs</td>
<td>0.16</td>
<td>.855</td>
</tr>
<tr>
<td>Balanced life</td>
<td>1.09</td>
<td>.344</td>
</tr>
<tr>
<td>Medical practices</td>
<td>0.81</td>
<td>.452</td>
</tr>
<tr>
<td>Manage stress</td>
<td>3.71</td>
<td>.030</td>
</tr>
<tr>
<td>Religious practices</td>
<td>4.23</td>
<td>.019</td>
</tr>
<tr>
<td>Maintain traditions</td>
<td>44.41</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

*Note. \(N = 60\).*
A Šidak alpha correction of .006 was used again to interpret the results as a means of reducing the risk of committing a type I error due to multiple comparisons. The results revealed a significant effect of culture on lifestyle. Post hoc Scheffé tests indicated that Anglophone participants ($M = 2.65$) placed more importance on lifestyle as a means of promoting their health when compared to First Nations participants ($M = 2.00$). Francophones ($M = 2.50$) did not significantly differ from the other two cultural groups. In addition, it was found that culture was significantly related to maintaining traditions. Post hoc comparisons, using Scheffé tests, revealed that more First Nations participants ($M = 1.65$) reported striving to maintain their traditions and culture as a health-promoting practice when compared to Francophones ($M = 0.25$) and to Anglophones ($M = 0.00$).

As was the case with the health definition dimensions, the differences found between the three cultural groups with respect to lifestyle and maintaining traditions may not be due to the effect of culture on these health practices, but to these dimensions being interrelated. An inspection of Table 4 revealed that lifestyle is negatively correlated with maintaining traditions. Therefore, in order to take into consideration the interdependence between the health practice dimensions, the results of the ANOVAs were complemented with a Roy-Bergmann stepdown analysis. The results are presented in the ANCOVA column in Table 7. The order of entry of each dependent variable was again determined by the frequency with which they were discussed during the interviews: lifestyle, being proactive, maintaining relations, understanding health needs, balanced life, medical practices, managing stress, religious practices, and maintaining traditions. At every step of the procedure, homogeneity of regression between the cultural groups was achieved.
Since lifestyle was entered at step one, the results of the Roy-Bergmann stepdown analysis were identical to the results obtained with an ANOVA. The results also revealed that when the effect of culture on all the other variables was taken into account, the effect of culture on maintaining traditions remained significant.

**Relationship between health definitions and health practices: Research question 4.** In order to address the fourth objective of this study, a series of multiple regression analyses were conducted on the health conception variables as a means of exploring whether definitions of health could predict the health practices the participants engage in to promote their health.

Prior to conducting these analyses, the predicted variables, namely, the health practice dimensions, were examined for fit between their distributions and the assumptions of regression analyses. These assumptions include univariate and multivariate normality, linearity, homoscedasticity, absence of univariate and multivariate outliers, and absence of multicolinearity. The three cultural groups were examined as a whole.

All the assumptions were deemed satisfactory with the exception of univariate and multivariate normality. Two variables appeared to be positively skewed: maintaining traditions and beyond individual health practices. In addition, the distribution of two other variables—maintaining relations and religious practices—was slightly flat. Contrary to MANOVA, regression analyses require that individual scores be normally distributed. Therefore, it was decided that the variables that showed non-normal distributions were transformed. Several transformation methods were applied to the problematic variables until their scores became more normally distributed. A logarithm transformation was applied to maintaining traditions and beyond individual health practices. No transformations could
bring maintaining relations and religious practices closer to normality. In addition to violation of the normality assumption, Durbin-Watson tests of independence of errors were inconclusive for a few variables: being proactive, understanding health needs, managing stress, religious practices, and beyond individual health practices. Therefore, the results of the analyses conducted with these variables should be interpreted with caution.

Ten multiple regressions analyses were conducted with the health definition dimensions being used as predictors, while the health practices were treated in turn as the predicted variables. The results are presented in Tables 8 and 9. A Šidak alpha correction of .005 was used to interpret the results in order to take into account the increased probability of committing a type I error as a result of multiple tests being performed. For two variables—maintaining traditions and beyond individual health practices—the analyses were first performed with the original data and then a second time, using the transformed data. The results were compared and it appeared that the models were slightly improved with the use of the transformed variables. Therefore, only the results of the analyses obtained with the transformed variables are presented here.

On the one hand, the results of the regression analyses revealed that the health definition dimensions taken together were not significantly related to the practices of being proactive, maintaining a balanced life, managing stress, and consulting health-care professionals. On the other hand, significant results were found with the other health practices.
Table 8

Regression Coefficients [and 95% Confidence Intervals] of Being Proactive, Understanding Health Needs, Lifestyle, Balanced Life, and Managing Stress on Health Definition Dimensions

