SUBJECTIVE INDICATORS OF HEALTH HELD BY THE LAY POPULATION: EUDAIMONISTIC MODEL

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SUBJECTIVE INDICATORS OF HEALTH HELD BY THE LAY POPULATION: EUDAIMONISTIC MODEL

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SYNOPSIS:

The research sought to explore the following:

A. Whether members of the lay population can reflect upon the notion of health.

B. If such reflection can occur against a multi-faceted concept of health embracing notions of health, well-being, life satisfaction, quality of life and happiness.

C. Whether it is possible for the lay population to identify factors which they regard as influencing the multiple facets of health.

D. Having addressed the preceding three questions, whether it is then possible to identify an emerging conceptual map or framework held by the lay population in respect of multiple faceted concepts of health.

E. The methodological debate underpinning the research study; thereby the deficits and level of appropriateness of different methodological approaches.

Interviews, health diaries and relevant literature were used to establish items for inclusion within a Q sort survey. The main Q sort of 49 items was administered to 64 lay individuals selected from the electoral register and living in Corby. The findings indicate a multi-dimensional appreciation of the notion of health (embracing related concepts of well-being, happiness, life satisfaction and quality of life) together with identification of life factors which have an influence upon the concept. Accordingly a conceptual map or eudaimonistic model is derived, and the implications of this are considered against current health promotion strategies, policies and priorities, and health professional educational curriculum, together with issues for further research. The thesis also seeks to engage the reader in a debate concerning the methodological dilemmas and choices for health research with particular reference to Q sort methodology.

Q-Sort Methodology
Lay Health Indicators
Eudaimonistic Health Model

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INTRODUCTION

The focus of this research is on the following four questions:

a. Can members of the lay population reflect upon the notion of health?

b. Can such reflection occur against a multi-faceted concept of health embracing notions of health, well-being, life satisfaction, quality of life and happiness?

c. Is it possible for the lay population to identify factors which they regard as influencing the multiple facets of health?

d. Is it then possible to identify an emerging conceptual map or framework held by the lay population in respect of a multiple faceted concept of health?

An additional aim is to contribute to the methodological debate underpinning the use of Q-sort in research. Accordingly the first chapter considers the increasing significance given to the lay or consumer's view in all aspects of health and hence provides a rationale for the lay perspective being the focus of the research. The second chapter critically explores the different theoretical perspectives offered within the literature in regard to the multi-faceted concept of health. From this the key concepts of health, happiness, life satisfaction, well-being and quality of life are identified as core concepts within the research. The

centrality of health as a concept within nursing theory is examined in chapter three, thereby re-affirming the value of exploring health as a concept. Chapter four examines the methodological issues relevant to the research principally that of Q-sort and other supportive approaches used. Chapter five considers the procedures used in developing the Eudaimonistic Model. The results of the research in terms of a eudaimonistic model of health containing three elements are presented in chapter six. In chapter seven a discussion of findings is undertaken, whilst chapter eight explores conclusions reached and recommendations for further research.

CHAPTER 1

The significance of Consumerism (the lay view) in health

1.1 INTRODUCTORY REMARKS

The aim in this chapter is to consider the increasing significance given to lay or consumer perceptions in both the planning and delivery of health care. Frequently this significance is focused upon such issues as service satisfaction, health behaviours and lifestyles and use of health services and some consideration may be given to discrepancies between professional and lay views. It is the author's contention that fundamental to the emphasis upon consumerism is the question of how lay individuals view health in a positive and multi-dimensional way. This question has to date rarely been explored. Health has tended to be contextualised in terms of ill-health, recovery or daily living practices.

It is on this premise that the research is built - i.e. that exploration of the concept of health and the way in which it is defined and shaped by the lay population is of value.

1.2 THE ADVENT OF CONSUMERISM

Increasingly the word 'consumer' is used to describe the recipient of health care within a market orientated health delivery system. The emergence of the consumer therefore in the context of health is a relatively new one and

may be attributed to a number of key changes in health policy and practice, namely:

1. The market orientated changes in health organisation outlined in Working for Patients (Department of Health, 1989) in which Hayes (1991) suggests consumerism is central.
2. As a forerunner to the above the patient responsiveness recommended within the Griffiths report (1983).
3. The Health of the Nation: (Department of Health, 1992) contained an emphasis upon informed consumerism as a strategy towards achieving health goals or targets.
4. The changing emphasis upon consumer responsiveness within the role of the General practitioner outlined in the two Department of Health White Papers Promoting Better Health (1987) and Primary Health Care (1986).
5. Attention given to consumerism with a community care setting with the National Health Service and Community Care Act. (Department of Health, 1990.)
6. Patient's Charter (1991) in which the rights as a consumer were articulated. (Department of Health, 1991.)
7. Principles of organisational survival and excellence proffered by Peters and Waterman (1982) in their seminal text In Search of Excellence which are being adopted in a range of managerial contexts, including health delivery. Closeness to the consumer is a major emphasis in their message.
8. Changes in nursing theory and practice including primary nursing and the development of ethical theories have placed the consumer at the

centre of professional decision making (see Brearley (1990), Henderson (1969), Orem (1985), Speeding and Rose (1985) and Kenny (1992)). Such principles have been reinforced within more formal professionally focused policy documents, notably the Strategy for Nursing (Department of Health, 1989). Robinson's study (1989) is an important example of the professional significance now given to the consumer as a partner in care.

9. The development of quality assurance mechanisms including surveys of consumer opinions and user satisfaction surveys (see Locker and Dunt (1978), French (1981), Jones et al (1989), Ricketts (1992), Cox, Bergen and Norman (1993) and Sheppard (1993)).

The lack of research on consumer views within quality assurance strategies is emphasised by Avis (1992):

> "the idea of patient choice and active participation in treatment is lacking a basis in research concerning the patients' views which could give foundation to this perspective." Avis (1992) (a) 6, p.14

This view is supported by Symonds (1988):

> "There was a great deal of work published by health care professionals on their perception of the needs of the consumer but a remarkable lack of literature by consumers themselves." p.14

The current inability fully to acknowledge consumer views and preferences is attributable to many factors not least of which is continuing uncertainty as to how health is really perceived by the lay individual (Higgins, 1992).

1.3 THE HISTORICAL GAP

The suggestion that emphasis be given to consumer perspectives is a relatively new one. It indicates that traditionally there has existed a potential discrepancy between perceptions held by the lay population and the professional. This historical difference is still important today if the criticisms concerning the reality and effectiveness of consumer power and perspectives in practice are to be believed. Therefore the professional vis-a-vis lay power basis in defining health is now briefly explored.

1.4 PROFESSIONAL VIS-A-VIS LAY POWER IN DEFINING HEALTH

Traditional models of nursing, which have been rooted within the medical model, have accepted that power rests with the professional rather than with the patient or client. The latter has tended to be regarded as a passive recipient of care and treatment. This power inequality is discussed by Frankenberg (1984).

> "There is however a tendency to see health like the British parliamentary socialism - a short period of intense struggle in which all are involved and none is an authoritarian expert, followed by a long period in which the experts re-establish control and act on the passive, powerless patient" p.99.

The author only partially agrees with this view, holding that even if covertly the health professional is always held as the authoritarian expert within the medical model approach to care. This power inequality is increasingly

being recognised and challenged by the recent models of nursing, giving advancement to such concepts as partnership in nursing care and patient advocacy. This imbalance in power between client and professional has been analysed by Curtin and Flaherty (1982) suggesting the necessity of the professional to structure consciously a collaborative relationship in order to avoid such unjustifiably patronising behaviour.

> "tragic error may occur unless patients are permitted, indeed assisted to be full partners in the development, design and implementation of their own care" p.90.

Leddy and Pepper (1985) suggest that such a partnership approach is both a challenge and an expectation of a professional nurse.

> "Interact with the client in a manner and quantity that permits exploration of his personal responses to health or threats to health, evaluation of environmental circumstances in which he exists, identification of strengths and limitations, identification of resources perceived to be needed and clear allocation of responsibility of client and nurse that ensures the client's assumption of responsibility for his own health and the nurse's assumption of responsibility for the informational and interactional support needed" p.290

Whilst these authors are commenting upon the situation within the U.S.A., the introduction of a market economy into the British health care system suggests that their views are increasingly transferable.

It would seem that to enhance awareness of how positive health is viewed generally by the public will help clarify expectations of the nurse's role. Evidence suggests that there exists considerable discrepancy between how the concepts of health and conversely ill-health are perceived by the professionals and lay people. Amongst such evidence is Oakley's (1980) widely acknowledged study demonstrating the discrepancy between the professional and lay view of pregnancy and childbirth. In addition, Pollock (1984) has studied the problems relating to the interaction between doctors and patients and relatives, particularly in terms of awareness levels and information giving. This aspect was further explored by Stewart, McWhinney and Buck (1979) who, in a study of 299 chronically sick patients, examined the doctor/patient interaction and relationship. They concluded that whilst the doctors' awareness of physical complaints and discomforts, together with the related limitations of daily living was moderately high, knowledge of social problems were poor. More specifically:-

a. the physical knowledge of the patient's complaint was greater when the patient initiated the consultation;
b. knowledge of social problems was lower the greater the number of problems the patient had;
c. variation in age, sex and education did not tend to influence knowledge, neither was an association found between the physician's knowledge and duration of care given nor the completeness of care to the patient's family.

Kessel and Shepherd (1981), when studying non or limited consultation patterns, concluded that the decision whether or not to seek health care is a complex chain of circumstances and that the key factors with respect to the individuals they studied were: gender and age perceptions of the doctor's role, and attitudes to self-medication and illness. Hence there exists extensive support for the view that subjective health perceptions or indicators are of significance in influencing health beliefs and behaviours. The complex origin of such subjective health indicators is acknowledged by Stainton Rogers (1987).

> "Lay accounting is not the mere watered down version of medicine that many physicians assume - lay accounting of health and illness deeply and intimately bound within a broader framework of accounting in which folk wisdom, the ideologies and values of particular outline or ethics all play a part. It is in recognition of the value of subjective health indicators and their potential complexity that the aims of this research are derived." p.121

1.5 EXPLORING LAY PERCEPTIONS / SUMMARY

The significance of the lay perception and definition of health has been identified, particularly in the context of today's consumerism and the difference in professional and lay perceptions. Attempts to explore lay views have been made as already indicated in terms of consumer satisfaction with the service. Amongst such attempts some studies have adopted a market research approach, (the significance of which in the context of this research is addressed later), where healthy lifestyles as well as use of health services are explored.

Consideration of the lay definition of health has, however, rarely been a focus of concern. The notion of health is frequently left undefined and unexplored within such consumer surveys. Where attempts are made to consider the definition of health by the lay population, this is usually done against a reflection of illness or recovery. Notable examples which are considered later are surveys undertaken by Parse (1985), and Stainton Rogers (1991).

It is the basic premise of this research that consideration of the lay person's framework of health in its positive sense is of fundamental importance. It is from such an understanding that appreciation of how such definition helps to shape health beliefs and lifestyles is gained together with patterns of health service usage and compliance with health treatments. Additionally, for effective consumerism and partnerships in care, it is important that the health professional has insight into lay definitions. From a more macro perspective, knowledge of such lay definitions can help inform health promotion strategies, set priorities of health service delivery, and influence professional training and educational curriculum and policies.

CHAPTER 2

Health - a multifaceted theoretical concept

2.1 INTRODUCTORY REMARKS

The theoretical concept of health is explored within this chapter by consideration of the current literature. From this, it is argued, emerges a multifaceted concept of health embracing the central notion of health itself and related issues of quality of life, life satisfaction, well-being and happiness.

This multifaceted model or concept of health serves as the framework by which lay perceptions are explored within the research.

2.2 NOTIONS OF HEALTH

The intention of this chapter is to review the ways in which the concept of health has been viewed, for undoubtedly, given the polymorphous nature of health, it has attracted a variety of interpretations. Nevertheless one may claim that the nature of health is still only partially understood and remains an area of intense debate. This situation has been vividly described recently by Seedhouse (1986):

> "What has emerged from the volumes of writing on health is an indigestible spaghetti of confusion" pxi

It must be acknowledged that notions of health are diverse, controversial and changing, and, in consequence, beyond simplistic definitions. The literature for inclusion was selected against the following criteria:

1. Geographical and hence inferred cultural relevance so that preference was given to British and then USA/European literature.
2. A twenty year time limit was imposed unless the contribution was seen as a classical or definitive contribution.
3. Representation from the relevant disciplines, nursing and medicine, sociology, psychology, anthropology and health philosophy.
4. It offered additional perspectives and definitions of health.

2.2.1 Health as the Absence of Physical/Mental Ill Health

This approach frequently says little actively about positive health, rather it describes health by a process of contrast against ill health, with the latter being identified more fully. Health is seen as merely an absence of illness, of physical or mental disability. There is a tendency within this approach to give physical aspects a greater significance, to the detriment of psychological, social or spiritual elements. It therefore adopts a very narrow perspective of health. In addition it tends to suggest normative elements, with the ensuing risk of those who fall outside such a narrow range being regarded as abnormal and in consequence stigmatised. Hence an individual with a physical handicap is viewed essentially in terms of physical limitations rather than considering wider aspects of health.

Inherent within this approach is the view by which health is seen as an extension of physical functioning to that of the performance of activities of daily living allowed by the individual's physiology. Such activities tend to be viewed in a normative way, derived through the process of socialisation. This is reflected by Mallick's (1979) definition of health in terms of two classifications. One is functional, relating to the ability to function despite the presence of sickness. The second classification is termed open-ended:

> "an ideal on the horizon that can be approached but never reached" p.30

2.2.2 Health - the Ideal State

Mallick (1979) is not alone in offering the definition of health as some ideal state. His view is supported by Seedhouse (1986), who suggests that such an approach to health has existed throughout the ages. Whilst it does serve to focus upon the wider aspects of health, it is of limited value remaining "well meaning rhetoric", due largely to its comprehensiveness. Indeed one could argue that health defined in such terms was the basis of the principles that gave birth to the NHS. Certainly the definition is normative and so is problematic for anyone who falls short of the ideal, resulting in possible stigma and discrimination. Further the ideal is shaped by the time and place, as different cultural groups will have their own expectations of the ideal. Certainly such a definition may prove a source of constant dissatisfaction for the individual, the health professional and health care planner as they all attempt to attain this gold mirage. The elusiveness

of this state is explored through Wylie's (1970) addition of a third classification of health, that of 'elastic'. This acknowledges the adaptive processes within health involving interaction between the individual, his environment and community.

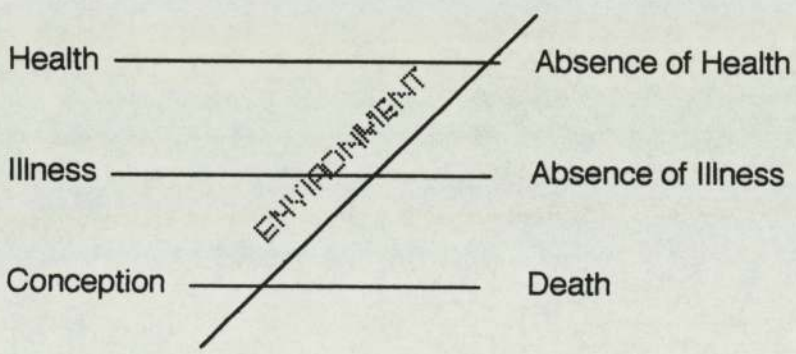
2.2.3 Health - Illness Continuum Approach

In acknowledgement of the falsity of the ideal health state, the concept of a health-illness (death) continuum has emerged along which an individual may move throughout his life-span. The continuum approach however begs several questions. Firstly, what factors will precipitate movement along the continuum? Are these primarily physical changes and so have connotations of the first approach discussed? Alternatively, are a wider range of factors considered to allow the expansion of the notion of health to include: social, emotional, spiritual or even interactional aspects? Without explicit statements as to what factors generate movement along the continuum, this approach falls, as others, into the trap of saying very little. The second question concerns the extremities of the continuum, particularly that of health. Again it seems to suggest that the end of the continuum is attainable, reflecting yet again the notion of an ideal state. This issue is identified by Twaddle (1977):

> "since no-one attains perfect health and not everyone is defined as sick there must be a range of less than perfect health that is defined as normal" p.103

In consequence, Twaddle suggests a modification of the continuum in which, within the middle area, there is an element of overlap between normal health and illness with the extremes representing perfect health and death. Several of the nursing models do incorporate this continuum notion of health as a holistic concept.

Indeed Lamberton (1983) has considered the health-illness continuum from a nursing theorist's perspective, suggesting that there might be value in considering health and illness not as a simplistic continuum but rather as co-existing. Such a co-existence view would demonstrate the way in which nurses can simultaneously focus on health when giving care to an ill individual. Additionally he argues that such a co-existence hypothesis would embrace a developmental continuum of conception to death, with the environment being the final element within the model as indicated below:



Lamberton (1983)

2.2.4 Holistic Health

Within this approach man is viewed as an interactive set of subsystems which together create a greater whole. In consequence, to explore one aspect or subsystem of man is not held productive as it destroys the integrity of the whole. In other words it is not sufficient to ask what are the physical problems but rather to explore the impact of such change throughout the completeness of man; social, emotionally, spiritually and interactively. A notable exponent of this approach is Flynn (1980) who maintains that illness indicates imbalance in the

> "harmonic integration of the body, mind, spirit and environment" p.12

He continues to suggest therefore that an opportunity for positive growth of the individual is provided. An opportunity to

> "further clarify values, affirm individual priorities and direction, and deepen a sense of meaning and value of life" p.28

It is the author's contention that many alternative medicine approaches adhere to this notion of health. These are steadily gaining popularity and limited professional acceptance and are becoming more widely adopted and slowly integrated into the NHS. Nevertheless, whilst appealing, such a definition is problematic for it does inherently require an individualistic

approach and considerable time and skill to be spent exploring the inter-relationship and interactions within the whole.

2.2.5 Further Approaches

Seedhouse (1986) has offered two further approaches to health namely:

1. **Health as a Commodity**

   Seedhouse contends that this is the predominant image within the NHS. Health is held to be separate, apart from the individual, and can therefore be acquired for the right price or if the correct procedural steps are taken. He continues to claim that the approach is derived directly from the values and approaches of medical science. Sack (1982) shares Seedhouse's scepticism concerning this approach in that he feels it concentrates upon the science aspect of health provision rather than the caring elements. Within nursing one of the current debates concerning models and their practice is whether nursing is a science or art together with how each can be demonstrated (Dunlop 1986).

   Sack continues to suggest that the notion that lost health can be addressed through the acquisition of commodities is an illusion that is encouraged at times by the physician and apothecary, and, one could add, the nurse.

2. **Health is a Personal Strength or Ability - either physical, metaphysical or intellectual**

Here Seedhouse (1986) suggests that health is not a commodity nor viewed as an ideal state, but rather in terms of personal tasks which are capable of being encouraged and also lost. This approach is therefore predominantly humanistic, not capable of precise definition as it embodies a way of life, with health being central to an individual's responsiveness to life's challenges. The role of the health worker becomes facilitating, with the goal of such a worker being to promote health to the extent that support from the worker is rendered unnecessary and can therefore be discontinued. It is the author's contention that elements of this notion of health can be found within Orem's (1985), and Roy and McLeod's (1981) nursing models. Problematically, such an approach to health is vague and unspecified, although it is perhaps the ambiguity that is appealing in its ability to accommodate all.

3. **Multidimensional Continuum**

This view is evident in Artinian's (1991) newly developed nursing theory, the Intersystem model.

> "Health and disease are viewed on a multidimensional health/disease continuum. It would be difficult to find a person in perfect health, totally sound in body, mind and spirit with full vigour and freedom from all signs of disease. On the other hand as long as a person lives, he has some soundness of body, mind and spirit. The goal of nursing is to assist the person to move toward health when confronted with stressors he is unable to manage independently" p.197.

2.2.6 Public - Private Health/Collective - Individualistic Health

It is the author's view that a further notion of health is that of the public - private and related collective - individualistic health. This is supported by Cornwell's (1984) case studies of twenty four individuals within East London. She suggests people define health in terms of public accounts:

> "sets of meanings in common social currency that reproduce and legitimate the assumptions people take for granted about the nature of social reality" p.15.

In other words health is defined in socially acceptable terms which may change dependent upon who is being addressed. The private view, however, Cornwell suggests:

> "springs directly from personal experience and from the thoughts and feelings accompanying it" p.16.

Certainly it is possible for there to be areas of commonality between the public and private notions of health; equally there may exist considerable variation. The latter is perhaps especially true if controversial aspects of health or health problems are addressed in which an individual may feel the need to limit expression of private views, for example abortion, Aids or sexual activity generally and even activities such as smoking or alcohol consumption regarding which there is some public ambivalence. Clearly if

one accepts the notion of public and private views of health, it does have methodological implications in endeavouring to establish views concerning health, an issue that will be addressed later.

Related views concerning one's own individual health may be at some variance to views concerning the collective or public's health. These are mediated by Cornwell's concept of 'acceptability', the process related to health belief models and feelings of control over private/public health.

2.2.7 Health Controllable - Powerlessness

This notion of health has a relationship with the notion of health as a commodity, but extends the idea in terms of arena of control and the extent to which events are seen as simply occurring in an unexplained and unpredictable way. Health therefore can be seen as something one can influence or control by 'appropriate' lifestyle, a notion embodied within many health education programmes. Alternatively it can be seen as a source of bewilderment, if not fear, giving rise to health related rites and folk beliefs, such as a continued adherence today to the humoral causative notions of ill health (Helman, 1986). Certainly Blaxter and Paterson (1982) in their study of health belief/seeking practices across three generations, found evidence of the continuation of such rites and folk beliefs. Supportive evidence for this view is first identified in her studies relating to the disabled (Blaxter, 1990) which showed that people who do feel threatened by unexplainable ill health desire to develop a feeling of control, and in consequence have a tendency to seek explanations for current health states by reference to prior

events and illness even if provably unrelated. This concept is further supported in studies undertaken by Wallston, Wallston, and De Vellis (1978) into health locus of control scales, within which individuals were identified as either 'health internals' who believe that health or illness is derived from his/her own actions or 'health externals' who consider that:

> "factors which determine health are such things as luck, fate, chance or powerful other factors over which they have little control" p.160

2.2.8 Health - A Belief Model: Primarily a Cognitive Process

Beliefs about health are seen as having a relationship to the way in which views and behaviours regarding other aspects of life are formed and held; and are seen as interconnected to a wide range of psychological and behavioural theories/models. Several health belief models have been developed. The discussion here is restricted to a brief review of three renowned models and elements within these relating to the previous discussions. Notions of fear, threat and expectancy, are found within the initial Becker (ed) (1974) model and in its subsequent refinements (Janz and Becker 1984). Within this model key elements include:

a. health motivations aroused by levels of concern relating to health, including any symptoms experienced;

b. the perceived threat of symptoms, both in terms of physical, social and emotional function;

c. the perceived benefit of action to reduce the perceived threat;

d. the cost or obstacles to the action aimed at reducing the threat.

It is acknowledged that certain factors further influence these four key elements and how they will ultimately affect health related behaviour. These include age, social identification/alienation and family or cultural based factors. Within this health belief model, health is defined primarily as a cognitive process affecting behaviour and the interpretation of physical aspects of health/illness. This emphasis is also found within Tones (1981) health action model; however within this model additional elements are developed, namely social norms, lay referral systems and the notion of drive factors. These combine to determine 'facilitatory or inhibitory' factors to whether cognitive behavioural intentions are translated into behaviour. Health is reaffirmed as an important cognitive process primarily and the model acknowledges the value laden nature of health. Such values are derived from personal factors and from societal, cultural, familial and health professional sources.

The significance of value and belief systems in respect to health is reaffirmed by Pill and Stott (1987) whose model develops a relationship between sociodemographic factors such as education, childhood, support and income, and beliefs/attitudes about community, responsibility and

prevention of illness. Factors which promote or hinder health maintenance and personal control and health behaviours are explored.

Nevertheless it has been acknowledged that the understanding of health beliefs as a cognitive process is not complete and is still open for further investigation and development as identified by Becker (1974):

> "No research has been done on how an individual position on the three health beliefs is related to other comparable beliefs he holds. The potential value of the model would be greatly enhanced if the origins and development of health beliefs were specified and if the beliefs were placed within a broader theoretical framework that would account for responses to a wide variety of stimuli" p.234.

It would be unrealistic to claim that this study is attempting to meet Becker's challenge fully, rather it is envisaged that it will serve to add one more piece to the proverbial jigsaw of health beliefs.

2.2.9 Health Theories relating to theoretical disciplines

An alternative view which is complementary to the classifications of health already outlined is offered by Stainton Rogers (1991), who suggests that health is classified against its theoretical origin or underpinnings for example derived from anthropology or sociology. Whilst this is of value academically its application to health as defined by the lay population is arguably limited, as such definitions are often jargonistic and are therefore not readily accessible and understood by the lay individual.

2.2.10 Summary

In review of the concepts of health presented so far, health does emerge as a complex entity capable of being viewed and interpreted from a variety of perspectives each with its own problems, yet each offering its own contribution towards an awareness of health. Such perceptions range from restricted or simplistic perspectives to multifactoral or complex ones. This view is supported in a discussion of health by Smith (1981) and reiterated by Fontes (1983) who suggests that notions of health can be seen as falling within four models:

a. the clinical model with classification determined by being life long free from disease signs and symptoms (Belloc and Broslaw 1973);

b. the role performance model classification against one's ability to undertake socially prescribed roles (Parsons 1958);

c. the adaptive model in which health is seen as an ability to change (Dubos 1959, Hinckle & Holmes 1961);

d. the eudaimonistic model in which health is extended to encompass general concepts of well-being and self actualisation (Maslow 1968). This model is given further consideration in Chapter Three, and is the approach adopted to health in this research.

The four models are serialistic in terms of complexity with the models of clinical and role being the most restrictive in definition, followed by adaptive and finally eudaimonistic model.

Figure 1 is an attempt by the author to diagrammatically represent the notions of health expounded within this chapter so far. The model highlights that at its core health is specific to the individual within an interplay between health beliefs and health behaviours with these potentially influenced by the individual physiological balance and homeostasis. This interaction may be perceived and defined as health by both the individual him/herself and by others. Such a definition may embrace the notion of a continuum of health/illness with psychological, emotional, physical, social and spiritual dimensions.

The outer circle is intended to indicate the way in which health as a notion may be applied to the individual or the collective societal group. Additionally, the diagram seeks to acknowledge that even at this definitional level there is potential tension between:

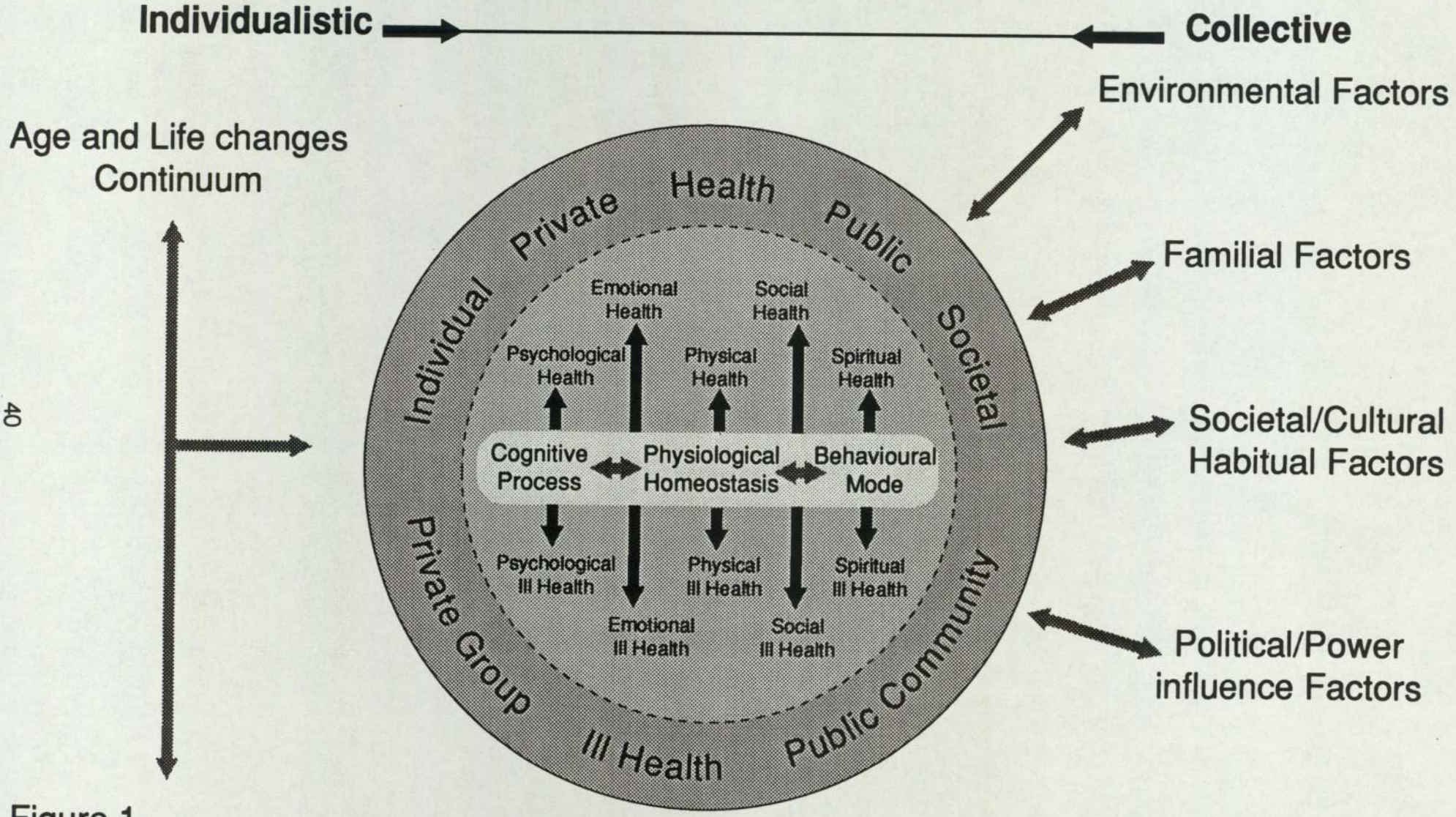

Individualistic
Collective
Environmental Factors
Familial Factors
Societal/Cultural
Habitual Factors
Political/Power
influence Factors
Age and Life changes
Continuum
Health
Private
Public
Individual
Societal
Private Group
Public Community
Ill Health
Emotional
Health
Social
Health
Psychological
Health
Physical
Health
Spiritual
Health
Cognitive
Process
Physiological
Homeostasis
Behavioural
Mode
Psychological
Ill Health
Physical
Ill Health
Spiritual
Ill Health
Emotional
Ill Health
Social
Ill Health

Figure 1

a. health in the private sense, that is aspects that remain hidden, unspoken or unacknowledged, perhaps due to the sensitivity of the health issue or simply lack of recognition.

b. health in a public sense, that is health factors which are acknowledged or discussed.

Both the inner core and outer circle are influenced by a diversity of factors, some of which are again individualistic such as age and life events, although even these may be culturally and societally defined and contextualised. Other factors are more collective or societally based such as political ideology and health policies, with these having implications for the individual.

2.3 KEY CONCEPTS

In order to advance, it is important that an attempt is made to derive from the aforementioned notions of health some key words that can be said to be embedded within the notions and may be found within health as expressed by nursing theories. This offers a sufficiently wide holistic framework to health in its positive sense, rather than a negative ill health orientation.

It is the author's contention that useful key concepts derived from the literature are: happiness, well-being/wellness, quality of life and life-satisfaction. In consequence a brief review will now be undertaken of these concepts.

2.3.1 Wellness/Well-being

The concept of well-being is particularly useful in that its emphasis is positive. Its value is affirmed by McClary et al (1985) who argues that the medical ill-health orientation is no longer the total answer to meeting health needs. They argue the necessity of a shift to a health era in which a new 'paradigm' of wellness is required, and cite Capra's (1982) definition of health as supportive evidence:

> "An experience of well-being resulting from a dynamic balance that involves the physical and psychological aspects of the organism as well as its interactions with its natural and social environment." p.162.

Wellness, then, does encompass physical, emotional or affective, as well as cognitive aspects. The inclusion of cognitive as well as affective elements within global well-being is reiterated by Harley and Little (1985) in which its relationship to quality of life is also identified.

Certainly the literature relating to the concepts of well-being attempts to explore the relationships between perceived well-being and actual physical condition. This is a key facet of the paper by Thomas and Livieratus (1978) which discusses how such perceptions of well-being may alter in respect to an individual's age.

Thomas utilised a general well-being scale with 18 points within which items were scaled and summed to give a total score.

> "The general well-being scale is self-administered and is designed to elicit responses to questions concerning the presence, severity or frequency of some clinical symptoms that are generally considered important in making assessments of subjective well-being." p.535.

When responses to Thomas's survey were examined thirteen of the eighteen items shared differences in perception in respect to age groups.

> "The first item which deals with illness and body disorders is the only one for which the average score decreases with age, for the other eight items the means score is higher." p.557.

Factors which were seen as having an important influence in terms of raising perceived well-being was age, racial origin (with people of caucasian origin having a higher score), and sex (with men also achieving a higher score).

The relationship of ethnicity to well-being is further discussed by Vaughan et al (1985), in which it is claimed:

> "ethnic groups are reference groups in which determinants of subjective well-being operate differently." p.315.

Thomas claimed that:

> "Psychological factors accounted for more of the explained variance in GWB scores than physical variables." p.544.

The psychological factors of self perceived health status, nervous boredom and level of professional contacts for counselling are key influences.

A discussion paper by Coleman (1979) supports many of the issues raised by Thomas. Coleman examined well-being in the elderly in terms of self-esteem, loneliness, attitudes to old age, worries and subjective health status, with self-esteem emerging as a central dimension In respect to ill health, the greater the disability the lower the level of well-being in all other areas. However, the relationship between actual levels of functional disability and perceived health was not always closely related. In examining this match in respect to people who had been given state housing on the basis of poor functional health, it emerged that perceived health was actually poorer in those who had not been given housing due to better functional health. Further:

> "changes in physical health with increasing age did not mean lower levels of subjective health status." p.58.

Haggart and Billington (1982) conducted a survey where different professional groups were asked to decide upon which factors were most influential in determining an individual's well-being:

> "Apart from a few exceptions the rank ordering of health dimensions by all six groups generally conformed to expectations. Mental and physical dimensions dominate, personal feelings and feelings of satisfaction in respect to self, work and family are also deemed extremely important." p.17.

The conclusion that emerges is that self perception of health status and well-being incorporate the concept of happiness and may not match actual functional health.

2.3.2 Wellness/Well-being: Reflections upon issues emerging from the literature

1. The concept of well-being/wellness is important by virtue of the fact that it does generate a positive focus for health.

2. It offers the opportunity to explore a subjective concept of health that relates to an individual's unique set of beliefs.

3. It offers a concept which incorporates issues of psychological happiness and satisfaction, perceptions of physical health and its potential impact upon an individual's lifestyle and related coping mechanisms. In addition it links with an individual's satisfaction with social factors and perceived levels of social attainment.

4. Only limited development of well-being, wellness measures have taken place. Work that has been undertaken has largely been done in the USA rather than Britain.

5. There does seem to exist the potential for a high degree of influence from 'here and now' factors. This element has not been highlighted within the literature to the same extent as in that discussing happiness.

6. An individual's expectations of levels of attainment strongly influences subjective beliefs. This is highlighted in studies relating to the elderly.

7. An individual's perceived level of well-being strongly influences reported episodes of ill health and ensuing pattern of seeking health care.

2.3.3 Quality of Life Indicators

This concept was most notably explored by Campbell, Converse and Rogers (1976) in respect to the North American citizens' beliefs regarding factors that influenced the quality of life:

> "An expression of satisfaction with specific domains of life experience." p.3.

In respect to life domains the following become the focus of attention - marriage, family life, health, neighbourhood, friendships, housework, job, life

in the city or country, non-work, housing, usefulness of education, standard of living, amount of education, savings. Individuals were asked to indicate their degree of satisfaction on a seven point scale in respect to each aspect. Health derived a mean score of 5.78, ranking third in terms of top area of satisfaction, although health showed a somewhat limited relationship to overall expression of well-being and in respect to other domains.

> "Farthest away from life satisfaction in the 3 dimensional space is the domain of health. Indeed this latter domain is distant from all the others..." p.377.

Health therefore was regarded fairly independently as a domain in terms of influencing quality of life.

> "The status of health as an isolated domain in a region of its own is not extremely perplexing but its location does raise an issue of interest. It is likely that for the considerable majority of the population, free of any history of chronic health implications or the multiplication of difficulties that occur in old age, the simple fact of adequate health is largely taken for granted" p.377.

If one accepts the view that people may not worry about health, until it deteriorates, it does raise potential problems in respect to asking people to identify health as a positive concept. It may also help us to identify the importance of how to ask about positive health. When people were asked in Campbell's study to judge domains in terms of importance to their life, giving health a positive emphasis, it resulted in 'being in good health' and 'in

a good physical condition', being given the highest rating. Although Campbell's survey also identified:

> "Almost one half of those people who reported disabilities severe enough to prevent them from doing a lot of things are unwilling to say they are dissatisfied in any degree with their health and a smaller number of these, 6%, insist that they are completely satisfied with it" p.378.

This further highlights earlier comments that an individual's perceptions of his health status and ensuing sense of well-being may not match with what may be regarded by others as reality.

The quality of life survey also attempted to explore perceptions pertaining to levels of happiness by asking:

> "taking all things together how would you say things are these days? Would you say you are very happy, pretty happy or not too happy?" p.401

They found that compared with a similar exercise in 1957 the number of people expressing themselves as very happy had decreased. This was particularly true for people of West Indian or African origin. It must be acknowledged however, that Campbell's survey took place both some time ago and outside Britain, thereby relying on a variety of sub-cultural norms that may differ from those in Britain.

The ESRC undertook a survey in Britain in 1973 in which they explored similar domains to those by Campbell, including the domain of health.

Respondents in this survey were asked on a ten point scale to express the degree of worry they felt about the different domains. Only 45% of people expressed no worry at all in respect to any domain. They were asked to express their degree of satisfaction in respect to health, using a 10-point scale where the score of 10 represented maximum satisfaction. Health was the area where most people expressed maximum level of satisfaction. Yet, when asked what domains they would need to change to bring them to the level of satisfaction they felt they were entitled to, health was mentioned as the sixth highest domain. A majority of individuals identified health as the most important factor that personally determined how satisfied they were with their life as a whole. The significance of health as a determinant of quality of life was also supported in studies by Mowry (1988) and Zhan (1992).

Recently Pearlman and Uhlmann (1991) interviewed a total of 258 elderly and chronically ill attendees at an outpatients' department to explore their perceived quality of life. This study again indicated the related importance of health, together with that of subjective measures:

> "Health care providers and researchers frequently use objective indicators, such as age and marital status as proxies for quality of life. We found however that objective indicators of quality of life correlate poorly with patient perceptions of their global quality of life.... The relative importance of subjective over objective indicators is further illustrated by the results of the multi-variate analysis in which the subjective indicators replaced objective ones and built stronger models of global quality of life. Thus indicators or perceptions and concerns appear to be the major determinants of quality of life" p.36.

2.3.4 Quality of Life: Reflections upon issues emerging from the literature

1. A multiplicity of factors influence perceived quality of life. Health is frequently acknowledged as important amongst these factors.

2. Objective measures of quality of life are acknowledged to be insufficient if used alone.

3. A subjective measure of the quality of life may be at variance to that derived from objective measures.

4. There is an acknowledged relationship between quality of life and happiness/life satisfaction.

5. Whilst some consideration of quality of life has taken place within Britain the majority of work has been undertaken within the U.S.A.

6. The literature indicates that whilst there is some similarity of issues in terms of quality of life and well-being the concepts are not synonymous.

2.3.5 Happiness (Life Satisfaction)

The term 'happiness' has various usages and meanings. Campbell (1976) has claimed that:

> "Happiness has rather central connotations involving short term moods of gaiety and elation that are quite different from the core meaning of satisfaction" p.401.

In addition he claims that happiness relates to the short term only and should be viewed in terms of its opposite, depression, rather than as frustration, as this is the polar opposite to satisfaction. He believes that the concepts of happiness and satisfaction, whilst sharing some similarities, are distinct from each other, a distinction which needs to be clearly established.

Many people who report a high degree of happiness are also likely to report a level of satisfaction. Campbell identifies this relationship as being likely to exist from a cross section of the population. Thus a significant number of the population are likely to report a degree of happiness yet express levels of dissatisfaction with their lives and indeed vice versa, with such a discrepancy most likely to occur particularly amongst the young or older age groups .

Bradburn and Caphourtz (1965) however, explored the concept of happiness in terms of being the end result of the presence of positive emotion and the absence of negative feelings.

A further exploration of the concept of happiness has been undertaken by Kamman et al (1979), who maintain that:

> "Paradoxically psychology has had very little to say about human happiness. Although there has been a steady trickle of isolated articles over the decades, happiness has not emerged as a psychological construct. It has lacked definition, it has received no explanation, it has gained no theoretical standing and is rarely mentioned in psychological texts" p.1.

They suggest that in part this 'omission' of happiness may lie in the belief that happiness is often assumed to be undefinable. Although, as Headey et al (1985) has suggested, even if it appears as if social scientists 'shy away' from writing the words happiness and unhappiness, it has been used as a concept in "different guises", in terms such as mental health, psychological distress and even adaptation.

Some attempts have been made to explore the concept of happiness by use of a scaled inventory (Kamman, 1979, Andrews and Withey, 1976). The use of such scales has helped to indicate that, perhaps contrary to Campbell (1976), the concept of happiness has a fairly high stability over a period of time rather than subject to constant change. Nevertheless the judgement of happiness with such scales is essentially a subjective one, even if derived from consideration of more objective life changes (Martinson et al, 1985, Wilson and Peterson, 1988). Such life changes may frequently include reference to health and well-being.

2.3.6 Happiness: Reflections upon Issues emerging from the literature

1. The absence of emphasis upon happiness does seem to mirror the general emphasis upon negative elements of health and well-being as opposed to the exploration of positive aspects of health.

2. An individual's level of happiness may be strongly influenced by previous life experiences and degrees of happiness/unhappiness experienced.

3. Happiness has been shown to be a stable concept rather than one subject to frequent change.

4. Happiness may be strongly influenced by cultural and sub-cultural norms and life expectations, and by spiritual beliefs.

5. Happiness is acknowledged to be subjectively based rather than an objective measure.

6. Judgement upon happiness often acknowledges such issues as health and quality of life.

2.4 DIVERSITY OF MEASURES

The notions of health, well-being, quality of life, happiness, and life satisfaction have over the years received considerable attention and debate with the literature. Frequently, however, each concept has been explored as single or independent issue rather than with attention to inter-relationship and similarities. Additionally, the emphasis in the literature has been to find objective measures or tools which, in relation to health, adopt a negative or ill health/poor functioning perspective.

An extensive review of tools or scales developed to determine health has been undertaken by McDowell and Newell (1987) and more recently by Bowling (1991). Not surprisingly Bowling's later publication offers a greater number of health measures and hence reflects more recent developments. Nevertheless, it is interesting to note that both texts:

a. adopt a similar structure and include measures not only directly measuring health but also the key concepts related to this as previously identified e.g. quality of life;

b. acknowledge the value of subjective measures as well as more objective ones;

c. reflect the tendency to have developed ill health and functional base measures of health rather than more positive health ones;

d. acknowledge the paucity of health indicators derived from the lay rather than the professional perspective.

A summary and comparative table of measures cited by both authors is given in Appendix 1.

2.5 INTER-RELATIONSHIP OF CONCEPTS

It is the author's contention that the concept of health, quality of life, well-being/wellness and happiness/life satisfaction can be seen as inter-related entities. All help to form the cognitive map an individual has of positive health.

The exploration of these potentially inter-related concepts pertaining to health is therefore the purpose of this study. The aim is to tease out commonalities and inter-relationships and so help to develop further the body of knowledge concerning health in its positive sense, and from the subjective perspective. Subjectivity is acknowledged as contentious in nature, but it is viewed by the author as being of central importance and to date poorly explored. It is important because it influences contact with and usage of health care systems. Certainly the significance and acceptance of such subjective perceptions pertaining to health has been supported, notably by Larsen et al (1985), Blaxter (1980), and Cornwell (1984). It has also addressed in the previous MSc study of the author, Fox (1984) unpublished:

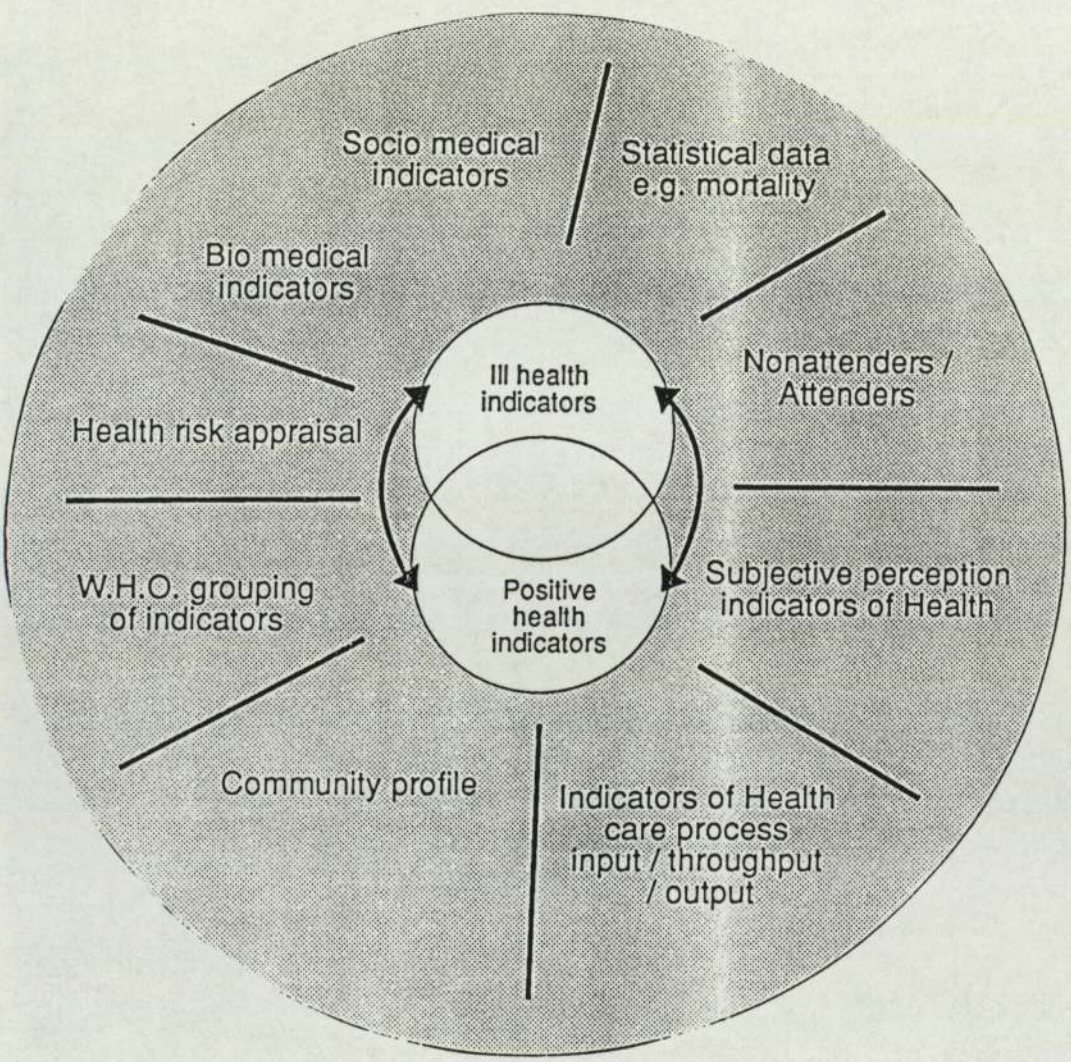
"It is necessary to rely upon a multiple of indicators. These should importantly however reflect not only objective measurable issues relating to ill health, but also incorporate some evaluation of subjective views. Views regarding satisfactions, expectations of ill health and positive health. Subjective indicators being derived from both the patient/client perspective and the health care professional.... The advantage of such inclusion of subjective indicators is that it would afford more realistic shared understanding between client and the health care worker." p.29.

2.6 SUMMARY

It is the author's contention that subjective indicators can provide valuable insights into the notions of health and be used as an additional element to the range of health indicators currently employed. This is represented by Figure 2. The notion of health explored through such subjective perception can be structured around the framework of issues discussed within this chapter, namely quality of life, life satisfaction, happiness, well-being and health, and used as parameters for exploration within this research study.

FIGURE 2: Diagrammatic representation of the present range of Health Indicators

Ref: Fox J.L.; Health Indicators MSc Public Sector Management; University of Aston; 1984. (Unpublished)



CHAPTER 3

Nursing Theory and Practice: relationship to health definition

3.1 INTRODUCTORY REMARKS

Recently health professionals have claimed to view health in a holistic manner which seeks to consider health from physical, social and emotional perspectives. (Certainly such a claim can in many ways be substantiated in that health is now seen in broader terms and often in a community context.) With regard to nursing theory the notion of health is acknowledged to be a central concept. Nevertheless it is the author's contention that whilst wider definitions of health have been adopted they do not overtly embrace the lay perspective. Even with such broader definitions the historical physical and illness orientation may still be the more significant factor. This is illustrated by consideration of current health indicators as explored within the previous chapter (Bowling, 1991, McDowell and Newell, 1987).

The focus of this chapter is to:

1. Establish the centrality of the concept of health for nursing theory and practice.

2. Indicate that despite such centrality the concept is often ill defined within nursing theories, with little consideration of lay definitions.

3. Identify one nursing theorist who has overtly attempted to embrace lay perspectives with her theory of nursing (Parse 1985). Yet this attempt remains unsatisfactory as it is still jargonistic and academic in emphasis.

4. Show that to achieve a multi-dimensional, holistic and eudaimonistic perspective of health within professional theory and practice it is important to embrace lay definitions of positive health.

3.2 HEALTH AS A BASIS OF PROFESSIONAL THEORY AND PRACTICE

The author's own background and interest is based within general nursing and nurse education. In these areas over recent years there has been considerable questioning concerning the theoretical basis and practice of nursing care. This is especially in relation to the alternative approaches and theoretical models that may be used by nurses, the relationship of nurses to their patient/client and to other health care workers.

Traditionally, the orientation of nursing theory and practice was the medical model, in which health was viewed in terms of illness and the nurse's role was that of 'handmaiden' to the medical staff.

> "Assumptions based on traditional paradigms of health have bound nursing curriculum and practice to the negative view of health in terms of absence of disease: Payne (1983) p.395.

Within the late seventies and early eighties however the position began to change with nursing theorists debating their heritage of nursing in the context of current health needs and delivery systems, as manifested by the advent of the proposals within U.K.C.C.'s Project 2000 (1986). Such theorists endeavoured to explore and develop the body of knowledge that could be regarded as unique to nursing activity, initially as related concepts and later in terms of theoretical perspectives and models. Amongst these early concepts Torres (1985) identified health, with the others being the human or individual, society/environment and nursing activity itself. This served to highlight the centrality of the notion of health to the theory and practice of nursing.

> "The concept of health constitutes a basic building block for nursing theory" Payne (1983) p.395.
>
> "There is a need to clarify the ideal of health because it plays a central directive role in every phase of nursing and medicine" Smith (1981) p.43.

From such elemental concepts a range of nursing theories have been developed, originated mainly in the United States of America, but more recently British models have been proposed. Such theories are, however, at present in their infancy, particularly in respect to their influencing nursing practice within Britain.

At the heart of such theories lies assumptions about the nature of health. If nursing theory is to truly inform practice, then it becomes imperative that all nurses gain awareness of the various theories and above all their inter-relationships. As Torres (1985) has attested:

> "the definitions of the concepts should provide a clear mental picture of the events or experiences that the theory is designed to explain and should clarify how these experiences fit together to describe, explain and predict 'reality'" p.5-6.

Such an achievement remains problematic, since a central concept, health, has not been described explicitly and has been predominantly from a professional perspective. The lay or consumers' perspectives regarding health may be at variance to those held by the professional.

This partially defined nature of health also proved problematic in respect to the other essential characteristics of a theory of nursing (Torres 1985, Meleis 1985) which are to:

a. provide hypotheses that can be tested within the arena of clinical practice;

b. contribute and facilitate in the increase in the body of knowledge relating to the discipline of nursing and health care;

c. be utilised by practitioners to guide and improve professional practice;

d. offer a level of consistency with other validated theories and bodies of knowledge that have a relationship to nursing practice.

