Balance, Balancing, and Health

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Abstract

In this article we explore the concept of balance in the context of health. We became interested in balance during a grounded theory study of lay conceptualizations of cancer risk in which participants were concerned with having a good life, which relied heavily on balancing processes. This led us to the qualitative literature about balance in the context of health, which was large and in need of synthesis. We identified 170 relevant studies and used Thomas and Harden's technique of thematic synthesis to identify key balance-related themes and develop these into more abstract analytic categories. We found that balance and balancing were salient to people in three health-related contexts: health maintenance, disease or disability management, and lay or professional caregiving. In each of these contexts, balance or imbalance could be a state or a process. In addition, those using the word *balance* had either an internally or externally focused orientation to the world around them. Clinicians and public health practitioners might benefit from using these insights in their research and communication.

Keywords

communication, medical; concept analysis; health and well-being; health promotion; qualitative analysis

Qualitative research sheds light on the ways in which people understand and experience health, disease, and health care. Qualitative researchers elicit rich accounts of people's beliefs about specific diseases and experiences of particular illnesses, and also empirically examine more abstract concepts such as risk (e.g., Hay, Shuk, Cruz, & Ostroff, 2005), health (e.g., Smith-DiJulio, Windsor, & Anderson, 2010), disability (e.g., Lutz & Bowers, 2005), community (e.g., Wong, Sands, & Solomon, 2010), and quality of life (e.g., Hendry & McVittie, 2004). Such concepts are central to communication and have a powerful capacity to organize thought and shape behavior, but their meanings cannot be assumed. This makes the systematic and comparative study of concepts necessary (Quinton, 1988). Qualitative research also allows us to explore lay knowledge and its meanings. As Popay and Williams have argued in relation to public health:

> If research in the field of public health is to develop more robust and holistic explanations for patterns of health and illness in contemporary society, then it must utilize and build on lay knowledge—the meanings health, illness, disability and risk have for people. (1996, p. 760)

In this research we explored the meanings of one abstract concept with particular salience in health: balance. We became interested in this concept while conducting a grounded theory study into lay people's conceptualizations of cancer risk. The central question in the study was: How do lay people understand the risk of getting cancer? We found that people thought of cancer risk only when cancer was personally salient. Their focus was not on disease but rather on having a good life, and this relied on balancing processes. In retrospect, this is unsurprising, given that balance is a concept that appears in many major systems of thought. Although varying in emphasis from time to time and from (sub)culture to (sub)culture, the concept is central to accounts of human security and flourishing. Psychology, sociology, philosophy, law, politics, and medicine all have long histories of inquiry into balance, and all stress its importance for individual and social well-being. The following are just a few examples: (a) in psychology, a desirable lifestyle is one in which roles, especially work and life, are balanced (Bulger, Matthews, & Hoffman, 2007); (b) in philosophy, a virtuous person with a strong personal morality is one who is moderate in thought, emotion, and action (Clor, 2008);

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and (c) balance is also salient in major healing systems, both ancient (e.g., the ancient Greek balance of earth, air, and water) and modern (e.g., our current focus on homeostasis within physiological systems; Arcury, Quandt, & Bell, 2001).

When we found that lay people seemed more focused on living a balanced life than on managing risk we investigated what was included in the qualitative literature about balance in health and illness. We found that the word *balance* emerged frequently in the talk of those contemplating health and risk, those navigating a wide variety of illnesses and disabilities, and those engaged in both lay and professional caregiving. Even when the word balance was not used by the lay people themselves, qualitative researchers often interpreted participants' accounts as representing talk about balance. We noted, however, that most authors did not focus on understanding the concept of balance, which was seen as just one of many themes to emerge in their participants' accounts. Moreover, authors seldom referred to other studies. This observation was also made by Campbell et al. (2003), who carried out the only synthesis we found (the focus in the article was on the concepts that enabled a person with diabetes to achieve balance in his or her life). This lack of cohesion is understandable considering that most researchers explored very specific aspects of health, and their articles were published in specialist journals. It does, however, mean that current work on balance is inaccessible to researchers and practitioners.

