

Constructing Bodies of Knowledge: Examining the Discursive Sites
Through Which Individuals Come to Understand What “Health” Means.

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Abstract

How individuals perceive and understand health will impact the health behaviours that they engage in, how they engage with the healthcare system, and how they perceive themselves on a spectrum of healthfulness. Perceptions of health are developed within specific contexts, such that individuals' understanding of what constitutes a state of health is shaped within the culture in which they are situated. The present study used semi-structured interviews to examine how individuals conceptualize health and health status, and through discourse analysis examined how culture and gender intersect to influence personal discourses of health. There were three main themes that emerged consistently within both lay and health-related participant groups around defining health and ill-health: Health as an absence of illness, Mechanistic conceptions of health (food and nutrition, obesity/overweight as unhealthy), and Holistic notions of health (psychological well-being, stress, and the role of environment on health). Lay persons have had greater access to biomedical discourse and medical professionals participate in social discourse, so the agreement between groups would be expected. Analyses by gender demonstrated that while males and females tended to use similar words to describe health, males appeared to use more active language references "activity" and "ability" more frequently than female participants. These research findings reflect a proliferation of biomedical discourse at the cultural level, in which the locus of control for health is located within the individual and their behaviours.

Constructing Bodies of Knowledge: Examining the Discursive Sites

Through Which Individuals' Come to Understand What "Health" Means.

There is a great deal of research being conducted in the field of health and medicine that is aimed at understanding how to better deliver healthcare, to decrease costs, and to improve the health status of individuals and the population (Entwistle, Firnigl, Ryan, Francis, & Kinghorn, 2012; Kongstvedt, 2013). This research is important and constructive, but there is a gap in its applicability; enhancing expert knowledge and applying it to strengthen our current healthcare system is certainly desirable, but an integral piece is often missing, and that is the perspective of those the system is meant to benefit – the consumers of healthcare services. In order to effectively deliver health services, it is important to understand how those who utilize these services perceive health, so that the delivery may be as efficacious as possible. It is also important to understand how those who deliver healthcare services perceive and understand health concepts so that there may be continuity between expert and layperson, doctor and patient.

Because perceptions and knowledge are consistently evolving, continued research in the area of perception of health is integral to maintaining an understanding of how both laypersons and medical personnel perceive and understand health phenomena. Research in the social and medical sciences regarding lay perceptions of health have most often focused on lay beliefs in relation to specific illnesses or disease, for example, beliefs about alcoholism, obesity, breast cancer, diabetes etc. (Cavanagh, Taylor, Keim, Clutter, & Geraghty, 2008; Kilpatrick, Ohannessian, & Bartholemew, 1999), rather than individuals' general beliefs about health. Furthermore, studies within the field of psychology that have examined lay individuals' general beliefs about health and the social construction of health are 20 years old or more and according to Lupton (1995) tend to undervalue humanistic, critical, and interpretive approaches to understanding

health and health behaviours (e.g., Connelly, Philbrick, Smith, Kaiser, & Wymer, 1989; Kirscht, 1972; Weinstein, 1984). Since these studies were conducted, ideas about health and health care have shifted. For example, health care consumers within Canada have available to them greater options – options outside of the biomedical model, such as more holistic, and Eastern models of health care services (Hughner & Kleine, 2004). Furthermore, understandings of health are inevitably tied into cultural mores, and these have also shifted over the past few decades. In understanding what is considered to be ‘healthy’ and the behaviours that individuals consequently engage in to attain a state of health, health researchers will then be better prepared to address effective healthcare delivery. Examining perceptions of health held by individuals and informed by their social contexts may also elucidate the manners in which individuals think about what constitutes a state of health, health practices, and may inform more effective public health advocacy and the dissemination of relevant information to individuals.

Therefore, the purpose of the present study is to examine the perceptions held by health-related professionals as well as lay persons to determine the ways in which individuals internalize messages about health from their contextual surroundings, how these perceptions are reflected in beliefs about health and healthfulness, and the myriad of ways in which individuals’ place in culture (their experiences, their age, their gender, their ethnicity, and so on) intersect to impact how health is perceived. The concept of constructions of health and the intersectionality of personal, biomedical, and cultural discourses will first be explored through the lens of social constructionist theory. Intersectional approaches aim to understand the person in relation to their varying sites of power and oppression within social contexts that vary across space and time and how these impact individual experience; it is concerned with recognizing and understanding the complex manners in which social locations and power structures shape the lived experiences of

humans (Hankivsky, 2014). Because of the emphasis on body size that is seen in research, media, and cultural discourses of health (Fox, Ward, & O'Rourke, 2004; Rail, 2008), the present study will examine the ways in which perceptions of health are related to the evaluations of appearance and body size. We construct our knowledge of the world through our experiences and the discourses to which we are exposed (Burr, 2003), so social constructionist theory was applied to make sense of the ways in which people come to know about health. For the present study, qualitative methods were employed; semi-structured interviews were conducted with students in health-related professions and lay individuals in which questions focused on personal conceptions of health (how one defines health, what constitutes a state of health or illness), and how they conceptualize and engage in health services (to determine if there are gendered and cultural differences in accessing health care, understanding health, or caring for one's health, and if a state of health means something different to individuals according to gender). These inquiries are informed by previous research that suggests that women consult their general practitioners more than do men; that medicalization of female bodies has increased conceptions of the female body as needing medical intervention; and that within medical interactions, women tend to receive more time and attention than do men (Hunt, Adamson, and Galdas, 2012). However, Hunt, Adamson, and Galdaas (2012) assert that the gendered differences in health behaviours are much more complex. Healthcare utilization also changes over the lifespan and by region (Roy & Chaudhuri, 2012).

Social Constructionism

In order to examine constructions of health and the perceptions individuals hold, it is important to consider the context in which these ideas are held. This context influences individual and cultural perceptions. Social constructionism is a theoretical paradigm that applies a critical

lens to knowledge and knowledge production; it provides a structure for critiquing and examining the taken-for-granted manners in which the world is understood, challenges the presumed objectivity of science, and opposes essentialist ideologies. Social constructionist theory posits that the categorical delineations that we use to understand natural phenomena do not exist in any real or fundamental way; they do not refer to real divisions in nature (Burr, 2003; Foucault, 1979). For example, the dichotomized gender binary of males and females is not inherently ‘real’, but a category that was constructed as a manner of comprehending our world. These categories that we apply to natural phenomena are located culturally and historically, so that they are specific to time and place. This becomes evident in the alterations that conceptions undergo across time, alterations that do not reflect any actual changes in the entities being constructed but are contingent upon and reflective of shifts in cultural mores and social processes (Gergen, 1985). Knowledge production and specific manners of understanding the world are dependent upon where in the world one is, and the social and economic clime of that culture and time (Burr, 2003). Not only is knowledge culturally specific and historically relative, it is inevitably a product of that culture. Therefore, those who have been socialized differently and whose conceptual backgrounds differ, live, at least partly, in a different world with different objects (Liebrucks, 2001). Four key concepts presented in the social constructionist literature which will be pertinent to this research study are knowledge production, language, discourse, and power. These inform an understanding of how perceptions of health are produced.

Knowledge production. Knowledge, then, is an artifact of the culture in which it is produced, a product of social interactions (Berger & Luckmann, 1966; Danziger, 1997); it does not take place in a social vacuum (Liebrucks, 2001). We must not assume that the bodies of knowledge that have been constructed, in particular in North American cultures or dominant

North American culture, are in any essential or fundamental way better or nearer the truth than bodies of knowledge constructed in other regions of the world. While the natural world exists, how it is perceived and conceptualized is rooted deeply in social processes; therefore, there cannot be any given, determined nature to the world or individuals (Burr, 2003). At the same time, the natural world sets limits to the constructive possibilities availed to us (Liebrucks, 2001). The theory of social constructionism posits that our knowledge is not a direct perception of reality, but is attained through a value-laden lens. The conceptual frameworks and categories that we use in the production of knowledge already exist and are embedded within the cultural milieu.

While knowledge is produced within the particular culture in which it functions and is embedded in cultural, social, and historical values, it may also conversely have a profound impact on social life (Waitzkin, 1989). Production of knowledge contributes to ideological hegemony - exerted through institutions such as schools, churches, family, and mass media (Waitzkin, 1989). Through these institutions, ideologies are (re)produced, and individual members of a society are inculcated with a system of values, attitudes, and beliefs. As Habermas (1968) asserted, scientific knowledge is an area in which this is most apparent given its claims of objectivity and value neutrality. Knowledge and ideology function as subtle mechanisms in which individuals internalize what they hold to be truths about the world, and which consequently contribute to the manner in which a society is structured and organized (Waitzkin, 1989).

Language. An integral component to the construction of knowledge is language; it is, arguably a precondition for thought in our culture (Burr, 2003). Language is never neutral or value-free, but is a process through which concepts and categories are acquired by each person in a culture as they acquire the language to describe and understand them, and is then reproduced with others who share that language. Language is central to our ability to communicate, and also

enables information to be transmitted (Lyons, 2000). Through language meaning is produced and reproduced, and meaning is deeply embedded in the words chosen to convey a particular meaning about a specific topic. The structures of our socially shared language are where the locus of social and personal knowledge production is considered to take place (Burr, 2003). Language, then, can be thought of as action; it serves a performative role. When people converse with others they are actively constructing the world and the individual human subject. It is the interpersonal interactions of everyday life that produce and transmit knowledge. As Burr (2003) suggests, knowledge is not something that an individual possesses, but is something that we, as people, actively participate in collectively.

Language can be seen to function at both the micro and the macro level. At the micro level, social constructions are taking place with each discourse between two or more people. Macro level social constructionism is concerned with the social and material structures and institutional practices that influence discourse, language, and knowledge production. That is, it concerns itself with how the distribution of material power (for example, economic structures, military, educational institutions, etc.) defines power between those with relative power and those without; it is these macro level institutional forces that are largely responsible for influencing dissemination of some discourses over others. These micro and macro level processes are not mutually exclusive of one another; individual discourses and social discourses are reciprocal, each informing the other.

Discourse. Language and knowledge production are integrally related to discourse, defined by Foucault (1972) as “practices which form the objects of which they speak” (pp. 49). A discourse is a set of representations or meanings that produces a particular event; it is, in part, the process of action that is derived from language. In other words, it is the language through which

understanding and perception is created; discourse is based contextually within a culture, such that how a phenomenon comes to be understood is dependent upon place, time, and the cultural milieu). Once available at a cultural level, discourses may be appropriated in the interests of a very few - those with relative power. Discourses are implicated in social control, yet this social control happens beneath the level of perception, so it is not recognized as such (Burr, 2003). The function of discourse in relation to power is obscured by the widely held ideas and beliefs that the discourse (re)produces; therefore, people are often unable to recognize and then challenge these discourses. In fact, power is maintained through its ability to mask a substantial part of itself, and the complicity of those upon which it is enacted.

Power. Discursive constructions have implications for what we can do, and what we are expected to do (Burr, 2003). Foucault (1979) regarded knowledge as intimately tied up with power, and power as an effect of discourse. Discourses often serve the interests of relatively powerful groups who benefit from its reproduction; it is how meaning is mobilized to serve the interests of powerful groups and institutions in a culture. However, this process of power and the endorsement of discourses that serve relatively powerful groups is not an intentional machination of those with power (Burr, 2003). Instead, power is a reciprocal process in which power is produced by those who have it as much as it is produced by those who do not possess such relative power. The degree to which any particular discourse prevails over time is dependent not on its empirical validity necessarily, but on the changeability of social processes - specifically processes of communication, negotiation, and rhetoric (Gergen, 1985). The prominence of any particular discourse is also reliant upon the social conditions that may be more suitable to reproducing certain representations over others. For example, discourses that are produced and reproduced in

our culture will be rooted in the Capitalist structure, as it is a system which permeates many aspects of daily life and modes of knowing.

Anytime a discourse is invoked - a particular form of knowledge is represented - the result is the enactment of power. Institutional knowledge (i.e., that which is produced within cultural institutions such as through education, biomedical discourse, scientific knowledge, religious discourse, etc.) permeates at the cultural level. Institutional knowledge is very powerful in that through the production of this knowledge the control of society is managed. It produces what Foucault (1977) has referred to as 'disciplinary power' - power that controls without force, but through the encouragement of self-examination and scrutiny, as opposed to a disciplinary or externally imposed form of power (e.g., individuals are encouraged to scrutinize their bodies and consequently manage their health; the locus of control is positioned within the person and their behaviours). This form of power is insidious in that one perceives themselves to be exerting agency and autonomy, when the lens through which self-scrutiny and self-examination take place is an externally imposed one. Therefore, it is an institutional power exerted at a personal level. Power can best be understood not as something held by individuals or particular groups but rather as a quality of social relations (Bury, 2008).

This mode of power became possible only through historical and cultural shifts. It was only through changes in the structure of society - increases in population, industrialization, and economic changes - that brought about new social priorities which resulted in the promotion of specific discourses held by the individual. As the concept of population emerged, so too did the concepts of management and control. Consequently, the eighteenth century saw an increased scrutiny of the populations' sexual behaviour, and the 'confession' of sins, which led people to self-scrutinize (Foucault, 1978). This shift saw a move away from the sovereign power in which

control was exerted through punishing, coercing, and killing subjects toward the disciplinary power of modern culture in which control is exercised through subjecting oneself to the scrutiny of others, especially experts, and to self-scrutiny (Burr, 2003). Power then is enacted through bearers of authority, such as the medical profession and psychiatrists and psychologists, in particular (Burr, 2003). Those in authority have the capacity to institutionally define normality and abnormality, which serves to surveil and control all members of that society (Foucault, 1973). Personal life, through discourse, is brought under surveillance and is then subject to expert intervention.

Historically, biomedicine was rarely subjected to examination and was accepted as an impartial, scientific body of knowledge, and it has only been in recent history that scholars (e.g., Foucault, 1973; Crawford, 1980; Gard, 1997 etc.) have recognized biomedicine as a site for the reproduction of power relations and constructions of health in relation to bodies (Lupton, 1995). These concepts continue to apply in contemporary settings, and theorists have evolved these concepts to apply to modern practices as the state of medicine, public health, and biomedical discourses have evolved. In conceiving of bodies through the discipline of public health, distinctions have been drawn between civilized (desirable) bodies and the grotesque body, stemming from the Middle Ages in which grotesque bodies were associated with the peasant class (Lupton, 1995). This dichotomized notion of bodies and health persists, today, with bodies which fall outside of the purview of specific aesthetic notions of health (i.e., bodies that are considered too large), falling within the category of the grotesque (Elias, 1978). The civilized body, on the other hand, is one that is controlled and individualized in which it is subjected to the conscious restraint of impulses, urges, and desires, as well as bodily processes, which we can see reflected in current attitudes toward health and the body (Lupton, 1995). Even with modern conceptions of

health, which include discourses of holistic health and self-care (referred to as healthism), health and disease and their solutions are still situated at the level of the individual (Crawford, 1980).

With the rise of the “new” public health, emerged the concept of health promotion, which is aimed at all persons in a population – both the healthy and the ill – and directs individuals to take responsibility for their own health status (Lupton, 1995). This presents the body as something that must be managed, and places the locus of control for the maintenance of a ‘healthy’ body on the individual. (Foucault, 1973).

Our knowledge of our world is socially constructed; it is contingent upon cultural, historical, and geographical contexts. It is through language that discourses are breathed into existence, and these discourses serve institutions of power through which knowledge is produced and disseminated. Individuals internalize the discourses that come to inform their worldview. Thus, it is through available discourses that we come to understand what it means to be healthy or unhealthy. It is important to examine the ways in which individuals perceive health – both laypersons and experts – so that we can determine what it is people believe constitutes a state of health or ill health, the behaviours they understand as healthful and those that they engage in, so that we might inform clinical practice and come to understand how to better deliver public health messages. Of course, it is important to acknowledge that public health information is not neutral, but also a site in which power and control is exerted; inasmuch, it should also be informed by consumer understandings of health. Much of the current health discourse is informed by biomedical discourse; it has permeated discourse at a cultural level. Therefore, it is necessary to understand how biomedical discourse functions, how it constructs health, and how it draws bodies into its purview.

Medical Knowledge and Discourse

Foucault (1973) theorized that the body is a major site of power relations. The body falls under the purview of biomedical discourse, becoming something which must be constantly monitored and managed (Wright, O'Flynn, & MacDonald, 2006). It is through this constant monitoring that the body becomes subject to expert intervention. As with any body of knowledge, medical knowledge is socially constructed. Medicine does not stand outside of social relations but can be seen to mediate them through practice and discourse. The body is spoken of in terms of its condition, as being disease-free, functioning normally and healthily or as being ill, malfunctioning, or diseased (Burr, 2003). Science and medicine may best be understood as symbolic systems within a culture that produce knowledge, and not as passive or autonomous institutions located outside of social relations (Bury, 2008). Conceptions of health and illness within the biomedical discourse are not inherently biological or psychological phenomena, but are socially constructed concepts.

At the micro level, medical encounters themselves transmit ideologic information which serves to maintain the current social structure and hegemonic discourses. What is said by both patient and doctor in a medical interchange produces and reinforces their individual perceptions about social life, illness, and health. Doctors and medical practitioners tend to focus on symptoms and illness or disease in medical interactions, and may even elicit diagnoses for syndromes through the questions they ask (Shorter, 1992). The language exchanged between doctor and patient may reinforce not only conceptions of health, but other hegemonic discourses related to gender, the individual, economy, and the body (Waitzkin, 1989). Our bodies are endowed with varied forms of social significance identified by their size, shape, smell, and demeanour and their interpretation is contingent upon our gender, ability, ethnicity, economic status, social context,

etc., so while the body is constructed by social context and the intersectionalities of the individual, bodies also construct meanings of health in a reciprocal exchange (Howson, 2012; Lupton, 1995; Shilling, 1995) This exchange of value-laden language is inevitable; it is through social processes such as the medical encounter that knowledge about health and the body is constructed and transmitted (Shilling, 1995).

