

## RESEARCH REPORT

# A preliminary study on the concept of health among the Chinese

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**ABSTRACT** *In this qualitative study, lay people's conceptions of health were explored through focus group discussions. Two hundred and one college students and 45 community female adults participated in the groups and they were considered as informants. Content analysis supported a four-dimensional model of health, hierarchically organized to represent clinical health, role health, adaptive health and well-being health. Although such a multidimensional model of health was similar to the Western models in structure, Chinese conceptions of health placed far greater emphases on social harmony and being at ease with life. The unique Chinese heritage of the Yin-Yang theory, its emphasis on homeostasis, and the characteristic Confucian values of social orientation were further discussed in the context of health.*

## Introduction

You know what health is, don't you? How would you define it? The dictionary says that health is 'a state of well, or not ill; freedom from illness of any kind' (*Eurasia's Modern Practical Dictionary*, p. 756). People are said to think of health in this way, too. More specifically, health is thought about in terms of an absence of: (1) objective signs that the body is not functioning properly, such as measured high blood pressure; or (2) subjective symptoms of disease or injury, such as pain or nausea (Birren and Zarit, 1985; Thoresen, 1984).

Both the linguistic and lay definitions seem to emphasize physical functioning exclusively, however objective or subjective the indicators are. However, there are contrasting definitions of health proposed by professionals of different disciplines. The biomedical model reflects the preoccupation with the physical state of the body in both health and illness. It proposes that all diseases or physical disorders can be explained by disturbances in physiological processes, which result from injury, biochemical imbal-

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ances, bacterial or viral infection, and the like (Engel, 1977; Leventhal *et al.* 1985). The biomedical model assumes that disease is an affliction of the body and is separate from the psychological and social processes of the mind. This medical conception of health is fundamentally a 'disease' model.

Psychologists have studied health, too. However, the prevailing psychological conception of health is still negative in nature, by equating and measuring health status with psychological symptoms. For instance, the 11 most widely used measures of 'psychological well-being' in the Western world are all symptoms checklists (Bowling, 1997). The psychological concept of health should encompass much more than the study of life stress and mental illnesses. More recent efforts by psychologists have reflected a focus on broader indices of health status. Positive affects, negative affects and long-term life satisfaction are now generally regarded as signs of health status, or subjective well-being (Andrews and Withey, 1967; Argyle, 1987; Lu, 1995). Common features of the psychological approaches to health are their great emphases on subjective evaluations and experiences and a full spectrum of psychosocial factors incorporated.

From a somewhat different vantage point, the socio-cultural concepts of health and disease place an emphasis upon the individual's capacity to perform certain social roles and life tasks in everyday living (Wolinsky, 1980). In this system, disease is a general disturbance of the individual's capacity to perform expected roles and tasks in life. Health is also relative to the individual's social status in the society, hence, health is socially defined. This broader view of health has introduced a new concept of 'social health' (Caplan, 1974; Cassel, 1976). Social health was viewed as a dimension of the individual's well-being distinct from both physical and mental health. Lerner (1973) noted that health status may be a function of non-health factors external to the individual, such as the environment, the community and significant social groups. Nonetheless, empirical studies of social health tend to focus on the individual, rather than on the community.

To stress the increasingly important roles of psychological and sociological factors in health and illness, the World Health Organization (WHO) had advocated a multi-dimensional conceptualization of health. 'Health is a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity' (WHO, 1958). Although no conceptual or operational definitions were provided, the WHO viewpoint of health has signified the end of the unidimensional model of health, and the beginning of a multidimensional paradigm.

The controversy provoked by this utopian definition does however, point to the need to understand lay people's concepts of health, which are pertinent to measuring subjective health status. People define their health variously, depending on sociodemographic factors and on their culture (Currer and Stacey, 1986; D'Houtard and Field, 1984). Their reported definitions include health as not being ill, absence of disease, as behaviour as role functioning, physical fitness, energy and vitality, social relationships and emotional well-being. Wright (1990) has summarized lay definitions of health as: health as being, health as doing, and health as having.