Syntheses of qualitative research, like meta-analyses of quantitative studies, can inform clinical and public health practice (Atkins et al., 2008; Campbell et al., 2003; Kuper, Reeves, & Levinson, 2008; Thomas et al., 2004). Thomas and colleagues, for example, argued for the use of qualitative synthesis to better understand particular health-related behaviors, such as healthy eating, to better plan interventions that can bring about sustainable behavior change, and to identify future research needs (Thomas et al., 2003). We therefore reviewed and synthesized the existing qualitative health literature on balance to determine what it could tell us about the meaning of balance in the context of health, and to provide empirical evidence to support the use of the concept of balance in clinical and public health communication and action.

Method

Methods for synthesizing qualitative research are currently under debate (Kuper et al., 2008). Our method of qualitative synthesis was based on Thomas and Harden's description of "thematic synthesis" (Thomas & Harden, 2008), a method designed for use in health promotion. Like methods such as Noblit and Hare's (1988) "meta-ethnography" (Campbell et al., 2003; Noblit & Hare) and Sandelowski and Barroso's (2007) approach to "metasynthesis," thematic synthesis involves identifying key concepts from published studies, and then going beyond the studies to identify similarities and conflicts, and to offer novel interpretations, "lines of argument," or "third-order" concepts not found in any single study (Britten et al., 2002; Noblit & Hare). We describe our methods below.

Identification of Articles for Review

We searched Medline, PsycINFO, and Web of Knowledge using the terms *balance* and *balancing* in combination with *qualitative*, and the names of qualitative methodologies (such as grounded theory, ethnography, case study, discourse, action research, and narrative) and data collection techniques (such as interview and focus group). As proposed by Sandelowski and Barroso (2007), our aim was to recall as many articles as possible; that is, we sought sensitivity more than specificity. We kept our search terms broad so as to avoid missing important articles. We identified more than 3,000 qualitative studies, even when we limited our search to articles in which *balance* or *balancing* emerged in the title or abstract. We could not devise reliable exclusion criteria, so we scanned all articles to identify those in which balance appeared to be a significant concept in the context of health. Through this iterative procedure, we identified three key contexts or situations in which balance was relevant to health: (a) balance as a means of maintaining health and managing risk (for example, studies about people's attempts at health improvement or responses to being told they were at risk of disease); (b) balance as a means of managing illness or disability; and (c) balance as a means of navigating lay or professional caregiving. We subsequently included manuscripts if they met the following criteria: (a) the article was relevant to health by fitting one of our three health-related categories (the most common exclusions according to this criterion were articles on work–life balance), (b) the data collection and analysis methods were reported as qualitative by the authors, and (c) the article was published in English in a peer-reviewed journal. We did not set date limits because we felt that old insights into the concept of balance might remain relevant. Nor did we exclude articles that did not focus exclusively on balance; indeed, some key insights emerged from research studies in which balance was just one of many concepts explored. By applying the above criteria, we identified 170 relevant articles, including 18 published in this journal.[1] Although this was a large number of articles compared to some thematic syntheses, the process was manageable because many of the articles had relatively short discussions of balance.

Appraisal

We found it difficult to exclude studies on the basis of methodological quality because of the frequent lack of detail in reporting methods and methodology, and the well-recognized epistemological challenges of critically comparing different qualitative methodologies (Kuper et al., 2008). Given that our aims were to find maximum variability and to usefully interpret the literature rather than identify the "best" publications on the topic, we decided, like Thomas and Harden (2008) and others (e.g., Atkins et al., 2008), to err on the side of inclusion and to judge quality on the basis of conceptual contribution as much as methodological rigor.

Extracting Data From Studies and Thematic Synthesis

Following Thomas and Harden (2008), we approached analysis of the manuscripts inductively with the broad research question: What does this research study tell us about the role of balance in health and illness? We kept the research question deliberately broad to facilitate inductive analysis. We were interested in balance as a central concept, but otherwise did not have preconceptions as to how the concept would manifest itself. The synthesis involved an initial phase of open, line-by-line coding, during which we tried to identify key balance-related concepts in each article. We then looked for similarities and differences between the codes to start grouping them into a hierarchical tree structure of descriptive themes. We developed these descriptive themes into more abstract analytic themes, and then grouped these into four overriding analytic categories (see Table 1). We repeated this cyclical process until all of the line-by-line and descriptive themes were adequately captured in one or more analytic themes and categories. Descriptive themes were first developed by the first author**.** All authors were involved in generating analytic themes and categories from these descriptive themes.

