WELLNESS AS PERCEIVED BY SEVENTH-DAY
ADVENTIST ANGLO WOMEN

by

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STATEMENT BY AUTHOR

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ALICE JEAN LONGMAN
Associate Professor of Nursing
THIS THESIS IS LOVINGLY DEDICATED TO MY HUSBAND,

Leland W. Yialelis

with much love, joy, and affection for his endless love, understanding, patience, encouragement, and support throughout all the stages in my pursuit for education, and who is a constant source of love in my life.
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ABSTRACT

This was a descriptive study designed to determine a definition of wellness in a selected group of Seventh-day Adventist Anglo women. Theories of perception and wellness were used as the conceptual framework for this study.

A convenience sample of 10 women participated in the study. The participants were interviewed in their homes or offices using a series of six open-ended questions. The responses were tape recorded.

The analysis of the collected data utilized the process of content analysis. Wellness was perceived by the majority of the participants as physical, mental, and spiritual. This recognition that wellness is wholistic in its relation to one's health is directly related to the teachings on health by the Seventh-day Adventist church to which the participants belonged.
CHAPTER 1

INTRODUCTION

What is the goal of the health care system and health professional? Is the goal only the treatment of illness and injury? Until recently these questions simply were not asked, or if they were, the answers assumed the traditional ones of treating the sick and the injured.

In recent years the focus has begun to change. It has been proposed that the true goal of the health care system is a positive not a negative one and that the alleviation of illness and injury is only the first step in a process that has as its ultimate goal the entire well-being of the individual. This new approach has termed this focus on total well-being "wellness."

Wellness is that positive state in which an individual is performing at his best. Wellness is the opposite of death on a continuum in which the absence of illness or injury would be somewhere near the midpoint. Wellness is described as an aggressive approach to health status and health care. Wellness focuses on the whole person, physical, mental, and social (Bruhn et al., 1977).

Health professionals have special clearly defined concepts of what constitutes wellness. There is a new focus on wellness as the result of the work of health professionals. In addition to a general "professional" definition of wellness, the nurse needs to understand how
those served define wellness. Byrne and Thompson (1972:38) pointed out that "there may be a wide discrepancy between the nurse's assessment of a patient's potential and his own evaluation of his situation."

Thus, the nursing professional must have an understanding of this discrepancy, which can be crucial to a nurse's effectiveness. Lerner (1975) pointed out that problems occur in determining what a population's health is because there is no standard definition that is widely accepted but that health is apparently socially defined and the definitions vary according to the social or professional setting. Because little has been done to understand how wellness and health are perceived by lay people, this study attempted to explore what these terms mean to people who are not health professionals.

The group to be studied was drawn from members of the Seventh-day Adventist church, which emphasizes health as a part of its teachings and doctrine (White, 1905). This emphasis is accepted by a large majority of the members (Phillips, 1978). A study such as this should help in an understanding of how an emphasis on healthful living affects the perceptions and understanding of those who accept and practice such a lifestyle.

Statement of the Problem

What are the perceptions of wellness in a selected group of Seventh-day Adventist Anglo women?

Statement of the Purpose

The purpose of the study was to obtain a definition of wellness in a selected group of Seventh-day Adventist Anglo women.
Significance of the Problem

This problem is relevant to nursing. By understanding how women of this group perceive wellness, nurses may be better able to understand how, when, and why they seek the services of the health care system. When nurses understand how this selected population defines wellness, they will be better able to use their knowledge, skills, and abilities to help these consumers meet their defined goals. The health professional makes a decision about the course of action that he or she should take, based on a professional concept of health and wellness (Byrne and Thompson, 1972). Culture, values, beliefs, religion, socio-economic status, education, and decision-making can influence an individual's perception of health, wellness, and illness. However, the main emphasis in most of the literature reviewed was on illness and disease with rather limited information on the concepts, theory, and definitions of wellness and health. It is rarely based on the consumer's point of view.

Conceptual Framework

Theories of perception and wellness formed the bases for the conceptual framework of this study.

Perception

Perception is defined as a single unified awareness from sensory processes while a stimulus is present (Spradley, 1972). Man calls upon his past experience to interpret present situations. Thus a man's choice of actions is guided by the personal meaning of his private world, created through experiences. A man's health behavior is thus
guided and limited by his personal and social values, his belief, and his attitudes toward himself, other persons, and the world about him (Knutson, 1965). In the realm of health, wellness, and illness, one person may perceive something one way and another person may perceive the same thing differently. Bloom (1963:98) stated that "people perceive illness in different ways. The pattern of these perceptions or definitions of illness varies according to culture and within cultures." Perception is developed by social expectations. The value systems of the cultures are reflected by their social expectations and these cultural definitions come to be perceived as reality.

From generation to generation, attitudes and activities are communicated. The culture and social milieu within which an individual develops conditions an individual's development through pattern and behavior (Mechanic, 1968). Thus man has an active role in his perception and is not a passive agent (Brunner and Postman, 1949). He reacts to each situation that he encounters in life in terms of his total perception of the memory of that situation (Hinkle and Wolff, 1957). Perception, then, attempts to explain why things or happenings appear as they do (Wu, 1973). Perceptions are formulated by each individual into defined concepts, which he can translate into words and which are understood by those who share his cultural experiences and backgrounds. These concepts provide the means by which perceptions of individuals become a part of the cognitive field of the person and his culture (Kay, 1972; Spradley, 1972).
Wellness

Dunn (1977:9) defined high-level wellness for the individual as "an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable, within the environment where he is functioning." Wellness is a process that encompasses all aspects of an individual's health. It is a process that continues in time. Wellness is a continually evolving and changing process that integrates as much as possible all aspects of a person's physical, mental, social, and environmental well-being (Bruhn et al., 1977; Jomann, 1971).

Good health has been defined by Bruhn et al. (1977:210) as a "continual process that can evolve into wellness." Good health thus becomes one point along the health continuum; it is one point in the process of being or becoming well. Disease and health are regarded as a continuum, where health would be the ability of the individual to function at full capacity and illness would be a diminishing of that capacity (Bartlett, 1961). Good health has been defined by lay persons in terms of absence of physical symptoms, a feeling of well-being, and the ability to carry out normal activities (Terris, 1975). Parsons (1958:176) defined health "as the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized."

Definitions

For the purpose of this study the following definitions of terms were used:
1. **Health**: "a state of complete physical and mental, and social well being and not merely the absence of disease or infirmity" (World Health Organization, 1948:100). Health and disease are regarded as a continuum where health would be the ability of the individual to function at full capacity and illness would be a diminution of that capacity (Bartlett, 1961:33).

2. **Health professional**: a person who has received training in medical-oriented fields such as a nurse, doctor, dentist, nutritionist, physical and occupational therapists, and pharmacist or a person who works in a field related to the health sciences.

3. **Lay person**: an individual who has not received educational training in the field of health sciences.

4. **Seventh-day Adventist Anglo women**: women members of the Seventh-day Adventist church of northern, central, or western European ancestry who were born in the United States.

5. **Wellness**: a positive state in which an individual is performing at his best. As defined by Dunn (1977:9), "high-level wellness is . . . an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable, within the environment where he is functioning."
CHAPTER 2

SELECTIVE REVIEW OF LITERATURE

Different aspects of health, wellness and illness have been studied by various investigators. There was nothing found in the literature that dealt with concepts of wellness as perceived by women. The literature related to concepts of health, wellness, and factors that may affect the perception of health and wellness were reviewed to help identify those factors that may influence the perception of wellness.

The major focus of this selected review of the literature is on the following areas: (1) health and wellness, (2) self-perceived health status, (3) beliefs, values, religion, culture, socioeconomics, and education in relation to health and wellness, and (4) interactions between health professionals and consumers in regards to health and wellness.

Health and Wellness

The literature that dealt directly with the issue of wellness and health did so primarily from the point of view of the health professional. There is, however, no corresponding literature available on how wellness and health are perceived or defined by consumers.