A hegemonic notion of health in North America is reliant on economy and productivity - the notion that work and economic production are indicators of a state of health. These values, when expressed in the medical encounter, reinforce cultural discourses about health at the micro level (but are also reliant upon them, as a macro level construction). These conceptions of health are often conveyed by medical practitioners to their patients in either explicit or implicit terms through messages that productivity is preferable to idleness (Waitzkin, 1989). For example, health has oft times been framed in terms of one's capacity to function productively at work, and the social costs of various diseases are often given dollar figures based on lost productivity (Wolf & Colditz, 2012; Zhang, Bansback, & Anis, 2011). Indeed, in an analysis of the WHO definition of health, Huber et al (2011) identified "the ability to participate in social activities including work" (pp. 1) as one of the social domains of health. In speaking to patients in terms of work and productivity, health becomes defined for those patients as the capacity to be economically productive. Medicine is a site that imposes ideological structures and knowledge production, even at the level of the doctor-patient interaction.

These discourses of health and illness that are conveyed in the medical encounter reinforce current social patterns; it is in this way that medical discourse exerts its power to control the behaviour of individuals, in manners deemed socially acceptable. Medical language tends to negate a critical exploration of the biomedical model and discursive constructions of health.

Waitzkin (1989) asserted that since the early twentieth century, medical practitioners have predominantly come from an upper-middle class socioeconomic status, a cultural position which does not encourage critique of the sociocultural factors contributing to client distress, such as socioeconomic status, hegemony, and environment. Further to this point, our individualist framework of health, placing the onus of health within the control of the individual, largely ignores social determinants of health and their impacts on individuals and their health behaviours. For example, poverty has been linked to chronic stress and poorer health outcomes, but rather than treating social circumstances, medical discourse relies on medicalization and medication of the body, without treating the source of ill health (Mikkonen & Raphael, 2010; Raphael, 2008; Wilkinson & Marmot, 2003). The medical model inherently discourages a critique of power and the role of institutions. Because of this, social change as a therapeutic option is precluded from the biomedical discourses on health.

Weight-centered approach to health. Over the past several decades, a focus on obesity as a health detriment has become ubiquitous in both medical and lay discourses, reflecting cultural anxieties about body size and beauty. The proliferation of the ‘obesity as a health detriment’ discourse can be attributed to the dramatic increase in research literature - epidemiological, physiological, and medical - on obesity and health-related consequences. The proliferation and dissemination of this particular discourse has resulted in obesity being labelled as an ‘epidemic’ (MacLean, Edwards, Garrard, Sims-Jones, Clinton, & Ashley, 2009), a notion which has been problematized over the years by a number of researchers. Coincident with the increased attention to obesity in scientific inquiry is a (re)production of this knowledge at various cultural levels, through media, schools, health and fitness practitioners, and through the dissemination of public health information (Rail, 2008).

Because of the perceived health risks associated with obesity, it has come to be defined as a medical condition, bringing it under the purview of the medical gaze and expert scrutiny (Foucault, 1973; Gard, 2004). The language of obesity as an ‘epidemic’ has been seized upon, and millions of dollars have been spent in public health campaigns aimed at warning the public about the dangers associated with overweight with a focus on weight loss as a treatment option (Cogan & Ernsberger, 1999; Ikeda, Amy, Ernsberger, Gaesser, Berg, et al., 2005). The ubiquity of these conversations about obesity, weight loss, and health has permeated our culture, such that many medical professionals and lay persons alike have come to believe that dieting is not only safe and efficacious, but that the loss of excess weight improves health (Cogan & Ernsberger, 1999). These discourses persist, despite the fact that research establishing the genetic heritability of body type and size was established as far back as the 1920s. Even still, genetic influence on body size is largely overlooked or actively downplayed by the biomedical discourse, resulting in clinical efforts focusing more on individual lifestyle behaviours than on recognizing genetic influences and personal weight set points (Lupton, 1995). Factors such as genetic influence, individual differences in resting metabolic rates, and set points all suggest that the relationship between body size and health is not solely determined by the behaviours of an individual (e.g., poor diet, inactivity, or engaging in weight loss programs). This assumption of individual responsibility in overweight is based on a mechanistic view of the body that assigns responsibility for body size to the individual (Rail, 2008). The relationship between weight and health is far more nuanced than individual behaviours, and weight - although a primary focus in treatment - is not highly amenable to change (Cogan & Ernsberger, 1999).

A common approach in treating obesity and overweight is focused on dieting and weight loss. This treatment approach is problematic for a number of reasons. Firstly, the defining of

what constitutes an unhealthy state (i.e., overweight or obesity), is rather arbitrary – based upon height-weight indices of body size, most commonly the Body Mass Index, or BMI, scale (Bostrom & Eliasson, 2006). Cutpoints for defining obesity have been changed over the years; most recently the cutpoint has been decreased from 27 to 25, which places more than half of Canadians in a weight category that may raise concerns about health (Jeffery, et al., 2000). According to Statistics Canada (2010), the national average is 26.2.

Aside from the problems associated with actually defining obesity, treatments focused on weight loss through dieting present a number of problems. The weight loss industry promulgates numerous diets every year which fall in and out of popularity, many of which may actually be hazardous to one's health (Miller, 1999). Restrictive dieting, a commonly used form of weight loss program, has been demonstrated to be highly ineffective. For example, in a research study assessing restrictive eating dieting programs used by freshman college students, it was found that a history of weight loss dieting predicted greater weight gain (Lowe, Annunziato, Markowitz, Didie, Bellace, Riddel, et al., 2006). Similarly, Pinto, Gorin, Raynor, Tate, Fava, et al. (2008) found that individuals who used very low calorie diets (300-800 calories per day) achieved significantly greater weight losses than those who used moderately restricted calorie diets (i.e., 800-1800kcal/day), but also regained the weight rapidly. Weight cycling has been evidenced to lead to both physical health problems and emotional and mental health issues – particularly decreased perceptions of health and well-being (Foster, Sarwer, & Wadden, 1997; Lahti-Koski, Mannisto, Pietinen, & Vartiainen, 2012; Pasman, Saris, Westerterp-Plantenga, 1999); it is also a risk factor for weight regain (Elfhag & Rossner, 2005). Furthermore, there is some concern that a focus on weight loss may have unintended negative consequences, such as increased body monitoring and preoccupation, disordered eating behaviors, reduced self-esteem and feelings of self-efficacy (as

weight is often not as amenable to change through behavioural treatments as is expected), and cycles of weight loss and weight gain, to name a few (Bacon, Keim, VanLoan, Dericotte, Gale, et al., 2002; Bacon & Aphramor, 2011).

In addition to issues with weight loss approaches, including dieting, there has been research documenting the dangers associated with weight fluctuation and weight loss itself. Weight loss itself may be detrimental to one's health, due to physical changes in the body. Weight loss has been associated with loss of bone mass, even in those with adequate nutrition and aerobic exercise (Berg, 1999; Hannan, Felson, Dawson-Hughes, Tucker, Cupples, Wilson, & Kiel, 2000; Villareal, Shah, Banks, Sincaore, & Klein, 2008). Significant weight loss has been defined as 10% weight loss; however, current research suggests that weight loss as low as 5% reduces obesity-related disorders, dependent, of course, upon method of weight loss used (Blackburn, 2012). The Framingham Heart Study has found that men and women who had lost the most weight over a ten year time period had the highest mortality, specifically due to heart disease and cancer (Berg, 1999). Weight loss may mean different things, depending on how it occurs; voluntary weight loss in obese or overweight individuals is considered to be healthy, while involuntary weight loss is often indicative of the presence of serious morbidity or disease (McMinn, Steel, & Bowman, 2011).

Data from the Framingham Heart Study was analyzed to assess the relationship between fluctuations in body weight and the onset of chronic disease at least four years after the last weight measurement; analysis was based on a chronologic separation of weight change and four ends points: total mortality, morbidity due to coronary heart disease, mortality from coronary heart disease, and morbidity due to cancer (Lissner, Odell, D'Agostino, Stokes, Kreger, et al., 1991). Results demonstrated that weight fluctuations are related to higher risk of coronary heart

disease and death than those with stable body weights. A review of selected medical records from the Framingham Heart Study showed that dieting was common among those subjects – documented in 50 percent - who had variable or fluctuating body weight, demonstrating a need to examine the health repercussions of weight fluctuations due to dieting (Lissner, et al., 1991). Furthermore, this study found that death rates were lowest in young men whose weight remained stable and in older men who gained weight. In young women rates were similar between all groups, and in older women were similar between weight-gain and weight-stable groups (Lissner, Odell, D'Agostino, Stokes, Kreger, et al., 1991). These findings support the theory that weight fluctuations, rather than overweight, may negatively impact health, and that, particularly as people age, weight gain may provide health benefits (Childers & Alison, 2010; Lissner et al., 1991).

The tendency for medical discourse to focus on a weight loss approach to health in spite of the absence of data to suggest this an efficacious and safe mode of treatment has come to be called the ‘weight-centered approach toward health’ (Cogan & Ernsberger, 1999). The weight-centered approach is rooted in a thinness bias (Ernsberger & Haskew, 1987). While the thinness bias is quite widely accepted as a prominent issue in media representations of bodies, it is rarely acknowledged by researchers or health professionals as an issue in medical discourse. In fact, research has demonstrated that health professionals hold biases against overweight and obese persons consistent with those held by individuals in the lay public, espousing negative feelings and assigning negative value labels (e.g., lazy, impulsive) to overweight and obese patients (Puhl & Brownell, 2001). Because obesity is also presented in moral and economic terms, it is not surprising that the medical gaze constructs the overweight body as lazy and expensive (Rail, 2008). This attention to obesity as a health determinant permeates cultural understandings of

health, such that it would be expected that it has become a central aspect of the construct of what constitutes a state of health. Thus, in examining conceptions of health, it will be important to examine if and to what extent that notions of body size as being representative of a state of healthfulness have been internalized.

Problematizing a weight-centered approach to health. The use of the term ‘epidemic’ to describe the issue of obesity has been challenged by a number of social scientists and biomedical researchers (Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006; Cogan, 1999; Gard, 2004). Cogan and Ernsberger (1999) identified four underlying and inaccurate assumptions upon which the obesity discourse is based: (1) people have the capacity to alter their weight through their behaviour; (2) dieting is effective; (3) dieting is healthful; and (4) fatness is equated with disease while thinness is presumed to indicate health. These assumptions are not based entirely on an objective reality, given that research has demonstrated that weight loss itself is not associated with improvements in health; rather, it is physical activity that has been shown to positively impact an individual’s state of physical health and well-being through mechanisms such as reduced blood pressure (Slentz, Houmard, & Kraus, 2009). The weight-centered approach to health is based on a conflation between medical discourses of health and a Western cultural bias against large bodies, a bias that is not globally shared in varying cultures.

The weight-centered approach is rooted in a cultural disdain of body fat and large bodies, a social discourse that stigmatizes the overweight and obese (Oliver, 2006b). The medical profession is not immune to these cultural discourses; there is reciprocity between medical and social discourse, as would be expected given that medical professionals are both social individuals and medical experts. These medical discourses on overweight as unhealthy emerged in concert with and through the promotion of discourses within a number of other institutions, as well. As

obesity research proliferated, the emerging ideas about obesity and health were enforced and reinforced through other institutions as well - psychological conceptions of health and well-being, understandings of nutrition and discursive constructions of 'healthy eating', education, and public health (Gleason, 2006; Mitchinson, 2013). The pervasive belief that overweight is synonymous with poor health is reflective of a selective interpretation of available research, as reviewed below. The paradigm shift that has led to the weight-centred approach to health emerged as several incomplete and inaccurate ideologies about the nature of weight, health, and dieting merged, the discourses of each reinforcing the other; these ideologies became widely accepted by professionals and lay persons, allowing for the obesity-as-health-detriment discourse to mediate understandings of health (Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006; Oliver, 2006b).

Experts on obesity and obesity researchers have relied entirely on cross-sectional studies, which are limited because they often fail to account for extraneous variables, and cannot determine causality, yet the consequent discourse on overweight and health have reinforced the notion that such studies are objective and veracious (Gaesser & Blair, 2002). Because of the nature of research on overweight and health, and the difficulty in creating experimental designs, the manner in which data is derived is limited, which in turn limits the generalizability of results. Gaesser (2003) asserts that the two sources most cited (and upon which consequent research proliferated) in support of the ideology that obesity is a disease, an epidemic, and a public health concern, were misinterpreted.

The first, conducted by McGinnis and Foege (1993), was a meta-analysis of studies that had conducted a quantitative assessment of morbidity and mortality factors. In synthesizing the data, diet and activity patterns were found to be associated with morbidity and mortality rates. While the authors have declared that their research was examining the broader health behaviours

and not the narrow effect of obesity, their findings have been cited as evidence of a relationship between obesity and ill health. For example, in a study assessing annual deaths attributable to obesity, Alison, Fontaine, Manson, Stevens, and Vanltallie (1999) misinterpreted the data presented by McGinnis and Foege (1993), relating ‘overnutrition’ to obesity-related mortality. The actual purpose of their study was to identify and quantify ‘nongenetic’ factors contributing to mortality; overweight and obesity are certainly related to both environmental and genetic factors. In their research, McGinnis and Foege did not identify obesity and overweight as contributing to ill health, but rather were focusing on the behavioural aspects – that is, adequate exercise and appropriate nutrition. They acknowledged the impact of social and environmental factors (such as socioeconomic status and access to adequate medical care) are difficult to quantify and measure so were not included in this research study. An additional issue with obesity research is that confounding variables have typically not been controlled for - variables such as weight fluctuation, pharmaceutical weight loss substances, and other factors that may impact health irrespective of weight (Oliver, 2006a).

The second study to which Gaesser refers, conducted by Allison, Fontaine, Manson, Stevens, and Vantallie (1999), sought to generate estimates of obesity-related mortality. It has been frequently cited by obesity researchers. In it the authors used data from studies that had failed to consider the possible confounding factors including fitness of participants, use of weight loss drugs, weight fluctuation, and social factors such as access to health care. The proliferation of obesity research stemming from these two studies (e.g., Mokdad, Ford, Bowman, Dietz, Vinicor, Bales, et al., 2003) is demonstrable of the manner in which social interactions, knowledge production, and discourse function.

A major tenet of the weight-centred approach to health is that patients can, through behavioural methods (i.e., weight loss), improve their health. This mode of knowledge production places the locus of control within the individual - the patient - and is based on a moral and mechanistic conception of health. However, just as the assertion that obesity is a health detriment is flawed, the notion that weight loss is a treatment that creates a state of health is not upheld by evidence. Cogan and Ernsberger (1999) argue that there has been no data from controlled trials that demonstrates weight loss to be an effective treatment for reducing disease or extending life expectancy. Methods that are often prescribed as part of a weight loss program, such as restrictive dieting, have not been demonstrated to 'cure' obesity in a significant number of participants (Cogan & Ernsberger, 1999); the weight loss that is achieved is often transient or temporary, with minimal permanent weight loss achieved by the majority of participants (Cogan, 1999; Curiioni & Lourenco, 2005; Pinto et al., 2008). Of greater concern is the fact that weight fluctuation has been found to be a health detriment, and continual participation in prescribed weight loss programs leads to repeated weight loss and regain - a pattern associated with increased mortality and cardiovascular disease (Berg, 1999). Also of concern is the psychological impact of obesity management on a patients' body image and self-perceptions (Grave, Cuzzolaro, Calugi, Tomasi, Temperili, et al., 2007). As has been noted, the biomedical discourse does not lend itself to self-criticism, which has allowed the obesity discourse to proliferate while remaining largely unexamined; it is not susceptible to the same self-scrutiny that the medical discourse imposes on its patients.

While obesity research and the biomedical discourse on obesity have constructed overweight and obesity as a disease, an epidemic even, the adverse effects of weight loss methods, and the negative health consequences of the pursuit of the thinness ideal have remained largely

unacknowledged. The relationship between weight, health, and life expectancy has actually been more accurately conceptualized as U-shaped with extremes of under- and overweight at either end posing potential health risks; this relationship is not widely known or accepted by either lay persons or health care professionals (Cogan & Ernsberg, 1999). Furthermore, researchers have discovered something which has been labeled the ‘obesity paradox’ – that obese or overweight individuals who suffer chronic illness or injury have lower mortality rates than their normal and underweight counterparts (Childers & Alison, 2010). Childers and Alison (2010) suggest that this decrease in mortality rate may be due to the beneficial immune-modulating effects of abdominal fat, believed to provide health benefits during times of biological stress or trauma. Studies have shown that overweight is associated with increased risk only at extreme levels, yet it has been labelled an epidemic (Childers & Allison, 2010); at the same time data has similarly shown that extreme thinness is associated with increased mortality, there is an increased social pressure for thinness (compounded by not just appearance ideals but by health discourses directed at weight loss), and the perception that weight is easily managed through behaviour has led many to engage in potentially dangerous weight-loss and dieting programs. Thus, the weight-centred approach has attained hegemony, excluding many other health concerns and constructions of health from public and expert attention and discussion.

Alternative and peripheral medical discourses. Although the weight-centered approach dominates medical discourse, there are alternative discourses which emphasize a more holistic approach to health, discourses that are not reliant on moralistic ideas about the individual or placing responsibility for ill health solely on an individuals’ behaviour; rather, these peripheral discourses recognize and acknowledge the complexity in maintaining a state of health, and the role of environmental, social, and individual factors.

Health at every size. One such alternative approach is the health at every size approach, which has critiqued obesity research and the weight-centered approach to health. Researchers have suggested that the obesity discourse may actually lead toward ill-health, particularly in populations which struggle with disordered eating behaviours and body image (Rail, 2008). Proponents of a health at every size approach have been concerned with the stigma and body shaming that is associated with the obesity discourse, and the conflation of thinness with health. This discourse is an additional mechanism of controlling bodies, reinforcing cultural notions of thin bodies represented in the media as attractive and healthy.

Conceptualizing the size of the body as indicative of health focuses treatment on managing the body. The health at every size approach contends that while body weight is not entirely unimportant, as extremes at either end of the spectrum increase health risks, evidence suggests that health risks associated with overweight can be managed irrespective of weight loss. Furthermore, weight loss methods such as restrictive dieting, excessive exercise regimes, and behaviour modification rarely succeed. Rather than a focus on weight loss or decreasing body size, a focus on eating well and adequate exercise has been shown to positively impact those health problems associated with overweight (Gaesser, 2003). This approach does not, however, suggest that all people are at their healthiest weight, but rather that engaging in a healthier lifestyle will result, over time, in a healthier weight for that individual (Jutel, 2008); it is reliant upon a more holistic conceptualization of what constitutes a state of health.