Bauman (1961) asked 201 clinical patients and 262 medical students for their definitions of health, and found three points of views, including feelings of well-being, absence of symptoms of disease, and the ability to perform what a person who is in good physical condition should be able to do. Although those expressed views still conveyed a

strong emphasis on physical state of well-being, over half of the respondents were aware that health may be a multidimensional concept, which encompassed more than one viewpoint. A later study with 264 first, fourth and seventh grade pupils generally confirmed the above findings (Natapoff, 1978).

Using a different approach, Smith (1981) systematically analysed the health concepts implied in modern education for health professions, and found four major types. They were named: (a) clinical model, meaning the absence of medical diagnosis of disease or disability; (b) role performance model, meaning the ability to fulfill social expectations of role functioning; (c) adaptive model, meaning the maintenance of optimal individual state in the process of the person-environment interaction; and (d) eudaemonistic model, meaning the highest state of self-actualization. Based on such a theoretical analysis, Laffrey devised a multidimensional health scale and administered it to 141 nursing postgraduate students (Laffrey, 1986). The results were generally confirmatory of the underlying model.

Although it is encouraging that the existing empirical evidence seems to support the multidimensional conception of health, these studies are dated. In the passage of time, a number of health-related phenomenon have emerged within medicine and in the larger society, which might in turn affect the lay people's cognition of health. For instance, the changing patterns of illness have raised many questions and challenges: Can someone with a chronic condition still be regarded as 'healthy'? Obviously, empirical evidence should be updated to take into account those profound changes occurring in the field of modern medicine.

Another more serious and important challenge is the issue of cultural relativity. Health may be a social goal common to all groups, its salience to individuals must be assessed relative to other goals. The place of health in one's value system will be reflected in one's definition of health. This has been amply demonstrated by the classic studies of Koos (1954) and Herzlich (1973) as well as by more recent research (Bowling, 1994). Although researchers have found that definitions of health varied according to age, sex, level of education (Cox *et al.* 1987) and socio-economic group (Blaxter and Patterson, 1982), the populations surveyed were all living in the Western world, and their beliefs and attitudes of health were all deeply embedded in the Western tradition.

Eastern civilizations, on the other hand, stress psychosomatic harmony. According to the Yin-Yang theory in Oriental healing arts, health is a state of physical and spiritual harmony with the great natural principle. Disease and sickness stem from a disturbance in the Yin-Yang principle (Hong, 1944). The Yin-Yang theory can be traced several thousands years back to an origin in Chinese history and culture of great antiquity. It is a life philosophy and a dualistic cosmic theory, which explains all activities of the universe, including human life. The central thesis is that the universe consists of two basic principles or natures, Yin and Yang; through the change of relationships between these two opposing forces, all creations were formed and are still constantly changing and keeping a state of homeostasis in nature, societies and human beings. Health is but one particular domain submissive to the influences of Ying and Yang. This view of health and disease thus surpasses the Western biopsychosocial model and calls for a holistic understanding of health, stressing a state of homeostasis in the human mind and body, the individual and his or her social, spiritual and natural environment. Scholars are now

strongly advocating for the potentially invaluable contributions that the Oriental healing arts can make to the modern Western health care system (Dorcas, 1997; Lee, 1985).

As briefly outlined above, the theory of Yin and Yang is a pervasive Chinese life philosophy, Confucianism as a guiding moral and value system translates the life philosophy into customs and rituals, beliefs and attitudes, rules and norms, feelings and behaviours. We will see later that its imprints on lay people's health conceptions are profound and obvious.

Confucian philosophy presupposes that the life of each individual is only a link in that person's family lineage and that an individual is a continuation of his or her ancestors. The same reasoning can be applied to the person's offspring. This teaching puts one's family or clan right in the centre of one's entire life and mundane existence. Unlike in Christianity-dominated Western cultures, Chinese culture does not proclaim the pursuit of salvation in the next life as the ultimate concern, rather it advocates that one should strive to expand and preserve the prosperity and vitality of his or her family. To achieve this goal, a person must work hard and be frugal to accumulate material resources, obtain respectable social status, suppress selfish desires, lead a virtuous life, and fulfill one's social duties (Lu and Shih, 1997). In becoming a person, the Chinese societies stress harmonious relationships between the individual and his/her significant social groups, whereas the Western societies stress integrity of the self and separation of the individual from the larger society. Hence, the Chinese self-construal has been dubbed 'the interdependent self', whereas the Western one dubbed 'the independent self' (Markus and Kitayama, 1991). Emphasizing the importance of social interaction, Confucianism provides a basis for understanding the Chinese conception of health.

