

Self-Care Responses to Respiratory Illnesses Among Vietnamese

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The health care system in the United States is highly technological and based on the biomedical model of disease. Individuals are expected to enter the formal health care system either for legitimization or treatment of deviations from health. Self-care activities that are independently initiated in response to illness are frequently viewed as being inherently dangerous and causing delay in seeking competent medical care (Knapp & Knapp, 1966).

Despite this prevailing perspective within the health care system, there has been a surge of interest in self-care by nurses (Dickson & Lee-Villasenor, 1982; Kearney & Fleischer, 1979); anthropologists (Kleinman, 1980; Parker, Shah, Alexander, & Neuman, 1979); and physicians (Berg, 1980). *Self-care* is defined by Orem (1980) as, "the practice of activities that individuals personally initiate and perform on their own behalf in maintaining life, health and well being" (p. 13).

THEORETICAL FRAMEWORK

The theoretical framework for this study is based on two constructs: (1) explanatory models of illness and (2) self-care. Kleinman (1978, 1980) noted that explanatory models (EMs) are ideas that both patients and providers have about specific illness or disease episodes and their treatment. The EMs of each group are different in that laypersons focus on illness and providers, for the most part, focus on disease.

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Differentiating between illness and disease is an important distinction in the literature on Ems (Eisenberg, 1977; Englehardt, 1974; Kleinman, 1980; Kleinman, Eisenberg, & Good, 1978). Kleinman et al.'s (1978) distinction between the two is that "disease . . . is malfunctioning or maladaptation of biologic and psychophysiologic processes in the individual; whereas illness represents personal, interpersonal, and cultural reactions to disease or discomfort" (p. 252). Illnesses and their explanations are shaped by culture and influence how persons express their symptoms, when and where care is obtained, and how it is evaluated. The language used by the layperson to describe illness is nontechnical and expresses illness in terms of its effect on the individual as a total person. On the other hand, explanations of disease as expressed by providers in the Western biomedical model are couched in abstract, highly technical language focusing on organs or organ systems.

Explanatory models of illness vary between and within cultures depending on both the popular and expert explanations prevalent in a given society. Tung (1980) reported that Vietnamese theories of illness causality are based on natural, supernatural, and metaphysical explanations that are derived from Sino-Vietnamese medical theory and popular folklore.

Two metaphysical concepts referred to in the literature on contemporary Sino-Vietnamese medical theory are *khi* (*chi'i* in Chinese) and *am* and *duong* (*yin* and *yang* in Chinese). Liu (1979) noted that *chi'i* "is regarded as a kind of life energy that supports movements and all activities of daily life" (p. 93). The concept of *am* and *duong*, more popularly known as the hot and cold theory of illness causation, is based on complex philosophical theory, that few Vietnamese can articulate (Bain, 1974). Briefly, the theory is that a balance between polarities of *am* and *duong* must be maintained if the universe, including each person, is to be in harmony. Application of this theory to everyday life involved balancing hot and cold foods, medicines, and other natural elements.

Another framework for explaining illness is based on supernatural beliefs. In this system diseases are believed to be manifestations of the powers of spirits or gods (Tung, 1980).

Finally, naturalistic explanations are also sought for many illnesses. Among Vietnamese, natural causes, such as contaminated water or food, accidents, trauma, and germs are usually the first considered.

Explanatory models, in addition to labeling and explaining illness, may also influence how individuals respond to an illness. Studies show

that the majority of illnesses are initially treated in the family context using some form of self-care (Kleinman, 1980; Pratt, 1977).

Self-care is defined by Levin, Katz, and Holst (1976) as "a process whereby a lay person functions on his/her own behalf in health promotion and prevention and in disease detection and treatment at the level of the primary health resource in the health care system" (p. 11). That a repertoire of self-care activities exists in all cultures is supported by Dean's (1981) statement that "self-care in its various forms, preventative, curative, and rehabilitative is neither contemporary nor reactionary. It is the basic health behavior in all societies past and present" (pp. 673-687).