It is certainly one of the key tenets of this study that one of the essential 'open unanswered' questions concerning nursing theory is the nature of health in its positive sense from the lay perspective.

Within the theories of nursing the way in which one of the key concepts or parameters is viewed has very significant implications for the way in which the others may be viewed. The 'Extant Nursing Practice' (Meleis 1985) is seen as being an arena in which the notion of the client, life transitions, environment and health all interact. Equally, if the 'ideal nursing practice' is accepted with its acknowledgement of the significance of nurse, client and interactive process, then the client and nurse would need to share the notion of health each held. Thus both the objective and subjective elements of health need to be incorporated. It is the author's claim that the skills and methodological approaches to enable this interchange to occur are at present poorly developed.

British nursing theorists, notable Aggleton and Chalmers (1986) have suggested that in attempting an analysis and critique of existing theories of nursing it is helpful to use common parameters as a frame of reference. Their suggested parameters include the Nature of Health together with others relating to the Nature of Patient/Person/Client/Consumer, the Nature of the Environment, and the Nature of the Nurse and Nursing. However, it is inadequate merely to ask what does the theory state about the nature of health and how does it relate to the other parameters. It is also important to question how the statements regarding the parameter of health within the theory relates to other theoretical perspectives of health and further to what

is known generally about lay views concerning health and how health is indicated. This assertion is one of the key rationales for this study. Certainly, nursing practice and theory, whilst attesting its uniqueness and individuality, can be seen to have its roots in other theoretical disciplines and in consequence one can argue that notions of health within nursing theories should be reflected against general theories of health within other disciplines to facilitate each informing the other.

> "Nurses therefore need to be aware of their own concepts while at the same time being prepared for the different concepts of others" Wright (1986) p.13.

It is worthwhile at this point to review briefly how the major nursing theories can be interpreted against the parameters already offered. It is important to stress that many of the nursing models and their related concepts are a source of much debate and criticism within the nursing profession. A summary of a few selected theories derived from Fitzpatrick and Whall (1983) p.340 is given in Appendix 2. The purpose now is to indicate:

a. the inter-relationship within theories of nursing of the parameters, not least of which the is one relating to the nature of health;

b. to identify any commonality of views concerning the nature of health amongst nursing theorists and in turn relationships to general theories of health.

In respect to point (b) it is the author's contention that within nursing theories health is seen in vague and uncritical terms. Health will be viewed in one of the following ways:

a. In terms of physiological normality and fitness to undertake particular roles or tasks, this view being particularly evident in theories offered by Henderson (1966), Peplau (1952), and Roper, Logan and Tierney (1985)

b. Health is seen only in contrast to illness, as an absence of illness and therefore described as extremes along a continuum. Theories by Neuman (1982) and Roy and McLeod (1981) exemplify this perspective.

c. Health is an elusive transient state subject to flux and change towards illness as a result of numerous factors, such as life events, age, knowledge and environment. Roy and McLeod (1981) and Orem (1985) reflect this view.

All of these views implicitly suggest that health is primarily an objective and therefore measurable entity. The potentially subjective basis of health is addressed by few nursing theories in any detail.

One nursing theorist who has sought to systematically explore the concept of health within her nursing model is Parse (1985). Parse used a phenomenological study designed to investigate what were the common elements in experiencing a feeling of health among several different age

groups. A phenomenological perspective was adopted to accommodate and reflect the view that health was a lived experience.

> "It is a unique experience describable only by the individual who is living it.... Health is not a linear entity that can be interrupted or qualified by terms such as good, bad, more or less. It is a synthesis of values, a way of living. Health is not determined by social norms, it emerges and changes as Man structures meanings in situations" p.28.

The study consisted of 400 subjects between the ages of 17-66 with the subjects asked to write descriptions of a personal situation in which they experienced a feeling of health. Parse suggested that the results indicated that health was perceived as having potentially four common elements, namely:

a. Health as a "resonating clarity powered by an invigorating force in constructing successfulness" p.33.

b. Health as a "symphonic integrity manifested in the spirited intensity of fulfilling inventiveness" p.33.

c. Health as a "serene unity lived in exhilarated potency toward creating triumphs" p.33.

d. Health as a "synchronous contemplation fired by transcendent vitality in generating completeness" p.33.

Whilst Parse's study does represent an attempt to embrace lay perceptions of health within a theoretical model, the results are presented in a jargon which provides little real insight into the detail of positive health beliefs.

In summary, the definitions of health embodied within nursing theories can best be reflected against Smith's (1981) four views of health that:

> "can be viewed as forming a scale - a progressive expansion of the idea of health" p.44.

Firstly, there is the narrow clinical model in which people are defined in terms of physiological systems which have inter-related functions with the key focus being absence of illness, (a state of biological homeostasis). Secondly, there is the ideal state of health as role performance which incorporates social and psychological elements. The criteria for health is that an individual is fit enough to fulfil his/her role(s). Thirdly, the adaptive model incorporates clinical and role performance models. Here individuals who are healthy engage in effective interaction. Health is now seen as a changing entity against a potential continuum of total health and illness. The final view put forward by Smith is the 'eudaimonistic' model which he suggests is the most comprehensive. Health is seen as the realisation of the individual's potential and is consistent with a high level of wellness. Notions of health within nursing theories have been more recently developing along Smith's views of health, attempting to achieve the ultimate eudaimonistic model. Such an attempt again serves to raise the issue of and the significance of the lay person's subjective notion of health, together with the effect of such notions upon the individual's health seeking behaviour

and relationship/responsiveness to health professionals and health care delivery systems.

To summarise, an awareness of the definitions of health, especially the definitions held by the lay person in a subjective way is important to nursing practice. Further, it is a complementary if not a central notion to the present advancement of nursing theories that are beginning to influence both the education and practice base of nursing in Britain today. This view is supported by Kristanson , Tamblyn and Kuypers (1987) who in respect to the concepts of health within nursing theories identify:

> "This domain is very important to the nurse-client interaction as it forms the backdrop against which the interaction unfolds and has a direct impact upon how problems and goals are conceptualised" p.528.

Exploration is needed in a systematic way of both the methodology for identifying the subjective indicators and definitions of health held by the populous. The nature of such indicators/definitions themselves is vital and offers a unique potential advancement of the present knowledge and practice base of nursing. This is one of the key rationales for this study.

3.3 THEORY/CONCEPT RELATIONSHIP DILEMMA

Fawcett and Downs (1986) have claimed that:

> "Regardless of the form, theories rarely are presented as an explicit set of concepts, definitions and propositions in research reports" p.15.

This assumes that theory is important. Its role is identified by Meleis (1985):

> "Theory is not a status symbol or a special honorary card that nursing needs in order to remain in the halls of academia or to achieve professional status. Theory provides the mechanisms from which we can organise our observations, focus our enquiry and communicate our findings" p.92.

The author has, in preceding chapters, outlined the theoretical perspectives currently held, with health being an important facet within this, together with an explanation of the developing theoretical basis of nursing practice concerning health. Nursing theory is still in its infancy and there is considerable debate about its key elements, of which health is one, together with the issue as to whether nursing theory may indeed legitimately claim the status of theory or represents instead a model. In the pursuit of subjective health it is important to clarify the contribution to theory that it is hoped this research will make. This section is intended to make explicit some of the issues involved in the nature of theory relating to nursing and health.

It would appear that there is some agreement about the characteristics of a theory, namely that it is at a level of abstraction, and it offers a way in which research findings of both a qualitative and quantitative nature can be represented meaningfully. Further, it suggests boundaries for the phenomena being explored, whilst suggesting questions to be posed including questions for further research. Finally, it offers guidelines as to how reality or practice may be viewed. These characteristics are summarised by Marx and Goodson (1976):

> "A theory is a provisional explanatory proposition, or set of propositions concerning some natural phenomena and consisting of symbolic representation of (1) the observed relationships among (measured) events, (2) the mechanisms or structures presumed to underline such relationships, or (3) inferred relationships and underlying mechanisms intended to account for observed data in the absence of any direct empirical manifestation of the relationships." (Marx and Goodson, 1976, p.237.)

It is also generally accepted that in the context of nursing theory may have different goals or functions. This is highlighted by Meleis (1985) who suggests that the goal orientation of theory in nursing may be classified as:

1. Definitions that focus upon structure.
2. Definitions that focus upon practice goals.
3. Definitions that focus upon tentativeness, in other words explorative.
4. Definitions that focus upon research.
5. Definitions that focus upon multiple uses.
6. Definitions that focus upon one or more of the specified domain concepts.
7. Definitions that focus upon any of the domain concepts (with these being invented or discovered realities).

In terms of Meleis' classification, this research may be viewed primarily as addressing the sixth classification, in that one of the domain concepts, namely health, is its focus. In this way, therefore, the theory concerning the nature of health will be developed particularly with regard to subjective notions. Further it is intended that the study will enhance the theoretical

understanding of nursing exploration of one of its domains. In respect to this sixth category Meleis (1985) contends:

> "and they address the metaparadigm phenomena of person, environment, health and nursing by specifying relationships among variables derived from these phenomena." p.27.

So it emerges that, within a theory of nursing, health is regarded as a metaparadigm, this term being used to denote a global perspective of a discipline acting as a framework for analysis. It should be noted, however, that it is here that one of the central debates about nursing theory emerges, at least in respect to the appropriate terminology to be used. For whilst Meleis (1985) sees nursing as the theory with health as a metaparadigm, Fawcett (1984) sees nursing as a metaparadigm with health as a concept within this.

The difficulty of reaching agreement about the appropriateness of terminology is exacerbated when viewed in the context of conceptual models of nursing. In the early stages of theory development it is likely that several conceptual models will be offered to explain and represent the same phenomena. It is intended to use Meleis' (1985) terminology where nursing is seen as a theory and health a metaparadigm.

3.4 THEORY DEVELOPMENTS

There exists a similar difference in view between Fawcett and Meleis as to the strategies for theory development in relation to nursing.

Meleis suggests five strategies, namely:

1. Theory - practice - theory strategy
2. Practice - theory strategy
3. Research - theory strategy
4. Theory - research - theory strategy
5. Modified practice - theory strategy

Alternatively Fawcett suggests theory development may be seen in terms of the thought processes used. The debate about theory development and strategies relating to this, has relevance since this research seeks to clarify the nature of health which in turn will expand the theory of nursing.

3.5 SUMMARY

It is the author's contention that the notion of health is a central concept to the theory and practice of nursing. Nevertheless, despite such centrality, health from a lay perspective has been explored in a very limited way within nursing theory. Indeed the relationship of health to nursing in terms of theory development is itself open to debate. The approach which the author will use is one which, in Meleis's terms, is a research-theory-strategy.

CHAPTER 4

Q-sort: Methodological Principles

4.1 INTRODUCTORY REMARKS

This chapter explores the methodological principles, strengths and weaknesses of the main research methodology, Q-sort, used within this study. The strengths and weaknesses will be illustrated by exploring health beliefs and perceptions in two health and illness Q-sort research studies.

Q-sort will also be considered in the context of the qualitative/quantitative classification of research methodologies and market research strategies. Additionally a brief review of supportive methodologies used in the developmental phases of the research will be undertaken, the use of diaries and structured interviews.

4.2 WHAT IS Q-SORT?

Q-sort is a method whereby statements or items (Q's) are placed upon cards which are then given to an individual to sort or place against a stated question or criteria.

Theoretical definitions are offered by Dennis (1986) who suggested that:

> "Q methodology is a unique research tradition with an epistemology and technique... developed to explore and understand the richness of human subjectivity" p.6.

Whilst Polit and Hungler (1987) suggested:

> "Q-sort is a method of scaling in which the subject sorts statements into a number of piles... according to some bi-polar dimension" p.535.

Dunlap (1978) suggested Q-sort might be defined as:

> "Q-sort method is a rank order procedure... of a set of cards that contain statements, words or phrases. These cards are given to an individual to sort according to certain criteria" p.195.

Q-sort is acknowledged to contain a number of procedural stages (Cronback 1960, Kerlinger 1964, Nunnally 1978, Stephenson 1953, Waltz and Bussell 1981, Wittenburn 1961, Wylie 1974, McKeown and Thomas 1987, Brown 1986, and Tetting 1988). The stages may be classified as follows:

1. The content for the Q-sort is developed from the literature of a field or discipline.

2. The items/statements to be sorted or ranked are placed on individual cards.

3. The respondent is asked to sort a predetermined number of items into a specific number of piles.

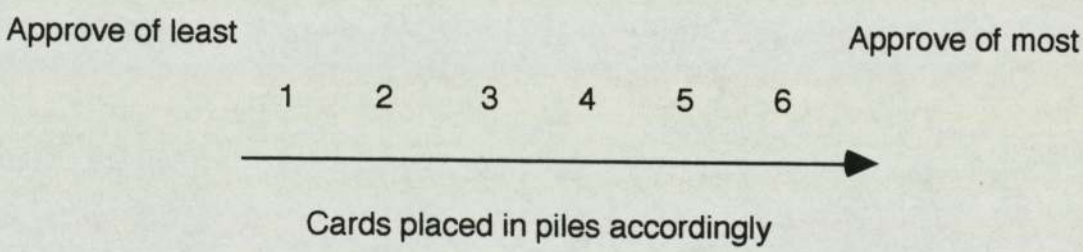
4. The desirable number of items presented for sort is recommended to be between 40-100.

5. The items should be sorted into number of piles that reflect a continuum - higher/lower, most/least.

6. At a later stage the same individuals may be asked to re-sort with different instructions.

The sorting identified in Steps 5 and 6 may in practice take place on more than one occasion, for example firstly to eliminate certain cards and then to place the cards in piles or categories of agreement often against a scale.

For example:



The Q-sort technique therefore has the facility to address two types of problems:

1. The correlation or level of similarity or differences between individuals' or groups' attitudes, expectations or opinions.

2. The degree of change over time in such opinions or expectations.

Whilst within the literature a level of agreement as to the principles and stages of Q-sort can be found, Brown (1986) highlighted that although Q methodology was approximately half-a-century old it had received limited attention. Accordingly he suggested that Q-sort could still be regarded as a new and perhaps innovative methodology. Despite the limited use of Q-sort to date, particularly in the context of health, it was viewed as having considerable potential for the issues within this research. This potential is attributable to the ability of Q-sort to explore subjective multi-faceted concepts. This potential is now addressed.

4.3 Q-SORT - ITS RELATIONSHIP TO SUBJECTIVITY

Dennis (1986) suggests that:

> "Q methodology offers unique insights into the richness of human subjectivity" p.7.

Many psychologists, notably Kantor (1971), have debated the nature and differences inherent within observable human behaviours and the more inaccessible mental activities of thought and belief, viewing these as objective and subjective respectively. Kantor contended that subjectivity should simply be regarded as a uniqueness of occurrence. This uniqueness arises from an individual's own perspective or self reference within the events to which he or she is exposed in the course of daily life.

Brown (1986) suggests that:

> "Broadly Q methodology provides the foundation for a science of subjectivity." p.57.

The scientific potential within the subjective frame of reference found with Q methodology is considered further by McKeown and Thomas (1987):

> "From the standpoint of Q methodology subjectivity is regarded as simply a person's point of view on any matter of personal and/or social importance. (Corollary to this conception is the two-fold premise that subjective points of view are communicable and always advanced from a position of self-reference.) Thus (construed) subjective communication is amenable to objective analysis and understanding provided that the analytical means for rendering such communications objective do not in the process destroy or alter the self reference properties of such communication." p.7.

Many aspects of nursing care and its relationship to the multi-faceted concept of health have an important individual and subjective perspective. The potential therefore for the Q-sort to systematically expose and consider such subjectivity has prompted Dennis (1986) to comment:

> "With Q methodology the domain is subjectivity, the emphasis is on the individual, the methods are unique. What evolves from the use of Q methodology are answers to questions that seek to develop and understand the dimensions of subjective phenomena from a perspective intrinsic to the individual" p.7.

Dennis reviews the relevance and application of Q methodology to nursing research and offers a summary of topics for which she feels Q methodology is particularly helpful, including health beliefs.

The relevance of Q methodology to exploring subjective health beliefs is also indicated by Parse (1985) on the basis that health is:

> "a lived experience, it is an open process of becoming, experienced by Man. It is a unique experience describably only by the individual who is living it... a continuously changing process in which Man knowingly participates" p.128.

Q-sort's potential as a methodology to systematically explore the individual's subjective is now presented.

4.4 THE SIGNIFICANCE OF SELF WITHIN Q METHODOLOGY

As indicated in the preceding discussion of subjectivity, the notion of self and self reference is an important concept within Q methodology and in consequence worthy of further consideration.

> "The first axiom of Q methodology is that it is the subjective self (a primitive and undefined term) that is at the centre of all meaning." Brown (1986) p.73.

The notion of self becomes significant due largely to the emphasis on person centred perspectives.

Stephenson considered the issue of self within Q-sort extensively (1982), (1979), (1974), (1953), identifying that individuals do attach meaning of self

reference to episodes and events in their lives and become the basis of an individual's own subjectivity with this being reflected in Q-sort.

> "The self in Q therefore is a documentation in multi-dimensional space of the obvious truth that an individual is central to his own subjectivity." (1979) p.13.

From this perspective are drawn laws of behaviour which, in turn, may be reflected in Q-sort. These laws were outlined by Brown (1978).

The role of self meaning and reference by the respondent within Q-sort was also addressed by Kemnitzer (1973). In his discussion he suggests there are potentially four sub-sets of self reference; ideal identity, claimed identity, real identity and fear identity. Accordingly Q-sort is also amenable to the exploration of conflict within an individual's belief system for example between the preferred ideal and the daily reality. Equally the sub-set facilitate exploration of beliefs over time, here and now for example compared with five years ago. Stephenson (1979) considered that Q-sort has revealed remarkable consistency in such time variance comparisons.

In summary the notion of self and self references is fundamental to Q-sort because it acknowledges that Q-sort systematically explores an individual's subjectivity. This subjectivity is derived from the meaning an individual gives to particular events. Such meaning and interpretation is inevitably focused upon the unique form of reference or concepts held by that individual. Hence the subjective meaning of events explored through Q-

sort is inevitably located in the uniqueness of the individual and his/her self and self reference.

It is the special relationship of Q methodology to self reference that Brown (1986) and McKeown and Thomas (1987) and Stephenson (1987) has cited as differentiating it from R methodology.

> "Q method in common with other interpretational approaches thus differs from those methods based upon hypothetico deductivism in two fundamental ways. It is anti-positivistic in that it stresses the importance of meaning as constructed, and it is abductive seeking to discover rather than merely test hypotheses" p.142.

This perceived difference from R methodology has implications for the judgements made about methodology with Q-sort, particularly in terms of sample size, use of the single case or respondent and inference/interpretation of results/data. It is to a discussion of such methodological issues that we now turn.

4.5 PERCEIVED BENEFITS AND LIMITATIONS OF Q METHODOLOGY

4.5.1 Potential Use:

> "The Q-sort can be used to explore unknown and unfamiliar areas and variables for their identity, their inter-relations and their functioning." Kerlinger (1964) p.598.

Q-sort has been used within a diversity of research issues or problems, the area of commonalty in its use largely rests on:

1. the importance of self reference within the research;

2. the ambiguity or multi-factorial dimension of the research issue;

3. the need to explore subjective meaning in respect to the research issue;

4. the need to use a systematic yet versatile research approach.

4.5.2 Benefits

The key advantage of such a methodology lies largely in its versatility, in which cards and parameters can be adjusted dependent upon the research problem or issue. Such flexibility is of particular benefit when exploring attitudes and beliefs. Q-sort is used experimentally:

1. to determine the individual's attitudes;

2. to determine what the individual holds to be ideal;

3. to establish what an individual thinks someone else believes.

In contrast to exploring such attitudes by means of a questionnaire or interview, it does, if only in part, eliminate the problem of interviewer bias and can therefore be said to have greater reliability and validity. It is more penetrating and discriminating than a questionnaire, allowing closer examination of the issue. In addition it is more amenable to a level of

experimental control. Polit and Hungler (1983) in discussion of its advantages suggest the following may be included:

1. It is user friendly, being more readily attractive to a respondent than a formal questionnaire.

2. It helps eliminate some of the interactional bias that exists within an open interview system or within written scale items.

3. It has been shown to be an objective and reliable procedure for the intensive study of an individual.

Many of the issues outlined by Polit and Hungler are further attested to within the wider literature relating to Q-sort. For example:

1. The value of Q-sort to explore often complex and inter-related issues such as health Schwartz (1978), Kleban (1979), Gould (1985).

2. Its potential to embrace an essentially qualitative exploratory focus whilst remaining within a systematic framework Sell and Craig (1983), and Nitzberg (1980).

4.5.3 Limitations and disadvantages of Q-sort

Clearly however such a methodology is not without its inherent disadvantages including:

1. It is time consuming to administer and in consequence is unsuitable for large samples.

2. It is not readily amenable to quantitative statistical analysis.

3. There exists the danger of careless item writing.

4. The subject may encounter potential discomfort and difficulty in attempting to sort a large number of cards into several category piles. Indeed Bolland (1985) has suggested Q-sort is beyond the cognitive ability of most people due to the number of items/cards involved.

5. Possible resentment in the subject when forced Q-sort techniques are used in which the subject is asked to sort the cards into categories involving differential choices e.g. amongst untrue statements, undesirable traits. However it has been suggested this can be eliminated by adopting a staged sorting approach (Stephenson 1953).

6. The risk of introducing bias; in generation of Q items, termed the sample, in the sorting procedure itself or selection of respondents. This risk can be minimised if due consideration is given to the theoretical principle pertaining to each aspect. It is to consideration of such principles that the debate now turns.

4.6 THEORETICAL PRINCIPLES TO ELIMINATE BIAS

4.6.1 Q statements/items: The sample and Issue of Meaning

One of the first philosophical issues that arises in respect to the statements or items that are generated for the Q cards is that these are assumed to have no prior meaning and only assume a meaning through the subjective reference of the respondent. This meaning is indicated by the sort and location of the item against the continuum offered within the study.

McKeown and Thomas (1987) have also suggested that the Q sample does, in fact, acquire meaning within the Q process, initially through the respondent's selection of the items or sort and secondly through analysis and interpretation of the researcher.

4.6.2 Development of the Q items and related classification

One of the unique aspects of Q methodology is that the term sample is employed, not to refer to the number and type of people selected to be respondents within the research project, but to refer to the items generated and placed on cards for sorting.

> "Large sample theory guides the determination of sample size in traditional quantitative studies, but it is not a consideration in Q where the items rather than the persons comprise the sample and the unit of analysis." Dennis (1986) p.11.

The development of the items or sample is perceived by McKeown & Thomas (1987) as being distinguishable in different categories, namely:

1. **Naturalistic Q samples.** These items are derived directly from a person or people's views, often by the means of an interview or perhaps by written narrative. Naturalistic samples are generally preferable as they reduce the risk of bias from external frames of reference. Studies adopting this approach include Ricks (1972), McKeown and Craig (1978), Brown (1971), Martin and Taylor (1978), Stephenson (1978) and Thomas, Martin, Taylor and Baus (1984).

2. **Ready made Q sample.** These samples are derived from sources other than the respondents and are of several forms:

a. **Quasi-naturalistic Q sample.** These are not generated from interview but from sources external to the study (Brown, 1970, 1974, and Tomkins, 1965).

b. **Hybrid Types:** This is a combination of items drawn from both naturalistic and quasi-naturalistic samples (Brown and Ellthorp, 1970, Suppasarn and Adams, 1984, Goldman, 1984).

c. More rarely used are standardised Q samples, for example to determine personality or samples for psychotherapeutic counselling. (Block, 1961, Butler and Haigh, 1954, Cartwright, 1972.)

4.6.3 Design Principles in Q Sample

McKeown and Thomas (1987) suggest that there are two fundamental approaches:

a. **Unstructured Sampling.** In this approach items, whilst perceived as relevant to the issues/topic under exploration, are not selected in an attempt to ensure all possible sub-issues or sub-sets are covered. Rather they are selected in acknowledgement of their general relevance only.

b. **Structured Samples.** These are selected in a more systematic way, embracing coverage of all the sub-sets or sub-issues. Such a coverage is derived either from a deductive design i.e. based on theoretical considerations, or derived inductively i.e. through emerging patterns as statements are collected.

4.6.4 Issues of Sample Number

There does appear to be a level of agreement about how many items should be offered on cards for the respondent to sort. It is suggested that the ideal should be within the range of 40 to 100 items (Dennis, 1986, Brown, 1986, Knight, Frederickson and Martin, 1987).

4.6.5 Issues relating to the Sort itself

A number of issues require consideration in respect to the sorting procedure itself (Dennis, 1986, McKeown and Thomas, 1987). These might usefully be summarised as:

1. **Space** - The environment in which the sort is conducted will require sufficient space e.g. a large table or floor area, in order to spread the cards in the required pattern of distribution.

2. **Consistency** - Both in terms of instructions and in terms of order/category of the continuum against which cards are sorted/ranked.

3. **Scoring with the sort against a continuum** - Frequently this is done against a +5 to -5 within which 0 is viewed as neutral or unselected and thus having no meaning. Scores are placed in an ascending order, although McKeown and Thomas (1987) suggest that it doesn't matter whether this is right positive to left negative or reversed provided consistency is maintained.

4. Respondents/subjects are advised that there is no correct or incorrect answer. All that is important is their own view.

5. Having undertaken the sort an opportunity is given to correct / change / re-align the sort.

6. Sorted cards are arranged usually to facilitate viewing rather than in hidden piles.

7. Two sorting approaches can be adopted; one where the respondent is 'forced' to select from the items/card sample only a specified number for each category within the continuum or for each rang score. Secondly a freer approach is adopted where the respondent may select any number or similarly reject any number he or she wishes. (More recently the forced method has tended to be adopted.)

8. It is important to remember that the divisions along the continuum are ordinal rather than nominal in characteristic.

4.6.6 Number of Respondents: Issue of the Single Case

There is considerable debate yet agreement in the literature about the number of respondents used in a Q-sort. In Q-sort there is a bias towards small person samples, or indeed even an argument for the use of a single case. This view is in accord with the previously discussed notion whereby the sample refers to the Q cards rather than respondents, hence respondents tend to be termed the P set or P sample. (McKeown and Thomas, 1987.)

The value of small numbers of respondents or set within Q-sort is illustrated by reference to such authors as Dennis (1986):

"Large sample theory guides the determination of sample size in traditional quantitative studies, but it is not a consideration in Q where the items rather than the people comprise the same as the unit of analysis. Instead the number of subjects for a Q study reflects the requirement for enough persons to define the factors that emerge." p.11.

"Q method is biased towards small person samples and single case studies." McKeown and Thomas (1987) p.36.

Indeed McKeown and Thomas (1987) continue to expand this view by reference to notions of extensive and intensive and how these terms have different value in Q-sort as opposed to R based methodology, namely that the purpose and nature of Q allows intensive study within small numbers of respondents with this small number still being acknowledged as an extensive exploration.

Inevitably the issue of a small P set raises the debate of generalisation within Q. Both Dennis and McKeown and Thomas attest that despite small numbers generalisation is possible due to a range of factors, for example:

1. The sensitivity of Q in that the respondents' subjective views are explored in depth and embrace multiple facets.

2. The purpose of Q-sort is not to explore the idiosyncratic but to explore in depth self reference perspectives in order to understand the nature of human behaviour and belief. Accordingly respondents are selected largely because of their perceived relevance to the issue being explored,

or their perceived experience in respect of the issue. Indeed this view is one that is evident within the wider literature and debate about selection of respondents within Qualitative Research. Morse (1991) suggests for example that in Qualitative Research the criteria should be:

> "selecting the informants best able to meet the informational needs of the study and a good informant i.e. one who is articulate, reflective and willing to share with the interviewer." p.127.

Morse continues to argue that the application of rigid and prescriptive sampling rules whilst appropriate for more quantitative research may actually be detrimental in qualitative based research.

> "Quota sampling also poses another threat to validity. The researcher may become so pre-occupied with finding informants that meet the criteria of the sample frame in order to fill the cells that the criteria for completion of the study becomes one of sample size rather than development of a theory." p.128.

De Boer (1983), and Van Tubergen and Olins (1979) suggest that even when using small numbers in Q, frequently one can identify patterns or configurations that are reflective of the larger population. If one accepts this, large samples may be not only unnecessary, but redundant.

Clearly the acceptance of a small P set or sample has given rise to discussion concerning the potential tension arising between the theoretical

significance vis-a-vis its statistical significance. It is to a brief consideration of this issue we now turn.

4.6.7 Theoretical Significance vis-a-vis Statistical Significance

The debate regarding theoretical and statistical significance is associated with the need for a small number of respondents being desirable within Q methodology and its related generalisation.

Dennis (1986), Brown (1980), and McKeown and Thomas (1987), particularly have all cautioned that sole reliance upon statistically significant findings might lose key insights or issues which:

> "although unimportant in terms of the proportion of variance explained nevertheless may hold special theoretical interest." McKeown and Thomas p.51.

A commonly held view therefore is that, whilst it is appropriate and useful to use such statistical tools, they must be interpreted more freely to allow responses which have attracted low statistical significance not to be discounted. This is important due to the need to embrace subjectivity and the qualitative elements.

> "It is common practice to report that a factor or set of factors account for x per cent of the total variance, but this is more habitual than informative. It is of course sometimes necessary to toss a statistical bone to the mastiffs which guard the professional journals but until the nature of factors and their functional connections are described and understood in situ there is little likelihood that a science of behaviour will be noticeably advanced" Brown (1978) p.124.

Similarly Dennis suggests that any factor to which at least four people agree should be considered as important. Having a number of people beyond these figures add very little.

Hence the literature does clearly articulate the case for both inductive and deductive reasoning in the analysis of the data in order that the subtleties of the nature and form of the issues are retained.

4.6.8 Forced or Free Selection

An important methodological issue within Q-sort is whether to use a forced or free selection of cards for grading.

Forced selection is where the respondent is given a specific number of cards that may be selected against each score. Typically this ranges from five cards up to twelve.

Free selection, however, allows the respondent to choose how many cards may be selected against each score.

The debate over this methodological issue can be traced to what might be regarded as a definitive view offered by Block (1956), with more recent notable contributions offered by such authors as Cronback (1960), Freeman (1962), Brown (1971), Cottle and McKeown (1980), Bolland (1985), and Nitzberg (1980).

Within recent years a greater use of forced sorting has tended to take place, one reason for this being the way in which forced sorting is more amenable to statistical testing particularly by the use of factor analysis. Indeed Stainton Rogers' research discussed in section 4.8 is one example of the use of forced sorting in respect of health. Clearly the forced sort does result in all respondents selecting in the same configuration and in consequence are easier to compare with one another.

> "Using the same mean and standard deviation, and making all sorters conform to the same distribution permits convenient computational and statistical operations." Nitzberg (1980) p.503.

One of the central criticisms of such a forced sort technique relates to this very notion of common configurations. It cannot be assumed that individuals would naturally select in the same way. In consequence individuals' natural preferences may be obscured, and hence important information not obtained. This issue was identified by Thompson (1980):

> "It should be readily obvious that this procedure 'throws away' information.... This procedure relates to logic of the method, which is best applied when most subjects will not feel exactly the same regarding the different objects being sorted." p.548.

In contrast the free sort procedure embraces and accepts the notion that individuals have a tendency to select in diverse ways. This principle is attested to by Brown (1986):

> "It has never been argued that people naturally sort statements in this form." p.59.

The free sorting approach was adopted in Bath District Health Authority's investigation of local health needs, see Farrell (1986) section 4.8.

A potential difficulty with the free sorting approach, especially if the people set or sample is not extremely large, is that it is not so amenable to statistical investigation by factor analysis. This issue is examined by such authors as Brown (1971, 1986), and Cottle and KcKeown (1980). Brown (1986) has remarked that:

> "Even under free-choice conditions significant deviations from normality are rare when the Q sample is sufficiently comprehensive in scope." p.59.

Nitzberg (1980) suggests that in free sort situations the use of means and ranking is more helpful than factor analysis. This arises from the notion that forced selection and use of factor analysis fails to explore the cards that might be selected outside the norm which are in themselves important.

> "One should not reject Q-sorts simply on the basis of the shape of the response surface. In fact some of the most interesting subjects for intensive analysis just might be those deviating from a response distribution approaching a normal curve." Cottle and McKeown p.62.

Finally, the choice between using a forced or free sorting procedure rests not with issues of analysis but with the more fundamental issue of the research emphasis and aims. This is clearly addressed by Block (1956) and more recently by Nitzberg (1980):

> "The decision of forced or unforced sorting should be determined by research objectives. If scatter and level are important free sorts are the choice. If self referent expression is the prime significance in examining the deeper personality dimensions the forced choice is preferred." p.503.

The need to select forced or free sort procedure against the research aims is of particular relevance to this research. Indicating the importance of considering the aims of the research with care in selecting and designing the Q-sort procedures. A free rather than forced sorting procedure was selected for this study. The principle focus of this study is exploratory in terms of seeking to identify the definitional relationship between the five key concepts (health, happiness, well-being, life satisfaction and quality of life) and life factors which might be regarded as influencing this. Consequently, scatter and level are of primary importance which are best explored by free sorting procedure. This is different from a detailed exploration of personality groupings in the population, which is best explored by forced sorting.

4.7 Q IN THE CONTEXT OF THE QUALITATIVE / QUANTITATIVE DEBATE

Q-sort is generally accepted as being a qualitative rather than quantitative approach, despite the apparent use of a number base scale against which the Q cards/items are selected and scored and the use of numerical based analysis by means and factor analysis. The location of Q-sort within the qualitative domain results from the self reference embedded within Q and its goals of constructing meaning of things and events as understood by the respondent. In essence it is an attempt to map the individual's cognitive world. Such mapping is dependent upon the creation of classifications, taxonomic trees or semantic networks derived from interpretive analysis of the data rather than mere calculation.

Spradley (1979), Werner and Schoepfle (1987) Weller and Romney (1988), Gladwin (1989) and Miller and Crabtree (1992) have all attested to the qualitative focus of Q methodology suggesting that it might be seen as an Ethnoscience or Cognitive Anthropology with a Qualitative classification.

In addition to the specific Q-sort strength and weaknesses already identified it shares the methodological benefits and disadvantages associated with Qualitative methodology.

4.7.1 Q-sort: a quantitative dimension within a qualitative approach

Within Q methodology however recourse is made to the use of a numbered scale and means and factor analysis to facilitate interpretation and coding of

the selected cards. In light of such numerical use therefore Q might justifiably be seen as having a tentative relationship to more quantitative approaches. This is true if qualitative and quantitative methods are seen as a continuum rather than discrete and opposing approaches. Q therefore, whilst resting philosophically within a qualitative frame of reference, also crosses the divide to quantitative methodology.

Accordingly the use of Q methodology might be perceived as a way of combining to some extent qualitative and quantitative approaches. Tripp-Reimer (1985) highlighted the value of combining qualitative ethnographic method with more quantitative approaches:

> "This fusion results in rich and complementary data sets and ultimately gives a more complete picture than could be obtained using either method singly" p.179.

Q method therefore is able to generate both numerical data and supportive qualitative descriptions. Accordingly more strongly focused qualitative means of analysis are required to facilitate analysis of these elements of the Q-sort. One approach is that of grounded theory.

4.8 CONSIDERATION OF Q WITHIN HEALTH

The preceding discussion has sought to highlight the potential value of Q-sort as a methodology for exploring a wide diversity of issues, whilst acknowledging the limitations inherent within Q methodology. Despite such potential, to date Q-sort has had limited use in the context of exploring

health-related issues although some examples within the domain of health and nursing can be found. Whitling (1955) used Q-sort to explore nurse patient inter-relationships as did Smith (1970). Nyatanga (1989) used Q-sort when exploring nursing education. Patients' views and reactions to care were considered using the Q-sort method by such authors as De Wolfe et al (1966), Lucente and Fleck (1972). Levin and Corell (1986) used Q-sort to generate a typology of 'new age healing' or complementary/alternative therapies.

With regard to the specific use of Q-sort to examine lay health beliefs, the author has been able to identify only two studies. Both studies however are significantly different to the issues addressed within this study in that they addressed health as a single undimensional concept in the context of ill-health and recovery. Nevertheless the studies are worthy of note and accordingly did provide a helpful vehicle for reflection against the finding of this study as discussed in a later chapter. The first study undertaken by Bath District Health Authority, Farrell (1986), was an attempt to understand:

> "- the health beliefs of the residents of the Bath Health District
> - their perceived health status
> - their desire for an improved health status
> - an indication of the residents' perception of which products and services need to be provided or improved in order to help them achieve a better health status" p.1.

The focus of the research was primarily to obtain information that might inform the Health Authority's health promotional activities and strategies.

Throughout its eighteen month duration a variety of methodologies were used including the concept of questions formatted upon a card:

> "It was necessary at this stage to formulate a questionnaire which allowed respondents to select the issues they felt described their perceptions of being healthy and to ask them a series of questions on each issue. The idea was hit upon to have a pack of cards with the key health issue on one side and the health status questions and possible options for change on the other" p.11.

Whilst not overtly labelled as a Q-sort the method adopted through the use of such cards clearly reflected Q-sort principles. For example the card based interview was found to last up to one-and-a-half hours. The Q item sample numbered 41 whilst a total of 100 individuals were interviewed. The nature of such respondents is however problematic having been selected without consideration of their representative characteristics by a random method. A free sort approach was adopted with analysis undertaken by mean calculations rather than factor analysis. The potential value and interest of the Bath study in the context of this research therefore lies in the fact that it helped to:

1. re-affirm that Q-sort has a potential value when exploring health beliefs;

2. re-affirm that individuals can indeed reflect and highlight life factors which they believe influence health, although in the Bath study health was left undefined as an undimensional concept.

The study by Stainton Rogers (1991) used a Q-sort methodology in respect of the questions:

1. What makes for good health?

2. What makes people ill?

3. What affects recovery?

Hence health in this study was addressed in the context of illness and recovery, in effect negative rather than positive health.

On reflection upon the two-phased study by Stainton Rogers, the following observations are helpful in terms of the Q-sort based survey undertaken by the author:

1. Incentives were used to stimulate the response rate.

2. Accounts of health/illness were generated and seen of value even when based upon a small number of the respondents. This is in accord with the preceding Q-sort methodology discussion, particularly Dennis (1986).

3. In contrast to the author's study, the population adopted in Stainton Roger's work embraced health professionals and other related professionals (as well as the lay population). These respondents were targetted as individuals rather than randomly selected.

4. The sample size of the Q-sort interviews was relatively small and not too dissimilar to that adopted by the author.

5. Health was explored only as a single faceted concept and contextualised against illness, recovery and explanations about blame and responsibility for ill health. In this respect therefore it is notably dissimilar from the author's research focus.

6. Stainton Rogers' results do indicate the potential of beliefs about health obtained from Q-sort to be demonstratively influential upon ill health beliefs and practices. This is consistent with the author's contention that knowledge about hidden health beliefs in the lay population is important and can have consequences for health/illness strategies, policies and education of professionals involved in health care.

7. Finally it serves to re-affirm the methodological value and appropriateness of Q-sort when exploring health beliefs/views.

4.9 GROUNDED THEORY ANALYSIS WITH Q-SORT

The concept of grounded theory was developed by Glaser and Strauss (1968) and is today commonly used within the context of qualitative health based research as a means of systematically analysing recorded statements in order to generalise a theory or classification.

It has as its basis a view of human behaviour as symbolic interaction, and involves the collation of qualitative data which is then continuously compared as a method of analysis to produce codes and categories that may serve as a basis for further data collation. This is undertaken in a repeated way until sufficient information is obtained whereby no further illumination or development of the concept can be achieved. Finally mapping of the key concepts and their relationships is undertaken and underlying theory shown. In consequence the research question and sample are not prescribed at the onset but rather modified and re-defined in light of findings en route. Its optimum usage is for:

> "Areas in which little research has been done. In these areas theory testing cannot be done since the variables relevant to the concepts have not yet been identified. Therefore, one of the major uses of grounded theory has been in preliminary exploratory and descriptive studies..... they are considered precursors for further investigation." Chenitz and Swanson (1986) p.7/8.

Nevertheless, it has to be acknowledged that in analysis and critique of grounded theory there is an element of misunderstanding. Chenitz and Swanson claim that to evaluate grounded theory by reference to the same criteria as other more quantitative based research is inappropriate.

> "They look for classic hallmarks of scientific rigour, such as randomly selected samples, strict adherence to pre-planned research design and data collection, and coding and analysis in precise order all of which are inappropriate criteria by which to evaluate grounded theory." p.151.

Grounded theory should be evaluated in respect to the nature of the research question and indeed subsequent ones that develop and become the focus of the research study as it progresses.

4.10 HEALTH FOCUSED Q-SORT METHODOLOGY WITHIN THE CONTEXT OF MARKET RESEARCH

The use of Q-sort within the context of a market research approach is evident within this research. Firstly the Q-sort items generated were of a naturalistic design derived from the lay population; the exploration of general population views is fundamental to market research principles.

Secondly within the main Q-sort itself financial incentives were offered to respondents, a practice rooted within market research methodology.

Thirdly market research methodology embraces a wide range of research tools including Q-sort and diaries both used within this research.

Fourthly strategies adopted for the identification, selection and contact of respondents was in accord with market research principles.

Accordingly it is appropriate to briefly consider the principles of market research in so far as their incorporation within this and other health-related research.

Whilst a wide range of definitions for market research may be found, Zikmund (1982), Aaker and Day (1986) and Green, et al (1988), key areas of agreement do emerge. Namely that market research:

a. Is an aid to decision-making.

b. Provides an information base.

c. Can be regarded as systematic in its approach and even scientific aspect to market research is questioned by Chisnall (1986) who states:

> "Marketing research can never be a pure scientific activity it is an applied field rather like engineering which involves knowledge of metallurgy, electronics, mathematics, etc. but which has a technique of its own." p.12.

This interpretation of the scientific base to market research it might be argued is reflected in both the stages, purposes and related methodologies which can be seen to embrace both qualitative and quantitative perspectives.

Zikmund (1982) has suggested that market research can be classified either on the basis of:

1. Technique such as experiments, surveys and observational studies.

2. Function or purpose, this being either to explain and clarify the nature of the problem (exploratory research), to describe the characteristics seeking to answer who, what, where (descriptive research) or to identify cause and effect (casual research).

Broadly this functional classification is supported by other authors including Green et al (1988) who also expand the classification to encompass not only functions of description and explanation, but also evaluation with these being directed towards effective planning of market activity, control of operations and evaluation of results.

Hence it might be argued that a central focus of a market research is that it is problem-solving, however, the nature of the problem concerned is diverse and can include as Zikmund identified the developing and evaluation of concepts and theories attempting to expand the limit of knowledge rather than seek the solution to any particular pragmatic or practical issue.

In this way therefore the potential value of market research is perceived as being wide ranging from strategic concept generation to more practical or pragmatic decision-making. Hence having relevance to health belief policies and behaviours rather than being limited to commercial products.

The stages within market research have a relationship to stages within other forms of research.

Essential ingredients of market research which guided the early stages of the research and Q-sort thereafter are that market research is:

a. clearly focused upon the consumer;

b. will embrace a consumer's perspective/need/view as a central focus;

c. designed to help in a decision process.

4.10.1 Use of Incentives in Market Research

Zikmund (1982) highlights the potential value of incentives within market research by way of increasing response rate. He claims that such an increase is derived from the way in which an offer of an incentive attracts attention and hence encourages the respondent to participate rather than as a result of the incentives value.

> "Although pens, trading stamps, lottery tickets and a variety of premiums have been utilised, monetary incentives appear to be the most effective and least biasing incentive. Although money may be useful to all respondents its primary advantage may be as a means of attracting attention. It may be for this reason that monetary incentives work for all income categories not exclusively for the poor." p.193/4.

The role of economic incentives is further discussed by Harvey (1987) during which he highlights:

a. the use of monetary incentives has been largely within the United States (Hancock, 1940, Erdos, 1951, Maloney, 1984, Kimball, 1961, Robin and Walters, 1976, Friedman and San Augustine, 1979, Paolillio and Loronzi, 1984).

b. That studies in which incentives were used showed to variable extent an improvement in response rates (Armstrong 1975, Linskey, 1965, Kanuk and Berenson, 1975).

c. That there is a general lack of agreement as to the optimal level of monetary reward/incentive that should be offered with response rates being shown to improve as a result of incentives ranging from 25 cents (Hansen, 1980, Friedman and San Augustine, 1979) to that of one dollar (Hopkins and Padolak, 1983, Hansen, 1980) whilst there has been use of as little as 10 cents (Robin and Nash, 1973) with a positive rise in response.

d. The use of incentives within Britain as opposed to its more extensive use in the U.S.A. has received a limited consideration with such authors as Moser and Kalton (1971) doubting its value, whilst a study by Shackleton and Wild (1982) found that financial incentives did have an effect in increasing the rate of responses from a questionnaire.

e. The potential bias that incentives might create has been considered by such authors as Sawyer (1975) and Hansen (1980) although generally authors, notably Goodstadt et al (1977), Nederhof (1983) and Mizes et al (1984) view that no evidence exists to suggest that incentives result in bias.

In considering the body of evidence relating to the potential value of cash incentives Harvey (1987) concludes:

> "Economic incentive also seems certain to raise response rates but may increase costs to unacceptable levels." p.148.

Harvey's discussion focuses upon mailed questionnaires, however, it is the author's contention that the debate is transferable to use of monetary incentives within market research situations other than that of interview. This view is supported by the use of incentives in Stainton Rogers (1991) research discussed in section 4.8.

4.11 SUPPORTIVE / DEVELOPMENTAL METHODS

The focus of this section is to consider the literature pertaining to the supportive and developmental research methods used, diaries and semi-structured interviews. Both of these are used widely within the context of market research.

4.11.1 Diaries

Diaries were used to provide supportive data in both the developmental and final Q-sort stage of this research. Diary approaches have been used by a few researchers in respect to health related studies, although, predominantly for ill-health rather than health. For example, Norman et al (1982) reported the use of a diary technique for a period of two years to study the influence of the psychological environment upon 500 subjects' health status (use of a diary over such a long period is in fact unusual). Dunnell and Cartwright (1972) studied medicines consumed, Roughman and Haggerty (1972) explored symptoms and related health seeking action and Patterson (1980) mothers' appreciation of their children's symptoms. More recent studies using diaries particularly in relation to children are described by Butz and Alexander (1991). The diary/log or calendar approach involves the individual or family in undertaking to record certain events, behaviours or views upon a regular basis. They have the advantage of being able over a period of time to reflect fairly 'minor' aspects of an individual's life or views that may not emerge within an interview approach where more 'major' issues only may be discussed. Yet such issues may be of importance to the ultimate research findings. Two key problems, however, are related to the use of a diary. Firstly, there is the need to obtain initial co-operation and secondly, to sustain interest as time progresses. There is clearly a tendency for this to diminish as shown in Mooney's (1962) study where the percentages of entries daily decreased. Mooney commented further that:

"As time went by there was an increasing tendency to omit the reporting of minor illness." p.46.

The difficulty of adequate response rates in diary usage is explored by Wykle and Morris (1988) in the context of outlining the advantages and disadvantages of diary use. One approach used by the authors to encourage response rate was a small monetary incentive. This is of particular interest when viewed in the context of market research (see debate, section 4.10.2).

The tendency of diminished response is exacerbated if the diary format is complicated and time-consuming to complete. To ensure adequate completion a simple format is preferable, such as a checklist approach that merely requires ticking. This was used by Mechanic and Newton (1965). However, this simplistic completion may serve to reduce the richness of the data acquired. To help minimise the reduction in completion rate over time it is necessary to consider extensive time commitment on the part of the researcher to undertake contact maintenance on a regular basis with the subject. Such contact usually takes the form of face-to-face visits and/or telephone calls, as demonstrated by studies undertaken by Moser and Kalton (1971), and Allen et al (1954). The importance of such follow-up activities is indicated by Mechanic and Newton (1965) who did not undertake such prompting and in consequence had only a 57% response rate to their illness logs, in contrast to other studies in which prompting activities was provided to a response rate of frequently 70-90% (Patterson 1980). The time period over which a diary is maintained has also been

addressed within the literature and ranges from one week up to a few years. Vergrugge (1980) suggests a common period is that of four weeks.

The very act of diary completion may in itself inadvertently cause modification of behaviours or views, or serve to highlight that which would normally not be considered in any depth by the individual. In consequence this could cause an element of bias. Studies by Dunnell and Cartwright (1972), and Morrell and Wade (1976) help to refute such bias. If the diary has a fairly open structure then the nature and extent of the data generated within a diary approach may prove a challenge to analyse systematically and comprehensively.

The most helpful methodological debate in relation to the use of health diaries is offered by Vergrugge (1980). Vergrugge suggests that diaries can be used for health based research for three main purposes:

a. as memory aids to improve recall of health events in later retrospective interviews;

b. to compare reporting levels for retrospective and prospective procedures;

c. as a primary data source.

Vergrugge briefly reviews 19 health diary surveys undertaken predominantly in the U.S.A. between the years of 1938 to 1977. As a result, he suggests:

> "A diary is ideal for learning about the whole iceberg of health" p.85.

The potential value of diaries is further re-affirmed by Woods (1981) particularly when used to explore positive dimensions of health rather than ill-health episodes or symptoms. Equally, diaries seen as one example of personal documents is advocated by Raffling (1986):

> "Personal accounts of health and illness are classifiable as topical autobiographies that is value laden reports of particular experience. They are likewise holistic products in that putting together a coherent life account pre-supposes rationality and ability to synthesize. As distillations of experience they represent conscious selections of the most meaningful and dramatic aspects of the experience from the actor-author's point of view" p.5.

Accordingly, despite the problems and disadvantages associated with the diary approach it has many advantages and has potential for this study.

4.11.2 Interviews

Interviews were conducted both in the developmental stage of the research, in the form of a semi-structured long interview to generate the naturalistic Q card items, and in the final stage in which a Q-sort was undertaken. The relative strengths and weaknesses associated with interviewing are now discussed.

4.11.3 Range of Techniques used within Interviewing

A key difference in the literature concerning interviewing in the context of market research rather than generic research is that the latter tends to use a fairly limited range of approaches, whilst market research has developed a wider range of tools/techniques to be used within the interview context including Q-sort.

The use of such techniques within an interview setting can be traced back to the 1950's and is said to be beneficial in helping to clarify and explore concepts, whilst Aaker and Day (1986) suggest that such techniques are used when it is:

> "believed that respondents will not or cannot respond meaningfully to direct questions about (1) the reasons for certain behaviours, or attitudes, or (2) what the act of buying, owning or using a produce or service means to them. People may be unaware of their own feelings and opinions unwilling to make admissions that reflect badly on their self image." p.126/7.

The rationale underpinning such techniques therefore relates to the notion of private and public revelation within interviewing within which certain issues are held to be private perhaps even intuitive, personal unconscious are pressed. Consequently such issues are difficult to access within an interview situation. This notion is explored within a market research context by Cooper and Branthwaite (1986) and is found to have parallel expression in the literature pertaining to general research interviews (Cornwell, 1984, and Blaxter and Paterson, 1982). Through the use of

such approaches market research does provide an arena in which both qualitative and quantitative philosophies meet, whilst acknowledging both strengths and weaknesses of each stance.

Lo Biondo, Wood and Huber (1986) suggested that criteria that might be used for judging the effectiveness and rigour of the interview in whatever the context it is undertaken. These are:

"1. Are all of the data collecting instruments clearly identified and described?

2. Is the rationale for their selection given?

3. Is the method appropriate to the problem being studied?

4. Is the method appropriate to the situation?

5. Is the schedule described adequately enough to know if it covers the subject?

6. Is there a clear indication that the subjects understood the task and the question?

7. Who were the interviewers and how were they trained?

8. Is there evidence of interview bias?" p.165.

4.12 SUMMARY

This chapter has identified the principles relating to the main Q-based methodology and the supporting developmental methods used.

1. Q methodology is effective/relevant to the eliciting of subjective views in a systematic and focused way.

2. Health as a subjective phenomenon is accessible through Q.

3. The emphasis upon self reference within Q facilitates systematic exploration of an individual's subjectivity.

4. Whilst Q is viewed as systematic and scientific in its approach, it remains distinct from the traditional R methodology.

5. Both strengths and weaknesses have been identified through extensive use of the methodology in a diversity of research situations and issues.