The objective of this study was thus twofold: first to reexamine whether the multi-dimensional conception of health could be supported by empirical evidence in the 1990's, and second, whether the contents of the health conceptions among the Chinese people were in any ways different from their Western counterparts as reported in the literature.

## **Methods**

Participants in this study were 201 undergraduate students and 45 community female adults in Taiwan. The students (aged 19–25 years) were in their second to fourth year, enrolled on a health psychology course at a medical college in a metropolitan city, and were majoring in medicine ( $n = 83$ ), other health-related disciplines ( $n = 85$ ), social sciences ( $n = 9$ ) and natural sciences ( $n = 24$ ). The community female adults (aged 25–63 years) were voluntarily attending an evening course on health psychology offered by a Kaohsiung county government neighbouring the above city.

To reflect the explanatory nature of the study, a qualitative approach was adopted. Data were collected through focus groups that took place in January and September 1998, and October 1999 in Fongshan and Kaohsiung, Taiwan. Focus groups are a qualitative research method of group interviews combined with participant observation where the researcher takes the role of moderator and relies on group interaction to produce data (Morgan, 1998). Focus group questions are aimed to elicit a wide range of responses from the group on a particular topic. In the present study, the focus group discussions were initiated by two probing questions: 'What is health?' and 'What is it like to be a healthy person?'. To strike a balance between a smooth flow of discussion and a sufficient generation of ideas, groups were formed with 5–8 members (mean = 6). No time limit was set, and discussions were concluded when group members felt that they had fully expressed their thoughts and ideas. Each group nominated a leader to manage the discussion. The study took place during the first class, hence, students and community

females participated at different times and different venues. Similarly, however, no substantial course materials were introduced, then.

Discussion records of the 41 groups were first carefully read through, and statements of health conceptions were then extracted to form the final transcript for analysis. As the purpose of this study was to examine the structure as well as contents of the lay person's health conceptions, necessary reorganization and rephrasing of respondent's responses were carried out. For instance, if an original statement contained two ideas or thoughts, it was then transformed into two statements to ensure that each statement entering the final analysis conveyed only one meaning or message. However, every effort was made to retain the informant's phrases as far as possible.

As focus groups were viewed only as a means for generating ideas and facilitate responses, no across group comparisons were envisaged. Since contents as well as frequencies of health conceptions were of interest, repetitive or very similar statements within informants, with group, across informants, across groups, were analysed and counted only once. Responses of the students and female adults were first examined separately due to clear demographic and socio-economic disparities. However, the responses from people of these two walks of life were strikingly similar. To be cautious, responses from groups conducted in two different years were also examined separately, and no systematic differences were found either. Altogether, the 246 respondents produced 86 distinct statements regarding their health conceptions.

A content analysis procedure was carried out with comments about health categorized into types or categories. The transcripts were read through, meanings interpreted, underlying themes searched and organized to develop a tentative classification scheme. After several cycles of revision, a master classification scheme consisting of four major categories and nine subcategories emerged.

One psychologist and one health-practitioner other than the researcher read the transcript independently later. Following the same procedure of analysis, they each came up with their own classification schemes, which were broadly similar in structure to that developed by the researcher. Trivial discrepancies in contents (e.g. which statement should go under which category or subcategory) were then discussed, and a consensus was reached in every instance. The master classification scheme was then retained and refined. Such an exercise was necessary to achieve intersubjectivity, hence contributing to the 'trustworthiness' of the study.

This analysis of the data was then conveyed back and explained to respondents during a later class session. This communication practice served as a validation of data and to gain any further insights, comments and clarification respondents wished to offer. Respondents agreed in general with the classification scheme, nonetheless, they used the opportunity to provide more detailed contextual information regarding the issues at hand. This exercise was another attempt to achieve intersubjectivity, hence further strengthening the 'trustworthiness' of the study.