The work of Dunn (1977) is invaluable in helping one arrive at a definition of wellness from the professional point of view. His work
is professional and theoretical, as exemplified by his definition, "high-level wellness for the individual is defined as an integrated method to functioning which is oriented toward maximizing the potential of which the individual is capable, within the environment where he is functioning" (Dunn, 1977:9). This is obviously the point of view of a professional in the health field and would not help in understanding how the consumer, who is not a health professional, would view the same issue.

There are other professionals and professional groups who have sought to define the concepts of wellness and health more clearly. The World Health Organization (1948:100) defined health as "a state of complete physical and mental, and social well being and not merely the absence of disease or infirmity." The definition by Perkins (1938) has a similar focus in that he saw health or wellness as the dynamic adjustment of the body to the forces acting against it. He regarded health not as a passive state of interaction but as an active response of the body to its environment. Dubos (1967) also linked his definition of health to the organism's ability to respond adaptively to environmental challenges. Besson (1967:1904) went so far as to say that "optimal health is not a condition of the individual." He focused entirely on the interaction of the individual and his environment, terming it a "ceaseless struggle." Parsons (1958) emphasized that health was a state of optimum functioning for an individual within a particular social context.

Another group of professionals focused their attention on the problem of relating disease and health. Bartlett (1961) said that
disease and health should be regarded as a continuum. Health, then, would be the ability of the individual to function at full capacity, and illness would be an inability or diminution of this capacity. Byrne and Thompson (1972) also placed health and illness on a continuum as did Gragg and Rees (1974), who noted that health and illness are on the opposite ends of a continuum.

Health professionals also emphasized that wellness must be viewed in a much wider context than simply the proper physiological functionings of the body. This has been hinted at already by the cited definitions. However, two additional references will be included to make this clear. Byrne and Thompson (1972:33) stated that there are three major elements involved in the dynamics of health and these are the biological, psychological, and social aspects of man. Jomann (1971) incorporated an even wider scope in her definition of health by considering it to be a dynamic process that included the biological, economic, educational, psychological, philosophical, spiritual, and social aspects of man's being.

The work of Bruhn et al. (1977) coordinated wellness with Jomann's (1971) point of view. Bruhn et al. (1977) identified wellness as a continually evolving and changing process that integrates as much as possible all aspects of a person's physical, mental, social, and environmental well-being. The unique contribution of their work to wellness was proposing an index for assessing wellness. Using the concept of Erikson's eight developmental stages, they noted that if an individual is growing and progressing, he will be accomplishing certain identifiable activities associated with wellness. Bruhn et al.
(1977:214) called this "successful wellness seeking behavior." This concept is very helpful in identifying specifics that make wellness a much more tangible and workable concept. In addition, Bruhn et al. also emphasized the necessity of establishing wellness as a value. Making wellness part of our value system would aid in motivating people to recognize that wellness is a part of their own personal responsibilities and something over which they can exercise a considerable degree of control.

Ultimately, Bruhn et al. (1977:210) defined good health as a "continual process that can evolve into wellness." Good health thus becomes one point along the health continuum; it is one point in the process of being or becoming well.

Good health has been defined by lay persons in terms of absence of physical symptoms, a feeling of well-being, and the ability to carry out normal activities (Terris, 1975, Baumann, 1961). Lay persons also relate health to the standards that have been established by the individual family, the community, and the society (Friedson, 1977).

Bruhn et al. (1977) identified the following four differences between wellness and good health:

1. Wellness is a process that continues in time. Good health is a state or a stage along the health continuum.

2. Wellness depends upon an individual's initiative and requires an individual's action, development, and value judgment. Wellness is active, whereas good health may exist without any effort from an individual.
3. Wellness is related to the process of learning and development. Good health is an objective assessment, a description of state.

4. An individual may experience wellness while at the same time be experiencing clinical symptoms. Wellness is a process that encompasses all aspects of an individual's health in the broadest sense.

Self-perceived Health Status

As Apple (1960) has pointed out, the perception of one's health status is important in determining one's practices in medical and preventive care. However, as studies have shown, the lay person does not base his actions on a particular concept of wellness or health but on an illness orientation. DiCenco and Apple (1958) found that the commonest way in which a person perceives health was by how it affected his activities. The issue of health only became important when it interfered with daily activities.

Sheeley (1973) attempted to identify relationships between perceived health status and symptoms, functional ability, and morale. She found that the perception of health and wellness was directly related to a decrease in the number of symptoms. Morale was positively related to this perception of increased health status. Here again one should note that the basic criteria of the consumer were symptoms or were based on illness.

Peppitt (1974) also attempted to find a correlation between perceived health status of retired school teachers and symptoms, functional ability, and morale. This study showed that a relationship
between symptoms and perceived health status apparently exists, although the relationship in the sample of 30 retired school teachers living in Tucson was found statistically significant. However, the study did show that there was no relationship between perceived health status and functional ability. Again, as in the Sheeley (1973) study, there was a positive relationship between perceived health status and morale. As in the earlier studies, the basis for decision making by the lay person in regard to health was illness-oriented by use of symptoms.

These studies demonstrate that there is a divergence between how the health of an individual is perceived by a lay person and by a health professional. The studies did not attempt to determine what these specific populations defined as wellness. These were studies of illness (limitations and symptoms as perceived by these individuals) rather than of health or wellness.

**Influence of Other Factors**

**Beliefs**

"Beliefs are formulated of what is thought about the universe. . . . A belief system is based upon . . . experience . . . and provides the basis for behavior" (Bauwens, 1974:25).

Beliefs are significant factors that affect a person's concern for prevention of illness. Schulman and Smith (cited by Bullough and Bullough, 1972:52) found that individuals in the Mexican-American villages in New Mexico and Colorado believed that, " . . . if a man was not emaciated or in pain and could perform his work role adequately he was well and had no need for medical care."
Mechanic (1968) pointed out that any social value is judged in relation to other social values. Bauwens (1974) suggested that the values underlying the behavior of individuals also influence their beliefs about medical care. Rosenberg (1957) associated values with the desirable factors which influence behavior. According to King (1962), there is a correlation between values and perception in health and illness. The significance of this is obvious, for here in our own culture with its emphasis on the immediate future and the value of the "now," some find it difficult to perceive the dangers of smoking, which will only be realized 20 or 30 years in the future.

According to Brownlee (1978), the differing values assigned various members of the family can have a significant effect on the health of these individuals and the care they receive. Brownlee pointed out that in some cultures children have the least status; thus their health care and health care needs are of least priority within the family structure. In other words, in some cultures individual attainment of health care depends on how he is valued by the culture or family structure.

In each culture, factors may be assigned different values. For example, Leininger (1970) suggested that in the American culture, good health is associated with cleanliness. This value, cleanliness, is very evident in nursing, where keeping the patient clean is seen as vital to the optimum health of the patient. In other cultures good health may not be associated with cleanliness.
Religion

Brownlee (1978) pointed out that religion may affect a person's entire way of living, which includes his beliefs, values, practices, and concepts of health and illness. Religion may play a predominant part in determining the health care a person receives.

It is important for the health professional to realize that religion and medicine are often intertwined. Glaser (1970:17) stated this relationship clearly,

...both religion and medicine provide explanations and offer remedies to persons experiencing suffering. Both prescribe from bodies of theory about physical events that provoke anxiety. Both expect the individual and his relatives to adapt certain beliefs and perform particular actions in order to reduce suffering.

Differing religious beliefs, reflecting the cultures from which they come, will determine the role that religion and its members play in the process of health and illness (Brownlee, 1978). In a study conducted by Clark (1959) conducted among Mexican-Americans in California, this relationship between religion and health practices was illustrated. Religion influenced both the diagnosis and treatment of disease in the barrio. Clark (1959) stated that various spells, prayers, and religious invocations of Mexican origin are used as part of the diagnosis and treatment of disease. This relationship between religion and health in the barrio is seen in the work of the curanderos (folk healers). These practitioners use various religious symbols and artifacts for part of the treatment of illness (Brownlee, 1978).