This holistic approach to the conception of health focuses on feeling good about oneself, rather than focusing on body size – a practice which often leads to potentially unhealthy eating behaviours (Jutel, 2008). According to Jutel (2008), the focus under this paradigm is eating well and being active in a manner that is comfortable to the individual (rather than regimented exer-

cise programs that often fail because the individual does not enjoy or is not invested in the activity). This approach is about wellness rather than body size. This shift in biomedical discourse stems from research that has repeatedly demonstrated that the focus on weight loss as the primary goal in achieving good health often has negative consequences. One such negative consequence is the weight cycling associated with dieting resulting in increased weight over time. When the focus is on health rather than on weight loss, it shifts away from body ideals that can lead to harmful eating behaviours and toward a view of health that is more conducive to healthfulness. This discourse, however, is not easily accessible to the general public, and is often highly contentious among medical professionals, with many asserting and maintaining that overweight is inherently unhealthy. This may be due to the fact that, while there has been an increase in research related to health at every size, there has not been a similar increase in public visibility through public health messages and the dissemination of health knowledge through media; public health messages are still primarily focused on overweight as being inherently unhealthy.

Social constructions of illness and social issues. As previously mentioned, the biomedical discourse precludes an examination of social issues as potential modes of therapeutic change. Although medical institutions in Canada have adopted a biopsychosocial model of health and wellness, with greater understandings of the social determinants of health, diagnostic and treatment methods still emphasize biomedical approaches over social approaches to health and treatments. In doing so, it does not prioritize examination of social issues as a source of illness, instead locating the cause within the individual. As has been alluded to, a state of health or illness is also a social, rather than a purely biological, structure. Illness is not a fixed entity that is entirely dependent on the nature of disease or health, but is laden with socially, culturally, and historically relevant values (Burr, 2003; Foucault, 1973). In this same vein, ‘disability’ is under-

stood as a function of the environment, not a quality of the body or of the individual, contrary to the medical model, which implicitly locates illness and disability within the person who suffers disability. What is not attended to in the medical model of health/illness and ability/disability is the manner in which the environment is fashioned according to the values of some groups of people in a culture over others, typically a practice related to institutions and power.

In this way, illness and obesity can be seen as not only socially created and located, but also as sustained by the social milieu and dominant discourses (Burr, 2003). The environment in which we live is constructed in such a way as to be efficient and useful to dominant groups, and is often problematic for those outside of this group; these individuals are then labelled as having some ‘disability’. While ‘deficiencies’ of the body only become apparent when constrained by the environment designed to suit the needs of others (Burr, 2003), the structure of the environment is not often considered as having imposed this disability but rather it is located within the person in biomedical discourse. It is in this tradition that the medical discourse seeks to treat illness and symptoms of illness but excludes an examination of the social, cultural, and environmental factors as a mode of treatment. In addition to biological and physiological factors that influence health and longevity, there are a number of social and environmental factors that are unexamined by the biomedical discourse on obesity, such as socioeconomic status, ethnicity, gender, access to health care, access to nutritional foods, education, consumerism, the food industry, and other sociocultural factors (Courtenay, 2000; Rail, 2008). In fact, persons who are deemed obese have been found to have a greater likelihood of living in poverty and lack education, socioeconomic factors that have been found to be highly correlated with health independent of weight (Cogan & Ernsberger, 1999). The relationship, therefore, is exceedingly complex in many cases.

In overlooking social factors and focussing on weight loss as a treatment, discursive constructions of overweight and obesity in the medical profession have largely neglected to examine, through research, the role of lifestyle changes that may promote health. It is not just in research that social issues are overlooked, but even in the medical interaction between physician and patient, the social issues that impact a person's health are not often acknowledged or accounted for as either part of the issue or a source to be addressed in creating a more healthful state (Waitzkin, 1989). Because of the focus on individual responsibility in relation to health, and particularly in terms of body weight and size, in examining individuals' understandings of health, this study will examine whether individuals are cognizant of social determinants of health and other more holistic aspects of health and healthfulness or if there is greater emphasis placed on the individual and self-control.

While the weight loss and dieting programs that are currently the predominantly prescribed solution or treatment to deal with the 'issue' of overweight have demonstrated to be highly ineffective and even potentially detrimental (Cogan, 1999), research has demonstrated that simple lifestyle changes such as improved nutrition and increased activity, and not weight loss, are associated with improvements in health. The health benefits of increased activity and exercise are seen in participants independent of weight loss (Cogan & Ernsberger, 1999). Oliver (2006) argues that the current research promulgates a weight-dependent health discourse over a lifestyle, holistic approach to health in part because it benefits many undertakers of health research - those with private obesity clinics who have a vested interest in maintaining a weight-centred approach to health. It is because these clinics are located within the cultural location of a capitalistic structure that they seek to maintain current power structures, and reinforce hegemony. Furthermore, an entire capitalist enterprise is invested in the maintenance of this discourse,

with diet magazines, the food industry, weight loss surgery, etc. holding a vested interest in continuing to promulgate the notion of overweight as inherently unhealthy (Williams, 2003).

Lay Constructions of Health

The obesity discourse has become ubiquitous through media representations, public health messages, and through the intercourse that occurs in medical encounters. However, the obesity discourse is not only a dominant biomedical discourse, but has attained hegemony at the cultural level, as well. The public has been privy to only a select discourse on obesity and health; much as medical and health practices are contingent upon cultural discourses, medical discourse also impinges on lay conceptions of health (Danziger, 1997). The two discourses are not mutually exclusive, but fluid, reciprocal, and each is dependent upon the context of the other, which is a logical imperative given that medical practitioners are also social beings and part of the larger cultural milieu. This reciprocity is the result of the complex interchange between lay and professional health discourses. In today's culture in which information is so readily and rapidly accessible through various forms of media (i.e., television, internet, public health advertising), the transmission of biomedical discourse to lay persons is even greater than at any other time in history. While there is congruence between medical and social discourses, however, medicine is also an institution that exerts power over those within its purview, and therefore this construction is not equal between social participants and the institution.

Research on lay perceptions of health has found that lay people often tend to conceive of health as an absence of illness and an ability to carry out daily functions, such as paid work (Hughner & Kleine, 2008; Wakewich, 2000). However, with the introduction of Eastern ideas of health and wellness, greater access to health information (for example, the internet), and due to the evolution of health perceptions individuals hold over time, perceptions of health have begun

to shift to encompass a more holistic understanding of healthfulness (Hughner & Kleine, 2004; Wakewich, 2007). Hughner and Kleine (2004) conducted a meta-analysis of available research assessing lay perceptions – specifically, lay perceptions of health in the general public (as opposed to specific afflicted populations) – using interdisciplinary literature published over a 20 year time frame (1983-2003). They found that there were 18 themes of health which emerged from the data, which were classified into four broader areas: (1) definitions of health (i.e., how lay persons define a state of healthfulness; for example, health is the absence of illness or health is being able to carry out daily functions, etc.), (2) explanations of health or how health is maintained (e.g. that health is dependent on mental state or attitude, or involving religious beliefs in conceptions of health state), (3) external or uncontrollable factors impinging upon health (e.g., the role of institutions in supporting and maintaining a populations' health, or environmental influences), and (4) the role of health in people's lives (e.g., the priority placed on health or the discord between beliefs and behaviours).

Hughner and Kleine (2004) also found that lay definitions could be characterized by two negative views: health as absence of illness and health as the ability to carry out responsibilities; and two positive views: health as a state of equilibrium and health as providing freedom to lead a fulfilling life. The conception of health as the absence of illness is aligned with the biomedical model – a manner of defining health that focuses on productivity and ability to carry out daily activities and engage in gainful employment (Hughner & Kleine, 2004). The manner in which individuals perceive and construct their health knowledge has important implications for their utilization of the health care system and the health behaviours they engage in.

The parallels between lay conceptions of health and the biomedical model is not surprising given how discourses of health function and the process of knowledge transmission; lay per-

ceptions of health are not merely diluted versions of the scientific modes of understanding, nor are they simple dichotomies identifying states of health and states of illness. Instead, the manners in which lay persons come to understand healthy bodies is reliant on complex interactions between the various sources from which their conceptions are constructed: dominant cultural discourses (lay knowledge), individual experiences, political orientation, religiosity or spiritual practices, philosophy, interactions with medical practitioners, and other related factors (Hughner & Kleine, 2004). Lay perceptions of health, then, may vary greatly within a single society, depending upon such factors as socioeconomic status, gender, age, geographical location, ethnicity, sexual orientation, and a multitude of other factors that are implicated in the construction of individual worldviews.

In addition to defining health as capacity for productivity, lay persons tend to locate the onus of poor health within the individual, rather than the environment in which the individual lives (Hughner & Kleine, 2004). Placing the responsibility for ill health on the individual who is ‘unhealthy’ is congruent with the biomedical body of knowledge that tends to overlook the environmental influences, particularly social factors, on states of health and illness or as a focus of treatment. These discourses are implicitly conveyed during interactions between a patient and health care professional, so the medical encounter is a site of knowledge production that inculcates patients to understand health in very specific, biomedical terms – this is the intersection of lay and medical discourse. Interactions between medical expert and patient also serve to inculcate the patient as a participant in their culture and reinforce the action of scrutinizing bodies to judge health status – a practice that inherently locates illness within the body. Additionally, ideas about health are acquired through exposure to public health messages, school education, media, and other sources; because these sources tend to be more ubiquitous than our interactions

with physicians, they may play a more prominent role in forming our ideas about health and healthfulness.

This has been quite successfully ingrained in personal discourses of health. Individuals spend a great deal of time self-regulating and attending to their body size as a result of dominant discourses of health and beauty (which are rather inextricably intertwined). Many of our ideas about health are informed by dominant discourses of health and beauty promoted by various media – through television shows which allude either implicitly or explicitly to overweight as unhealthy, magazines, advertisements, and so on. Perceptions of health and body image are closely related then, with body dissatisfaction as a major reason that obese patients seek medical treatment; it is also a principal motivation for weight loss in a large portion of overweight individuals (Cuzzolaro, Calugi, Tomasi, Temperilli, & Marchesini, 2007). This self-monitoring and self-surveillance is a product of current discourses of health and institutions which maintain power through the exertion of expert opinion and encouraging individuals to self-surveil (Burr, 2003; Foucault, 1973). There is some research, however, which has suggested that this self-surveillance of the body (e.g., calorie counting or weighing oneself regularly) is associated with lower BMI in overweight women (Linde et al., 2007), but may also have negative effects on mental and physical health (Kwan, 2009).

Media. Lay conceptions of what it means to be healthy and how to define states of healthfulness are reliant upon worldviews, developed as a result of the complex interplay between individual, cultural, social, and political factors (Hughner & Kleine, 2004). As media has become increasingly ubiquitous over the past few decades, it has played an ever increasing role in the development and transmission of cultural discourses and has played a large role in shaping

worldviews. In particular, media has had a profound impact on lay and professional perceptions of health, and the development of specific health discourses.

Just as the weight-centered approach to health has proliferated throughout the medical community, it has been relentlessly promulgated in the media, as well. Advertisements for weight loss solutions, public health messages, and television shows focusing on weight loss framed within a health discourse have all fed cultural anxieties about large bodies and obesity (Fox, Ward, & O'Rourke, 2004; Rail, 2008). Due to an availability heuristic, in which the media overemphasize or misrepresent certain health risks, lay persons may come to overestimate their own risk of health threats (Lyons, 2000). While these media representations produce knowledge and construct meanings of health and illness in the lay public, they also limit the framework through which such concepts are understood; the manner in which we understand and acknowledge bodily symptoms may only be understood through the cultural and social framework that we have as a reference (Foucault, 1973, Lyons, 2000). There has been a veritable increase in media attention on the ‘obesity epidemic’, an idea which proliferated in the late 1990s and stemming from increased publications of papers defining overweight as a serious health issue in the 1980s (Oliver, 2006a; Wright & Harwood, 2009). Although there have been critics of the overweight-as-unhealthy discourse, these discussions have occurred mainly outside of public purview, leaving no alternative public discourse on health and weight.

The imagery and words employed in media representations of health lend to the construction of lay and professional conceptions and experiences of health. The discourses that have become available through various media – newspaper, magazines, advertising, and television – are based on a very mechanistic conception of the body. Thus, lay perceptions have been informed by this mechanistic view of the body in which there is a perceived or over-exaggerated relation-

ship between the size of the body and health status – specifically in relation to activity levels and diet. In addition to a mechanistic view, media representations of health are also entangled with moralistic conceptions of the body, wherein slender bodies are adulated, conflated with health, and are rendered morally appropriate. This has been referred to as the ‘healthism’ discourse, in which slender bodies achieved through individual behaviour (i.e., exercise) are equated with health (Wright, O’Flynn, & MacDonald, 2006). Both the mechanistic and moralistic views of health that are promulgated by various media emphasize an individual focus, in which it is reinforced that health is the consequence of specific individual actions or inaction. As noted by Foucault (1973), as much as it is within the medical encounter, the body becomes a cultural object that is to be monitored and controlled, and judged as morally acceptable or unacceptable.

The biomedical discourse of health locates the locus of control in the individual; this discourse is also reflected in public health messages and other media, resulting in public health promotion aimed exclusively at individuals. Media, then, is highly reflective of the medical discourse, failing to account for social factors that may constrain or otherwise impact health (Lyons, 2000). The framework that is available to lay persons is one of highly moralistic and mechanistic tones, that locates the responsibility for ill health solely within the individual for their behaviour. It does not provide a mechanism for critiquing the dominant medical or cultural discourses of health and individual responsibility, nor does it provide an alternative discourse that would facilitate examination of social or political factors. Media is another institution that maintains power and hegemony, therefore the representations of health and health promotion available through these sources maintain the status quo. As Rail (2008) asserts, subversive and alternative discourses of health and obesity are needed in order to provide a vision of health that is accessible to marginalized individuals.

Gender. Gender has been demonstrated to be an important factor in utilization of health services, in discourses on health and illness, the manner in which doctors interact with their patients, in the health behaviours that an individual engages in, and in constructions of health perceptions and healthy bodies (Conron, Mimiaga, & Landers, 2009; Garcia, Broda, Frenn, Coviak, Pender, et al., 1995; Paeratakul, White, Williamson, Ryan, & Bray, 2002). The social constructionist perspective recognizes the import of addressing how males and females think and act in relation to health. The health-related beliefs and behaviours that are held or exhibited by any one individual are largely influenced by their gender. Health behaviours can be seen as a means of producing gender (Courtenay, 2000).

Research has established notable differences in the health behaviours and beliefs of males and females. Historically, females have been encouraged to attend to and take care of their health, as well as the health of others (Courtenay, 2000). Women tend to be more knowledgeable about health issues, more likely to engage in healthful behaviours, and more likely to utilize health services (Owens, 2008; Pinkhasov, Wong, Kashanian, Lee, Samadi, et al., 2010). Discourses of femininity also construct women as weaker and more vulnerable than males, which makes accessing health care services more acceptable for females. The greater tendency for females to access health care services than males has been framed as an ‘overutilization’ of health services. Courtenay (2000b) asserts that there is a tradition of pathologizing women’s health by framing their use of health services as ‘excess’ or ‘overutilization’, while males have been traditionally held as a normative referent or standard of health. There are two general hypotheses that address this discrepancy in healthcare utilization between males and females: 1. The differential exposure hypothesis, which asserts that women report higher levels of health problems because of greater stress associated with gender and marital roles and social conditions of life that foster

health are less accessible and available to women than men, and 2. The differential vulnerability hypothesis, which suggests that women react differently to stressors and psychosocial conditions related to health than do men (Denton, Prus, & Walters, 2004). Although more attention has been paid to these issues in research and medical discourse in recent years, sexism still persists in the medical encounter and in knowledge production. Additionally, how females perceive health may vary across the life span; it is not static. Women's ideas about health have been found to evolve over time from a biomedical conception of health as the absence of illness or disease to a more holistic and environmental notion of well-being. Younger women also tend to relate their ideas about health to how their bodies look, but as women age they begin to base their perceptions of health on how their bodies feel more than how their physical appearance fits into the cultural standards of beauty (Wakewich, 2000).

Masculinity, on the other hand, may actually be detrimental to the health of boys and men. Health beliefs and behaviours are used by males and females as a means of demonstrating their gender; for males, this may involve demonstrating masculine ideals of invulnerability, powerful bodies, and strength (Courtenay, 2000a). Hegemonic masculinity may inhibit men from showing any signs of weakness (e.g., seeking out health advice or health services), but even further encourages males to eschew health behaviours. Powerful men may be concerned with health and safety in different ways than men who are poorer, indigenous, or members of other minority classes (Courtenay, 2000a; Hunt, Adamson, & Galdas, 2012; Schofield, 2012). When a man brags about not utilizing health care he is both reinforcing masculine discourse and positioning himself within the discursive construction of masculinity. Masculinity, however, is enacted in different ways by men, relative to a number of factors such as social class, sexual orientation, ethnicity, or race (Kimmel & Messner, 2001).

Gender not only impacts self-perceptions and personal discourses of health, but it also impacts how doctors interact with patients. Research has shown that males actually receive less time than females during their visits to a physician (Courtenay, 2000a; Umberson, Crosnoe, & Reczek, 2011). Furthermore, males tend to receive less advice about disease prevention than do females. The relationship is complex, however, in that the gender of the doctor has also been found to impact the doctor-patient interaction. Research has demonstrated that female doctors tend to conduct longer patient visits, to have more positive interactions, and to elicit more medical information from their patients (both male and female) than do male physicians (Hall, Irish, Roter, Erhlick, & Miller, 1994; Roter, Hall, & Aoki, 2002). This further reinforces the position of medical professionals as social individuals, in which they are also impacted by the cultural and social discourses; they not only produce and reproduce biomedical discourse, but also reinforce gendered interactions through their relationships with patients and their personal demeanors.

The present study will examine how gender impacts individual conceptions of health by examining data for any systematic differences between how males and females talk about their own health, the health of others, and general perceptions of what constitutes health.