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Proactive</th>
<th>Understand needs</th>
<th>Lifestyle</th>
<th>Balanced life</th>
<th>Manage stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative health</td>
<td>0.12</td>
<td>0.16</td>
<td>-0.12</td>
<td>-0.04</td>
<td>0.19</td>
</tr>
<tr>
<td></td>
<td>[-0.18, 0.42]</td>
<td>[-0.13, 0.44]</td>
<td>[-0.33, 0.09]</td>
<td>[-0.36, 0.28]</td>
<td>[-0.12, 0.49]</td>
</tr>
<tr>
<td>Functioning</td>
<td>0.21</td>
<td>0.18</td>
<td>-0.03</td>
<td>0.26</td>
<td>-0.10</td>
</tr>
<tr>
<td></td>
<td>[-0.09, 0.50]</td>
<td>[-0.11, 0.46]</td>
<td>[-0.24, 0.18]</td>
<td>[-0.06, 0.58]</td>
<td>[-0.40, 0.21]</td>
</tr>
<tr>
<td>Well-being</td>
<td>0.32*</td>
<td>0.47**</td>
<td>-0.19</td>
<td>0.21</td>
<td>0.13</td>
</tr>
<tr>
<td></td>
<td>[0.05, 0.59]</td>
<td>[0.21, 0.73]</td>
<td>[-0.39, 0.00]</td>
<td>[-0.09, 0.50]</td>
<td>[-0.16, 0.41]</td>
</tr>
<tr>
<td>Developmental health</td>
<td>0.00</td>
<td>-0.07</td>
<td>-0.11</td>
<td>0.19</td>
<td>0.08</td>
</tr>
<tr>
<td></td>
<td>[-0.26, 0.26]</td>
<td>[-0.32, 0.18]</td>
<td>[-0.29, 0.08]</td>
<td>[-0.09, 0.47]</td>
<td>[-0.18, 0.35]</td>
</tr>
<tr>
<td>Physical health</td>
<td>0.02</td>
<td>-0.47</td>
<td>0.17</td>
<td>-0.02</td>
<td>-0.29</td>
</tr>
<tr>
<td></td>
<td>[-0.51, 0.56]</td>
<td>[-0.99, 0.04]</td>
<td>[-0.21, 0.55]</td>
<td>[-0.59, 0.56]</td>
<td>[-0.84, 0.26]</td>
</tr>
<tr>
<td>Mental health</td>
<td>0.07</td>
<td>-0.16</td>
<td>-0.09</td>
<td>0.25</td>
<td>0.12</td>
</tr>
<tr>
<td></td>
<td>[-0.28, 0.42]</td>
<td>[-0.49, 0.04]</td>
<td>[-0.33, 0.16]</td>
<td>[-0.13, 0.62]</td>
<td>[-0.24, 0.48]</td>
</tr>
<tr>
<td>Social health</td>
<td>-0.08</td>
<td>0.37*</td>
<td>-0.14</td>
<td>0.20</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td>[-0.37, 0.21]</td>
<td>[0.09, 0.65]</td>
<td>[-0.35, 0.06]</td>
<td>[-0.12, 0.51]</td>
<td>[-0.25, 0.36]</td>
</tr>
<tr>
<td>Spiritual health</td>
<td>0.01</td>
<td>-0.12</td>
<td>0.04</td>
<td>0.10</td>
<td>-0.25</td>
</tr>
<tr>
<td></td>
<td>[-0.24, 0.26]</td>
<td>[-0.36, 0.12]</td>
<td>[-0.14, 0.21]</td>
<td>[-0.17, 0.37]</td>
<td>[-0.51, 0.01]</td>
</tr>
<tr>
<td>Beyond individual</td>
<td>-0.05</td>
<td>0.03</td>
<td>-0.34*</td>
<td>-0.04</td>
<td>-0.24</td>
</tr>
<tr>
<td>health</td>
<td>[-0.41, 0.31]</td>
<td>[-0.32, 0.37]</td>
<td>[-0.60, -0.09]</td>
<td>[-0.43, 0.34]</td>
<td>[-0.61, 0.12]</td>
</tr>
<tr>
<td>( F )</td>
<td>1.31</td>
<td>4.51**</td>
<td>4.01**</td>
<td>2.05</td>
<td>0.92</td>
</tr>
<tr>
<td>( R^2 )</td>
<td>.19</td>
<td>.45</td>
<td>.42</td>
<td>.27</td>
<td>.14</td>
</tr>
</tbody>
</table>

Note. \( N = 60 \).

\*p < .05. \**p < .005.
Table 9


<table>
<thead>
<tr>
<th>Dimension</th>
<th>Maintain relations</th>
<th>Medical practices</th>
<th>Religious practices</th>
<th>Maintain traditions</th>
<th>Beyond ind. practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative health</td>
<td>0.23</td>
<td>0.32*</td>
<td>-0.02</td>
<td>-0.01</td>
<td>-0.05</td>
</tr>
<tr>
<td></td>
<td>[-0.08, 0.54]</td>
<td>[0.02, 0.62]</td>
<td>[-0.27, 0.23]</td>
<td>[-0.06, 0.05]</td>
<td>[-0.11, 0.01]</td>
</tr>
<tr>
<td>Functioning</td>
<td>-0.04</td>
<td>0.02</td>
<td>0.06</td>
<td>0.02</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>[-0.35, 0.26]</td>
<td>[-0.28, 0.32]</td>
<td>[-0.18, 0.31]</td>
<td>[-0.04, 0.07]</td>
<td>[-0.03, 0.09]</td>
</tr>
<tr>
<td>Well-being</td>
<td>0.13</td>
<td>0.16</td>
<td>0.05</td>
<td>-0.04</td>
<td>-0.04</td>
</tr>
<tr>
<td></td>
<td>[-0.15, 0.41]</td>
<td>[-0.12, 0.43]</td>
<td>[-0.18, 0.27]</td>
<td>[-0.09, 0.02]</td>
<td>[-0.09, 0.01]</td>
</tr>
<tr>
<td>Developmental health</td>
<td>0.04</td>
<td>-0.07</td>
<td>0.35**</td>
<td>0.01</td>
<td>-0.03</td>
</tr>
<tr>
<td></td>
<td>[-0.23, 0.31]</td>
<td>[-0.33, 0.20]</td>
<td>[0.14, 0.57]</td>
<td>[-0.04, 0.06]</td>
<td>[-0.09, 0.02]</td>
</tr>
<tr>
<td>Physical health</td>
<td>-0.75*</td>
<td>0.20</td>
<td>-0.02</td>
<td>-0.03</td>
<td>-0.06</td>
</tr>
<tr>
<td></td>
<td>[-1.30, -0.20]</td>
<td>[-0.34, 0.74]</td>
<td>[-0.47, 0.42]</td>
<td>[-0.13, 0.07]</td>
<td>[-0.17, 0.04]</td>
</tr>
<tr>
<td>Mental health</td>
<td>0.32</td>
<td>0.08</td>
<td>-0.09</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>[-0.04, 0.68]</td>
<td>[-0.28, 0.43]</td>
<td>[-0.38, 0.20]</td>
<td>[-0.04, 0.09]</td>
<td>[-0.04, 0.10]</td>
</tr>
<tr>
<td>Social health</td>
<td>0.32*</td>
<td>-0.21</td>
<td>-0.18</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>[0.02, 0.62]</td>
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<td>[-0.05, 0.06]</td>
<td>[-0.05, 0.07]</td>
</tr>
<tr>
<td>Spiritual health</td>
<td>-0.17</td>
<td>0.03</td>
<td>0.59**</td>
<td>0.08**</td>
<td>0.05*</td>
</tr>
<tr>
<td></td>
<td>[-0.43, 0.08]</td>
<td>[-0.23, 0.28]</td>
<td>[0.38, 0.80]</td>
<td>[0.03, 0.13]</td>
<td>[0.00, 0.10]</td>
</tr>
<tr>
<td>Beyond individual health</td>
<td>-0.14</td>
<td>0.34</td>
<td>0.11</td>
<td>0.13**</td>
<td>0.15**</td>
</tr>
<tr>
<td></td>
<td>[-0.51, 0.23]</td>
<td>[-0.02, 0.71]</td>
<td>[-0.19, 0.41]</td>
<td>[0.07, 0.20]</td>
<td>[0.08, 0.22]</td>
</tr>
<tr>
<td>$F$</td>
<td>3.29**</td>
<td>1.65</td>
<td>11.74**</td>
<td>6.98**</td>
<td>5.25**</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.37</td>
<td>.23</td>
<td>.68</td>
<td>.56</td>
<td>.49</td>
</tr>
</tbody>
</table>