Results

Two things soon became evident: First, balance could be used to describe a state of balance or imbalance, or a process of balancing. Second, those using the word *balance* differed in their orientation to the world around them. Some had a strongly external orientation, focusing on the communities in which they were embedded; we called these "externalist balancers." Others were primarily inwardly orientated; we called these "internalist balancers." We identified a general tendency for externalist balancers to identify more with balance as a state, and for internalist balancers to be more concerned with balancing as a process (see Figure 1).[2]

Balance as a State of Health and Well-Being

In some cases, the word *balance* was used as a noun, to refer to a state of balance, or the opposite state of imbalance (see Figure 1, part A). In most cases, the state of balance was associated with physical or psychological health: the more one was balanced, the more likely one was to be healthy. Indeed, in some cases, people saw the state of balance as the definition of health. This was particularly common in non-Western populations, for whom health was defined as balance among the physical, spiritual, cognitive, emotional, and/or social domains of life. For Iranian migrants in Sweden, for example, continuity and balance resulted from having a well-functioning social network in combination with mental strength, as well as a harmonic, holistic balance in which body and mind mutually responded to each other (Emami, Benner, Lipson, & Ekman, 2000). For Westerners, balance as a state was also associated with health and well-being, but the focus was less on the meaning of health and illness in general, and more on the trajectory of a particular experience of illness or caregiving. Illness and caregiving were seen as upsetting a preexisting state of balance, or being thrown off balance. Illness itself was then experienced as a life out of balance, and recovery was associated with regaining balance in everyday life. This kind of trajectory was illustrated in Keady, Williams, and Hughes-Roberts' (2007) narrative analysis of a woman in the early stages of Alzheimer's disease, "Sarah," whose initial experience of her illness was of a life "out of balance" because of the uncertainty and fear of her symptoms. In this case, however, it was diagnosis rather than recovery that provided an explanation for Sarah's symptoms, and enabled her to recover a sense of balance in her life.

In addition to connoting health, people also saw balance as a state as an optimal way of relating to oneself, to time, and to one's life narrative. Achieving a state of balance was associated with being creatively engaged with the world and not needing to be in conscious control of every moment; growth; finding meaning; a sense of "standing on solid ground" (Finfgeld & Lewis, 2002), and with the emergence of "a new cadence of life" (Whittemore, Chase, Mandle, & Roy, 2002).

Objects of balance as a state. We found that there were objects of balance as a state; that is, some "thing" was in or out of balance. For people of both Western and non-Western origin, these objects were most commonly the major domains of life, i.e., some combination of the physical, emotional, cognitive, spiritual, social, and/or

Table 1. Method of Thematic Synthesis

Examples of Descriptive Themes	Examples of Analytic Themes
Analytic Category 1: Balance as a State	
Health is a balance of physical, emotional, and social well-being	Balance as health (or health as balance); imbalance as illness (or illness as imbalance)
The onset of illness is a loss of balance; the experience of being ill includes being out of balance; recovery is a regaining of balance	
Balance is achieving growth; finding meaning in life; standing on solid ground	Balance as transcendent, optimal experience
Balance is relating well to oneself	
Balance is subtle	
Balance is fragile	Balance as a fragile coexistence and interaction of several/many desirable objects
Analytic Category 2: Balancing as a Process	
Many different objects/ dimensions of life need to be combined (or need to move back and forth to accommodate all)	Balancing as integrating/varying/oscillating
Advantages and disadvantages of choices need to be weighed to make health-related decisions	Balancing as choosing (decisional balance)
Extremity (either excess or deprivation) is not a good thing	Balancing as moderating
It is okay to engage in unhealthy (or otherwise nonideal) behavior as long as one is "good" at other times	Balancing as counteracting
Keeping things in balance requires ongoing effort and adjustment	Balancing (of any kind) as work
Analytic Category 3: The Externalist Balancer	
Balancing is something one does as part of one's community or family	Balance as conforming
The community/family determines what balance means and how it should be achieved	
The community helps with balancing	Receiving guidance & support
Balancing is not solely the responsibility of the individual	
Loss of community leads to an inability to achieve balance	Depending on community
Communities can sometimes stand in the way of an individual's capacity to balance	
Analytic Category 4: The Internalist Balancer	
Balancing involves looking inward and considering what is important	Balancing as self-reflection
Balance involves weighing one value against another and prioritizing accordingly	Balancing as prioritizing
It is important to be in control of oneself; to restrain oneself	Balancing as self-control
Everyone has different priorities; everyone balances differently	Balancing as an individual act
Others should not stand in the way of one's balancing; by balancing one can assert one's desires	Balancing as an act of personal autonomy
It is important to negotiate with others to get one's (balance-related) needs met	Balancing as negotiating on one's own behalf