Culture. The discourses that inform our perceptions of health and a state of healthfulness are highly dependent upon our culture (i.e., time, place, socioeconomic status, ethnicity, and so on). It may be that goals of prevention, treatment of disease, and maintenance of health are the same across cultures, but the discourses of any individual culture and its members will vary in how they conceptualize what ‘healthy’ means and what treatments look like (Gesler & Kearns, 2005; Tseng & McDermott, 1981). Our Western model of health is informed greatly by the biomedical discourse, yet there are subcultures within Western culture (e.g., Italian Canadians, in-

digenous populations, immigrant students, etc.) which may have different conceptions of healthfulness. The conceptions of health entertained by members of subcultures are often overlooked in medical interactions and medical discourse, and when accessing health services, these individuals are drawn into the biomedical discourse which may be drastically different from their own perceptions of what constitutes health and what treatment methods are appropriate. Even within Canada, persons living in various regions (i.e., rural regions versus urban regions) may espouse different ideologies about health and healthfulness; they may also have different access to healthcare and health discourses (Bourgeault & Sutherns, 2012; Law, Wilson, Eyles, Elliott, Jerratt, Moffat, et al., 2005; Odoi, Wray, Emo, Birch, Hutchison, Eyles, et al., 2005). It is essential to consider these cultural differences in perceiving health and approaches to treatment as cultural beliefs and practices impact how the individual defines and conceptualizes the problem (Berry Porting, Segall, & Dasen, 1992). Compliance with treatment may be reduced if the biomedical discourse of a medical encounter is not congruent with an individual's personal and cultural conceptions of health.

Present Study

While there has been some research on health perceptions conducted in past years, the very nature of conceptions of health are fluid, and not static. Because discursive constructions of health and wellness are dependent upon time, place, gender, and cultural context, it is important to pursue research in the area as these discourses evolve, to determine how best to promote healthfulness and health behaviours in individuals. With increased transmission of biomedical knowledge at the cultural level, it is also pertinent to examine the ways in which biomedical discourse functions in influencing how people think of and engage in health behaviours. It is important to understand individuals' perceptions of health because these perceptions inform health-

related behaviours and the utilization of health services. This qualitative research study seeks to fill in the gaps in current research on the relationship between lay and biomedical discourses of health.

The present study examined dominant health discourses and their impact on individual and cultural perceptions of health, and the manners in which individual discourses and biomedical discourse function in creating health perceptions. Through interviews, the present study examined the manners in which individuals, both within and outside of the context of the medical institution, construct their knowledge of what constitutes health. This qualitative data provided important insight into how the biomedical discourse functions within the medical profession as well as in individual discourses. Because research has indicated that doctors, nurses, psychologists and other health and mental health professionals hold biases about overweight and obesity (Puhl & Brownell, 2001; Waller, Lampman, & Lupfer-Johnson, 2012), it is important to examine how this might be associated with students in health-related professions and medical professionals' perceptions in a fat-phobic, weight-centered discourse of health (Ciao, Latner, & Durso, 2012; Waller, Lampman, & Lupfer-Johnson, 2012). In addition to examining how appearance impacts how people think of and perceive health, the present study examined themes that emerged through the interviews about how participants think about and talk about health and the beliefs they hold about what health means.

Because culture is integral to the development of discourses and knowledge production, the present study also examined how cultural location and a person's ethnicity impacts conceptions of health. In order to do this, participants were asked to identify their ethnicity and to reflect on how their cultural affiliation impacts their perceptions and understandings of health.

Rationale for Qualitative Methods

Qualitative research methods in psychology have opened up possibilities in health research, expanding the kinds of research questions that can be asked, generating different kinds of data and lending to more diverse and different analyses of psychological phenomena (Malson, 2010). This method of research inquiry provides understanding of the world from the perspective of the research participants, revealing their experience of the lived world. Discursively analyzing interviews with participants provides information on how language and discourse shape the social context of the world in which we live. The qualitative interview can inform a well-founded knowledge of our discursive reality, in addition to describing the qualitative human world (Kvale & Brinkmann, 2009). Much as there is reciprocity between personal and biomedical discourse, the research interview is a reciprocal pursuit, in that knowledge derived from interview research is produced, contextual, and linguistic (Kvale & Brinkmann, 2009; Stake, 2010). While social sciences are largely reliant upon quantitative research in studying natural phenomena, qualitative research is valuable and adds considerable information to theories and knowledge in the field. Some researchers believe that an over-reliance upon quantitative methods – due to the legitimacy applied to quantification over more socially-oriented methods – may stifle more appropriate scientific inquiry (Berg, 2001). This study will employ the research interview, which attempts to make sense of the participants' world from their perspective, unfolding the meaning of their own experiences; this will provide the most valuable information on the different discourses employed by participants in constructing their understanding of health (Kvale & Brinkmann, 2009). Qualitative methods have become key methods of research in the social sciences; this approach emphasizes focus on cultural and everyday aspects of human thinking, learning, and being – integral components of the proposed research study (Potter &

Hepburn, 2008; Ritchie, 2003).

Discourse analysis, which the present study utilized, focuses on how language constructs the social worlds that we inhabit. There are four key concepts central to discourse analysis: multivoicedness (wherein contradictoriness is embraced within the research context, dissimilar to other methods of research in which outliers are dropped to better discriminate the targeted idea), semiotics (the way in which language is put together and how meaning is already derived from existing discourses), resistance (the things language does; an examination of how what one is saying keeps power relations in place or resists them), and discrete discourses - that is, specifying versions of the world and its individual subjects (Parker, 2005). Discourse analysis is a systematic method that examines not just what a person is saying, but how meaning is derived from what is said, and particularly within the context of power relations (in this case, specifically the medical institution as a power structure).

Using content analysis, the interviews were also analyzed to allow for thematic analyses. Content analysis is a systematic method that identifies the properties of a set of data, such as keywords used by participants and word frequencies (Berg, 2001). From this basic systematic analysis, patterns and themes can then be identified, which become the categories for analyses. Through these methods, themes that emerge through the interviews were drawn out and interpreted to inform an understanding of how lay persons and students in health-related professions understand and construct their knowledge of health. Interviews were scored by the primary researcher, and any difficulties in interpretation were discussed with a second rater; any disagreements were resolved through dialogue.

Knowledge production is never value-free. Through this qualitative inquiry, we can glean a better understanding of how individuals are constructing their world, how they conceptu-

alize a state of healthfulness, and the ways in which they translate this knowledge into health behaviours in their own lives.

Research questions. The present study seeks to answer the question of how individuals perceive health based on the social constructions and discourses upon which they draw to define health and health behaviours. This main research theme will be addressed through the following research questions:

1. How do participants define a state of health? And what does “health” look like?
2. How do participants define a state of ill health? And what would “ill-health” look like?
3. How does culture influence how participants think and talk about health?
4. How does gender impact discourses of health?

In assessing cultural influences, participants were asked specifically about how they perceived their cultural contexts to have impacted their personal conceptions of health and healthfulness. While gender is part of a cultural context, it is a particularly salient feature that itself largely impacts how a person perceives themselves and, because of how gender is culturally treated, may impact how persons understand health and healthfulness. Therefore, in determining impacts of gender on health perceptions, participants were asked specifically how they felt their gender may have influenced their health perceptions, but data was also analyzed to determine whether there were any gender differences in participants’ responses. There has been a dearth of qualitative research exploring individuals’ perceptions of health over the past few decades. However, qualitative methods have become key methods of social research and wield important information about natural phenomena.

Method

Participants

Participants were recruited from two groups: persons who have received health-related training (i.e., students in medically-related programs from Lakehead University and Confederation College; and medical professionals who have completed a degree in medicine) and laypersons (i.e., students at Lakehead University in non-health related programs of study and/or individuals from the community in non-health related fields). There were five participants in each of the two groups. For the purposes of qualitative research, a sample size that is larger than 10 is difficult to transcribe and interpret (Kvale & Brinkman, 2009); while a larger sample size would have been ideal for addressing the complex issue of addressing multiple identities, because this is a master's project, time constraints limited more extensive sampling. Participants were six males (two in the health professional group and four from the layperson group) and four females (three in the health professional group and one in the layperson group). Participants came from a variety of ethnic backgrounds and ages (see Table 1). Participants were asked to identify their ethnicity, as an individual's self-identified ethnicity is a particularly relevant contextual factor that may influence health perceptions. For the purposes of the present study, while ethnicity does not reflect culture specifically, it was the most salient and readily identifiable aspect of culture that could be assessed in analyzing the data. Of the 10 participants, only three indicated that they were born in Canada. All participants are currently living in Canadian cities (six in Thunder Bay, one in Toronto, two in Ottawa, and one in New Brunswick).

Table 1

Participant Variables

| Health Professions | | | | | Laypersons | | | | |
|--------------------|-------------------------------|--------|-----|-----------------------|------------|---------------------------------------|--------|-----|-------------------|
| ID | Position | Gender | Age | Ethnicity | ID | Position | Gender | Age | Ethnicity |
| 1 | Kinesiology student | F | 20 | Costa Rican/Caucasian | 3 | Aerodynamic engineering student | M | 18 | Indian |
| 2 | Medical massage | F | 39 | Caucasian | 5 | Chemical engineering student | M | 23 | African |
| 4 | Laboratory technician student | M | 24 | Black/Other | 6 | MBA Financial Services Representative | M | 27 | African/Yoruba |
| 9 | Medical Doctor | M | 40 | Haitian/Black | 7 | Mechanical engineering student | M | 22 | African |
| 10 | Medical doctor/student | F | 36 | Iranian | 8 | Stay at home mom/hobby farmer | F | 30 | Caucasian/ Native |

Procedure

Participants were recruited via posters that were displayed on campus at Lakehead University, Confederation College, and at the Northern Ontario School of Medicine, requesting participation and providing contact information (see Appendix A). Emails were sent out to course instructors for undergraduate students at Lakehead University, as well as nursing students and students studying at Northern Ontario School of Medicine and through word of mouth. To avoid what might be viewed as a power differential of conducting interviews in a laboratory setting, interviews were conducted in rooms on campus at Lakehead University and Confederation Col-

lege to provide a comfortable and neutral setting (e.g., ATAC 5033). Three participant interviews were conducted over the telephone for the convenience of the participant. Participants were provided full disclosure about the nature of the study and confidentiality, and were given a cover letter (see Appendix B) and a consent form (see Appendix C) that they were required to read and sign before participating in the study.

Interviews were conducted with participants one-on-one and were audio recorded for later transcription and analysis. Interviews lasted an average of 18.41 minutes, ranging from 11.22 minutes up to 30.97 minutes. The interview was semi-structured, with a predetermined set of interview questions (see Appendix C), but directed by participants' responses. In order not to influence individuals' responses and extract themes as they emerge, the interviews were conducted to provide a conversational tone; while there was a set of questions to be addressed, the pace and content of the interviews was largely led by the responses of participants. Several challenges were encountered in the interview process. Firstly, participants tended to report that they had not given their ideas about health much thought previously, and therefore had some difficulty in answering the interview questions. Further to this, participants struggled to understand what was meant by culture, or did not conceive of culture as influencing their conceptions of health, leading to a paucity of discourse around how they perceived culture to have shaped their own health knowledge. Additionally, one participant (Participant 3 who identified himself as Indian) struggled to understand what was being asked in the interview due to the language barrier, having newly moved to Canada. These challenges are discussed further below in addressing limitations and future directions.

Given the nature of discourse, it is impossible to come forth to these interviews entirely value-free. However, I attempted to mitigate any influence my presence may have had by being

aware of my discursive position within the context of the interview. The interview guide was constructed carefully to minimize value-laden language in hopes to generate as authentic a conversation with the participant as possible. Specific prompts were not used in eliciting conversation about how participants thought about health in order to maintain the flow of the interview. Instead, questions were asked within the context of each interview as participants spoke of their perceptions that pertained specifically to what that participant was conveying. Additionally, I have to acknowledge any power relations within the research interview – as the researcher, I made every attempt to mitigate any power differential between myself and the participant prior to beginning the interview process. To accomplish this careful consideration was given to positioning in the room – where I sat in relation to the participant, the language used (i.e., accessible to the participant, without being patronizing), establishing rapport with the participant and ensuring that they were comfortable before beginning the interview, all important to setting the tone and attempting to mitigate power imbalance in the interview process (Potter & Hepburn, 2008). Additionally, I had to consider how my gender may or may not impact the trajectory of the interviews – if this might have elicited different responses depending upon the gender of participants. Gender may have impacted responses in two ways: 1. The gender of participants may have impacted the extent to which they were aware of their own health, had been exposed to and attended to messages of health, and the extent to which they were comfortable discussing their own health and conceptions of health – e.g., women's tendency to engage with and consume health services more readily than men (Hunt, Adamson, & Galdas, 2012) and 2. Research has shown that both male and female patients tend to speak more to female physicians than to male physicians and to make more positive statements (Hall & Roter, 2002); while I am not a physician, it is possible that participants were likewise more inclined to disclose biomedical and psychosocial

information to myself as a female researcher than they might have been with a male interviewer. Patterns of responding, however, were not directly assessed (Bottorff, Oliffe, Robinson, & Carey, 2011). While it is impossible with any research to remain completely value free, all of these factors were taken into consideration when data was analyzed so as to minimize subjectivity.

Analyses

Once the data were obtained, the interviews were transcribed and typed into a Word document. Once transcribed, interviewees were asked to review the transcripts to give them the opportunity to ensure that the transcripts accurately reflected what they conveyed. This is a practice called member-checking that ensures accuracy and limits subjectivity in qualitative research (Oliver, Serovich, & Mason, 2005) and allowed participants to confirm that they have been accurately represented. Participants were advised that they could not make substantial changes to the things that were said, but rather could make clarifications such that they could be certain that the transcriptions accurately reflected their thoughts. After participants confirmed that the data had been accurately recorded, the interviews were systematically analyzed through a combination of thematic synthesis of the data obtained and discourse analysis. Thematic synthesis consists of three stages: coding of the text, developing descriptive themes, and then analyzing emerging themes (Thomas & Harden, 2008). Discourse analysis is an analytic method that attempts to understand the meaning of the themes within the context of knowledge production and power structures (Wodak & Meyer, 2009).

Interviews were analyzed using NVivo software, which extracts and organizes themes. This facilitated analyzing the data into categories of themes that emerged. The interviews were read several times over in order to analyze layers of concepts and meanings which emerged through discursive constructions from the interview dialogues and I conferred with my supervi-

sor, Dr. Mirella Stroink, at several points throughout the analysis process to counteract an overly idiosyncratic analysis of the interview data. Any disagreements about scoring of the interviews were resolved through dialogue. Triangulation was used to check results; this is why data was first analyzed using general analyses, and then later content and thematic analyses were run.

Results

In order to most accurately and reflectively represent the data, word frequencies were first run to determine the words that participants were using most frequently in response to each of the main questions. From these word frequencies, the data was examined more closely to extrapolate contextual use of each of the words that were iterated across participants and then themes were drawn from a discursive analysis of the data. The data are presented, then, as first a broad general analysis of the data, and then narrowed down to reflect more pointed analyses through thematic analyses of the contextual use of specific words in relation to the main research questions. The main research questions being investigated were: (i) How do participants define health? (ii) How do they define ill-health? (iii) What impact does culture have on perceptions of health? and (iv) What influence does gender have on health perceptions?

General Analysis - Word Frequencies

In order to extrapolate themes from the data, as an initial stage in the thematic analysis of the data, word frequencies were run on each of the groups to determine consistencies among participants, as well as unique ideas. Word frequencies observed across the entire interview for participants in health-related fields (see Table 2.0) and laypersons (see Table 2.1) are reported. Words that were not pertinent to the analysis - words that were simply required to compose a sentence but provided no meaning to the data were excluded. This basic systematic analysis provided the basis for later thematic analyses. Because the interviews consisted of four main questions: how do participants define health? How do they define ill-health? What impact does

culture have on perceptions of health? and What influence does gender have on health perceptions?, data was then broken down into themes reflecting answers to these questions for further analysis.

Table 2.0

Word Frequencies from Interviews with Health Professionals

| Word | Count | Weighted Percentage |
|---------------------------------|-------|---------------------|
| Eat, Eats, Eating | 435 | 1.50% |
| Food, Foods | 261 | 0.90% |
| Body | 226 | 0.78% |
| Sick, Sickly, Sickness | 147 | 0.51% |
| Environment | 147 | 0.51% |
| Stress, Stressed, Stressful | 129 | 0.45% |
| Exercise, Exercised, Exercising | 126 | 0.44% |
| Active, Activity, Activities | 117 | 0.40% |
| Mind, Mindful, Mindfulness | 103 | 0.36% |
| Disease, Diseases | 51 | 0.18% |

Table 2.1

Word Frequencies from Interviews with Laypersons

| Word | Count | Weighted Percentage |
|---------------------------------|-------|---------------------|
| Eat, Eats, Eating | 410 | 1.37% |
| Food, Foods | 254 | 0.85% |
| Body | 218 | 0.73% |
| Sick, Sickly, Sickness | 144 | 0.48% |
| Environment | 134 | 0.43% |
| Stress, Stressed, Stressful | 127 | 0.43% |
| Feel, Feels, Feeling | 108 | 0.36% |
| Exercise, Exercised, Exercising | 104 | 0.35% |
| Active, Activity, Activities | 101 | 0.34% |
| Able | 93 | 0.31% |

Health Professionals Group - Word frequencies. After a general examination of word frequencies, the scope of the analyses was narrowed to more specifically reflect how participants had responded to each of the main questions that facilitated the semi-structured interview. Word frequencies for participants in the medical professional category are reported for perceptions of health (see Table 3.0), perceptions of ill health (see Table 3.1), reflections of cultural influence on health perceptions (see Table 3.2), and reflections on the role of gender in the formation of health perceptions (see Table 3.3). From these data, themes which emerged from participant interviews were extrapolated.