Note. $N = 60.$

* $p < .05.$ ** $p < .005.$
An inspection of Table 8 revealed that the health definition variables were significantly related to the practice of understanding one's health needs. The regression coefficients showed that only one definition of health was significantly and positively related to understanding one's health needs, namely, well-being. Those who defined health in terms of well-being were more likely to report monitoring their health needs as a means of promoting their health.

The results presented in Tables 8 and 9 showed that the definitions of health taken together were significantly related to lifestyle and maintaining good relationships. However, none of the health definitions appeared to be independently related to these health practices ($p > .005$).

With respect to religious practices, the regression model was found to be significant. Two definitions of health appeared to be significantly and positively related to religious practice: developmental health and spiritual health. Those who defined health as a developmental process or as having a spiritual component were more likely to report engaging in spiritual practices to promote their health.

Using a logarithm transformation on maintaining tradition scores, the results reported in Table 9 revealed that the health definitions were significantly related to the practice of maintaining traditions. By considering the health definitions independently, it appeared that spiritual health and beyond individual health were positively related to the practice of maintaining one's traditions and culture. Those who defined health in terms of spiritual health and those who defined health by referring to others, their community, or the environment were more likely to report promoting their health by engaging in practices aimed at maintaining their culture.
Finally, using a logarithm transformation on beyond individual health practice scores, the results of the regression analysis presented in Table 9 showed that the health definition dimensions were significantly related to the practice of taking care of others, of one's community, or the environment. Only one definition of health was significantly linked to this health practice. Indeed, those who held a definition of health that expands beyond themselves to include their family, their community, or the environment were more likely to report health practices aimed at promoting the health and well-being of others and the environment.
Discussion

Principal Research Findings

Conceptions of health. The first two objectives of this study were to provide rich descriptions of the health definitions and health practices of Anglophones living in an urban setting as well as Francophones and First Nations individuals, whose historical experiences of contact with the Anglophone population present some parallels.

With respect to health definitions, content analyses of the interviews produced the following interesting findings: First, it appears that illness is not seen as the opposite end of a healthy-sick continuum. Rather, the presence or absence of illness is conceptualized as one dimension of the superordinate health-nonhealth construct, which is in accordance with the dichotomy and organization corollaries described by George Kelly in his theory of personal construct (Bannister, 1962; Blowers & Connor, 1996; Kelly, 1963, 1970/2003). Second, the presence-absence of illness dimension seems to be evolving, possibly to reflect new realities, such as the rising prevalence of chronic health conditions (Statistics Canada, 2010a). Indeed, this dimension is changing from the absence of disease to manageable disease. Participants believe that one can still be healthy despite the presence of illness, disability, or pain, as long as these health conditions are under control and do not impede one’s daily functioning. Third, the health conceptions of the participants are multidimensional. In addition to a negative definition of health, the interviewees hold a positive view of health. They consider that certain characteristics should be present in a healthy individual. Many participants define positive health as an end state, which includes a general sense of well-being and functional capability, while others perceive health in terms of a dynamic developmental process towards positive growth and actualization of one’s potential. Finally, the participants also believe that
health is not limited to the realm of the body, but also includes other aspects of the self, such as the mind, spirit, and social self. These perspectives point to a more holistic view of health, recognizing that all aspects of the individual are interconnected and can influence one another. These findings suggest that the health conceptions of the interviewees depart from the biomedical model.