6. There has emerged from such extensive usage a level of agreement concerning the stages of Q.

7. The sample in Q relates to the items on cards for sorting rather than the respondents.

8. There exists a level of agreement concerning the design of such Q samples.

9. Q is essentially a small sample methodology with the respondents or people being termed the P set or sample.

10. There is general acceptance that whilst statistical analysis is of value, this should not detract from factors which, although being of no statistical significance, might be viewed as theoretically significant. Both inductive and deductive reasoning have value within Q.

11. The use of free or forced Q-sort should be determined by the focus and nature of the research question.

12. Q-sort has been identified as having value in consideration of a diversity of issues including two studies which have a focus upon health albeit in a undefined way and in the context of ill-health.

13. Q-sort has been described as an Ethnoscience and therefore has a greater affinity to qualitative rather than quantitative approaches.

14. Q-sort is amongst the techniques employed within Market research and accordingly must be viewed in that context as well as the qualitative/quantitative one.

15. Within a Q-sort non-numerical data is often generated by way of supportive description; the analysis and coding of which can prove challenging. One strategy is to view this in the context of grounded theory approach.

4.12.1 Summary of issues arising from consideration of supportive/developmental approaches (diary interviews)

1. The use of incentives is valuable.

2. The potential value of diaries with an acknowledgement of the difficulties associated with some notably poor response/completion and return made.

3. The acknowledged principles underpinning the use of interviews, including in the context of market research, in an attempt to avoid and/or minimise bias.

One of the intentions of this chapter has been to endeavour to meet the challenge set by Lo Biondo, Wood and Huber (1986) that:

> "enough description should be evident so that the reader is able to evaluate the appropriateness of the methodology" p.291.

The intention therefore has been to share with the reader methodological considerations which occurred in determining the approach finally used within the research.

CHAPTER 5

Procedures in developing the Eudaimonistic Model

5.1 INTRODUCTORY REMARKS

The purpose of this chapter is to present the findings of the research in terms of an emerging eudaimonistic model of health held by the lay population. The model was derived from a free Q-sort procedure of 49 items and based upon responses from 64 individuals resident within the Corby area.

5.2 DEVELOPMENTAL STAGES

The model was derived from four developmental research activities followed by the use of the main Q-sort survey itself. Discussion of the developmental stages and related findings in detail are confined to the appendices. A summary is presented here in the form of the research calendar.

5.2.1 Research Calendar

1. **Developmental Stages**

Preliminary stage:

1. - Definitional framework derived from the literature.
   - Consideration of research issues (including association with the South Birmingham Health Authority/Aston University market research project.

2. Use of South Birmingham population to undertake:

a. An exploratory question within South Birmingham Household survey to confirm the ability of individuals to reflect upon the influence of life events upon health.

b. Use of a diary within the South Birmingham Survey of elderly respite care services. The diary was used to explore the relevance of the five concepts relating to health within a diary format.

Stage One:

Development of a questionnaire using the five concepts together with a supporting diary.

The semi-structured questionnaire was piloted by interviewing eight individuals selected from the South Birmingham area.

Stage Two

Refinement of questionnaire and diary used in Stage One.

Use of the questionnaire and diary posted to ten residents of South Birmingham followed by distribution to 30 residents selected from the electoral register, together with a further 30 individuals selected from respondents of the South Birmingham and Aston University project. Following a poor response rate of 20%, non-respondents were contacted by telephone to explore reasons for non-completion. This identified the difficulty of questionnaire completion without interviewer support.

Stage Three (Details of analysis given in Appendix 3)

The questionnaire and diary used in Stage Two was used as the basis for structured interviews. Respondents were selected randomly from the electoral register and contacted by letter and telephone before interview. Initially 20 people were contacted from which 15 agreed to be interviewed (group A). Subsequently a further 20 people were contacted from which 10 individuals agreed to participate (group B). Thus a total sample of 25 individuals was obtained.

Stage Four (Details of analysis is given in Appendix 4)

Factors identified in Stage Three were used to develop 52 items for a Q-sort. A pilot of these items was undertaken with seven individuals. Some modifications were made prior to the main Q-sort survey itself.

The modifications consisted of:

(a) placing Q-card 'a good sex life' last - i.e. card 52
- due to its sensitivity.

(b) re-phrasing of card 37 to read 'boredom'.

(c) omission of cards 38 and 23 from the main Q-sort - i.e. cards 'not using illegal drugs' and 'free from the threat of nuclear war'.

2. **Main Q-sort** (*Stage Five*)

Initial discussion and application

July/August 1990 - discussion with Kettering Health Authority seeking permission for the Q-sort survey to use a sample of individuals derived from the electoral register held by them for the purpose of their own C.H.O.I.C.E. project. Formal application made July 1990.

Discussion and agreement of sampling October 1990

Criteria for and selection of fieldworkers October 1990

Ethical permission received	November 1990
Selection and fieldworker interview	Late Oct 90 - Dec 90
10 pilot interviews	January 1991
Discussion/review and modifications	February 1991
Main survey with maintenance of regular dialogue and monitoring	March 91 to Nov 91
Review and de-brief of fieldworker interviews	December 1991
Completion of fieldwork	January 1992

5.3 STAGE 5: MAIN Q-SORT - SUPPORTIVE DETAILS

This section presents additional information in support of the research calendar pertaining to:

a. the people sample
b. selection and training of fieldworker
c. use of incentives
d. duration of Q-sort.

5.3.1 The people sample

A target of sixty respondents selected from the lay general population of Corby was set, with selection made of individuals over eighteen years whose names were listed on the local electoral register. In accordance with prior experience of response rates with Corby, an initial selection of 127 individuals to achieve 60 respondents was anticipated. The intention was that an additional selection criteria should be to achieve a male/female balance reflected in the population of Corby, that is a slightly higher proportion of female to male. Additionally, as it was the intention that this research should provide supplementary information to the C.H.O.I.C.E. project as previously described, consideration was given to this relationship when selecting respondents.

The C.H.O.I.C.E. lifestyle questionnaire had embraced all electoral wards of Corby; however, the other elements of the C.H.O.I.C.E. project were largely centred in one electoral ward of Kingswood. Accordingly it was agreed that selection and interviewing would initially commence in this electoral ward. This afforded an opportunity to check out the appropriateness of selecting, and identified and confirmed the need to involve all electoral wards to ensure sufficient response.

Consequently the initial pilots were conducted in Kingswood with all interviews thereafter undertaken in all electoral wards of Corby and embracing selection of respondents from the full electoral register.

5.3.2 Method of Contact - Outline of Strategy

Activities within the C.H.O.I.C.E. project had identified that by and large residents within Corby responded poorly to contact by post alone. Accordingly it was decided that individuals drawn as potential respondents (the P set) should initially have a personal contact to seek their involvement. This personal contact made either by telephone where possible or by a visit to the residence. This contact allowed an explanation about the research, its relationship to C.H.O.I.C.E., and nature of the involvement required. Where there was agreement by the resident to become involved, a supportive letter was left and an appointment made for the Q interview. Individuals were also advised at this time of the incentive/reward for such involvement.

5.3.3 Interviewers/Fieldworkers: selection

Due to the geographical distance it was negotiated and agreed through the research supervisor that it was acceptable to utilise a fieldwork assistant to conduct the Q-sort based interviews. Principally this was accepted because the Q-sort cards, methodology and related piloting development had already been undertaken, additionally that the main survey could still remain under the direction of the author whilst still adopting the use of such a fieldworker.

Criteria for selection

Given the complexity of Q-sort, it was agreed to establish criteria by which any fieldworker could be selected prior to preparatory training, namely:

1. Evidence of past research based interviewing experience.
2. Evidence of effective communication and interpersonal skills.
3. An ability to record accurately.
4. A willingness to undergo preparatory training.

Accordingly it was possible to identify two suitable fieldworkers.

5.3.4 Initial Induction and Training of the fieldworkers

The author initially spent over four hours introducing the concept of Q-sort, relating this to traditional interviewing approaches, discussing the development of the Q research to date, and explaining the interview stages.

A further discussion took place centred around the Q methodology, but in this instance involving a demonstration of the procedure. This was re-inforced by creating an opportunity for the selected fieldworkers to undertake the procedure themselves within a small group setting, followed by discussion of related perceptions and issues.

The fieldworkers were then encouraged to undertake a Q-sort interview on a friend or relative before further discussion.

5.3.5 Q-sort Practice

It was agreed that a total of 10 Q-sort interviews should be undertaken with the **results of these not incorporated into the survey.** This provided an opportunity for the fieldworkers to 'practise' in reality the Q-sort approach, with further discussion and review occurring after the pilot.

5.3.6 Shadowing

Following the pilot and in respect of the main survey interviews, by way of a quality check and further consistency measure a shadow activity was undertaken.

5.3.7 Continued Dialogue with C.H.O.I.C.E. Co-ordinator/Field-worker and Author

Throughout the interviewing timetable a regular dialogue was maintained by the author in respect of the sampling, interviews and recording, this being achieved both by telephone and face-to-face contact. On average this occurred at least on a monthly basis, although more frequently at key periods. Unfortunately it did not in the end prove feasible for the author to engage in regular shadow visits, hence part of the regular dialogue time was spent on re-checking with the fieldworkers the adherence to the Q-sort procedure.

5.3.8 Checking of Recording

During the interview the data pertaining to the selection and grading of the Q cards were recorded on a total of 3 sheets of A4. To allow ease of analysis, however, these were later transcribed on to a single summary sheet. To avoid error this was always done initially by the individual who had conducted the interview and checked by a second person. These were also sampled for review and discussion by the author with the fieldworkers during the afore-mentioned dialogue meetings.

In view of the strategies identified above, it is therefore the author's contention that adequate induction and ongoing monitoring occurred in order to achieve consistency of approach.

5.3.9 Use of Incentives

At the onset of the survey brief consideration as to whether such incentives should be used was given. However, it was decided initially not to do so, rather to judge through the pilot the response rate and use incentives if felt appropriate thereafter. The pilot did highlight the difficulty in achieving a response rate and agreement to be interviewed, hence incentives were introduced. The incentive was verbally referred to at the initial contact and offered in the form of £5 left in a sealed envelope after the interview was completed, with a receipt obtained for this. It must be acknowledged that initially an incentive of £3 was used; however, it was raised to £5 after ten incentive-based interviews were undertaken to further enhance the acceptance rate, with £5 thereafter appearing to be a satisfactory amount.

5.3.10 Duration of Q-sort

In conducting the interview and related Q-sort procedure, the fieldworker was asked to record the duration of the Q-sort itself; accordingly the initial discussion outlining the purpose of the interview, key concept definitions and the completion of respondent profile was excluded. (The exclusion of these elements was undertaken in order that a more accurate picture of the Q-sort itself might be obtained.) The Q-sort procedure took between 31 minutes and 105 minutes as identified below:

Mins	Number of Respondents	Mins	Number of Respondents
31	One	56	Three
33	One	57	Two
35	Three	60	Six
37	One	65	Four
40	Two	70	Six
42	One	75	Three
45	Eight	76	One
46	One	80	Five
50	Seven	105	One
55	Eight		

The above therefore supports the Q-sort methodological literature which suggests that Q-sort is a relatively lengthy procedure. Indeed the majority of respondents, 46, i.e. 72%, took 50 minutes or over to complete the Sort, whilst 26 respondents, i.e. 41%, took one hour or over to complete the Sort.

CHAPTER 6
Results: the Eudaimonistic Model

6.1 INTRODUCTORY REMARKS

EMERGING MODEL

Analysis of the research findings provided a eudaimonistic model of health (Fig. 3) which contained three main elements. Each element is derived from analysis of information obtained from steps within the Q-sort procedure. This relationship is summarised in Table I on the following page.

6.2 Q-SORT: ELEMENTS OF THE MODEL

6.2.1 Step 2 - Definition of the Key Terms

The respondents were shown 5 cards on which were written the key concepts - health, well-being, life satisfaction, happiness and quality of life. The respondent was asked to define in their own words each of these key concepts. The response was written down on a sheet of paper and left in front of the respondent to act as a point of reference throughout the interview. An opportunity to re-write or revise the definition if wished was also given at the end of the Q-sort procedure Step 8.

Table 1: Relationship of Q-sort steps to the elements of the eudaimonistic model

Elements:	*Q-sort Steps:*
Nil	Step 1: Icebreaker and personal details (a) re-affirming the purpose of the interview, (b) answering any immediate questions arising from this, and (c) completion of personal details. The focus was therefore to establish rapport with the respondent.
Element One Definitional themes emerging against the key words: happiness, life-satisfaction well-being, quality of life and health.	Step 2: Definition of key terms Five key cards bearing the terms health, well-being, happiness, life satisfaction and quality of life were shown to the respondents. They were asked to define these in their own words, the response was written on paper and left beside the relevant word throughout the Q-sort interviews as a point of reference. On conclusion of the interview (Step 8) opportunity was given to modify these definitions if wished.
Element Two Linear relationship (direct/indirect) between the five key concepts.	Step 3: Perceived Relationship The respondent was asked to place the five key cards in any pattern in order to indicate the relationship between the concepts of health, happiness, well-being, life satisfaction and quality of life. The respondent was advised this would be recorded and scored. The pattern selected was left as a point of reference throughout the Q interview. An opportunity was given at the end of the Q-sort (Step 8) to modify the pattern if wished.

Element Three

Q card cluster: Emerging themes.

A free sort procedure

Step 4: Initial Selection

Initial selection of Q cards having either a positive or negative influence upon any of the key concepts. Selected cards were placed in a pile against each of the key concepts. A total of 49 items were presented on Q-cards for selection.

Step 5: Review of Cards

Each pile of selected Q cards was reviewed and an opportunity to reconsider selection was given.

Step 6: Grading of Cards

Each selected Q card was reviewed against each of the key concepts and graded on a scale of 1-5 for both positive/ good influence and negative/ bad.

Additionally, the respondent was encouraged to comment upon the rationale for the grade awarded. The comments were recorded.

Step 7: Further Items Identified

Any additional items not previously shown on the Q cards which the respondent felt to be an influence were recorded and graded as in Step 6.

Step 8: Revision

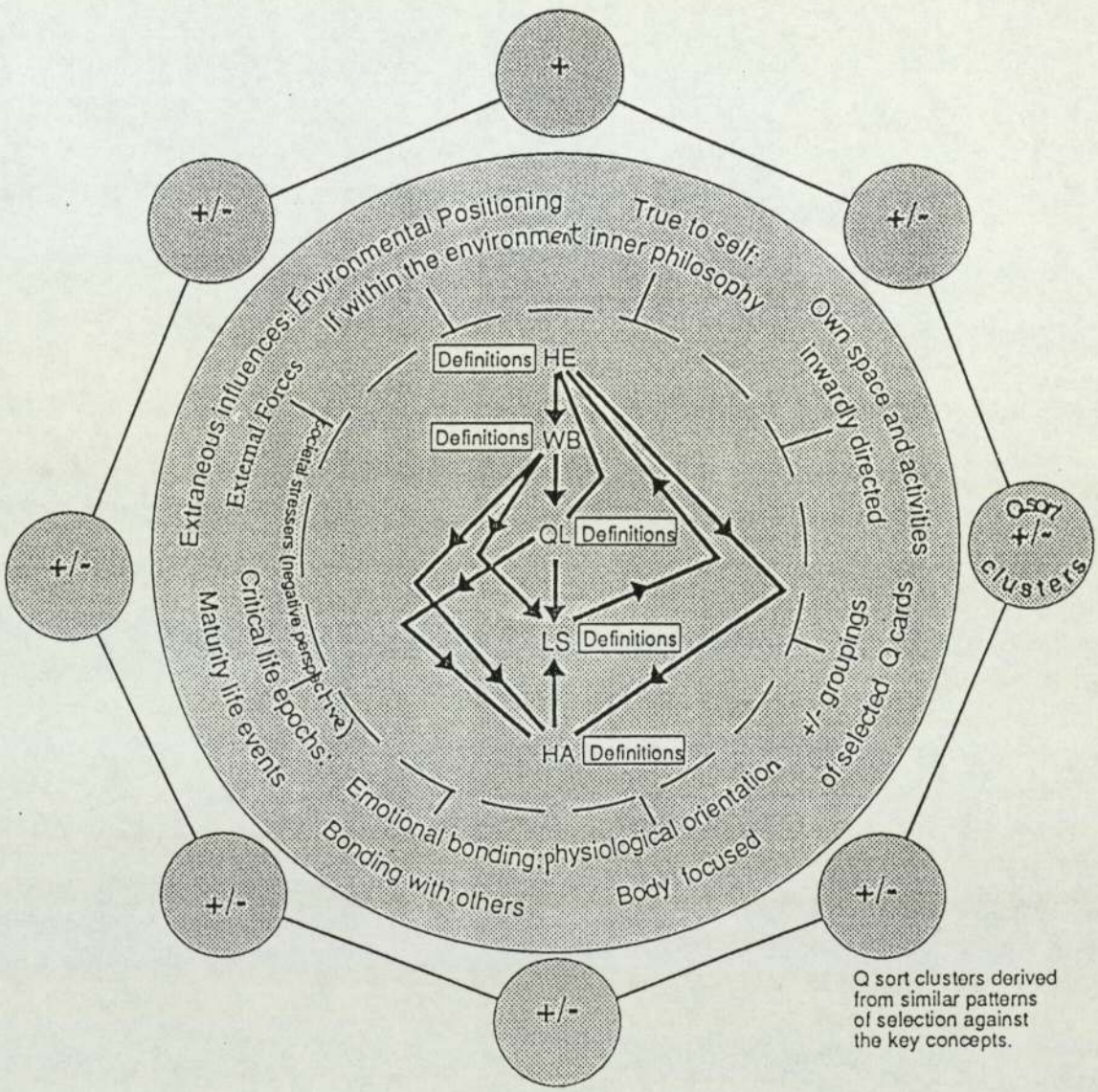
Revision and adjustment if wished of the respondents' previous responses.

Step 9: The Diary

A diary constructed against the key concepts of health, well-being, happiness, life satisfaction and quality of life was left with the respondents to be completed once a week over a period of one month.

The final models derived from the process outlined above is given in Fig. 3. A detailed discussion of each element of the model is now undertaken.

FIGURE 3: Conceptual Map



Lay Perceptions of a Multidimensional Concept of Health.

6.2.2 Definition of Key Concepts by Respondents

This section reviews the range of definitions given by respondents in relation to the five key concepts of health, happiness, life satisfaction, well-being and quality of life as explored within Step 2 of the Q-sort procedure. The analysis of the definitions is essentially qualitative in nature and is derived from the respondent's definitional phrase for each concept as follows:

1. The phrase is transcribed onto a card. This allows the construction of a qualitative data matrix (Miles & Huberman 1984).

2. The respondent's phrase is compared against each key concept in turn.

3. Key ideas or sub-themes are identified within the phrases in relation to each concept.

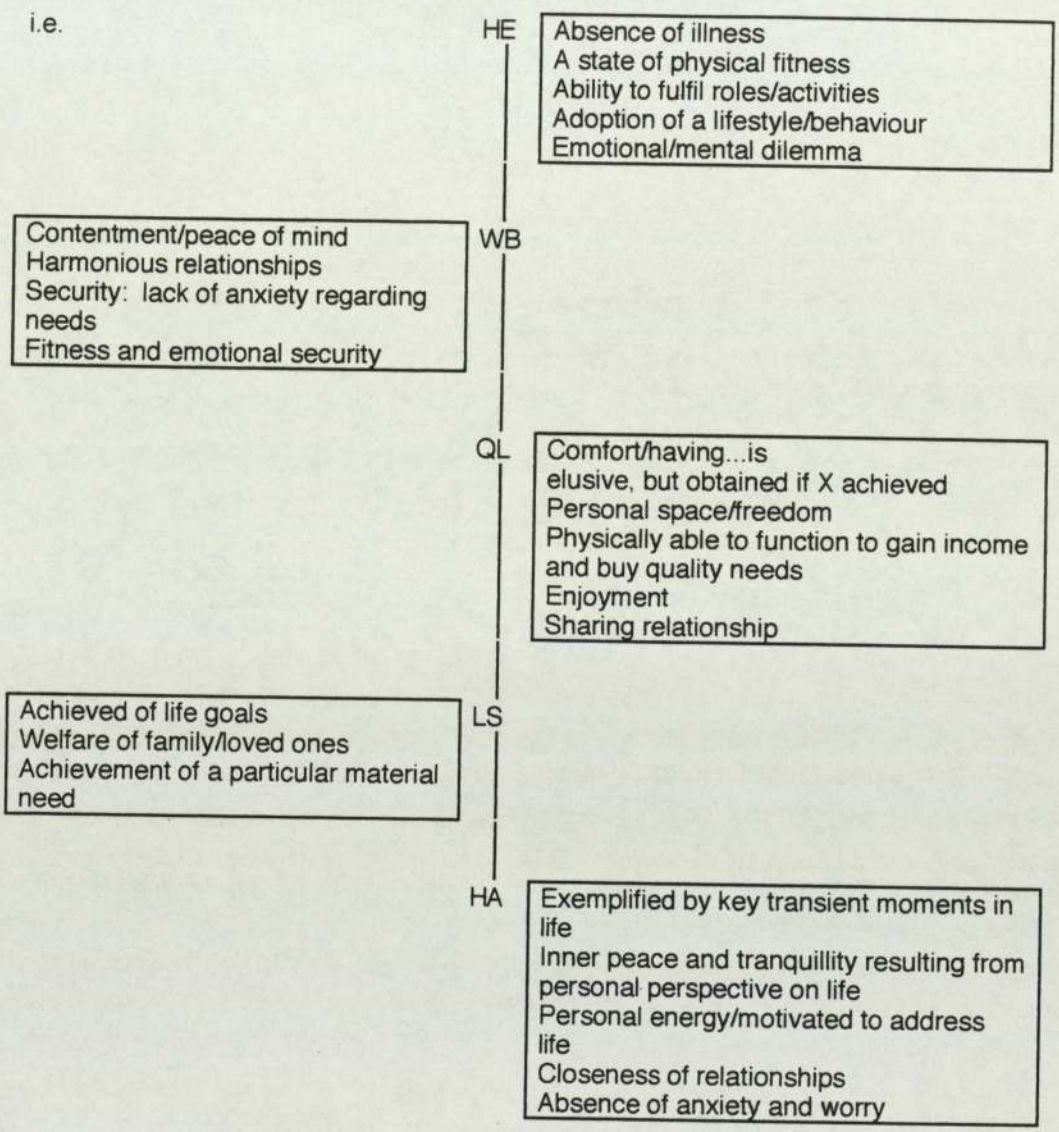
4. Potential inter-relationship and/or conflicts in (3) are considered.

5. Definitional phrases are selected as exemplars of key concepts and related sub-themes.

Qualitative analysis is limited to identifying where a number of respondents shared the same key words within their individual definitional phrase or were perceived as sharing the same key idea. Fig. 4 presents a summary of the definitions derived against each of the keywords, with a discussion of each undertaken in the following sections of the chapter, i.e. 6.2.3 - 6.2.7.

FIGURE 4

Element One: (Definition) is established by the consideration of the definitions offered against each of the five concepts,



Key Concepts:

HE = Health, WB = Well-being, QL = Quality of Life, LS = Life Satisfaction, HA = Happiness

6.2.3. Health

The definitional phrases revealed five key ideas or sub-themes:

1. **Absence of illness**. This phrase was offered by 32 of the respondents, confirming that health is frequently perceived as the opposite to illness or on a continuum. This notion was further detailed by 12 respondents who saw health in the context of avoidance of doctors, hospitals and medication.

   Illustrative phrases: "no doctor or hospitals", "getting out without pain", "feeling OK, you know, not ill", "stop taking pills".

   Only one respondent considered health as an issue of on-going concern suggesting that one was healthy when one "was not having to think about it". In other words one becomes conscious of the notion of health or healthiness when it is removed or when illness is imposed.

2. **A state of physical fitness**. This phrase was explicitly given by 15 respondents, and was expanded in terms of:

a. operating within perceived normal ranges.
   Illustrative phrases: "not being fat", "my bits all in order", "feeling OK, body in shape and energy like others", "function normally".

b. a state of general activity.
   Illustrative phrases: "an active life", "keep going", "energy to be out and about doing".

3. **Ability to function physically in order to undertake roles and activities**. This phrase was offered by 28 respondents.

   Illustrative phrases: "able to work", "to do things you have to do", "doing things work and home", "able to be active and do for yourself and not need others", "basic things such as walking, shopping without help".

4. **Adoption of particular lifestyles and behaviours**. This phrase was offered by 12 respondents.

   Illustrative phrases: "stop smoking", "good eating", "taking exercise", "keeping slim and active", "an active life".

5. **Mental or emotional dimensions to health**. Only five respondents offered this phrase.

   Illustrative phrases: "peace of mind"' "contented", "well it's physical and spiritual".

6.2.4 Well-being

Four respondents were unable to define this concept, and the remainder highlighted the following key ideas or sub-themes.

1. **Emotionally based**. 43 respondents identified this phrase against the central notions of contentment and peace of mind.

Illustrative phrases: "it's just being contented", "a peace of mind", "peace and quiet", "contentment and no problems", "feeling that all is well", "content and proud of my achievements".

2. **Harmonious relationships with others**. 14 respondents identified this.

   Illustrative phrases: "at one with the family", "at peace with self and others", "friends knowing someone is there for you", "my family being with them".

3. **Awareness of security**. This was indicated by 22 respondents. Security embraced finances, home, family and basic needs, and was in essence an absence of fears about the future and its effects.

   Illustrative phrases: "hope in the future", "just being in control", "a well-stocked larder", "knowing I can buzz for help", "all bills paid", "knowing there is a good job and a comfortable home", "my own place where I feel safe".

4. **A physical dimension**. Where this occurred it was also linked to other ideas of emotion or security, and was not perceived solely as a physical or fitness state.

   Illustrative phrases: "it's health and peace of mind", "fitness and at one with family and environment", "being well and happy".

6.2.5 Quality of Life

The definitional phrases revealed six key ideas or sub-themes:

1. The majority of respondents, 57 in all, perceived quality of life in terms of 'having' or 'comfort', of these nine respondents used the term "standard of living". The remainder, however, either used the notion of comfort or being comfortable itself or cited things to have or achieve for a quality of life, such as money, good housing, warmth, clothes, food and a good job.

   Illustrative phrases: "how much is received from life", "having a husband with a good job", "standard of living/amount of money at disposal", "secure future sufficient money to buy things", "savings", "status", "to be secure and live a comfortable life", "having basic needs", "money", "to buy what I want", "things being good", "having a home and a job", "being able to live like others".

2. **An elusive element to which one was always moving or seeking, achievable only by the addition of elements to their life**. A total of 21 respondents perceived quality of life in this way.

   Illustrative phrases: "be better when children are at school", "when the provision arises", "if I move away from Corby", "need a new house and job".

3. **Personal space and freedom** was indicated by 16 respondents.

   Illustrative phrases: "able to please myself", "being free and independent", "to look after myself and be myself in my home and garden", "just to have choice to go anywhere", "being able-bodied and independent", "to get out and about", "satisfaction and contentment to do what you like".

4. **Being able to function, gain income and purchasing power through work**. A total of 10 respondents identified this belief; all of whom indicated that a pre-requisite to such function was physical health and fitness.

   Illustrative phrases: "health is being mobile and having time to get out and enjoy yourself", "being all right to do and enjoy things", "being healthy and financially secure".

5. **Enjoyment** was a theme expressed by 17 respondents.

   Illustrative phrases: "standard of satisfaction and enjoyment gained from all aspects of life, home, job, family, friends, etc.", "day-to-day happiness and pleasure", "worthwhile and enjoyable life", "getting out to enjoy yourself", "happy secure and normality in life".

6. **Relationships**. This theme was identified by only two respondents.

   Illustrative phrases: "going through life sharing your troubles with someone else", "sharing life's ups and downs with the family".

6.2.6 Life Satisfaction

There were three emerging ideas or sub-themes in relation to definitional phrases of life satisfaction.

1. **A feeling of contentment in respect of life achievements and goals**. This was the predominant theme for 58 respondents.

   Illustrative phrases: "satisfied with what you have done in life", "being able to reach out and live your life attaining the goals you have", "getting what you wanted from life", "achieving ambitions", "to achieve my dream and sail round the world", "not having to work and being able to travel like I want", "output in life", "reaching my goals", "achieved rewards", "accomplishing what I want in my life", "done something with my life", "doing all the things you wanted in life", "doing what you set your mind on", "happy with everything you have done in life".

2. **Pleasure in seeing and/or facilitating the welfare of immediate family or loved ones**. This was cited by seven respondents.

Illustrative phrases: "house, family, making sure they're OK", "happy marriage and seeing family grow and have a life", "doing a good job, seeing your children grow up", "home clean family", "OK doing my own work", "health and happiness not just me but my family", "relationships and helping loving others", "helping ensure there is no problems to my family", "my grandson and the time we spend, I help teach him", "knowing I have done a good job with my family", "children seeing them develop and be all right", "having a long and happy married life".

3. **Quality of particular aspects of their life such as having job and general material rewards as a source of security and safety**. This theme was identified by a small number of respondents, four in all.

   Illustrative phrases: "having all you want for a good life", "no worries and one step ahead", "a good home for the family".

6.2.7 Happiness

This concept had the largest range of associated ideas and sub-themes. The main ones are identified as:

1. **The feeling and belief engendered at key moments in life**. In consequence this was defined as transient, a high epoch in contrast to a lower key and more consistent feeling of well-being. A total of 18 people identified such events.

Illustrative phrases: "holidays", "Christmas", "free at weekends", "a new baby", "new car", "visit to family and grandchildren in South Africa".

2. **Quiet tranquillity and inner peace**. This view was offered by eight respondents.

   Illustrative phrases: "content it's another day", "peace and tranquillity", "peace of mind", "worry free so you can see joy in life", "happy in yourself".

3. **Ability to see life in context**. This was offered by eight respondents.

   Illustrative phrases: "pleasure you can take and see in life", "well it's to do with yourself and how you see life and its challenges", "it's what you make of it all yourself", "being healthy, reasonable income to follow life as you want it and can make it", "what you make of it", "it's you and what you see of life and make of it".

4. **Joy seen as a motivation/energy for life**. Six respondents identified this theme.

   Illustrative phrases: "energy and joy to do in life and reach goals", "up in the morning being positive", "enjoying and making what you can having the energy to do what you want".

5. **Closeness with loved ones**. The importance of such relationships was considered by 11 respondents.

   Illustrative phrases: "no cares in the world and together", "family doing well and being happy together", "family life being together".

6. **The total absence of anxiety and worries**. This definition was offered by 14 respondents.

   Illustrative phrases: "no worries", "feeling good, no stress", "fulfilment knowing all is OK", "what I want to do no worries", "no problems", "not having any worries", "having a laugh away from it all", "no cares in the world", "free from stress and enjoying life".

6.3 SUMMARY OF DEFINITIONS

Overall the key concepts did have meaning for the respondents, and this was demonstrated by their ability to define the concepts in their own words or definitional phrases. Qualitative consideration of such phrases further indicates that each key concept is viewed as different and discrete, having its own meaning. Consequently, the emerging sub-themes from analysis are distinct for each key concept. Although some elements or inter-relationship might be suggested by the inclusion, for example, of relationships and security in four of the five concepts, even here however the emphasis and focus given within the notion of relationship changes. The discreteness and relevance of each key concept to the respondent was

re-affirmed by the analysis of Step 3 of the Q-sort procedure in which the ability of respondents to interpret the key words in a meaningful way was signalled by the development of a "directional flow relationship model".

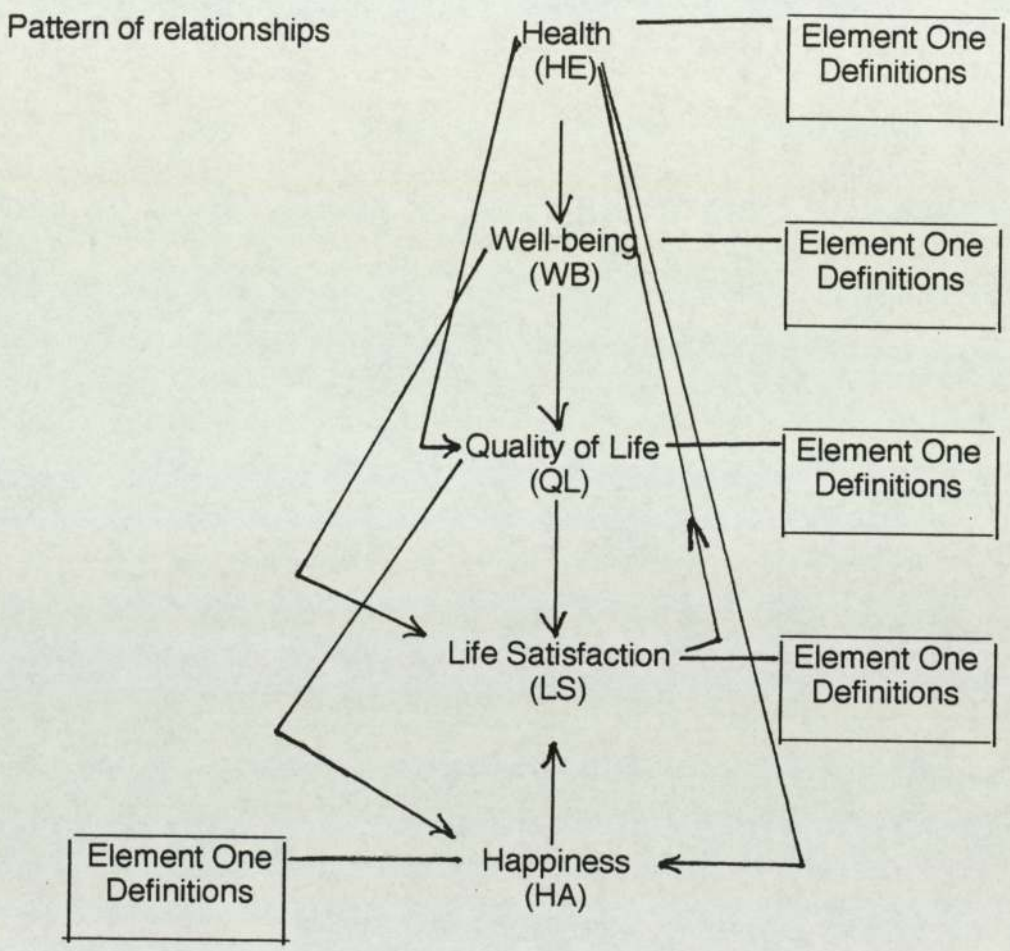
Additionally, both the analysis of the definitional phrases and the "flow of relationship" suggest a potential inter-connection of the key concepts whilst acknowledging their distinctiveness.

6.4 ELEMENT TWO (STEP 3 OF Q-SORT PROCEDURE)

Element Two develops the definitional framework identified in Element One of the model by demonstrating the pattern of relationships between the key concepts perceived by the respondents. (See Figure 5 on following page.)

FIGURE 5:

Element 2:



6.4.1 Key Concept Cards: Analysis of Perceived Relationship and Commentary (Step 3 of Q-sort)

Introduction

Step 2 of the Q-sort procedure required respondents to define the key concepts of health, happiness, well-being, life satisfaction and quality of life. Step 3 required respondents to place the defined key concepts in a pattern or order that represented the way in which they perceived these as relating to each other.

The majority of the patterns were linear, although 17 respondents offered alternative patterns. In order to analyse these emerging patterns the following coding was derived:

0 = No relationship shown
1 = Indirect relationship evident
2 = Direct relationship

Direct relationship represented a situation where the cards were immediately next to each other, whilst indirect relationship was viewed as being applicable where the cards were placed so that a relationship was present but one or more cards removed.

The correctness of the interpretation of the selected pattern of card was ensured by the use of arrows of communication within the recorded diagram.

6.4.2 Worked examples

Linear pattern

Recorded pattern

Health → Life Satisfaction → Quality of Life → Well-being → Happiness

In the above example coding would reveal

health to life satisfaction = 2

life satisfaction to quality of life = 2

quality of life to well-being = 2

health to quality of life, well-being and happiness = 1

life satisfaction to well-being and happiness = 1

quality of life to happiness = 1

happiness to well-being = 0

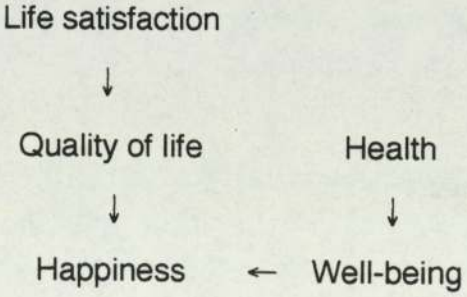
well-being to quality of life = 0

quality of life to life satisfaction = 0

life satisfaction to health = 0

Non-linear pattern

Recorded pattern:



Coding of the above example reveals:

life satisfaction to quality of life = 2

happiness to quality of life = 2

quality of life to health = 2

health to well-being = 2

well-being to happiness = 2

quality of life to well-being = 1

quality of life to happiness = 1

happiness to health = 1

happiness to well-being = 1

well-being to quality of life = 1

well-being to health = 1

life satisfaction to health = 1

life satisfaction to well-being = 1

life satisfaction to happiness = 1

quality of life to life satisfaction = 0

health to happiness = 1

health to quality of life = 1

health to happiness = 0

happiness to life satisfaction = 0

well-being to life satisfaction = 0

Figures 6, 7 and 8 show three different emerging patterns following coding, a direct relationship, an indirect relationship, and finally one which combines both direct and indirect. These are discussed in some detail in the following sections: 5.5.3 - 5.5.13.

FIGURE 6:

Diagrammatic representation of direct relationship between Key Concept cards number of respondents selected

Direct

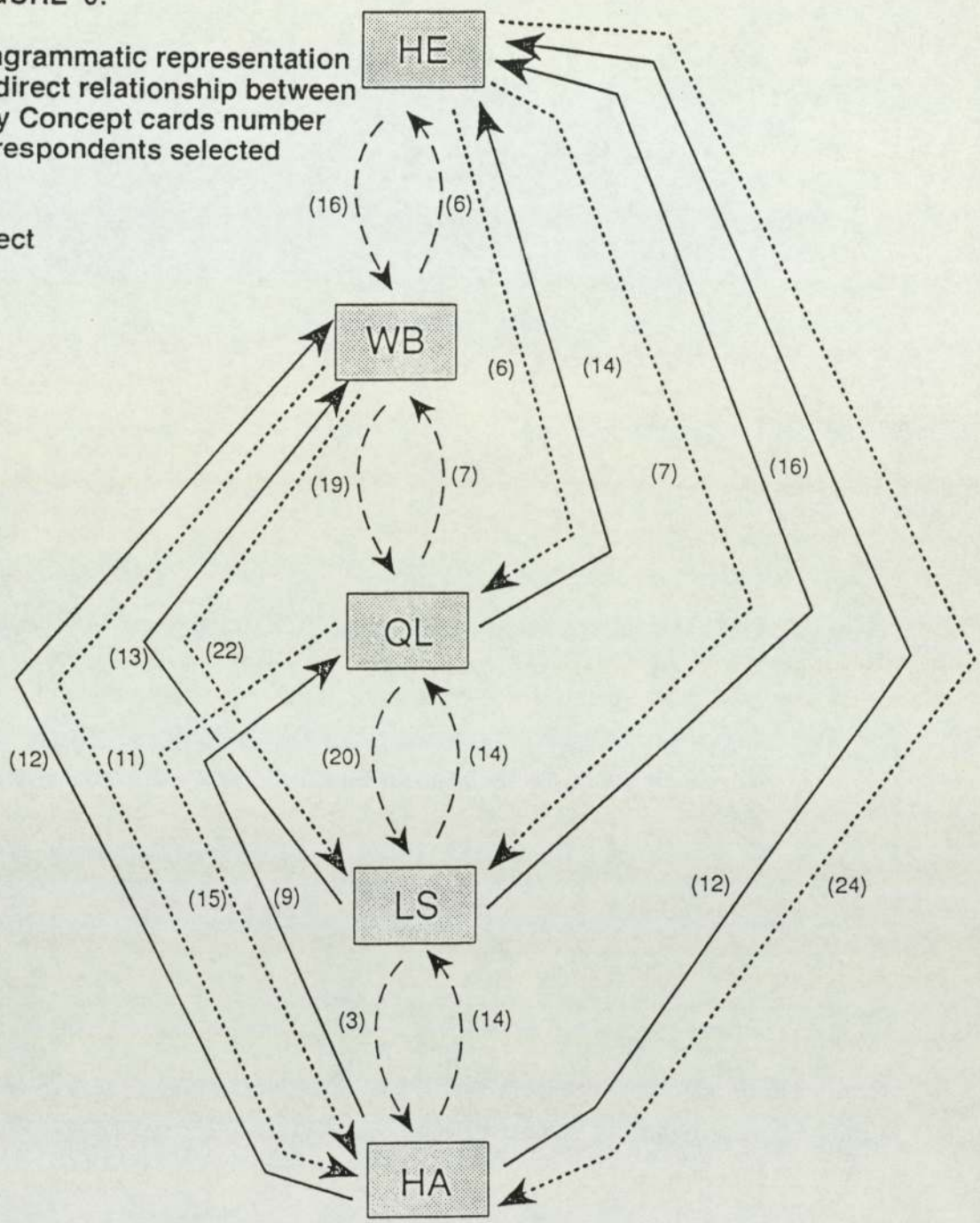


FIGURE 7:

Diagrammatic representation of indirect relationship between Key Concept cards number of respondents selected

Indirect

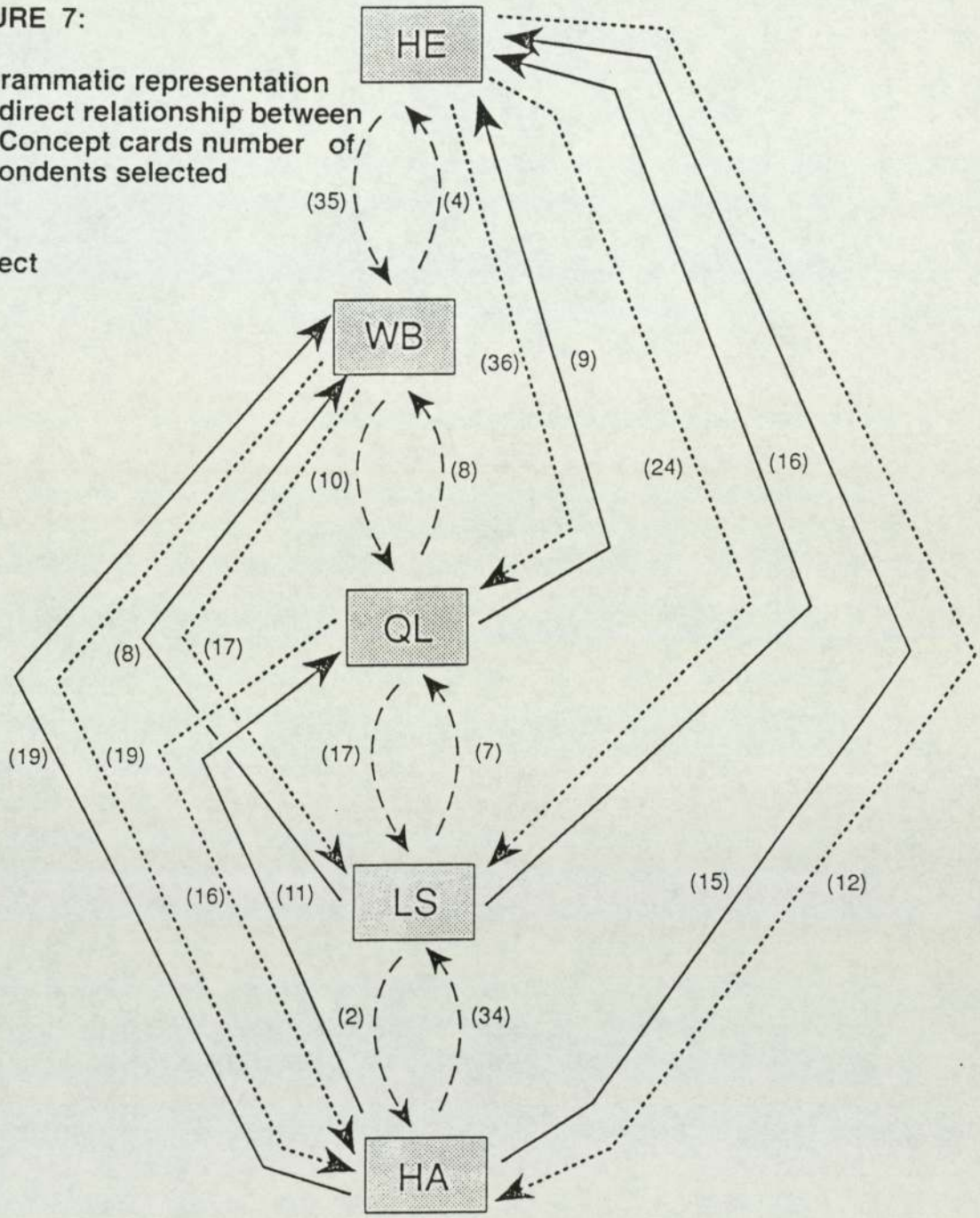
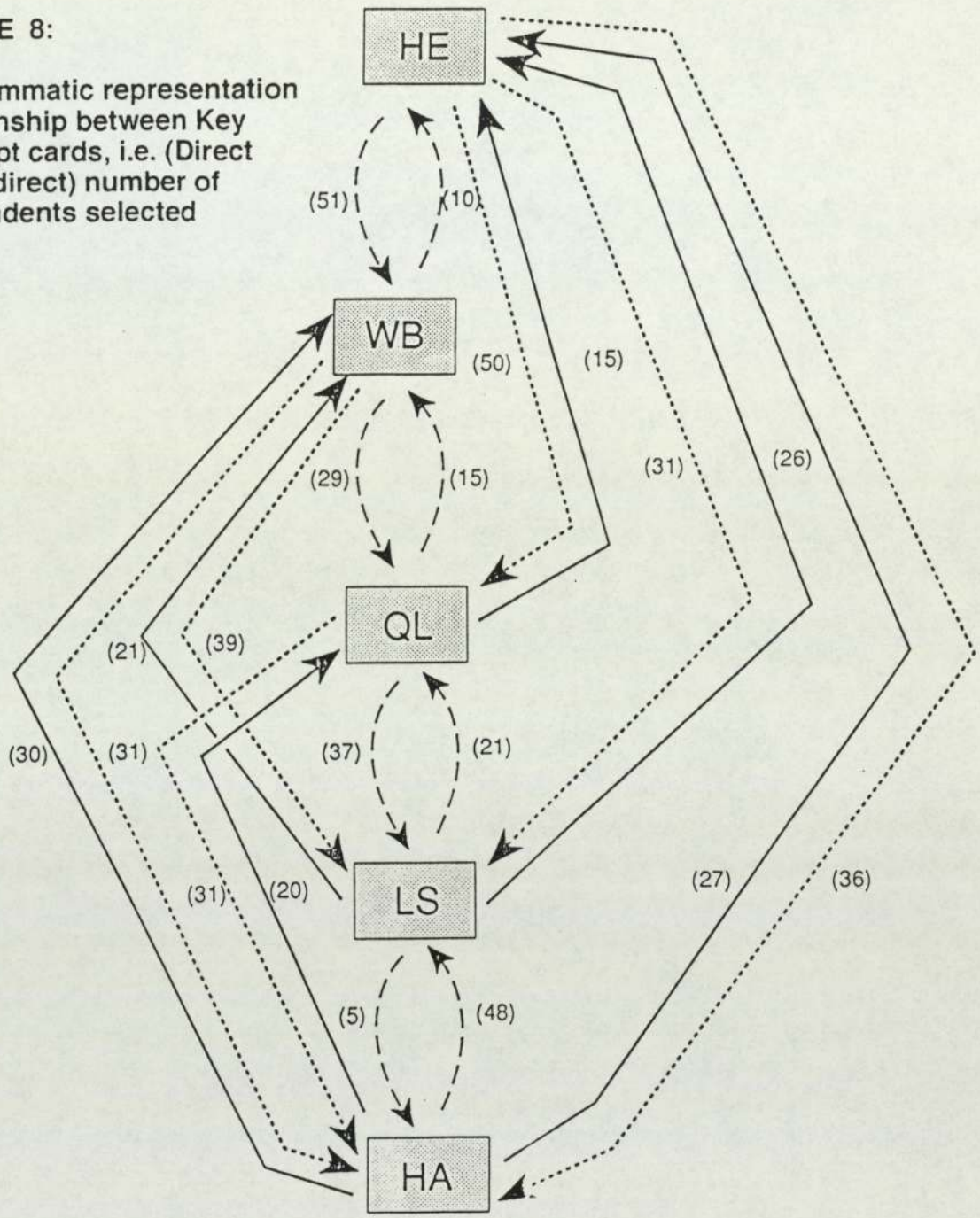


FIGURE 8:

Diagrammatic representation relationship between Key Concept cards, i.e. (Direct and Indirect) number of respondents selected



6.4.3 Direct Relationship/Indirect Relationship and Combined

Whilst there was a measure of perceived direct relationship to all the key cards, differences in the directional flow of relationships between key concepts did emerge. In addition there were clear differences in strength of relationships measured by the number of respondents.

6.4.4 Health to Happiness/Happiness to Health

1. **Direct Relationship** (Fig. 6)

   Whilst the relationship was evident in both directions there was a 50% stronger relationship perceived in the direction of health influencing happiness, i.e. 24 respondents, than the direction of happiness influencing health, i.e. 12 respondents.

2. **Indirect Relationship** (Fig. 7)

   This situation however was reversed if indirect relationships were considered, with a slightly high perceived relationship for happiness influencing health, i.e. 15 respondents as opposed to 12 for health influencing happiness.

3. **Combined Relationship** (Fig. 8)

   If viewed collectively then the relationship of health and happiness as key concepts emerges clearly with a preference in respect of health influencing happiness, i.e. 36 respondents, whilst happiness influencing health attracted a total of 27 respondents.

6.4.5 Health to Life/Satisfaction/Life Satisfaction to Health

1. **Direct Relationship**

   A direct relationship was perceived by respondents in both directional flows, however, it was 50% stronger in the direction of life satisfaction influencing health, i.e. 16 respondents, whilst health influencing life satisfaction attracted 7 respondents.

2. **Indirect Relationship**

   An indirect relationship indicates a reverse of priority when health influencing life satisfaction was selected by 24 respondents.

3. **Combined Relationship**

   When viewed in a combined way then a strong relationship between the concepts emerges with the influence of health upon life satisfaction being the greater, i.e. 31 respondents whilst 26 respondents indicate life satisfaction influencing health.

6.4.6 Health to Quality of Life/Quality of Life to Health

1. **Direct Relationship**

   A relatively small direct relationship is evident between health influencing quality of life, i.e. 6 respondents, whilst the relationship of quality of life affecting health is 50% stronger, i.e. 14 respondents.

2. **Indirect Relationship**

The opposite relationship 'flow of direction' is indicated in indirect pattern, i.e. 36 respondents selected health influencing quality of life, whilst 9 selected quality of life influencing health.

3. **Combined Relationship**

When viewed collectively the relationship between the two concepts is clear with preference for the directional flow of health influencing quality of life, i.e. 50 respondents and 15 respondents selecting an influence of quality of life upon health.

6.4.7 Health to Well-being/Well-being to Health

1. **Direct Relationship**

Health influencing well-being emerged clearly with 16 respondents, whilst well-being influencing health was evident in a weak way, i.e. only 6 respondents.

2. **Indirect Relationship**

The same pattern emerges with health seen as influencing well-being with 35 respondents, whilst well-being as an influence upon health was almost irrelevant with only 4 selections.

3. **Combined Relationship**

The clear emphasis upon one directional flow of health influencing well-being is particularly evident if viewed in a combined way, i.e. 51, whilst only 10 selections are made for well-being influencing health.

6.4.8 Happiness to Well-being/Well-being to Happiness

1. **Direct Relationship**

The direct relationship does indicate a perceived relevance to each other, however, the directional flow is almost the same in strength, i.e. happiness influencing well-being attracted 12 responses, whilst well-being influencing happiness attracted 11 responses.

2. **Indirect Relationship**

The parity of directional flow is also reflected in indirect relationship with 19 respondents for each.

3. **Combined Relationship**

This parity is maintained when viewed in a combined way with happiness influencing well-being selected 30 times and 31 respondents indicating well-being influencing happiness.

One explanation for this parity might be that the two concepts are seen as equivalent, however, examination of the supporting definitions offered by respondents does identify some differences.

6.4.9 Life Satisfaction to Well-being/Well-being to Life Satisfaction

1. **Direct Relationship**

   These concepts do emerge clearly as having a perceived relationship with preference given to well-being influencing life satisfaction, i.e. 22 selections as opposed to 13 selections for life satisfaction influencing well-being.