Table 3.0

Word Frequencies for Perceptions of Health in Health Professionals

| Word | Count | Weighted Percentage |
|------------------------------|-------|---------------------|
| Eat, Eats, Eating | 24 | 1.19% |
| Body | 22 | 1.09% |
| Mind, Mindfulness | 19 | 0.94% |
| Able | 17 | 0.84% |
| Active, Activity, Activities | 15 | 0.74% |
| Physical, Physically | 14 | 0.69% |
| Balance, Balanced | 13 | 0.64% |
| Food, Foods | 12 | 0.60% |
| Environment | 12 | 0.60% |
| Exercise | 11 | 0.55% |
| Mental, Mentally | 10 | 0.50% |
| Stress, Stressed | 10 | 0.50% |

Table 3.1

Word Frequencies for Perceptions of Ill-health in Health Professionals

| Word | Count | Weighted Percentage |
|-----------------------------|-------|---------------------|
| Physical, Physically | 13 | 1.14% |
| Eat, Eating | 12 | 1.05% |
| Ill, Illness | 7 | 0.61% |
| Body | 7 | 0.61% |
| Food, Foods | 6 | 0.53% |
| Mental, Mentally | 6 | 0.53% |
| Smoking | 6 | 0.53% |
| Activity, Activities | 5 | 0.44% |
| Stress, Stressed, Stressful | 5 | 0.44% |
| Drink | 5 | 0.44% |
| Obese, Obesity | 4 | 0.35% |

Table 3.2

Word Frequencies for Cultural Influences on Health Perceptions in Health Professionals

| Word | Count | Weighted Percentage |
|-------------|-------|---------------------|
| Eat, Eating | 7 | 1.61% |
| Food | 4 | 0.92% |
| Beliefs | 2 | 0.46% |
| Community | 2 | 0.46% |

Table 3.3

Word Frequencies for the Role of Gender in Health Perceptions in Health Professionals

| Word | Count | Weighted Percentage |
|------------------------|-------|---------------------|
| Belief, Beliefs | 5 | 2.27% |
| Body | 3 | 1.36% |
| Control, Birth Control | 3 | 1.36% |

Note. *N = 4 (One participant did not provide a response to this question).

Laypersons - Word frequencies. The analyses were repeated for each of the main questions in the layperson category, as well, with similar terms used by this group and similar themes about health perceptions emerging. Word frequencies for laypersons' perceptions of health, ill-health, reflections of cultural influences on health perceptions, and reflections of the influence of gender on the formation of health perceptions are reported (see Tables 4.0-4.3).

Table 4.0

Word Frequencies for Perceptions of Health in Laypersons

| Word | Count | Weighted Percentage |
|-------------------------|-------|---------------------|
| Eat, Eats, Eating | 23 | 1.93% |
| Exercise, Exercising | 15 | 1.26% |
| Food, Foods | 13 | 1.09% |
| Body | 8 | 0.87% |
| Physical, Physically | 5 | 0.42% |
| Disease | 4 | 0.34% |
| Environment | 4 | 0.34% |
| Sleep, Sleeps, Sleeping | 4 | 0.34% |
| Active, Activities | 4 | 0.34% |

Table 4.1

Word Frequency for Perceptions of Ill-Health in Laypersons

| Word | Count | Weighted Percentage |
|-------------------------|-------|---------------------|
| Food, Foods | 13 | 1.66% |
| Body | 10 | 1.28% |
| Eat, Eating | 8 | 1.02% |
| Sick | 7 | 0.89% |
| Smoking | 5 | 0.64% |
| Tired | 5 | 0.64% |
| Sleep, Sleeping | 5 | 0.64% |
| Exercise, Exercised | 4 | 0.51% |
| Environment | 4 | 0.51% |
| Drink, Drinks, Drinking | 3 | 0.38% |
| Obese, Obesity | 3 | 0.38% |

Table 4.2

Word Frequencies for Cultural Influences on Health Perceptions in Layperson

| Word | Count | Weighted Percentage |
|-------------|-------|---------------------|
| Eat, Eating | 7 | 1.92% |
| Food | 4 | 1.10% |
| Environment | 3 | 0.82% |

Table 4.3

Word Frequencies for the Role of Gender in Health Perceptions in Health Professionals

| Word | Count | Weighted Percentage |
|-------|-------|---------------------|
| Look | 4 | 1.16% |
| Buff | 2 | 0.58% |
| Built | 2 | 0.58% |
| Curvy | 2 | 0.58% |

Note. *N = 4 (One participant did not provide a response for this question)

Content and Thematic Analyses

From the broader analyses, more specific analyses were conducted, to examine how participants were talking about health and what it means, and to determine themes that had emerged from preliminary analyses. A text search was conducted for each group, focusing on the words that had emerged as having been most frequently used through the word frequency analyses. Themes were then extracted by discursively analyzing the contextual uses of each of the frequently used terms as they related to the overarching research questions.

Based on these analyses and repeated readings of the transcribed interviews, participants' answers to the main questions appear to fall into the following themes: Health as the absence of illness or disease; Mechanistic views of health and illness (i.e., the body and how it works or performs as central to health and ill-health, especially relating to size and behaviours) - and stemming from this theme the themes of overweight as inherently unhealthy and of the centrality of food to conceptualizations of health; and Holistic ideas of health (e.g., "balance", environment, and psychological well-being as central to one's state of health). These themes may hold differ-

ent meanings for men and women, however, in relation to how the body is conceived of and constructed both socially and by the individual (Kuhlmann & Babitsch, 2002; Saltonstall, 1993).

Each theme is elaborated upon below with analyses provided for each group of participants.

Perceptions of health. In regards to the first research question - How do participants define health? - perceptions of health were broken down by the themes which emerged from extensive analyses of the data. The data was coded to reflect this theme, and word frequencies were run to determine which words were most frequently used to describe a state of ill-health. These terms were then used to conduct a text search to see how the participants were speaking of the terms and the context of their use.

For participants in health-related fields, there were 10 key words which were iterated in regards to defining “healthy” and what constitutes health: Active, Body, Disease, Eating, Environment, Exercise, Food, Mind, Sick, and Stress. Each of these was further analyzed for the context in which it was said, its meaning, and its coverage (percentage of the participants’ interview devoted to that specific word). Values for the number of iterations of each word by participants and their percentage of interview coverage are reported in Table 5.0. “Exercise” and “Mind” were the only two terms among participants in health-related fields that were iterated by all participants in talking about what health means and defining being healthy.

Table 5.0

Text Search: Terms Used by Participants in Health-Related Fields to Describe and Define Health

| Term | Participant Reference (# of iterations) and Coverage (in %) | | | | |
|-------------|---|------------|-----------|------------|-----------|
| | 1 | 2 | 4 | 9 | 10 |
| Active | 2 = 0.40% | 1 = 0.14% | 7 = 1.69% | — | 5 = 1.81% |
| Body | 7 = 0.81% | — | 1 = 0.13% | 1 = 0.07% | 2 = 0.32% |
| Disease | 1 = 0.20% | 1 = 0.16% | — | — | 4 = 1.10% |
| Food | 6 = 0.75% | 3 = 0.29% | 2 = 0.25% | 1 = 0.07% | — |
| Eating | 9 = 1.38% | 2 = 0.20% | 5 = 0.84% | 8 = 0.67% | — |
| Environment | 1 = .32% | — | — | 11 = 2.19% | — |
| Exercise | 7 = 0.98% | 7 = 1.06% | 5 = 1.00% | 1 = 0.07% | 3 = 0.95% |
| Mind | 1 = 0.12% | 10 = 1.06% | 2 = 0.25% | 2 = 0.14% | 4 = 0.63% |
| Sick | 2 = 0.46% | — | 1 = 0.13% | 2 = 0.22% | — |
| Stress | 4 = 0.69% | — | — | 4 = 0.95% | 2 = 0.25% |

Note. Dashes indicate that the term was not used by the participant in defining health.

The same analyses were conducted for laypersons, and it was found that there were eight key words which were iterated in defining “health” and what constitutes a state of health: Able, Active, Body, Eat, Environment, Exercise, Feel, and Food. These words were extrapolated after having examined the context in which they were used to ascertain whether their use was thematically relevant. Values for the number of references and coverage of each of the terms are reported in Table 5.1. Among laypersons, “Food”, “Eat”, and “Exercise” were the only terms used consistently by all participants in this category to define health and what it means to be healthy.

Table 5.1

Text Search for Terms Used by Laypersons to Describe and Define Health

| Term | Participant Reference and Coverage | | | | |
|-------------|------------------------------------|-----------|-----------|-----------|-----------|
| | 3 | 5 | 6 | 7 | 8 |
| Able | 1 = 0.60% | — | 1 = 0.11% | — | — |
| Active | 1 = 0.90% | — | 3 = 0.80% | — | — |
| Body | — | — | 6 = 0.64% | 1 = 0.16% | 1 = 0.42% |
| Feel | — | 1 = 0.13% | 1 = 0.19% | 1 = 0.16% | 1 = 0.42% |
| Food | 1 = 0.75% | 1 = 0.13% | 5 = 0.53% | 4 = 0.62% | 2 = 0.83% |
| Eat | 4 = 3.60% | 6 = 0.58% | 7 = 0.72% | 3 = 0.47% | 3 = 1.04% |
| Environment | — | — | 2 = 0.58% | 1 = 0.43% | 1 = 1.14% |
| Exercise | 1 = 1.20% | 1 = 0.26% | 6 = 1.54% | 5 = 1.795 | 2 = 1.66% |

Note. Dashes indicate that the term was not used by the participant in defining health.

Health as absence of illness or disease. In defining health, the thematic idea of Health as an absence of illness or disease emerged. Participants in the medical professional group mentioned “disease” and “sickness” when asked to define health: “*I think health is defined as your ... presence of disease and illness and your overall quality of life...*” (Participant 1); “*You’re not in any kind of, how do I put it now, distress or whatever*” (Participant 4); “*I would define it as a person that uh, is not experiencing any sickness... It’s a state where you’re not sick. You’re not stressed. You’re sleeping. You’re eating properly. It’s a state where you’re able to interact with your peers in a healthy way.*” (Participant 9); and “*no suffer and no disease... no depression or no very specific disease*” (Participant 10).

While lay participants also discussed and defined health in terms of an absence of disease or illness, they spoke of disease and illness less frequently than did participants in health-related fields. Only two of the five lay participants spoke about illness and disease when defining health: “*Being healthy, without having any disease. Things like that... To be immune of epidemic diseases.*” (Participant 3 - male) and “*How [my body] performs usually. I know that if it's sick, I feel weak.*” also “*Well you're not sneezing and coughing.*” (Participant 8 - Female).

Mechanistic views of health. Participants in both groups spoke of health and the body in mechanistic terms. A mechanistic view of the body locates the locus of control within an individual and their behaviour - diet and activity levels, for example - and over-exaggerate the relationship between body size and health status. Participants in medical health-related fields of study and laypersons alike spoke of the body in mechanistic ways. Participants in health-related fields spoke about activity and exercise when defining health and what a healthy body might look like: “*Being able to exercise. Motivated to exercise because if you're not feeling too well you're not really motivated to exercise. Being active.*” (Participant 4); “*having some moderate activity, walking, hiking, is healthy.*” (Participant 10), and

I don't think for me it's so much about um the shape of the body or the physical structure as much because I think everybody's shaped differently but definitely not to have the excess weight on and things like that. No question; I mean if there's excess weight there's something that's off in the body, there's something imbalanced, right. So um, so I would say a healthy physique. A toned physique. (Participant 2).

One participant in the health-related profession group spoke about activity and exercise in defining health, but also about appearance: “*Um, physical activity is a big part of my life. Um, I go to the gym every single day. I try to keep a nice figure. And not just a nice figure.*” (Participant 1 -

female); research literature of the loathing of fat has suggested that this fear of fat is largely gendered, with women being more likely to conflate their health and appearance when thinking about healthfulness and body size (Rivstovski-Slijepcevic, Bell, Chapman, & Beagan, 2010). Lay participants also used mechanistic language in describing health and healthfulness: “*just eating well and then exercise.*” (Participant 3); “*thinking about health I think about... what kind of food you eat, I think about exercising yourself*” (Participant 6); and “*Being healthy I'll say it's like practicing being healthy, like exercising. Like you don't have to do it all the time but like find time.*” (Participant 7). Two subthemes emerged within the theme of mechanistic views of health.

Obesity and overweight. Participants, in defining health, brought up obesity, overweight, and fat as indicators of health. Two participants in health-related fields spoke about fat in relation to health, one to problematize the idea that overweight is inherently unhealthy (although she also reinforced the idea that overweight is unhealthy when discussing what a healthy body looks like, as quoted above): “*I'm overweight, but if I look at genetics, I should be diabetic, I should have heart disease, I should have all these problems. I've got nothing.*” (Participant 2), and one defining health as the absence of obesity: “*It's somebody... it doesn't have to be all build up, all muscled up, the average person that's like, not obese but has some, a little bit of fat is okay*” (Participant 9). One lay participant defined health in mechanistic terms of the body as being an optimal size: “*one who isn't too thin and one who isn't too fat.*” (Participant 8).

Food and Nutrition. Within a mechanistic understanding of health, the role of food and nutrition is understood in relation to the function, size, and appearance of the body (Rail, 2008). Participants in both the medical professional group and the lay group identified food as pertinent to health. Participants in health-related disciplines defined health in relation to the mechanistic

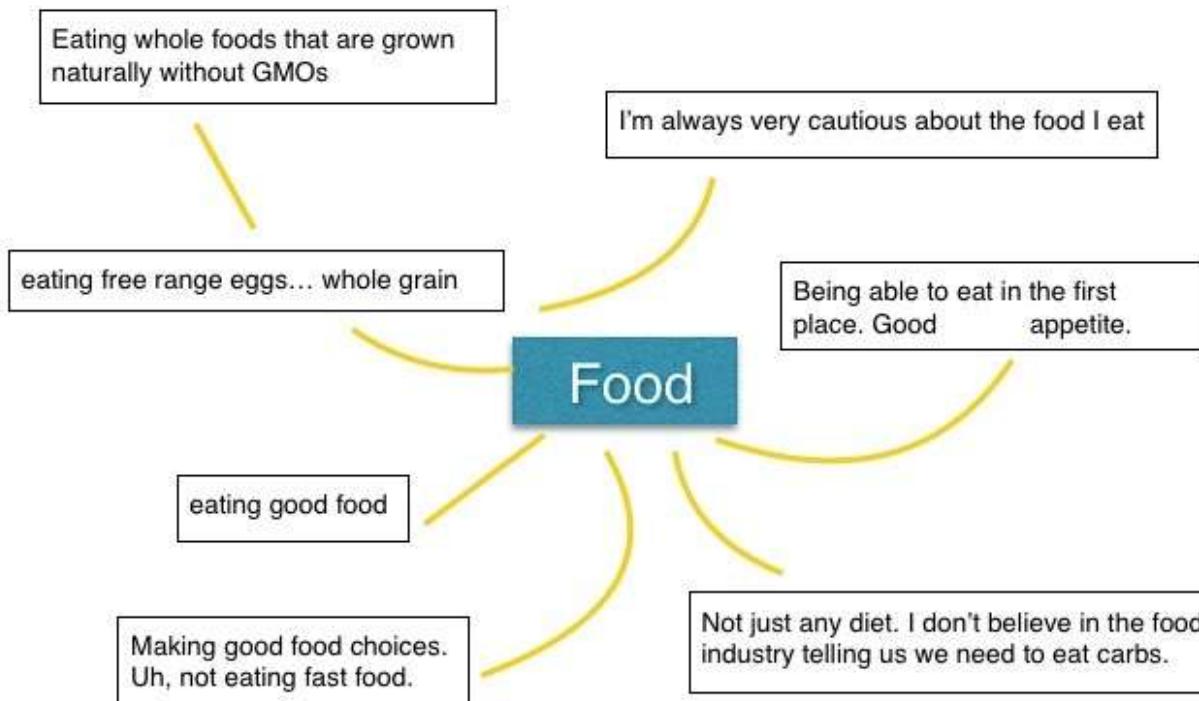
view of consuming foods that are healthful for the body and avoiding those that are not healthful, as well as speaking about behaviours they believe to be healthy:

I'm always very cautious about the food I'm eating... I don't believe in the ... food industry um telling us we need to eat carbs and Health Canada and I don't really believe in that because I've seen a lot of research that goes against it and that also a lot of people that recommend us eating carbs um are also paid by bread companies, you know?... I don't really I don't believe in eating um those starches, refined starches. (Participant 1),

and "*Drinking organic milk or eating organic cheese, eating grassfed beef, eating um free range eggs um ... whole grain you know food maybe here and there like quinoa, quinoa's a seed I guess but seeds, nuts, things that aren't genetically modified*" (Participant 1); "*Making good food choices. Uh, not eating fast food.*" (Participant 2); "*eating good food. Being able to eat in the first place. Good appetite... eating properly, eating fruits, vegetables... The person isn't eating wrongly.*" (Participant 4); "*So, if you are healthy it means... you're eating properly*" (Participant 9); and having "*A balanced diet*" (Participant 10). The below image is a word tree created from data generated by NVivo to reflect the ways in which those in health-related disciplines spoke about food, specifically.

Figure 1.

Health Professionals' use of the word "food" content analysis

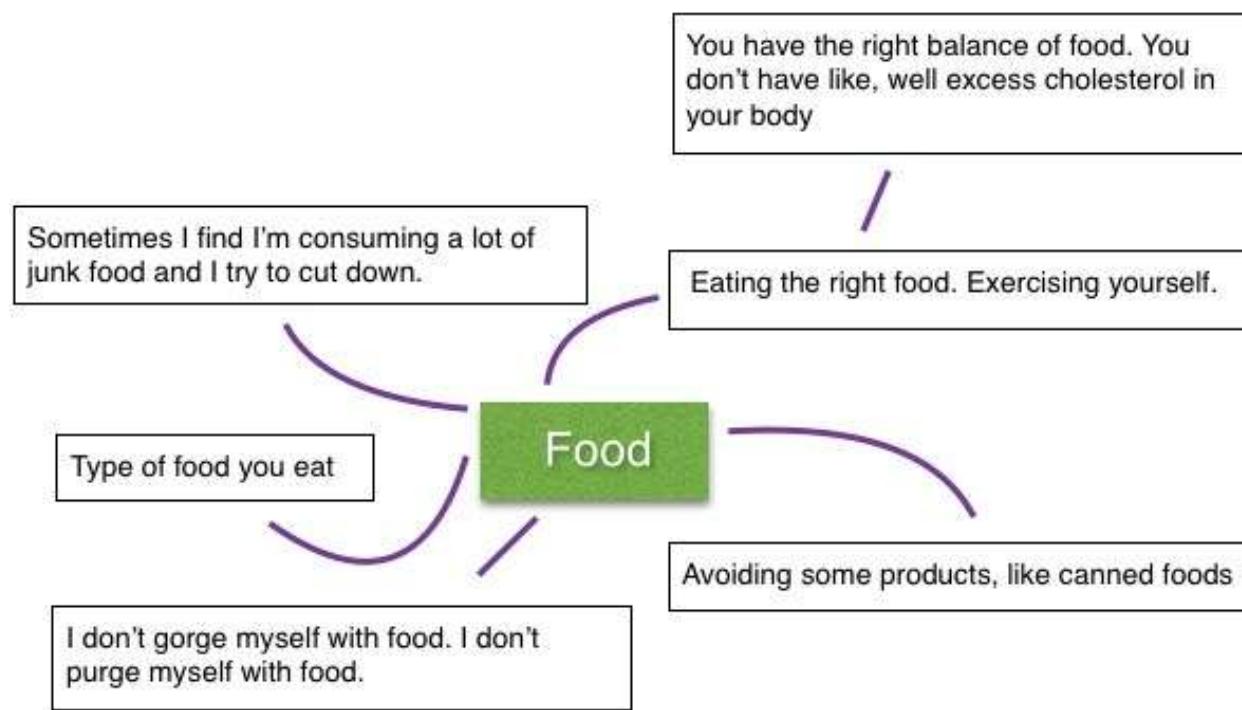


Laypersons also spoke of food in terms of being both healthful and as potentially causing ill health when defining health and discussing behaviors that they believe to be healthy or engage in themselves: “Eating vegetables. Other nutrients… Avoiding some products like canned foods, etcetera.” (Participant 3); “I personally prefer to eat everything that’s organic. I don’t eat from a can. Reason being that I know what kind of preservatives in those cans. However, the organic material is organic.” (Participant 5); “eating the right food… So basically you have the right balance of food, you don’t have like well excess cholesterol in your body” (Participant 6); “Food, diet… Practice eating healthy, not just McDonalds.” (Participant 7); and “I eat healthily… I don’t gorge myself on food. I don’t purge myself with food.” (Participant 8). To provide a clear-

er understanding of the data, the following image is a word tree derived from data generated by NVivo to illustrate the ways in which laypersons spoke about food in relation to health:

Figure 2.