This multidimensional health conception offers a less fatalistic perspective than the traditional biomedical health perspective: An individual who suffers from a chronic condition can still move towards fulfilling other health expectations, since health is viewed as more than the mere absence of disease and since health and illness are not seen as two mutually exclusive states (Laffrey, 1986a; Pender, 1990). In contrast with the multidimensional health views of the participants, past studies have shown that the biomedical model continues to guide medical practices and health research (Alonso, 2004; Cass et al., 2002; Julliard, Klimenko, & Jacob, 2006; Li, Desroches, Yum, Koehn, & Deagle, 2007; Ngo-Metzger et al., 2003; Pahal & Li, 2006; Reiff et al., 1999; Thorne, TernulñNyhlin, & Paterson, 2000). Findings of the present study shows that health strategies should not be solely geared towards treating disease as this approach might not lead to health as conceptualized by the patients. Effective health strategies should also aim at achieving positive health at the physical, mental, social, and spiritual levels. Health professionals as well as researchers working in medical fields should be aware of alternative views of health.

Concepts of health defined as functional capability, a general sense of well-being, and a developmental process are more in line with the health definitions reported in multidimensional models (Baumann, 1961; Pender, 1990; Saylor, 2004; Schlenger, 1976; Smith, 1981). Moreover, the four structures or aspects of the self encompassed or subsumed
by the state of being healthy or the process of moving towards positive health—the physical, mental, social, and spiritual aspects of the self—parallel the ones advocated in the biopsychosocial model (WHO, 1948) as well as the ones described by Saylor (2004). The emphasis placed on the concept of wholeness also reflects Saylor’s health model.

With respect to health-promoting strategies, the interviewees engage in a variety of health practices. Many believe in the importance of being proactive. They view health as dynamic and changing and as being the result of one’s actions. They argued that even though a person is free of disease, he or she can exert harmful effects on his or her health in the future by engaging in unhealthy behaviours. Being healthy and maintaining long-term health require constant effort and attention. The participants particularly emphasized the importance of having a healthy lifestyle. This finding suggests that when planning and implementing health-promoting programs, simply educating people about the benefits of exercising and eating well may not be sufficient as every participant in this study recognizes the role of nutrition and exercises in promoting long-term health. The broader social context surrounding one’s choice of behaviours should be taken into account (Stevens, 2006).

Cultural and gender variations in health conceptions. The third objective of this study was to identify possible cultural and gender variations in the participants’ health definitions and their health practices.

We found that First Nations participants have a unique way of defining health. Compared to the Francophones and Anglophones, who talked about health from an individual perspective, First Nations interviewees tended to provide a definition of health that goes beyond the boundaries of the individual self to include their family, their community, and the environment. They emphasized the interconnections that exist between their own
health and the health of their close relatives, their community, and the environment and how they can influence one another. For instance, some First Nations participants discussed how the effect of the high prevalence rate of diabetes among Aboriginals and the effect of their parents’ or grandparents’ experiences in residential schools reverberate throughout the entire Aboriginal community, affecting their own health and well-being.

Another health definition that distinguished First Nations participants from Anglophones and Francophones is spiritual health. Although content analyses of the interviews revealed that members of all three cultural groups shared this health definition, statistical analyses showed that First Nations participants placed more importance on spiritual health compared to Anglophones and Francophones.

Finally, First Nations participants also emphasized a developmental health definition to a greater extent than Anglophones, but did not significantly differ from Francophones. Developmental health was often defined by First Nations interviewees as a process of balancing the different parts that comprise the individual self, including the physical, mental, social, and spiritual self. Other studies examining the health conceptions of Aboriginals have also found that health is often defined as an internal balance between the body, the mind, the spirit, and the social self (Hunter, Logan, Goulet, & Barton, 2006; Labun & Emblen, 2007; McMullin, 2005; Polakoff & Gregory, 2002).

With respect to health practices, one theme was found among First Nations and Francophone participants—maintaining traditions and culture. Past studies have shown that members of cultural minorities often report promoting their health by maintaining their traditions and culture (Hakim & Wegmann, 2002; Jan & Smith, 1998; Labun & Emblen, 2007; McMullin, 2005; Van Uchelen et al., 1997). Although this theme was shared by
Francophone and First Nations interviewees, statistical analyses revealed that First Nations participants embraced the practice of maintaining their traditions and culture to a greater extent. Moreover, when asked what spiritual health meant for them, some of the First Nations participants explained that spiritual health involves being connected to their culture and having a strong cultural identity. McMullin (2005), who reported similar results with Aboriginal Peoples in Hawaii, explained this emphasis on the maintenance of culture by suggesting that among Aboriginals, the quests to revitalize their cultural identity and their health are intricately linked. Revitalizing their cultures can have a beneficial impact on the health of Aboriginal Peoples.

Finally, one health practice appeared to be unique to the First Nations participants: beyond individual health practice. When asked what they do to promote their health, these participants not only talked about practices aimed at promoting their own health, but also discussed what they do to contribute to the health of other individuals, especially their family members, the health of their community, and that of the environment.

These unique health views articulated outside the boundaries of the individual self by First Nations individuals can be explained by the theory of individualism-collectivism and the self-construal theory (Capstick et al., 2009; McCarthy et al., 2004). Collectivism is described as a social system structured in a way that people are interconnected and are perceived as being constituent parts of a larger group (Hofstede, 1980; Triandis et al., 1986). Similarly, people who hold an interdependent self-construal view themselves as connected with others and as a part that belongs to a larger social whole. Their self-concept is based on their relative position within their community and on their network of relationships with significant others (Markus & Kitayama, 1991). Since First Nations individuals are believed...
to share certain values that are more in line with collectivism and an interdependent construal of the self, it is not surprising that they hold a definition of health that includes their family members, their community, and their environment and that they emphasize the interconnections between their own health and the health of others and the environment.