An example of this relationship of religion to health is provided by the Seventh-day Adventist church, which has made healthful
living an integral part of its teaching for over a hundred years (Seventh-day Adventist Church Manual, 1967). This emphasis has become a part of the life style of its members, most of whom follow its teachings quite closely.

The church has as a part of its doctrinal position a very clear and definite stand on various health practices. The most significant area of emphasis in Adventist teaching about health is diet. Vegetarianism (predominantly the lacto-ovo form, which includes eggs and dairy products) is encouraged (White, 1905), but if a member should elect a diet that includes meat, the doctrinal position is that the laws governing clean and unclean meats as stated in Leviticus 11 should be observed. The use of unrefined or natural foods, restricted use of sugar, and abstinence from caffeine, alcohol, and tobacco are also encouraged. The church also advocates that its members get adequate exercise, rest, and recreation. The use of natural remedies rather than drugs is suggested, and the use of drugs such as marijuana and heroin is prohibited (White, 1905).

Other aspects of the Seventh-day Adventist life style include an emphasis on education, which results in a relatively high educational background; encouragement to avail oneself of good medical care; an interest in preventive health care; and a religious philosophy that encourages less stress and anxiety (Phillips, 1978).

In a study conducted from 1958 to 1965 among Seventh-day Adventists living in California, it was discovered that Adventists have a longer life expectancy than comparable Californians (Phillips, 1965). The study also showed that they have lower death rates from all types
The study also showed that they have lower death rates from all types of cancer and from coronary and vascular disease. They were also found to have markedly lower death rates from those diseases associated with smoking tobacco and drinking alcoholic beverages, as might be expected from their life style (Phillips, 1965).

Phillips (1978) has also reported preliminary results from an ongoing study conducted by the School of Health at Loma Linda University (the church's medical center) that show that 45 percent of the Seventh-day Adventists are vegetarians (use meat, poultry, and fish less than one time per month), while 40 percent use meat lightly (one to four times per week), and 15 percent use meat heavily (more than four times per week). This same study showed a markedly lower death rate for Seventh-day Adventists for many of the most common causes of death in America today. This results in a life expectancy that is 3 to 4 years longer than it is for the general population.

Culture

Spradley and McCurdy (1975:3) defined culture as "the acquired knowledge that people use to interpret experiences and to generate social behavior." They (1975:6) further suggested that the cognitive definition of culture "excludes behavior and restricts the culture concepts to ideas, beliefs, and knowledge. Bloom (1962) related a person's perceptions of illness or health to the culture from which the person came. Mechanic (1968) expounded on this same concept. He said that cultural patterns are essential to the ways in which illness is perceived, expressed, and reacted to. The cultural context is also
significant in defining what conditions are to be recognized as illness, what the causes may have been, and which persons have the authority to make the ultimate decisions regarding the illness. According to Brownlee (1978) culture influences the health professional's concept of what is "illness" and what is "health." Thus, what consumers from other cultural backgrounds consider "good health" and "illness" may vary widely from that of the health professionals. Lerner (1975) pointed out that there appears to be a wide range of cultural variation in the meaning of the concept of health.

**Socioeconomics Status**

Several authors have found a relationship between a person's economic position and his health. Gragg and Rees (1974) found that health is often related to economic status, linking optimum nutrition, favorable living conditions, education, and availability of medical care of people in higher economic status with better health. Antonovsky (1967) showed that persons in the lowest income class have the poorest life expectancy. Linder (1966) also found a positive relationship between poor health and low income. For example, persons in the lower income brackets have more days of disability than did those in higher income brackets. Koos (1967) found that persons in the upper class considered themselves ill if they have certain symptoms and and that they reported these symptoms or illnesses more frequently than the lower class person. Koos pointed out that if income is inadequate and there is competition for the money available, the culture's and the group's membership have an influence in determining by peer pressure or
by definition of priority or importance how the available funds will be used. Thus the health needs and the family's other needs and luxuries compete for the available funds. This factor is important in the perception of health or illness (Koos, 1967). An individual with money available with which to seek health care may well define a given condition as an illness and seek care. But if there is no money available that same individual will ignore the condition, calling it "part of normal life."

This difference in social class reveals itself in other ways as well. Levine (1962:30) suggested that members of the lower class worry more about their health status and are "... more unnerved when confronted with the possibility of serious disease." Kadushin (1964) stated that people of the lower classes feel sicker and are more concerned with illness. Another difference that social class makes is in the way those in the health professions are perceived. Bauwens (1974) found that lower class Anglos of Douglas, Arizona, expressed lack of confidence in the doctor's ability to care for them and dissatisfaction because of the difference of their own definition of illness and that of the doctor's. Koos (1967) demonstrated that the lower class individuals felt a difference between the way the health professionals treated them and the way they treated people in the upper class.

Poverty strikes at the health of the poor in another way that is even more subtle. As has been alluded to already, a person's perceptions are affected by his socioeconomic status. Bullough and Bullough (1972) suggested that persons who are poor, regardless of their culture, are usually not oriented toward the prevention of illness because the
overall outlook for preventive health is associated with an ability to control the future and this control is impossible for those in poverty. Irelan (1967:59) made this same point when she said, "... the diffuse fatalistic feeling of powerlessness which informs so strongly on the relationship of the poor to the rest of society is imbedded most pathetically in resignation to illness."

**Education**

Koos (1967) pointed out that social class membership does affect the amount of education an individual may get. Thus those with the least education are more likely to be the least familiar or acquainted with what education people define as constituting good health. He (1967:142) went on to say that what the individual expects of treatment depends on the level of education he has, "since education more or less replaces dependence upon folk ideas with dependence upon knowledge ... , the educated individual is better able to view realistically the course and outcome of treatment."

**Summary**

The review of the literature revealed that health professionals are beginning to make a distinction between health and wellness. Writers generally agree that wellness emphasizes not only physiological capacity but also optimum functioning of the whole person. There is, however, no corresponding literature about how wellness and health are perceived or defined by consumers.

The literature that dealt with self-perceived health status showed that the lay person uses criteria based on symptoms or illness.
The review then focused on the literature that dealt with other aspects of our lives such as beliefs, values, religion, culture, socioeconomic status, and education that affect our decision making about health. The literature demonstrated that a strong correlation does exist between these areas of our lives and our decisions and responses to issues concerning health.
CHAPTER 3

METHOD OF THE STUDY

This chapter includes a description of the design, the sample and setting, pilot study, data collection, data collection tools, coding, reliability of coding, data analysis.

**Design**

This was a descriptive study designed to delineate a clear understanding of what a selected group of women perceived as wellness. One interview was conducted per informant. For the study a series of six open-ended questions were given to each participant and their verbal responses to these questions were tape recorded. The recorded responses were transcribed into specific categories that emerged from the collected data. The specific categories and subcategories of words and phrases were identified by two coders and the investigator.

Content analysis at the manifest level was the procedure for categorizing what the participants said. In content analysis the categories must accurately represent the ideas or concepts listed. The analysis is simply a direct transcription of the response in terms of some system of classification. The coding into categories converts qualitative data to quantitative measurements (Fox, 1970; Simon, 1969). Holsti (1965:74) defined content analysis as "any technique for making inferences by objectively and systematically identifying specific
characteristics of messages." According to Holsti (1965) only the manifest attributes of the text may be coded and are implied by the requirement of objectivity. The analyses of the collected data—words and/or phrases were calculated according to a simple frequency distribution of the categories and subcategories.

Sample and Setting

The informants in this study were 10 women who lived in a southwestern city. It was a convenience sample.

The following criteria were used for the inclusion of the informants in the study: (1) Female; (2) 18 years of age and above; (3) members of the Seventh-day Adventist church; (4) American-born Anglo; (5) able to read, write and speak English; (6) high school graduates; (7) lay person; and (8) self-described as "well".