Laypersons' use of the term "food" content analysis



Holistic ideas of health. Participants tended to espouse holistic ideas of what constitutes health as they responded to questions of how they define health and healthful behaviours. Within a holistic conception of health, participants in both groups spoke about environment, psychological health, stress, and balance.

Environment. Two participants in the health-related field spoke of the environment in relation to health; they talked about environment as part of health both in regards to the environment surrounding a person and the ways a person interacts with or impacts their environment:

“My environment around me. Um What I’m surrounding myself by. Like I usually think about a lot of chemicals.” (Participant 1) and *“Also holistically healthy. So it’s also thinking about how your body health is in health but how you’re interacting with your environment um in a healthy way. So healthy is also treating the environment with respect. And then taking things from the environment that is not going to harm yourself and things around you.”* (Participant 9). Participant 1 had also discussed a preference for organic foods and grass-fed beef, which may fall within the environmental theme as well, as a concern for eliminating chemicals found in our food is associated with eating organically. Three lay participants referred to environment in relation to health, also in terms of the environment as impacting the individual and the individual as impacting the environment:

I try to be mindful of the environment I am in, to make sure that it’s not something that you know like maybe you know the atmosphere I get ill or get sick or get infected with any kind of ailment or disease... I’m in like one of the metropolitan cities so the chances of more CO₂ emission and things like that... so I guess in my own case I’m conscious of my environment. If I’m aware that there is like a poisonous substance or gas that could affect me healthwise I probably won’t be within that area (Participant 6),

and *“clean environment, being healthy, good hygiene. Uh, being organized.”* (Participant 7).

Participant 8 also mentioned “environment” when describing characteristics that come to mind when thinking of health, though she did not say anything specifically about environment.

Stress. Of the participants in health-related professions, two also spoke of stress in defining health: *“They would also have you know um low amount of stress in their life. Um healthy relationship with people. Um good social support system. Um they would engage in intellectual, interpersonal emotional skills... I think having no stress, or low stress is definitely a big part of*

[being healthy]" (Participant 1) and "normal to moderate stress in life. Not too much." (Participant 10), while only one lay participant spoke directly about stress: "I can usually tell if somebody has a healthy psychological state based on how they respond to a certain situation. For example, some people can't handle stress really well and when they get under stress they snap and start throwing things. That's not healthy." (Participant 5).

Psychological or mental health. Participants in both groups talked about an overarching definition of health that encompassed mental or psychological well-being. Three participants in the medical professional category referred to or alluded to mental health: "Well I mean for me health is a combination of all those factors so having a good mental state, I believe, is key to having a good physical state." (Participant 2); "Health is... I would define health as the complete well-being of a human being, psychologically and physically." (Participant 4); and "So somebody that's healthy has to be mentally healthy, physically healthy, and spiritually healthy. You have to have the triangle to achieve um a state [of health]" (Participant 9) and two participants in the layperson category: "personally, I would define it as, how you behave with other people as well. It could be considered healthy or not healthy... Like a psychological state." (Participant 5) and "well I would define health as a general state of being, of well-being of which it could be either good, bad, or average but basically would see it as a general state of well-being encompassing the body, the soul, the mind." (Participant 6).

Perceptions of ill-health. In regards to the second research question, How do participants define ill-health?, participants were asked to define what it means to be unhealthy. The data was coded to reflect this theme, and word frequencies were run to determine which words were most frequently used to describe a state of ill-health. These terms were then used to conduct a text search to see how the participants were speaking of the terms and the context of their

use. Among the health-related field group, there were seven terms which were iterated and contextually relevant: Behaviour, Eat, Food, Ill, Physical, Sick, and State. Values for each term and its number of references and coverage are reported in Table 6.0. Among laypersons, there was less consistency in terms used to describe and define a state of ill-health. Laypersons iterated six terms that were extrapolated from the data for further analysis: Consume, Exercise, Look, See, Sick, and Sleep (see Table 6.1 for reported values). There was greater agreement among participants in health-related fields with more using the same or similar terms to describe a state of ill-health than for laypersons who did not consistently use any one term in describing what unhealthy means.

Table 6.0

Text Search for Terms Used by Health Professionals to Describe and Define Ill-health

| Term | Participant Reference and Coverage | | | | |
|-----------|------------------------------------|-----------|-----------|------------|-----------|
| | 1 | 2 | 4 | 9 | 10 |
| Behaviour | 1 = 0.48% | — | 1 = 0.45% | 4 = 1.17% | 1 = 0.65% |
| Eat | 4 = 1.01% | 1 = 0.31% | 2 = 0.54% | 4 = 0.53% | 1 = 0.22% |
| Food | 4 = 0.82% | 1 = 0.21% | 1 = 0.23% | — | — |
| Ill | — | 1 = 0.16% | 1 = 0.32% | 1 = 0.09% | 4 = 0.86% |
| Physical | 1 = 0.38% | — | 7 = 2.90% | 2 = 0.53% | 3 = 2.01% |
| Sick | — | — | 2 = 0.36% | 10 = 1.40% | — |
| State | — | 1 = 0.26% | 4 = 0.91% | 4 = 0.58% | — |

Note. Dashes indicate that the term was not used by the participant in defining health.

Table 6.1

Text Search for Terms Used by Layperson to Describe and Define Ill-health

| Term | Participant Reference (# of iterations) and Coverage (in percent) | | | | |
|----------|---|-----------|---|-----------|------------------------|
| | 3 | 5 | 6 | 7 | 8 |
| Consume | 2 = 5.49% | — | — | 2 = 0.80% | — |
| Exercise | — | — | — | 2 = 0.87% | 2 = 0.89% |
| Look | — | — | — | 2 = 0.48% | 1 = 0.19% 4 = 2.50% |
| See | — | — | — | 1 = 0.13% | 2 = 0.56% 1 = 0.42% |
| Sick | — | — | — | 4 = 0.69% | 3 = 0.56% |
| Sleep | — | 2 = 0.73% | — | — | 3 = 0.70% |

Note. Dashes indicate that the term was not used by the participant in defining health.

As with perceptions of health, the ways in which participants defined ill-health were broken down into the main themes which were extrapolated from the data. They are discussed in detail below.

Health as an absence of illness or disease. When discussing and defining ill-health, participants referred back to the presence or absence of illness and disease. Three medical participants specifically referenced disease and illness when defining a state of ill-health: “*A state of unhealth is when you are not sound in either one or all aspects of human living. Maybe psychologically or physically, maybe as a result of illness or trauma.*” (Participant 4); “*Ill health is a state where um the person is constantly sick, physically or mentally, and the person is, the person’s strength, physical strength, inner strength, is completely being drained and it’s chronic.*” (Participant 9), and “*regarding unhealthy, the only thing that comes to my mind is ill. If someone*

is physically ill or mentally ill" (Participant 10). Lay participants also spoke about sickness or disease when defining ill-health: "*in a situation where you take in some substance and then it affects you health wise, and then maybe you've fallen sick, you've been weak, and then you can't perform the, you know, the typical daily activities that you're supposed to perform*" (Participants 6) and "*Okay, if you say what an unhealthy person might look like, let's say seeing someone sick, right. Like a sick person.*" (Participant 7).

Mechanistic views of health. As in answering questions aimed at defining health, when participants were asked to define ill-health, they continued to speak of health and the body in mechanistic ways. In talking about behaviours and physical activity as related to ill-health, participants position the body as something to be managed. Four participants in the health-related group talked about ill-health using mechanistic language: "*lack of exercise for sure.*" (Participant 1); "*Not getting any exercise whatsoever*" (Participant 2) "*Sedentary behaviours, sitting and not doing nothing... You harm yourself by not exercising, not eating properly, not taking your medication. Causing arguments with your significant others.*" (Participant 9); and lastly one participant who spoke of the mechanistic relationship between the body and activity, but talked also about agency "*I'm not really concerned about the activities. Um you know it's mostly about unhealthy any intentional activity that's going to harm me is unhealthy.*" (Participant 10).

Two laypersons defined ill-health using mechanistic language: "*failing to exercising, maybe you're smoking like 20 packs a day, um maybe you're eating the wrong type of food, and maybe you're also endangering yourself, and your body, the environment outdoors, so you know the kind of activities you do*" Participant 6); and "*you know exercising. Those things count, you know. Sometimes you could just go for a walk, go for a jog. You know, go to the gym.*" (Participant 7).

Obesity and overweight. In defining ill-health, participants centered on the body and its size as indicative of health or ill-health. Three participants in the health-related field referred specifically to obesity or overweight in talking about ill-health: “*it would be you know potentially overweight, but at the, but that doesn’t mean anything either because I see a lot of really skinny people that are extremely unhealthy.*” (Participant 2); “*And physically is being extremely obese. That’s one thing I look at as a physical they’re unable to participate in daily activities because of their state of health then they’re unhealthy.*” (Participant 4); and

Unhealthy. Definitely obesity. Obesity is one of the biggest things that I’ve been seeing. I see it every day. And maybe not even just obesity. Being overweight. Being overweight. It holds you back, you know, throughout your day. It can cause and it can also cause a different train of events, you know? Like it can it can make you feel... bad about yourself. It can limit what you do. It can cause other bad health effects. (Participant 1).

Three lay persons also referred to obesity or overweight as pertaining to ill-health: “*obesity, people being obese can count as being unhealthy because again um you could come to this conclusion from if I would see that kind of you know human that okay look at people who are obese may be slow, may get tired often*” (Participant 6); “*Someone that gains like a massive amount of weight.*” (Participant 7); and “*As an overweight person I don’t feel like I want to say this, but it does transcribe as unhealthy if you see somebody that is grotesquely overweight. You automatically, or I automatically feel like they’re not healthy.*” (Participant 8). The image below is a word tree using data from NVivo to illustrate the ways in which participants in health-related disciplines and laypersons spoke about ill-health and overweight/obesity.

Figure 3

Medical professional and layperson use of words “obesity” and “overweight” content analysis



Note. Lines stemming from the centre in green indicated participants in health-related fields; lines in purple indicate laypersons.

Food and nutrition. As with defining health, in defining ill-health participants used mechanistic conceptions of nutrition and food as relative to the body's functionality, size, and health status. All participants in the medical professional group referred to food as relative to ill-

health, including specifying what types of foods would be deemed unhealthy: “*unhealthy eating habits. Processed foods.*” (Participant 1); “*Unhealthy. Honestly, I think it’s what you put in your mouth, too. So unhealthy for me is when you’re filling your body full of junk, right.*” (Participant 2); “*Bad eating is one of the biggest ones... someone that doesn’t eat properly*” (Participant 9); “*I’m not really concerned about the nutrition because it can be modified. Once I can eat too much and then I can modify it with the next meal.*” (Participant 10); and

Firstly too much alcohol intake is not very healthy because it can lead to accidents or unwanted fall and eating unhealthy foods. Like taking too much sugar. Taking too much, because we all have different systems, right. There’s a way that we handle pop easily as compared to somebody else who drinks pop and the person just pfft blows up kind of. (Participant 4).

While participants in the lay group all spoke about food in relation to health, only four participants referred to food in defining ill-health: “*... avoiding good nutrient foods and eating like fancy food items. Instead of consuming fancy food items, just like canned like noodles.*” (Participant 3); “*Not watching your diet. Just sitting on the couch eating chips and watching tv all the time, junk food. High consumption of junk food. Not watching your calories*” (Participant 7); and that would be just I guess a state in which your body isn’t functioning the way it should be and again that could be based on the kind of things you eat, the kind of attitude in what you do, um and failing to exercising, maybe you’re smoking like 20 packs a day, um maybe you’re eating the wrong type of food, and maybe you’re also endangering yourself, and your body... And again generally the kind of food you eat. Basically if there are things high in cholesterol, those are generally not good for the body. (Participant 6);

with one participant mentioning food or eating to problematize the mechanistic idea of activity and food as the only determinants of good health: “*people think not being healthy is not going to the gym, not eating right but part of being unhealthy is sleeping for two hours a day.*” (Participant 5).

Holistic ideas of health. Participants again iterated holistic ideas of health when defining ill-health, as well. Within this conception of health, participants referred back to earlier meta-themes of environment, stress, balance, and psychological well-being as relative to a state of ill-health.

Environment. When defining ill-health, only one medical professional referred to environment as an indicator of ill-health: “*I'm exposed to chemicals in the world that are from cars and in my environment around me so there's that.*” (Participant 1). Two lay participants referenced the environment when talking about what ill-health means: “*the environment outdoors, so you know the kind of activities you do*” (Participant 6) and “*Not just uh taking good care of... not only yourself. I feel like being healthy has to do with not just yourself but your environment, right? Taking your garbage, disposing stuff like in the proper way.*” (Participant 7).

Stress. In defining ill-health, participants spoke about the role of stress. Two participants in the health-related group talked about stress as a determinant of ill-health: “*stressful situations that are going to affect you in the long run. Even for your blood pressure, over time, you might think you're fine but over years you might come to a state where it's irreversible. Where your arteries are clogged up. Where all your organs are starting to get damaged, your eyes are damaged, all irreversible*” and in talking about what an unhealthy person might appear like: “*they would, you know, be stressed out too, not just not just physical, emotionally unhealthy*” (Participant 5).

pant 1) and one layperson spoke about the role of stress in ill-health: “*They always have a stressed ... a lot of stress in their work and studies*” (Participant 3).

Psychological or mental health. Finally, in relation to holistic ideas of ill-health, participants spoke about psychological well-being. Four participants in health-related fields spoke about having emotional regulation, interpersonal relationships, and psychological well-being as related to ill-health: “*In my experience, I find that people who have a lot of irrational emotions, right, carry a lot of anger or things like that, that tends to lead to health problems too*” (Participant 2); “*Unhealthy. When somebody is unhealthy is more like to me psychologically I think is withdrawal.*” (Participant 4); “*the way you interact with other people can also have some kind of unhealthy... You have people that are, that are very, they try to create conflicts*” (Participant 9); and “*Psychological - well it can be obvious physical condition or disease or it can be mental situation that isn't naturally uh obvious but that somebody's suffering from it's like depression or anxiety, something like that or loneliness.*” (Participant 10). Only one lay participant referred to psychological aspects of health when discussing ill-health: “*So if you're quick to get angry or quick to respond violently, that's very unhealthy. Because it's more or less a destructive choice that you're making instead of acting logically*” (Participant 5).

Cultural influences on health perceptions. Participants in both groups were from a variety of cultural backgrounds, and there was little agreement within groups on cultural influences on health perceptions. There were a couple of themes, however, which were extracted from the data. Because differences between the lay and medical groups were less distinct for cultural perceptions, data from both groups are reported together in Table 7.0. Terms that were most frequently used and thematically relevant for participants in health-related professions and layperson alike were: Eat and Food.

Table 7.0

Text Search for Terms Related to Cultural Influences on Health Perceptions

| Term | Health Professionals | | | Lay Persons | | |
|------|----------------------|-----------|----------|-------------|-----------|----------|
| | ID | Reference | Coverage | ID | Reference | Coverage |
| Eat | 1 | — | — | 3 | — | — |
| | 2 | 1 | 0.63% | 5 | — | — |
| | 4 | — | — | 6 | 6 | 1.32% |
| | 9 | 1 | 1.02% | 7 | 1 | 0.63% |
| | 10 | — | — | 8 | — | — |
| Food | 1 | — | — | 3 | — | — |
| | 2 | — | — | 5 | — | — |
| | 4 | 3 | 1.05% | 6 | 3 | 0.75% |
| | 9 | 1 | 0.68% | 7 | 1 | 0.42% |
| | 10 | — | — | 8 | — | — |

Note. Dashes indicate participants did not use this word in reference to cultural influences on health perceptions.

Culture, which is a broad term that encompasses many aspects (including place, time, age, gender, and a multitude of other relevant factors which influence how a person understands and perceives the world around them), is much more difficult to assess the influence of in the context of this research as participants came from a range of backgrounds, many of them being international students, and thus being exposed to different cultures and ideas about health and healthfulness. Perceptions may vary widely, depending on dominant cultural discourses, indi-

vidual experience, political orientation, gender, religiosity, philosophy, and so on. To understand better how perceptions might be impacted by the culture in which one has been raised, participants were also asked specifically how they thought their culture or background had influenced the manners in which they think about health. The most consistent and universal response was related to food - identifying good foods and bad foods, and the role food plays in nutrition and health, again relating to the theme of holistic health and its meta-theme of the centrality of food and nutrition to health. For example,

I would say the culture in which, well growing up most of the things you get to eat, actually affects the kind of food you eat, more natural, less of induced chemical or whatever, so from that angle, I would say also I've grown into being picky about the food I eat, making sure as much as possible I try to eat fresh food, vegetables, and eating things not processed so to that extent I would say my culture, you know my culture did affect that (Participant 6, Layperson).