A variety of self-care activities has been reported in the literature, although few studies have focused specifically on Vietnamese self-care practices. Yeatman and Dang (1980) investigated the uses of *cao gio* by Vietnamese in the United States. *Cao gio*, or coin rubbing, is a practice in which a mentholated substance is rubbed vigorously with a coin or spoon onto an affected area of the body until bruising occurs. Of the 50 persons interviewed, all but 1 used this practice.

Other reported self-care practices of Vietnamese include diet change and self-medication. Mandersen and Mathews (1971) found that Vietnamese women modified their dietary practices during pregnancy. And Hickey (1964) and Tung (1980) indicated that dietary modification to balance hot and cold foods is one component of the self-care response to illness among Vietnamese. Although studies of self-medication among Vietnamese were not found in the literature, the propensity toward self-medication was noted by Tung.

PURPOSE

The purpose of this study was to determine individual self-care responses to respiratory illness among Vietnamese persons residing in Texas.

RESEARCH QUESTIONS

The two major research questions posed for this study were

- (1) What explanatory models are used to describe respiratory illness among Vietnamese?
- (2) What self-care practices of Vietnamese are engaged in during an episode of respiratory illness?

DESIGN AND METHODOLOGY

The method of data collection in this exploratory study was the interview, which ranged in length from 20 to 90 minutes. Questions included in the interview were related to the research questions posed for the study. The wording of the questions was adopted from the ideas and formats gleaned particularly from the work of Bauwens (1979) and Kleinman (1980). The interview schedule, made up of 30 items, consisted of standard demographic questions, fixed choice and open-ended questions, with the latter constituting the bulk of the interview. Demographic data were elicited briefly at the beginning of the interview and continued at the end. It was felt that because all subjects had experienced a recent illness, they would be most responsive to initial questions concerned with their illness. Questions asked in the body of the interview were primarily open-ended, such as "What do you think caused your illness?" "What was the first thing you did to treat your illness?" and "How did the treatment you used make you feel?"

Content and face validity for the questions were determined by an anthropologist, a doctoral student from Vietnam, and two key members of the Vietnamese community. At a meeting with each of these individuals the investigator sought input on possible changes needed to ensure that the questions were culturally acceptable, and that they would elicit the data sought. Each person was also asked for assistance in identifying potential subjects. Additional subjects were obtained when the investigator and translator visited English-as-a-second-language classes in Austin and Houston.

Two Vietnamese individuals, fluent in English and Vietnamese, were hired as translators. Both were born in Vietnam and were attending college. Approximately 2 hours were spent with each translator prior to data collection in order to review the interview schedule, identify questions that they might have difficulty translating, and discuss their role as translators.

Prospective respondents were informed by the investigator, through the translator when necessary, about the purpose, confidentiality, and

amount of time needed for the interview. Informed consent was obtained from all respondents. The interviews were conducted either in the home of each respondent or at an agreed-upon alternate location. The investigator wrote interview responses on a recording form and as soon as possible after each interview, elaborated upon data obtained but not written down during the interview. A component of this process involved the assistance of the interpreter. Specific Vietnamese words used by subjects were recorded along with the English translation. Notes taken during the interview were also reviewed with the interpreter to ensure accuracy and completeness.

The interview schedule was pretested with 3 subjects. No substantive changes were made after the pretest.

Sample

A convenience sample of 30 subjects was selected from residents of Austin and Houston, Texas. Subjects were born in Vietnam and had arrived in the United States no earlier than 1975 and no later than 1 month before the date interviewed. The wide variation in U.S. residency of subjects was chosen in order to investigate the influence of length of residency on explanatory models and self-care practices. Subjects had an episode of respiratory illness within 2 months prior to the interview. The subjects ranged in age from 18 to 62, with a mean age of 34.23 years. The length of time they resided in the United States ranged from 7 months to 7 years.

Definitions

The definitions used in the study are listed below.

Local medical care system: a system of health and medical care delivery in which practitioners are "self-trained" or "have an undetermined length of master-pupil education." Such a system is also known as "folk," "primitive," or "traditional" (Dunn, 1976, pp. 138-140).