The investigator contacted the pastor of the Seventh-day Adventist church to explain the study and the criteria established. The investigator requested an opportunity to speak to the associated women members to obtain volunteer participants. Twelve women volunteered to participate in the study and 10 were used in the study. One informant withdrew from the study due to an acute illness, and one informant was the subject for the pilot study. Once the study was explained and the informants who met the criteria had volunteered to participate in the study, an appointment was made to conduct an interview at a time convenient for the informant. At the beginning of the interview, a written consent was obtained (see Appendix A). The interview was conducted by the investigator in seven of the participants'
homes and in three offices. The average length of time for each interview was 30 minutes.

**Human Rights**

The human rights of the informants involved in this study were protected according to the guidelines of the University of Arizona Human Subjects Committee. The protection of human rights was addressed in the following manner: (1) the investigator explained the purpose of the study and what the participation would involve; (2) the informants were given the right to withdraw from the study at any time; (3) the informants were told that the results of the study would be published and that their identity would remain anonymous; (4) informants were advised of the risks, costs, benefits and demands of the study; and (5) the investigator obtained the written consent of each subject (see Appendix A).

A pilot study was conducted to assess the adequacy of the tool for data collection. The tool used in the pilot study comprised eight open-ended question (see Appendix C), which were given to one of the participants who volunteered for the study to determine whether they were understandable or if changes in terminology or wording were necessary. Most importantly, the pilot study was useful in determining if the questions elicited responses related to wellness.

An appointment was made with the informant to conduct the interview in her home. The interview took approximately 30 minutes. The series of eight open-ended questions with alternative questions were read so that all the questions would be consistent when given to
each participant in the actual study. The informant's responses were tape recorded.

It was established that these questions were understood by the informant and that no changes in terminology or wording need be made. However, the pilot study did show that questions 7 and 8 did not elicit answers related to wellness, and these questions were therefore omitted in the final questionnaire (Appendix E).

The informant's responses to the eight open-ended questions were transcribed from the tape recording and a taxonomy of the words and phrases used by the informant in her answers was written (Appendix D). From the taxonomy a list of all words and phrases was made, which was used by the investigator to identify specific categories and subcategories.

This list of words and phrases was also given to four coders, who were faculty members in a school of nursing. The investigator gave the following instructions individually to each coder:

1. Place words and phrases as subcategories under specific categories and subcategories that emerge from the list of words and phrases.

2. The two coders who identified the specific categories and subcategories the closest would be asked to be coders and would participate in the study.

The specific categories and subcategories identified by the four coders varied greatly. The four coders used words identified as specific categories that were not words emerging from or taken from the words and phrases listed. It was this use of words other than those
emerging from the study that accounted for the wide variation between the four coders. The two coders (A and B) who came the closest in identifying specific categories and subcategories were asked to participate as the two coders for the study.

Based on the pilot study, information for the study was given to these two coders at the same time. The instructions given included the following:

1. Specific categories must be chosen from the words and phrases emerging from the list.

2. Words and phrases be placed as subcategories under the specific categories.

3. Specific categories and subcategories were to be made for each of the four topics that emerged from the six open-ended questions used in the study (Appendix E): Topic I—wellness defined; Topic II—How do you keep well?; Topic III—health defined; and Topic IV—difference between health and wellness.

Data Collection

An appointment was made to conduct the interview at a time convenient for each participant. The interview was conducted by the investigator in seven of the participants' homes and three of them in offices. The average time for the interviews was 30 minutes. One interview was conducted with each informant. Each interview was tape recorded to obtain the informant's verbal response to a series of six open-ended questions related to their perception of wellness (see Appendix E). Each of the questions and its alternative were read to
each of the participants so that all questions were consistent when given to each of the participants.

Demographic data such as age, marital status, highest level of education completed, occupation, and number of years one had been a Seventh-day Adventist was also obtained (see Appendix B).

Data Collection Tool

A series of six open-ended questions and alternative questions for each of the questions in the series (see Appendix E) were developed by the investigator and two graduate nursing students based on a review of nursing literature and their own individual professional experiences and expertise. These questions were reviewed and accepted by two other graduate nursing students using the above procedure. Thus these questions had content validity.

Coding

The verbal responses to the six open-ended questions were transcribed from the tape recording and words and phrases were subcategorized under specific categories that emerged from the data collected. The investigator then gave the two coders (both registered nurses, with Master's degrees, who were faculty members in a school of nursing) the transcribed words and phrases and asked them to identify the specific categories that emerged from the words and phrases and then subcategorize the words and phrases into these specific categories.
Reliability of Coding

Reliability was established through computing the percent that the two independent coders and the investigator agreed upon when each coded the same material. To estimate reliability of the coder, the investigator developed a standard set of responses on which she and the two other coders agreed by the 85th percentile. Words and phrases transcribed from the tape recorded verbal responses were given to the coders to identify specific categories. An 85th percent agreement was reached before it was considered sufficiently reliable for use in this study (Fox, 1970:282-283, Holsti, 1965:135-149).

Method for Analyzing Data

The analysis of the collected data—verbal response of words and phrases—used the process of content analysis. The analysis of the qualitative data yielded nominal and verbal ordinal data. A simple frequency distribution of the categories and subcategories was calculated.

Summary

This was a descriptive study, designed to delineate a clear understanding of what a selected group of women perceived as wellness. The participants were each interviewed in their homes or offices using a series of six open-ended questions, which had been formulated by the investigator and two other graduate nursing students. At the beginning of each interview the investigator obtained a written subject consent from the participants.
The responses, by each of the participants, for each of the six open-ended questions were tape recorded and then transcribed. From the transcribed recordings words and phrases were selected by the investigator which accurately reflected the responses of the participants in regard to their understanding of wellness. The method used for their subsequent categorization of words and phrases was content analysis. Two coders participated in the categorizing of the data along with the investigator.

From those who originally volunteered to participate in the study, one was selected to serve in the pilot study. This pilot was done to test the data collection tool to select the two coders who would work with the investigator.
This study was designed to determine a definition of wellness in a selected group of Seventh-day Adventist Anglo women. This chapter presents the analysis of the data, including the characteristics of the sample, interview content, interrater reliability, and summary.

Characteristics of Sample

The findings of this study were based on a sample of 10 informants who met the criteria for inclusion into the study.

The ages of the informants ranged from 21 to 70 years with a mean age of 33.4 years (Table 1). Forty percent (4) of the informants were in the age group of 20-25 years. The age groups of 26-31 years and 32-37 years each contained two participants. Two informants were older than 38 years of age.

Table 1. Age of Informants

<table>
<thead>
<tr>
<th>Age (in Years)</th>
<th>Number of Informants</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-25</td>
<td>4</td>
<td>40.00</td>
</tr>
<tr>
<td>26-31</td>
<td>2</td>
<td>20.00</td>
</tr>
<tr>
<td>32-37</td>
<td>2</td>
<td>20.00</td>
</tr>
<tr>
<td>38-43</td>
<td>1</td>
<td>10.00</td>
</tr>
<tr>
<td>44-over</td>
<td>1</td>
<td>10.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>
As shown in Table 2, 90 percent (9) of the informants were married and one was single. All informants had completed high school and 8 had attended college (Table 3). One participant attended beauty school and one attended a business school.

**Table 2. Marital Status of Informants**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number of Informants</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>9</td>
<td>90</td>
</tr>
<tr>
<td>Single</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Table 3. Education of Informants by Type and Years Completed**

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of Informants</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School</td>
<td>10</td>
<td>100.00</td>
</tr>
<tr>
<td>College</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 years</td>
<td>3</td>
<td>30.00</td>
</tr>
<tr>
<td>2 years</td>
<td>4</td>
<td>40.00</td>
</tr>
<tr>
<td>3 years</td>
<td>1</td>
<td>10.00</td>
</tr>
<tr>
<td>4 years</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Business School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 years</td>
<td>1</td>
<td>10.00</td>
</tr>
<tr>
<td>Beauty School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 year</td>
<td>1</td>
<td>10.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>
As seen in Table 4—50 percent (5) of the informants were housewives. One informant was retired and the other 4 worked in a variety of positions.