Also related to the theme of holistic conceptions of health, participants from international countries also mentioned a greater sense of community over the North American individualism:

where I come from where everybody is more of community, children are brought up by the community, and everybody's taking care of each other. Like sisters who are older and get bigger and they take care of the younger ones and the younger ones get bigger and take care of their cousins, that kind of lifestyle. As compared to here where once you leave your dad's home, that's the end. You don't have any business with your dad and that relationship is strained kind of (Participant 4, Medical Professional).

This conception of health - that is, of social support and connectivity as it relates to healthfulness - is in contrast to North American notions of independence and individuality. The participant is

identifying aspects of connectivity as it relates to his ideas of health and healthfulness, specifically in relation to social support, and relating these ideas back to his cultural milieu, having grown up in an African culture where this was particularly important to ideas of well-being. However, participants also spoke about connections and friendships as central to a state of well-being, which indicates that connectivity is an important part of what participants perceived to be healthy.

Gender influences on health perceptions. Finally, in regards to the question about gender influences on perceptions, the following was found. Participants were unsure when responding if their gender had influenced how they perceive health. This is likely explained by the fact that gender, as a construct, is not often considered as exerting influence on our daily lives; while we enact gender and it influences our perceptions, behaviours, and ideas about ourselves and the world, most individuals do not actively and consistently examine the ways in which gender might be impacting on their lives. However, data from those who answered this part of the interview were analyzed to examine any common themes. Further, participants were divided by gender to examine if their use of language in describing health demonstrated any significant or systematic differences. The relevant term used most frequently in relation to health perceptions as influenced by gender among health-related participants was “Body” (3; 2.27%). Among laypersons, the only thematically relevant term used was Look (4; 1.78).

Because gender is a social construct that influences how people experience day-to-day phenomena, data was split by gender to examine for gendered differences in constructions and perceptions of health. When data was split by gender, word frequencies were conducted to examine for systematic difference in ways in which males and females talk about health. Due to the small sample size, it was not possible to make a gender by group (medical/lay) analysis.

The gender analysis showed that males and females used similar words to describe health, healthfulness, and ill-health, with some slight differences.

Data reflected that Females ($N = 4$) iterated five words that were used by all participants in this category: Body, Disease, Eat, and Exercise. There were seven more words that were used consistently by most participants in this category: Active; Feel; Food; Look; Mind; Physical; and Skin. Text searches include stemmed words (e.g., Eat, Eats, Eating). Frequencies and weighted percentages are shown below in 8.0.

Table 8.0

Word Frequencies for Female Participants

| Word | Count | Weighted Percentage |
|----------|-------|---------------------|
| Active | 14 | 0.46% |
| Body | 34 | 1.12% |
| Disease | 10 | 0.33% |
| Drink | 13 | 0.43% |
| Eat | 25 | 0.83% |
| Exercise | 13 | 0.43% |
| Food | 19 | 0.63% |
| Look | 15 | 0.50% |
| Mind | 22 | 0.75% |
| Physical | 11 | 0.36% |
| Skin | 9 | 0.30% |

Males ($N = 6$) showed agreement on four terms, which were iterated by all participants in

this category: Active; Eat; Exercise; and Food. There were nine additional terms which were iterated with consistency across male participants: Able; Body; Control; Feel; Mind; Physical; Sick; Stress; and Work. Frequencies and weighted percentages reported below in Table 8.2.

Table 8.2

Word Frequencies for Male Participants

| Word | Count | Weighted Percentage |
|----------|-------|---------------------|
| Able | 26 | 0.57% |
| Active | 23 | 0.50% |
| Body | 20 | 0.44% |
| Control | 8 | 0.18% |
| Eat | 64 | 1.40% |
| Exercise | 23 | 0.50% |
| Feel | 17 | 0.37% |
| Food | 38 | 0.83% |
| Mind | 10 | 0.22% |
| Physical | 24 | 0.53% |
| Sick | 26 | 0.57% |
| Stress | 10 | 0.22% |
| Work | 12 | 0.26% |

In examining the construct of gender in analyzing the data, there was evidence of a difference in how male versus female participants spoke about health. While males and females used many of the same words, the frequency with which words were used varied. Males and fe-

males both referred to being “active” and “activities”, but male participants used the word with greater frequency (23; 0.50%) than did female participants (14; 0.46%). Participant 10, a female participant, moderated her use of the word “activity” by referring to “having some moderate activity, walking, hiking, is healthy.” Male participants, on the other hand, would refer to being “active” in relation to both body image and exercise. Previous research has found that males tend to distance themselves from concerns about appearance when talking about their workout habits, emphasizing the utility of working out – i.e., a need to train in order to be accepted into fire service or for self-defense (Gill, Henwood, & McLean, 2005; Saltonstall, 1995). Males also used “activities” to refer to one’s ability to do their work, or carry out expected daily activities as a measure of health. Male participants also spoke about “ability”, mostly in relation to carrying out specific health behaviours (i.e., relating to peers, to engage in physical exercise, to fulfill work obligations). This term was used by only one female participant one time. It appeared that male participants constructed their health discourses using more active language, like ability and activity. Both male and female participants also used the words “physical” and “exercise” when talking about behaviours that are healthy.

Both male and female participants also referred to the “body”, though female participants referred to the body with greater frequency (34; 1.12%) than did male participants (20; 0.44%). When speaking of the body, both groups referred to the body as a way to determine health, although male participants tended to speak more about the functional role of the body, keeping it healthy by identifying “*what your body needs, right. You have to feed the body, too*” (Participant 7, Layperson), while female participants referred to “also how your body feels” (Participant 10, Medical professional) and the body’s appearance: “*I try to keep a nice figure*” (Participant 1). One word that was used by males, but did not appear with any frequency in female participants’

interviews was “control”. Male participants spoke about valuing control, whether it was ability to control one’s diet or one’s emotional regulation. This was an interesting finding, given that constructions of gender construe masculinity as requiring such control (Kimmel and Messner, 2001), and this was reflected in the responses male participants provided. There were more male participants than females (6:4), so it is important to note that some of the discrepancy in word frequency may be related to the difference in the number of participants.

Also of interest was how participants regarded the role of gender in helping to shape their perceptions, so participants were asked specifically in what ways they believed, if at all, that gender may have influenced how they thought about health. Eight of the ten participants answered this question specifically, although most participants showed some gendered influence in their responses overall, as demonstrated above. Two participants referred to body image issues when asked about how gender has influenced how they think about health. A male participant (Participant 5, Layperson), spoke about how body image issues impact both males - “*they’re pushed to try to stay healthy, stay active, be built to look like the guy in the magazines and such*” - and females - “*Mostly the females are under the perception that you have to be model thin in order to be considered attractive*” - in Canada. A female participant (Participant 1, Medical Professional) elucidated the complex relationship between body image and ideas about health in her response: “*well maybe body image in a way it’s, it’s a lot more pressure for girls so I think that could be a part of why I like to be so healthy. Maybe it was at first or when I was younger, but now it’s like I’m more focused on ... um health versus what I what I look like.*” Some participants also referred to external expectations placed on them based on their gender: “*I would say for my gender, I would say a little bit because you know how like people around you look at you too, like how they see you as what kind of person you are and how. Like for an example my*

housemate is like ‘I can’t believe you’re a guy and you’re this organized and neat’” (Participant 7, Layperson). Participants also referred to stereotypes of health related to gender, specifically regarding female as sicklier: “*Maybe. I feel like women are more sickly than men according to, you know, the world out there*” (Participant 8, Layperson) and

I think the um we actually have limited perceptions as women that we can achieve a certain level of health. I think that we have this belief, a lot of people have the belief, that men can get healthier easier and quicker and lose weight faster and build muscle faster and all those thing and I think that they’re just beliefs, really (Participant 2, Medical professional).

One participant contradicted this common conception of women and health by stating that “*females has a very higher threshold for pain so um . . . I don’t know, maybe I guess being female it has make it very easy for me to deal with everything*” (Participant 10, Medical Professional).

This participant also suggested that she can “*bear and handle*” physical and mental health issues better than her male cousin, which counters the popular discourse that females tend to be more susceptible to illness than males (Courtenay, 2000b). Two female participants also referred to sexual health, for example reproductive health, when talking about health and gender, referring to birth control and expectations of women in relation to reproductive healthcare: “*sometimes. I think maybe like birth control would be a big part of it. I’m not on birth control anymore but I used to be. Um and I think that is messed with my body a lot.*” (Participant 1) and “*It’s always the woman’s fault when it comes to sexual health*” (Participant 8), which elucidates the internalized cultural expectation that women are responsible for reproductive health.

While gender, like health, is a construct, it is something that is constructed and reconstructed through our everyday interactions, and thus it would be expected that participants would

not have explicitly thought about how their gender might impact their lives prior to the interview. In spite of it not being something that is frequently deconstructed, participants, when asked to think about it, were able to provide some specific ways in which gender had impacted how they think about health.

Discussion

How people think about and understand health has important implications for the health behaviours that they engage in, the ways they conceptualize their own health, and, for participants involved in the health field, how they understand the health of their patients. Health information is more accessible than at any other time in history, and so there is a great deal of medical discourse that permeates cultural discourses of health. Many of the conversations regarding health in media are centered on eating “clean” and being “fit”, with television shows like The Biggest Loser promoting weight loss as healthful, and niches on social media like Instagram and Facebook promoting and reinforcing very specific ideas of health and fitness (i.e., thin, toned bodies, restricting caloric intake, and exercising often). When people interact and converse with others, they are actively constructing the world and the individual, so these social media niches are important to understanding the ways in which people conceive of health and illness (Burr, 2003). We often tend to speak of the body in terms of its condition, because it falls under the purview of biomedical discourse, as being disease-free, functioning normally, or as being diseased and malfunctioning (Foucault, 1973; Burr, 2003).

In regards to the present study, it is important to consider the research interview as a form of producing and reproducing knowledge. While the intent was to allow participants to speak of their own personal perceptions of health, I also inevitably had to direct the conversation to specific aspects of health (e.g., what does health **look** like to you); some of the semi-structured in-

terview questions came up organically without probing, and others needed probing further explanation or to direct the participant toward a more pointed answer. As with any everyday conversation or transmission of information, then, the interview process itself was an active process of discursive construction informing both the researcher's understanding of how participants conceived of health, and invoking participants to think of health in explicit terms that they may not have previously.

Data analyses demonstrated that there were several main themes that emerged from how participants perceive and talk about health. These themes were consistent between the groups, with more similarities than differences between laypersons and the health-related group; responses from participants in each group fell within the themes of: health as an absence of illness; mechanistic views of health; and holistic views of health. Word frequencies demonstrated that both participants in health-related fields and lay persons tended to use the same words to describe health and illness, deriving similar meaning and understandings about health and illness. This can be accounted for through the fact that medical professionals, although exposed to biomedical discourse and immersed in the power structure of the medical institution, are also cultural beings and exposed to cultural discourses similar to laypersons. Likewise, with the increased transmission of information through the internet and other sources, laypersons have become increasingly exposed to biomedical discourse, decreasing the disparities between cultural discourses of health and the biomedical discourse. For this reason, it is not unexpected that laypersons and medical professionals would espouse similar ideas about health and healthfulness. However, there may have been greater variance in perceptions between students in health-related programs and laypersons if there had been greater range of students in the medical health field, or with practitioners who had been practicing in the field for a significant amount of time.

In responding to the main questions posed by the research study, four themes emerged from the data: Health as the absence of illness or disease; Mechanistic views of health and illness (i.e., the body and how it works or performs as central to health and ill-health, especially relating to body size and behaviours) - and stemming from this theme the themes of overweight as inherently unhealthy and of and the centrality of food to conceptualizations of health; and Holistic ideas of health (e.g., “balance”, environment, and psychological well-being as central to one’s state of health). These themes reflected both biomedical discourses of health and more holistic conceptions of health.

The present study reflected existing data regarding how individuals tend to think about health as an absence of illness, an ability to work, and health as a state of equilibrium and providing freedom to lead a fulfilling life (Hughner & Kleine, 2004). In examining the data from the present study, the thematic notions of health expressed by both laypersons and participants in health-related fields were similar to previously extrapolated themes identified by Hughner and Kleine (2004), particularly that participants defined health as an absence of illness and considered health as contingent on mental state or attitudes. While perceptions of health are fluid and may shift over time, this suggests that there is some cultural continuity over the past decade in how individuals conceptualize health. Conceiving of health as an absence of illness and an ability to work is tied into capitalist conceptions of health as productivity (Wolf & Colditz, 2012; Zhang, Bansback, & Anis, 2011). It is unsurprising that participants in health-related disciplines and laypersons would conceive of health in terms of productivity, as the WHO definition identifies “the ability to participate in social activities including work” (pp. 1) as a social domain of health (Huber et al, 2011). Participants spoke of ability to work as indicative of health, and emphasized an absence of illness as a defining characteristic of health. These ideas that participants

iterated are consistent with previous research suggesting that people tend to define health in terms of ability to be productive citizens in a capitalist structure (i.e., to fulfill work obligations) and as an absence of disease or illness. Although sample sizes were small, participants falling in the medical professional category spoke in terms of absence of illness more than did lay participants. All participants in the medical professional group referred to “disease” or “sick” when defining health, while only one lay participant referred to an absence of disease specifically as indicative of health. By its nature, medical training emphasizes the presence and absence of disease as demonstrative of health status, so it would be expected that participants in health-related fields would be more likely to define health in these terms.

Mechanistic views of health and illness are dominant in medical discourse, where the locus of control for health, especially in relation to obesity, is located within the individual and their behaviours. Participants tended to speak of health as located within the body; conceptualizing the appearance of the body, especially large bodies, as being indicative of health status focuses treatment on managing the body, a common discursive tool for maintaining power (Foucault, 1979; Gard & Wright, 2005). Biomedical discourse has long drawn the body within its purview, and the current focus on obesity-as-epidemic has resulted in the proliferation of obesity as a health detriment discourse both within the medical profession and at the cultural level (Rail, 2008). Although research dating as far back as the 1920s has established the genetic heritability of body type and size, this view of the body does not fall within the idea that individual behaviour is responsible for how one’s body looks, and thus is not part of popular discourse. Instead, the assumption of individual responsibility in overweight, based on a mechanistic view of the body that assigns responsibility for body size to the individual, has been adopted into popular and medical discourse (Rail, 2008). Participants demonstrated an absorption of this discourse in

their discussion of health and ill-health, with all participants referring to body size or weight as indicative of health status, often relating body size to physical activity, type of foods eaten (specifically “bad” foods), and personal behaviour.

In keeping with a mechanistic conception of the body promulgated through various media, participants tended to talk about health and the body in mechanistic ways, focusing on activity levels and diet and nutrition as sources of both healthfulness and ill health. In addition to mechanistic tones, there were some tones in relation to bodies, mirroring the healthism discourse in which slender bodies that are achieved or attained through individual behavior are lauded and equated with a state of health (Wright, O’Flynn, & MacDonald, 2006). These slender bodies are also then rendered morally appropriate through this healthism discourse. All of the participants in the medical professional category made reference to food, diet, or eating in regards to defining health. As with ideas about the relationship between body size, food intake, and activity levels promulgated by media and discourse, participants spoke about the relationship between health and food using both moralistic and mechanistic ideas equating diet and nutrition with body size and healthfulness. Similarly, participants’ responses reflected mechanistic conceptions of overweight and obesity in relation to activity levels and exercise.

In the health-related group, all participants except for participant 10 referred to overweight or obesity. All participants in the category discussed eating, food, and diet as necessarily related to health. Each participant in the health-related discipline category also made reference to exercising or working out as a healthful behaviour. Similarly, lay participants also spoke of the relationship between food and health, exercise, and bodies. All five of the lay participants mentioned eating, specifically eating healthy, good foods (for example, fruits and vegetables, eating organic), often at the same time as speaking about activity levels or exercise.

Because there is a cultural anxiety about body size and obesity (Rail, 2008), particularly focused on large bodies as being inherently unhealthy, it was expected that participants would have internalized many of the notions of health and body size that are disseminated through media. Eight of the ten participants referred to overweight, obesity, or fat in discussing their perceptions of health and ill-health. When participants spoke about overweight, obesity, and fat, it was generally in regards to what they conceived to be unhealthy, or the appearance of ill-health. These messages are invasive and consistent in media, across multiple sites, in which appearance, beauty standards, and health are intertwined, leading people to conceive of large bodies as inherently unhealthy, needing management, and falling, then, under the purview of expert (i.e., medical) intervention (Foucault, 1979; Fox, Ward, & O'Rourke, 2004; Rail, 2008). Interestingly, while most participants made reference to large bodies in some way when speaking about ill-health, there was also some hesitation to name large bodies as inherently unhealthy, specifically from participants who self-identified as being overweight themselves: "again it would be the opposite of what I just described so it would be you know potentially overweight, but at the, but that doesn't mean anything either because I see a lot of really skinny people that are extremely unhealthy" (Participant 2, Medical Professional) and another who stated

As an overweight person I don't feel like I want to say this, but it does transcribe as unhealthy if you see somebody that is grotesquely overweight. You automatically, or I automatically feel like they're not healthy...Like when I go to the doctor's office and they see that I've put on five pounds and I get that scorned look that you know, I'm not healthy because of my weight. But I don't have any health issues that you would attribute to being overweight. I have no high blood pressure or diabetes or anything like that. So when somebody looks at somebody my size they just automatically think those are my

issues and they're not. (Participant 8, Layperson).

These same two participants were also the only two who mentioned being overly thin or “skinny” as being potentially detrimental to one’s health. None of the other participants alluded to the U-shaped notion of weight and health (Cogan & Ernsberger, 1999), where those outliers at either end of the spectrum may be more susceptible to health problems than average people who fall in the middle of the spectrum. This isn’t surprising as the availability heuristic, in which media overemphasize certain health risks, may influence laypersons to overestimate certain health risks over others (Lyons, 2000).