Cosmopolitan medical care system: a system of health and medical care delivery in which practitioners receive "scholarly education at a school" and must pass a formal examination before being licensed to practice. This system is also known as "modern," "scientific," or "Western" (Dunn, 1976, pp. 138-140).

Data Analysis

Frequency distributions and two-way chi-square tests were used to analyze the study findings. Content analysis was used to analyze broad categories that included illness name and causality, rationale for self-care practices and rationale for cosmopolitan care. Content analysis is a systematic, objective procedure for examining the content of documented information. It reduces the language to a set of categories or statistically manipulable symbols that represent the presence, frequency, or nature of selected characteristics (Waltz, Strickland, & Lenz, 1984).

RESULTS

Quantitative

Question 1. What explanatory models were used to describe respiratory illness? Explanatory models were defined in this study as having two components: the name given an illness and a statement concerning beliefs about the cause or causes of that illness.

The names given to the respiratory illnesses were "cold" (N = 20), "flu" (N = 4), "allergy" (N = 4), "headache" (N = 1), and "wind enters the body" (N = 1).

The causes of the respiratory illnesses reported by 26 subjects were weather change or cold wind. These causes were reported either alone or in combination (see Table 1). All subjects who included weather change as a cause of illness stated that the change was from warm or hot to cold.

No significant relationship was found between the name used for the respiratory illness and demographic variables. However, when time was collapsed into three categories, the identification of weather change as a cause of illness and length of time in the United States was significant ($X = 7.663760$, $df = 2$, $p = .0220$). As years of residency increased, identification of weather change decreased.

Question 2. What self-care practices are engaged in during an episode of respiratory illness? The two most frequently reported self-care practices were the use of patent medicines (N = 22) and coin rubbing (*cao gio*; N = 20). (See Table 2.) Patent medicines used include aspirin, Tylenol, Alka-Seltzer, and various cough remedies. A total of 17 subjects used both coin rubbing and patent medicine.

TABLE 1 Cause of Illness Reported by Subjects

<i>Cause of Illness</i>	<i>Frequency</i>
Weather change	15
Cold air	5
Weather change and cold air	4
Weather change, cold air, trees, dust, and chemicals	1
Air pollution	1
Bad health	1
Don't know	2
Total	30

Reliance on patent medicines varied slightly, although nonsignificantly, depending on the length of time subjects had resided in the United States. They were used the least frequently by subjects with 2 or fewer years of U.S. residency.

Use of coin rubbing was related to length of subjects' U.S. residency in a nonpredicted manner. In all, 90% (N = 10) of the subjects in the 3-to-4-year residency range used coin rubbing compared with 57% (N = 8) and 60% (N = 3) in the 2-years-or-less and 5-to-7-year range, respectively.

Illness duration at the time of interview was found to be significantly related to choice of treatment method (see Table 3). Self-care treatments such as those listed in Table 2 were initiated by 29 subjects on the first day that symptoms appeared. Of these 29 subjects, 20 used self-care as the only treatment method, whereas 9 combined self-care and cosmopolitan care. The 1 subject whose initial treatment was cosmopolitan care used self-care subsequently.

Qualitative Results

Presentation and analysis of subjects' responses to open-ended questions reveal insights into their explanatory models and selection of treatment options.

Illness Name

The predominant label applied to the respiratory illness experienced by subjects was *cold* or *cam*. Weather change (*tro troi*) or cold wind (*gio lanh*) were cited as the primary causes of their respiratory illness. Subjects reported:

TABLE 2 Self-Care Practices Reported by Subjects

<i>Self-Care</i>	<i>Frequency</i>	<i>Percentage^a</i>
Medicines	22	73.3
Coin rubbing	21	70.0
Diet	15	50.0
Cupping	2	6.0
Steaming	2	6.0
Other self-care	12	10.0

a. Frequency totals are greater than 30 and percentage totals are greater than 100.0 as subjects used more than one self-care practice.

TABLE 3 Duration of Illness by Treatment Method

<i>Duration of Illness</i>	<i>Self-Care Alone (N = 20)</i>	<i>Self-Care and Cosmopolitan Care (N = 10)</i>	<i>Total Group (N = 30)</i>
2 to 4 days	16	2	18
5 to 7 days	2	5	7
8 to 14 days	—	1	1
Over 2 weeks	2	2	4

NOTE: $X = 11.107143$, $df = 3$, $p = .0113$; significant at .05.