2. **Indirect Relationship**

   This preference of relationship for well-being influencing life satisfaction is reflected when the indirect relationship is considerable, i.e. 17 respondents whilst life satisfaction as an influence upon well-being is some 50% lower, i.e. 8 respondents.

3. **Combined Relationship**

   This pattern is particularly evident when the combined perspective is taken, i.e. 39 respondents indicated a relationship of well-being influencing life satisfaction, whilst the potential of life satisfaction to influence well-being is still evident with 21 respondents.

6.4.10 Quality of Life to Happiness/Happiness to Quality of Life

1. **Direct Relationship**

   The potential for quality of life to influence happiness is evident with 15 respondents, whilst 9 select happiness influencing quality of life.

2. **Indirect Relationship**

The same preference of direction is indicated, i.e. quality of life influencing happiness attracted 16 respondents, whilst happiness influencing quality of life attracted 11 responses.

3. **Combined Relationship**

The perceived relationship between these two concepts is particularly clear when viewed in a combined way, although some preference for quality of life influencing happiness is evident, i.e. 31 selections with 20 for happiness as an influence upon quality of life.

6.4.11 Quality of Life to Well-being/Well-being to Quality of Life

1. **Direct Relationship**

These key concepts emerged as being perceived as relevant to each other although there was a 50% stronger relationship of well-being influencing quality of life with 19 selections as opposed to 7 selections for quality of life influencing well-being.

2. **Indirect Relationship**

This preference of directional flow is less clear when indirect relationships are viewed in that well-being as an influence on quality of life attracts 10 responses with 8 responses for quality of life influencing well-being.

3. **Combined Relationship**

The preference for well-being influencing quality of life is clear if viewed in a combined way, i.e. 29 selections whilst the ability for quality of life to influence well-being is still important attracting 15 selections.

6.4.12 Quality of Life to Life Satisfaction/Life Satisfaction to Quality of Life

1. **Direct Relationship**

The perceived relationship between these cards is evident but with some preference for quality of life to influence life satisfaction, 20 selections, whilst life satisfaction influence upon quality of life was selected 14 times.

2. **Indirect Relationship**

The same preference is reflected in indirect relationship with quality of life influencing life satisfaction selected 17 times and life satisfaction as an influence upon quality of life 7 times.

3. **Combined Relationship**

If viewed in a combined way the potential relationship between these concepts emerges clearly, but with some continued preference for quality of life to influence life satisfaction, i.e. 37 selections, whilst life satisfaction on quality of life is selected 21 times.

6.4.13 Life Satisfaction to Happiness/Happiness to Life Satisfaction

1. **Direct Relationship**

   The relationship of happiness to life satisfaction is clear with 14 selections, whilst the influence of life satisfaction to happiness is small with only 3 selections.

2. **Indirect Relationship**

   This pattern is particularly evident in indirect relationship, i.e. happiness to life satisfaction attracting 34 selections whilst the potential of life satisfaction as an influence on happiness is only selected 2 times.

3. **Combined Relationship**

   Again the combined relationship indicates a low selection of 5 for life satisfaction to happiness, whilst happiness to life satisfaction has a selection of 48.

6.4.14 Summary of Relationships

By way of further summary of the strength of perceived relationship directly, indirectly and in a combined way, Table 2 (below) indicates ranking of concepts. In addition, diagrammatic representation of preferred directional flow for each key concept only is given in figures 9, 10, 11, 12,13 and 14.

Table 2:

Summary of the strength perceived relationship

DIRECT			INDIRECT			COMBINED		
Ranking Position	Number Selected	Cards	Ranking Position	Number Selected	Cards	Ranking Position	Number Selected	Cards
1	24	HE-HA	1	36	HE-QL	1	51	HE-WB
2	22	WB-LS	2	35	HE-WB	2	50	HE-QL
3	20	QL-LS	3	34	HA-LS	3	48	HA-LS
4	19	WB-QL	4	24	HE-LS	4	39	WB-LS
5	16	LS-HE	5	19	HA-WB	5	37	QL-LS
6	16	HE-WB	5	19	WB-HA	6	36	HE-HA
7	15	QL-HA	7	17	WB-LS	7	31	HE-LS
8	14	LS-QL	7	17	QL-LS	7	31	WB-HA
8	14	QL-HE	9	16	QL-HA	7	31	QL-HA
8	14	HA-LS	9	16	LS-HE	10	30	HA-WB
11	13	LS-WB	11	15	HA-HE	11	29	WB-QL
12	12	HA-WB	12	12	HE-HA	12	27	HA-HE
12	12	HA-HE	13	11	HA-QL	13	26	LS-HE
14	11	WB-HA	14	10	WB-QL	14	21	LS-WB
15	9	HA-QL	15	9	QL-HE	14	21	LS-QL
16	7	HE-LS	16	8	LS-WB	16	20	HA-QL
16	7	QL-WB	16	8	QL-WB	16	15	QL-WB
18	6	WB-HE	18	7	LS-QL	17	15	QL-HE
18	6	HE-QL	19	4	WB-HE	19	10	WB-HE
20	3	LS-HA	20	2	LS-HA	20	5	LS-HA

HA = Happiness, HE = Health, LS = Life Satisfaction, QL = Quality of Life, WB = Well-being

FIGURE 9:

Diagrammatic representation of ranked order of relationships (Direct) between Key Concept cards.

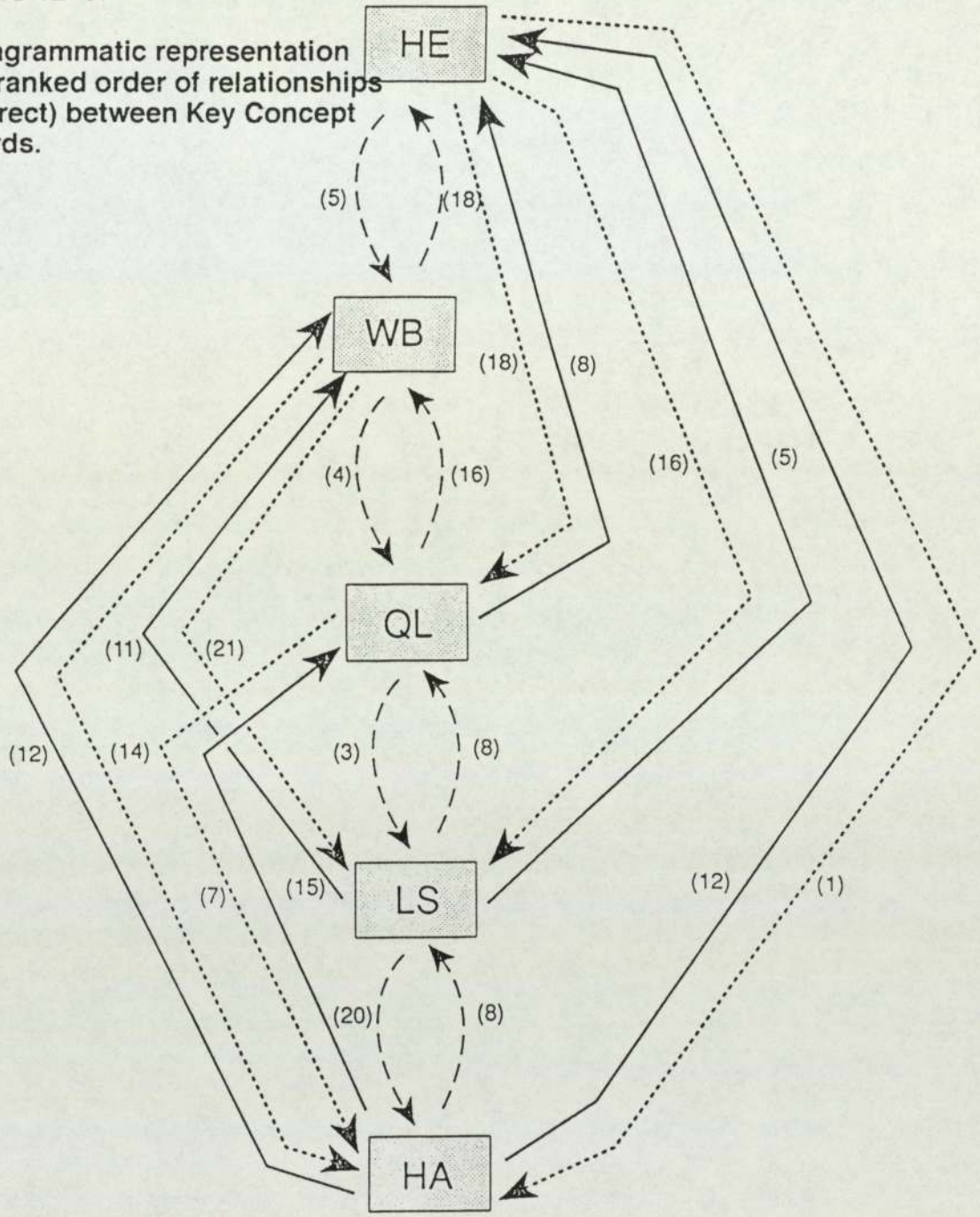


FIGURE 10:

Diagrammatic representation of Ranked order of Indirect relationship between Key Concept cards.

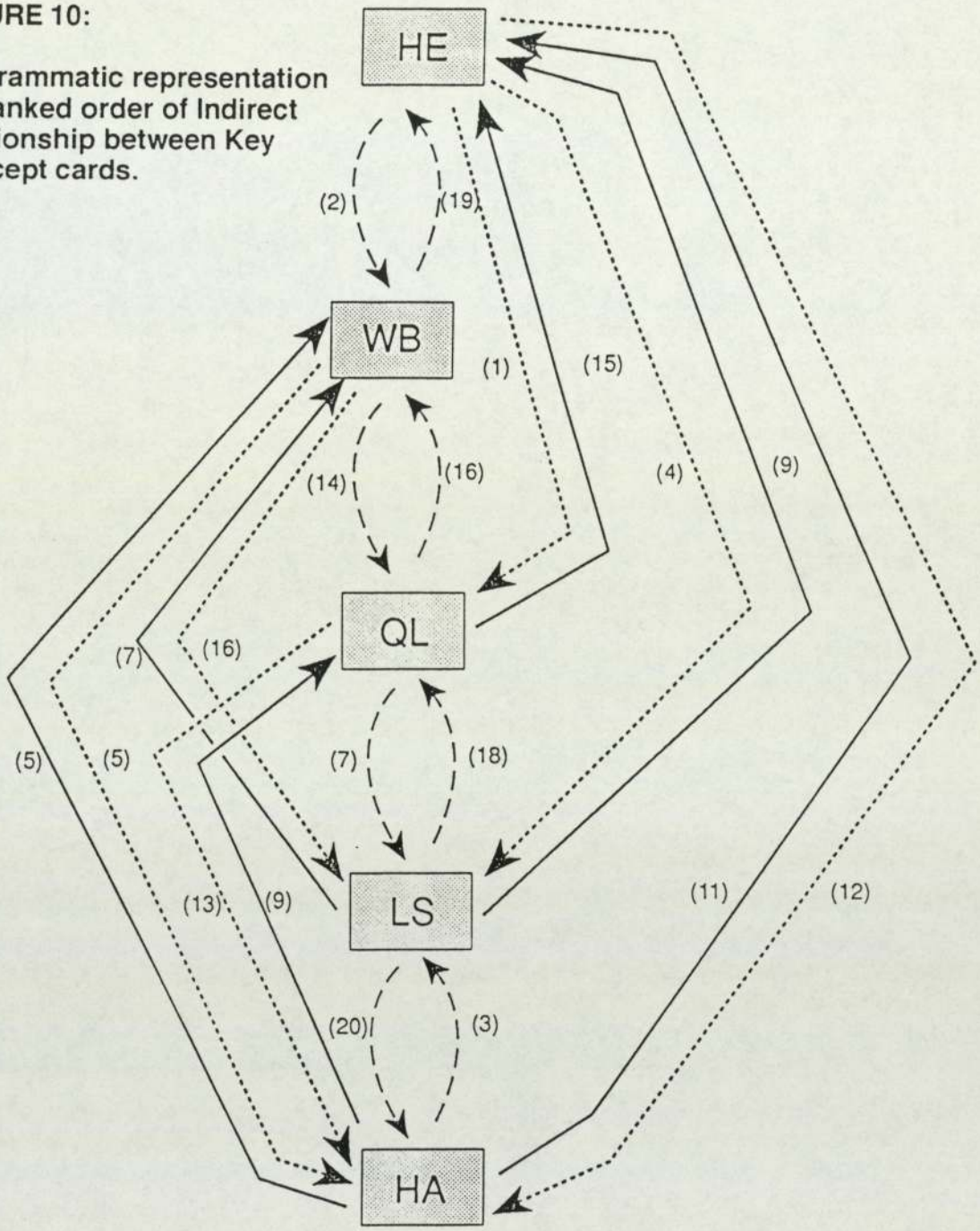


FIGURE 11:

Diagrammatic representation of Ranked order of combined (Direct & Indirect) relationship between Key Concept cards.

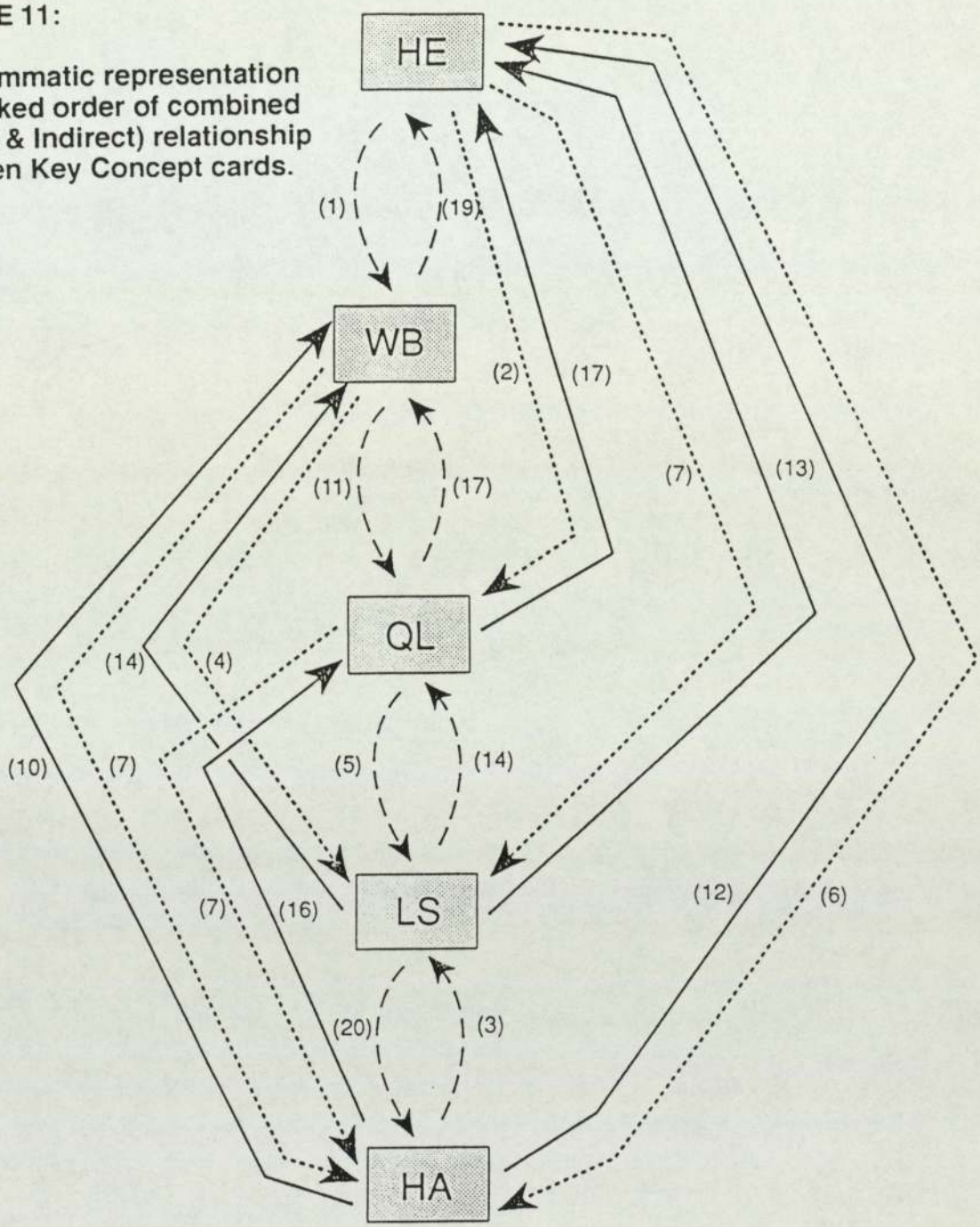


FIGURE 12:

Direct Relationship
Diagrammatic representation of preferred directional flow of influence for Key Concept cards.

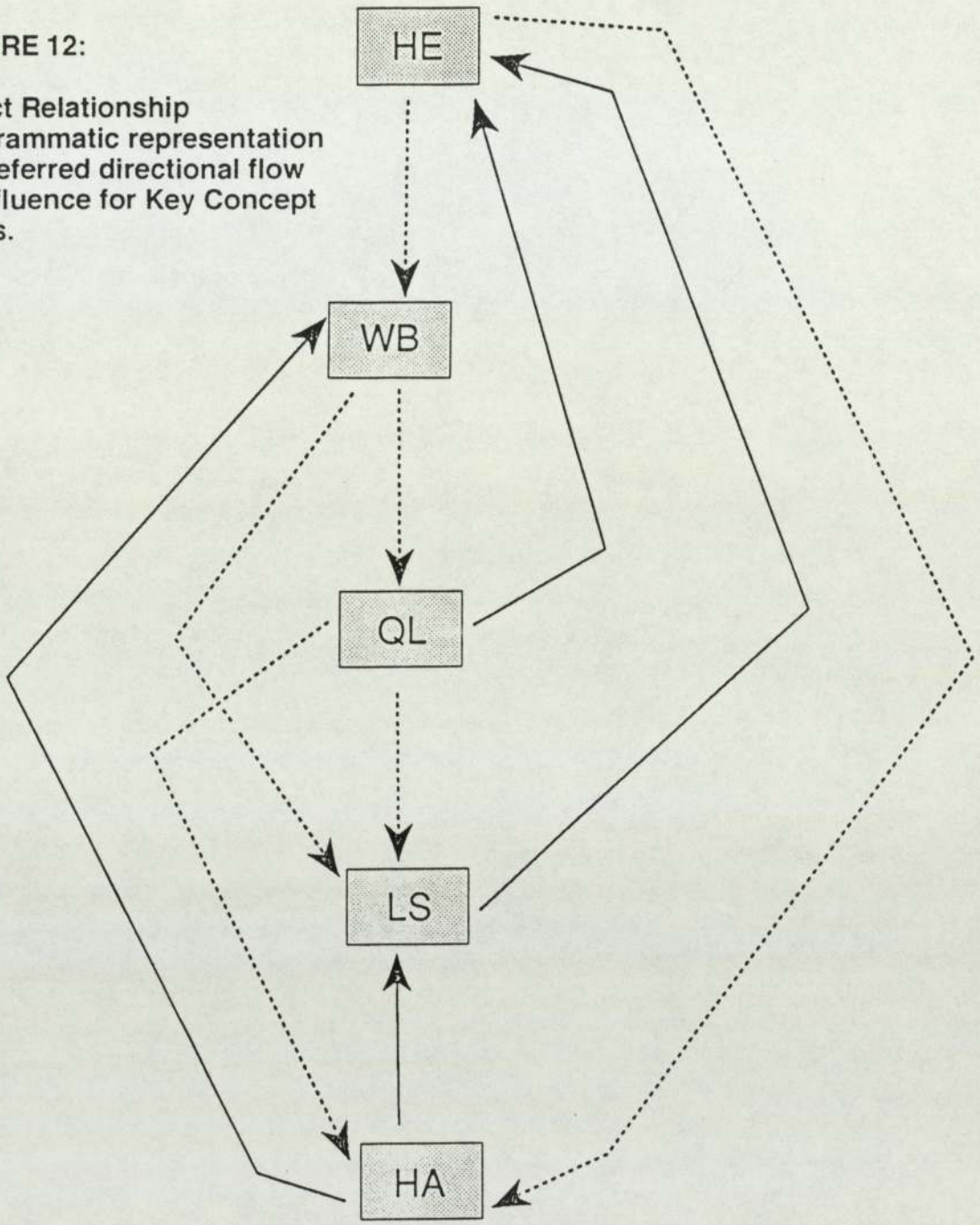


FIGURE 13:

Indirect Relationship Diagrammatic representation of preferred directional flow of influence for Key Concept cards.

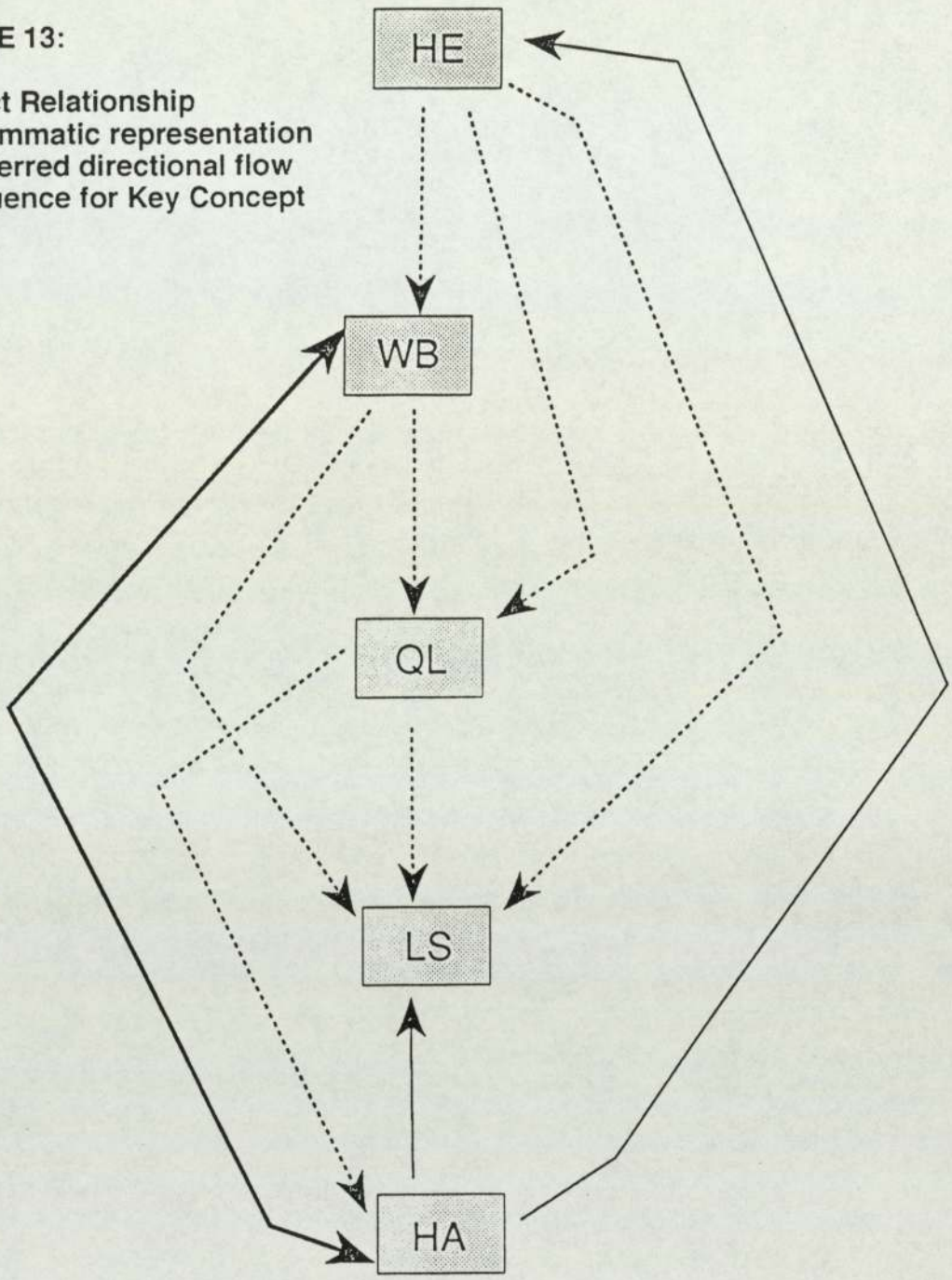
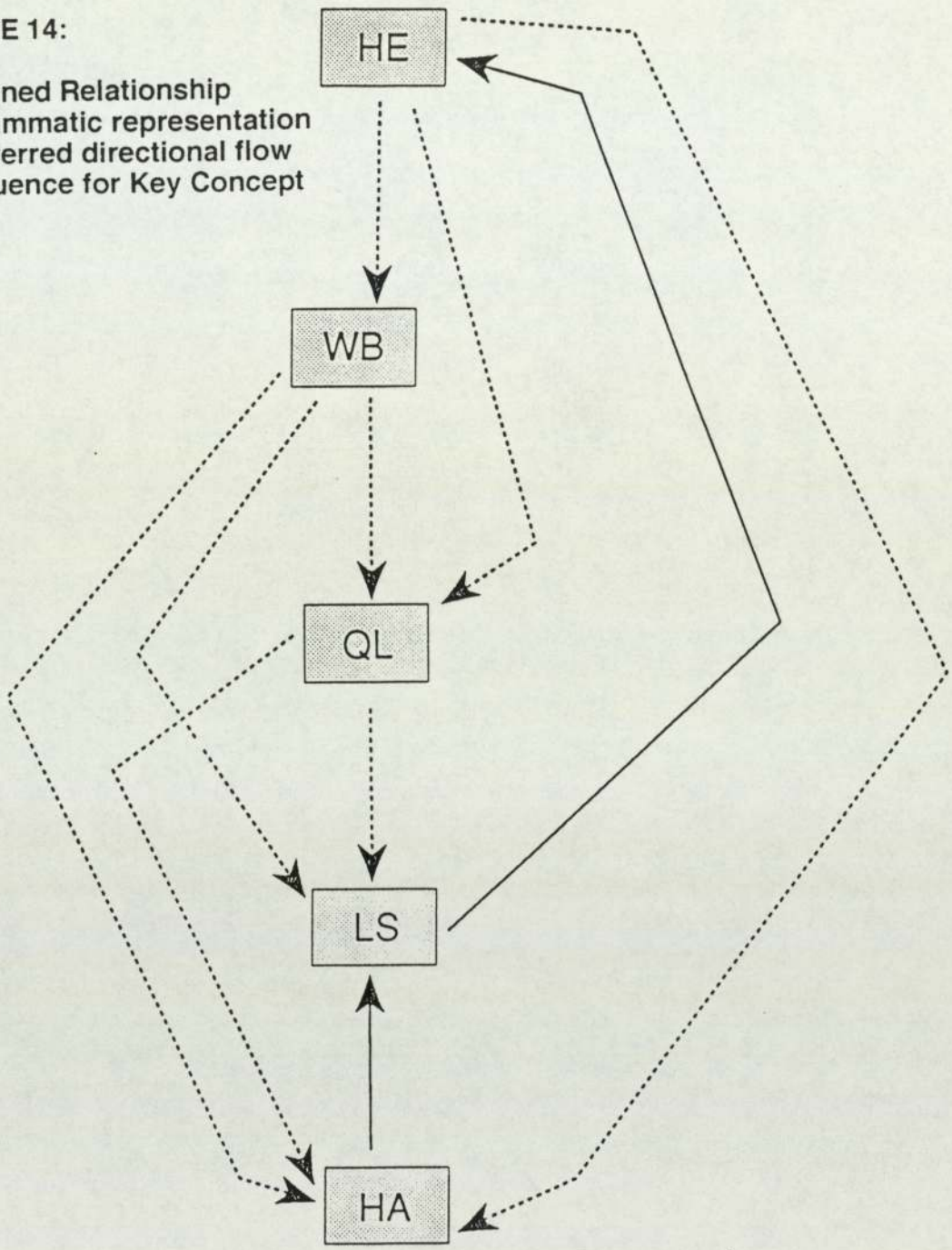


FIGURE 14:

Combined Relationship Diagrammatic representation of preferred directional flow of influence for Key Concept cards.



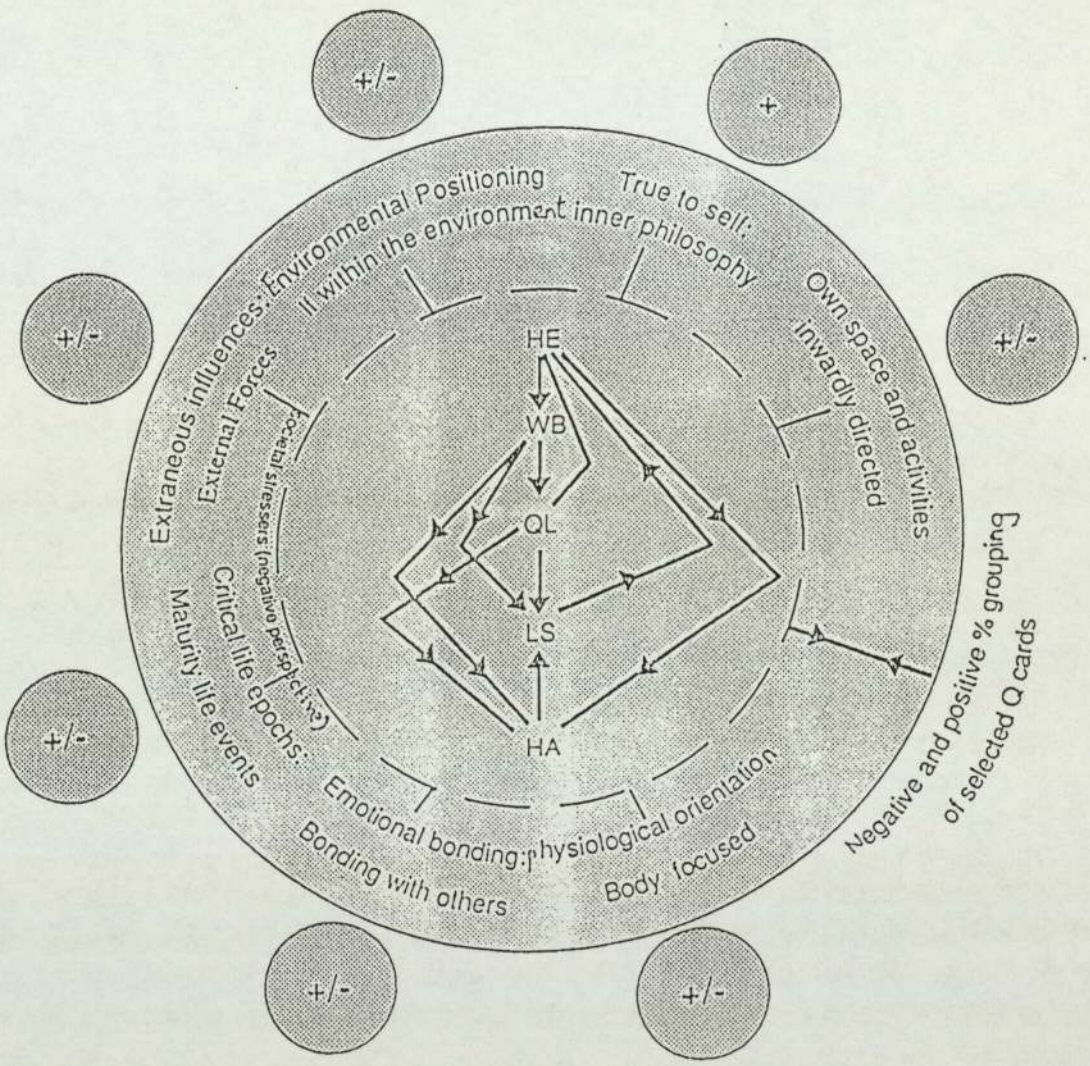
6.5 ELEMENT THREE: Q-SORT STEPS 4, 5, 6, & 7

Element Three of the model was derived from Q-sort Steps 4, 5, 6 and 7. This final element involving the consideration of the Q-card and grouping, both positive and negative, together with the conceptual and influencing themes related to the grouping. The themes established against the five key concepts, are shown in Figure 15.

6.5.1 Q Step 4 - Initial Selection of Q cards

The respondent was shown each of the Q cards in turn and asked whether they thought the item shown on the card had any influence or effect on any of the key concepts, i.e. on health, happiness etc. It was emphasised that each Q card could be selected as having effect or influence on more than one or all of the key concepts. When a card was selected it was placed under each relevant concept. Accordingly each Q card was reproduced 5 times in the event of it being selected against each of the key concepts. In this way therefore, on completion of Step 4 a pile of selected Q cards was located under each of the key concepts with an additional pile of cards that had not been selected or had been rejected.

FIGURE 15: Element Three - Proposed Model
(derived from Q-sort Steps 4-7)



6.5.2 Q Step 5 - Opportunity to Reconsider

Each pile of Q cards associated with the key concepts was revisited, with an opportunity for the respondent to reconsider the selection and reject a previously selected card.

6.5.3 Q Step 6 - Grading of each Selected Q Card

Each pile of selected Q cards associated with each key concept was revisited again in turn and the respondent was asked to grade each Q card against a grade shown on a card placed upon the table. The grade card is reproduced below.

Good/positive influence

A little				A great deal
1	2	3	4	5

Bad/negative influence

A little				A great deal
1	2	3	4	5

The respondent was reminded that the grade related to the good/positive or bad/negative influence or effect on the relevant key concept, e.g. happiness.

In this way each of the key concepts and its associated pile of selected Q cards were considered and graded in turn.

Additionally the respondent was encouraged to comment upon the card and its grade with the comments recorded by the interviewer.

6.5.4 Q Step 7 - Additions

The respondent was now asked if there were any extra factors that they would wish to add that influenced/affected any of the key concepts, and had not appeared on the cards. Where this occurred (i.e. 2 respondents only) the key concept and related grade/comments were recorded.

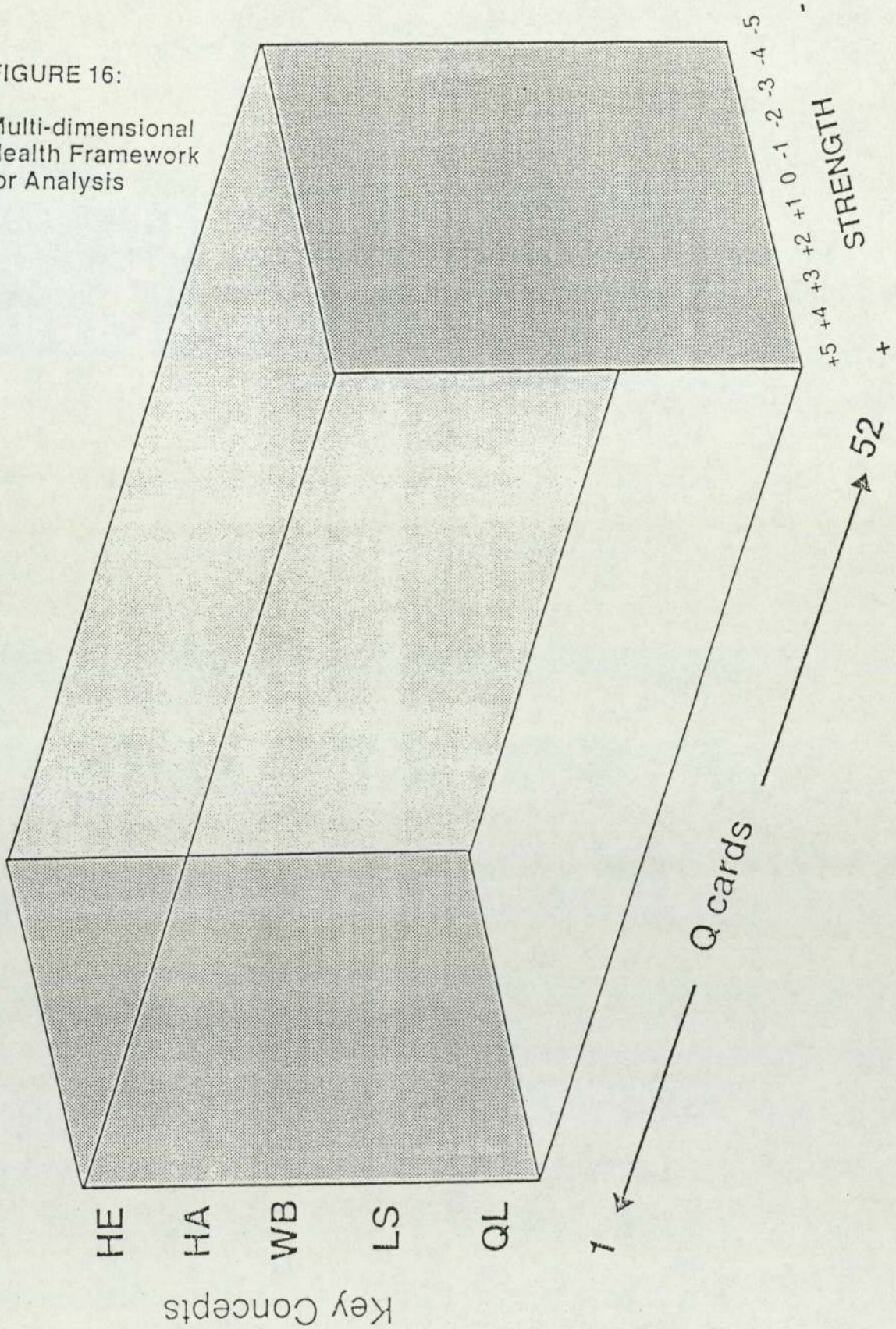
6.5.5 Analysis of Q-cards and Emerging Patterns

As a result of the selection of each Q-card against the key concepts and grading thereafter on a scale of -5 to +5, it is possible that each Q-card may be located in a diversity of positions. This is represented by the cube of analysis in Figure 16.

Consequently, in order to locate more clearly the position of each Q-card against each concept in respect of both positive and negative scores, the following steps of analysis were taken:

FIGURE 16:

Multi-dimensional Health Framework for Analysis



6.5.6 *Preliminary Analysis*

Free rather than forced Q-sort technique was used subsequently factor analysis was inconclusive as is often the case with free sort particularly as a very large sample was not used. Further analysis consisted of calculating means and rankings. This was done with regard to:

a. Counting the cards, the number of times selected against the five concepts, i.e. without reference to whether the selection resulted in a positive or negative grading.

b. The means derived from (a) were reviewed and placed into groups or clusters where in at least 3 of the key concepts there was a similarity of mean score of at least 50 points. This activity was undertaken to allow the identification of tentative groupings for further investigation. The groups were identified by use of a colour-coded matrix; the use of such a matrix for qualitative based data was in accord with analysis strategies suggested by Miles and Huberman (1984).

6.5.7 *Full Analysis*

The means for the Q-cards selected were further calculated with reference to their strength (-5 to +5) grading against each of the concepts. Additionally a review of the means in terms of their ranked selection against the 5 concepts was undertaken.

On the basis of these calculations a further grouping or clustering activity was performed again using a colour matrix and supported by consideration of initial groups identified in (b) above.

The groups were then examined to check the relevance and appropriateness of the emerging themes by construction of a number of Matrixes (Miles and Huberman, 1984) as indicated below:

1. Matrix checking groups/themes against supportive recorded comments.

2. Matrix checking groups/themes against supportive diary finding.

3. Matrix checking groups/themes against those identified with the pilot Q-sort exercise.

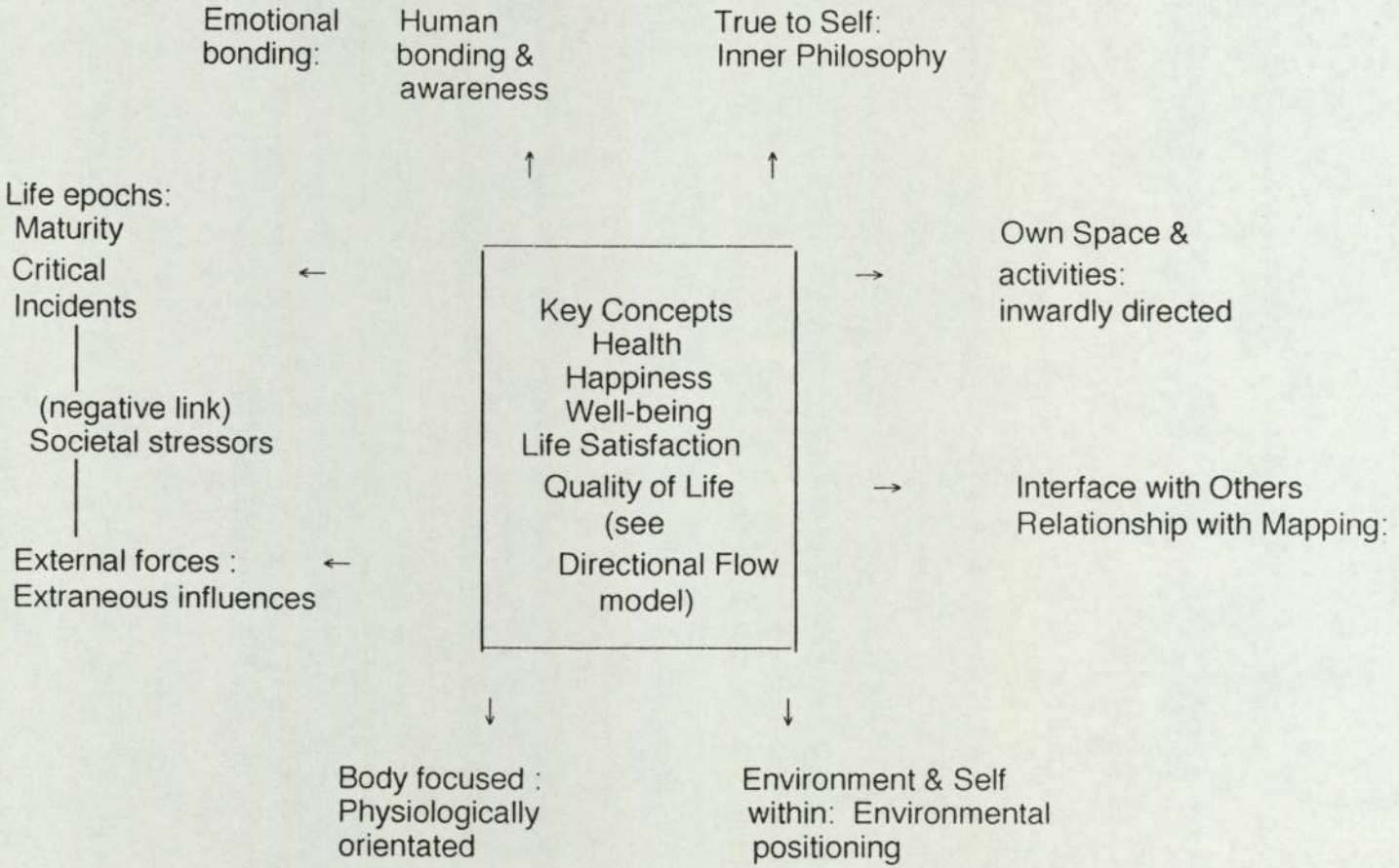
4. Matrix checking groups/themes against concepts identified in other Q-sort based research, e.g. Stainton Rogers (1987).

5. Matrix checking groups/themes against definitional framework Q-sort, Step 2, and Element 2 of the model.

The verification activity offered by the matrices served to further revisit and check the groupings/themes derived from the Q-card selection and means.

The grouping/themes that finally emerged from the analysis are discussed below and represented in Fig. 17. A more detailed presentation of Q-card analysis is provided in the Appendices.

FIGURE 17: EMERGING THEMES



6.5.8 Emerging Themes : Positive/Negative Groupings

a. **True to Self or Inner Philosophy**

Supportive Rationale. The grouping relating to this theme commonly contains a notion of self, belief and pursuit of own desires, for example, self-esteem, spirituality and freedom. In essence it consists of an awareness of one's inner core and choices.

b. **Having one's own space or environment and activities that occur within this or in other words inwardly directed.**

Supportive Rationale. Groupings associated with this theme commonly contain two key notions of oneself and own space within which private, small group or family activities occur. The focus in this however remains inwardly directed towards self rather than emphasising the environment. Q-cards such as 'close community", 'isolation', 'housing' and 'independence' are found here.

c. **The interaction and interface with others or human corresponding/mapping.**

Supportive Rationale. The main emphasis within this grouping is the notion of relationship with others. The interaction however is largely of a social and public one without necessary close intimacy. Q-cards such as 'others company', 'friends health' and 'travel' are located here.

d. **The larger environment and the location of oneself within this or environmental positioning**.

Supportive Rationale. This theme gives greater attention to the environment within which an individual is located with acknowledgement of key events and factors within this. Q-cards associated with this are 'leisure', 'housing', 'close community' and 'privacy, boredom'.

e. **The notion of external factors or forces that might impinge upon oneself or extraneous influences**.

Supportive Rationale. This theme is solely externally focused, acknowledging events and forces that impinge upon the individual, for example, 'social change', 'finance', 'education' and 'employment'.

f. **Critical periods in one's life, i.e. life epochs or maturity critical incidents**.

Supportive Rationale. These represent significant events or milestones that commonly occur within the lifespan, hence Q-cards such as 'first home', 'childhood', 'becoming a parent' and 'employment' are located here.

Negative groupings indicated a potential sub-theme of *societal stressors*, with this linking between themes (e) and (g).

Supportive Rationale. The negative factors are those that area commonly associated with life change and stress with an association of both external events and location at key periods along the lifespan accordingly relate to both themes.

g. **The notion of bonding with others in a close relationship and awareness of emotions within this or emotional bonding.**

Supportive Rationale. The key focus here is relationship with others, but in a more intimate and emotional way, hence there is acceptance of effect upon the individual as a result of such association. Accordingly, Q-cards such as 'love and trust', 'personality' and 'immediate family' are located here.

h. **Physiological orientated activities and concepts or body focuses.**

Supportive Rationale. These groupings are focused upon body activities and physiological need and Q-cards such as 'exercise', 'diet' and 'warmth' and located here.

The potential relationship between the groupings derived from Q-card analysis and proposed eight emerging themes (and one sub-theme) is demonstrated in Tables 3, 4 and 5, and shown diagramatically in Fig. 18. It will be noted that in some instances, whilst a grouping can be identified as having a principle relationship with one theme there is also a potentially weaker relationship perceived with an additional theme(s). For other groupings the relationship to a theme is essentially singular, particularly positive groupings against the body focused theme.