## Results

Results are presented below and grouped into categories and subcategories representing the main themes emerged from the focus groups. Numbers in brackets are frequency counts for each category and subcategory.

### *Category 1: clinical health (15)*

Health was viewed as the absence of physical, mental and behavioural deviations. There were three elements in this view.

*Subcategory 1: normal physical functions (8).* For example, 'having the basic ability to carry out daily living activities', or 'the absence of disease'. Health was viewed as freedom from physical disease and abnormalities, indicated by signs and symptoms. Also, the

concept of functional ability was implied here. Health was conceptualized to be freedom from impairment, disability and handicap, and being able to perform basic daily activities without depending on others for help.

*Subcategory 2: normal mental functions (3).* For example, ‘absence of mental illness’ or ‘maintaining good moods’. Health was indicated as freedom from mental illness and symptoms. However, a more positive state of affect and psychological well-being were also envisaged.

*Subcategory 3: normal behavioural functions (4).* For example, ‘absence of bad habits’ or ‘absence of harm afflicting behaviours’. Health was indicated as absence of ‘bad behaviours’, or socially unacceptable undesirable behaviours.

### *Category 2: role health (28)*

This means the fulfilment of socially desirable role functions. There are two elements in this view.

*Subcategory 1: healthy life style (8).* For example, ‘keeping a regular regime in daily life’ or ‘having healthy leisure habits’. Health was regarded as the ability to lead a healthy life, to work, to leisure, to live. Contrasting to Clinical health, this conception of health conveyed a more positive connotation. Health was defined in the context of performance of socially desirable activities, and in the current case, keeping a health regime of life.

*Subcategory 2: fulfilment of social role obligations (20).* For example, ‘managing harmonious interpersonal relationships’ or ‘being sociable and relating to others’. Health was defined as the performance of normal social roles, depending on one’s age, gender and social standing in the society. Roles are obviously socially defined. Despite their variety and differing contexts where they are embedded in, their commonalities were stressed: social integration and harmony. Reaching out and relating to people, furthermore, building, maintaining and managing harmonious interpersonal relationships were viewed as an important obligation of a fully functioning social being.

### *Category 3: adaptive health (14)*

This means flexibility and balance in life. There are two elements in this view.

*Subcategory 1: effective coping with stress (10).* For example, ‘capable of adapting to the external environment’ or ‘being able to cope with stress, and not letting it interfere with social relations with others’. Health was defined in terms of personal and social adjustment. The concept of adaptive health was broader in scope than both clinical health and role health. It encompassed not just the absence of disease, the absence of interference with the performance of normal social roles and daily activities, but also the ability to cope, to seek and obtain social support, to adjust to the environment, to rise to challenges, and to maintain efficiency of mind and body.

*Subcategory 2: maintaining the balance (14).* For example ‘seeking a balance between optimism and pessimism, in accordance with the majority views in the society’ or ‘striking a balance between senses and sensibility’. In addition to the emphasis on resilience, coping and adjustment, ‘balance’, ‘equilibrium’ and ‘homeostasis’ were key concepts in this view of health, and all accorded vital importance in assessing health and wellness.

*Category 4: well-being health (29)*

This means upholding and pursuing the ultimate values in life. There were two elements in this view:

*Subcategory 1: being happy and content (10).* For example, ‘being happy and at ease with life’ or ‘spiritually calm and rich’. Health was defined as the ability to enjoy life, a high level of joy and positive affect, a clear sense of a spiritual commitment and satisfaction. Understanding the meaning of life and achieving psychological and spiritual tranquility were underlined as a very desirable state of health.

*Subcategory 2: positive beliefs and goal pursuing (19).* For example, ‘a positive outlook in life’ or ‘living one’s full potentials’. Health was viewed as an important goal in life and integrated with other life goals and values. Health was the state experienced when one was at the top of forms, when one was fully functioning and realizing one’s complete range of potentials. Health was equated with optimal autonomy, personal strength, and the ability to sustain a positive outlook in life. Health was also regarded as a means to pursue and achieve other important goals in life and as a route leading to ultimate happiness.