When the weather changes and you go outside, you get *cam*. The symptoms are the same as in Vietnam when you get *cam*.

I'm not used to the wind or the change in weather.

When *allergy* was the label applied to an illness, most subjects indicated wind or weather change as one of its causes. Other causes of allergy reported were

Air from fans or air conditioning can cause wind to get into the body and make a person sick.

Trees, air conditioning, chemicals, and a change in the weather can cause allergy. During cold weather it is the worst.

Cold wind or change from hot to cold, with the latter often accompanied by wind, was reported as the cause of illness by 26 subjects regardless of the name applied to the illness. Animistic or metaphysical explanations were not reported by any subjects.

Rationale for Self-Care

The most frequently used traditional treatment is *cao gio*, getting the wind out, which is referred to in English as *coin rubbing*. The areas of the body treated with coin rubbing were the back, chest, and shoulders. The practice described as cupping is called *giac hoi* and means sucking the air out. The cupping technique was described as follows: The insides of several small jars are rubbed with kerosene and then one jar at a time is lighted and applied to the skin so that a tight seal is formed and the flame is extinguished. The jar, held on the skin by a vacuum, remains in place for approximately 15 minutes.

The belief that wind entering the body causes respiratory illness appears to be the rationale for treatments that rid the body of wind, as with coin rubbing and cupping. However, few subjects could explain how coin rubbing worked. Explanations offered included:

It helps the circulation in some way.

Coin rubbing makes the blood flow freely.

If you feel tired and heavy, then coin rubbing makes you feel better and lighter with about 50% relief.

Patent medicines were viewed as an effective therapy, particularly when combined with coin rubbing. Of the 22 subjects using patent medicine, 17 combined them with coin rubbing, and 1 subject reported that "coin rubbing and medicines were both good, but together they are better and work faster."

Patent medicines were used from 1 to 3 days prior to coin rubbing by 7 subjects. The reason given was that they had to wait to have coin rubbing done because they or the person to do the coin rubbing was too busy. Medicines were selected by "reading the label" to determine if they were good for the treatment of the illness.

Rationale for Cosmopolitan Care

Cosmopolitan care was often used in combination with self-care treatment. The reasons for seeking cosmopolitan care were twofold: Self-care treatments were not effective, and prescription medication was perceived to be more effective than traditional treatments or patent medicines.

Subjects who sought cosmopolitan care stated:

I waited until the fourth day. I had used coin rubbing but it didn't help this time; so I went to the doctor.

I treated myself but it didn't work. I looked in the Vietnamese newspaper and saw the name of a doctor I knew in Vietnam and decided to go.

The perceived effectiveness of the treatment furnished by cosmopolitan providers—namely, prescription medicines—appears to be an important criterion in selecting that form of care. It should be noted that in Vietnam most medications could be purchased over the counter, without a prescription.

DISCUSSION

Illness models using personal, nontechnical language rather than abstract, technical disease models were used by subjects to name and explain the causes of their illness. The explanations offered relative to illness causation were related to the treatments chosen, in that self-care practices such as coin rubbing helped to stimulate circulation and make a person feel better. Patent medicine usage and the seeking of cosmopolitan care appear to be consistent with the natural etiology cited for common respiratory illnesses.

Although natural, supernatural, and metaphysical explanations for illness causality were expected to be found, all subjects used naturalistic explanations, such as weather change, cold air, and pollution. These findings suggest, first, that metaphysical and supernatural causality, based on scholarly writings, is applied to illness by practitioners versed in Sino-Vietnamese medical theory rather than by the person experiencing the illness. Therefore, although persons may be familiar with such causes, they do not apply them independently. Second, the narrow range of respiratory illnesses reported and the fact that only respiratory illnesses were examined, suggest either that supernatural and metaphysical causes are not attributed to common respiratory illness or that subjects simply did not report them as causes. Additionally, these findings lend support to Tung's (1980) description of popular Vietnamese concepts of common respiratory illness. He stated that

in the most straightforward use of the term "Gio" stands for the natural elements associated with bad weather, cold drafts and simply indicates that the illness has resulted from the patient's exposure to inclement atmospheric conditions. A common cold, mild fever, ill-defined ailments . . . are examples of diseases due to the wind or bad weather "Gio" and often lumped together under the generic denomination of "Cam" (common cold). (p. 16)