Table 3

Percentage Groupings
Negative Groupings

GROUP 1 (-)	Q-cards			
Concept	**Marital Status**	**Financial Prospects**	**Spirituality**	**Retirement**
HE	X	X	X	15
HA	20	20	X	X
WB	X	20	20	5
LS	20	X	20	10
QL	60	60	60	68

GROUP 2 (-)	**Q-cards**				
Concept	**Friends Death**	**Relations**	**Relations Death**	**Isolation**	**Others ill-health**
HE	14	11	26	14	9
HA	53	33	46	32	56
WB	21	44	15	23	19
LS	X	X	1	7	3
QL	11	11	9	11	9

GROUP 3 (-)	**Q-cards**					
Concept	**Social Change**	**Childhood**	**Personality**	**Relatives**	**Unemploy-ment**	**Boredom**
HE	14	11	12	11	12	17
HA	21	22	37	33	23	35
WB	22	22	12	14	11	30
LS	14	22	12	X	14	12
QL	28	22	25	11	38	15

GROUP 4 (-)	**Q-cards**		
Concept	**First Home**	**Friends**	**Indepen-dence**
HE	X	X	X
HA	50	50	56
WB	50	50	33
LS	X	X	X
QL	X	X	X

GROUP 5 (-)	Q-cards		***GROUP 6*** (-)			
Concept	**Employ-ment**	**Parent-hood**	**Concept**	**Safety**	**Keeping Warm**	**Freedom**
HE	22	28	HE	X	X	X
HA	11	14	HA	33	33	33
WB	11	X	WB	33	33	33
LS	11	14	LS	X	X	X
QL		42	QL	33	33	33

GROUP 7 (-)	**Q-cards**			
Concept	**Leisure**	**Housing**	**Environ-ment**	**Travel**
HE	33	40	40	25
HA	X	X	X	X
WB	33	40	26	25
LS	X	X	X	X
QL	33	20	33	50

GROUP 8 (-)	**Q-cards**		
Concept	**Own ill-health**	**Pollution**	**Climate**
HE	43	51	42
HA	17	4	14
WB	9	14	28
LS	6	2	X
QL	23	28	14

GROUP 9 (-)	**Q-cards**		
Concept	**Age**	**Medication**	**Check-ups**
HE	56	54	57
HA	12	X	28
WB	X	X	X
LS	12	27	X
QL	18	18	14

Percentage Groupings
Positive Groupings

GROUP 1 (+) Concept	Q-cards Info to keep health	Avoid over indulgence	Age	Medical check-ups	Diet	Medicines	Rest/ Sleep
HE	72	83	76	78	66	78	55
HA	X	3	X	2	6	2	7
WB	12	2	5	13	10	6	24
LS	2	7	5	2	4	2	2
QL	12	4	13	6	12	12	10

GROUP 2 (+) Concept	Q-cards Child hood	Friend Health	First Home
HE	7	2	X
HA	60	54	51
WB	12	13	12
LS	17	10	20
QL	4	20	15

GROUP 3 (+) Concept	Q-cards Age	Over indulgence	Health Service	Diet	Exercise	Check ups	Pollution	Medication	Info to keep health
HE	76	83	60	66	69	78	53	78	72
HA	X	3	3	6	2	2	7	2	X
WB	5	2	18	10	13	13	15	6	12
LS	5	7	3	4	7	2	X	2	2
QL	13	4	16	12	8	6	23	12	12

GROUP 4 (+) Concept	Q-cards Own ill-health	Isolation	Unemployed	Climate	Close Community
HE	25	16	22	30	21
HA	12	31	11	11	23
WB	25	31	5	27	17
LS	12	X	16	12	11
QL	25	23	44	14	26

GROUP 5 (+)	Q-cards							
Concept	**Safety**	**Age**	**Avoid over indulgence**	**Diet**	**Exercise**	**Keep Warm**	**Medical Check-ups**	**Res Slee**
HE	64	76	83	66	69	44	78	55
HA	7	X	3	6	2	11	2	7
WB	18	5	2	10	13	23	13	24
LS	X	5	7	4	7	2	2	2
QL	9	13	4	12	8	17	6	10

GROUP 6 (+)	Q-cards			
Concept	**Indepen dence**	**Self Esteem**	**Marital Status**	**Retire-ment**
HE	4	5	2	4
HA	28	26	37	31
WB	20	25	9	2
LS	12	18	19	24
QL	34	25	31	36

GROUP 7 (+)	Q-cards				
Concept	**Age**	**Safety**	**Health Service**	**Diet**	**Exer-cise**
HE	76	64	60	66	69
HA	X	7	3	6	2
WB	5	19	18	10	13
LS	5	X	3	4	7
QL	13	9	16	12	8

GROUP 8 (+)	Q-cards						
Concept	**Bore-dom**	**Leisure**	**Own Ill-health**	**Self-Esteem**	**Spiritu-ality**	**Close com-munity**	**Others ill-health**
HE	8	10	25	5	3	21	10
HA	16	22	12	26	25	23	20
WB	41	29	25	25	42	17	30
LS	8	16	12	18	8	11	X
QL	25	28	25	25	20	26	20

GROUP 9 (+)	Q-cards			
Concept	**Pollution**	**Keeping warm**	**Health Service**	**Rest/ Sleep**
HE	53	44	60	55
HA	7	11	3	7
WB	15	23	18	24
LS	X	2	3	2
QL	23	17	16	10

GROUP 10 (+)	Q-cards		
Concept	**Company of others**	**Freedom**	**Travel**
HE	2	2	3
HA	44	43	37
WB	25	14	8
LS	17	6	13
QL	10	36	37

GROUP 11 (+)	Q-cards			
Concept	**Childhood**	**Becoming a Parent**	**Love/ Trust**	**Becoming a Parent**
HE	7	3	4	1
HA	60	59	66	74
WB	12	4	4	X
LS	17	26	10	13
QL	4	7	14	10

GROUP 12 (+)	Q-cards				
Concept	**Personality**	**Social Life**	**Marital Status**	**Travel**	**Retirement**
HE	X	2	2	3	4
HA	34	37	37	37	31
WB	26	9	9	8	2
LS	28	20	19	13	24
QL	11	30	31	37	36

GROUP 13 (+)	Q-cards			
Concept	Self Esteem	Freedom	Travel	Spiritu-ality
HE	5	2	3	3
HA	26	43	37	25
WB	25	14	8	42
LS	18	6	13	8
QL	25	36	37	20

GROUP 14 (+)	Q-cards			
Concept	Self Esteem	Leisure	Indepen-dence	Spiritu-ality
HE	5	10	4	3
HA	26	22	28	25
WB	25	29	20	42
LS	18	10	12	8
QL	25	28	34	20

GROUP 15 (+)	Q-cards			
Concept	Environ-ment	Finance	Social Change	Education
HE	31	3	3	2
HA	10	10	10	3
WB	14	14	16	10
LS	3	24	10	35
QL	41	47	60	48

GROUP 16 (+)	Q-cards					
Concept	Employ-ment	Education	Social Change	Unem-ployment	Finance	Social Life
HE	2	2	3	22	3	2
HA	12	3	10	11	10	37
WB	7	10	16	5	14	9
LS	36	35	10	16	24	20
QL	41	48	60	44	47	30

GROUP 17 (+) Concept	Q-cards First Home	Becoming a Parent	Rela-tives	Child-hood	Free-dom	Housing	Friends Health	Immediate Family Health
HE	X	3	5	7	2	11	2	2
HA	51	59	60	60	43	18	54	63
WB	12	4	11	12	14	15	13	9
LS	20	26	5	17	6	11	10	14
QL	15	7	15	4	36	42	20	9

GROUP 18 (+) Concept	Q-cards Social Life	Freedom
HE	2	2
HA	37	43
WB	9	14
LS	20	6
QL	30	36

GROUP 19 (+) Concept	Q-cards Pri-vacy	Close Com-munity	Housing	Lei-sure	Bore-dom	Indep-endence	Own Ill-Health
HE	14	21	11	10	8	4	25
HA	29	23	18	22	16	28	12
WB	20	17	15	29	41	20	25
LS	8	11	11	10	8	12	12
QL	37	26	42	28	25	34	25

GROUP 20 (+) Concept	Q-cards Unem-ployed	Environ-ment	Privacy
HE	22	31	14
HA	11	10	24
WB	5	14	20
LS	16	3	8
QL	44	41	37

21 (+)	Q-cards Parent-hood	Sex Life	Imm. Family Health	Friends Health	First Home
HE	1	7	2	2	X
HA	74	65	65	54	51
WB	X	10	9	13	12
LS	13	6	14	10	20
QL	10	10	9	20	15

22 (+)	Q-cards Imm. Family Health	Love/ Trust	Parent-hood	Sex Life	Become parent
HE	2	4	1	7	3
HA	65	66	74	65	59
WB	9	4	X	10	4
LS	14	10	13	6	26
QL	9	14	10	10	7

23 (+)	Q-cards Trans-port	Unem ploy	Social Change
HE	2	22	3
HA	22	11	10
WB	6	5	16
LS	8	16	10
QL	61	44	60

24 (+)	Q-cards First Home	Friend Health	Imm fam hlth	Love/ Trust	Person-ality	P/ hood	Sex Life	Clim ate	Soc Life	Oth Co.	Become Parent
HE	X	2	2	4	X	1	7	30	2	2	3
HA	51	54	65	66	34	74	65	11	37	44	59
WB	12	13	9	4	26	X	10	27	9	25	4
LS	20	10	14	10	28	13	6	12	20	17	26
QL	15	20	9	14	11	10	10	14	30	10	7

Table 4: Relationship of Themes and Percentage Groupings

THEME	POSITIVE % GROUPINGS (From Table 5)	NEGATIVE % GROUPINGS (From Figure 18)
True to self/inner philosophy	10 6 13 14 8 18 12	
Own space and activities	4 10 8 18	6 (-) 7 (-)
inwardly directed	6 13 14 12 19	
Interface with others/ human corresponding and mapping	4 13 21 / 22 2 12 6 13 17 24 10 8 6 11	10 (-) 8 (-) 4 (-) 2 (-)
Self within environment/ environmental positioning	16 4 19 15 12 8	1 (-)
External forces/ extraneous influences	9 19 15 20 16 23	8 (-) 1 (-)
(Societal Stressors)		3 (-)
Critical life epochs/ maturity critical incidents	11 21 10 16 22 15 17 24	5 (-) 4 (-)
Bonding with others/ emotional bonding	6 2 21 17 11 22 12 24	2 (-)
Physiological orientation/ body focused	13 9 57 14 48 24 19 22	6 (-) 8 (-) 9 (-)

Key: Primary strong link
Secondary weaker link

TABLE 5: Positive Percentage Groupings — Q Grouping

(17) First Home Becoming a Parent Relatives, Childhood Freedom, Housing Friends' Health	(16) Employment Education Social Change Unemployment Finance	(9) Pollution Keep Warm Health Service Rest/Sleep
(7) Age Safety Health Service Diet Exercise	(19) Privacy Close Community Housing, Leisure Boredom, Independence Own Ill-Health	(8) Boredom, Leisure Own Ill-Health Self-Esteem Spirituality Close Community Others' Ill-Health
(1) Information to keep healthy Avoid Over Indulgence Age, Diet, Medicine Medical Check-ups Rest/Sleep	(12) Personality, Travel Social Life, Retirement Marital Status	(18) Social Life Freedom
(15) Environment Finance Social Change Education	(20) Unemployment Environment Privacy	(2) Childhood Friends' Health First Home

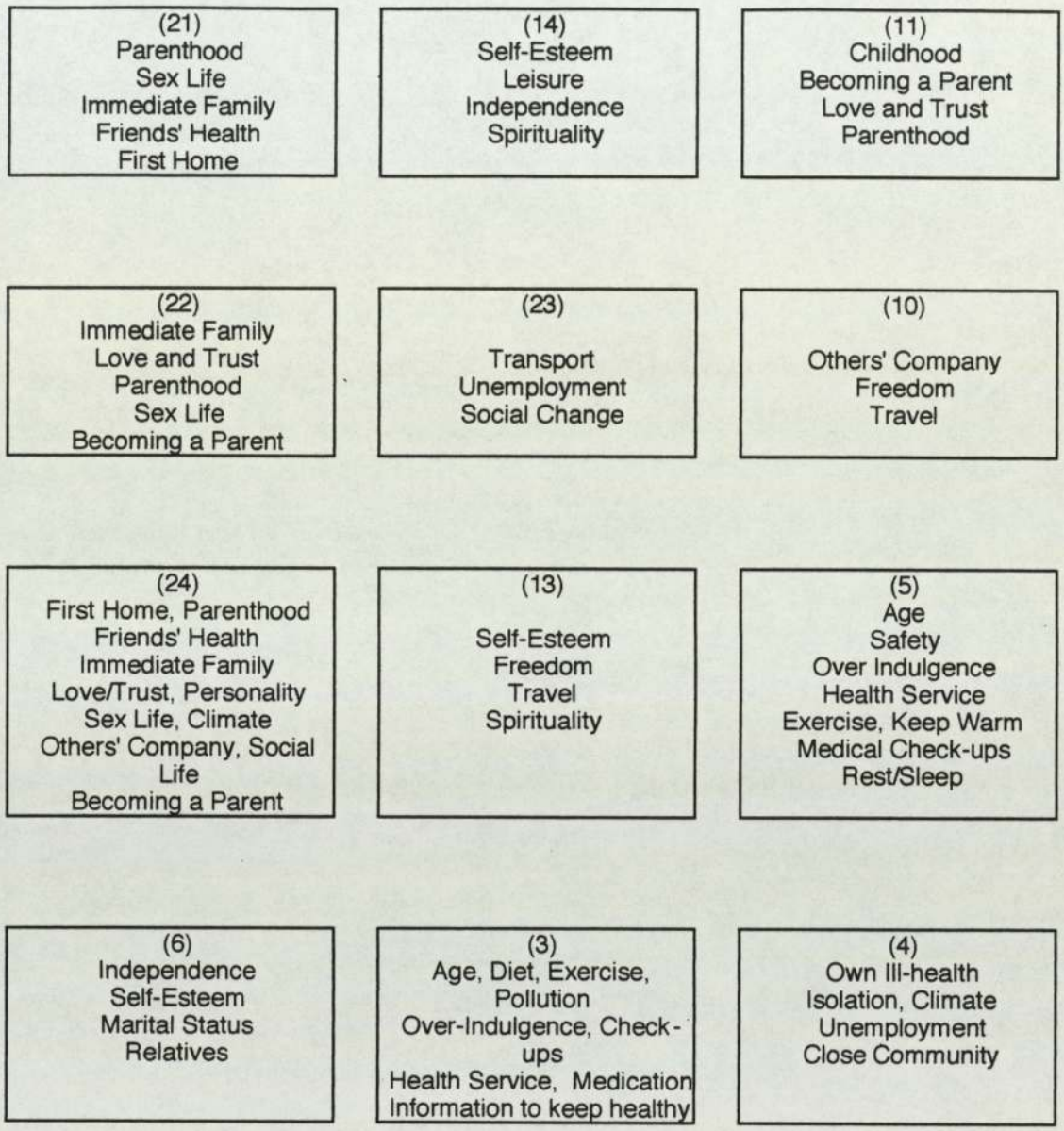

(21)
Parenthood
Sex Life
Immediate Family
Friends' Health
First Home
(14)
Self-Esteem
Leisure
Independence
Spirituality
(11)
Childhood
Becoming a Parent
Love and Trust
Parenthood
(22)
Immediate Family
Love and Trust
Parenthood
Sex Life
Becoming a Parent
(23)
Transport
Unemployment
Social Change
(10)
Others' Company
Freedom
Travel
(24)
First Home, Parenthood
Friends' Health
Immediate Family
Love/Trust, Personality
Sex Life, Climate
Others' Company, Social Life
Becoming a Parent
(13)
Self-Esteem
Freedom
Travel
Spirituality
(5)
Age
Safety
Over Indulgence
Health Service
Exercise, Keep Warm
Medical Check-ups
Rest/Sleep
(6)
Independence
Self-Esteem
Marital Status
Relatives
(3)
Age, Diet, Exercise, Pollution
Over-Indulgence, Check-ups
Health Service, Medication
Information to keep healthy
(4)
Own Ill-health
Isolation, Climate
Unemployment
Close Community

FIGURE 18: NEGATIVE PERCENTAGE GROUPINGS

9 (-)	6 (-)	5 (-)	1 (-)
Age Medication Medical Check-ups	Safety Freedom Keeping Warm	Employment Parenthood	Marital Status Financial Prospects Spirituality Retirement
8 (-)	**7 (-)**	**4 (-)**	**2 (-)**
Own Ill-Health Pollution Climate	Leisure Housing Environment Travel	First Home Friends Health Independence	Friends' Death Relatives Relatives Death Isolation Others' Ill-Health
3 (-)			
Social Change Childhood Personality Relatives Unemployment Boredom			

Cards not Grouped

Becoming a Parent
Having Privacy
A Close Community
Others' Company
Immediate Family
Diet
Information about Keeping Healthy
Exercise
Avoid Over Indulgence
Transport
Rest and Sleep
Education
Self-Esteem

6.6 CONCEPTUAL MAP: SUMMARY

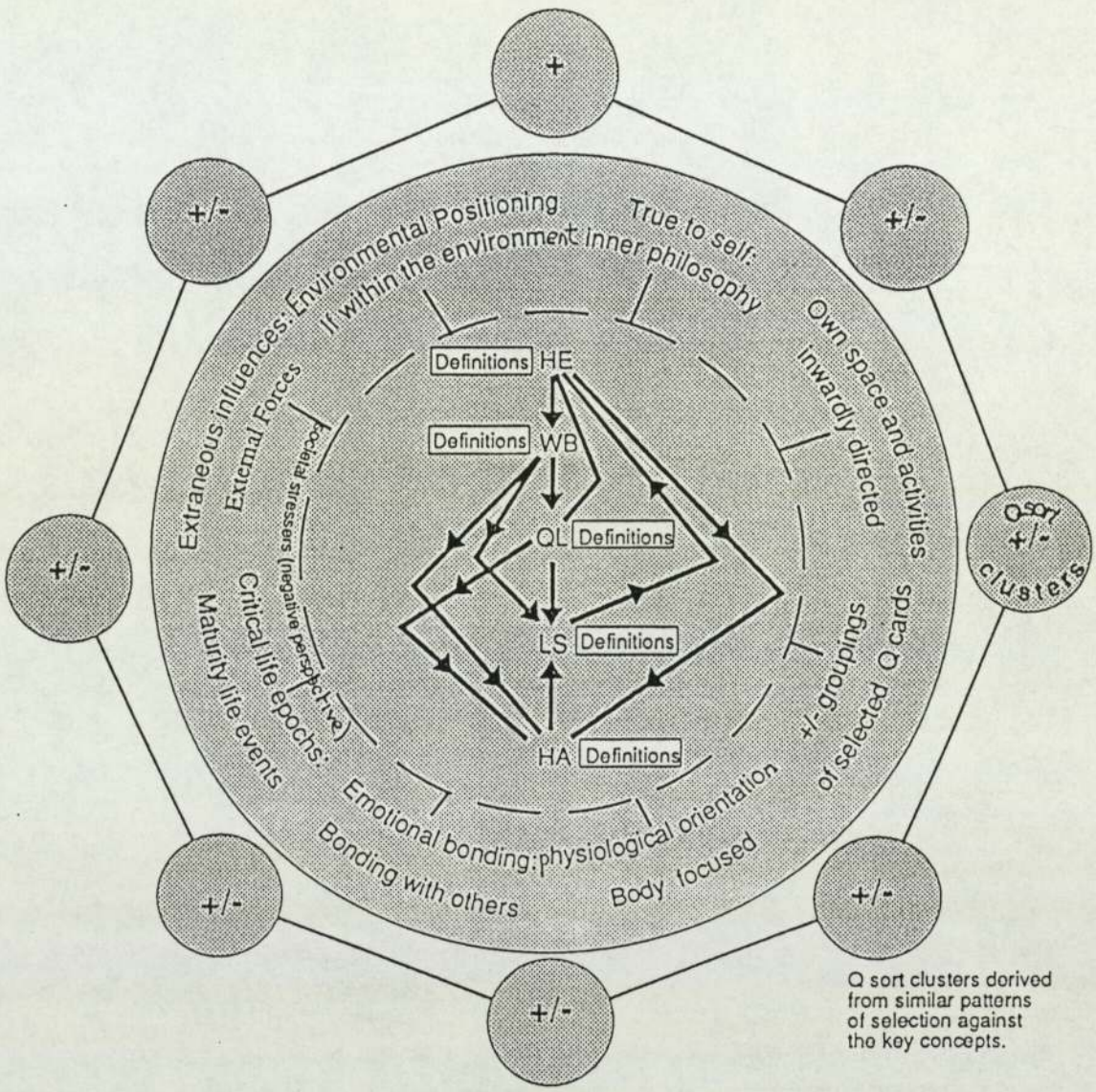
The final conceptual map (Fig. 19) emerging from the research offers a eudaimonistic lay perspective of health as identified by Smith (1981) in that it encompasses multi-dimensional, positive, and individual based notions of health. The model is structured against the concepts of health, well-being, life satisfaction, quality of life, and happiness, and consisting of three elements, namely:

1. a definitional framework for each of the key concepts;

2. directional relationships between each of the key concepts;

3. themes identified from Q-card groupings.

FIGURE 19: Conceptual Map



Lay Perceptions of a Multidimensional Concept of Health.

CHAPTER 7

Discussion of Findings

7.1 INTRODUCTORY REMARKS

The focus of this chapter is to discuss whether the research aims have been achieved, to review the strengths and weaknesses of the methodologies adopted, and finally to place the findings within the context of the literature.

7.2 THE RESEARCH AIMS

a. To explore whether members of the lay, i.e. non-health-professionals' population can reflect upon the notion of health.

b. To explore if such reflection can occur against a multi-faceted concept of health embracing notions of health, well-being, life satisfaction, quality of life and happiness.

c. Whether it is possible for the lay population to identify factors which they regard as influencing the multiple facets of health.

d. Having addressed the preceding three questions, whether it is then possible to identify an emerging conceptual map or framework held by the lay population in respect of a multiple faceted concept of health.

e. An additional aim is to share with the reader not only the outcomes of the investigations related to the above, but additionally to share the methodological debate underpinning the research study, and thereby the deficits and level of appropriateness of different methodological approaches.

Aim A/B

It is worthwhile considering these two aims together in that it is the author's contention that they have been fulfilled. This is attested to by the extensive and rich nature of the views expressed by the lay population initially in the context of the interviews which in themselves served to generate Q-card items as a basis for further enquiry. The Q-Sort survey and the ability of respondents to become engaged in the process supported the lay population's ability to reflect actively and purposefully upon the notion of health. The multi-faceted aspect of health was identified and re-affirmed by consideration of the direct and indirect pattern of relationships established as a central core to the conceptual map. The respondents showed ability to define in meaningful and contextually rich ways each of the key terms, and finally to sort and grade the Q-cards against all of the five concepts.

Accordingly, the ability of the lay population to appreciate the complexity of health is affirmed. Hence it can be contended that the lay population do not perceive health in a uni-dimensional or physical way, but rather have adopted a eudaimonistic perspective, insight into which is offered by the multi-dimensional conceptual map of health emerging from this research.

Aim C

This research has indicated that the lay population can identify factors which have influence across the five key concepts forming the multi-dimensional notion of health. Additionally the lay population has

'measurable' views as to the extent of influence, predominantly positive, of such factors upon the five key concepts. This has been supported by the generation of items through the initial interview and their later use within the Q-Sort. Indeed the Q-Sort analysis in terms of rate and pattern of selection/grading indicates underlying themes which inform the clustering of such factors as referred to in this aim.

Aim D

The consideration of aims A-C inclusive has enabled fulfilment of aim D through the generation of an exploratory framework in the form of the conceptual map. This provides the springboard or basis for further investigation and enquiry.

Aim E

It is the author's contention that by and large, aim E has been achieved. There has been a conscious and overt attempt to be explicit and share with the reader cognitive perceptions and tension and how these have eventually affected the research decision and approaches adopted. Authors such as Jensen (1989), Brink (1991), and Ely (1991) emphasise that frequently insufficient information is provided to allow the reader to understand the process as well as the final product. A compromise has had to be made between brevity and clarity of debate and explanations supportive to the main arguments. Certainly there are limitations and it is not claimed that within the methods used, i.e. diaries, questionnaire, interviews and Q-Sort, all methodological strengths and weaknesses have been explored in full.

Nevertheless this dissertation, it is contended, has gone some way in exploring the potential value of these approaches to issues of health.

7.3 REVIEW OF PRELIMINARY STAGES OF DEVELOPMENT

The preliminary stages were, on reflection, fairly unproductive in terms of furthering the final research approach. They were largely influenced by two factors: firstly, the association with the South Birmingham and Aston project within which real linkage and parallel research strategies proved problematic, with difficulties stemming from the project's timetable, contracted focus and breadth of material, which did not readily accommodate extension in terms of exploratory questioning concerning health definitions. The second factor was the emergence of an area of tension in terms of the wish to pursue a primarily qualitative research focus. This is derived from consideration of the respective strengths and weaknesses of the qualitative and quantitative approaches and acknowledgement of the subjective emphasis inherent within the research questions, whilst culturally at that time within the University's doctoral programme there was an implicit suggestion that students give some consideration to quantitative perspectives. Through consultation with the research supervisor it was felt appropriate, therefore, to pursue initially the use of quantitative approaches via:

a. the inclusion of a question within the South Birmingham survey;

b. use of a postal questionnaire Stage 2 (a/b) to the population of South Birmingham which, if it resulted in a poor response, would then clearly give support to the use of qualitative approaches.

On reflection this early work was unnecessary and did not enhance the final approach. One small helpful feature was the comments received when individuals who had failed to respond to the postal questionnaire were contacted. These discussions helped re-affirm the view that consideration of health in its positive sense was challenging as, frequently, individuals tend to accept positive health without thinking. It must however also be recognised that the amount of time and effort dedicated to such quantitative approaches was very small, and therefore represents only initial exploratory elements within the total research timetable.

7.4 DEVELOPMENT OF Q ITEMS

Developmental stage three was the basis for the generation of the Q items, supported by comments within the diaries.

The strategy for Q item generation was to develop Q cards that were naturalistic in origin, on the basis that these would offer least biased reflection of items. The semi-structured questionnaire proved to be generally an effective vehicle for eliciting and recording of people's views in a way that was relatively unconstrained and yet amenable to review and analysis. It did result in rather lengthy interviews, however this did not prove problematic as indicated by general discussion and de-briefing afterwards of respondents. Indeed many respondents continued the

discussion in a general way after completion of the questionnaire with such data being used as supportive information. Initial entry and gaining of co-operation from a respondent was, as might be anticipated, a little difficult with a total of 40 individuals approached to secure a response from 25. The fact that the interviews were undertaken within the individual's own home was important in terms of privacy and openness of response given the potentially sensitive and private nature of the questioning. It must be acknowledged that the open framework of the questions did enable the respondent to place boundaries upon the reply with which they felt at ease. This of course begs the question as to the depth and reliability of the response. Perusal of the items generated does indicate a frankness and openness of reply as many personal areas are identified, for example issues relating to family relationships. The use of South Birmingham's electoral register from which to randomly select potential respondents gave a population/geographical focus which could be mirrored within the Main Q-sort survey. It would allow the findings to be seen alongside those of a more formal and extensive survey. Additionally it helped to support the claim that the Q items were relatively unbiased and naturalistic in design as the population was selected in a random way rather than chosen from particular groups or sub-groups of individuals.

7.5 THE DIARY: A SUPPORTIVE STRATEGY

The use of a diary was seen as supportive to the main Q-sort focus rather than as a central approach within its own right. On reflection this probably

resulted in insufficient use of the information obtained from the diaries. The diary information was used to:

a. enhance and check the Q items generated;

b. help re-affirm the appropriateness of the emerging conceptual map which was achieved by the comparison of findings/themes from the Q-sort and diary through the generation of a comparative grid, (Miles and Huberman, 1984).

Location of the diary as a more significant part of the strategy would however have been problematic largely due to the poor response rates achieved. Such low rates are acknowledged within the literature as a difficulty commonly associated with diaries.

7.6 THE MAIN Q-SORT

1. The respondents' profile

The relocation of respondent selection from South Birmingham to Corby can be perceived as both advantageous and disadvantageous. It was helpful because the similarity in responses between the pilot study and the main Q-sort itself helped to suggest that the results obtained are not necessarily specific to one geographical area. Equally it must be acknowledged given the Q items were generated and piloted within the South Birmingham district there is a rationale for conducting the main survey in the same area. Certainly the reasons for relocation were mixed. They were partly derived from the wish to continue the Q-sort survey set alongside a wider exploration of health behaviours. The

South Birmingham/Aston University collaborative project had been discontinued and the recently started Choice Project offered a similar opportunity.

The final composition of the main Q-sort respondents was reflective of the residents of Corby as a whole; in that no individuals of ethnic origin were included and the educational background of individuals was largely at the technical level. The use of the electoral register as a basis for selection may preclude particular sub-groups of the population, for example the homeless or those in temporary accommodation, and provides a data base that is inevitably slightly historic in nature. Indeed the follow-up of non respondents often re-affirmed this with people having moved house or died in some instances. Nevertheless the use of the electoral register in this way is justified in terms of facilitating a structure and random selection, the alternative selection from walking in the area having a greater potential for bias.

2. **Use of a fieldworker within the main Q-sort**

The decision to use a fieldworker within the main Q-sort was not taken lightly and only after consultation and agreement of the research supervisor. Whilst such use had obvious pragmatic advantages in terms of distance and time, this was not the rationale for such usage. The reasons for use of a fieldworker were derived from consideration of the following issues:

1. The use of fieldworkers if selected against criteria and appropriately trained and monitored is compatible with the market research ethos of the research.

2. Use of fieldworkers would help mitigate against potential bias that might arise if the same individual generated the Q items and then continued to 'test' them in the main Q survey. The reduction of unintentional bias in this respect is a further factor if the researcher had a health background.

3. This response rate might be improved where a fieldworker was perceived as being associated with a project which had already gained local acceptance.

In deciding to use fieldworkers full acknowledgement of the potential difficulties, particularly in terms of continuity of approach was given. The criteria for selection and a protocol for initial training and on-going monitoring was clearly established at the outset. In view of this, it is the contention of the author that the use of a fieldworker in the final stage did not necessarily diminish involvement or responsibility for the research. Instead, use of the fieldworker helped to provide a 'balance and check' within the research against bias and transfer of such bias from Q item generation to the main Q-sort survey itself.

3. **Methods of analysis**

The main Q-sort was not amenable to quantitative analysis by factor analysis largely because of the use of free rather than forced sorting strategies being adopted in full accord with the research emphasis. Accordingly analysis did rely upon a pathway which incorporated elements of interpretation. Essentially pathways of analysis tended to rely upon the pattern as outlined below:

Review of raw data → cluster & classify → interpretation → further clustering

Review for themes → final review of material and classification

To provide further insight into this approach it is helpful to review briefly the approaches adopted for each step of the Q-sort.

Step 2: Definition of key terms[1]

Analysis of the key terms was undertaken from a predominantly grounded theory perspective. Initially a matrix of comments per individual and then per concept was generated. Such matrices are in accord with strategies adopted for later stages of the Q-sort and those recommended by Miles and Huberman (1984). The matrices enabled the production of cards bearing commonly held perspectives or categories. These were processed and refined to further groups of categories, until all of the respondents views were able to be represented within a category. Hence a Table (2) representing a summary of definitional items was generated.

Step 3: Perceived Relationship

The role of data review and interpretation is acknowledged by the author. The use of a numerical code was used to facilitate identification of commonly agreed relationships. To this end therefore the accurate recording of the card pattern selected together with arrows of communication was fundamental to such analysis. The reader may recall that this recorded pattern was left as a visual point of reference for the respondent throughout the Q-sort itself and an opportunity was provided at the end to adjust or alter the pattern if wished. Each

[1]The reader is reminded that Step One was merely an 'ice-breaker' activity.

individual pattern was coded and then translated onto a collective grid showing each relationship. From this the diagrammatic lines of relationship and related tables were derived.

The potential for bias in analysis was reduced as the pattern for coding was seen as recorded by respondent throughout the Q-sort. There is potentially an issue as to whether in the event of the respondent deciding to alter the pattern the revised pattern only should have been used for analysis. Indeed it could be suggested that comparison of the first and second selection and the differences within these might have been helpful. This activity however was not undertaken on the basis that the revised selection represented the final considered view and that analysis of collective patterns was the focus rather than individual variances within this. A further issue for debate might be the coding actually used: a variation could have been a scale of 1-3 rather than 0-2. The latter was selected since it gave a clear emphasis to direct and indirect relationships. Alternatives were explored briefly in the development of the Q-sort concept, however individuals found placing of the cards in a pattern easier to accommodate.

Steps 4-6: Selection and grading

Analysis of the Q items and their respective grades towards identification of Q-sort clusters and themes within these, took place again in a series of stages which embraced a small element of quantitative analysis, interpretative review and the use of matrices or grids.

Preliminary identification of clusters or groups

Preliminary identification was reliant upon the analysis of selection/grades in terms of means. Firstly, means were tabulated against selection of a Q-card for the key concept without reference to the grade awarded. Secondly, tabulation of means which acknowledged the -5 to +5 scale were used. The use of simple means is in full accord with the relevant Q-sort literature.

Translation of means into clusters

The table of means generated were then translated into a grid from which by means of colour-coding in numerical bands initial clusters of Q-cards were identified for further consideration.

The generation of Themes from cluster of Q-cards

The generation of themes was primarily achieved through the development of a series of grids or matrices as used by Miles and Huberman (1984). The matrices facilitated comparative review of information derived from the means, qualitative commentary and supportive diary data where available. Matrices were generated in respect of each Q-card, each key concept, and the five key concepts collectively. From such matrices an interpretative sifting of concepts took place to allow further matrices to be generated in respect of the emerging themes for further review and classification. Matrices were developed specifically to allow comparison of the Q-sort clusters and emerging themes within this survey to Q-sort findings and health

definitions in other significant research (Stainton Rogers, 1987; Blaxter, 1990; Farrell, 1986). Such comparisons are of value in terms of helping to clarify and re-affirm emerging themes.

The use of multiple matrices has been recommended as a vehicle for analysis within qualitative approaches by Miles and Huberman (1984). Matrix usage within this research has, however, substantially extended their approach.

7.7 SUMMARY OF RELATIONSHIP TO Q-SORT LITERATURE

The Q-sort procedure used can be seen as within the parameters of Q-sort as offered within the literature. This comparison is shown on the next page (Table 6).

Table 6: Relationship of Q-sort to Q literature

Methodological Key Issues and Principles from the Literature	Relationship to Q-sort Adopted within the Research (Main Survey)
1. Sample i.e. Q-cards derived from either: i. Naturalistic origin ii. Ready-made origin i.e. standardised iii. Hybrid types	The approach used was essentially naturalistic with Q-cards developed from open inter-views but with some reference to literature base.
2. Sample i.e. pertaining to Q-cards Suggested number between the range of 30-60 items.	A total of 49 Q-cards.
3. Design of Q-sort Either unstructured sampling or structured sampling.	A structured approach was adopted in that the subsets of health were embraced together with all the Q-cards generated in the developmental phase relating to such subsets of health - i.e. happiness, well-being etc.
4. A Priori concept of self reference with Q-sort	This was maintained throughout by retention of focus upon lay individuals' own views and perceptions.

5. Conduct of the Sort itself:	
a. Environment, space, non-stressful etc.	In respondent's home.
b. Categorise cards against a continuum.	The +5 to -5 grading scale was used with clarification of the terms following the pilot.
c. Opportunity to change and realign given.	This was provided on two occasions, once in respect of the key concept cards and secondly in terms of the Q-cards selected against these.
d. Adoption of a free or a forced sort.	A free sort approach was adopted in that the respondent could freely select any number of Q cards against each key concept.
e. Advising respondents that it is their own view that is required.	This was re-inforced at the onset of the Q-sort by the interviewer.
f. Consistency of Sort Approach.	Consistency was obtained and monitored by induction, piloting and ongoing checking of procedures used by the interviewers, with supportive monitoring by C.H.O.I.C.E. project leader.
6. Respondents of 'P set' or P sample Relatively small number based i.e. 50 viewed as intensive.	A total of 64 respondents, hence meets requirements.
7. Avoid statistical analysis overshadowing the qualitative small respondent number perspective.	Qualitative rather than pure quantitative analysis undertaken.

CHAPTER 8

Conclusions and Recommendations

8.1 INTRODUCTORY REMARKS

This chapter reviews the implications of the survey findings:

- to consider emerging questions and issues for further research
- for education and training of health professionals
- for health care practices and policies

8.2 EMERGING QUESTIONS AND ISSUES FOR FURTHER RESEARCH

1. **Question: Is the sample appropriate?**

The sample used within the research was relatively small, although it did have a reasonable breadth in terms of age span, gender balance. The under-representation of ethnic minorities and those with educational attainment over and above that of technical qualifications is reflective of the population characteristics of the area.

Accordingly generalisations cannot be made, nor indeed inference made about particular sub-groups. This raises the question therefore whether if such sub-groups perhaps reflecting age groups, social groups, sex or geographic location were investigated, the same or similar issues and conceptual map would emerge. Indeed international sub-group perspectives might also be an arena for further enquiry.

Issue for Further Research

Accordingly one issue for further research would be to utilise the same Q-sort approach but on a sample of individuals selected to reflect relevant sub-groups of the population.

2. **Question: Was the use of free Q-sort appropriate?**

The research aims indicated adoption of a free Q-sort procedure. Subsequently, in order to explore the conceptual map further, it would be appropriate to adopt a forced sort procedure. Clearly the use of such forced approach would inevitably provide some difference in the emerging data, not least of which is that it would be amenable to statistical analysis by factor analysis. Nevertheless the findings from the use of forced Q-sort should still largely support, if refine, the conceptual map. Additionally it would facilitate exploration of whether embedded within the conceptual map particular 'archetypes' of perception could be identified as being held by certain types of individuals.

Issue for Further Research

To revisit the Q-sort with the use of forced rather than free sorting procedure; to further test and refine the conceptual map and to identify potential archetypes of perception held within the population.

3. **Question: Are the results reliable?**

Clearly the map was derived from individuals' perceptions elicited at a particular moment in time. This inevitably begs the question as to whether such views would change over time and to what extent and whether such perceptions are relatively constant.

Issue for Further Research

The adoption of a longitudinal approach would clearly therefore be an avenue for further research; perhaps following a given group of individuals for a two-year period in order to monitor changes in perception.

4. **Question: Is the map individualistic?**

The map was derived from essentially an individual perspective which was then amalgamated into the collective. This approach does appear to beg the question as to the benefit and potential outcomes from adopting a collective approach from the outset.

Issue for Further Research

The collective approach might be achieved through use of Q-sort in a group discussion forum. (Indeed the author did undertake this activity on one occasion to confirm that the Q sorting procedure would lend itself to such collective group use.) Not only would the finding from such group use provide an interesting point of comparison but, by nature of the group process, provide a rich discussion base and hence qualitative supportive comments in support of the Q-sort itself.

5. **Question: Does the map represent the final answer?**

An almost inevitable question centres around whether the conceptual map would be supported or be refined if further investigation was undertaken by the use of different research methodology, thereby approaching the notion of 'triangulation' as a means of verification (although the map itself was derived by different methodologies, including semi-structured interview).

Issue for Further Research

Using the map as a starting point, further research could be initiated using methods other than Q-sort such as the long interview to seek to test the validity of the map.

6. **Question: Can the map be related to the professional health worker's perception?**

The focus of this research has clearly been the lay population with the emerging conceptual map relating to their views alone. An obvious question therefore is the potential relationship of this to views of heath held by health professionals.

Issue for Further Research

To use the same Q-sort strategy upon a group of health professionals to explore their health perceptions and hence provide a point for comparison with those held by the lay population.

8.3 CONCLUSIONS AND RECOMMENDATIONS

The conclusions and ensuing recommendations centre around five domains, namely:

a. use of the lay conceptual map/eudaimonistic model of health within nursing, midwifery and professional educational curriculum;

b. the use of the lay conceptual map-eudaimonistic model of health in health promotion strategies;

c. the use of the lay conceptual map/eudaimonistic model of health and implications of same within health indicators/measurements currently available;

d. the general implications of the lay conceptual map/eudaimonistic model for current health related policies and priorities including the use of market research based activity by the purchasers of health provision.

e. the use of Q-sort methodology within health focused research.

8.4 THE USE OF THE CONCEPTUAL MAP / EUDAIMONISTIC MODEL OF HEALTH WITHIN HEALTH PROFESSIONAL EDUCATIONAL CURRICULUM

Today within many educational curricula relating to both pre- and post-registration for nurses (and indeed other paramedical health professionals), the notion of health is perceived as the central or initial point of reference. This has largely been influenced by the professional bodies re-defining the curriculum boundaries and related competencies or outcomes, and placing health as a central cognitive concept within this. Examples include:

- U.K.C.C.'s Project 2000 (1986)
- ENB Framework for continuing professional education and training for nurses, midwives and health visitors (1990)
- Department of Health's Community Care Initiative (1990)

Secondly, recent changes in government policy have sought to place the notion of health on professional agendas. Recent examples are:

- The Health of the Nation: A Strategy for Health in England (Department of Health, 1992)
- Audit Commission: Community Care: Managing the Cascade of Change (1992).

Within most curriculum, therefore, some attempt is made to 'unpack' this complex notion of health. It is the author's contention, however, that frequently this is undertaken:

a. with reference to a limited range of relevant literature;
b. with little consideration of the diversity of health measures and indicators currently developed (see comparative table Appendix 1);
c. still dominated by professional definitions and perspectives of health;
d. where lay views of health are considered this is often undertaken from an anecdotal perspective or from the basis of particular focus such as health belief models or satisfaction with ill-health care delivery.

e. with limited attention paid to health definitions derived from the literature base of other health professionals. (Fox and Forman 1992.)

Accordingly it is the author's view that nursing and other paramedical health professionals should have educational curriculum which give much more attention to exploring the notion of health and its related literature base. Specifically they should consider not only the academic and professional perspective but those of the lay population. The emerging conceptual model from this research is intended to provide an additional eudaimonistic model of health to inform the curriculum of health professional training.

8.5 THE USE OF THE LAY CONCEPTUAL MAP/EUDAIMONISTIC MODEL OF HEALTH IN HEALTH PROMOTION

Historically health promotion has been recognised as a significant aspect of some health professionals' roles, notably that of the Health Visitor (Robinson J. 1985, and Twinn 1991). More recently health promotion has been given greater emphasis within all nursing roles, becoming not only the province of the Health Visitor. This is illustrated by the inclusion of health promotion with the 10 key characteristics and related outcomes with the English National Board for Nurses, Midwives and Health Visitors Higher Award proposals of 1991. Additionally, the recently published Health of the Nation (Department of Health, 1992) prompted the following remark in an editorial in the Nursing Times of July 15th/21 1992:

> "Above all the White Paper is an official signal to the NHS that everyone involved needs to practise and think in a health-promoting way. We need the specialists and experts, but health promotion is a thread running through every activity and a responsibility for everyone." p.3.

Nevertheless to achieve effective health promotion strategies is problematic. Fundamental to such success is achieving greater insight into lay perceptions of health, as these form the basis of health related behaviour. To this end the emerging conceptual map and eudaimonistic model becomes helpful, not only in the development of health professionals'

insights into the notion of health and health promotion strategies but also as a possible 'template' for the assessment of lay perceptions of health and therefore of value in assisting in the planning and implementation of health promotion strategies. This meets Calatonia's (1988) call for more research into conceptions of health in the general population and different socio-demographic subgroups.

8.6 THE USE OF THE LAY CONCEPTUAL MAP/EUDAIMONISTIC MODEL OF HEALTH WITHIN HEALTH INDICATORS/MEASUREMENTS CURRENTLY AVAILABLE

Measures of health by the use of a variety of tools clearly is influenced by and dependent upon the definition of health. By and large the majority of measures currently available give emphasis to health in its negative ill-health sense and to definitions derived from medical or health professional perspective (Payne, 1991, and Bowling, 1991).

To some extent this emphasis is perhaps readily understandable in that it does provide more easily indicators which can be judged, measured and readily tested. Indeed the priority given within recent years to efficiency, effectiveness and economy within health care settings has facilitated the continued emphasis and development of such health indicators and measures in that they do more closely highlight health outcomes as a result of health interventions. Nevertheless there has been increasing acceptance that such quantitative measures focused on ill-health are in themselves not sufficient and need therefore to be set alongside more qualitative and positive health measures (Bowling 1991). Central to such qualitative measure of positive health is the lay perception, definitions and realities.

> "Health is indisputably to do with people. The best approach must be to look at people in everyday circumstances to examine real lives." Seedhouse (1986) p.3.

> "What matters in the 20th Century is how the patient feels, rather than how doctors feel they ought to feel on the basis of clinical measurements." Bowling (1991) p.1.

Clearly the emerging conceptual map does not in real terms represent in any way a health measure. Nevertheless the map may usefully be seen as a framework or guide to aid exploration of lay health perspectives. This is particularly true if aspects of the map are considered rather than in its entirety. For example the location of the five key cards in a pattern that reflects the lay individuals' cognitive model gives insights into the relationship and dynamics of the five key concepts, and this is further enhanced by definition in the individuals' own words of the key concepts and consideration of these against the definitional parameters within the model. Certainly use of the Q card items and the rating of these against the five key concepts can give insight into the factors the individual perceived as significant. Accordingly elements of the map could be used as indicators rather than measures of the individuals' views of health and life events as an influence upon this. In this way therefore elements within the conceptual map can be used as 'subjective self-report measure'.

8.7 THE GENERAL IMPLICATIONS OF THE LAY CONCEPTUAL MAP/EUDAIMONISTIC MODEL FOR CURRENT HEALTH RELATED POLICIES AND PRIORITIES

Health policies and priorities are subject to a diverse range of influences including such factors as political agendas, economic viability and new health treatments. Amongst these influences is also the changing definition of health over time, which is also in itself subject to influence and change by health priorities and policies. Hence a dynamic and mutually influential relationship can be identified between health definitions and health policies/priorities. This relationship has been illustrated in a recent edition of Medicine Now (Radio 4 14th July 1992) within which the new policy and priorities for health embraced in Health of the Nation were discussed. It identified that within this policy framework the pursuit of health defines health in its widest sense, hence embracing not only health but the other key concepts used in this research and the conceptual map. The discussion progressed to give an account of a recent challenge to the way in which happiness is defined in relation to health offered by Dr. Richard

Benthall. This challenge, which suggests happiness might be regarded as a psychiatric illness, is not really intended as a serious suggestion that happiness should be re-categorised as a disease state. Rather the challenge lay in highlighting the problematic and value based nature of definitions of health and illness. Clearly Dr. Benthall's view is rather idiosyncratic in many ways, however, it does also illustrate and re-affirm that, over time, definitions of health do change and hence are cultural based as well as being informed by emerging empirical knowledge. This, in turn, influences and is influenced by health policies.

The relevance and value of the eudaimonistic conceptual map/model emerging from this research to current health related policies and priorities can perhaps best be illustrated by further brief consideration of Health of the Nation and the creation of a purchaser/provider relationship within the NHS. These two health policies and their inter-relationship was recently explored by Turner and Carlisle (1992). Within this debate the requirement for the purchaser of health care, District Health Authority or a Fund Holding General Practitioner, to undertake an assessment of health care needs was identified. This acts as a basis for setting local health targets in accord with those priorities within the Health of the Nation.

> "When the purchasers make their health care assessments before setting up contracts to buy care they must be aware of the role of nurses in achieving the target." p.19.

The identification of health targets and the purchase of relevant care if undertaken in the context of Health of the Nation will inevitably embrace, as identified in the preceding discussion, defining health in a broader way and accordingly will involve consideration of multiple agencies including health professionals, voluntary agencies and local authorities, together with focused health promotion strategies. The assessment of health care need can clearly be undertaken either on an individual or collective basis. An individual assessment will require not only a physical current health status assessment but to be effective needs also to embrace and acknowledge the individual's subjective perspectives. These perspectives should specifically consider how the individual perceives health in its widest sense and lifestyle

factors influence upon this. It is this very issue Turner and Carlisle (1992) assert which forms the heart of the Health of the Nation initiative.

The relevance of the eudaimonistic model to individual assessment for health promotional activities has already been detailed. The model's use in the context of collective assessment rests with the identification of a particular sub-group within the population who may have specific characteristics and health needs. Through use of the model and its related Q-sort within this targeted group the findings can be used as a basis of health planning and provision.

8.8 THE USE OF Q-SORT METHODOLOGY WITHIN HEALTH FOCUSED RESEARCH

It is the author's contention that this research and the emerging conceptual map has re-affirmed the value of Q-sort methodology within the context of health based research, particularly where the focus of the research is largely exploratory, to seek an understanding of people's perspectives and to consider in a qualitative way the range of factors perceived to influence health and the priorities given to these.

Q-sort has been shown to offer a self referenced, systematic yet unconstrained method by which to explore perceptions within which context rich data can be elicited and examined. The potential limitations and disadvantages associated with Q-sort and attested to within the literature have not been ignored. Rather the recommendation for greater use of Q-sort methodology within health based research is made in full acknowledgement of such deficiencies and difficulties, not least of which is the debate pertaining to the selection of forced or free sorting procedure. Nevertheless all methodologies have to be selected with reference to their particular benefit and advantages given the nature of the research problem and issue. Q-sort methodology therefore does offer a valuable approach to explore the personal value base of an individual, because Health is inevitably dependent upon value based frames of reference.

8.9 SUMMARY

By way of summary it is the author's contention that the original research aims have been fulfilled within the emerging conceptual map or lay eudaimonistic model of health and it offers a significant contribution to the current body of knowledge. To this end the findings have significance for notions of health both in an abstract and conceptual way and for the use of health as a concept in health professionals' education, health promotion strategies and assessment and negotiation of health care needs. Additionally, the overt sharing of methodological debate and dilemmas, particularly those relating to the principle methodology of Q-sort, does provide a helpful contribution to the ongoing qualitative and/or quantitative debate in relation to health issues. Nevertheless all research will inevitably pose almost as many questions as it seeks to explore or consider, with this research proving no exception.

8.10 CONCLUSION

To return at the end to where one began is often helpful. Early in the debate reference was made to the still confused and ambiguous nature of health and definitions thereof. This point was illustrated by Seedhouse (1986):

> 'What has emerged from volumes of writing on health is an indigestible spaghetti of confusion." pxi

Accordingly this research has not sought to add to the volume of confusion, rather to tease out one strand of the spaghetti representing lay perspectives for closer consideration. In doing so an acknowledgement of the practicalities of eating spaghetti is made. Namely that even if successful in teasing out one strand it will inevitably remain anchored at its ends to the remainder of the whole! Accordingly the emerging conceptual map or eudaimonistic model of health held by the lay population will be required to be considered still linked or in the context of the rest of the spaghetti which is the remaining body of knowledge pertaining to health and its perceptions.

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APPENDIX 1:
Table of Comparison Health Measures/Indicators identified by Bowling & McDowell

Nature of Measure	Bowling A. (1991) Measuring Health: A Review of Quality of Life Measurement to Scale	McDowell I, Newell C (1987) Measuring Health: A Guide to Rating Scales & Questionnaires
	Open University	Oxford University Press
Functional Measures inc. Disability/Handicap	The Older American's Resource & Services Schedule (OARS) Multi-dimensional functional assessment questionnaire Fillenbaum Fillenbaum & Smyer 1981. For age 55 and over.	ADL Scales: 1. The Pulses Profile (Eugene Moskowitz & Cairbre B. McGann 1957) to determine function of chronically ill, ill and edlerly predict rehabilitation potential, six categories.
	The Barthel Index	2. The Barthel Index (formerly the Maryland Disability Index) Florence I. Mahoney & Dorothea W. Barthell 1965 to measure multi-functional indepencencies before and after treatment - rehabilitation neuro-muscular patients.
	Index of ADL	3. Index of ADL Sidney Katz 1959 reviewed 1976 to measure physical function of chronically ill patients with stroke and hip fractures
	The Stanford Arthritis Centre Health Assessment Questionnaire (HAQ) Fries et al (1980)	4. The Kenny Self-Care Evaluation Herbert A. Schoening and Staff Sister Kenny Institute 1965 to measure functional ability to live at home independently.
	The Arthritis Impact Measurement Scale (AIMS) Meenal et al (1980) adopted from Katz assessment arthritis patients.	5. The Physical Self Maintenance Scale M. Powell Lawton & Elaine M. Brady 1969 to evaluate abilities of people of 60 years living in community or institutions.
	Townsend Disability Scale (1979) Community Survey of the Elderly	6. The Functional Status Rating Systems Stephen K. Farer 1981 to determine assistance required by rehabilitation patients.

Karnofsky Performance Scale (1948) Physical Performance and Dependency lung cancer patients.

The quality of Well-being Scale (QWBS) (Kaplan et al 1976, Bush 1984) Mortality and quality of life for a general health policy.

The Crichton Royal Behaviour Rating Scale (CRBRS) (Robinson 1968) Use on elderly and psychiatric wards.

The Clifton Assessment Procedures for the Elderly (CAPE) Pattie Gilleard (1979)

7. A rapid disability rating scale Margaret Whinn 1967 revised 1982 research tool to summarise functional capacity and mental status of elderly chronic patients.

8. The functional status index Alan M. Jette 1978 revised 1980. The functional status of adults with arthritis living in the community.

9. The patient evaluation conference system Richard F. Harvey, Hollis M Jellinek 1981. Functional and psycho-social status of rehabilitation patients.

10. The functional activities questionnaire Robert I. Pfeiffer 1982 reviewed 1984. Screening normal aging and mild senile dementia.

11. The OECD long-term disability questionnaire (Organisation for economic co-operation & development 1981.)

12. The Lambeth Disabillity Screening Questionnaire Donald L. Patrick and others 1981. Postal questionnaire screen disabilities in adults in community.

13. The Disability and Impairment Interview Schedule A.E. Bennett and Jessie Garrad 1970 to determine prevalence and severity of disability in epidemiological surveys.

Psychological Wellbeing

Zang's Self Rating Depression Scale (1965), Montgomery Asberg Depression Rating Scale (1979) a 65-item psycho-pathology scale.

Hamilton Depression Scale 1967 Assess cognitive and behavioural components of depression.

The Health Opinion Survey Allister M. Macmillan (1957). Adult in a rural community to identify psycho-neurotic types of disorder.

The Twenty Two Screening score of Psychiatric Symptoms Thomas S. Langner 1962. 22-item scale to indicate physical impairment in life function due to psychiatric symptoms.

	The Beck Depression Inventory (BDI) Beck 1961 21-item inventory depression and anxiety self-evaluation	The Affect Balance Scale Norman M. Bradburn 1965/69. To test psychological reaction to events in daily life.
	Hospital Anxiety and Depression Scale (HAD) Zigmund & Snaith 1983 14-item assessment of anxiety and depression	The General Well-being Schedule Harold J. Dupuy 1977 Psychological well-being and stress for community surveys.
	The Symptoms of Anxiety and Depression Scale Bedford et al 1976. Use in the elderly focuses on recent symptomotology.	Mental Health Inventory Rand Corporation & John E. Ware 1979 Measure of psychological distress for general population survey.
	The General Health Questionnaire	The General Health Questionnaire David Goldberg 1972. Self-administrated diagnostic psychiatric disorders
	The Geriatric Mental State (GMS) Copeland et al 1976	
	The Mental Status Questionnaire (MSQ) Pfeiffer 1975 Measure orientation and memory.	
	The Abbreviated Mental Test (AMT) Hodkinson 1972 Test memory and recall	
Social Health (Social networks and Support)	Inventory of Social Supportive Behaviour (ISSB) Barrera 1981. 40-item scale to investigate networks and their structure.	The Social Relationship Scale Allan H. MacFarlane 1981. Extent of social network and perceived help in cushioning effect of life stress.
	Social Support Questionnaire Arizona Social Support Interview Schedule (ASSIS) Barrera 1981. Identify support networks and subject satisfaction with this.	The Social Support Questionnaire Irwin G. Sarason 1983. Availability and satisfaction with social support.
	Perceived Social Support from Family and Friends Procidano & Heller 1983. Measure of perceived social support.	The Social Maladjustment Schedule Anthony W. Clare 1978. Social maladjustment amongst adults with chronic neurotic disorders.

The Social Network Scale (SNS) Stokes 1983. Assess 4 dimensions of network, size no family, friends and density - provide measure of satisfaction.

The Katz Adjustment Scale Martin M. Katz 1963. Measure social adjustment of psychiatric patients.

The Family Relationship (FRI). Measure support within from the family. Mees (1981), Billing & Mees (1982)

The Social Health Battery Rand Corporation 1978. Objective indicators of level of social resources and social interaction.

The Social Support Appraisals Scale (SS-A)
The Social Support Behaviour Scale (SS-B)
Vaux et al 1986/87

The Social Dysfunction Scale
Margaret W. Linn 1969.
Assess negative aspects of person's social adjustment.

Inter-personal Support Evaluation List (ISEL). Cohen et al 1985
Assess perceived availability of support.

The Social Functioning Schedule
Marina Remington & P.J. Tyrer 1979.
Semi-structured interview assess the problems a person expereriences in aspects of social functioning.

Interview Schedule for Social Interaction (1980)

The Interview Schedule for Social Interaction Scott Henderson 1980. Assess availability and supportive quality of social relationships.

The Revised University of California at Los Angeles (UCLA) Loneliness Scale Russell et al (1978/80) Identify common themes that characterise experience of loneliness.

The Structured & Scaled Interview to Assess Maladjustment Barry J. Garland 1972. Social role performance as indicator of outcomes from psychotherapy.

The Social Adjustment Scale Myrna M. Weissman 1979. Measure from drug treatment and psychotherapy for depressed patients.

The Quality of Life and Life Satisfaction

The Quality of Life Index W.O. Spitzer 1980. Measures well-being of patient with cancer and other chronic illness.

Delighted-Terrible Faces
D-T Scale i.e. one of the four items. Andrews 1976 & Wittey

Four Single Item Indicators of Well-being F.M. Andrews 1976. Population and clinical setting to assess satisfaction with life. Use of four scale techniques.

The Life Satisfaction Index
Index A & Index B
Neugarten et al 1961

The Life Satisfaction Index Bernie L. Neugarten & Robert J. Havighurst 1961. General feeling of well-being amongst older people to identify successful ageing.