At the end of the focus group discussions, every group reached a general consensus, claiming that health should be labelled with multiple indicators. Although each group nominated different numbers of health indicators, ranging from 2–15 (mean = 5.34), they all evoked more than one viewpoint of health as delineated above. More specifically, in every focus group discussion, health was viewed more than the freedom from disease

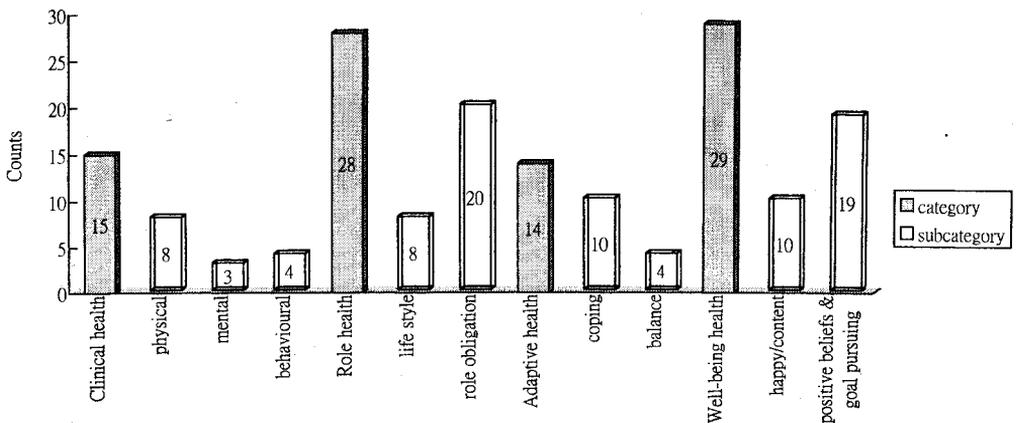


FIG. 1. The Chinese conception of health.

and abnormalities (clinical health). In fact, participants in each group went further to conceptualize health as the ability to perform social roles (role health), or the ability to adjust and keep a state of equilibrium (adaptive health), or a sense of 'completeness' and a general sense of well-being (well-being health), or a combination of these viewpoints. In other words, all participants were aware that health may be a multidimensional concept, which encompassed more than one viewpoint. Furthermore, these different viewpoints formed a hierarchical order, with clinical health at the base, role health and adaptive health in the intermediate, and well-being health at the top of the hierarchy. One participant described the hierarchy beautifully:

The lowest criterion for health is free from illness and pain. After that, we should abide with the social norms and not to harm other people. However, the highest measure of health should be a positive outlook in life.

During the later class session when preliminary results of the analysis were communicated back to the participants, the aforementioned viewpoints of health were made explicit and their meanings and implications fully explained. Participants agreed that the medical approach or negative conception (clinical health in this study) alone could not capture the rich meanings of health. Participants reasoned that clinical health may be necessary but is not sufficient in defining the concept of health. For instance, one student remarked:

If a terminal cancer patient can still retain his cheerfulness and positive outlook in life, then we should regard him as healthy. In the contrary, if someone who possesses tact limbs and perfect physical condition, enacts a lot of negative (socially unacceptable) behaviors, we would not regard him as healthy.

## **Discussion**

In terms of model structure, the Chinese conceptions were similar to the Western ones as delineated by Smith (1981). Both sets had four dimensions, depicting clinical health, role health, adaptive health and well-being health. There seems no doubt that health is better thought of as a multidimensional construct, and perhaps with a hierarchical organization. Clinical health can be regarded as a prerequisite to overall health and personal happiness (Lu and Shih, 1997); role health ensures smooth individual-to-others relationships and socially desirable functioning in the larger society; adaptive health emphasizes personal equilibrium in the face of stress or life upheavals; and finally, well-being health denotes the ultimate state of positive living, and also the highest state of wellness.

Although the Chinese and Western conceptions of health have similar dimensions, their constituting contents differ in several culturally meaningful ways.