In addition to these two major themes, a few related subthemes reflecting collectivist and interdependent values were also discussed predominantly by First Nations participants. For instance, within the functionality theme, one subtheme—being able to take care of others, especially family members—was more frequently discussed by First Nations participants; within the social health theme, two subthemes—having healthy relationships with the community and contributing to one’s community—appeared more frequently in interviews conducted with First Nations.

Among First Nations participants, gender differences were also found with respect to these subthemes. Being able to take care of others, having healthy relationships with the community, as well as health practices aimed at promoting the health of family members are themes that were discussed predominantly by First Nations women. Again, these findings provide support for the theories of individualism-collectivism (Hofstede, 1980; Triandis et al., 1986) and self-construal (Markus & Kitayama, 1991), as well as past research showing that within a given cultural group, women tend to adhere more to collectivist and interdependent values compared to men (Dhawan, Roseman, Naidu, Thapa, & Rettek, 1995; Kashima et al., 1995; Li, Bhatt, Zhang, Pahal, & Cui, 2006). No other gender differences were observed in this study.

In contrast to First Nations participants, Anglophones and Francophones defined health as being contained within the limits of the individual self, which also provides
evidence for the theories of individualism-collectivism (Hofstede, 1980; Triandis et al., 1986) and self-construal (Markus & Kitayama, 1991). People of individualist cultures who hold an independent self-construal tend to view themselves as being unique, distinct, and separated from others. They maintain clear boundaries that distinguish themselves from the social context (Markus & Kitayama, 1991). Furthermore, Anglophones and Francophones placed more importance on physical health compared to First Nations participants.

With respect to health practices, statistical analyses showed that Anglophones stressed the importance of having a healthy lifestyle to a greater extent than First Nations participants, while Francophones did not differ from the other two cultural groups. The emphasis Anglophones placed on lifestyle and health behaviours reflects values commonly found among members of individualist cultures, such as independence, self-control, and self-reliance (Chan et al., 2006; McMullin, 2005; O’Connor, 1998; Stein, 1990). These findings seem to indicate that Anglophones are more individualistic than First Nations, with Francophones in between.

Indeed, the results of the quantitative analyses revealed that on two dimensions—developmental health and lifestyle—Francophones had mean scores falling at mid point between Anglophones and First Nations participants. While statistically significant differences were found between Anglophones and First Nations with respect to these dimensions, Francophones did not significantly differ from these two groups.

These results can be explained in terms of the acculturation and adaptation model (Berry, 1980, 2005) with reference to Francophones’ historical experiences of contact with the majority group. Because of their history of contact and proximity and because of their common European background, it is not surprising to find that Francophones and
Anglophones share similar views on health. However, it has been argued that by maintaining their language, Francophones in Canada have evolved as a subcultural group within the majority culture (Allan, 1997; McPherson, 1995; Parker, 1983), which can explain the differences between Anglophones and Francophones with respect to the practice of maintaining their traditions and culture. Differences were also found on a few subthemes. For instance, within the concept of health as a developmental process, more Francophones discussed the themes of balancing the different aspects of the self and developing one’s potential compared to Anglophones.

Overall, the results of this study provide strong support for the influence of culture on the way people conceptualize health and on the practices they engage in to promote their health. These findings are in accordance with the commonality corollary of Kelly’s theory of personal construct, suggesting that members of a given cultural or subcultural group tend to share similar constructs (Bannister, 2003; Davidson & Reser, 1996; Kelly, 1963, 1970/2003; Scheer, 2003). They also parallel the work of other scholars in the health conception field who hold the view that culture gives meaning to personal experiences of health and illness (Angel & Thoits, 1987; Hufford, 1992; Kleinman, 1978; Jobanputra & Furnham, 2005; Jovchelovitch & Gervais, 1999; O’Connor, 1998; Torsch & Ma, 2000). The findings of the present study also support the notion that cultural differences exist in the meaning people ascribe to health (Felton et al., 1997; Hakim & Wegmann, 2002; Hjelm et al., 2005; Jobanputra & Furnham, 2005; Torsch & Ma, 2000).

One practical implication of the research findings is that health-care providers should be better informed of alternative health views. Moreover, they should be cautioned about the dangers of viewing cultures as homogeneous entities (Browne & Varcoe, 2006; Garcia, 2006;
Johnson et al., 2004). They should not assume that every member of a given cultural group shares the same views on health. For instance, Morrissette et al. (1993) argued that colonialism affected Aboriginal individuals differently, resulting in a mixture of cultural beliefs and values. The degree of identification with Aboriginality ranges on a continuum that goes from traditional to non-traditional, which could possibly lead to important interindividual variations in health conceptions, especially with respect to traditional health beliefs. Therefore, instead of relying on assumptions about cultural representations of health held by members of various cultural groups, an alternative would be to have health professionals engage in the practice of inquiring about and sharing views of health with their patients. This practice could lead to mutual understanding of each party’s perspectives on health, which represents one step towards achieving culturally appropriate health care (Ailinger & Causey, 1995; Ailinger et al., 2007; Hunter et al., 2004; O’Connor, 1998).

Moreover, asking patients to share their perceptions on health and their beliefs about what can be done to promote their health also shows they have a right to self-determination (Häggman-Laitila & Ästedt-Kurki, 1995). Overall, these practices can contribute to building a positive rapport between health-care providers and their patients, which in turn can have a beneficial effect on the patients’ health (Belliard & Ramírez-Johnson, 2005), in part by influencing their health behaviours and adherence to the recommendations of their caregivers (Jobanputra & Furnham, 2005; Kenney, 1992; Reiff et al., 1999).