environmental (e.g., Canales, 2004). Although people usually saw the state of balance as incorporating several domains of life, balance or imbalance could also inhere within a single domain. Some emphasized balance within the physical/bodily domain, such as yin and yang (e.g., Jovchelovitch & Gervais, 1999); others emphasized emotional balance (e.g., Mendelson, 2002), or balance within relationships, family systems, societies, and even the whole universe (e.g., Albrecht & Devlieger, 1999). Balance in the physical domain was a common motif; for example, among women at risk of ovarian cancer who were unwilling to undergo prophylactic oopherectomy because it would involve "upsetting the natural balance of the body" (Hallowell, 1998, p. 268).

Participants could not always clearly or easily describe the objects of balance as a state. Indeed, the state of balance often had a subtle, almost transcendent quality, as something that was sensed or experienced in moments, or felt as an undercurrent (e.g., Bottorff et al., 1998). Nor did people see these objects as isolated domains. Rather, the domains could interact, and loss of one—such as social and family support—could make one susceptible to loss of another—such as physical robustness. For example, migrants in one study saw mental strength—the psychological domain—as being nourished by a well-functioning social and family support system. They had a confident feeling of belonging, and felt that physical disease could only assault a body that was already vulnerable because of preexisting disruptions in continuity and balance (Emami et al., 2000). Balance as a state also reflected the complexities of life as a whole, and the interrelatedness of all dimensions of life. In other words, people tended to