Although almost all participants referred to body size and shape as relevant to health, food was universally discussed as a basis for health. This is not surprising given how media has conflated healthy diet with thin bodies in advertising and conveying health messages. What was interesting was that the notion of “overweight as inherently unhealthy” was only problematized by the two participants who self-identified as being overweight, where both indicated that they would presume someone overweight to be unhealthy, but know from personal experience that one can be overweight and have good health. This is related to a health at every size discourse, an alternative to the weight-centred approach that is touted in a cultural disdain of body fat and large bodies (Ernsberger & Haskew, 1987; Gaesser, 2003; Rail, 2008). The health at every size approach to weight emphasizes eating well and being active in a manner that is comfortable to the individual with the focus being on wellness rather than body size.

Similar to participants in the medical professional group, laypersons focused on food and nutrition and activity as defining healthfulness. This is not surprising given how often this conception of health is promoted by media, with advertisements for weight loss solutions and television shows which focus on weight loss framed within a health discourse fueling anxiety about

overweight and obesity (Fox, Ward, O'Rourke, 2004). Through the interviews, all participants reproduced a mechanistic conception of the body in some way, particularly in reference to activity or exercise and diet. Interestingly, one participant even referred to the body as a machine: “Like maintenance of your body. Just like we engineers maintain machineries” (Participant 7, Layperson).

In relation to mechanistic ideas of health, it has been found that people tend to moralize health and wellness, revering thin, toned bodies as a standard of health (Oliver, 2006; Rail, 2008). It was interesting that participants also tended to use value-laden language to describe healthy and unhealthy behaviours and states. Eight of the ten participants used the word “good” to describe either a behaviour or aspect of health. Specifically, participants tended to refer to “good” foods and “bad” foods or eating habits when speaking about healthfulness. Some participants also talked about bodies in moralistic ways. For example, participant 1 (medical professional) stated that “a healthy person would look like good skin very good skin. Umm... very good body proportion and weight body percent fat would be very very good”, drawing directly from cultural discourses of thin bodies as “good” bodies. When data was split by gender, it was noted that none of the males spoke of the body in moralistic terms; it was female participants who would refer to bodies in such a way. Both males and females would speak of food and nutrition and exercise, however, moralistically in relation to conceptions of health.

In defining health, participants largely used biomedical models of health, highlighting biological and physiological factors related to health and wellness. However, there are a number of social and environmental factors that are often unexamined by biomedical discourse, including socioeconomic status, ethnicity, gender, and other sociocultural factors (Courtenay, 2000; Rail, 2008). While participants referred to environment - specifically alluding to the environ-

ment surrounding a person (e.g., having a living space free of chemicals or pollutants) and interactions with one's environment (e.g., having a clean environment, taking care of one's environment) - none of the participants alluded to or made any direct reference to sociocultural factors that might impact one's health. Although there is greater access to health information, and dissemination of biomedical discourse at the social level, there tends not to be included in discussions of health social determinants that impact well-being, so it is unsurprising that participants did not speak to this aspect of health.

In addition to a proliferation of medical discourse at the cultural level is also an increase in access to alternative understandings of health, with the introduction of Eastern ideas of health and wellness, which has allowed for shifting perceptions to encompass holistic understandings of what it means to be healthy (Hughner & Kleine). This was evidenced in participants' responses to defining health and wellness, as well as what it means to be unhealthy. Also consistent with research of Hughner and Kleine (2004), which found that laypersons conceptions of health are characterized by two positive views - a state of equilibrium and a state of health as providing the freedom to lead a fulfilling life - participants from both groups also spoke of health in terms of "balance", quality of life, the connection to families and communities, ability to participate in leisure activity, and to live "well".

As Eastern ideas about health and wellness have permeated our cultural milieu, it would be expected that these ideas would influence individuals' perceptions of health. Data from the present study reflected this, with the theme of holistic health emerging as a major part of their discursive constructions of health in participants' interviews. While participants frequently referred to health as relative to the body and its maintenance and control, they also spoke about a more holistic notion of health, including environment and interpersonal connections as being in-

tegral to an individual's wellbeing. Five of the ten participants referred to their environment as integral to understanding health, emphasizing the internalization of a more holistic notion of health, which includes having a healthy environment in which one might thrive. Relating to that, participants spoke about maintaining good interpersonal connections, having good relationships with people, and making sure to spend time with family and friends as healthful behaviours. As part of this more holistic conception of health, participants also referenced maintaining mental health, having psychological health, and engaging in activities that are good for the mind. Subversive and alternate discourses of health and obesity are necessary to provide a vision of health that is accessible to marginalized individuals, so it is promising to see that, while participants tended to focus on body size as indicative of health, they also spoke about health in holistic terms. Interestingly, it has also been found that females tend to be more likely to be both consumers of and practitioners in complementary and alternative medicine (Keshet & Simchai, 2014), so while both male and female participants in the present study acknowledge holistic ideas of health and wellness, utilization of these services may also be gendered.

Participants also frequently mentioned psychological well-being, viewing health as a combination of bodily, physical health and emotional or mental health. For example, participants pointed to having a balance between a mental and physical state of health: "Well I mean for me health is a combination of all those factors so having a good mental state, I believe, is key to having a good physical state." (Participant 2, Medical Professional), as well as a balance of healthy relationships with others:

It's a state where you're able to interact with your peers in a healthy way. It's a balance, it's a balanced state. Like a yin and yang... Very balanced. You're healthy in that you're you're blending in with your environment, like you are one with your environment. So, if

you are healthy it means you are living properly, enjoying your life properly, going out with your friends, you're eating properly, you studying (Participant 9, Medical Professional).

These same sentiments were iterated several times by participants, with focus on mental health, connection to peers, and maintaining a good life balance, which includes healthy leisure activity. Participants in both categories also referred to holistic forms of health, like keeping the mind healthy through study and intellectual pursuits.

In addition to conceptions individuals hold regarding health, data was analyzed to examine for cultural influences on their perceptions and constructions of what health means. There has been a great amount of emphasis placed in North American media on eating “good” foods, which is also closely tied to capitalism and the commodification of food. Media also has a tendency to advertise foods as healthful, and frequently in gendered ways (an example of this would be the gendering of yogurt as a healthful, primarily female-consumed product), often moralizing certain foods for each gender (Turner, Ferguson, Craig, Jeffries, & Beaton, 2013). Food is central to notions of health, so it is unsurprising that cultural ideas that participants shared in relation to health perception centered around foods and eating. Because participants came from varying backgrounds, it was also suggested by the data that cultural influences on perceptions of health vary by place and time. Participants who were not from Canada mentioned differing views of health, or ways that their ideas about health and healthfulness might have changed since becoming immersed in Canadian culture. This is demonstrative of cultural transmission of health discourses, as participants appeared to have adopted North American discourses of health into their conceptions of health and illness.

In addition to culture, gender impacts how people think about health in general, as well as

about their own health (Bird & Rieker, 1999). While participants tended to have difficulty deconstructing the role of gender in their constructions of health explicitly, some participants did provide poignant responses to the question. Two of the female participants specifically referenced sexual health in relation to being female, mentioning birth control and a culture of blame around sexual health for women. One female participant also mentioned media making women appear the “sicker” of the genders, while another female participant suggested the opposite, that she believed females were more able to withstand pain. One male participant specifically referenced body image and expectations of muscularity for men – a common expectation for males in relation to health and appearance of health (Watson, 1993) – but also indicated that he felt the pressure was greater for females to appear attractive and “healthy”; similarly, one female participant made reference to pressures of body image in motivating her to exercise to appear fit. These discourses of health focusing on body appearance as indicating health status have become increasingly prevalent in recent years (Courtenay, 2000a).

Interestingly, while the data was analyzed to compare and contrast participants who were in health-related professions and fields of study to laypersons, it was noted that participants tended to use multiple definitions when speaking of health. For example, Participant 1 conceived of health in terms of environment (“My environment around me. Um What I’m surrounding myself by. Like I usually think about a lot of chemicals.”), mechanistically in relation to food, exercise, and appearance (“definitely the food I eat. I’m always very cautious about the food I’m eating. What’s in it, where it’s coming from. Um, physical activity is a big part of my life. Um, I go to the gym every single day. I try to keep a nice figure.”) and in relation to the absence of illness and disease (“I like to give my body a chance to fight off you know sickness... I think health is defined as your ... presence of disease and illness and your overall quality of life”). This multitu-

dinous defining of health was seen across participants. Participants sometimes also had conflicting ideas about health, particularly evident in relation to body size. For example, Participant 8 spoke about the conflict between how she thought about what is healthy – “As an overweight person I don’t feel like I want to say this, but it does transcribe as unhealthy if you see somebody that is grotesquely overweight. You automatically, or I automatically feel like they’re not healthy.” and how her own health is constructed by those in the medical profession:

Like when I go to the doctor’s office and they see that I’ve put on five pounds and I get that scorned look that you know, I’m not healthy because of my weight. But I don’t have any health issues that you would attribute to being overweight. I have no high blood pressure or diabetes or anything like that. So when somebody looks at somebody my size they just automatically think those are my issues and they’re not.

Because individuals are complex and knowledge acquisition is related not just to dominant cultural discourses but also to a person’s position within a specific time and place, it is unsurprising that individuals hold multiple definitions of health and what it means. Health is a complex construct that is impacted by a number of intersectionalities – where access to health care, external appraisals of one’s health status and body, beliefs about the self and others, etc., are all impacted by age, gender, ethnicity, sexual orientation, socioeconomic status, geographic location, and so on.

The present study suffered several limitations. Firstly, the sample size was small. While qualitative research method standards suggest that a sample size of five per group is sound and that too much data results in an overabundance of information that is difficult to interpret (Kvale & Brinkmann, 2009), data derived from the present study cannot be used to generalize to an entire population. Because of the limited sample size, it might have been appropriate to use quota

sampling; more homogeneous groups would have allowed for more in-depth analyses. It was valuable, however, in providing information on how individuals within the community may conceive of health, particularly coming from diverse ethnic backgrounds, providing information on not only health perceptions informed by the culture in which they are living, but also being able to draw from how their perceptions were formed by other cultures to which they have been exposed. Secondly, there were an uneven number of male and female participants, making gender analyses difficult. However, inquiring of participants the role gender may have played in how they have come to think about health may have offset this limitation to some degree, providing participants a platform to speak about how gender roles impact perceptions. Thirdly, participants were from a wide range of ethnic backgrounds. This can be considered both a strength and a limitation, in that persons living in Canada would be expected to have been exposed to health discourses that permeate our culture, which was reflected in participants' responses. However, it is likely that because seven of the ten participants were born in other regions of the world, their perceptions of health were shaped by the context in which they lived, thus impacting the results of the present study, as persons born and raised in Canada would likely not have been exposed to the same discourses. Additionally, even health discourses within Canada might fluctuate or differ by region – e.g., rural versus urban neighbourhoods (Odoi, et al., 2005). Heterogeneity of the participants, then, may be seen as both a strength and a limitation to the present study. While this may make the data less reflective of North American discourses of health, it also serves to provide an understanding for how cultural location might impact understandings and perceptions of health. Additionally, although interpretation of the data was conducted by the primary researcher in collaboration with the thesis supervisor, it might have been beneficial to have a third rater to allow for assessment of inter-rater reliability and consistency of interpretation of the data.

results. Another limitation of the study was that in allowing participants to self-identify ethnicity, a number of participants self-disclosed as being “Caucasian” or “Black”, which are not actually ethnicities; a future study might provide a list of ethnicities from which to select to avoid this confusion. Lastly, the age range of participants - from 18 to 40 years of age - excluded persons of older generations who may have different perceptions of what it means to be healthy. Future research should examine a larger age range to enable a comparison of generational perceptions of health and healthfulness, as discourses change over time. Also, future research might actively recruit Aboriginal participants - both laypersons and those in the health profession - to get a better sense of how Aboriginal conceptions of health may differ from or incorporate popular discourses of health.

In conclusion, cultural discourses of health inform individual ideas about what it means to be healthy, what behaviours are healthy (and consequently what health behaviours are engaged in), and what constitutes ill-health. Whenever a person discusses health in conversation, in a medical encounter, or consumes a piece of media information about health, it is incorporated into their existing ideas about what health means. We need to have more alternative discourses to the weight-centered approach available to average persons to counteract the overweight as inherently unhealthy messages that are promulgated ubiquitously by media. Eastern and alternative discourses of health are already becoming more accessible to individuals because of the ease of access to information provided by the internet, which appears to have permeated the dominant discourses of health. With the proliferation of fitness inspiration niches on social media and public health messages and television shows focusing on weight loss framed within a health discourse (Fox, Ward, & O’Rourke, 2004), it is important to counteract these discourses which feed cultural anxieties about large bodies and obesities with alternative discourses that do not conflate

beauty ideals with health. The health at every size approach to health as an alternative discourse may reduce the anxiety about body size by focusing on eating a healthy diet and engaging in activities that are healthy and pleasurable, rather than on managing the size of the body to be considered healthy (Gaesser, 2003; Jutel, 2008).

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Appendix A – Recruitment Posters

Seeking Participants: How do you think of health?

I am looking for students interested in participating in a research study examining how people think of and talk about health. Participation will consist of a brief interview that will be recorded in which you discuss how you think about health. Participants' names will be entered into a draw for a \$50 gift card to InterCity Shopping Centre.

If interested in participating, please contact:

Jasmine Peterson at jpeters2@lakeheadu.ca

Jasmine
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**Appendix B
Cover Letter**

Dear Potential Participant,

I am a Master's student in Clinical Psychology at Lakehead University working under the supervision of Dr. Mirella Stroink. I am researching the ways in which people think of and understand health and health behaviours.

Your participation is being requested in a research study. Before you provide your consent to participate, please read the following information. Please ask as many questions as necessary to clarify and assure your understanding of what is being asked of you as a participant in this study.

The present study is an examination of the ways in which people have come to understand health and how we talk about health. It will examine how experience shapes our concept of health. Interviews will be conducted with thirty participants. Eligible persons will be: students at Lakehead University in non-health related programs; nursing students at Lakehead University; medical students studying at the Northern Ontario School of medicine; males and females, and also persons who identify as Aboriginal, First Nations, or Metis.

Interviews will take place in a conference room or classroom at Lakehead University. Interview questions will ask you to discuss your health beliefs and the ways in which you think about health and healthfulness. The interview is expected to take approximately one hour to complete and will be recorded.

If you are willing to take part in this study, please read and sign the consent form provided. The consent form outlines your rights as a participant. Your participation is valued and appreciated. If you have any further questions about the research now, please ask.

Please keep this form, and if you have questions or concerns at a later time, or if you would like to receive a summary of the results of the study, please contact me or my supervisor using the information below. Alternatively, you may contact the research ethics board at (807)343-8283.

| | |
|--|---|
| Jasmine Peterson, Master's Student Jpeters2@lakeheadu.ca (807) 343-8010 x6642 | Dr. Mirella Stroink, Supervisor mstroink@lakeheadu.ca (807) 346-7874 |
|--|---|

Thank you for your consideration in participating in this study,
Jasmine Peterson, BA
Department of Psychology

Appendix C
Lakehead University – Consent Agreement

Understanding health perceptions: Intersectionality and reciprocity in medical, social, and personal discourses.

You are invited to participate in a research study on the ways in which you understand health.

Risk of participation is minimal. Discussing health may become uncomfortable; if you do not wish to answer any specific question you may indicate so at any time. You may also discontinue participation at any time if the interview becomes unpleasant or uncomfortable for you. There are no direct benefits that can be expected from participation in this study. Your participation will, however, provide a better understanding of how individuals understand and conceptualize health.

Interviews will be audio recorded for later analysis. By signing this agreement, you are consenting to having an audio recorder running for the duration of the interview.

Once the interviews have been transcribed, a follow-up email will be sent out to you; you will be asked to read over the transcribed interview to ensure that your ideas were recorded accurately, and to respond within a week. A summary of the data will be available once analysis is complete.

Because of the nature of interview research, anonymity cannot be guaranteed during the interview process. However, data will be codified, so you will not be identifiable. The digital audio recordings of the interviews will be stored in a secured computer in Dr. Stroink's research lab at Lakehead University and will be destroyed after five years. Recordings will be accessible only to the primary researcher, Jasmine Peterson, and the thesis supervisor, Dr. Mirella Stroink; all names and identifying information will be removed upon transcription ensuring confidentiality of your responses. Transcribed interviews will also be stored in the secure lab and will be destroyed after five years.

Your interview responses will be kept confidential. However, there are several situations in which confidentiality is limited that you need to be aware of. If I become aware that a child is being or is at risk of being abused, I would be obligated to report this to the Children's Aid. If I become aware that a health practitioner (doctor, nurse, psychologist) has engaged in unethical behavior, I would be obligated to report this to the appropriate regulatory body. If I become aware that you are a threat to yourself or to others, I would be required to take appropriate steps to minimize potential harm. Finally, if my records were to be subpoenaed by a court, I would be legally obligated to relinquish them to the court.

Incentives to Participate: In appreciation of your participation in this research study, your name will be entered into a draw for an InterCity Shopping Centre gift card valued at \$50. If your name is drawn, you will be contacted via email to collect the gift card.

Participation in this study is voluntary. Your choice of whether or not to participate will not influence your future relations with Lakehead University. If you decide to participate, **you are**

free to withdraw your consent and to stop your participation at any time without penalty or loss of benefits to which you are allowed. At any particular point in the study, you may refuse to answer any particular question or stop participation altogether.

If you wish to receive a copy of the summary of findings, please indicate so below or contact me by email, and they will be emailed to you upon completion.

Agreement: Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to be in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement.

You have been told that by signing this consent agreement you are not giving up any of your legal rights.

Name of Participant (please print)

Signature of Participant

Date

Signature of Investigator

Date

If you wish to be entered into the draw for a \$50 gift card to InterCity Shopping Centre, please enter your email address below.

Email address

If you wish to a summary of research findings upon completion of data analysis, please indicate so below and a copy will be emailed to you.

Yes I would like to receive a summary of research findings _____

**Appendix D
Interview Guide**

When you think of ‘health’, what comes to mind?

How would you define health?

Probe: When you think of health, what defining characteristics come to mind?

Probe: What behaviours do you consider to be healthy?

How would you define unhealthy?

Probe: When you think of being unhealthy, what comes to mind?

Probe: What behaviours do you consider to be unhealthy?

When you envision a state of health, what comes to mind?

Probe: What would a healthy person look like?

Probe: What would an unhealthy person look like?

What health behaviours do you engage in regularly?

Do you feel your perceptions are impacted by Culture? Gender?

I note that you are a [medical professional student], do you think this training has influenced how you understand health? If so, how?