Table 4. Occupation of Informants

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number of Informants</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housewife</td>
<td>5</td>
<td>50.00</td>
</tr>
<tr>
<td>Secretary</td>
<td>2</td>
<td>20.00</td>
</tr>
<tr>
<td>Retired from Secretarial Work</td>
<td>1</td>
<td>10.00</td>
</tr>
<tr>
<td>Real Estate</td>
<td>1</td>
<td>10.00</td>
</tr>
<tr>
<td>Escrow Office Manager</td>
<td>1</td>
<td>10.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The number of years the informants had been a Seventh-day Adventist ranged from 6 months to 33 years, with a mean of 12.5 years. The length of time that the participants had been Seventh-day Adventists was: 1-6 months—1; 3-4 years—3; 5-6 years—2; 20-25 years—3; and 30-33 years—1.

Interview Content

A series of six open-ended questions (see Appendix E) were given to each participant and their verbal responses to these questions were tape recorded. Their verbal responses were then transcribed from the
recording. From the data, the investigator developed a taxonomy of words and phrases for each of the questions answered by each of the informants (Appendix F). From these data the following information emerged:

1. Four topics
   a. Topic I—Wellness Defined
   b. Topic II—How Do You Keep Well?
   c. Topic III—Health Defined
   d. Topic IV—Difference between Health and Wellness

2. Definition of wellness—as having to do with the whole man
   a. Spiritual
   b. Mental
   c. Physical

The first three questions, (1) What does wellness mean to you?, (2) Tell me certain key words that come to your mind when you think of wellness, and (3) What is it like when you feel your best?, all defined wellness. The words and phrases used by the participants to answer these questions defined wellness as having to do with the whole man, the physical, mental, and spiritual.

In question 4, How do you keep well?, the majority of the informants stated that the way they kept well was by utilizing the following three methods: mental, spiritual, and physical (Appendix F).

In the last two questions, (5) How would you define being healthy?, and (6) Do you think there is a difference between health and wellness? If yes, how would you describe this difference?, the
difference between health and wellness was identified and was essential in giving the investigator a basis for comparison between the health and wellness responses. Understanding the informant's definition of health determined whether the informant was distinguishing health and wellness or using them synonymously. These two questions provided interesting data. Six of the participants responded that there was a difference between health and wellness and four informants responded that there was no difference between health and wellness.

The six informants who saw a difference between health and wellness identified this as being in either of the two areas: (1) the physical, or (2) the totality of the physical, spiritual, and mental. Five informants identified health as being physical only and one identified health with the three aspects of man: Physical, mental, and spiritual, with the difference only one of degree. Wellness was identified by one of the participants as being only physical; whereas five of the informants defined wellness as having to do with the whole man, the physical, mental and spiritual (Table 5).

A trend was noted between the length of time the participants had been a Seventh-day Adventist and in how they defined wellness (Table 5). Wellness was defined by five of the participants as involving the whole person—physical, mental, and spiritual. One of the five participants who gave this definition for wellness, one had been a Seventh-day Adventist for over 5 years and four had been a Seventh-day Adventist longer than 20 years. The one participant who defined wellness as only physical had been a Seventh-day Adventist for 6 months.
Table 5. Differences Identified between Health and Wellness by Six Informants in Relationship to the Number of Years They Have Been a Seventh-day Adventist

<table>
<thead>
<tr>
<th>Health and Wellness by Categories</th>
<th>Number of Informants</th>
<th>Time in the Church</th>
<th>Number of Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Physical</td>
<td>5</td>
<td>5 years</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20-25 years</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>33 years</td>
<td></td>
</tr>
<tr>
<td>2. Physical</td>
<td>1</td>
<td>6 months</td>
<td>1</td>
</tr>
<tr>
<td>Mental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wellness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Physical</td>
<td>1</td>
<td>6 months</td>
<td>1</td>
</tr>
<tr>
<td>2. Physical</td>
<td>5</td>
<td>5 years</td>
<td>1</td>
</tr>
<tr>
<td>Mental</td>
<td></td>
<td>20-25 years</td>
<td>3</td>
</tr>
<tr>
<td>Spiritual</td>
<td></td>
<td>33 years</td>
<td>1</td>
</tr>
</tbody>
</table>
Another trend that was noted was between the length of time a participant had been a Seventh-day Adventist and whether the participant saw a difference between health and wellness. Of the six informants who saw a difference between health and wellness, one participant had been a Seventh-day Adventist for 6 months, one for 5 years, and four for over 20 years. Of those informants who did not see a difference between health and wellness, one had been a Seventh-day Adventist for three years, two for 4 years and one for 6 years.

This suggests that the length of time one is exposed to the teachings of the Seventh-day Adventist church, with its emphasis on a wholistic (this is the preferred spelling of the Seventh-day Adventist) approach to the individual, is related to one's acceptance and identification with that teaching.

**Development of Taxonomy**

From the taxonomy (Appendix F), the investigator selected words and phrases to be placed under each of the four corresponding topics. This list of words and phrases was developed for the following reasons:

1. This made access to the data easier and also made the data more concise and more readily workable.
2. This action protected the anonymity of the informants.

The number of words and phrases under each of the four topics identified were as follows:

1. Topics I—Wellness Defined—83 words/phrases
2. Topics II—How Do You Keep Well?—125 words/phrases
3. Topic III—Health Defined—57 words/phrases
4. Topic IV—Difference between Health and Wellness—10

Health—21 words/phrases
Wellness—26 words/phrases

From this list of words and phrases, the investigator then identified the following three specific categories for each of the four topics which emerged from the words and phrases:

1. Physical
2. Mental
3. Spiritual

This was done so that the investigator could compare the data analyzed with the other two coders. This constituted the agreement reliability of coders.

The investigator met the two coders at the same time and the following instructions were given:

1. That the specific categories must be chosen from the words and phrases from the list;
2. That the words and phrases be placed as subcategories under the specific categories;
3. That the specific categories and subcategories for each of the four topics be identified;
4. That the list of words and phrases be returned to the investigator within seven days, and
5. That each coder work individually in coding the specific and subcategories and are not to compare their results.
The investigator gave the coders identical lists of the words and phrases under each of the four topics. Each coder then identified:

1. Specific categories that emerged from the words and phrases.
2. Words and phrases taken from the list as subcategories.
3. Specific categories and subcategories under each of the four topics.

Both coders returned their list of identified specific categories and subcategories to the investigator within a seven-day period.

**Interrater Reliability**

To estimate interrater reliability of the coders, the investigator developed a standard set of responses on which she and the other two coders had to agree by the 85th percentile. The agreement, by the three coders, of the specific categories under each of the four topics, as 90 percent (Table 6).

In each of the four topics the following specific categories were identified:

1. Physical
2. Mental
3. Spiritual
4. Whole

In each of the four categories three specific categories—mental, physical, and spiritual—had a 100 percent agreement among the three coders. The category—whole—had a 33 percent agreement among the coders, thus not having reliability.
Table 6. Agreement by the Three Coders of the Specific Categories by Each of the Four Topics

<table>
<thead>
<tr>
<th>Topics Specific Categories</th>
<th>Number of Coders</th>
<th>Percent of Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topic I—Wellness Defined</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Mental</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Spiritual</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Whole</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td><strong>Topic II—How Do You Keep Well?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Mental</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Spiritual</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Whole</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td><strong>Topic III—Health Defined</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Mental</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Spiritual</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Whole</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td><strong>Topics IV—Difference between Health and Wellness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Mental</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Spiritual</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Whole</td>
<td>1</td>
<td>33</td>
</tr>
</tbody>
</table>
Analysis of Data

The analysis of the collected data—verbal responses of words and phrases—utilized the process of content analysis. The analysis of the qualitative data yielded nominal and verbal ordinal data. Frequency distributions for the specific categories and subcategories were calculated.