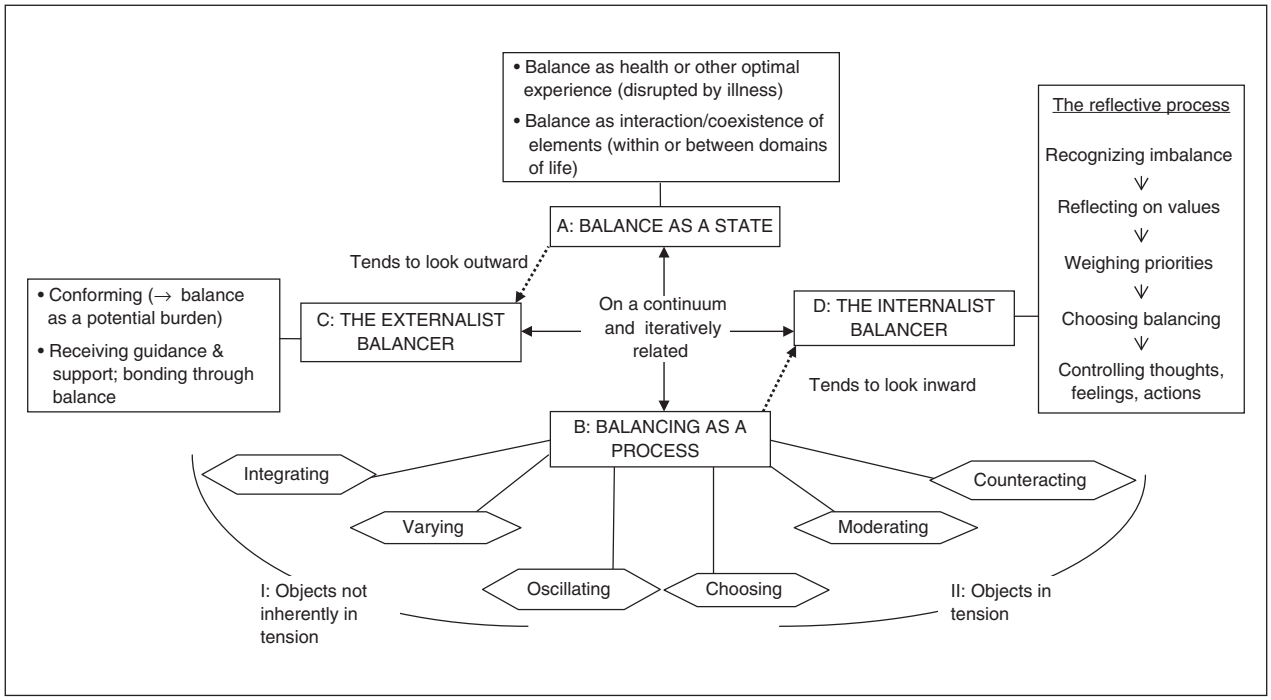

Figure 1. Balance and balancing in health

relate balance as a state not only to health, but rather to a whole life in balance.

The stability of balance. When talking about a state of balance or imbalance, people used related metaphors and analogies. These included synonyms of balance such as stability and steadiness. Sometimes these terms had natural connotations, such as wholeness, continuity, coherence, harmony, and holism. At other times, the connotations were more scientific, such as equilibrium, homeostasis, proportion, and synthesis. Balance as a state, however, was never completely stable. Rather, people described it as fragile, delicate, tentative, temporary, precarious and easily disrupted, threatened, or lost. Its fragility could stem from lack of control of the objects of balance, or from personal weakness, such that people were not able to maintain the state of balance (see "Burdens of balancing," below). This related balance as a state to balancing as a process. People spoke of "balancing on a tightrope" (Proot et al., 2003, p. 115), or "walking a fine line" (Thulesius, Hakansson, & Petersson, 2003, p. 1368). For example, Sarah, the woman described above who had early dementia, described life out of balance as a state in which a seesaw was tilted too far from the middle line; the middle line represented stability and an ideal state of being. The seesaw was pushed upward by the uncertainty and fear that surrounded her life at the time of symptom onset. She recognized, however, that although movement—and momentum—were constantly changing and stability went "up and down," balance was never completely lost. Sarah described this background stability as a "horizon" of balance, representing good quality of life (Keady et al., 2007). In summary, balance as a state was closely associated with health, well-being, and more abstract optimal states. It usually involved simultaneous incorporation of several domains of life, but could also entail balancing within these domains, which were all related to each other. As discussed above, balance as a state was fragile, easily disrupted, and in constant need of attention.

Balancing as a Process

People used balance as a state to articulate relatively static concepts such as health and well-being. Others spoke of balancing as a process, usually describing their active approaches to managing health, risk, illness, disability, or caregiving (see Figure 1, part B).

Objects of balancing as a process. We also found that there were objects of balancing as a process; that is, some "thing" had to be balanced. When people sought to maintain their health or reduce their risk of disease, they tended to balance the benefits of health-promoting activities against either the risks associated with these activities—for example, balancing the risks and benefits of immunization—or against desirable, unhealthy activities. People making food choices, for example, balanced "food-related values," including taste, cost, time, and social

relationships, against health benefits (Connors, Bisogni, Sobal, & Devine, 2001). In the context of illness or disability, people balanced a wide variety of objects. In general, this involved balancing accommodation of illness—for example, by taking a medicine—against the desire to maintain some degree of normality, role fulfillment, and personal control. For lay caregivers, balancing acts tended to stem from maintaining other social roles and preserving a normal relationship with an ill family member. Professional caregivers generally balanced conflicting roles and responsibilities, either within their professional lives or between their professional and personal lives; the rewarding aspects of their jobs with more stressful dimensions; and closeness to their patients against protective distance.

In this regard, it is worth noting that people balanced not only physical activities and actions, but also components of identity. There were many examples. People tried to maintain a prior sense of self while constructing a new sense of self. Some balanced self-perceptions (e.g., balancing a sense of worthlessness against a sense of personal value), attitudes (e.g., both accepting illness and minimizing its impact), attention (e.g., trying to find a middle ground between preoccupation with illness and denial), and emotions (e.g., to manage ambivalent feelings, maintain hope, and avoid being overwhelmed, often by balancing attachment and detachment, or grief and acceptance). Finally, some people balanced acts of communication. This was particularly evident among caregivers, who needed to pass on information without causing alarm, or to acknowledge both their own expertise and that of others. Sometimes the recipients of information were the ones engaged in balancing, to ensure that they received enough information, but not more than they could handle emotionally (Clare, 2002).