In this study, while contemplating the definition of health or a healthy person, role health was the second most frequently evoked viewpoint, closely tracing behind well-being health. Within this viewpoint, role obligation was the more important element (20 out of 28 statements). Chinese respondents emphasized greatly the performance of social role, in particular the importance of harmonious social relationships, being socially integrated, having a lot of good friends, and being able to love others.

Participants also used social interaction as a framework when thinking about adaptive health, and evoked the maintenance of smooth interpersonal relationships as a criterion to judge effective stress coping and personal adaptation. For a Chinese person, adaptation is a heavily social phenomenon. Feeling well and being satisfied with oneself is not enough, one's overt behaviours, physical fitness, psychological state and spiritual commitment must be acceptable to the group where he/she is a part. 'Being a good person' is far more important and socially sanctioned than 'doing things right' in a Chinese society. More specifically, 'being a good person' implies adequately performing one's social duties towards one's immediate family, larger social groups where one is a part, and the human society at larger. Most of all, a Chinese person has to invest ample energy on managing a harmonious social network and ensure smooth and effective interpersonal transactions at all costs. Compared to the Western view of adaptation, the Chinese view is heavily embedded in the context of interpersonal relationships and social integration. Furthermore, the Chinese view of health as adaptation encompassed the idea of homeostasis within the individual as well as between the self and the others. This cultural imprint of moderation, balance and homeostasis can be traced back to the ancient Yin-Yang theory, which is not to be found in the Western literature.

All the Chinese conceptions of health (except clinical health) could be regarded as reflections of the deep rooted cultural value of relationship harmony and the supremacy of collective (social) welfare over individual desires. Corroborative evidence came from a recent cross-cultural study with college students in Hong Kong and the USA (Kwan *et al.*, 1997). Researchers found that 'relationship harmony' had a greater impact on life satisfaction in a collective society (Hong Kong) than in an individualistic society (USA).

In this study, the most frequently elicited viewpoint of health was well-being health. In this viewpoint, health was also defined in terms of inner contentment, feeling thankful to life, and striving for psychological and spiritual enrichment. Evidently, the ideal of achieving a virtuous life and peace of mind through understanding the meaning of life intricately embedded in the Chinese culture were reflected in these thoughts. The well-being health referred mainly to practising moral virtues through self-monitoring and self-improvement, and being at ease with life. This ultimate state of health corresponded nicely to the traditional Chinese philosophy of submission to, rather than controlling over the environment. It also represented the desirable end state of life, namely, harmony between Heaven, Earth, and people. In other words, a state of homeostasis in nature, human societies and individual human beings brought about by the harmonious relationships between Yin and Yang is the utmost aspiration of the Chinese conceptions of health.

Finally, the Chinese respondents on this study quite explicitly endorsed the idea of illness and wellness as ends of a continuum. For instance, on the one hand, 'early diagnosis and early treatment of illness' was articulated under the category of clinical health; on the other hand, 'positive attitudes towards illness' and 'living one's full potentials despite physical and mental disabilities' were articulated under the category of well-being health. This awareness that illness and wellness are not two separate concepts—they overlap—may be influenced by the changing patterns of illness and the emergence of the biopsychosocial model. As Antonovsky (Antonovsky, 1987, p. 3) noted

'We are all terminal cases. And we all are, so long as there is a breath of life in us, in some measure healthy'.

Several inferences can be drawn from this study. First, providers of health care services should be made aware that the Chinese conception of health may be at variance with those of health care professionals, who are normally trained and practicing in the tradition of the Western culture. This cultural sensitivity and cross-cultural communication is particularly vital in a health care system delivering service to people of multiple ethnicity. Second, to reflect the multidimensional conception of health articulated by the Chinese respondents in this study, we should seriously revise our focus, giving more attention to what enables people to stay well than what causes people to become ill. Thirdly, a better understanding of health conceptions of various socio-demographic subgroups could assist the health care providers in the planning and implementation of health promotion programmes to improve the quality of life for everyone in the society. Finally, the cultural differences unravelled in this study should also have important implications for developing measures of health or health status cross cultures.

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