The analysis of the summary of the taxonomy (Table 7) for each of the questions answered by each of the informants demonstrated the following data:

1. In questions (1) What does wellness mean to you?, (2) Tell me certain key words that come to your mind when you think of wellness, and (3) What is it like when you feel your best?, wellness was perceived by five of the six informants as being physical, mental, and spiritual.

2. In question 4, How do you keep well?, the majority of the informants perceived how they keep well as being physical, mental, and spiritual.

3. In question 5, What does being healthy mean to you?, the following number of participants perceived health as being:
   a. Physical—10
   b. Mental—7
   c. Spiritual—3

4. In question 6, Do you think there is a difference between health and wellness?, the data gathered were as follows:
   a. Health was perceived as only physical by five of the participants.
Table 7. Summary of Taxonomy by Categories

<table>
<thead>
<tr>
<th>Informant</th>
<th>Physical</th>
<th>Mental</th>
<th>Spiritual</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1: What does wellness mean to you? (Wellness)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td>not categorized</td>
</tr>
<tr>
<td>B</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>good health</td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td>not categorized</td>
</tr>
<tr>
<td>E</td>
<td></td>
<td></td>
<td></td>
<td>not categorized</td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td>X</td>
<td>not categorized</td>
</tr>
<tr>
<td>G</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Question 2: Tell me certain key words that come to your mind when you think of wellness. (Wellness)

| A         |          |        |           | not categorized |
| B         | X        |        |           |                 |
| C         |          |        |           | not categorized |
| D         | X        |        |           |                 |
| E         | X        |        | X         |                 |
| F         | X        |        |           |                 |
| G         | X        |        | X         |                 |
| H         | X        |        |           |                 |
| I         | X        |        | X         |                 |
| J         |          |        |           | healthy         |
Table 7. Summary of Taxonomy—Continued

<table>
<thead>
<tr>
<th>Informant</th>
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<th>Mental</th>
<th>Spiritual</th>
<th>Remarks</th>
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</thead>
<tbody>
<tr>
<td><strong>Question 3:</strong> What is it like when you feel your best? (Feel best)</td>
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<td>A</td>
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</table>

**Question 4:** How do you keep well? (How keep well)

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<th>Mental</th>
<th>Spiritual</th>
<th>Remarks</th>
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Table 7. Summary of Taxonomy—Continued

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<th>Remarks</th>
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</thead>
<tbody>
<tr>
<td>Question 5: What does being healthy mean to you? (Healthy defined)</td>
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<tr>
<td>D</td>
<td>X</td>
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<td></td>
<td>wellness, physical, mental, spiritual</td>
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<tr>
<td>E</td>
<td>X</td>
<td></td>
<td></td>
<td>to be well, to be healthy</td>
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</table>

Question 6: Do you think there is a difference between healthy and wellness? If yes, how would you describe the difference.

<table>
<thead>
<tr>
<th>Difference</th>
<th>Health Physical</th>
<th>Mental</th>
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<th>Wellness Physical</th>
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</tbody>
</table>
b. Health was perceived as physical, mental, and spiritual by only one informant.

c. Wellness was defined as only physical by one of the informants.

d. Wellness was defined as physical, mental, and spiritual by three of the participants.
CHAPTER 5

CONCLUSIONS

This chapter related the findings to the conceptual framework and to previous findings reported in the literature. Its limitations are discussed, and recommendations for further study are presented.

Relationship of Findings to the Conceptual Framework and the Literature Review

A fundamental part of the framework was the concept that a man's health behavior is guided and limited by his personal and social values, his beliefs, and his attitudes toward himself, other people, and the world about him (Knutsen, 1965). This concept has proved to be true in the particular context of this study. It has been shown that as a church, the Seventh-day Adventist church places a high value on health and the proper functioning of the whole man. This value has been perceived as being both a part of the social context of the church to which the individual belongs and an accepted part of the value system of the individual member. This study also demonstrated that what the church believes in regard to the wholistic view of man has been accepted by the informants in the study and forms a fundamental part of the average member's understanding that wellness involves the whole being—physical, mental, and spiritual.

Wellness is then perceived as a value that the church holds and the individual accepts as his own. This perception has very
tangible results that affect the person's lifestyle choices and his health practices. Anyone working with this particular group (Seventh-day Adventist) would be aided in his work by recognizing both the strength of this value and its sophistication in relation to its integration into the various parts of the individual member's life.

As the conceptual framework started, perceptions are formulated by each individual into defined concepts that can be translated into words understood by those who share his culture. These concepts provide the means by which perceptions of individuals become a part of the cognitive field of the person and his culture (Kay, 1972; Spradley, 1972). This statement suggests that an important part of the process of perception is the ability to formulate this perception into words and by this means the perception is made a part of the cognitive field of the individual and his culture. This study found a relationship between the perception and the ability of the individual participant to clearly define his concepts and to state these concepts in words. As has been noted earlier, those who perceive most clearly the church's and their own understanding of wellness and health were best able to distinguish and clearly differentiate these concepts and to state these understandings in clearly defined terms.

A second fundamental part of the framework dealt with those definitions of wellness proposed by various health professionals. The framework noted two aspects of wellness. First, wellness is associated with the optimum functioning of a person or the maximizing of the individual's potential (Dunn, 1977). Secondly, this optimizing or maximizing is related to the whole man, his physical, mental, social,
and environmental well-being (Bruhn et al., 1977; Jomann, cited by Kintzel, 1971). This study was designed to determine whether a distinction between health and wellness existed on the part of lay persons and, if so, what that definition of wellness was.

The study found that the majority of the subjects do make a clear distinction between health and wellness and that this distinction is related to the length of time as a member of the church (Table 5). The findings also show that their definition of wellness was very similar to that made by health professionals. In the definition of wellness given by the participants in the study, the individual would be capable of functioning at his potential and this would involve his mental, physical, and spiritual dimensions—the whole person.

The basic distinction the health professionals have made between health and wellness is the emphasis on the integration of the whole man as fundamental to his concepts of wellness. That this is also what marked the definition and distinction made by the majority of the participants in the study demonstrates a rather marked sophistication on the part of this particular population. It is undoubtedly due to the fact that health and wellness are an important value of the Seventh-day Adventist subculture and, as has been stated in the literature (Brownlee, 1978), this plays a significant role in shaping beliefs, values, and perceptions. It is interesting to note that an emphasis on a wholistic view of man is not only central to the church's teaching about health but also forms one of the fundamental beliefs that underlies the whole religious and doctrinal system of the church.

This perception of the integrated nature of man's functioning should
be seen in the light of the whole teaching of the Seventh-day Adventist church and not only as a part of its health emphasis.

The literature stated that the most common way a person determines his own health status was by how it affected one's activities (DiCenco and Apple, 1958). The issue of health only becomes important when it interferes with daily activities. In this study, most informants did define health and wellness according to physical ability, conditions and activities; however, they also included the status of mental and spiritual health as helping to define the overall conditions of one's health or wellness.

The study also showed that there is an integration between perception and activity. The participants not only accepted the values and definitions of the church but also most of them follow quite closely the health practices suggested by the church such as the diet (lacto-ovo vegetarian; abstinence from caffeine, tobacco, alcohol, and drugs; adequate exercise; and preventive medical care).

It can be concluded then that the study has, as was suggested by the conceptual framework, demonstrated a relationship between perception as influenced by one's values, beliefs, and attitudes particularly as these are influenced by one's religious subculture and one's understanding of wellness. The study also showed that concepts of wellness that involve an integrated, wholistic approach to man's being could be accepted and understood by lay persons. It also showed that this understanding of wellness would have a positive influence on one's attitude and responses to the health-care system.
Limitations

The limitations identified in this study were:

1. The following bias may have occurred because the investigator is the wife of the Seventh-day Adventist church pastor:
   a. The informants may have volunteered to impress the pastor.
   b. The informants' responses may have been affected by their desire to appear as members accepting the official standards of the church.