The findings regarding explanatory models of common respiratory illness have implications for cosmopolitan care providers. In order to furnish individualized care, providers need to assess the meanings clients ascribe to the labels they use for their illnesses. The explanatory models offered by clients may be expressed in popular terminology based on everyday experiences and may or may not be similar to the expert models found in the scholarly literature. It is important to note that the findings of this study, although important in terms of understanding the sample studied and giving clues to potential EMs of other Vietnamese, should not be generalized to the Vietnamese community.

Subjects' extensive use of self-care supports previous findings that most illness episodes are initially managed outside the cosmopolitan health care system. Given that all except one subject used self-care as the initial treatment choice, it appears that duration of illness was a factor that influenced seeking cosmopolitan care.

The finding that 22 of 30 subjects used self-medication is comparable with findings reported by Dunnell and Cartwright (1972) and Knapp and Knapp (1972). That patent medications were used the least frequently by subjects with 2 or fewer years' U.S. residency may be attributable to the fact that those persons had not yet learned sufficient English to identify medications suited to their problems. To surmise that this group relied more on traditional practices is not justified in light of the finding that persons with 2 or fewer or 5-7 years' U.S. residency used coin rubbing less frequently than those with a midrange duration of residency.

Subjects reported seeking cosmopolitan care because the medicines available from a physician were perceived as being more effective than those available over the counter. Regardless of the treatment method, subjects appeared to use the criterion of efficacy to determine which treatment was used.

Nonuse of local health care providers by subjects residing in Austin may be explained by the absence of such practitioners in the city. A possible explanation for the lack of reported use of local providers in Houston, where several practice, is that the natural etiology attributed to the common respiratory illness experience may not have been of such nature as to require diagnosis and treatment by such practitioners.

An interesting and important finding related to self-care practices pertains to the similarity between the self-care practices of the Vietnamese subjects and those that may be used by the dominant Anglo culture for relief of common respiratory illnesses. Coin rubbing and cupping would be obvious exceptions.

The self-care behaviors described, although having limited generalizability due to issues of study methodology, may be useful in furthering development of the conceptual models of self-care and explanatory models. This study provides some support for the proposition that when explanations are based on natural etiology, treatment remedies that are appropriate to the cause are selected.

In this study, simple self-care practices were selected for the initial treatment in keeping with the nonsevere nature of the illnesses described. The process of acculturation, seen in the interplay between cosmopolitan and traditional self-care treatments provides support for a component of Orem's (1980) model that indicates that self-care practices are part of one's culture.

When health care providers interact with persons from other cultures, there may be a tendency to focus on the differences or on unusual practices. Recognizing and accepting differences is necessary, but identification of similarities may help bridge the gap between persons from different cultures. One way of minimizing ethnocentric tendencies is to conceptualize what has been traditionally termed *folk practices* to the less culturally biased term *self-care practices*.

RECOMMENDATIONS

Research questions suggested by the study's findings include: What explanatory models are used for other types of respiratory illness? Does the duration of illness influence the explanatory models used or the order in which types of care are used? And last, what self-care practices are used in response to other illnesses?

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Commentaries

The investigator is to be congratulated for this important study in an area needing much research. Health care professionals must understand the Vietnamese and other immigrant groups' conception of illness and self-care. As the investigator acknowledges, guessing by health care professionals as to differences and similarities between cultures is likely to lead to misunderstandings.

The author's review of others' differentiation between illness and disease in the explanatory models literature and between health and illness beliefs not only is central to the present study but also is valuable in other culturally diverse populations. Furthermore, this differentiation is critical to consider in the same population (Vietnamese) with diseases and illnesses other than the one studied (respiratory illness).