The practice of inquiring and sharing health conceptions with patients is in part related to the concept of cultural safety, which is increasingly discussed in the Aboriginal nursing literature. Cultural safety is defined as an environment where people feel that their identity and needs are not denied, but respected, and where they feel safe and accepted for
who they are (Williams, 1999). Cross-cultural contact represents a situation that can potentially threaten one’s cultural identity, especially when cross-cultural relationships are characterized by inequalities in terms of social status and power, which often is the case when health-care providers interact with patients. When such relationships occur in a mainstream setting embedded in a social context that, historically, has discriminated and marginalized minority group members, the sense of cultural threat can be overwhelming for these members (Brascoupe & Waters, 2009; Purdie-Vaughns, Steele, Davies, Ditlmann, & Randall Crosby, 2008).

To promote a sense of cultural safety among members of cultural minority groups within the Canadian health-care settings, one avenue would be to encourage these members to enter health disciplines (Williams, 1999), thus increasing the professional workforce that can provide a culturally safe environment for members of their cultural groups. However, this approach does not ensure that these health-care providers would recognize the particular health views of their minority patients since, through their medical training, they are socialized and enculturated to think about health and illness in a certain way (Ailinger & al., 2007; Stein, 1990). Another avenue is to increase awareness among health professionals with respect to issues of inequalities and cultural threat, and with respect to the way they can provide health-care services that promote a sense of cultural safety, which involves sharing knowledge, meanings, and power with patients (Brascoupe & Waters, 2009). Inquiring and sharing views on health with patients can contribute to creating a safe environment where patients feel they are respected and accepted as individual and cultural beings.

Public health planners as well as policy makers should also be aware of the role culture plays in the way people conceptualize health. Health policies and programs should be
tailored in accordance with the particular health views and needs of their target populations.

By ignoring variations in health perspectives, project planners may develop health-care programs that are irrelevant to the concerns of members of cultural minority groups (Ailinger & Causey, 1995; Long, 1993; Strandmark, 2007).

Finally, the present study revealed that for some of the First Nations participants, health is defined as expanding beyond the boundaries of the self. This health definition is distinct from the multidimensional health models recently developed to replace the biomedical model. Indeed, other health definitions reported by the participants in this study are reflected in the health models found in the literature, with the exception of the health definition that expands beyond one’s individual health. This finding shows that the health models advocated in the literature might not be appropriate representations of the health conceptions of members of certain cultures. Therefore, these health models should be expanded to reflect cultural variations in health conceptions.

**Relationship between definitions of health and health practices.** The fourth objective of this study was to examine whether the health definitions embraced by the participants could predict their health practices. The results of regression analyses revealed that certain health definitions and health practices were significantly related.

For instance, participants who defined health as a general sense of well-being were more likely to report engaging in the practice of monitoring their current state of health and tailoring health-promoting strategies in accordance with their particular health needs. In addition, those who defined health in terms of a developmental process and spiritual well-being were more likely to engage in spiritual and religious practices to promote their health. The results showed that the participants who defined health in terms of spiritual well-being
were also more likely to report maintaining their traditions and culture as a health-promoting strategy. Finally, health as expanding beyond the individual self was related to two health practices—maintaining traditions and culture as well as practices aimed at promoting the health of one’s family, one’s community, or the environment.

The connections found between health definitions and health practices are consistent with the postulates of Kelly’s theory of personal construct (Kelly, 1963). Indeed, according to Kelly, one’s choice of behaviours is guided by one’s personal construct system (Bannister, 2003). These findings also appear to make sense in light of theoretical perspectives on health conceptions suggesting that health definitions and health practices are part of the same organized system of interrelated knowledge and beliefs (Engel, 1977; O’Connor, 1998). Laffrey’s health conception model (Laffrey, 1986a) and Pender’s model of health promotion (Pender, 1990) suggest that the way health is defined and conceptualized represents a guide for actions. Past studies have also found a link between health definitions and health practices (Bagwell & Bush, 1999; Cook, 1991; Laffrey et al., 1985).

The practical implication for health professionals is that they should pay attention to the way patients define health because there may be a link between the definitions people ascribe to health and their health practices (Laffrey et al., 1985). Since health behaviours are believed to play an important role in the development of chronic health problems, efforts should be placed on the adoption of health-promoting practices among patients (Bandura, 2005; Friedman, 2002; Friedman & Silver, 2007). Therefore, if health professionals want to increase their ability to explain and predict people’s health behaviours, they need to understand how those individuals perceive and define health.
Limitations

There are several limitations to our study that should be taken into consideration. First, the research findings may not be generalizable to populations other than the ones represented in the study. Even among Anglophones, Francophones, and First Nations Peoples, it is possible that different trends would emerge if interviews were conducted among those who live in a rural setting and on reserves or those who live below the poverty line or among the upper classes. A related issue lies in cultural identity being self-declared by the participants. Manitoba has a fairly large French-speaking Métis population and many of them identify themselves first and foremost as Francophones. As a result, the Francophone sample in this study may not be representative of other Francophone communities outside of Manitoba.

Second, the use of convenience and snowballing sampling strategies could have resulted in a biased sample. It is possible that the research project was more attractive to those who are concerned with health views. It could also have been more attractive to those who are in better health as most participants in this study rated their health as good or excellent. The participants were also relatively well educated and thus may not be representative of the general Anglophone, Francophone, and First Nations populations of Winnipeg. Since past studies have shown a link between health conceptions, health status (Baumann, 1961; Laffrey, 1986b; Laffrey & Crabtree, 1988; Mansour, 1994; Morse, 1987), and education (Baumann, 1961; Kenney, 1992; Laffrey & Crabtree, 1988; Mansour, 1994; Woods et al., 1988) different results could be expected when investigating health conceptions among individuals who are less educated or in poorer health.
Third, the researcher's and the research assistant's characteristics could have influenced the participants to answer the interview questions in a certain way. Even though the research assistant who conducted the interviews is a Francophone Métis, she can easily be mistaken for a Caucasian. Some participants may have provided definitions of health that are more in line with what they believed was expected of them or what they believed represented the "right" way of viewing health.