2. The informants may not have answered the question as honestly if they were not following the guidelines of the church in regard to health.

3. The sample was a limited, convenience sample.

4. Seven of the interviews were held in the informants' homes and three in offices. Many variables may have influenced the informant's responses in the two different types of environments.

Recommendations

Based on the findings of this study, the following recommendations are made:

1. Repeat the study using a larger sample.

2. Repeat the study using a comparative approach by:
   a. Having half of the informants Seventh-day Adventist Anglo women and half non-Seventh-day Adventist Anglo women.
   b. Having half of the informants Seventh-day Adventist Anglo men and half Seventh-day Adventist Anglo women.
3. Repeat the study using the same type of environment for each interview.

4. Repeat the study to compare how education, beliefs, values, socioeconomic status, and culture affect the perception of wellness in Seventh-day Adventist Anglo women.

5. Repeat the study with someone other than a pastor's wife collecting the data.
APPENDIX A

HUMAN SUBJECT'S CONSENT FORM

I agree to participate in a study entitled "Wellness as Perceived by Seventh-day Adventist Anglo Women."

The purpose of this study is to determine how I perceive wellness.

I understand that I will be asked a series of questions related to my understanding of wellness. The estimated time for the interview will be thirty minutes and my participation will be required for only one interview. The interview will be conducted in my home or an office. I understand that the interview will be tape recorded to aid in the accuracy of the study and that upon the conclusion of the study the tape will be erased.

I understand there will be no physical or mental risks involved in my participation in this study. By agreeing to participate in this study, my spiritual care will not be affected. The information which is obtained will be treated as privileged and confidential. I understand that the results of this research will be published but that my identity will remain anonymous.

I also understand that this consent form will be filed in an area designated by the Human Subjects Committee with access restricted to the principal investigator or authorized representative of the College of Nursing. I understand that a copy of this consent form is available to me upon request.

I agree to the above "Subject Consent." The purpose and procedure have been explained to me. I understand, although I will not derive any personal benefits from the study, that the results may lead to improvements in the care of health care consumers. I understand I may ask questions during the interview for explanation and may withdraw from the study at any time. I also understand that there is no monetary payment involved with my participation and there are no costs that I am expected to assume.

Subject's Signature _______________________________ Date ____________

Investigator's Signature ___________________________ Date ____________

Witness' Signature ________________________________ Date ____________

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APPENDIX B

TAXONOMY OF WORDS AND PHRASES FOR EACH OF THE QUESTIONS USED IN THE PILOT STUDY

Question 1: Wellness

- Attitude
- Mind
- Integration
- Body
- Vivaciousness
- Positiveness
- Feeling of being on top of the world

Question 2: Wellness

- Being together
- Happiness
- State of mind
- Good attitude toward the world around you
- Good attitude toward your work
- You can take things
- Quickness of Mind
- Effetvescence
- Your body is in tone and shape
- Feel you can do anything

Question 3: Feel Your Best:

- Your mind is at the edge of things
- You can cope with whatever things come up
- Keep in balance
- physical body
- mind
- active

Question 4: How Keep Well:

- exercise, diet activities
- well balance
- balancing program
- Total Program
- for everyday living
- mental balance
- balance of all nutrients, rest, spiritual, creative
Question 5: Healthy
Not being incapacitated
Being able to do things you need to do
Not being held back by physical inability to do them

Question 6: Difference between health and wellness
Health—health is purely physical
Wellness—total well being

Question 7: Factors that influenced understanding of wellness
Classes (on health)
Study-ready
Personal experience past present
Staying away from drugs
Natural remedies
Go to doctor as last resort
Recognize that there is a health problem

Question 8: Understanding of wellness in regards to seeking health care
diet analysis
Preventive
take extra remedies
go to chiropractor
exercise balance
nutrition balance
APPENDIX C

SERIES OF OPEN-ENDED QUESTIONS
USED FOR PILOT STUDY

1. What does wellness mean to you?
   Or
   How would you define wellness?

2. Tell me certain key words that come to your mind when you think of wellness
   Or
   Tell me some words that you associate with wellness.

3. What is it like when you feel your best?
   Or
   Describe how you feel when you feel your best.

4. How do you keep well?
   Or
   What do you do to stay well?

5. What does being healthy mean to you?
   Or
   How would you define being healthy?

6. Do you think there is a difference between health and wellness?
   If yes, how would you describe this difference?
   Or
   Do you make a distinction between health and wellness?
   If yes, how would you describe this distinction?

7. What factors have influenced your understanding of wellness?
   Or
   What have been the significant factors that have developed your understanding of wellness?

8. How does your understanding of wellness influence you in regards to seeking health care?
   Or
   Could you describe how wellness affects your decisions in seeking health care?
APPENDIX D

SERIES OF OPEN-ENDED QUESTIONS USED IN STUDY

1. What does wellness mean to you?
   Or
   How would you define wellness?

2. Tell me certain key words that come to your mind when you think of wellness.
   Or
   Tell me some words that you associate with wellness.

3. What is it like when you feel your best?
   Or
   Describe how you feel when you feel your best.

4. How do you keep well?
   Or
   What do you do to stay well?

5. What does being healthy mean to you?
   Or
   How would you define being healthy?

6. Do you think there is a difference between health and wellness?
   If yes, how would you describe this difference?
   Or
   Do you make a distinction between health and wellness?
   If yes, how would you describe this distinction?
APPENDIX E

TAXONOMY OF WORDS/PHRASES FOR EACH QUESTION BY INFORMANTS

Question 1

Informant A:

Wellness

Being able to do what I want to do, when I want to do it

Not having to worry about coming home and dying for a couple of hours after I finish doing it

Informant B:

Spiritual (is most important)

relationship with Christ, time everyday to study the Bible, praying, communion with God.

Physical

keeping fit, exercise, good diet, keeping body physically fit

Mental

more capacity to be mentally balanced
see life in more joyful perspective
having meaning for your life
feel life is worth living

Informant C:

Physically

Wellness—good health

Mentally

Spiritually

healthy outlook on life

Informant D:

Feeling fit

Wellness

To be able to do what I'd like to do without being hindered
Informant E:

**Wellness**
- Not being sick
- Physically able to do for yourself and family.

Informant F:

**Wellness**
- Spiritual
- Physical  
  - mental
- Free from sickness = physical

Informant G:

**Wellness**
- Physical  
  - if one of these is lacking or is a problem area it will affect physical
- Mental  
  - if one of these is lacking or is a problem area it will affect physical
- Spiritual  
  - if one of these is lacking or is a problem area it will affect physical
- Absence of sickness and disease

Informant H:

**Wellness**
- Physical
- Mental
- Spiritual  
  - working toward a relationship
- Optimum health
  - physically
  - didn't have any problems  
  - mentally
  - could handle just about physically
- any situation that came up  
  - mentally

Informant I:

**Wellness--**
- Physical
- Mental
- whole being
  - whether you feel or not feel well
- way you feel, attitude
- complete picture

Informant J:

**Wellness--**
- Physical health
- Mental health
- Spiritual health  
  - (everything to make you personally as a whole healthy. If lack in some of these areas = cause themselves not to be well)
Informant A:

Wellness

Feeling good
Nor having to worry about being sick

Informant B:

Peace of mind
Joy, Joy in life
Joy in what you're doing
Joy in daily life

Wellness
Feeling physically fit
Feeling energetic
Having energy to go about your life
Physical energy to deal with daily routines
Mental energy

Informant C:

Wellness
Health
Enjoyment of life

Informant D:

Vigor
Stamina
Rosy cheeks

Wellness
Not being tired
Perfect health
able to jog without getting out of breath

Informant E:

Wellness
Mentally fit
Physically fit
Spiritually fit

if you have spiritual fitness you can handle the other two if you don't have them