The potential threats to the internal validity of the design in the present study were identified and controlled with thoughtful methodological strategies. Such precision in the methods is especially warranted because the investigator was not a member of the Vietnamese culture. Two additional procedural steps the investigator took to overcome this disadvantage were to have Vietnamese people check the questions for "cultural acceptability" and to train two translators. Although the use of the translators was clearly needed in this study, the data obtained through open-ended questions were only as good as the translators' ability both to understand what was said and to convey successfully not only the literal meaning of what was said but also the subtle meanings of the message. No matter how talented the translator is in this or other studies in which the investigator relies on a translator or interpretation by another, there is still one more person separating the investigator from the study participant.

Finally, of considerable interest to this reader was the number of areas of similarities between the Vietnamese participants' responses and Westerners' responses to the same questions. For instance, there were remarkable similarities between: names given respiratory illnesses, causes attributed to the illness, and the belief that prescribed drugs were more efficacious than over-the-counter drugs. Several thoughts came to mind regarding these similarities. First, how Westernized were these people regarding the names of illnesses and the taking of patent medication before their arrival in Texas? Through the occupation of the Americans and before that the French in Vietnam, exposure to names of illnesses and self-medication may have been long established. In the naming of

the illness and in reporting the cause of the illness the translators may have gotten "censored" answers, that is, responses to questions that would reflect older cultural views were underreported in the keenness of the participants to report socially acceptable "American" responses. If this tendency did influence the participants' verbal responses, it does not appear to have influenced their self-care practice (coin rubbing). There was one statement that may have reflected the devaluing of the old methods and treatments in favor of the new techniques, "I went to the doctor because he can give you better medicines than people use in Vietnam."

As with any pioneer study in a new area, the present report raises many questions. Continued research endeavors will provide further understandings of immigrant groups' health and illness practices.

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As nursing is defined as the diagnosis and treatment of human responses to actual or potential problems (American Nurses' Association, 1980), the study of self-care responses to an illness episode is an important nursing concern. Likewise, the notion of health and illness held by specific population groups, and the ways in which these groups attempt to maintain or regain health is important to nursing. Therefore, the study examined here addresses a topic central to nursing.

The study presents a theoretical framework based upon two constructs, that of explanatory models of illness and that of self-care. The purpose of the study was to determine self-care responses to respiratory illness among a group of immigrant Vietnamese persons. The research questions concern the nature of explanatory models used by these subjects during a respiratory illness episode and the self-care practices used during this episode.

The theoretical framework points out that explanatory models of illness are different from health beliefs. Health beliefs are seen as formulated and held independently of an actual illness episode, whereas explanatory models—although influenced by beliefs—are formulated during an illness episode to explain that experience. This is a helpful distinction that can be accepted for this study. It is unclear, however, if this is a generally held distinction, as no references are given.

The methods that are used are exploratory in nature, and this is appropriate in that little is known about illness explanatory models and self-care in this

population group. In that exploratory studies examine the nature of and relationships among variables of interest, it is appropriate that both quantitative and qualitative methods and analyses are used. This approach yields data that otherwise would not have been available had either quantitative or qualitative methods alone been used. In terms of the procedures used, explanations at times are unclear. For example, the length of the interviews varied from 20 minutes to 1½ hours. The effect of this variation upon the data obtained is an important consideration. If the subjects who devoted 20 minutes to the interview were less interested in participation, then their responses may have been less thoughtful. Some explanation of the wide variation in the length of the interviews would, therefore, have been helpful.

The nature of the subjects chosen might have been more fully discussed, for the age of the sample varies from age 18 to 62. The effect of age upon self-care practices might be an important consideration. In addition, if subcultures and classes exist among the Vietnamese as they do in most cultural groups, then the homogeneity of the sample should be more fully described. Educational level, for example, is generally believed to affect health care practices; therefore, any educational variation among subjects should be discussed. These factors were undoubtedly considered by the researcher and most likely can be readily addressed.