The Philadelphia Geriatric Morale Scale

The Philadelphia Geriatric Centre Morale Scale M. Powell Lawton 1972. Measure emotional adjustment aged 70-90 in community and institutions.

The Life Satisfaction Index Z 13 Item Version (LSIZ)
Woods et al 1969

The Affect-Balance Scale (A65)
Bradburn 1969
Indicator of happiness & general psychological well-being.

The (Psychological) General Well-being Schedule (GWBS)
Dupuy 1978. Subjective indicator of multi-dimensional of sell-being and distress.

The Self-Esteem Scale
Rosenberg 1965.

The Tennessee Self Concept Scale Fitts 1965-1972 Test Maslaw self actualisation concept.

Self-Esteem Inventory
Cooper Smith 1976
Self judgements of personal worth.

General Health Measures

The McMaster Health Index Questionnaire (MHIQ) Chambers et al 1976. Measures physical social and emotional functioning.

The Arthritis Impact Measurement Scale. Robert F. Meenan 1980. Indicator of outcomes of care for arthritis patients.

The Cornell Medical Index (CMI). Use physicians taking medical history. Bradman et al 1949.

The Physical and Mental Impairment of Function Evolution Lee Garel 1972 revised 1973. Institutionalised elderly physical mental impairment.

Spitzer's Quality of Life Index (QL)
Physicians use patients cancer and chronically ill. Spitzer et al 1981.

The Functional Assessment Inventory Nancy M. Crewe & Gaary T. Athelstan 1981 revised 1984, for clinical use potential for vocational rehabilitation.

Linear Analogue Self Assessment (LASA) Priestman & Baum 1976. Quality of life concept treated with cytotoxic therapy.

The Nottingham Health Profile dev further Hunt et al 1986.

The Sickness Impact Profile (SIP) Dev Deyo et al 1982/1983. Developed from Bergner et al work.

The Rand Health Insurance Study Batteries (HIS) Ware & Karmos 1976, Stewart et al 1978, 1981, 1989, Ware et al 1979, 1980

i. Physical Health Battery - functional status
ii. Mental Health Battery - measure affect mood depression
iii. The Social Health Battery - social resources and contract
iv. General Health Perceptions Battery - self rating of health.

The McGill Pain Questionnaire was included by Bowling in the Broader Measures of Health Status section.

The Nottingham Health Profile Carlos Martini & Sonja Hunt 1977 revised 1981, 2 forms version, 1 Nottingham Health Index, version 2 Nottingham Health Profile. Indicate problem of perceived physical social emotional health.

The Sickness Impact Profile Marilyn Bergner, Betty S. Gilson, Ruth A. Babbitt and William B. Carter 1976 revised 1981. Measure perceived health status and changes in person's behaviour due to sickness.

The Multi-level Assessment Instrument M. Powell Lawton 1982. Measure overall well-being elderly in the community.

The OARS Multi-dimensional Functional Assessment Questionnaire
Older Americans Resources and Services, Duke University 1975. Level of functioning and need for services older impaired people at home.

The Comprehensive Assessment & Referral Evaluation Barry Garland 1977 revised 1983. Health and social problems people 65 years +

The Quality of Well-being Scale (formerly the Index of Well-being) J.W. Bush, J.P. Anderson, R.M. Kaplan and others 1973 revised 1976. Indicator of disability and need for care.

APPENDIX 2: Nursing Models

Peplau

Nature of Nurse/Nursing	A practice to facilitate productive energy transformation. A goal orientated process involving interpersonal process between nurse and patient.
Nature of Person	A self system, composed of biochemical, physical and psychological characteristics and needs. Emphasis is placed upon the psychological characteristics within this model.
Nature of Environment	A microcosm of others who are significant to the person and with whom they interact.
Nature of Health	A level of anxiety which is productive in that it facilitates interpersonal activity and allows the accomplishment of development tasks.

Henderson

Nature of Nurse/Nursing	Assisting the individual sick or well in activities of which there are fourteen components, that contribute to health and recovery that he or she would perform had he/she the knowledge, will or strength.
Nature of Person	Biological being with inseparable mind and body.
Nature of Environment	Not explicitly defined within the model but seen as capable of acting either negatively or positively upon the individual.
Nature of Health	Ability to function independently in respect to the fourteen components, i.e.:

1. breathe normally
2. eat and drink adequately
3. eliminate body waste
4. move and maintaian desirable postures
5. sleep and rest
6. select suitable clothing
7. maintain body temperature within the normal range
8. keep the body clean and groomed protecting the integument
9. avoid changes in the environment and avoid injuring others
10. communicate with others expressing emotions, needs, fears and opinions
11. worship according to one's faith
12. play or participate in various forms of recreation
13. work in such a way as to obtain a sense of satisfaction
14. learn, discover or satisfy the curiosity that leads to normal development and health and use the available health facilities.

Orem

Nature of Nurse/Nursing	A human service involving judgements as to why patients need nursing as to overcome human limitations in self care actions for health related reasons.
Nature of Person	Man is an integrated whole functioning biologically, symbolically and socially.
Nature of Environment	A sub-component of man which together comprises an integrated system relating to self care.
Nature of Health	A state of wholeness or integrity of the individual and modes of functioning.

Roy

Nature of Nurse/Nursing	A process of assessment and intervention within the context of the nursing process and involving the manipulations of stimuli
Nature of Person	A bio-psycho-social being interacting with a changing environment the person is an adaptive open system
Nature of Environment	All conditions, circumstances and influences surrounding and influencing the development of an organism or group of organisms.
Nature of Health	The health/illness continuum is a continuous line representing degrees of health or illness that an individual may experience over time. Health/illness becomes an inevitable aspect of a person's life.

Neuman

Nature of Nurse/Nursing	A unique activity concerned with the whole person, the nurse intervenes to effect either reduction or mitigation of the effect of stressors.
Nature of Person	A physiologic, psychologic, sociocultural and developmental being must be viewed as a whole and as a dynamic inter-relationship of variables.
Nature of Environment	May be viewed as external and internal. External is all that is external to the person. Internal is the person's own internal state in terms of physiologic, psychologic, sociocultural and developmental variables.
Nature of Health	A state of wellness or illness which is determined by the variables of physiologic, psychologic, sociocultural and developmental. It is relative and in a dynamic state of flux.

Rogers

State of Nurse/Nursing	A learned professional whose focus is compassionate concern for the maintenance and promotion of health and caring for the rehabilitating sick and disabled. It seeks to promote symhomic interaction between environment and man in all settings.
Nature of Person	A four-dimensional negentropic energy field identified by pattern and organisation encompassing all that is outside any given human field.
Nature of Health	A value world broadly defined by cultures and individuals to denote behaviours that are of high and low value.

APPENDIX 3:

Developmental Stage 3 - Review of Results

The nature of responses received from the postal distribution of the questionnaire did seem to indicate that the concept of Health, Well-being, Life Satisfaction, Happiness, and Quality of Life were all meaningful to respondents, with reflection in relation to these concepts generating identifiable life factors which were perceived as influential. Nevertheless the level of response was poor, with the follow-up contact by telephone of non-responders seeming to re-affirm the notion that the concepts were not routinely contemplated by people and, in consequence, views were not readily obtained by postal questionnaire. This further reinforces the need to explore such issues by more qualitative methodological approaches, certainly by adopting a methodology in which personal contact with respondents is achieved in order to facilitate reflection. It became important, therefore, before using qualitative based approaches, to further explore use of a questionnaire administered by an interviewer rather than post, with this being undertaken to establish:

1. The difference in response rate and extent of information obtained.
2. To monitor the level of comments offered that extended beyond the confines of the questionnaire and may indicate further the value of qualitative approaches.
3. To generate Q-sort items.

Accordingly twenty people were selected randomly from the electoral register for the area of Kings Norton for participation in Stage Three of the survey, initial contact being established by letter with a follow-up telephone contact to confirm arrangement for interview. Of the twenty people, two were found to have died and a remaining three people declined to be associated with the survey; the reasons for this were given as:

> "having insufficient time at present due to family illness and commitments."
>
> "I feel health is a private thing and I am not willing to talk about it."
>
> "I don't really feel I can help ... you see, I am so busy, we are moving house soon."

The remaining fifteen respondents were interviewed, using the same questionnaire as that administered by post. To increase the number of respondents, a further 20 people were contacted in the same manner, providing 10 individuals who were willing to participate, thus producing a total of 25 respondents in all. The shortest interview lasted 40 minutes, and the longest 2 hours 20 minutes; on average, however, the interviews lasted one hour.

The results are indicated in the following pages. However, outside the formal responses to the questionnaire, all respondents offered additional views and comments with these being extensive discussion for seven respondents. The additional comments were recorded in writing, in terms of the central ideas.

Reflections in respect to additional views and comments offered by respondents when considering the key concepts:

i. ***Happiness: Life Satisfaction***

These seem to indicate some notion of a continuum in which Happiness was perceived as something achieved at intervals only, whereas notions of Life Satisfaction were achieved more routinely in that its location was not so far along the continuum.

Views which supported this concept included:

> "Well I would like to think I could be happy all the time but you can't can you, you don't have time anyway, most of the time you're just satisfied and grateful for what you have, sort of muddling along."
>
> "I think I am satisfied with my life in that I get on with it without thinking too much about what if's or this could be better; now and again something happens which makes me step back from it all and see it all more clearly; well the good parts then it's happiness but you only really feel that now and again."
>
> "I don't expect to be happy all the time, it's impossible, you know happiness is there and sometimes you reach it. In my past life I think I was very aware of unhappiness and dissatisfaction, in my previous marriage you know, but my new life's better, I don't have those constant feelings so I think I am satisfied with periods in which I move beyond that to happiness."
>
> "Well, happiness occurs now and again, often when something special happens but Life Satisfaction, well I think it's possible to have that most of the time, it all depends on your state of mind. Everything really, how much you're going to give way, what you expect from life; it's a question of personality and seeing things in perspective."

Accordingly, lack of happiness/satisfaction was seen as vulnerability in terms of illness.

ii. Quality of Life

This was seen as having influence upon Happiness and Life Satisfaction but these were not solely dependent upon the Quality of Life. Equally Quality of Life was seen as influencing Health and Well-being in a minimal way. There emerged a dimension of Quality of Life in respect to:

a. Environment and standards to maintain Health, e.g. food, housing etc.

b. Emotional relationship dimensions - with these having a linkage to Happiness and Life Satisfaction, together with Well-being.

c. Independence and self autonomy - with this supporting Life Satisfaction and Health/Well-being.

Whilst principally beneficial, Quality of Life also was perceived as having negative aspects. Comments supporting this "model" of Quality of Life included:

> "Quality of Life ... that's a difficult one, there's a lot to it ... well yes you have to have a certain quality, enough to feed yourself, keep warm, to stay fit, otherwise you can get ill. Mind you, if the quality of your life is too good, you can over-indulge, and get ill that way."
>
> "Money doesn't matter that much so long as there's enough to keep going, clothing, food and the like; there's other things

that affect my Quality of Life, give me Happiness, my family, seeing friends, the support they give me. But I think for real Quality of Life, especially as you keep getting older, you have to be able to do things for yourself, not dependent on others."

"Feeling free and independent is a key thing for me, really adds to my Quality of Life. If you have too little money to keep going that would reduce your Quality of Life and if you had no job, not just because of the money, but work gives you a sense of purpose, independence and you mix with other people. Yes, able to have friends and see others affects Quality of Life."

"My mental illness affected my Quality of Life, I was unable to work, so had no money for even basic things, but more important, it was difficult for my friends and family. I felt isolated. Also I couldn't cope along just with ordinary things, I had to rely on others, that was dreadful."

iii. Health and Wellness/Well-being

Health and Well-being were most meaningful as terms. Health was perceived as having various dimensions akin to the findings of other research. Namely:

a. *Health was perceived as something largely taken for granted*;;

it became an issue of consideration in its absence if you became ill. A notion supported by the work of Blaxter and Paterson (1982)

"Well I don't think about it much, except when I am ill, and then I am reminded of how important it is."

"I think most people take it for granted, except if you have a health problem or have done so in the past in a serious way, then you see how important it is."

b. *Health was perceived and valued in terms of it enabling you to cope with the demands of life;*

this having two focuses, firstly physical fitness so you can function optimally, supported by Pill & Stott (1982); secondly, a mental and emotional capacity to meet the demands of life, with this latter element relating to the notion of Health as controllable, a state of mind.

> "Well you have to be healthy to cope with it all, not just the physical things, but all the stress and the worry of life today."
>
> "Yes I have to stay healthy to look after the family, you need to be fit to do all the work, but also to have the energy and stamina mentally as well."
>
> "Well there's physical health which I think can decline with age, but mental health is another problem, one I have had to fit for many years. You see I look healthy, but no-one really understands mental illness, it's so difficult trying to stay healthy in that way and cope with everything."

c. *Health as a State of Mind*

Respondents did indicate that Health could be seen as a state of mind, in which certain people, due to their mental outlook and in part personality, were more vulnerable to illness, less able to fight to maintain health, too ready to succumb to illness.

> "Well it's a question of outlook, we can all give in."
>
> "What you see as illness is a state of mind, some people are all too ready to say I am ill and go to the doctor."
>
> "It's down to personality, some people just don't have the same ability to fight it off, but you have to try."

In this way Health also emerged as having a further dimension.

d. *Health as a Controllable Factor*

In accordance with previous views of health as a state of mind for some respondents, this was extended to health being, in part, controllable. An individual could ensure health by their own mental outlook and actions. The control of health suggested by the respondents in this study appeared to operate in two ways; firstly, the mental individual outlook and personality as indicated above, and secondly in terms of action and lifestyle, e.g. diet, rest and exercise. If one had an appropriate range of lifestyle and actions, you could maintain health. In this context, illness just occurred in an uncontrolled way, as bad luck.

> "I take responsibility for my own health, you have to look after yourself, I do exercise twice a week, don't over-indulge, eat a good diet."

> "You can influence how healthy you are not just by the things you do, your lifestyle, but your mental outlook as well. If this is positive you can keep healthy, but if not, you worry, feel sorry for yourself, and then you can more easily get ill."

e. *Well-being:*

On the whole, this term had meaning for the respondents and was perceived in a wider conceptual way.

> "I think Well-being is more important, it's everything, not just being healthy or fit, it's your whole being, the life you lead, how happy you are, your outlook. It's difficult to put it into words, even if you're ill you can be left with a sense of Well-being, so it must be more than Health."

"Well, it's hard to separate them because if you are ill or healthy it can affect your Well-being. In the same way if you have a loss of Well-being - not so happy - life isn't so good in all ways, it can make it easier for you to become ill."

"Yes they're different, but affect each other. You do need to be healthy to have real Well-being, but it's more than just being fit. My whole life and family and work affects my Well-being, it's affected even by my past life, childhood, what I believe in."

"I think I am fairly healthy for Well-being. However, I need for to be independent, not worried about the future for my family and the wider world, a sense of contentment, it's related to the quality of my life."

f. *Wellness:*

Was rather less meaningful, attracting a range of responses. For some it equated to Health and physical fitness; for others it had a similar meaning to Well-being.

Sample of Questionnaire used in Stage 3

THE FOLLOWING QUESTIONS WILL BE ABOUT HOW YOU SEE YOUR HEALTH

1. Which of the following best describes how you see your life at present: (please circle appropriate score)

Boring	1	2	3	4	5	6	Interesting
Enjoyable	1	2	3	4	5	6	Miserable
Tied down	1	2	3	4	5	6	Free
Rewarding	1	2	3	4	5	6	Disappointing
Rough	1	2	3	4	5	6	Smooth
Full	1	2	3	4	5	6	Empty
Discouraging	1	2	3	4	5	6	Hopeful
Easy	1	2	3	4	5	6	Hard
Frustrating	1	2	3	4	5	6	Fulfilling
Full of fun	1	2	3	4	5	6	No fun at all
Controlled by others	1	2	3	4	5	6	Under my control
Full of possibilities	1	2	3	4	5	6	In a rut
Unsuccessful	1	2	3	4	5	6	Successful
Brings out the best in me	1	2	3	4	5	6	Doesn't give me a chance
Unhappy	1	2	3	4	5	6	Happy
Carefree	1	2	3	4	5	6	Worried

2. Thinking back over your life, can you tell me if you think the following ***has influenced your health or well-being*** (please circle appropriate score)

		Minimal Effect					Maximum Effect
i.	Nature of employment Comments:	1	2	3	4	5	6
ii.	Your housing Comments:	1	2	3	4	5	6
iii.	Your relatives Comments:	1	2	3	4	5	6
iv.	Your friends Comments:	1	2	3	4	5	6
v.	The climate Comments:	1	2	3	4	5	6
vi.	The amount of exercise you usually take Comments:	1	2	3	4	5	6
vii.	Type of diet you usually eat Comments:	1	2	3	4	5	6

viii. Your childhood 1 2 3 4 5 6

Comments:

ix. Amount of rest & sleep you usually have 1 2 3 4 5 6

Comments:

x. The type of personality you have 1 2 3 4 5 6

Comments:

xi. Marital status (widowed, single, etc.)

a. Present 1 2 3 4 5 6

Comments:

b. Past 1 2 3 4 5 6

Comments:

xii. Your current age 1 2 3 4 5 6

Comments:

xiii. Your level of independence at present 1 2 3 4 5 6

Comments:

xiv. Your standard of living

a. Present 1 2 3 4 5 6

Comments:

b. Past 1 2 3 4 5 6

Comments:

xv. Your level of income

a. Present 1 2 3 4 5 6

Comments:

b. Past 1 2 3 4 5 6

Comments:

xvi. Whether you are male or female

Comments:

xvii. Are there any other factors not mentioned so far that you believe influence your health?

Comments:

3. I would now like to ask what aspects of your life have given you the greatest happiness - in the space below write down 3 or 4 important aspects of happiness for you. Then rate each of them in terms of their degree of importance, ticking the appropriate box:

	Some happiness						A great deal of unhappiness
a. In the past	1	2	3	4	5	6	

b. Now	1	2	3	4	5	6	

4. What aspects of your life have been the source of greatest unhappiness? In the space below write down 3 or 4 important aspects of unhappiness for you. Then rate them in terms of their degree of importance ticking the appropriate box.

	Some unhappiness					A great deal of unhappiness	
a. In the past	1	2	3	4	5	6	

b. Now	1	2	3	4	5	6	

5. Do you think being ***unhappy*** affects your life in any way? In the space below write down 3 or 4 ways in which you think unhappiness affects your health. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	A little 1	2	3	4	5	6	A great deal

6. Do you think being happy affects your life in any way? In the space below write 3 or 4 ways in which you think being happy affects your health. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	A little 1	2	3	4	5	6	A great deal

7. Please consider the statements below, indicating any agreement.

I feel: Agree Disagree

	1	2	3	4	5	6
Things are going my way						
I wish to change part of my life						
A complete person						
Life is meaningful						
Confident regarding decisions						
Loved and trusted						
Alone						
I can't be bothered						
I think clearly						
I smile a lot						
I have few regrets						
Free and easy						

8. Do you think your feelings of satisfaction about your life have had an ***influence*** on your health? In the space below write down 3 or 4 important influences. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

A little influence A great deal of influence

a. In the past	1	2	3	4	5	6	

	A little influence					A great deal of influence	
b. Now	1	2	3	4	5	6	

9. In what ways do you think the quality and standard of your life may have ***influenced*** your health? In the space below write down 3 or 4 important influences. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	Affect a little					Affect a great deal	
a. In the past	1	2	3	4	5	6	

b. Now	1	2	3	4	5	6	

10. In what ways do you see Health and Well-being, similar or dissimilar?

Comments:

11. In what ways do you see Wellness and Well-being, similar or dissimilar?

Comments:

12. How important to you are the following? (Please circle the appropriate number.)

	Not very important					Very important
a. Being well	1	2	3	4	5	6
b. Being happy	1	2	3	4	5	6
c. Being satisfied with life	1	2	3	4	5	6
d. Live a long life	1	2	3	4	5	6
e. Having a good standard of living	1	2	3	4	5	6
f. Being independent	1	2	3	4	5	6
g. Being physically active	1	2	3	4	5	6

13. If one of the above had to decline, which would you choose, and why?

14. Which of the above would you like to increase, and why?

15. All things considered, how would you describe your present state of health? (Please circle the appropriate number.)

Very good	1
Good	2
Fair	3
Poor	4
Very poor	5
Don't know	6

16. What factors in your lifestyle contribute most to keeping you healthy? In the space below please write down 3 or 4 important factors for you. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	Some contribution					Contributes a great deal	
	1	2	3	4	5	6	

17. What factors in your lifestyle are most likely to lead to a deterioration of your health? In the space below please write down 3 or 4 important factors for you. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	1	2	3	4	5	6	

18. Most people have some things to worry about. Generally, what do you worry about most? In the space below please write down 3 or 4 important worries for you. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	A little to to worry about					A great deal to worry about	
	1	2	3	4	5	6	

19. Is there anything else that has worried you in the last few days?

Comments:

20. What effect does worry have on your health?

Comments:

21. Being healthy enables you to do a great deal. What things do you most value? In the space below write down 3 or 4 important things you value. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	Value a little					Value a great deal	
	1	2	3	4	5	6	

22. Can you think of areas of your life which most contribute to a feeling of Well-being? In the space below write down 3 or 4 important areas for you. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	A little						A great deal
a. In the past	1	2	3	4	5	6	

b. Now	1	2	3	4	5	6	

23. Can you think of areas in your life which adversely affect your feeling of Well-being? In the space below write down 3 or 4 important areas of your life for you. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	A little effect						A great deal of effect
a. In the past	1	2	3	4	5	6	

b. Now	1	2	3	4	5	6	

24. All things considered, how satisfied/dissatisfied are you with your life at present? In the space below write down 3 or 4 important areas of satisfaction/dissatisfaction for you. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	Dissatisfied 1	2	3	4	5	6	Satisfied

25. How would you rate yourself five years ago?

	Dissatisfied 1	2	3	4	5	6	Satisfied

26. What are you optimistic about in the future? In the space below write down 3 or 4 important areas for you. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	Limited Optimism 1	2	3	4	5	6	Very Optimistic

27. Think how your life is going, ***at present***, what areas would you like to change? In the space below write down 3 or 4 important areas for you. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	Change a little 1	2	3	4	5	6	A great deal

28. What would you ***least*** like to change in your present life? In the space below write down 3 or 4 important areas for your. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	Change a little					A great deal	
	1	2	3	4	5	6	

29. Think about the ***past***, what areas would you like to have changed? In the space below write down 3 or 4 important areas you would have liked changed. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	Very little					A great deal	
	1	2	3	4	5	6	

30. What would you ***least*** like to change in your past life? In the space below write down 3 or 4 important areas for you. Then rate each of them in terms of their degree of importance, ticking the appropriate box.

	Very little						A great deal
	1	2	3	4	5	6	

STAGE 3: Results and Discussion

QUESTION 1

	Score					
	1	**2**	**3**	**4**	**5**	**6**
Boring - Interesting	3	1	3	7	10	1
Miserable - Enjoyable*	-	3	3	6	9	4
Tied down - Free	5	3	6	2	5	4
Disappointing - Rewarding*	3	1	3	5	10	3
Rough - Smooth	4	2	5	3	4	3
Empty - Full*	-	4	2	6	8	5
Discouraging - Hopeful	1	1	4	3	11	5
Hard - Easy*	5	8	3	3	3	2
Frustrating - Fulfilling	3	5	4	6	5	2
No fun - Fun*	1	3	7	4	7	3
Control others - Control self	1	2	3	4	8	6
In a rut - Possibilities*	3	5	2	5	7	3
Unsuccessful - Successful	2	2	3	7	8	4
No chance - Best*	-	1	6	8	7	2
Unhappy - Happy	1	1	3	5	8	8
Worried - Carefree*	2	6	4	4	8	1

*Grading reversed to give comparability

Notions that tended to reflect a negative view in terms of score 1-2 were: in a rut, frustrating, hard, and, to a slightly lesser extent, rough and worried.

Middle range scores were awarded to enjoyable, interesting, and, to a lesser extent, brings out the best in me, and happy.

High positive scores of 5/6 were awarded to such terms as enjoyable, free, rewarding, full, hopeful.

Clearly there was some divergence of opinion with notions of worried - happy. Rough - smooth received high response at both extremes of grading.

Nevertheless, this does tend to reflect the pattern of scoring in the first questionnaire, further supporting the view that people can engage in reflection concerning perceptions of life.

QUESTION 2

		Score					
		1	2	3	4	5	6
Employment		2	-	1	3	9	7
Housing		2	1	2	3	9	1
Relatives		2	2	2	7	4	1
Friends		1	1	7	9	1	1
Climate		1	2	1	4	3	3
Exercise		-	3	4	7	7	2
Diet		1	1	-	8	9	4
Childhood		2	1	2	9	3	6
Rest/sleep		-	-	3	9	5	3
Personality		3	2	3	5	4	3
Marital State:	Present	2	3	4	3	1	4
	Past	-	-	-	2	3	-
Age		-	-	3	1	7	6
Independence		-	2	2	8	4	5
Standard of living:	Present	4	-	3	4	9	5
	Past	1	1	4	11	10	4
Income:	Past	3	-	1	6	2	3
	Present	3	-	2	5	1	5
Gender		5	6	-	1	4	1

QUESTION 2

Number of People Commented = 1

Areas cited:	*Comments:*
Housing:	Financial worry and burden
Childhood:	Affected self care as adult - diet
Marriage:	Freedom - single. Reduces self-neglect
Employment:	Travel, money, limits worry/financial security

Number of People Commented = 2

Employment:	Unemployment
Housing:	Isolation; depressed
Relatives:	+ source of advice/stress and further responsibility
Childhood:	Residual effects as adult; childhood illness - emotional effects
Independence:	Reaction to illness - not go to doctor minor illness
Rest & sleep:	Emotional and physical ability to cope

Number of People Commented = 3

Area s cited:	*Comments:*
Employment:	(-) physically tired, (+) social contact
Housing:	(-) stress and worry; ownership, depression if poor quality
Childhood:	(-) physical environment, (-) affects
Rest/Sleep:	affects concentration
Personality:	stress - illness
Age:	less able to cope life stress
Independence:	affects self-care pattern
Standard of living:	mental happiness; over-indulgence
Income:	less options self-care
Relatives:	support and comfort

Number of People Commented = 4

Housing:	good conditions, physical effects
Friends	affect activities, e.g. leisure
Climate:	cold, physical effects
Diet:	special diet, maintain health
Childhood:	good physical care - adult health
Rest/Sleep:	emotional health
Age:	affects mental health

Number of People Commented = 5

Employment:	(+) stimulation; (-) stress
Relatives:	(+) security, comfort
Friends:	help in need
Climate:	heat, physical (-)
Rest/Sleep:	less energetic
Personality:	cope with illness
Standard of living:	poor (-) worry, negative effect

Number of People Commented = 6

Relatives:	(+) can help if ill
Climate:	emotional affect happy/depressed
Diet:	obesity, fibre, bowels, fit
Childhood:	(+) care security, mental outlook
Rest/Sleep:	ability to deal with life
Gender:	type of illness prone to

Number of People Commented = 7

Employment:	(-) working conditions
Housing:	security, mental health, poor conditions, physical
Relatives:	(-) stress and worry
Diet:	fresh food, positive; harmful, convenience
Standard of living:	ability to care for self physically

Number of People Commented = 8

Area s cited:	*Comments:*
Friends:	happiness, comfort
Exercise:	emotional, mental outlook
Diet:	energy; able to cope
Marriage:	mental health; better -> support; share stress
Independence:	mentally happier; healthy

Number of People Commented = 9-12

Age:	reduced physical health

Number of People Commented = 12-15

Housing:	environment; mental health

Number of People Commented = 15 or above

Exercise:	physical (+) e.g. bowel, muscle weight

Additional Comment: 1 only

Environmental pollution

QUESTION 3/4

No. who commented	Happiness (past)	Happiness (now)	Unhappiness (past)	Unhappiness (now)
1	faith in God	faith in God	crime, isolation	own ill health child abuse
2	being needed	retirement security - home	low self-esteem	environment
3	financial security	travel	own ill health environment examinations	
4	academic success	work		ill-health of others; death of relative
5	environment leisure, travel		others' ill-health	unemployment
6	first home		unemployment	financial worries work
7	work success	leisure, parent-hood	work	
8				
9				
10				
11	parenthood			
12				
13			Death of relative or friend	
14				family/friends relationship
15				
16				
17	family relation-ships			
18	personal relationships		family disputes and friends	
19		family		

QUESTIONS 3/4

Score awarded (No. of people)

	1	2	3	4	5	6
Happiness - Past						
1st entry		1	2	3	6	10
2nd entry		1	3	4	7	9
3rd entry			2	4	8	4
4th entry			1	1	1	1
Sum		**2**	**8**	**12**	**22**	**24**
Happiness - Present						
1st entry		1	2	2	8	8
2nd entry		1	4	3	4	8
3rd entry			2	2	6	2
4th entry						2
Sum		**2**	**8**	**7**	**18**	**20**
Unhappiness - Past						
1st entry			1	2	6	15
2nd entry		1	1	3	6	8
3rd entry		1		3	4	2
4th entry	1				2	1
Sum	**1**	**2**	**2**	**8**	**18**	**26**
Unhappiness - Present						
1st entry	2	1	1	4	4	8
2nd entry		3	2	1	8	3
3rd entry		1	2	5	2	
4th entry				1		
Sum	**2**	**5**	**5**	**11**	**14**	**11**

QUESTION 3/4 - Comments

Interestingly this does tend to reflect the findings of the first survey, in that there is a commonalty of issues in terms of past and present causing both happiness and unhappiness. Again family/personal relationships feature most strongly.

Again, scoring in relation to the past is rather higher than the present overall, a feature found in the first survey, with scoring in relation to issues causing unhappiness in the present being identified more easily with higher scores than those of the present unhappiness.

QUESTION 5/6

Nos. who commented	Areas cited Unhappiness	- Effects of: Happiness
1		
2		
3		
4		
5	Affects relationship with family	Increased resistance to minor illness

QUESTION 5

No. of mentions	Unhappiness effects	Happiness effects
1		
2	Slows recovery	
3		
4	Diet and eating pattern	
5		Motivation to look after self
6		
7		Resistance to minor illness
8	Resistance to illness	
9	Relationship with others/family	Levels of energy
10		
11	Sleep pattern	
12		
13	Tiredness, energy levels	Physical fitness
14	Physical effects/neglect	Ability to cope (emotionally better - sense of humour)
15	Behaviour changes (irritability)	
16		Better relationship with family

QUESTION 5/6

Score Awarded

	1	2	3	4	5	6
Unhappiness - effect on health						
1st entry			4	3	13	4
2nd entry		1	4	4	3	4
3rd entry	1	1	1	2	5	2
4th entry					1	1
Sum awarded	**1**	**2**	**9**	**9**	**22**	**11**
Happiness - effect on health						
1st entry			4	5	6	9
2nd entry			2	2	4	6
3rd entry			1	3	6	10
4th entry					2	2
Sum awarded			**7**	**10**	**18**	**27**

QUESTION 5/6

This does reflect the findings of the first survey in that both happiness and unhappiness are perceived as having a physical and social impact upon the individual, acknowledging a cause effect relationship. Notions of vulnerability does emerge in terms of perceived increases to illness.

In contrast to the first findings, a greater scoring of unhappiness in terms of impact upon health is indicated.

QUESTION 7

This question is of interest in terms of the preceding questions concerning happiness and unhappiness in which it seemed that the respondents did indeed reflect both emotions. for this duality emerges in the response to this question also. For a majority tended to agree with the notions that they wished to change parts of their life, were uncertain that they felt a complete person. Whilst equally positive agreement was given to concepts of life being meaningful, that life was worth living, they had confidence in decisions made.

Nevertheless, there was a range of responses and some ambiguity in terms of concepts feeling free and easy, having few regrets and loneliness.

QUESTION 7 (grade awarded)

	+ Agree Negative Emotion					- Disagree Positive Emotion
	1	**2**	**3**	**4**	**5**	**6**
Things going my way*	2	4	6	5	5	3
Wish to change parts of my life	6	6	1	1	6	5
Complete person*		1	2	1	2	4
Life in meaningful*	1	2	2	2	8	8
Life is not worth living		2	1	1	4	15
Confident re decisions*		5	4	4	3	9
Loved and trusted*	3	4	1	2	6	8
Feel alone	1	7	4	2	4	7
Can't be bothered		5		2	5	13
Think clearly*		3	4	5	11	2
Smile a lot*		2	4	7	7	5
Few regrets	5	5		4	7	4
Free and easy*	2	2	5	6	7	3

*Reversed from original to ensure parity of score

As in the first sample, this does reflect duality of positive and negative emotions towards life in that whilst many feel life is going their way, there is a strong response to the notion of changing part of life. Although the notion of not feeling a complete person is less strong in this questionnaire, there is still relatively a mixed response. Equally, scoring on the extremes also tends to occur in respect to few regrets, feeling lover and trusted, and feeling alone.

QUESTION 8/9

Areas in relation to Life Satisfaction and Quality of Life influencing Health

It would appear that there are some areas of commonalty in respect to Life Satisfaction and Quality of Life, for example, work, relationship with others and security, whilst some areas are perceived as influencing. One dimension only, for example, childhood is cited in respect to Life Satisfaction only together with notions of success and personal achievement.

It is of interest that the level of comment made concerning certain areas does change in the categories, for example, relationship with others features more strongly in Life Satisfaction than it does in Quality of Life. It does, however, seem that people are able to reflect upon these concepts in a meaningful way and identify areas of influence.

The grading of factors within the present is slightly stronger in respect to both Quality of Life and Life Satisfaction. Throughout, however, a high grading is the norm, although there is a wider range in Quality of Life factors. Equally,

respondents were able to identify a greater number of 4th entries for Quality of Life than Life Satisfaction. This may serve to suggest that Life Satisfaction is seen as having a slightly narrower range of influences than Quality of Life, but that factors nevertheless are perceived as having great influence.

QUESTION 8/9

Areas affecting:

No. of comments made	Life Satisfaction (past)	Life Satisfaction (now)	Quality of Life (past)	Quality of Life (now)
1	School	Freedom, child-hood		Diet
2	Environment	Physical fitness	Emotional happi-ness	Leisure Environment
3	Personal achievement Childhood		Freedom illness	Freedom
4				
5	Life achieve-ments, work	Environment	Work	Work Fitness
6		Life's achieve-ments	Relationship with others	Emotional happiness
7		Security	Environment	Security
8	Security			
9	Relationship with others			
10				
11		Relationship with others		

QUESTION 8/9 Grade Awarded

	Score awarded					
	1	**2**	**3**	**4**	**5**	**6**
Areas of Life Satisfaction influencing health (past)						
1st entry		1	3	6	8	3
2nd entry		1		2	4	1
3rd entry					3	
4th entry						1
Sum awarded		**2**	**3**	**8**	**15**	**5**
Areas of Life Satisfaction influencing health (present)						
1st entry			3	3	7	5
2nd entry			1	1	3	3
3rd entry			1	1		1
4th entry					1	
Sum awarded			**5**	**5**	**11**	**9**
Areas of Quality of Life influencing health (past)						
1st entry			3	6	4	4
2nd entry		4		1	5	2
3rd entry			3	2	3	1
4th entry			1		1	
Sum awarded		**4**	**7**	**9**	**13**	**7**
Areas of Quality of Life influencing health (present)						
1st entry		1	4	6	5	5
2nd entry		1		2	4	2
3rd entry		2			3	2
4th entry			2		2	
Sum awarded		**4**	**6**	**8**	**14**	**9**

QUESTION 10/11

Definition of Terms

Notion	*Comment*	*No. of Respondents*
Health and Well-being	Similar	7
	Dependent on each other	7
	Health = physical	12
	Well-being = emotional/mind	8
	Well-being = social	3
	Uncertain	2
Well-being - Wellness	Well-being needed for Wellness	2
	Well-being = social	10
	Wellness = physical	12
	Well-being = mental/emotional	5
	Similar to each other	2
	Well-being = physical	1
	Wellness not meaningful	5
	Well-being = social	3

QUESTION 10/11 - Definition of Terms

A fairly similar pattern emerges to the findings of the first survey in that for the majority the terms were meaningful (although this is not true for the notion of wellness). Again, in terms of Health a fairly large number of people perceived this as primarily physically related; with Well-being given a wider social emotional perspective, and with seven identifying an interdependence.

Similarly, in contrast to Wellness, Well-being is perceived in a wider social emotional context by many.

In this survey the respondents were also asked to reflect upon the terms Happiness and Life Satisfaction as used in the preceding questions. No respondent found these terms unmeaningful to them although two people found them as similar. For the others it tended to represent a continuum in which Happiness was greater (and for some in consequence achieved only on a few occasions) than Life Satisfaction.

QUESTIONS 12/13/14

	Score Awarded					
Perceived importance of concepts	**1**	**2**	**3**	**4**	**5**	**6**
Being well				5	2	21
Being happy			1	1	5	18
Satisfied with life				3	9	13
Long life	4	4	5	6	1	5
Standard of living	1	2	2	9	6	5
Independence			2	7	8	8
Physically active		1		5	9	13
Sum awarded	**5**	**7**	**10**	**36**	**40**	**83**

QUESTION 13/14

No. of Respon-dents	Area of decline	Justification	Area of Increase	Justification
1			Life satisfaction	Contentment affects health
2				
3	Being satisfied with life	Learn to cope: offer a challenge		
4	Independence physically active	Always someone to help; mental health but able to adapt	Being well	Better able to cope, less worried
5				
6	Standard of living	Always survive with less able to adapt	Physically active	Do more, able to cope
7			Happiness	Affects all aspects of life; important, but hard to obtain
8			Standard of living	Like better food: keep healthy affect all areas of life
9	Living a long life	Depends on quality and health		

Values placed upon Concepts relating to Health

Perhaps the most obvious data arising from the table above is the low importance attached to living a long life, and to a lower extent standard living. This is equally reflected when these are the two areas selected for decline. Happiness and standards of living are rated highly as areas people wish to increase, although the latter is also an area listed for decline. Whilst interestingly being well and physically active is given consideration as areas for both a desired increase and decline.

QUESTION 15/16/17

Table a:

Perceived Ranking of Selection of Health State

Selection	*No. of Respondents*
Very good	7
Good	10
Fair	7
Poor	3

Table b:

No. of responses	Factors contributing to Health	No. of responses	Factors deteriorating
1		1	
2	Medication, luck, independence	2	Smoking, lack of independence
3	Work, self-esteem	3	Unemployment, increased age, relationship with others
4	Income, leisure activities	4	Financial worries, housing
5	Rest	5	Family problems, inadequate rest
6	Avoid over-indulgence	6	
7		7	Work, insufficient activity
8		8	Diet
9	Relationships with others	9	Stress
10	Mental outlook	10	
11	Physical activity	11	
12	Diet	12	
13		13	

QUESTIONS 15/16/17

Table b

	Score awarded					
	1	**2**	**3**	**4**	**5**	**6**
Factors contributing to Health						
1st entry		1	4	5	7	12
2nd entry			3	7	7	7
3rd entry			1	2	6	5
4th entry						2
Sum awarded		**1**	**8**	**14**	**20**	**26**
Factors leading to a deterioration						
1st entry			1	4	9	10
2nd entry				7	4	4
3rd entry		1	2	3	2	7
4th entry	1		2		1	2
Sum awarded	**1**	**1**	**5**	**14**	**16**	**23**

In respect to table a, it is of interest that the majority of respondents perceived their present state of health to be either good or very good. This may in part help inform the previous questions in which being well and indeed physically active were graded of high importance, yet not cited as areas for selection in terms of increase/decrease.

In respect to factors that contribute to and detract from health, diet is alone in its level of perceived importance, perhaps a testimony to the impact of current health education. Nevertheless, emotional dimensions in terms of relationship with other and mental attitude are fairly predominant. In terms of detrimental factors, the pattern changes with work and stress becoming predominant.

In terms of score awarded, contributory factors are perceived as only rather than marginally greater than deterioration factors, as indicated by grade 6 selection, although both attract quite a wide range of score selection.

QUESTION 18

Worry over : Topics cited

No. who commented	*Area*
1	
2	Previous life events, old age, transport reliability
3	Independence
4	Own ill-health, friends' ill-health
5	Environment, social issues
6	Unemployment
7	About children
8	
9	
10	Work
11	
12	
13	
14	Financial issues
15	
16	Family and friends

QUESTION 18

	Score awarded					
	1	**2**	**3**	**4**	**5**	**6**
Worry over:						
1st entry			3	6	11	2
2nd entry		3	2	5	5	3
3rd entry		1	1	5	1	3
4th entry	1	1	3	1	1	
Sum awarded	**1**	**5**	**9**	**17**	**18**	**8**

QUESTION 19

Worry over the last few days:

No. who commented	***Area***
1	
2	Work, financial issues, weather
3	Job change, quality of life
4	Isolation, own health
5	Family, relatives
6	

QUESTION 20

Effects of worry on health

No. who commented	***Area***
1	Increases tendency to smoke
2	
3	
4	
5	Reduces resistance to illness
6	Sleep disturbance
7	
8	Less able to cope
9	Changes my behaviour
10	
11	
12	
13	
14	
15	
16	Depression
17	Physical disturbance (tired, appetite loss)

QUESTIONS 18-20

Worry is identified as having both physical and social/emotional consequences. Worry caused by issues pertaining to family or friends is identified as a key aspect both in the immediate and longer term. Work also features as a worry in this way, as does financial concerns. Worry attracts a relatively high score in terms as grades 4 and 5 being predominant.

QUESTION 21

Being healthy enables:

No. of comments	*Areas cited:*
1	
2	
3	
4	Employment
5	
6	
7	
8	
9	
10	
11	
12	
13	Independence, fulfil work/home commitments
14	
15	
16	Leisure, social activities

QUESTION 21:

Being healthy enables:-

	Score awarded					
	1	**2**	**3**	**4**	**5**	**6**
1st entry			2	3	9	4
2nd entry			2	4	5	6
3rd entry		1	1		2	1
4th entry			1			
Sum awarded		**1**	**6**	**7**	**16**	**11**

In contrast to the preceding question where work was rated highly as a source of worry, it is given a relatively low rating in the question, in a direct way but acknowledged in terms of a commitment. In contrast, leisure and social activities are most valued as an outcome of being healthy, this serving to reflect the importance of these areas previously in terms of Happiness. Interestingly, the notion of independence emerges fairly strongly reflecting perhaps the notions of social function in a wider context. Scoring tended to be at the higher end of the continuum, with grades of five and six being the highest awarded respectively.

QUESTIONS 22/23

	Areas affecting:		Areas adversely affecting:	
No. of comments	**Well-being (past)**	**Well-being (now)**	**Well-being (past)**	**Well-being (now)**
1				
2	faith in God	faith in God		
3		home		bereavement
4				
5	fitness childhood		stress, own ill-health	financial worries
6	independence	leisure	death of relative or friend	
7				work, unemployment
8		work, independence	work,unemployment	
9		financial security		
10	work, life achieve-ments	physical fitness		
11				family/friendship problems
12			family/friendship problems	
13				
14				
15	friends/family relationships			
16				
17				
18				
19		family relationships		

QUESTIONS 22/23

Factors affecting well-being:

Again there is a commonalty in areas that are perceived to have both a negative and positive effect upon Well-being, with work and family/friend relationship featuring strongly. There is, however, an inter-relationship acknowledged between physical fitness and Well-being as well as the social emotional aspects. Interestingly, the notion of independence occurs as it did in the preceding question as a contributory factor, whilst stress is identified (if in a minimal and global way) as having adverse effects.

QUESTION 22/23

	Score awarded					
	1	**2**	**3**	**4**	**5**	**6**
Contributions to Well-being - past:						
1st entry				7	6	6
2nd entry		1	3	3	4	3
3rd entry	1		2		1	2
4th entry					1	1
Sum awarded	**1**	**1**	**5**	**10**	**12**	**12**
Contributions to Well-being - now:						
1st entry			2	4	12	5
2nd entry			1	5	5	6
3rd entry			1	5	3	1
4th entry			1		1	
Sum awarded			**5**	**14**	**21**	**12**
Adversely affect Well-being - past:						
1st entry	1		4	1	6	5
2nd entry		1	2	5	4	4
3rd entry	1	1	1	3	1	1
4th entry		1				
Sum awarded	**2**	**3**	**7**	**9**	**11**	**10**
Adversely affect Well-being - now:						
1st entry			1	3	8	6
2nd entry			5	3	3	5
3rd entry			1	2	1	
4th entry						1
Sum awarded			**7**	**8**	**12**	**12**

It is interesting to note, and perhaps not surprising given the effects of recency, that for both concepts scores relating to the present are overall slightly stronger than those given for the past, with the highest selection of the top range of scores - i.e. grades 5-6 - being given to factors perceived as currently contributing to Well-being rather than those which were detrimental.

QUESTIONS 24/25/26

Factors affecting Satisfaction

No. of comments	Now	5 years ago
1		spiritual comfort
2		environment/housing
3	own ill-health	
4	independence	living standards, independence
5	own fitness, leisure	
6		own fitness/health
7		
8	living standards	
9		
10		
11		work
12		family/friends relationships
13		
14	work	
15		
16		
17		
18		
19		
20	family/friends relationships	

QUESTION 26

Factors affecting Dissatisfaction

No. of comments	Now	5 years ago	Optimistic for future
1	psychological health	spiritual comfort	
2	own health	leisure activities friendship	education/knowledge
3	physical health	environment/housing	social & world issues leisure
4	independence	living standards	
5	leisure	own fitness	living standards and health
6			work, independence
7			family welfare
8	living standards		
9			
10		work	family/friends relation-ship
11			
12	work		
13		family/friends relation-ship	
14			
15			
16			
17			
18			
19			
20			
21			
22	family/friends relation-ship		

QUESTION 24/25/26

Family relationships emerge as the key issue affecting Life Satisfaction, both currently and in the past, with this remaining high as an area of optimism for the future. Work also features as a key issue, but is less prominent in terms of an area of optimism for the future. Some concepts remain relatively static in their importance and level of optimism, notably living standards, whilst physical fitness is cited as an influencing factor both currently and in the past.

QUESTIONS 24/25/26

Table of Factors affecting Life Satisfaction

	Score awarded					
	1	**2**	**3**	**4**	**5**	**6**
Question 24: Now						
1st entry	2	3	4	3	6	4
2nd entry	1	2	3	4	4	3
3rd entry		2	2	4	4	3
4th entry		1		2	1	
Sum awarded	**3**	**8**	**9**	**13**	**15**	**10**
Question 25: Past - 5 years						
1st entry	1	1	5	4	2	5
2nd entry			2	3	4	5
3rd entry		1	2	2	3	1
4th entry		1		1	1	
Sum awarded	**1**	**3**	**9**	**10**	**10**	**11**
Question 26: Optimistic						
1st entry	2		2	3	6	2
2nd entry	1	1	3	7	4	2
3rd entry		2	1	3	2	
4th entry				2	1	
Sum awarded	**3**	**3**	**6**	**15**	**13**	**4**

In terms of the above table, grading in relation to present factors tends to have a more middle grading pattern than in the past, with middle grading also being a feature in terms of optimism.

QUESTIONS 27-30

Areas cited

No. of comments	Like to change present	Like to change past	Least like to change present	Least like to change past
1				
2	education, personality, independence	own health, leisure, behaviour, e.g. smoking	independence faith in God leisure	
3	housing	death of friend/relative	standard of living	living standards
4	environment	living standards		leisure activities childhood, work
5	friendship/ relationships	housing environment	work	
6	standard of living, work	work,childhood	housing	
7		relationships		
8	leisure activities	education		
9			family relationships	
10	own health/fit-ness		friendship	
11				
12				
13				
14				family/friends relationships

	Score awarded					
	1	**2**	**3**	**4**	**5**	**6**
Question 27: *Areas Like to Change (Now)*						
1st entry			3	6	6	5
2nd entry		4	1	2	3	4
3rd entry	1		2	4	3	1
4th entry					1	1
Sum awarded	**1**	**4**	**6**	**12**	**13**	**11**
Question 28: *Areas Least Like to Change (Now)*						
1st entry	4	1	1	3	5	2
2nd entry	3	3		2	4	2
3rd entry	1	2			1	
4th entry						
Sum awarded	**8**	**6**	**1**	**5**	**10**	**4**
Questions 29/30: *Like to Change (Past)*						
1st entry			3	1	7	3
2nd entry	1	3	2	7	3	3
3rd entry			3	1	1	1
4th entry			1			
Sum awarded	**1**	**1**	**9**	**9**	**11**	**7**
Questions 29/30: *Like to Change (Now)*						
1st entry	3	2	1	1	4	4
2nd entry	4	1	1	1	4	2
3rd entry	2	2	2			
4th entry						
Sum awarded	**9**	**5**	**4**	**2**	**8**	**6**

QUESTIONS 27/28/29/30

Overall, these questions attracted fewer comments, perhaps reflecting a level of difficulty in reflecting in this area.

Family relationships were given a key issue, however, it became a focus of least like to change both currently and in the past, and to a lesser extent a

desired area for change in the past. This duality is reflected in other questions where a family is seen as both a positive and negative contributor towards Happiness and Life Satisfaction. Work also features as an area of desired change both currently and in the past, together with standard of living.

Areas for change both currently and in the past attract a wider range of scoring, with least like to change being scored at the extremes.

APPENDIX 4: Pilot Q-sort Stage 4

Review of Results

STAGE 4

A 5-Item card Q-sort was administered to seven individuals as a pilot activity. Appendix 4:

1. reviews the results obtained from each card;
2. offers a summary of lessons learnt from the pilot.

CARD 1: Able to have Privacy

Description of Scores

This card was selected against all key concepts with Quality of Life having the highest number of selections i.e. seven, six of these giving a positive score and one negative, with the negative score being given by an individual who also rated it as a positive. Five selections were made in respect to both Happiness and Life Satisfaction, each with four positive and one negative, with the negative score again being given in conjunction with a positive. Health was a relatively low selection of four, three positive and one negative, again one individual selecting both positive and negative. Well-being had no divided scores, but attracted only two selections; both of these were at the highest point of the scale. Generally this card attracted the upper range of score across all five concepts, with a score of +5 being selected eleven times, a score of 4 six times, a 3 twice. Of the four negative scores this ranged from 5 to 3.

Summary of Related Comments

The notion that privacy reduced stress was found in terms of the concepts happiness, Health and Well-being, the notion that privacy would facilitate reflection and peace being attached to Quality of Life and Life Satisfaction, whilst the idea that it would allow an arena for freedom, meeting of own needs, and space for self was found for all concepts except Health.

CARD 2: Age

Description of Scores

This card was predominantly selected against three of the key concepts, namely: Quality of Life, Health, and Life Satisfaction. The card was selected against Well-being and Happiness, but with a low rate of selection, only three for the first and two for the latter. Six selections were made against Quality of Life, four of which were negative and only two positive, although two respondents selected against both. Five selections were made against both Health and Life Satisfaction. In respect of Health, age was mainly seen as negative, with only one individual giving a positive score in conjunction with a negative one, whilst in terms of Life Satisfaction, the reverse was true. Three of the five selections were positive, and only two were negative, one of which was made with a positive score. Scores awarded tended to be quite varied in respect to this card, with slightly higher scores being selected in terms of negative responses.

Summary of Related Comments

As a positive notion across all concepts was the idea that increased age facilitates maturity and an ability to view life and its problems in perspective and to place life's demands, both current and in the past, in balance. Similarly across all concepts in a negative way was the notion that age as it increased did pose a threat to physical and mental abilities and potentially reduced freedom options and a worry of dependence. In respect to Health this was mitigated by

the belief that an individual's own resources and mental outlook could enhance adaptation and coping, and hence limit the effects of ageing.

CARD 3: Active Social Life

Description of Scores

This card was not selected at all in respect to Health, but was chosen with four selections in terms of both Well-being and Life Satisfaction. Three selections only were made for this card against Quality of Life, with five selections made for the concept of Happiness. No negative scoring was given to this card against any key concept; when selected, the score was generally high in terms of a score of 4 or 5, although 2 and 3 were selected by one individual.

Summary of Related Comments

With the exception of the concept of Health, which attracted no score or comments, an active social life was seen as having some similarities of influence across all concepts. Principally that this allowed the mixing with others and as a result was an arena of support and sharing of life's worries and achievements. Equally it was seen as an opportunity to divert oneself from life's demands. In respect to Well-being and Life Satisfaction, however, comments did identify the need for a balance between company and being alone, with the search for constant company being seen as a negative activity, as an avoidance behaviour from the reality of life. The notion of personal enrichment and widening through both mixing and learning from others was a concept expressed in respect to Well-being and Quality of Life.