Informant F:

Wellness
Happy, fitness
Not fat
Positive outlook on life
Enjoy life
Informant G:
Wellness

Informant H:
Wellness

Informant I:
Wellness

Informant J:
Wellness

Informant A:

Informant B:

Question 3
Informant B: (Continued)

Informant C:
Feel your best
Ready to do things

Informant D:
Feel like it is a perfect day
I'm in a better frame of mind
Feel your best
Feel like going and digging in garden
Feel like mowing the yard
Getting things done

Informant E:
Feel I can do anything
Take care of myself
Feel your best
Have time for myself
Being able to do things
Feel good in your mind— not depressed
don't feel down
feel good

Informant F:
Look good to others
Feel good about helping others
Feel your best
Can relate better to people
Like being around people

Informant G:
Spiritual
Have right relationship with God, feel
Feel your best— feel contentment in knowing you have close relationship
good about feeling joy in knowing you have close relationship (with God)
Informant G:  (Continued)

Mental
feel mentally stable and happy

Physical
taking good care of your health

Informant H:
Fantastic
Feel like doing all kinds of things
Feel like going for a walk
Feel like working

Feel your
best

Feel like meeting people
Feel excited over little things
Treat people nicely
Treat kids nicely
Feel really great
Feel like cleaning the house

Informant I:
Super great
Feel your
best
Feel good all over
Feel happy
Good feeling
A feeling

Informant J:
Physically in good shape
Being together

Feel your
best
mentally happy
happy with what is going on in my life
Things are going right
Good wholesome feeling

Question 4

Informant A:
How keep well
Eat the right things
Get enough physical exercise

Informant B:
How keep well
Spiritual
having a going relationship with God
mind clear to perceive spiritual things
Spiritual balance
Informant G:

Physical
  conscious about having a good diet
  body stays in proper condition
  exercise---muscles stay in tone
  physically fit
Mental
  exercise mental capacity in relation to
  other people
How keep well (three areas)
  keeping up on things that happen---world events
  keep active---reading, schooling
Spiritual
  keep spiritual life active
  prayer, Bible study,
  reading something to improve spiritual health

Informant H:

Eat three meals a day
Get enough sleep
  seven and one half to eight hours
Get exercise
Don't let things pile up---try not to get behind
  in work like washing and ironing
How keep well
  Spiritual
  continue relationship with God
  Keep busy
  Keep your mind
    fill it with good things, things that are happy
    fill with real life stories (not novels)
    something that is inspiring to you
  Good food

Informant I:

Eating habits
  big breakfast
  big lunch
  popcorn and fruit for supper
  eat light so don't go to bed with heavy feeling
Sleep
  with window open
  with cool air
Informant B: (Continued)

Physical exercise
   read information on education to keep body well, about diet, kinds of things that bring you mental satisfaction
   improve life style
Living out in the country
Conscious about way I eat

Informant C:

Exercising
   walking, taking long walks
   doing ordinary work
   yard work
Eating properly
Study
   the Bible

Informant D:

Eating the right things
Getting exercise
Keeping mind from worrying
   by prayer
   read the bible
   avoid different subjects with different people

Informant E:

Balanced diet
Plenty of water
Sunshine
Fresh air
Exercise
Sleeping at regular hours
Time for spiritual being

Informant F:

Exercise
Watch what I eat—diet
Drink enough water
Try not to sneeze too much
Being outside a lot
Informant I: (Continued)

Total health:
spiritual—with help from God, asking
His guidance or help if feeling down
mental—attitude
healthwise—way you eat, way you sleep,
exercising

Informant J:

Physically
eating—eat the right foods
healthful foods
vegetarian-type diet
exercising—keep in shape physically
sports/tennis

Mental
maintain mental happiness
working things out
by communication
studying in field of psychology
sit down and iron it, (problems) out.

Question 5

Informant A:

Healthy
Being able to do what I want to do
when I want to do it
without side effects
Feeling good

Informant B:

Healthy
Physical
having relationship with God
maintain spiritual growth
everyday exercising
eating right
physically fit

Informant C:

Healthy
Not illness
Healthy people can be ill at some time too
Able to do activities you like to do
Eat properly, eat things you like to eat
Not having to take medications
Mental health
Informant D:

Wellness
Being sick but healthy
Healthy
Rosy cheeks
No physical infirmities

Informant E:

Not being sick
To be healthy
Healthy
To be well
Without illness

Informant F:

Not sick
Sense of well being
Healthy
Feels the healthiest
Feels well being
not down on yourself
not depressed
have positive attitude about life
feel good about yourself

Informant G:

Rarely becoming sick
when sick you recuperate quickly
Healthy
Whole life affected
physical--do more physically
mental--do more mentally
spiritual--do more spiritually
if sick in one of these areas, will affect
other two

Informant H:

Want to get up in the morning
Want to go to work
Want to have a family
Healthy
Want everybody to be nice
Not having aches and pains that make you
feel down and depressed
Feeling good about yourself
Not feeling someone down on you
Informant H: (Continued)

Healthy

- Not feeling you were down on yourself
- Think well of yourself
- Healthy
- If had aches and pains you would be able to handle that situation
- Not having worries or anxieties that make you feel down or depressed

Informant I:

- Eating
- Healthy— whole health
- Eating food you eat or don't eat
- Sleeping
- Exercise

Informant J:

- Healthy— somebody that cares about themself in all aspects/categories
- Mental health—emotional
- Physical
- Spiritual
- Strive to complete all the categories

Question 6

Informant A:

1. Is there difference between health and wellness: No
2. Difference
   you have to be well in order to be healthy
   being healthy means: being physically fit
   - not having a cold
   - won't get sick
   being well is not being physically fit

Informant B:

1. Is there difference between health and wellness: Yes
2. Difference:
   - health— not as broad term as wellness
   - feel okay that day
   - healthy today (means they feel fine right now)
   - not necessarily means long term program of their life is going to lead to well being
   - health not necessarily all of those things: physical, mental, spiritual
Informant B: (Continued)

Wellness—accurate balance in your life
  spiritual well being
  physical well being
  mental well being—right attitudes, right relationship with spouse

Informant C:

1. Is there difference between health and wellness: No
2. Both the same
   There isn't wellness unless there is health

Informant D:

1. Is there difference between health and wellness: Yes
2. Health—having good complexion
   feeling good
   being bright
   being able to answer these questions
3. Wellness—
   vigor
   stamina
   rosy cheeks
   not being tired
   jog without getting out of breath
   feeling fit
   able to do what I'd like to do without being hindered

Informant E:

1. Is there difference between health and wellness: No
2. If you're healthy you'll be well
   healthy—always healthy, therefore, never get sick, so I never have to be well
   good diet
   things I said before for wellness
   physically able to do for yourself and family
   mentally fit
   physically fit
   spiritually fit

Informant F:

1. Is there difference between health and wellness: Yes
2. Health—can be healthy and still be lacking (mentally and spiritually healthy).
   Wellness—mentally and spiritually (physical)
Informant G:

1. Is there difference between health and wellness: Yes
2. Difference:
   health—definition—more physically being healthy
   wellness— involves more than physical being:
   physical being
   attitude towards life is optimistic,
   keeps you going
   whole life and all areas of your life have:
   a purpose
   a meaning
   promote a feeling and attitude of wellness
   have feeling and importance that you
   you belong
   have a place in life
   have a goal

Informant H:

1. Is there difference between health and wellness: Yes
2. Difference:
   healthy—physical body
   wellness—includes all three—physical, mental, spiritual

Informant I:

1. Is there difference between health and wellness: No
2. If you are well you are going to be healthy
3. If you are healthy you are well.

Informant J:

1. Is there difference between health and wellness: Yes
2. Difference:
   health—more broad term than wellness
   get more categories as a whole—mental, physical, spiritual
   Wellness—takes in healthiness
   can be well and not necessarily health
   could be well physically and not mentally well
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