Fourth, although a sample of 60 participants is considered sufficient to provide rich and exhaustive descriptions of their health views— in fact, saturation was reached after 20 interviews— for statistical analyses, this sample is considered relatively small. A small sample can reduce the statistical power of analyses, increasing the probability of committing a type II error. The small sample was especially problematic when Culture x Gender interaction effects were considered as these analyses were conducted with only 10 cases in each cell. However, for the gender and culture main effects, which had 30 and 20 cases per cell respectively, the issue of reduced statistical power due to small sample sizes was not as pressing. Moreover, a very conservative approach to adjusting the alpha level could also have reduced the statistical power of the analyses. It is possible that more significant effects would have been found with a larger sample and by choosing a different alpha level.

Finally, one must be cautious when considering the results of ANOVAs as some of the health definitions and health practices were interrelated. Therefore, it is possible that culture does not have a direct effect on each of these dimensions; the effect may be explained by these dimensions being related to one another. Physical health, developmental health, and spiritual health were all significantly correlated with one another. Therefore, when the effect of culture on physical health was taken into consideration, the effect of culture on
developmental health was no longer significant. Moreover, when the effect of culture on physical health and on developmental health was accounted for, the effect of culture on spiritual health was not significant. With respect to health practices, lifestyle and maintaining traditions and culture were significantly correlated. However, when the effect of culture on lifestyle was taken into account, the effect of culture on maintaining traditions and culture remained significant.

In a similar vein, one should be cautious when interpreting the results of regression analyses as they do not take into account the interconnections between the predicted variables. Therefore, it is possible that the health definitions that are significantly correlated with more than one health practice are in fact not independently related to each one of these practices. Rather, these relationships may be explained by certain health practices being interrelated. This is the case with the health definition that goes beyond the self, which was significantly related to maintaining traditions and to health practices aimed at promoting the health of others, the community, and the environment. In reality it is possible that this health definition is not independently related to these practices. Similarly, religious practices and maintaining traditions were significantly related with one another, indicating that the correlations found between spiritual health and these two practices may be explained by an overlap of these practices.

**Future Research**

This study was conducted with English-speaking and French-speaking Canadians from a European background as well as with First Nations individuals. Future studies could investigate the health conceptions of people from other cultural backgrounds, including immigrants and refugees. Moreover, within the Anglophone, Francophone, and First Nations
populations, future studies could expand to other segments of these populations, such as individuals below the poverty line or from higher social classes and individuals living in a rural setting or on reserves.

To comprehend the role of divergent cultural representations of health on the quality of the doctor-patient relationship and on the patient's health, it would be informative to compare the health conceptions of health professionals with those of their patients to examine how similarities and differences in health views are related to the quality of their relationship. The use of a health-conception-eliciting protocol by a group of health professionals and its impacts on the process of building a positive rapport with patients could also be the focus of a future study.

In summary, this research advances knowledge in the following ways: First, by investigating health conceptions across cultural frontiers, it provides new insight into how health is defined. The unique health views articulated outside the boundaries of the individual self by First Nations participants are not reflected in current individualistic health models. These models should thus be expanded to represent better the views of cultural minorities. Second, by ensuring that the three cultural groups were homogeneous with respect to other health conception determinants through the use of a quasi-experimental design, we were able to isolate the role culture plays in the way health is conceptualized. Third, in contrast to past studies, which focused only on qualitative variations in health conceptions as a function of culture, the use of a scoring procedure developed for the purpose of this study allowed for quantitative comparisons with respect to the importance interviewees placed on shared health definition and health practice dimensions. Qualitative and quantitative research methods complemented one another, allowing for a better understanding of the similarities and
differences in the way health conceptions are defined and in the importance placed on these health conceptions across cultural groups. Finally, by investigating health definitions and health practices simultaneously, we were able to examine the relationship between health definitions and health practices, providing evidence for the role of health definitions in the practices people engage in to promote their health. Overall, these findings point to the importance of considering the constructive view of health, especially for health professionals, public health planners, as well as policy makers working with members of diverse cultural backgrounds.
References


Appendix A

Interview Questions

1. How do you identify yourself culturally?

2. How would you define health? / What does “being healthy” mean to you?

3. How do you know when you’re healthy?

4. What are the characteristics of a healthy person? / How would you describe a healthy person?

5. Do you consider your descriptions of a healthy person to be different from the idea people generally have of a healthy person?

6. To what degree do you see yourself as a healthy person?

7. What have you done or currently do to keep yourself healthy?

8. What do you do differently from the general population to stay healthy?

9. Would you like to add anything else?

10. The results of this study will be presented in a doctoral thesis, which will be shared with affiliated universities and might also be published in academic journals or presented at academic conferences. In these reports, do you want your contribution to this study to be recognized or do you want your participation to remain confidential?
Appendix B

Demographic questions

1. Using the following scale, how do you rate your current health status? ______________

   1 2 3 4 5
   Excellent  Good  Somewhat Not very Very
              good    good   poor

2. Age: ________________

3. Gender:
   Female___________ / Male_________

4. What is the highest level of education you have achieved?
   - Did not finish high school: ______________
   - High school diploma: ______________
   - College diploma: ______________
   - Undergraduate university diploma: ______________
   - Graduate university diploma: ______________
   - Other (please specify): ______________________________

5. What is your marital status?
   - Single: ______________
   - Common law: ______________
   - Married: ______________
   - Divorced: ______________
   - Widow/widower: ______________
   - Other (please specify): ______________________________

6. Are you currently employed?
   Yes_______ / No_______
   If you indicated yes, what is your occupation? ______________________________
7. Are you currently pursuing post secondary education?