CARD 4: A Close Community

Description of Scores

This card attracted a greater selection of four in the areas of Happiness and Quality of Life. In all the other domains a selection of only two was made. In terms of Health and Happiness a negative score was given in conjunction with a positive one. The scores given for this card were generally in the upper range with three scores of 5, three scores of 4, and six scores of 3.

Summary of Selected Comments

The notion that a close community was a source of security, knowing someone was there at times of need, was expressed in respect to all concepts. Equally, community as an active source of support and help was identified as an influence in all concepts, whilst the notion of influence by being valued and recognised as an individual with such a community was evident in relation to Quality of Life, Well-being, Happiness and Life Satisfaction. Negative comments were expressed in relation to Happiness and Health in terms of emotional worry and apprehension imposed by the closeness of a community, and equally physical stress of such a close environment.

CARD 5: A Good Sex Life

Description of Scores

This card had a high level of selection against all concepts, with eight selections against Quality of Life, six for Happiness, Well-being and Life Satisfaction, with five selections for Health. Generally scores were positive, although against all concepts there was one negative selection, with the exception of Health; such selection was made in conjunction with a positive score. Quality of Life attracted scores within the positive range of 2-5, whilst in all other domains scores ranged from 3-5.

Summary of Related Comments

Across all concepts the notion of self value was identified together with the idea of support and closeness within a good sex life. The idea of time for each other and shutting out other demands and life problems also emerged in respect to Life Satisfaction, and arguably in respect to Quality of Life in terms of the concept of creativity. The notion of wholeness of life being achieved by a good sex life also was evident in terms of Well-being, Quality of Life, and Health. with this mirrored in both positive and negative comments.

CARD 6: Avoid Over Indulgence

Description of Scores

This card attracted relatively low rates of selection for Happiness (a selection of two) with a selection of three for Quality of Life and Health, concepts of Well-being and Happiness attracting four selections. Scores given were all within the positive scales with the exception of one negative score against Life Satisfaction, which was given in conjunction with a positive score. Scores tended to be across the range of scores from 1-5.

Summary of Related Comments

The notion that a balance and self control had an influence emerged in terms of Life Satisfaction and Quality of Life. Acknowledgement that such avoidance improved fitness and in consequence ability to follow life pursuits emerged in terms of Well-being, Happiness and Health.

CARD 7: Access to Transport

Description of Scores

This card attracted a fairly high level of selection, with seven selections against Quality of Life, five for Happiness and Life Satisfaction, and four for both

Health and Well-being. Scores awarded were all positive and tended to be within the upper range, with eight scores of 5, eight scores of 4 and eight scores of 3, and one score of 2.

Summary of Related Comments

Transport was clearly related to the notion of freedom and choice being enhanced and therefore an influence upon all concepts. It also was linked to the notion of security and reduction of worries at times of crisis in respect to Well-being, Health, Happiness and Quality of Life. Similarly it was seen as helping to reduce the worry and problems of other life demands if available, e.g. parenthood, in terms of Well-being, Health and Happiness. The ability to have autonomy and control was also seen as relevant to transport in terms of quality of life and Life Satisfaction. Some negative comments were expressed in respect to Health.

CARD 8: A Good Local Health Service

Description of Scores

This card attracted no selection for the concept of Life Satisfaction, with a selection of five in respect to Health, four selections for both Well-being and Quality of Life, and only one selection for Happiness. Two negative scores were given in terms of both Health and Quality of Life, with the latter being given in conjunction with a positive score. A relatively wide range of scores from 2-5 was given against the concepts of Health and Well-being.

Summary of Related Comments

The notion of security, knowing it was there at times of need as an influence was cited in terms of Well-being, Health and Happiness. The issue of locality was also relevant in respect to the above notion in terms of its immediacy at times of need. It also was an issue in terms of ability to have choice or influence upon the type of provision offered and was seen as an influence in terms of Quality of Life and Health.

CARD 9: Becoming a Parent

Description of Scores

This card had a high rate of selection against all concepts, the highest selection of eight being against Happiness, seven against Well-being and six against Life Satisfaction and Quality of Life and five for Health. Against all concepts both negative and positive scores were given, equal proportions of positive and negative scores being given against Life Satisfaction and Quality of Life, whilst Health attracted a higher rate of negative than positive scores. In terms of Life Satisfaction and Happiness, scores of 4 and 5 were the norm. In the other concepts a range of 3-5 positive scores were given. Negative scores had a wider range of scores in all concepts except for Life Satisfaction, when the range was limited to 2-1.

Summary of Related Comments

The notion of parenthood was viewed across all concepts as enriching, fulfilling and as a widening experience. Equally, in respect to Health and Happiness it was seen as an arena for balance and creativity against other life demands. Equally all concepts attracted negative comments relating to restriction and stress imposed by parenthood in addition to physical consequences such as tiredness.

CARD 10: Company of Others - To Avoid Loneliness

Description of Scores

This card attracted a fairly high rate of selection against all concepts. With seven selections against Qualify of Life, eight against Happiness, six against both Well-being and Life Satisfaction, and five for Health. Selection was predominantly against the positive range of scores, although there were negative scores for all of the concepts. In respect to Well-being, however, there

was an equal selection of positive and negative scores. The range of scores was wide-ranging for all concepts, although tended to be more concentrated in the upper range of 4 and 5+ for Life Satisfaction.

Summary of Related Comments

Across all concepts the notion of support and sharing emerged, together with the idea of relaxation and removal from life demands. The significance of a balance between being alone and in company emerged across all concepts, with the ability for an individual to be able to spend time alone in a state of reflection and inner peace being viewed as essential, whereas the seeking of company to avoid being alone was viewed as negative.

CARD 11: Diet

Description of Scores

This card attracted a high selection for the concepts of Health (with 10 selections) and Well-being (7 selections). Concepts of Quality of Life and Happiness both attracted three selections, with Life Satisfaction attracting two selections. With the exception of Quality of Life, all concepts had both positive and negative scores, the concept of Health having a higher selection of negative than positive scores. The range of scores across the concepts was quite wide, from a score of 2-5 positive and 4-1 negative.

Summary of Related Comments

The notion of control and balance emerged in respect to Life Satisfaction, Well-being and Health. The role of diet with social sharing as an influence emerged in respect to Life Satisfaction and Happiness and Health. One individual commented upon the influence of special dietary needs in terms of

Well-being, Health and Quality of Life. The notion of physical and mental energy and ability to cope with life demands being associated with diet emerged for the concepts of Well-being, Life Satisfaction, Health and Quality of Life.

CARD 12: Childhood

Description of Scores

This card attracted a high rate of selection for Happiness with seven selections. Four selections were made for the concepts of Well-being and Quality of Life, whilst the concepts of Health and Life Satisfaction had a low rate of selection, namely two for the former and only one for the latter. The concepts of Happiness, Quality of Life, and Well-being attracted both positive and negative scores. The highest range of positive scores occurred in relation to Happiness and Health, in which a positive score of 5 was given. Positive scores of 4, however, were given in all of the concepts, whilst low range positive scores of 1 and 2 were given in Quality of Life and Happiness. High range negative scores of 4 and 5 were given in relation to the concepts of Well-being and Happiness, whilst a low range of 1 and 2 negative scores was given in Quality of Life. In all cases of negative scoring there was an element of negative scores being given alone and negative scores being given in conjunction with positive ones.

Summary of Related Comments

The notion that childhood created problems for adult life and was therefore an influence emerged in respect of Life Satisfaction, Well-being, Health, Quality of Life, and Happiness; the concept of childhood having negative legacies was found in terms of Well-being, Happiness, and Quality of Life, and related to emotional aspects and values rather than physical ones.

CARD 13: Climate

Description of Scores

This card attracted selections in all concepts. A relatively high rate of selection occurred in Well-being (a selection of eight), and a selection of six in both Quality of Life and Health. The concept of Happiness had a low selection of three and the concept of Life Satisfaction only one. The concepts of Happiness and Well-being attracted a higher positive score than negative ones, whilst the concepts of Quality of Life and Health both attracted an equal proportion of positive and negative scores. Positive scores across all concepts ranged from 2.5 with the highest score selection being that of 3 with six selections of this score. Negative scores ranged form 5-3 with the highest score against being negative three, with six selections of this score.

Summary of Related Comments

The notion that climate influenced an individual's coping ability was identified in terms of Well-being; Health, Happiness, and Quality of Life. The notion that weather influenced physical abilities was similarly identified in terms of Well-being, Health and Quality of Life. Across all concepts climate was seen as having an emotional influence. The climate ability to influence disease states was identified by one individual in terms of Health and Well-being.

CARD 14: Death of a Friend

Description of Scores

The highest rate of selection of this card was against the concept of Happiness with a rate of seven, whilst the concept of Well-being attracted a rate of five, and a selection of one occurred in the concepts of Life Satisfaction, Quality of Life and Health. All selections were made within the negative range of scores, with the concept of Happiness attracting a slightly higher range of negative scoring that Well-being.

Summary of Related Comments

Across all concepts this was perceived as having physical and emotional influences, with loss of support being specifically identified in terms of Life Satisfaction, Well-being, Happiness and Quality of Life.

CARD 15: Death of a Relative

Description of Scores

As for Card 14 (Death of a Friend) the highest selection was against Happiness with a selection of eight and Well-being with a selection of four. Life Satisfaction achieved no selection, whilst the concepts of Health and Quality of Life attracted two selections. With the exception of Happiness, in which one positive score of 5 was given in conjunction with a negative one, all scores were within the negative range. Scoring was in the high range of negative scores with a total of seven scores of -5 being given and two scores of -4, although both -1 and -2 attracted two selections.

Summary of Related Comments

Again, in all concepts except Life Satisfaction, this was seen as having both physical and emotional influences. Emotional dimensions indicated loss of support (this also emerged in terms of Card 14 - Death of a Friend). In respect to this card emotional dimensions of regret for past conflicts was cited in terms of Quality of Life and Happiness and fears of own vulnerability for concept of Well-being. One individual did cite the notion of relief and benefit if a relative had been cared for and influence upon Health positively as a result.

CARD 16: Exercise

Description of Scores

This card was selected against all concepts, the highest rate of selection being against Health with five selections. Four selections were made against both Well-being and Quality of Life, with the concept of Happiness attracting three selections and only being selection being made against Life Satisfaction. Against all concepts (with the exception of Happiness where one negative choice was made in conjunction with a positive one) scoring was against the positive grades. A range of 1-5 positive scores were selected across the concepts.

Summary of Related Comments

The action of relaxation and expression as an influence was identified for concepts of Life Satisfaction, Well-being, Happiness and Quality of Life. Influence upon physical and mental coping ability was identified in terms of Well-being, Health, Happiness and Quality of Life.

CARD 17: Environment

Description of Scores

This card attracted selection against all concepts. The concepts of Well-being and Health attracted ten selections each, whilst six selections were made against Quality of Life, six against Happiness, and only two against Life Satisfaction. The concepts all attracted nearly half positive and negative scoring, predominantly in the upper range of 3-5.

Summary of Related Comments

The emotional impact of the environment was identified in respect to all concepts, with particular emphasis upon its potential for inner reflection, peace and recovery. Again, notions of environment influencing mental and physical

coping in other aspects of life emerged. Physical influences, particularly negative ones, were mentioned in terms of Well-being, Health and Quality of Life.

CARD 18: Employment

Description of Scores

This card attracted a high rate of selection against all concepts, with eight selections made for Well-being and Life Satisfaction, seven for Health and six for both Quality of Life and Happiness. Whilst the scores for all concepts was highest within the positive range, all attracted negative scoring. In respect to the concept of Health, a higher proportion of negative selections were made, namely three against four positive ones. Positive scoring was largely in the upper range for all concepts with seven scores of five and fifteen scores of four. Negative scores were generally in the mid-lower range of scores.

Summary of Related Comments

Emotional enrichment and influence was indicated across all five concepts with this including notions of interest, fulfilment and company of others. Negative aspects were indicated in terms of Quality of Life, Happiness and Well-being relating to effects upon these concepts of stress and boredom. Economic security and gain was mentioned as an influence in terms of Life Satisfaction, Well-being, Quality of Life, Happiness and Health, particularly in the context of allowing increased control and choices. The notion of self value and development through employment as an influence was identified in Life Satisfaction, Quality of Life and Happiness.

CARD 19: Education

Description of Scores

This card was selected against all concepts, with the concept of Quality of Life attracting seven selections, Happiness five selections, and the other concepts four selections. With the exception of Well-being, where a negative score was given in conjunction with a positive one, all scores were within the positive range. Positive scores were in the upper range of positive scores, with eleven selections of +5 and nine selections of +4.

Summary of Related Comments

The notion that education facilitated increased awareness and choice and there was an influence emerged in terms of Life Satisfaction, Health, Happiness and Quality of Life, whilst education as a source of self expression and confidence and hence enhanced control was found in Well-being, Quality of Life and Happiness. Education in terms of Life Satisfaction, Happiness and Quality of Life was also perceived as widening perspectives and interest and therefore an influence. One individual, however, did comment upon the potential frustration and dissatisfaction such perspective might raise and saw this as a negative influence upon Well-being.

CARD 20: First Home

Description of Scores

This card attracted selection against all concepts except that of Health. The selection rate was, however, relatively low with three selections for Life Satisfaction and Quality of Life and two selections for Happiness and Well-being. All selections were made within the positive range of scores and without exception in the upper range of 4 or 5. Indeed, in respect to the concept of Life Satisfaction, all scores awarded were within the range of +5.

Summary of Related Comments

This emerged as an influence upon Life Satisfaction, Well-being, Happiness and Quality of Life by the provision of a secure base, this providing an arena from which to escape after life demands, to develop oneself and meet own needs. The influence by the notion of independence was given in terms of Life Satisfaction and Quality of Life, the notion of an arena for memories and reflection was found.

CARD 21: Financial Prospects

Description of Scores

This card was selected against all concepts. The highest rate of selection was seven against both Quality of Life and Life Satisfaction. Happiness attracted five selections, Well-being four, and Health three selections. Selections were predominantly in the positive range of scores, although each concept also attracted negative scores. Positive scores were mainly awarded in the upper range of 3-5, whilst negative scores were within the range of 4-3.

Summary of Related Comments

This was seen in terms of a security and resulting influence across all concepts. In terms of Life Satisfaction, Health and Quality of Life, it was viewed as widening options and choices, whilst in respect to Well-being the notion of control was used. The notion of forward planning and resulting reduction of worry was cited an as influence against Life Satisfaction, Happiness, and Quality of Life. The negative effect of stress and worry arising from poor financial prospects were specifically cited against Health and Happiness.

CARD 22: Freedom

Description of Scores

This card attracted high selection against all concepts, the highest rate of eight being made against Happiness, and a selection of seven for both Life satisfaction and Quality of Life. Well-being attracted a selection of six, whilst the lowest rate of selection of four was made against the concept of Health. With the exception of one negative score made in conjunction with a positive one against Happiness, all scores were positive ones. Scores were predominantly in the upper range with twenty-two scores of five, and eight scores of four.

Summary of Related Comments

The notion of freedom and control was evident as an influence across all concepts, with this linked to the idea of following own needs and destiny. This was viewed across all concepts as important upon emotional and mental aspects. In respect to Quality of Life and happiness, removal of freedom was commented upon in terms of negative influence.

CARD 23: Free from the Threat of Nuclear War

Description of Scores

This care was selected against all concepts but at a relatively low level. the highest, a selection of five, was against the concept of Well-being, whilst the concept of Health attracted four selections. Three selections were made against both Quality of Life and Happiness, and two for Life Satisfaction. Both positive and negative selections were made for all concepts except Happiness in which only positive ones were made. When selections were made it tended to be against the upper range of scores.

Summary of Related Comments

This was largely viewed against two notions, the first in terms of own survival and continuity, and the second against the continuity of humanity in terms of own family. In respect to Well-being and Happiness, respondents did identify moments of concern occurring.

CARD 24: Friends

Description of Scores

With the exception of the concept of Health which attracted only two selections, this card had a fairly high rate of selection for all concepts. Both Quality of Life and Happiness attracted a selection rate of seven, whilst Well-being and Life Satisfaction attracted a selection rate of five. The concepts of Well-being and Happiness both attracted one negative score made in conjunction with a positive one. Positive scoring was within the upper range of 3-5, with three scores of three, seven scores of four, and fourteen scores of five.

Summary of Related Comments

Across all concepts this was seen as an influence in terms of a source of support and security and was cited in terms of advice upon Health. Similarly friends were seen as an influence upon Life Satisfaction, Quality of Life, and Happiness by way of diverting worries and attention from other problems. Influence by increased self-esteem and value was found in terms of Well-being, Happiness and Quality of Life, whilst negative influences through the demands of friendship and anxieties at failing to meet these was cited in terms of Well-being and Happiness.

CARD 25: Housing

Description of Scores

This card attracted a high rate of selection across all concepts, eight selections being made for Quality of Life and Health, whilst the concept of Well-being had seven selections, and six selections were made for both Life Satisfaction and Happiness. Equal proportions of negative and positive scores were given in terms of Life Satisfaction, Health, Happiness and Quality of Life, whilst scoring for Well-being had a positive ratio of five to two negative scores. For both positive and negative scores there was a wide range of selection, although ten scores of +5 were awarded across the concepts and three scores of +4, whilst a score of -3 was the most popular choice with seven selections of this.

Summary of Related Comments

Across all concepts this was seen as an influence in terms of being an arena for reflection and self-fulfilment, 'an emotional base', its role in providing security being cited against the concepts of Health and Well-being. Negative influences were cited in terms of Life Satisfaction, Quality of Life and Happiness in terms of both physical effects of poor housing, but also in terms of the stress and worry involved in maintaining adequate housing for self and family.

CARD 26: Ill-health of Others

Description of Scores

This card attracted all negative scoring with five selections being made against Health, three for both Well-being and Happiness, two for Quality of Life, and only one for Life Satisfaction. Minus five attracted four selections, whilst -4 had three selections, with five selections made of -3, and two of -2.

Summary of Related Comments

Across all concepts the emotional impact of another's ill-health and its negative consequences was cited. In respect of Quality of Life, Happiness, Well-being, Health and Life Satisfaction, the physical effects of caring for the sick was identified as an influence, whilst emotional implications of guilt and resentment was indicated as an influence upon Quality of Life and Happiness.

CARD 27: Isolation

Description of Scores

This card attracted a relatively high rate of selection for the concepts of Quality of Life and Life Satisfaction, with a selection rate of seven and six respectively. The remaining concepts all attracted a selection rate of four. Whilst scoring for all concepts was predominantly negative, all concepts did attract some positive scoring with the concept of Well-being attracting equal proportions. Negative scoring fell within the range of -5 to -2, the most popular score being -4 with six selections, whilst -5 attracted five selections, as did -3.

Summary of Related Comments

Across all the concepts the need and influence of a balance between company and isolation was identified. In this way isolation was not necessarily viewed as undesirable, but rather an opportunity for reflection, relaxation and recovery. Negative influences of isolation were cited in respect to Health, Happiness and Quality of Life in terms of reduced stimulation and interest leading potentially to depression.

CARD 28: Immediate Family

Description of Scores

This card was selected against all concepts, the highest rate of selection being that of six for Life Satisfaction, whilst Health attracted five selections. The concepts of Quality of Life and Happiness both attracted four selections with Well-being attracting three. Scoring was predominantly within the positive range, although negative scores were given for the concept of Happiness, Health and Life Satisfaction, the last two being given negative scores in conjunction with positive ones. Positive scores fell within the range of 3-5, with the most popular scores begin -4 with seven selections, and +5 with eight selections. Negative scores fell within the range of -4 to -2.

Summary of Related Comments

Across all concepts this was viewed in terms of the notions of mutual support and sharing. The influence of support upon feeling cared for and self value was identified against Quality of Life, Well-being, Life Satisfaction and Happiness. Negative influences by way of worry, demands and stress were cited against Happiness, Health, Well-being and Life Satisfaction.

CARD 29: Independence

Description of Scores

This card had a relatively high rate of selection across all concepts, the concept Quality of Life having seven selections, whilst Life Satisfaction and Happiness attracted six, Health attracted five selections, and Well-being the lowest of three. Scoring was all within the positive range of scores and within the upper range of +3 to +5, +3 attracting four selections, +4 six, and +5 seventeen.

Summary of Related Comments

The notion of choice, being oneself and control were linked to independence across all concepts. The loss of independence was cited as a particular issue in terms of Health, with dependence in others cited as a real fear and source of worry.

CARD 30: Keeping Warm

Description of Scores

This card had a high rate of selection for the concepts of Health and Well-being, attracting selection rates of six and five respectively. The remaining concepts, however, had a low rate of selection with two selections for both Life Satisfaction and Quality of Life and only one for Happiness. All scoring was within the positive range and predominantly within the mid to upper range with +3 having six selections, +4 four selections, and +5 four selections.

Summary of Related Comments

The mental and emotional influence of warm and cold respectively was cited across all concepts, with warmth being associated with relaxation, peace of mind and ability to concentrate and cope with demands. In respect to Well-being, the notion of feeling good about self and life was also cited, whilst conversely cold inhibited thought, ability to cope, and was seen as leading to depression in terms of Well-being, Quality of Life and Happiness.

CARD 31: Medical Check-Ups

Description of Scores

The concept for which this card was mainly selected was not surprisingly that of Health, with seven selections. The concept of Well-being attracted only two selections, and Quality of Life only one, whilst the concepts of Life Satisfaction and Happiness had no selections. All scores were, with the exception of one negative score for Health made in conjunction with a positive score, positive in range. Scores ranged from +2 to +5 but the most popular selection was +4, with six selections.

Summary of Related Comments

No comments were given in terms of Life Satisfaction or Happiness. Mental influences in terms of security and peace of mind as a result of check-ups were indicated against Well-being, Quality of Life and Health. Specific effects derived from early detection of physical problems was only mentioned against the concept of Health, although one person saw such detection as negative as generating further worry and anxiety.

CARD 32: Keeping Informed in order to Keep Healthy

Description of Scores

Whilst this card was selected against all concepts, it had a low rate of selection in each, the highest being Health with three selections. Quality of Life attracted two selections, whilst the remaining concepts only had one selection each. Positive scoring was given throughout with a score of +3 being selected three times, and +4 four times, although the range of scores was extended to +2 in respect to Life Satisfaction.

Summary of Related Comments

The notion of security and reduced worry was identified in respect to Well-being and Happiness and increased choice and control for Health and Quality of Life and Well-being, whilst a few individuals viewed this negatively in terms of Qualify of Life if such information-seeking became too important or as they saw it obsessional.

CARD 33: Leisure

Description of Scores

This card had a relatively high rate of selection across all concepts, Quality of Life having seven selections with the concepts of Life Satisfaction and Health both being given six selections, Happiness had five selections and Well-being four. Scoring was mainly within the positive range, although for Health and Quality of Life one negative score was given in conjunction with a positive score. Positive scores all fell within the range of 3-5, with +3 having seven selections, +4 eleven selections, and +5 eight selections.

Summary of Related Comments

The notion of reducing stress was identified against concepts of Life satisfaction, Well-being and Quality of Life, with this being linked to the notion of strength to carry on for the concepts of Well-being, Health and Happiness. Fulfilment and widening of self, e.g. self-expression, emerged against Happiness and Quality of Life, with the notion of recovery and seeing life in a balance was evident for Life Satisfaction, Well-being, Health and Happiness. Recognition of negative influences through an excess of relaxation and leisure was evident for Health and Quality of Life in terms of mental lethargy.

CARD 34: Love and Trusting Relationship

Description of Scores

This card had a high rate of selection for all concept except Well-being which attracted only three. In contrast Quality of Life had seven selections and the remaining concepts all had six selections. With the exception of one negative score for Health made in conjunction with a positive score, all scoring was within the positive range. Scoring fell between +3 and +5, with the most popular score being +5 with twenty-four selections.

Summary of Related Comments

This was viewed in terms of security and support within all concepts, whilst such relationship was also seen as enhancing self-value, with this being an influence upon Life Satisfaction, Well-being, Happiness and Quality of Life. Such support was seen as helping one to cope and influencing Well-being, Health and Life Satisfaction. an enhancement of life meaning was also cited in terms of Quality of Life and Happiness. Negative comments were given in respect to the demands and worry about the relationship and seen in the concepts of Life Satisfaction and Health.

CARD 35: Marital Status

Description of Scores

In contrast to Card 34 (Loving and Trusting Relationship) this card had a low rate of selection with a rate of four in respect to Life Satisfaction and Quality of Life, whilst Happiness had no selection and the concepts of Health and Well-being only one selection. This card also had a higher rate of negative scoring that Card 34, with an equal proportion of negative and positive scores occurring for both Life Satisfaction and Quality of Life, whilst the score for Health was within the negative range only. Both positive and negative scores fell within the 2-5 range.

Summary of Related Comments

This attracted negative comments across all concepts in respect to limitations/restrictions, this being in marked contrast to Card 34 (Loving and Trusting Relationship). It would seem that respondents generally viewed the concept of marital status in its legal role context, seeing it secondary to the nature of the relationship.

CARD 36: Medication

Description of Scores

Not surprisingly, this card was mainly selected against the concept of Health, with seven selections. Two selections were made against Well-being, and one only against Quality of Life. The concepts of happiness and Life Satisfaction had no selections. Whilst scoring was mainly within the positive range, the concepts of Health and Well-being attracted negative scores made in conjunction with positive scores. Positive scores fell within the range of 2-5, and negative within the range of 4-1, the score of +3 being selected on three occasions, and +4 twice.

Summary of Related Comments

No comments were given for Life Satisfaction or Happiness. Positive comments were given for the other concepts in terms of restoration and control of Health, whilst for the concept of Health negative influences were also perceived in terms of potential side-effects.

CARD 37: Not being Bored

Description of Scores

This card attracted five selections for the concepts of Life Satisfaction, Happiness and Quality of Life, whilst the concept of Well-being had only three selections and Health only one. All selections were made within the positive range of scores from +3 to +5, with +4 attracting ten selections, +5 five selections, and +3 four selections.

Summary of Related Comments

This card was viewed as having influence across all concepts in terms of purpose to life and desire to continue, active enrichment of life being given as a comment for Life Satisfaction, Happiness, and Quality of Life. Removal of stimulus and boredom was commented upon as contributing to mental depression against the concepts of Well-being, Health and Happiness, with such depression being seen as giving rise to ultimate physical illness in the concepts of Well-being and Health.

CARD 38: Not using Illegal Drugs

Description of Scores

Whilst this card was selected against all concepts, the rate of selection was low, Health having three selections, Happiness one selection, and the remaining concepts all having two selections. With the exception of Quality of Life, scoring was within the positive range, with +5 having four selections, +4 three selections, although the range of selections included +1 and 2.

Summary of Related Comments

This was seen in all concepts in terms of self control and ability to influence own life and self worth. Resulting physical ill-health from usage was reflected in Health, with mental health appearing in Health and Happiness.

CARD 39: Own Ill-health

Description of Scores

With the exception of Health which attracted six selections, all of the other concepts fell within the mid selection range of three or four, with Quality of Life and Well-being each having four, and Happiness and Life Satisfaction three. All scores fell within the negative range from -3 to -5, with the latter attracting ten selections.

Summary of Related Comments

The notion of worry, threat and powerlessness appeared in all concepts, whilst reduction of choices and options was indicated in Quality of Life, Happiness, and Life Satisfaction. Dependency upon others as a particular fear was indicated in Health, Well-being and Life Satisfaction, and expressed in terms of a reduction in ability to cope in the concepts of Well-being and Quality of Life.

CARD 40: Parenthood

Description of Scores

This card was selected at a fairly high rate across all concepts. The concept of Life Satisfaction had the highest rate of selection of eight, followed by a selection rate of seven for Happiness, six for Quality of Life, five for Health, and four for the concept of Well-being. All concepts attracted both positive and negative scoring, with this being in equal proportions for the concepts of Life

Satisfaction, Well-being, and Quality of Life, whilst the concept of Health attracted a slightly higher rate of negative scores and Happiness slightly higher positive scores. The range of positive scores was within the mid upper level, with a score of +3 being selected on two occasions, +4 seven occasions, and +5 on seven occasions. Negative scoring, however, was across the -1 to -5 score.

Summary of Related Comments

This was viewed in positive terms across all concepts, particularly in respect to influencing one's sense of achievement and fulfilment. Parenthood as a source of creativity and learning was indicated in the concepts of Happiness and Quality of Life, whilst this was viewed as a source of relaxation and diversion from other life concerns in respect to Health and Well-being. Negative comments were also evident across all concepts relating to worry and stress and restriction of freedom and choices. In addition, in relation to the concepts of Health and happiness, physical ill effects and influences were mentioned, e.g. tiredness.

CARD 41: Pollution

Description of Scores

This card attracted a high rate of scoring in respect to the concepts of Health and Quality of Life, with each having seven selections. The other concepts, however, had a fairly low rate of selection, with Well-being having four selections, Happiness three, and Life Satisfaction one. All concepts had negative scoring with the exception of one positive score in conjunction with a negative one for Quality of Life. The score range was widespread from -5 to -2, although -5 had ten selections.

Summary of Related Comments

Negative comments were given across all concepts with physical influences being cited against the concepts of Well-being, Health and Quality of Life, mental ill effects in terms of disturbed aesthetic and rest needs were given

against Life Satisfaction, Quality of Life and Happiness. Active concern about pollution was cited as an influence upon Life Satisfaction, Well-being, Health, Happiness and Quality of Life.

CARD 42: Personality

Description of Scores

This card scored highly within all concepts with Life Satisfaction being selected eleven times, Happiness ten, Quality of Life nine, and Health and Well-being both having six selections. All concepts had both positive and negative scores with positive scores being in the higher range than negatives. For all concepts the rate of negative scoring equalled and exceeded that of positive scores.

Summary of Related Comments

Across all concepts this was seen as an influence particularly in that personality was viewed as affecting one's ability to cope with life demands, this being expressed in terms of ability to achieve a balance for the concepts of Life Satisfaction and Happiness, whilst it was viewed as influencing expectations and outlook for concepts of Well-being, Life Satisfaction, Happiness and Quality of Life. Personality was cited as having a relationship with stress in concepts of Life Satisfaction and Health.

CARD 43: Relatives

Description of Scores

This card attracted fairly high rates of selection for the concept of Life Satisfaction and Quality of Life, with selection rates of six and five respectively, whilst the concepts of Happiness and Health both attracted four selections, with the concept of Well-being having only one selection. All concepts attracted both positive and negative scores. The range of positive scores was more

widespread than negative ones, ranging from +2 to +5, whilst negative scores were limited to the range of -5 to -3.

Summary of Related Comments

The notions of support sharing and closeness were cited as relevant in terms of Life Satisfaction, Happiness and Quality of Life. Negative comments in terms of conflict, demands and effect of caring for relatives were seen as an influence upon Life Satisfaction, Well-being, Health and Happiness.

CARD 44: Retirement

Description of Scores

This card had a fairly high rate of selection across all concepts, with the concepts of Quality of Life, Life Satisfaction and Health each having six selections, whilst the concept of Happiness had five selections and Well-being four. Whilst scoring was largely positive, all concepts with the exception of Happiness had one negative score. The range of scoring was largely in the higher range, with +5 attracting twenty-three selections, +4 five selections, and one selection only for +3 and +1.

Summary of Related Comments

Negative influences by way of isolation, loss of interest to goals and self value were expressed against all concepts. Positive comments were also expressed against all concepts, particularly in relation to the actions of increased freedom, time for self and interests. Reduction of stress was cited against the concept of Health and financial loss reducing choices against Life Satisfaction.

CARD 45: Rest and Sleep

Description of Scores

With the exception of the concept Life Satisfaction which had only three selections, this card had a fairly good rate of selection across all concepts, Health and Well-being both attracting seven selections, and the concepts of Happiness and Quality of Life six each. Each concept had both positive and negative scores, with positive ones being in a high range of +3 to +5, whilst negative scores ranged from -4 to -2. The most popular score was +4, with ten selections.

Summary of Related Comments

This was viewed against the notion of helping one to cope for all concepts. It was viewed as influencing resistance to illness and recovery in terms of Health, whilst mental serenity and peace of mind was indicated for the concepts of Well-being and Happiness. Derived pleasure was indicated as being influenced by lost sleep against the concepts of Well-being and Happiness. Lack of sleep and rest was seen as affecting behaviour, particularly concentration, in terms of Health and Quality of Life.

CARD 46: Safe from Accident

Description of Scores

This card had generally a poor rate of selection. With respect to the concept of Health, five selections were made, three selections in relation to Life Satisfaction and Quality of Life and two for Well-being, whilst Happiness had only one selection. All scores were within the positive scale, ranging from +2 to +5.

Summary of Related Comments

This attracted no comments against the concept of Happiness, with notion of peace of mind being reflected in concept of Life Satisfaction and Well-being, whilst security was indicated in all concepts.

CARD 47: Self-Esteem

Description of Scores

This card had a good rate of selection for the concepts of Happiness and Quality of Life, each attracting seven selections; Life Satisfaction attracted six selections, and the concepts of Health and Well-being each had four selections. With the exception of Health each concept attracted both positive and negative scoring, although positive scores were more favoured. The range of both positive and negative scores fell within the upper range of 3-5, with +5 having ten selections - the greatest number.

Summary of Related Comments

This was viewed against the notion that view of self and value of self influenced view and value of one's life and the world for concepts of Life Satisfaction, Happiness and Quality of Life. In addition self-esteem was viewed in terms of one's interest and ability to carry on or meet new demands for the concepts of Life Satisfaction, Well-being, Health, Quality of Life, and Happiness. Relationship between low self-esteem, poor mental health and subsequent physical neglect was expressed in concepts of Health. Interestingly the notion that some self doubt was inevitable and to that extent need not disrupt one's Quality of Life was also cited and similarly against Happiness, although the power of disruption was acknowledged here.

CARD 48: Social Change

Description of Scores

The rate of selection across all concepts had little variation with Health and Life Satisfaction each having five selections, and all the other concepts four. Scoring was predominantly within the negative range from -5 to 1. Positive selection, except in respect to Health and Life Satisfaction, was always made in conjunction with a negative one. Positive scoring had a narrower range from +3 to +5.

Summary of Related Comments

Positive influences in terms of increased contact and options was cited against all concepts with particular implications for women being given in terms of Well-being, Health, Happiness and Quality of Life. Negative influences were also commented upon for all concepts against the notions of insecurity, lack of control and influence and disharmony. The relationship of this to stress and impact upon Health was also cited, whilst its impact upon self worth was commented upon in terms of Life Satisfaction and Happiness.

CARD 49: Spiritual Beliefs

Description of Scores

The highest rate of selection, six, was in respect to Quality of Life, whilst Life Satisfaction attracted five selections in relation to this card. Other concepts had a poor rate of selection with Happiness and Well-being each having two and Health only one. Concepts of Life Satisfaction, Well-being, and Quality of Life all had negative and positive scores. Positive scores in respect to the highest selected concepts of Life Satisfaction and Quality of Life ranged from +1 to +5 with a high level of joint + and - scoring.

Summary of Related Comments

For the concepts of Life Satisfaction and Well-being this was seen against the notion of enhanced life purpose and balance, whilst for Happiness and Well-being it was expressed in terms of understanding meaning and perspectives upon life. Conflict of alternative teachings and wishes were commented upon in terms of negative influences upon Life Satisfaction and Quality of Life.

CARD 50: Unemployment

Description of Scores

With the exception of Life Satisfaction, this card attracted selection for all concepts, Quality of Life and Happiness each having six selections, whilst Health and Happiness had four and three selections respectively. All scoring was within the negative range and within the upper limits of -5 to -3, with -5 attracting twelve selections. This is in contrast to the largely positive scoring and selection pattern of Card 44 (Retirement).

Summary of Related Comments

Loss of control was given as an influence in terms of Life Satisfaction, Well-being and Quality of Life, whilst the notion of lost purpose was used against Happiness, Health and Quality of Life. Insecurity and worry was seen as important in terms of Quality of Life and Health, whilst a loss of self worth was cited in Life Satisfaction and Well-being and Health. Only Life Satisfaction attracted any positive influence in terms of time for own interests.

CARD 51: Travel

Description of Scores

For the concepts of Quality of Life, Happiness and Life Satisfaction, this card had a fairly high rate of selection with rates of seven, six and five respectively, whilst Health attracted only three selections and Well-being only two. Scoring for Happiness and Quality of Life was all positive, whilst for Life Satisfaction, it was largely negative. Both positive and negative scoring fell within the upper ranges of three to five.

Summary of Related Comments

The notion of freedom in relation to travel was evident against Well-being, Health and Happiness, whilst a notion of development and enrichment through travel was seen as relevant to Life Satisfaction, Well-being, Quality of Life and Happiness. Notions of stress reduction and relaxation emerged against Health and Life Satisfaction and Well-being. Negative influences in terms of physical effects of travel were cited against Health and mental dissatisfaction for Life Satisfaction.

SUMMARY - Lessons Learnt and Implications for the Main Survey

In summary the pilot exercise proved beneficial in that it:

1. Affirmed the potential value of Q-sort methodoloty in respect of this investigation.

2. It allowed the Q-sort procedure to be operationalised and confirmed as appropriate in practice rather than a more theoretical perspective.

3. It indicated that it was possible for Q-sort to be used meaningfully by the lay population against the five key concepts of health, well-being, happiness, life satisfaction and quality of life. Indeed, four of the seven respondents commented specifically upon the level of enjoyment and interest they had achieved with the Q-sort procedure.

4. It facilitated minor modifications to be made before the main survey in that:

    a. The Q-card with the item 'a good sex life' was identified as being better placed last - i.e. as Card 52, due to the potential sensitivity of the card and the value accordingly of using maximum time available to establish a rapport between interviewer and respondent.

    b. Omission of cards number 38 'Not Using Illegal Drugs' and number 23 'Free from Threat of Nuclear War' due to their poor performance and acceptability within the pilot.
    c. Re-phrasing of card number 37 to read simply 'boredom' rather than 'not being bored'.

5. It facilitated early consideration of approaches to data analysis and identification of possible data volume.

APPENDIX 5: Main Q-sort Supplementary information

PREFACE

This provides additional information concerning the data obtained from the main Q survey.

Each card is reviewed against the following framework:

1. Total number of respondents and related percentage of some who selected the card against each of the key concepts of Health (HE), Happiness (HA), Well-being (WB), Life Satisfaction (LS), and Quality of Life (QL).

2. The pattern of selection and grading against -5 to +5 and in respect of each of the key concepts.

3. The percentage of negative and positive grading for the key concepts derived from those respondents who selected the relevant Q-card.

4. A commentary upon the qualitative comments provided by the respondents for each Q-card in relation to the five concepts. It should be noted that the emerging key words used to analyse the emerging themes within the comments were found to be similar to those within the pilot exercise. Accordingly the discussion has been limited to reflecting upon the comments in terms of emerging themes' levels of similarity to the pilot with identification of any differences found, with the commentary supported by selection of exemplar comments.

INTRODUCTION

The intention is to review each Q-card and its related pattern of selection against both a positive and negative grading, together with the associated qualitative based comments offered by respondents in support of their selection. Accordingly, this data served as a basis for further analysis and consideration towards the emerging 'model' and conclusions. In each instance the following abbreviations apply:

Happiness	= HA
Health	= HE
Life Satisfaction	= LS
Quality of Life	= QL
Well-being	= WB

Q-Card Title: Able to Have Privacy (Coded Card No. 1)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	10 respondents	15.6%
HA	=	16 respondents	25%
WB	=	5 respondents	23.4%
LS	=	7 respondents	10.9%
QL	=	23 respondents	35.9%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE							1	4	2	3
HA						2		5	5	5
WB		1				1	3	4	2	4
LS			1						5	1
QL						3	2	6	6	6

Percentage Pattern of Positive & Negative Selection

Positive	HE	14.3%	Negative	HE	x
	HA	24.3%		HA	x
	WB	20%		WB	50%
	LS	8.6%		LS	50%
	QL	32.9%		QL	x

Supportive Comments (key words)

Health	Be yourself, Peace, Recuperation
Happiness	Affect State of Mind, Rest & Relax at Peace, Less Stress
Wellbeing	Well, Freedom, Think about me and what I need, No interference
Life Satisfaction	Peace, A State of Mind
Quality of Life	Freedom, Space for Self, Do what I like

Comments

Privacy, therefore, appeared to have meaning across all concepts. Reflective comments indicated notions of space, stress reduction, peace and meeting of own needs. Accordingly, such comments were not dissimilar to those identified within the pilot exercise.

Q-Card Title: Age (Coded Card No. 2)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	38 respondents	59.4%
HA	=	2 respondents	3.1%
WB	=	2 respondents	3.1%
LS	=	4 respondents	6.3%
QL	=	8 respondents	12.5%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	1	1	4	1	2		3	5	10	11
HA	1		1							
WB						1				1
LS				1	1			1		1
QL		1	1	1		1	1	2	1	1

Percentage Pattern of Positive & Negative Selection

Positive	HE	[illegible]	Negative	HE	56.3%
	HA			HA	12.5%
	WB	5.3%		WB	
	LS	5.3%		LS	12.5%
	QL	13.2%		QL	18.8%

Supportive Commentary

Health	Be yourself; Peace; Recuperation
Happiness	Affect State of Mind; Rest & Relax at Peace; Less Stress
Wellbeing	Well; Freedom; Think about me and what I need; No Interference
Life Satisfaction	Peace; A State of Mind
Quality of Life	Freedom; Space for Self; Do what I like

Comments

Age was perceived similarly to that in the pilot exercise in as much as there seemed to exist a tension between the benefits of age upon life perspective and the potential threats of reduced activity and ill-health. There was also reference to the way in which age is perceived by self and others and affects interaction with others and status in society, a potential influence upon Quality of Life particularly.

Q-Card Title: Active Social Life (Coded Card No. 3)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	2 respondents	3.1%
HA	=	27 respondents	42.2%
WB	=	7 respondents	10.9%
LS	=	15 respondents	23.4%
QL	=	22 respondents	34.8%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE								1	1	
HA							5	4	10	8
WB						1	2		3	1
LS						2	2	4	4	3
QL						1	3	7	7	4

Percentage Pattern of Positive & Negative Selection

Positive	HE	2.7%	Negative	HE	Not selected
	HA	37%		HA	Not selected
	WB	9.6%		WB	Not selected
	LS	20.5%		LS	Not selected
	QL	30.1%		QL	Not selected

Supportive Commentary

Health	Benefit because you're active and mixing with others, so relaxed, but can work both ways, become too tired. Support from others; Reduces worries for a time
Happiness	Affects my happiness in both ways - if too active, yearn for peace and to be by myself; Help you feel you belong; Divert from problems
Wellbeing	I would benefit from this; Frustrated by demands of family; Feel closed in, need to share with others
Life Satisfaction	Uplifting; Forget worries for a time
Quality of Life	Feel better, warmer, more fulfilled mixing and relaxing with others. Family life can restrict my social life and reduce my quality of life

Comments

Again, qualitative comments were not too dissimilar from those within the pilot, although a view point upon social life and health was now offered. The comments suggested notion of relaxation, reduction of worry, support sharing and fulfilment. Nevertheless, the need for balance between social life and individual privacy was highlighted with acknowledgement of the potential restriction imposed by family demands and how this might lead to frustration and lack of personal enrichment.

Q-Card Title: A Close Community (Coded Card No. 4)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	11 respondents	17.2%
HA	=	12 respondents	18.6%
WB	=	9 respondents	14.1%
LS	=	6 respondents	9.4%
QL	=	16 respondents	25%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE						2	4		3	2
HA								4	4	4
*WB						1	1	5	2	
LS							2	1	2	1
QL					2	3	2	5	3	1

*One further respondent selected the card and gave both a negative and positive score, omitted for this purpose.

Percentage Pattern of Positive & Negative Selection

Positive	HE	21.2%	Negative	HE	Not selected
	HA	23.1%		HA	Not selected
	WB	17.3%		WB	Not selected
	LS	11.5%		LS	Not selected
	QL	26.9%		QL	100%

Supportive Commentary

Health	Helpful at times of crisis; Reduces worry knowing there is help near
Happiness	Don't feel along, as if I belong and others care; Security and self value
Wellbeing	Nice to know someone is there in an emergency
Life Satisfaction	Need a support system; A sense of roots and belonging
Quality of Life	I don't have a sense of community, I know no-one and feel isolated and vulnerable. Sharing with others an identity enhances my life

Comments

Again, the comments are reflective of those within the pilot with key concepts of help and security offered by community being important, particularly at crisis periods, with such support either being actual or simply knowing someone was there in case of need. A further dimension, however, was the notion of roots/belonging and self-identity through membership of the community influencing self-worth and life quality.

Q-Card Title: A Good Sex Life (Coded Card, Pilot Study No. 5, re-coded 52 for main study)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	5 respondents	7.8%
HA	=	44 respondents	65.7%
WB	=	7 respondents	10.9%
LS	=	4 respondents	6.3%
QL	=	7 respondents	10.9%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE									1	4
HA								8	10	26
WB						1	1		4	1
LS								1	2	1
QL							1	1	3	2

*Two further respondents selected this card grading it both positively and negatively, omitted for this purpose.

**One further respondent selected this card grading it both positively and negatively, omitted for this purpose.

Percentage Pattern of Positive & Negative Selection

Positive	HE	7.5%	Negative	Not selected
	HA	65.7%		
	WB	10.4%		
	LS	6%		
	QL	10.4%		

Supportive Commentary

This card was located later in order than in the pilot exercise. Despite this, however, the nature of the comments remained largely unchanged, with the same themes emerging against the five concepts. Namely, support and emotional closeness, time for each other with this reducing other worries and concerns, improved self-worth.

The negative perspectives again emerging from perceived lack of closeness and comfort but also on two occasions from potential conflict arising in this area affecting Happiness and Life Satisfaction. The acceptance of conflict not emerging with the pilot exercise; "It can lead to rows and unhappiness and guilt". One respondent also highlighted a further element not considered in the pilot, that of different sexual needs within the life span; "Difficult needs vary at different times of your life."

Q-Card Title: Avoiding Over Indulgence (Coded Card No. 6)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	50 respondents	78.1%
HA	=	3 respondents	4.7%
WB	=	1 respondents	1.6%
LS	=	4 respondents	6.3%
QL	=	2 respondents	3.1%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	1		2	1	1	7	4	9	7	18
HA			1					1		1
WB								1		
LS				1				3		1
QL							1		1	

Percentage Pattern of Positive & Negative Selection

Positive	HE	83.3%	Negative	HE	71.4%
	HA	3.7%		HA	14.3%
	WB	1.9%		WB	x
	LS	7.4%		LS	14.3%
	QL	3.7%		QL	x

Supportive Commentary

Health — This attracted most comments with notion of fitness, body hormones and balance, and ability to follow normal social roles with reference to self control and willpower, mind over matter as a key influence

Happiness — Brief comments were made in respect to Life Satisfaction with total abstinence of good food/alcohol etc. perceived as reducing Life Satisfaction due to the constant rigour or demand imposed by self control and restriction and that such activities were often associated with a social activity or discourse which increased Happiness and Life Satisfaction

Q-Card Title: Access to Transport (Coded Card No. 7)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	2 respondents	3.1%
HA	=	13 respondents	20.3%
WB	=	4 respondents	6.3%
LS	=	6 respondents	9.4%
QL	=	38 respondents	59.3%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE				1						1
HA							1	2	4	6
WB						1	1		2	
LS				1				3	2	
QL		1			1	4	4	4	11	13

Percentage Pattern of Positive & Negative Selection

Positive	HE	1.7%	Negative	HE	25%
	HA	22%		HA	
	WB	6.8%		WB	
	LS	8.5%		LS	25%
	QL	61%		QL	50%

Supportive Commentary

This card really only attracted comments to any great extent against the concepts of Quality of Life and Happiness, with these reflecting similar perspectives to each other and indeed those expressed within the pilot exercise. Namely, notions of freedom, ability to get around and pursue own interests and activities easily, independence. Indeed three respondents identified they felt a car was all important and indispensable to their Quality of Life and ability to fulfil the demands of everyday life.

Q-Card Title: A Good Local Health Service (Coded Card No. 8)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	45 respondents	70.3%
HA	=	2 respondents	3.1%
WB	=	14 respondents	21.9%
LS	=	2 respondents	3.1%
QL	=	12 respondents	18.8%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE							3	6	11	25
HA								2		
WB							1	3	5	5
LS								1		1
QL						1	1	4	2	4

Percentage Pattern of Positive & Negative Selection

Positive	HE	60%	Negative	No selection made
	HA	2%		
	WB	14%		
	LS	2%		
	QL	12%		

Supportive Commentary

This card attracted few supportive comments of any diversity. The key ideas expressed focused against issues of hlepfulness and security of knowing help was there at times ofneed, and issues of ease of access and use if provided locally with these reflecting those in the pilot exercise, the ideas being located primarily against the concept of Health itself and Quality of Life.

Q-Card Title: Becoming a Parent (Coded Card No. 9)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	5 respondents	7.8%
HA	=	46 respondents*	71.9%
WB	=	4 respondents	6.3%
LS	=	21 respondents	32.8%
QL	=	7 respondents	10.9%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	1		2						1	
HA	2	1				1	1	6	11	24
WB	1						1	2		
LS	1		1					1	2	16
QL	1			1					3	2

*One respondent selected both a positive and a negative score, omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	2.8%	Negative	HE	27.3%
	HA	59.7%		HA	27.3%
	WB	4.2%		WB	9.1%
	LS	26.4%		LS	18.2%
	QL	6.9%		QL	18.2%

Supportive Commentary

These comments reflected similar ideas and tension that were explored within the pilot exercise, with acceptance of enrichment, fulfilment and sense of achievement in becoming a parent, but also the anxiety, stress and restriction upon own needs and lifestyle that was also a feature of parenting, this view being located against the key concepts of Happiness, Life Satisfaction and Quality of Life predominantly. The physical effects of birth referred to in the pilot were not highlighted by any respondent in the main survey.

Example of key words/comments:-

"Sometimes my family holds me back"

"I feel I achieved something worthwhile"

"I get a lot of enjoyment and satisfaction, but worry as well"

"It's hard to adjust and achieve a balance, and you worry about doing it right"

Q-Card Title: Company of Others (Coded Card No. 10)

(Note - To avoid loneliness omitted from card in main study)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	1 respondents	1.6%
HA	=	31 respondents	48.4%
WB	=	17 respondents	26.6%
LS	=	12 respondents	18.6%
QL	=	7 respondents	10.9%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE							1			
HA					1		1	7	14	8
WB						3	3	4	3	4
LS							2	2	4	4
QL							2		3	2

Percentage Pattern of Positive & Negative Selection

Positive	HE	1.5%	Negative	HA 100%
	HA	44.8%		Only selection made
	WB	25.4%		
	LS	17.9%		
	QL	10.4%		

Supportive Commentary

Across all of the key concepts, the supportive comments were of a similar nature and indeed reflective of those found within the pilot exercise. Key ideas focused upon the value of company in providing a source of support, diversion from anxieties and personal comfort and enrichment. Nevertheless, the need for periods alone for peace and reflection was also seen as necessary and beneficial. The absence of others' company, however, was seen as detrimental to the individual, and resulting in isolation and loneliness or a sense of loss; "My friends have mostly gone now, no-one to share or understand and who has lived through the same times and experiences as me", with such isolation perceived as detrimental to Health as well as Happiness, Well-being, and Quality of Life.

Q-Card Title: Diet (Coded Card No. 11)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	4 respondents	73.4%
HA	=	4 respondents	6.3%
WB	=	7 respondents	10.9%
LS	=	3 respondents	4.7%
QL	=	8 respondents	12.5%

*One further respondent selected the card and gave a positive and negative selection score, omitted for this purpose.

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE		1		2		6	7	2	13	15
HA						1			2	1
WB							1	3	1	2
LS								1	1	1
QL							3	3		2

Percentage Pattern of Positive & Negative Selection

Positive	HE	66.2%	Negative	HE 100%
	HA	6.2%		No Other Selected
	WB	10.8%		
	LS	4.6%		
	QL	12.3%		

Supportive Commentary

Supportive comments largely focused upon issues of Health and Quality of Life, and again reflected views expressed within the pilot exercise. Diet was seen as important in terms of physical health and balance with anxieties about potential effects of being overweight, although two respondents indicated they felt too much emphasis was given to diet control; "Too much talk about it". The relationship between income and diet was acknowledged; "Can't eat what I want on a pension". In addition there was the consideration of the social context to diet/eating, i.e. relax and mix with others over a special meal.