The results of the study are very interesting. Most subjects included weather change as a cause of their respiratory illness. It would be interesting to contrast this belief with that of members of the dominant Anglo culture, particularly given that as years of residency increased, identification of weather as a causative factor decreased. The predominant use of coin rubbing along with patent medicines is also interesting in terms of the flexibility of Vietnamese self-care practices. As the researcher noted, the nonuse of animistic or metaphysical explanations for respiratory illness may be related to the perception of respiratory illness as a minor condition. Further study might examine supernatural attributions for more life-threatening illnesses.

Cosmopolitan care was generally sought when self-care was seen as ineffectual. The researcher noted that the interplay between cosmopolitan and traditional care provides support for Orem's (1980) model, which indicates that self-care practices are part of one's culture. It is true that Orem (1985, p. 108) states that self-care beliefs are learned according to the cultural way of life of the group to whom the individual belongs. Self-care practices should, therefore, vary by cultural group. This aspect of Orem's model, however, is not developed to any great extent, and Orem discusses very little about the interplay of various cultural factors. Therefore, this study is supportive of Orem's model only in a very general sense. In summary, "Self-Care Response to Respiratory Illness Among Vietnamese" is an interesting and useful study for nursing.

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Qualitative research can and should be every bit as rigorous as other approaches. Qualitative research in nursing, more and more, is moving beyond simple production of specific baseline knowledge, which is still nevertheless greatly lacking in the discipline, to seek appropriate methods to examine the real meaning of these data. This does not necessarily imply that all such data must be subjected to quantification whether indicated or not. Explanatory models that examine the social and cultural context of health-seeking behaviors do have a contribution to make to nursing theory if they are carefully examined and evaluated. This study represents a beginning of such effort.

Because sound research data focusing on health behaviors of Vietnamese immigrants are just beginning to appear in the nursing and medical literature, and explanatory models of these behaviors are, in the main, lacking, this study is timely and relevant. The author has proposed examining two major constructs: explanatory models of illness (EMs, after Kleinman, 1980) and self-care actions by patients experiencing episodes of respiratory illness. This type of qualitative research illustrates a potential contribution to baseline cultural data useful to theory development, while testing the model. My comments address this study as an example of such research and present some thoughts about additional means for examination of similar data.

Although the purpose of the study might have stated more specifically its focus on illness *episodes*, the two major research questions follow logically from the conceptual framework and clarify the focus of the study. Some problems with presentation of the design and method require comment, however.

A convenience sample was selected, but the sampling procedure is not elaborated. It is suggested that some judgment was used to vary the sample according to length of residency, but criteria employed are not mentioned. Was the group stratified on the basis of time, or of locale (Austin or Houston)? On what further basis were potential subjects identified by consultants and interviewer?

Instrument development generally follows usual procedure for this Level I exploratory transcultural study: evaluation of the questions for cultural relevance and for content and face validity, followed by pretest of the interview guide. Reliability, always a factor when the investigator is not bilingual or bicultural with the group studied and must use translators, was not discussed *per se*. Checking and rechecking of data between investigator and interpreter

during the data collection period served to address part of this issue. My own experience has indicated that tape recording of such interviews, when acceptable to the respondents, can be an extremely useful adjunct when the investigator is not fluent in the language. Although transcription can be very time consuming, especially if translation is also a consideration, taping greatly assists recall, picks up easily overlooked data by placing other information in clearer perspective, and may provide further insights about researcher-translator-informant communication. In the latter instance, it is crucial that transcription be verbatim as the subject responded if the inherent problem of accuracy in translation is to be controlled.

Additional information about the number and content of the nondemographic interview questions would have been helpful. Although it is unrealistic to expect inclusion of the entire questionnaire, I felt a need to know more about other questions asked in order to evaluate the qualitative findings. How did the open-ended questions demonstrate the flexibility inherent in this means of data gathering? For example, after obtaining a response to the question "What was the first thing you did to treat your illness?" was the informant asked to state the next action taken, and the next? In addition to "How did the treatment make you feel?" were subjects asked which therapy worked best, next best, and so on? A similar sequence of questioning about persons consulted would be expected to reveal any number of lay or professional care- or cure-givers, about which the researcher could then ask who was perceived as the best help in this particular episode. More explanation of the process here would be useful. Incidentally, this means of examination of internal category content (Molgaard & Byerly, 1981) would produce cultural knowledge of aid to quantitative analysis of the data in a way more explanatory of behavior during illness episodes than can be accomplished by simple category frequencies, thereby producing more complete and accurate information regarding the explanatory models and self-care actions.