  Yes_____/No_______
  If you indicated yes, what is your program of study?

8. What is your annual income?

  - Under $20,000
  - Between $20,000 and $40,000
  - Between $40,000 and $60,000
  - Between $60,000 and $80,000
  - Between $80,000 and $100,000
  - Above $100,000
CALL FOR PARTICIPATION IN A RESEARCH PROJECT

Conceptions of Health: A Cross-Cultural Comparison

Annabel Levesque, Ph.D student in psychology at the University of Northern British Columbia and professor at the Collège universitaire de Saint-Boniface, is conducting a research project in order to gain a better understanding of First Nations Peoples’, English-speaking Caucasians’ and French-speaking Caucasians’ perceptions and definitions of health and of the health practices they engage in to promote their health.

Therefore, she is looking for volunteers who would be interested in taking part in that project. To be eligible to participate in that study, volunteers must:

- Self-identify as being a member of one of the following groups:
  a) First Nations
  b) French-speaking Caucasians (Francophones from European descent)
  c) English-speaking Caucasians (Anglophones from European descent)
- Be born or have attended school in Winnipeg
- Be a resident of Winnipeg
- Have an annual income between $21 000 and $100 000

Participants will be asked to talk about the way they define and perceive health and about their health practices during a face-to-face interview that will last approximately 30 minutes. Interviews will be conducted at an agreed upon time and place. Respondents will also be asked to answer a short questionnaire, which will take approximately 5 minutes.

Participants will receive a 10$ gift certificate.

If you want to learn more about this project, or if you are interested in participating, please contact either Annabel Levesque, or her research assistant, Mireille Bohémier.

Annabel Levesque
Email: 
Office telephone:

Mireille Bohémier
Email:
Appendix D

INFORMATION SHEET / CONSENT FORM

Title of the Research Project: Conceptions of Health: A Cross-Cultural Comparison

Principal Researcher: Annabel Levesque,
Researcher's supervisor: Dr Han, Z. Li
Research assistant: Mireille Bohémier

This research project is being conducted by Annabel Levesque within the framework of her PhD Dissertation, with the assistance of a research assistant. The researcher’s supervisor, Dr. Han Z. Li, will oversee all aspects of this research project to make sure that the study progresses in a proper and respectful manner.

Objective: The purpose of this study is to gain a better understanding of how members of three ethnic groups perceive and define health and of the health practices they engage in to promote their health.

Men and women who; a) self-identify as being First Nations, English-speaking Caucasian or French-speaking Caucasian; b) were born or attended school in Winnipeg; c) are residents of Winnipeg and; d) who have an annual income between $21,000 and $100,000 are invited to participate in this study. People who voluntarily agree to take part in the project will be asked to talk about their perceptions of health and their health practices during a face-to-face interview that will last approximately 30 minutes. Interviews will be conducted by the researcher or a research assistant. Volunteers will also be asked to complete a short questionnaire.

With your approval, the interviews will be recorded. The recorded interviews will be erased after having been transcribed by a research assistant. Your name and any other information that may lead to your identification will be removed from the transcriptions, unless you explicitly state at the end of the interview that you wish your contribution to be acknowledged. All the information collected during the course of this study will be stored securely for approximately five years and after that time, it will be destroyed. Only the researcher, the research assistant and the researcher’s supervisor will have access to the interview transcriptions and questionnaires. The information collected will not be used for any other purpose than for the present study. The results of this study will be shared with the affiliated university (University of Northern British Columbia) and might also be published in academic journals or presented at academic conferences.
A summary of the research results will be sent by mail or by email to those who take part in the study. As a participant you will also be invited to attend a meeting where the researcher will share the research results and where the participants will have the opportunity to ask questions and to provide their feedback.

It is believed that this study doesn’t present a risk for the participants. The potential benefit of this study is that people will have the opportunity to share their perceptions of health which in return may provide a valuable tool for health professionals working with members of the three target groups.

It is important to note that your participation in this study is strictly voluntary and that you can, at any time, put an end to your participation without any repercussions. If you do withdraw, all the information that you provided will then be destroyed.

I, __________________________, accept to participate in this research project.

Name of participant

I, __________________________, am committed to respect the terms of this project as described in

Name of interviewer this consent form.

Participant’s signature __________________________ Date __________________________

Interviewer’s signature __________________________

Any complaints that you may have about this research project can be directed to the Office of Research, University of Northern British Columbia (Phone: 250 960-5650, Email: reb@unbc.ca).

Also, any questions that you may have in connection with this project can be addressed to Annabel Levesque, to the research assistants or to the research supervisor.

* One copy of this form is to be given to the participant and one will be kept by the researcher.
Appendix E

Scoring sheet

Participant #: ____________________________
Scorer's name: ____________________________

<table>
<thead>
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<td>Negative health</td>
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<td>Functioning-performance</td>
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<td>Spiritual health</td>
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<td>Beyond individual health</td>
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<th>HEALTH PRACTICES</th>
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<td>Understand your health needs</td>
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<td>Lifestyle</td>
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<td>Balanced life</td>
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<td>Managing stress</td>
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<td>Maintaining good relationships</td>
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<td>Medical practices</td>
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<td>Spiritual-religious practices</td>
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<td>Maintain traditions/culture</td>
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<td>Beyond individual health practices</td>
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0 = Did not mention the theme; 1 = Mentioned the theme and may have provided a few details; 2 = Provided a somewhat elaborated description of the theme 3 = Provided an elaborated description of the theme, giving examples (the theme is really central to the participant's conception of health).