Q-Card Title: Childhood (Coded Card No. 12)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	5 respondents	7.8%
HA	=	37 respondents	57.8%
WB	=	9 respondents	14.1%
LS	=	12 respondents	18.8%
QL	=	4 respondents	6.3%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE		1				1		1		2
HA	2					2	2	6	10	15
WB		1		1			1	1	3	2
LS	1	1					1	2	3	4
QL	1		1					1		1

*One further respondent selected this card and gave a positive and negative selection, grade omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	6.9%	Negative	HE	11.1%
	HA	60.3%		HA	22.2%
	WB	12.1%		WB	22.2%
	LS	17.2%		LS	22.2%
	QL	3.4%		QL	22.2%

Supportive Commentary

Again, there was considerable similarity in the key words identified within the pilot exercise, with childhood emerging as both a positive and negative influence upon the key concept. Positive comments indicated childhood as being a happy period to look back upon, a time during which key adult beliefs and values were established with these enduring into current behaviours and perceptions; "It influences how I am a parent now", "I learnt good habits I still stick to". In some instances childhood was giewed as a golden age for ever last; "Wasn't life satisfying", "Kids today don't have the same childhood, they're not the same". For some respondents, however, it was seen as a negative influence which still endures; "Painful, too much regret", "Not too happy incluences my relationship with my parents and family now".

Q-Card Title: Climate (Coded Card No. 13)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	20 respondents	31.6%
HA	=	7 respondents	10.9%
*WB	=	17 respondents	26.6%
LS	=	6 respondents	9.4%
**QL	=	11 respondents	17.2%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	3	1	2				3	2	5	4
HA	1				1		1	1	2	1
WB	1		2		1	5	1	5	1	
LS						1		2	2	1
QL			1	1		2	2	4	1	

*One further respondent selected this card and gave a positive and negative selection, grade omitted for this purpose

** = Three further respondents

Percentage Pattern of Positive & Negative Selection

Positive	HE	29.8%	Negative	HE	42.9%
	HA	10.6%		HA	14.3%
	WB	27.7%		WB	28.6%
	LS	12.8%		LS	\
	QL	19.1%		QL	14.3%

Supportive Commentary

The majority of comments were offered against Health, Well-being and Quality of Life, reflecting viewpoints and key words identified within the pilot exercise. The climate was seen as an influence upon physical health in terms of fitness and energy in addition to mental health and well-being affecting mood, how life was viewed and general optimism perspective upon life; "Happier in a warm place", "Function better in the sun", "Irritable and discontent with no energy in the heat", "More relaxed, able to cope if sunny", "Cold weather affects my hips, not able to get about, painful, less happy, poor quality to my life".

Q-Card Title: Death of a Friend (Coded Card No. 14)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	10 respondents	15.6%
HA	=	37 respondents	57.8%
WB	=	15 respondents	23.4%
LS	=	- respondents	
QL	=	7 respondents	10.9%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	7		1	1						
HA	20	7	2	1		1				
WB	7	3	2	1			1		1	2
LS									2	
QL	5		2							

Percentage Pattern of Positive & Negative Selection

Positive	HE	14.3%	Negative	HE	14.5%
	HA	57.1%		HA	53.2%
	WB	x		WB	21%
	LS	x		LS	x
	QL	28.6%		QL	11.3%

Supportive Commentary

The largest number of comments were made in respect of Happiness and Life Satisfaction, and both embraced notions of loss, grief and influence upon one's own sense of vulnerability. The loss or reduction of support gained previously from the friend was also referred to, particularly in the context of Quality of Life and Well-being. Examples of such statements include: "Miss the sharing and friendship he gave me", "Made me think about my own lifespan", "I was so distressed a gap was left".

In the context of Health, its effects was attributed to the detrimental aspects of the depression and grief upon both physical and emotional dimensions of Health.

The supportive statements, therefore, did reflect the key words/comments found within the pilot exercise.

Q-Card Title: Death of a Relative (Coded Card No. 15)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	20 respondents	31.3%
HA	=	34 respondents	53.1%
WB	=	12 respondents	18.8%
LS	=	1 respondents	1.6%
QL	=	6 respondents	9.4%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	15	1	1					1		2
HA	24	4		1	1				1	3
WB	8	1		1					1	1
LS	1									
QL	4	1	1							

Percentage Pattern of Positive & Negative Selection

Positive	HE	33.3%	Negative	HE	26.6%
	HA	44.4%		HA	46.9%
	WB	22.2%		WB	15.6%
	LS			LS	1.6%
	QL			QL	9.4%

Supportive Commentary

The supportive comments perhaps not surprisingly had a high level of similarity to those of Card 14 "Death of a Friend", although two additional aspects emerged. Firstly, the notion of regret with this also found in the pilot exercise, with the regret derived from things left unsaid or relationship that had been allowed to continue in disharmony: "Later we were not close. I regret this, but it's too late now", "I didn't have a chance at the end to say what I wanted".

Alternatively, regret derived from death inhibiting witnessing of a forthcoming important event for the family, such as a wedding or birth.

The second factor was the acceptance that the death had a positive dimension due to the removal of suffering or the burden of caring: "It was both in the end, it was a strain caring for her".

Q-Card Title: Exercise (Coded Card No. 16)

No. of Respondents selecting this card against the key concepts/% of P Sample

*HE	=	46 respondents	71.9%
HA	=	1 respondents	1.6%
WB	=	10 respondents	15.6%
LS	=	4 respondents	6.3%
*QL	=	5 respondents	7.8%

*One further respondent selected this card and gave a positive and negative score, omitted for this purpose

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	1		2		3	3	7	8	4	13
HA										1
WB			2			1		5	1	1
LS							1	2	1	
QL							2	2		1

Percentage Pattern of Positive & Negative Selection

Positive	HE	Negative	HE
	HA		HA
	WB		WB
	LS		LS
	QL		QL

Supportive Commentary

In respect of the concept of Health, the comments reflected its perceived positive and benefician contribution, although this rarely was explored in any physiological detail, rather it was highlighted in more general terms of fitness: "Important to me, keeps me fit", "Wish I could do more to keep fit, but a bit old now".

Comments in relation to the other key concepts also referred to notions of relaxation and reduction of worry due to exercise: "I feel refreshed and relaxed, more energy to cope".

Accordingly, the comments did reflect those offered within the pilot exercise.

Q-Card Title: Environment (Coded Card No. 17)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	26 respondents	40.6%
HA	=	6 respondents	9.4%
WB	=	13 respondents	20.3%
LS	=	2 respondents	3.1%
*QL	=	31 respondents	48.4%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	2		1	3		1	4	3	7	5
HA							1		2	3
WB			2		2	2		1	3	3
LS								1		1
QL	3	1	1			1	5	5	6	9

Percentage Pattern of Positive & Negative Selection

Positive	HE	31.7%	Negative	HE	40%
	HA	9.5%		HA	x
	WB	14.3%		WB	26.7%
	LS	3.2%		LS	x
	QL	41.3%		QL	33.3%

Supportive Commentary

This attracted a relatively low level of comments with the data not being as rich as that within the pilot exercise. Nevertheless, similar notions did emerge, namely that the environment did influence one's "peace of mind", could be uplifting and a source of relaxation and tranquillity or be a source of depression and concern: "the noise, dirt and dogs soiling the pavement gets me down".

In three instances the environment was viewed in wider more global terms: "We have ruined the world, it will affect us all". This latter aspect was not evident as key words within the pilot exercise, and might be accounted for by the time lapse between the two activities and the media promotion/general public awareness of environmental friendly issues in the meantime.

Q-Card Title: Employment (Coded Card No. 18)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	3 respondents	4.7%
HA	=	9 respondents	14.1%
WB	=	6 respondents	9.4%
LS	=	24 respondents	37.5%
QL	=	30 respondents	46.9%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE		1			1				1	
HA				1		1	2		1	4
WB		1						1	2	2
LS	1					2	2		6	13
QL	1	1	1		1		1	2	7	16

*One further respondent selected this card and graded it both positively and negatively, omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	1.6%	Negative	HE	22.2%
	HA	12.7%		HA	11.1%
	WB	7.9%		WB	11.1%
	LS	36.3%		LS	11.1%
	QL	41.3%		QL	44.4%

Supportive Commentary

There was considerable similarity in the comments offered to these within the pilot exercise. With employment perceived in two major ways. Firstly, in terms of the money and purchasing power it gave with this in turn affecting Quality of Life and security itself an element within Happiness and Well-being/Life Satisfaction, the purchase potential influencing Health in as much as ensuring basic provisions for health, such as warmth and food.

Secondly, the emotional dimension of employment which could be positive in providing company/support and achievement or negative as a source of stress and worry. With this influencing Health and all of the other key concepts: "It's just routine, I like the company and money helps in the home", "I am often worried by work"' "My job is not very secure, I worry a lot about that, how I would manage the mortgage and everything".

Q-Card Title: Education (Coded Card No. 19)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	1 respondents	1.6%
HA	=	2 respondents	3.1%
WB	=	7 respondents	10.9%
LS	=	23 respondents	35.9%
QL	=	33 respondents	51.6%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE									1	
HA									2	
WB						1		2	3	1
LS								5	6	12
QL	1		1			2	2	4	4	19

Percentage Pattern of Positive & Negative Selection

Positive	HE	1.6%	Negative	QL 100%
	HA	3.1%		No other selection made
	WB	10.9%		
	LS	35.9%		
	QL	48.4%		

Supportive Commentary

This card attracted relatively few comments, arguably the emerging data not as 'rich' as that within the pilot, but with similar themes emerging nevertheless. The concepts of Well-bieng, Life Satisfaction, and Quality of Life attracted the majority of the comments made. Essentially two themes emerged with influence across the key concepts of Happiness, Well-being, and Life Satisfaction. Firstly, the idea that education was passport or could potentially open a door to a better life, notably, in respect of employment opportunities: "Well-educated helps you get a good job".

Secondly, it offered in some way personal enrichment: "Well just to be informed and know more about the world", "I think I would feel more self confident", "It makes me more interesting as a person and others more interesting".

Q-Card Title: First Home (Coded Card No. 20)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	Nil respondents	%
HA	=	34 respondents	53.1%
WB	=	9 respondents	14.1%
LS	=	13 respondents	20.3%
QL	=	10 respondents	15.6%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE										
HA	1					2	3	2	10	16
WB			1						5	3
LS							3	1	7	2
QL						1	2	2	3	2

*One further respondent selected this card and graded it both positively and negatively, omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive			Negative		
	HE	x		HE	x
	HA	51.6%		HA	50%
	WB	12.5%		WB	50%
	LS	20.3%		LS	x
	QL	15.6%		QL	x

Supportive Commentary

There was considerable similarity to that within the pilot exercise, with no comments against the concept of Health, whilst the comments largely reflected a perceived positive dimension in terms of achievement, space for self, start a new life and security resulting in happy memories. The negative dimension evident in the pilot also emerged in terms of anxiety derived from such responsibility: "Well it caused some problems such as money"' "I felt I had achieved something of my own to be myself".

Q-Card Title: Financial Prospects (Coded Card No. 21)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	2 respondents	3.1%
HA	=	7 respondents	10.9%
*WB	=	9 respondents	14.1%
LS	=	15 respondents	23.4%
**QL	=	30 respondents	46.9%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE						1				1
HA	1							1	2	3
WB							1	1	2	
LS			1			1	4	1	4	4
QL	2			1		1	2	7	5	12

*One further respondent selected this card grading it both positively and negatively, omitted for this purpose

**Two further respondents selected this card grading it both positively and negatively, omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	3.5%	Negative	HE	x
	HA	10.5%		HA	20%
	WB	14%		WB	x
	LS	24.6%		LS	20%
	QL	47.4%		QL	60%

Supportive Commentary

Again the comments fully reflected those views highlighted within the pilot exercise in terms of two main perspectives influencing all key concepts. Namely, the acceptance that financial security was a significant factor influencing mental outlook, allowed purchase of essentials and luxury to some extent impacting upon Quality of Life, Happiness etc.

Secondly, that it had negative dimensions if financial prospects were poor, not only in terms of items actually purchased, home, food etc., but also an emotional impact in terms of anxiety and stress: "It means I have some choices"' "If I knew I had enough for business and then plan ahead"' "Well if poor prospects it's a worry then affects everything".

Q-Card Title: Freedom (Coded Card No. 22)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	1 respondents	1.6%
HA	=	28 respondents	43.8%
WB	=	10 respondents	15.6%
LS	=	4 respondents	6.3%
QL	=	22 respondents	34.4%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE					1					
HA				1	3	2	4	7		11
WB	1				2		2	2		3
LS					1	1		2		
QL		1			2	3	3	9		4

Percentage Pattern of Positive & Negative Selection

Positive	HE	1.6%	Negative	HE	x
	HA	43.5%		HA	33.3%
	WB	14.5%		WB	33.3%
	LS	6.55		LS	x
	QL	33.9%		QL	33.3%

Supportive Commentary

The comments offered did not reflect the concept of health, unlike the pilot exercise where this was considered to some extent. Other than this, however, the comments offered were similar th those of the pilot exercise, with freedom largely incluencing choice and emotionally enriching and hence one's own sense of control. The reduction of freedom and perception that this was detrimental was also identified: "If only I have so little now ... stopped that, not always happy about this, not myself so much".

One element that did arise and was not identified in the pilot was that of a philosophical one offered by one respondent in which freedom, whilst acknowledged to be positive was questionable as an entity in itself without a focus or goal: "Yes, but for what purpose".

Q-Card Title: Free from the threat of Nuclear War (Coded Card No. 23)

(This card omitted from main survey after review of pilot activity)

Q-Card Title: Friends (Coded Card No. 24)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	1 respondents	1.6%
HA	=	38 respondents	59.3%
WB	=	10 respondents	15.6%
LS	=	7 respondents	10.4%
QL	=	14 respondents	21.9%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE										
HA			1			1	3	8	10	15
WB			1				1	6		2
LS								1	2	4
QL						1	1	4	4	4

Percentage Pattern of Positive & Negative Selection

Positive	HE	1.5%	Negative	HE	x
	HA	54.4%		HA	50%
	WB	13.2%		WB	50%
	LS	10.3%		LS	x
	QL	20.6%		QL	x

Supportive Commentary

There was considerable similarity between comments offered and those within the pilot exercise against all of the five key concepts. Emerging themes across this were accordingly the same, of a positive contribution by way of support, social company distraction from concerns, a source of advice and promotion of self value. Negatively, a potential source of anxiety and commitment: "I don't have to see my friend often but there for nevertheless at time of worry and need", "Well they help take you out of yourself", "Well one friend in particular needs more help from me that I can sometimes give".

Q-Card Title: Housing (Coded Card No. 25)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	10 respondents	15.6%
HA	=	13 respondents	20.3%
WB	=	13 respondents	20.3%
LS	=	8 respondents	12.5%
QL	=	31 respondents	48.4%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE		1			1	2			2	4
HA						1		2	6	4
WB		1	1				1	1	7	2
LS									2	6
QL		1				1	2	5	7	15

Percentage Pattern of Positive & Negative Selection

Positive	HE	11.4%	Negative	HE	40%
	HA	18.6%		HA	x
	WB	15.7%		WB	40%
	LS	11.4%		LS	x
	QL	42.9%		QL	20%

Supportive Commentary

As with pilot exercise, housing was commented upon across all of the five key concepts with the physical environment of the housing having the potential to affect an individual, both positively and negatively. However, with the additional identification on influence emotionally with this also being either negative in terms of stress and worry associated with maintenance and upkeep and/or depression if poor housing was at issue. Positively, the emotional impact rested with notions of an area for being oneself, being with loved ones and reflection, relaxation and fulfilment. These positive and negative dimensions having potential impact upon all five key concepts: "It's my island to come back to rest and be with my family", "Well somethimes I worry about the mortgage and upkeep of it all", "It needs to be dry and warm as a shelter, but a happy pleasant place too".

Q-Card Title: Ill-Health of Others (Coded Card No. 26)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	6 respondents	9.4%
HA	=	33 respondents	51.6%
WB	=	15 respondents	23.4%
LS	=	2 respondents	3.1%
QL	=	7 respondents	10.9%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE		1	1	2	1		1			
HA	8	6	10	3	2		1	1		2
WB	2	3	3	2			1	2		
LS	1	1								
QL	1	3		1				1	1	

Percentage Pattern of Positive & Negative Selection

Positive	HE	10%	Negative	HE	9.8%
	HA	40%		HA	56.9%
	WB	30%		WB	19.6%
	LS	x		LS	3.9%
	QL	20%		QL	9.8%

Supportive Commentary

This card attracted relatively few and rather brief comments, withthis also being a card with a lower rate of comment within the pilot exercise. Emerging themes were, however, the same in terme of:-

a. Emotional dimension and influence with all of the concepts derived from sadness, worry.

b. The potential physical demand and detrimental effect of having to provide care and support.

"difficult if you have to look after them"

Unlike the pilot exercise, however, comments did not reveal an element of guilt/resentment in respect of Quality of Life and Happiness.

Q-Card Title: Isolation (Coded Card No. 27)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	13 respondents	20.3%
HA	=	22 respondents	34.4%
WB	=	17 respondents	26.6%
LS	=	4 respondents	6.3%
QL	=	13 respondents	20.3%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	8	1	1		1	1				1
HA	11	2	3	1	1		1	1		2
WB	3	6	2	1	1	1	1		2	
LS	2	1		1						
QL	2	5	1	2		1				2

Percentage Pattern of Positive & Negative Selection

Positive	HE	15.4%	Negative	HE	19.6%
	HA	30.8%		HA	32.1%
	WB	30.8%		WB	23.2%
	LS	x		LS	7.1%
	QL	23.1%		QL	17.9%

Supportive Commentary

The comments revealed isolation to be regarded somewhat as a mixed blessing reflecting therefore the views within the pilot exercise. Isolation was seen as having beneficial attributes across all five concepts in terms of time for oneself, removal from life stress and anxieties, opportunity for relaxation and tranquillity: "I like this for some peace".

In some instances a desire for greater isolation due to these perceived benefits was expressed: :I wish I could get away from my family responsibilities".

Alternatively, isolation was viewed as detrimental (although this perspective attracted fewer comments) leading to boredom, reduced contact and stimulation, and eventual depression: "I cannot bear to be alone and miserable".

Q-Card Title: Immediate Family (Coded Card No. 28)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	2 respondents	3.1%
*HA	=	38 respondents	59.4%
**WB	=	9 respondents	14.1%
**LS	=	8 respondents	12.5%
QL	=	5 respondents	7.8%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE					1					1
HA					2		3	4	8	21
WB	1	2	1					1	2	2
LS						1	1	1	1	4
QL						1	1		2	1

*Five further respondents selected this card grading it both positively and negatively, omitted for this purpose

**One furhter respondent selected this card grading it both positively and negatively, omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	1.8%	Negative	HE	14.3%
	HA	65.5%		HA	28.6%
	WB	9.1%		WB	57.1%
	LS	14.5%		LS	\
	QL	9.1%		QL	\

Supportive Commentary

The ambiguity of feeling in respect of immediate family evident within the pilot exercise was clearly mirrored in the main survey with identical themes and views. Essentially, immediate family was perceived as having a positive effect across the key concepts in as much as support and sharing mutual caring and valuing. Negative influences were derived from family demands and conflicts leading to anxiety, guilt and depression with physical tiredness associated with this also: "I am happy and relaxed whey they're here and okay", "Well good and bad", "Too many of their problems become entwined with my own", "Family very important to me, loved and supported but can make me unhappy and stressed also".

Q-Card Title: Independence (Coded Card No. 29)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	3 respondents	4.7%
HA	=	23 respondents	35.9%
WB	=	16 respondents	25%
LS	=	12 respondents	18.8%
QL	=	25 respondents	39.1%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE								1		2
HA			1	1			1	3	6	11
WB	1					1	3	4	4	3
LS							1	1	6	1
QL						1	3	4	11	6

Percentage Pattern of Positive & Negative Selection

Positive	HE	4.1%	Negative	HE	x
	HA	28.8%		HA	66.7%
	WB	20.5%		WB	33.3%
	LS	12.3%		LS	x
	QL	34.2%		QL	x

Supportive Commentary

This attracted a lower rate of comments, nevertheless, the emerging themes were compatible to those within the pilot exercise. Namely, across all five key concepts the perception of independence as being positive and desirable in providing self worth, choice and enrichment: "Just so I can choose and please myself", "So I can be free without having to wait or depend on others". Importantly, however, the reduction of independence was cited as a real concern positively in respect to Health and Quality of Life, and with impact upon Happiness, Well-being and Life Satisfaction: "It is important to me not to be a burden on others", "I would worry and be unhappy if I lost my independence and had to look after others", "Loss of my independence is the thing I feel the most, especially as I get older".

Q-Card Title: Keeping Warm (Coded Card No. 30)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	30 respondents	46.9%
HA	=	9 respondents	14.1%
WB	=	17 respondents	26.6%
LS	=	1 respondents	1.6%
QL	=	13 respondents	20.3%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE						2	4	9	8	7
HA				1				3	1	4
WB					1	6	2	6	1	1
LS									1	
QL			1			3	1	3	2	3

Percentage Pattern of Positive & Negative Selection

Positive	HE	44.8%	Negative	HE	\
	HA	11.9%		HA	33.3%
	WB	23.9%		WB	33.3%
	LS	1.5%		LS	\
	QL	17.9%		QL	33.3%

Supportive Commentary

Comments offered again reflected the pilot exercise with warmth being identified as having physical benefits, e.g. have more energy and feeling more comfortable and emotional elements of feeling happier and better. Four respondents highlighted the belief that warmth was more important as you become older, with this view not being particularly evident within the pilot exercise: "More important as you get older", "Needed as I get older", "I feel the cold more now being warm makes such a difference to my joints and I feel happier".

Q-Card Title: Having Medical Check-Ups (Coded Card No. 31)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	50 respondents	78.1%
HA	=	3 respondents	4.7%
WB	=	8 respondents	12.5%
LS	=	1 respondents	1.6%
QL	=	4 respondents	6.3%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE			1	3		1	7	8	10	20
HA	1		1							1
WB							2	2	2	2
LS									1	
QL				1						3

Percentage Pattern of Positive & Negative Selection

Positive	HE	78%	Negative	HE	57.1%
	HA	1.7%		HA	28.6%
	WB	13.6%		WB	\
	LS	1.7%		LS	\
	QL	5.1%		QL	14.3%

Supportive Commentary

As with the pilot exercise this card attracted a lower rate of commentary largely against Health and Well-being. Similar beliefs emerged in that it was perceived as potentially helpful: "Important at all ages"' "Good idea", with this helpful derived not only from early detection of ill-health, but also a peace of mind is afforded. However, with the latter also potentially negative in terms of anxiety provoking: :Well depends on the outcome", "I always worry what the test will show".

Q-Card Title: Keeping Informed about How to Keep Healthy (Coded Card No. 32)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	47 respondents	73.4%
HA	=	- respondents	
WB	=	8 respondents	12.5%
LS	=	1 respondents	1.6%
QL	=	10 respondents	15.6%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE				1	1	3	6	10	14	12
HA										
WB						1	2	4	1	
LS									1	
QL							1	2	2	3

Percentage Pattern of Positive & Negative Selection

Positive	HE	72.6%	Negative	HE 100%
	HA	x		No other selection
	WB	12.9%		
	LS	1.6%		
	QL	12.9%		

Supportive Commentary

This attracted a low rate of comment and arguably proportionally less than within the pilot exercise. Largely as within the pilot comments reflected positive perceptions in terms of Health, Well-being and Quality of Life with themes as within the pilot and improved choice, peace of mind they are doing the right thing and feeling reassured. Only two respondents reflected the negative perspective shown within the pilot: "Too much all the time and it contradicts", "Well if you took it all on you would do nothing else but worry about it".

Q-Card Title: Leisure (Coded Card No. 33)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	8 respondents	12.5%
HA	=	16 respondents	25%
WB	=	22 respondents	34.4%
LS	=	7 respondents	10.9%
QL	=	21 respondents	32.8%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE				1				4	2	1
HA						1	3	3	4	5
WB				1		3	2	3	9	2
LS						1		1	3	2
QL					1	2	1	9	6	2

Percentage Pattern of Positive & Negative Selection

Positive	HE	9.9%	Negative	HE	33.3%
	HA	22.5%		HA	\
	WB	29.6%		WB	33.3%
	LS	9.9%		LS	\
	QL	28.2%		QL	33.3%

Supportive Commentary

Supportive comments and related emerging themes were reflective of those within the pilot exercise in terms of notions of stress reduction, self fulfilment and facilitation of perspective in terms of life demands. However, rather more forcefully in the main survey were comments which indicated the percieved negative effects of insufficient leisure time being available, particularly due to work or family pressures with this having a detrimental effect upon all of the five key concepts: "It's difficult I have no time to myself with the family", "The children stop me", "It's all work there's no space for leisure and that's no good for you".

Q-Card Title: Loving and Trusting Relationship (Coded Card No. 34)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	3 respondents	4.7%
*HA	=	49 respondents	76.6%
*WB	=	3 respondents	4.7%
*LS	=	8 respondents	12.5%
QL	=	11 respondents	17.2%

*One further respondent selected this card grading it both positively and negatively, omitted for this purpose

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE										3
HA						1	1	5	7	35
WB							1		2	
LS						1			3	4
QL								1	3	7

Percentage Pattern of Positive & Negative Selection

Positive	HE	4.1%	Negative	No negative selection
	HA	66.2%		
	WB	4.1%		
	LS	10.8%		
	QL	14.9%		

Supportive Commentary

Again, the supportive comments in themain survey morrored those key words/themes found within the pilot exercise, positive effects being evident in respect of all key concepts in terms of support enhanced self value, enrichment of life and comfort at times of difficulty. Negative dimensions were similarly offered, particularly at times of disharmony. Notably, however, unlike the pilot exercise three respondents specifically commented upon the perceived detrimental effect of not having a current loving and trusting relationship influencing particularly Happiness and Life Satisfaction: "I would like one", "I miss this in my life", "Without it life is not so full or content".

Q-Card Title: Marital Status (Coded Card No. 35)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	1 respondents	1.6%
*HA	=	20 respondents	31.3%
**WB	=	6 respondents	9.4%
**LS	=	10 respondents	15.6%
**QL	=	19 respondents	29.7%

*Three further respondents selected this card grading it both positively and negatively, omitted for this purpose

**One further respondent selected this card grading it both positively and negatively, ommited for this purpose

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE										1
HA	1						2	3	4	10
WB			1				1			4
LS								4	1	5
QL	1	1	1			1	2	3	3	7

Percentage Pattern of Positive & Negative Selection

Positive	HE	2%	Negative	HE	x
	HA	37.3%		HA	20%
	WB	9.8%		WB	20%
	LS	19.6%		LS	x
	QL	31.4%		QL	60%

Supportive Commentary

The similar level and nature of ambivalence found within the pilot exercise to this card was evident in the main survey's supporting comments. In that the negative perspectives were most prominent: "It has its problems", "It's often difficult and demanding", "Yes, it's certainly negative at times".

As with the pilot, therefore, marital status tended to be differentiated from the preceding card of a loving and trusting relationship.

Q-Card Title: Medication (Coded Card No. 36)

No. of Respondents selecting this card against the key concepts/% of P Sample

*HE	=	45 respondents	70.3%
HA	=	1 respondents	1.6%
WB	=	3 respondents	4.7%
LS	=	4 respondents	6.3%
QL	=	8 respondents	12.5%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE		1		1	4	3	5	7	8	16
HA									1	
WB									3	
LS	1	1			1		1			
QL	1				1		2	1	2	1

*One further respondent selected this card grading it both positively and negatively, omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	78%	Negative	HE	54.5%
	HA	2%		HA	\
	WB	6%		WB	\
	LS	2%		LS	27.3%
	QL	12%		QL	18.2%

Supportive Commentary

As within the pilot exercise, supportive comments were predominantly related to the concept of Health, reflecting a positive and negative perspective: "Well if you need it of course it's helpful", "I try to avoid it, not good physically or mentally unless essential", "I have to take tablets in one way they do help, but sure not good for me overall".

Q-Card Title: Boredom (Coded Card No. 37)

(Note - This card re-worded from pilot after review)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	9 respondents	14.1%
HA	=	14 respondents	21.9%
*WB	=	22 respondents	34.4%
LS	=	7 respondents	10.9%
QL	=	12 respondents	18.6%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	3	3		1					1	1
HA	4	3	1	1	1			2	1	1
WB	3	3	4		2	4	2	1	2	1
LS	3	1		1		2				
QL	2	1	2	2		1	1	2	2	

*One further respondent selected this card grading it both positively and negatively, omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	8.3%	Negative	HE	17.5%
	HA	16.7%		HA	25%
	WB	41.7%		WB	30%
	LS	8.3%		LS	12.5%
	QL	25%		QL	15%

Supportive Commentary

The wording of this Q-card was modified from the pilot exercise; nevertheless, the emerging themes within the supportive comments remained relatively unchanged, in that boredom was percieved as mainly having a negative influence across all concepts but particularly in terms of Happiness and Well-being, in that it generated frustration, lethargy and demotivation: "After a whle nothing's worthwhile and you have no get up and go", "It eats away at you, you get depressed and irritable".

Two respondentd perceived boredom in the light of a welcome anecdote, however, to their stressful lives: "I would love the chance", "I don't get time to be bored, it might make a nice change".

Q-Card Title: Not Using Illegal Drugs (Coded Card No. 38)

(This card omitted from main survey after review of pilot activity)

Q-Card Title: Own Ill-Health (Coded Card No. 39)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	31 respondents	48.4%
HA	=	13 respondents	20.3%
WB	=	8 respondents	12.5%
LS	=	5 respondents	7.8%
QL	=	18 respondents	28.1%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	20	3	4	1	1		1	1		
HA	9		3							1
WB	3	1	1	1				1	1	
LS	4								1	
QL	13	2		1					1	1

Percentage Pattern of Positive & Negative Selection

Positive	HE	25%	Negative	HE	43.3%
	HA	12.5%		HA	17.9%
	WB	25%		WB	9%
	LS	12.5		LS	6%
	QL	25%		QL	23.9%

Supportive Commentary

As in the pilot exercise, supportive comments largely interpreted this item against notions of worry, anxiety and fear of dependence upon others, rather than in the context of any particular physical distress or symptoms: "My back injury affects my Quality of Life and independence", "I worry about how my family would cope". Three respondents, however, unlike the pilot exercise identified within their comments a level of ambivalence and resignation: "Have to accept at sometime", "No point worrying over it, we are all at times".

Q-Card Title: Parenthood (Coded Card No. 40)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	3 respondents	4.7%
*HA	=	44 respondents	68.8%
**WB	=	- respondents	
LS	=	11 respondents	17.2%
QL	=	9 respondents	14.1%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE		1	1					1		
HA	1					1		1	13	25
WB										
LS				1					2	6
QL	2	1						3		3

Percentage Pattern of Positive & Negative Selection

Positive	HE	1.7%	Negative	HE	28.6%
	HA	74.1%		HA	14.3%
	WB	\		WB	\
	LS	13.8%		LS	14.3%
	QL	10.3%		QL	42.9%

Supportive Commentary

As with the pilot exercise, this card attracted a high rate of supportive comments which mirrored each other, in that whilst positive influences across all five concepts were evident through such ideas as satisfaction, fulfilment, achievement and a source of relaxation and joy, negative factors were also evident, these principally reflecting parenthood as a source of considerable anxiety, stress and restriction: "My best time", "Can be difficult", "My best and lowest times", "Certainly both negative and positive effects", "Works both ways as kids can be a great worry and stressful", "When I am with my kids other worries don't matter as much", "Your life's not your own with kids around". An additional element, however, with the main survey was three respondents who explicitly identified a feeling of loss and deficit as a result of not having children with this influencing their Happiness, Life Satisfaction and Quality of Life: "I wish I had I would have had a more satisfied life", "It's a missed experience I think I would have been happier and had more fulfilment", "I always wanted more, my life's not been as rich as a result".

Q-Card Title: Pollution (Coded Card No. 41)

No. of Respondents selecting this card against the key concepts/% of P Sample

*HE	=	39 respondents	60.1%
HA	=	4 respondents	6.3%
WB	=	11 respondents	17.2%
LS	=	1 respondents	1.6%
QL	=	20 respondents	31.8%

*Two further respondents selected this card grading it both positively and negatively, omitted for this purpose.

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	12	8	4		1	4		1	4	5
HA	1			1			1		1	
WB	4		2		1			1	1	2
LS		1								
QL	6	4	2		2	2	1	2		1

Percentage Pattern of Positive & Negative Selection

Positive	HE	53.8%	Negative	HE	51%
	HA	7.7%		HA	4.1%
	WB	15.4%		WB	14.3%
	LS	x		LS	2%
	QL	23.1%		QL	28.6%

Supportive Commentary

Again, the nature of the supportive comments in the main survey mirrored those of the pilot exercise in that pollution was perceived as influencing Health, Happiness with life and environment around you and accordingly Quality of Life. Within the main survey, however, there were more explicit examples of local pollution that were a source of concern to people, these included such things as traffic, noise and fouled pavements. Three respondents did highlight the level of public attention and awareness currently paid to pollution issues: "Lot of emphasis these days", "Much more aware of pollution and its effects now".

Q-Card Title: Personality (Coded Card No. 42)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	1 respondents	%
*HA	=	21 respondents	%
WB	=	15 respondents	%
LS	=	16 respondents	%
QL	=	8 respondents	%

*Two further respondents selected this card grading it both positively and negatively, omitted for this purpose

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE		1								
HA		1	1		1		3	3	6	6
WB			1			1	2	3	3	5
LS		1				1	1	1	6	6
QL			2			1	1	2	2	

Percentage Pattern of Positive & Negative Selection

Positive	HE	x	Negative	HE	12.5%
	HA	34%		HA	37.5%
	WB	26.4%		WB	12.5%
	LS	28.3%		LS	12.5%
	QL	11.3%		QL	25%

Supportive Commentary

The nature of supportive comments offered mirrored those within the pilot in that personality was perceived as influential in respect of all five concepts. It positively promoted an ability to cope and tackle life's difficulties, improved resilience and indeed recovery from illness and influenced your original vulnerability or susceptibility particularly to stress illness. Equally it influenced how you saw life and your satisfaction and quality derived from it. Equally, a particular but unspecified type of personality could reduce ability to deal with life recover and 'bounce back': "It influences the balance you have in life", "It is down to you and how you see things, some people let it get them down more", "Certainly it influences how you get well and how quickly".

Q-Card Title: Relatives (Coded Card No. 43)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	4 respondents	6.3%
*HA	=	34 respondents	53/1%
**WB	=	10 respondents	15.6%
LS	=	4 respondents	6.3%
***QL	=	9 respondents	14.1%

*Five further respondents selected this card grading it both positively and negatively, omitted for this purpose

**Two further respondents selected this card grading it both positively and negatively, omitted for this purpose

***One further respondent selected this card grading it both positively and negatively, omitted for this purpose

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	1						2		1	
HA	1	1			1	1	2	6	10	12
WB	1	2	1			1	1		4	
LS							1		1	1
QL				1			1	3	3	1

Percentage Pattern of Positive & Negative Selection

Positive	HE	5.9%	Negative	HE	11.1%
	HA	60.8%		HA	33.3%
	WB	11.8%		WB	44.4%
	LS	5.9%		LS	\
	QL	15.7%		QL	11.1%

Supportive Commentary

As in the pilot exercise, this card was viewed in both a positive and negative way, positive comments indicating elements of support sharing as an influence upon all key concepts, although less so for Health. Negative perceptions centred around the demands and stress of relatives, again affecting all five concepts: "Works both ways", "In-laws are a source of stress, the rows are awful", "Too demanding", "Depends on how you look at it, can be a help but other times definitely not", "Can be both ways - depends on the relatives".

Q-Card Title: Retirement (Coded Card No. 44)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	5 respondents	7.8%
HA	=	13 respondents	20.3%
WB	=	2 respondents	3.1%
LS	=	12 respondents	18.8%
QL	=	28 respondents	43.8%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	2	1					1		1	
HA							2	4	3	4
WB					1			1		
LS	1		1			1	1	1	3	4
QL	7	2	2		2	2	1	6	3	3

Percentage Pattern of Positive & Negative Selection

Positive	HE	4.9%	Negative	HE	15.8%
	HA	31.7%		HA	\
	WB	2.4%		WB	5.3%
	LS	24.4%		LS	10.5%
	QL	36.6%		QL	68.4%

Supportive Commentary

Again, comments in the pilot and main survey mirrored each other, positive effects in respect of all five key concepts were highlighted in terms of space for own pursuits, removal from work demands and stress: "Bliss", "I now have some time for me", "Work was becoming too much, and such a worry". On occasion, however, the approval was conditional upon such issues as fitness and money: "Yes, but depends on pension". Negative influences were cited and similar to those in the pilot against all concepts in terms of loneliness, isolation, reduced purchase ability and self value. Four respondents, however, in the main survey did identify they found it difficult to address or contemplate due to their age: "Difficult to think of it, too young really". This was not a feature found in the pilot.

Q-Card Title: Rest and Sleep (Coded Card No. 45)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	40 respondents	62.5%
HA	=	6 respondents	9.4%
WB	=	18 respondents	28.1%
LS	=	2 respondents	3.1%
*QL	=	7 respondents	10.9%

*One further respondent selected this card grading it both positively and negatively, omitted for this purpose

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE		1			1	1	3	5	10	19
HA					1			2		3
WB	1					1	1	6	6	3
LS										2
QL							1	1	3	2

Percentage Pattern of Positive & Negative Selection

Positive	HE	4.9%	Negative	HE	50%
	HA	31.7%		HA	25%
	WB	2.4%		WB	25%
	LS	24.4%		LS	\
	QL	36.6%		QL	\

Supportive Commentary

Again, there was no real difference in the nature of comments found in the pilot and the main survey. Positive influences against all the concepts were acknowledged in terms of recuperation, energy to cope both in a physical and emotional way and to see life in a balanced way. Equally as in the pilot a loss of rest and sleep was cited as particularly resulting in irritability, reduced effectiveness and inability to see life in perspective and hence achieve satisfaction.

Q-Card Title: Safe from Accidents (Coded Card No. 46)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	43 respondents	67.2%
HA	=	6 respondents	9.4%
*WB	=	14 respondents	21.9%
LS	=	- respondents	
QL	=	7 respondents	10.9%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE						4	6	5	4	19
HA	1					1			1	3
WB				1				3	2	8
LS										
QL	1						1	2	1	2

*One further respondent selected this card grading it both positively and negatively, omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	64.2%	Negative	HE	x
	HA	7.5%		HA	33.3%
	WB	x		WB	33.3%
	LS	19.4%		LS	x
	QL	9%		QL	33.3%

Supportive Commentary

Unlike the pilot, this card did not really attract any comments to a great extent, indeed only three respondents offered comments: "Needs more attention not just for physical safety but peace of mind", "Yes, is important for me and the family", "A good idea hard to achieve there's always hazards".

Q-Card Title: Self-Esteem (Coded Card No. 47)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	3 respondents	4.7%
*HA	=	17 respondents	26.6%
*WB	=	17 respondents	26.6%
*LS	=	12 respondents	18.8%
QL	=	16 respondents	25%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE									1	2
HA	1						3	5	2	6
WB	1				1	3	2	2	5	3
LS	1						2	1	4	4
QL				1			1	5	2	7

*One further respondent selected this card grading it both positively and negatively, omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	5%	Negative	HE	\
	HA	26.7%		HA	20%
	WB	25%		WB	40%
	LS	18.3%		LS	20%
	QL	25%		QL	20%

Supportive Commentary

Again, comments by in large reflected the pilot, the exception lying in the fact that three respondents indicated they were uncertain as to the meaning of the term self-esteem. Otherwise the same themes emerged in terms of positive influence upon all concepts, such as affecting interest and view of life, ability to deal with demands and place these in context or balance, with a low self-esteem negatively influencing mental/emotional health and recovery.

One difference in the main survey was four respondents who specifically identified the viability of self-esteem its tendency to fluctuate: "Yes, important and influential but varies by each day and situation".

Q-Card Title: Social Changes (Coded Card No. 48)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	3 respondents	4.7%
*HA	=	6 respondents	9.4%
*WB	=	8 respondents	12.5%
**LS	=	5 respondents	7.8%
***QL	=	24 respondents	37.5%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	2									1
HA			2	1		1			2	
WB					3	2	1		1	1
LS				1	1			2		1
QL	1		1	1	1	3	3	3	4	5

*One further respondent selected this card grading it both positively and negatively, omitted for this purpose

**Two further respondents selected this card grading it both positively and negatively, omitted for this purpose

***Five further respondents selected this card grading it both positively and negatively, omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	3.3%	Negative	HE	14.3%
	HA	10%		HA	21.4%
	WB	16.7%		WB	21.4%
	LS	10%		LS	14.3%
	QL	60%		QL	28.6%

Supportive Commentary

As in the pilot, social change attracted considerable comment, particularly in terms of Quality of Life, again issues of control and influence was a feature within social change both in a positive and negative sense for all concepts. In other words that social change, whilst beneficial on occasion, often occurred beyond one's scope of influence and at an accelerated rate with this as a potential source of insecurity influencing Health, Happiness, Well-being and Life Satisfaction/Quality of Life. These views are well illustrated by one respondent's comment: "Yes, but not sure how always will influence us and sometimes just too fast".

Q-Card Title: Spiritual Belief (Coded Card No. 49)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	1 respondents	1.6%
HA	=	9 respondents	14.1%
*WB	=	16 respondents	25%
LS	=	4 respondents	6.3%
QL	=	10 respondents	15.6%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE								1		
HA								1	2	6
WB					1	3		3	3	5
LS			1			1			1	1
QL			3				2			5

*Two further respondents selected this card grading it both positively and negatively, omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	2.9%	Negative	HE	\
	HA	25.7%		HA	\
	WB	42.9%		WB	20%
	LS	8.6%		LS	20%
	QL	20%		QL	60%

Supportive Commentary

This attracted relatively few comments within the main survey, but these still mirrored the notions expressed within the pilot exercise. Namely a positive influence in terms of inner peace and support and meaning affecting Happiness, Quality of Life, Life Satisfaction and Well-being. Indeed three respondents highlighted their lack of spiritual belief but nevertheless indicated that if held they thought it to be beneficial: "I am a non-believer, but yes, for other a real help I think in terms of meaning to life and support".

The negative perceptions as in the pilot focused upon potential ambiguity and conflict of perspectives in life. "It can be difficult a conflict between teaching and what I actually do causes me sadness".

Q-Card Title: Unemployment (Coded Card No. 50)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	12 respondents	18.8%
HA	=	17 respondents	26.6%
WB	=	8 respondents	12.5%
LS	=	12 respondents	18.9%
*QL	=	33 respondents	51.6%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	8					1		1		2
HA	11	1	3					1		1
WB	5		1	1						1
LS	4	1	2	2		1				2
QL	18	5			1	3				7

*One further respondent selected this card grading it both positively and negatively, omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	22.2%	Negative	HE	12.7%
	HA	11.1%		HA	23.8%
	WB	5.6%		WB	11.1%
	LS	16.7%		LS	14.3%
	QL	44.4%		QL	38.1%

Supportive Commentary

Comments in the main survey reflected those in the pilot in that the same themes against the five concepts were evident. Negative influences by way of insecurity and stress, lack of purpose, financial hardship; positive elements, however, also emerged in terms of time provided for own interest and pursuits facilitating a better Quality of Life and Life Satisfaction: "Happy if poor", "At least it's nice to be at home", "Low income not get what you want", "Affects everything", "I feel so wasted especially as I am young".

Q-Card Title: Travel (Coded Card No. 51)

No. of Respondents selecting this card against the key concepts/% of P Sample

HE	=	3 respondents	4.7%
HA	=	23 respondents	35.9%
WB	=	6 respondents	9.4%
*LS	=	8 respondents	12.5%
QL	=	25 respondents	39.1%

Pattern of Selection

	-5	-4	-3	-2	-1	+1	+2	+3	+4	+5
HE	1						1			1
HA							2	4	5	12
WB		1						1	3	1
LS							1	2	3	2
QL					2	2	4	4	5	8

*One further respondent selected this card grading it both positively and negatively, - omitted for this purpose

Percentage Pattern of Positive & Negative Selection

Positive	HE	3.3%	Negative	HE	25%
	HA	37.7%		HA	x
	WB	8.2%		WB	25%
	LS	13.1%		LS	x
	QL	37.7%		QL	50%

Supportive Commentary

The comments reflected those found within the pilot. Positive themes centred around enhanced life, new insights and experiences, freedom, removal from daily routine and worries with these affecting all five concepts. Negative themes were few embracing two elements, firstly the physical effort and effects of travel, and dissatisfaction and depression on return to normal routine demands and environment.

Q-Card 52 - please see Card 5

Rank Order of Cards indicated by Card No., Key Concepts, and Respondents selecting Card

	HE	HA	WB	LS	QL
64					
63					
62					
61					
60					
59					
58					
57					
56					
55					
54					
53					
52					
51					
50	6, 31				
49		34			
48					
47	11, 32				
46	16	9			
45	8, 36				
44		40, 52			
43	46				
42					
41					
40	45				
39	41				
38	2	24, 28			7
37		12, 14			
36					
35					
34		15, 20, 43			
33		26			19, 50
32					
31	39	10			17, 25
30	30				18, 21
29					
28		22			44
27		3			
26	17				
25					29, 51
24				18	48
23		29, 51		19	1
22		27	33, 37		3, 22
21		42		9	33
20	13, 15	35			41

19					25
18			45		39
17		47, 50	10,13,27,30,47		
16		1, 33	29, 49	42	4, 47
15			1, 14, 26, 42	3, 21	
14		37	8, 46		24
13	27	7, 25, 39, 44	17, 25	20	27, 30
12	50	4	15	10,29,44,47,50	8, 37
11	4		41	40	13, 34
10	1, 14, 25		16, 22, 24, 43	35	20, 32, 49
9	37	18, 30, 49	4,12,20,21,28		40, 43
8	33		31, 39, 48, 50	25,28,32,34,51	2, 11, 36, 42
7		13, 21	3, 11, 19, 52	1, 24, 33, 37	9,10,14,26,45, 46,52
6	26	17, 45, 46, 48	18, 35, 51	4, 7, 13	15
5	9, 12, 44, 52			39, 48	16, 28
4	43	11, 41	7, 9	2,6,16,22,27,36, 43,49,52	12, 31
3	18,29,34,47,48, 51	6, 31	34, 36	11	
2	3, 7, 21, 28	2, 8, 14	2, 44	8, 17, 26, 45	6
1	10,19,22,24,35, 40,42,48	16, 36	6	15,30,31,32,41	
Not selec -ted				32, 40	46

Index

Q-Card Title	Coded No. Pilot/ Main Study
Able to have privacy	1
Age	2
Active social life	3
A close community	4
A good sex life	5/52
Avoid over indulgence	6
Access to transport	7
A good local health service	8
Becoming a parent	9
Company of others	10
Diet	11
Childhood	12
Climate	13
Death of a friend	14
Death of a relative	15
Exercise	16
Environment	17
Employment	18
Education	19
First home	20
Financial prospects	21
Freedom	22
Free from threat of nuclear war	23/omitted
Friends	24
Housing	25
Ill-health of others	26
Isolation	27
Immediate family	28
Independence	29
Keeping warm	30
Medical check-ups	31
Keeping informed in order to keep healthy	32
Leisure	33
Love and trusting relationships	34
Marital status	35
Medication	36

Q-Card Title	Coded No. Pilot/ Main Study
Not being bored	37
Not using illegal drugs	38/omitted
Own ill-health	39
Parenthood	40
Pollution	41
Personality	42
Relatives	43
Retirement	44
Rest and sleep	45
Safe from accident	46
Self-esteem	47
Social change	48
Spiritual beliefs	49
Unemployment	50
Travel	51

Cards selected and given both a positive and negative grade/supportive comment

Card	Coded No.	Concept	No. of Respon-dents	Grade/s	Comment
A Close Community	4	Well-being	1	-4/+4	Supportive but negative, lack of privacy
A Good Sex Life	5/52	Happiness Well-being Life Satisfaction Quality of Life	2 1 1 1	-5/+5 -5/+3 -5/+3 -5/+5 -5/+5	A difficult one to explain. Yes, well good/bad - it's so tied up with love and the rest of the relation-ship
Becoming a Parent	9	Happiness	1	-5/+5	Rewarding, but very stressful
Diet	11	Health	2	-5/+5	Diets a misery, its negative if you have to watch and think about it
Childhood	12	Happiness	1	-5/+5	Some very sad moments affect my life now
Climate	13	Well-being	1	-4/+3	Difficult to function and feel settled in extremes
Climate	13	Quality of Life	2	-1/+1 -4/+3	I feel happier in the sun, but snow gives me peace of mind
Exercise	16	Health Quality of Life	1 1	-2/+4 -2/+4	It's a question of balance; must do some, but not an obsession
Environment	17	Quality of Life	1	-5/+5	It influences my mind and how I deal with life
Employment	18	Health	1	-3/+4	I get satisfaction, but also a lot of stress
Education	19	Life Satisfaction	1	-4/+4	Learning can be stressful as well as an achieve-ment

Card	Coded No.	Concept	No. of Respon-dents	Grade/s	Comment
First Home	20	Happiness	1	-3/+3	It was good to have your own, but a worry and an anxiety
Financial Prospects	21	Happiness	1	-3/+3	Just enough to feel secure
Financial Prospects	21	Well-being	2	-5/+5 -3/+2	If I had a lot I would worry how to manage it well
Housing	25	Well-being	1	-3/+4	You worry over mortgage and security but you need your place to call your own
Ill-Health of Others	26	Well-being	1	-1/+1	It's a worry, but they do need me then
Immediate Family	28	Happiness	5	-3/+2 -4/+5 -5/+5 -3/+5 -2/+2	They are a constant worry and delight. You feel too much for them and get upset. The ups and downs matter so much because you care
Immediate Family	28	Well-being	1	-1/+1	
Immediate Family	28	Life Satisfaction	1	-2/+2	
Loving & Trusting Relationship	34	Happiness Well-being Life Satisfaction	1 1 1	-5/+5 -5/+5 -5/+5	You worry it will always remain the same. You sometimes hurt each other. At times it's so difficult. You're so close it can become difficult
Marital Status	35	Happiness Well-being Life Satisfaction Quality of Life	3 1 1	-5/+5 -5/+5 -3/+5 -5/+5 -5/+5 -3/+3	Dependence can be frustrating. You lose yourself sometimes - there's no space for me
Medication	36	Health	1	-5/+5	Yes, well good if you need it, but there's side-effects

Card	Coded No.	Concept	No. of Respon-dents	Grade/s	Comment
Boredom	37	Well-being	1	-3/+2	Good in that I would like rest and no stress; but need stimulation
Parenthood	40	Happiness	5	-5/+5 -4/+4 -5/+5 -5/+5 -4/+4	Well what can I say - good and bad. Very stressful at times. A constant worry and pleasure. Sometimes you wonder if it's worth it.
		Life Satisfaction	1	-5/+5	
		Well-being	2	-5/+3 -5/+5	It's my greatest source of stress and happiness. It's all I have, but not always happy
Pollution	41	Health	2	-1/+1 -1/+1	We have ruined our world, yet still lovely at times
Personality	42	Happiness	2	-4/+4 -3/+2	It can so influence your happiness and health. Will it can work for you and against you
Relatives	43	Happiness	5	-1/+1 -3/+1 -3/+5 -3/+3 -5/+5	Often a worry and so demanding, but I do care for them. I love seeing them, but sometimes we argue.
		Well-being Quality of Life		-3/+4 -2/+3	Well it's both as we don't always get on
Rest and Sleep	45	Quality of Life	1	-1/+1	You do need rest for energy, but you can waste the day away
Safe from Accidents	46	Well-being	1	-5/+5	Well yes, naturally need to be safe, but can be protected to point of restriction
Self-Esteem	47	Happiness Well-being Life Satisfaction	1 1 1	-3/+4 -5/+5 -2/+3	I often sell myself short and affect my happiness. Sometimes I feel good about myself, and it helps what I do, but not always

Social Changes	48	Happiness Well-being Life Satisfaction Quality of Life	1 1 2 5	-4/+3 -4/+4 -2/+2 -3/+4 -2/+2 -5/+5 -1/+1 -3/+2 -2/+4	You don't know what will happen next and how to deal with it. The kids today have no respect. I don't like a lot of it; noisy and fast
Spiritual Belief	49	Well-being	2	-1/+1 -1/+3	It helps, but not enough at times. I feel I should work harder at it
Unemployment	50	Quality of Life	1	-4/+1	Well for a time it would be good to have no work stress, but how would I cope moneywise
Travel	51	Life Satisfaction	1	-4/+4	Yes, it's good, but hard to settle back after