Explanatory model is not included among terms defined and inconsistency in its use occurs elsewhere. In discussing quantitative results, the author states that in this study EMs have two components: the name (label) given an illness and the attributed etiology. The conceptual framework, however, indicates that these models also influence individual responses, and the discussion of the qualitative results does include the broader interpretation, by providing examples of self-care behaviors.

Of possible confusion to readers not familiar with the term, is reference to *cosmopolitan medicine*, the label preferred by Dunn (1976) to the more frequently used *biomedicine*. It is not clear why the author changed to this terminology in mid-article while referring to biomedicine in both the conceptual framework and the latter part of the article.

There is a need for sound research of health beliefs and self-care practices as components of explanatory models of Vietnamese illness behaviors. I found this

report somewhat disappointing from the standpoint of the model, because data were grouped and no individual EMs were presented for comparison. Although, as the author notes, findings cannot be generalized beyond this sample, the qualitative results are interesting and informative. A comment regarding how these compared with findings of other studies would have been in order. Because the sample was small, quantitative analysis was limited and did not appear to add greatly to understanding of either the model or self-care behaviors.

Self-care actions, it appears, constitute a narrower construct than do explanatory models of which these activities are a part. The author has, possibly for heuristic reasons, examined the two separately and thereby added concrete descriptive data to cultural knowledge of health seeking by a small segment of the immigrant Vietnamese population. I would hope that similar research would be initiated by this or other investigators with a larger sample of subjects and a wider spectrum of illness episodes in order that some generalizations can be derived.

From one added perspective, Helman (1985) suggests a need to evaluate the physician's explanatory model to determine beliefs about EMs of the patient and the resulting expectations associated with these beliefs as they influence physician-patient communication. Similar examination of the EMs of nurses seem indicated. If the nurse's knowledge in such context could in some way be measured, some predictors of the success of nurse-patient communication might be identified. The model has good potential for use in qualitative research as the method is further developed.

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Response by the Author

The thoughtful commentaries raised many important questions, but due to space limitations I shall address only three of them. One of Dr. Dodd's questions concerned the degree to which respondents were influenced by Western illness names and treatment methods prior to arrival in Texas. The extent to which respondents were Westernized could be influenced by two factors. First, all of the respondents were from urban areas in Vietnam, where historically there was considerable French and later American influence on health care practices and illness terminology. Second, antibiotics and other medications were available at low cost on an over-the-counter basis in Vietnam and therefore could well have contributed to their use of these therapeutics.

Inclusion of the full interview tool was, as noted by Dr. Byerly, not feasible. However, I agree that inclusion of significant questions would be useful to interpret the findings and will therefore do so briefly. The interview questions addressed topics of illness name, cause, severity, degree of feeling sick, duration of illness, treatments used and how chosen, treatment outcome, and lay referral. Each response was followed up by further inquiry for clarification and elaboration. Subsequent questions were based on the response given. Also, for each account of a treatment recommended or prescribed, the respondents were queried as to whether or not it was used, for how long, and whether or not it made them feel better.

In response to one of Dr. Byerly's questions, the decision whether to tape-record the interviews or take notes was reached after much deliberation. Tape recording of the interviews was the method preferred by the author. However, key members of the Vietnamese community discouraged me from using tape recorders, as they felt that many of the persons would be suspicious of how the recordings might be used. Another, but separate, consideration in using tape recordings is that each would have had to be transcribed by a bilingual typist. Cost considerations were, unfortunately, a factor in this study and coupled with the controversy in the research literature on taping versus note taking, it was decided to follow the latter route.

Last, in regard to Dr. Whall's question regarding length of each interview, it is felt that the range of interview time from 20 minutes to 1½ hours reflected the continuum of simplicity/complexity of illness account rather than interest of the respondent in the study. Blumhagen's (1980) study of explanatory models of hypertension revealed similar variation in interviewing time as well as variation in the complexity of the models described.

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