Ways people engaged in the process of balancing. Balancing could be about integrating, or alternatively about managing tensions. When there was no inherent tension between commitments, people balanced by interweaving several commitments into a unified whole (see Figure 1, part BI). This kind of balancing was associated with the act of varying (for example, having a varied diet), and at times involved rapid movement between one action and another. These rapid shifts were described as "continuous moving back and forth" (Carmack, 1992), a "dialectic" (Ohlen & Holm, 2006), a "juggling" act (Paparini, Doyal, & Anderson, 2008) and an "oscillation" between poles (Hallin & Danielson, 2007). Usually, however, there was tension between commitments, and people engaged in a number of discrepancy management processes to manage these tensions, such as comparing and choosing, moderating and counteracting.

The process of balancing as weighing advantages and disadvantages so as to select the best alternative was closely related to the process of decisional balance and, given the large amount of psychological literature on the topic, we did not attempt to review studies that focused only on this kind of balancing. More interesting to us were studies of balancing as moderating and counteracting. Moderating usually entailed limiting one commitment to accommodate another that would be threatened by extremity or complete denial. For example, Chambers, Lobb, Butler, and Traill (2008) found that people thought that denying themselves particular foods was unwise, and that "everything in moderation" was essential to ensure a healthy diet. Counteracting involved engaging in a desired act without limiting it, and then later attempting to counteract this with an opposite or corrective act. This could be enacted according to varying time scales. The shifts could either be rapid, closely related to the oscillating described above, or take place over long time periods, as, for example, in Paisley, Sheeshka, and Daly's (2001) study of people for whom eating local strawberries daily for 2 weeks in summer offset their later absence from the menu. Balancing strategies were not mutually exclusive, and several authors identified more than one of the balancing acts described above. Indeed, many authors emphasized the overall complexity of the balancing process, noting that strategies were intertwined and tended to be used simultaneously and instantaneously.

Whatever the particular strategy or strategies used, balancing as a process demanded effort. People frequently used words and phrases such as *energy* (Bottorff et al., 1998), *ongoing struggle* (Carmack, 1992), *consistent effort* (Sulik, 2007), and *keeping up* (Guirguis-Younger & Grafanaki, 2008). There was little sense that a stable state of balance could ever be reached. This need for effort was underpinned by frequent descriptions of balancing as a dynamic process that was "fluid" (Shyu, Archbold, & Imle, 1998), "shifting" (Clare, 2002), "ongoing" (Brodsky, 1999), and "circular" (Pearce, Clare, & Pistrang, 2002). Shyu et al., for example, described the balancing act of those caring for frail elderly relatives as being "like adjusting the shouldering point of a carrying pole according to the weight of the loads while walking" (p. 264). Moreover, as discussed above, even when reached, people saw the state of balance as fragile and in need of constant maintenance. In this way, balance as a state and balancing as a process were iteratively related to each other.

The Externalist Balancer vs. the Internalist Balancer

A second major distinction emerged in the broader health-related narratives of those making use of the concept of balance. People tended toward one of two broad

orientations: an external orientation, which was focused more on community, and an internal orientation, which was focused more on the self.

The externalist balancer. For some people, balance was about the communal dimensions of health and life (see Figure 1, part C). This was particularly common among non-Western populations. These people had little need to define for themselves what balance meant; whether it was a state or a process; what its objects were; and what was required to enact/maintain it. Rather, balance seemed to be built into everyday understandings and people were able to draw on a "common representational system" (Jovchelovitch & Gervais, 1999) with respect to health and illness. Moreover, balance or balancing was built into everyday communal life, not expected to be achieved or carried out in isolation. This meant that at least some of the responsibility for balance or balancing lay with the community rather than with the individual. This is not to say that communal balancing was idyllic, because communities could oppress as well as facilitate their members' balance or balancing. South African women with HIV, for example, were able to focus on achieving balance for themselves only if they had fulfilled their culturally constructed duties to men (Dageid & Duckert, 2008).

The internalist balancer. In contrast, some people viewed and enacted balance or balancing primarily on their own, as part of a personal life project (see Figure 1, part D). This narrative of the internalist balancer was most common in Western accounts of balance. The internalist balancer needed to be self-reflective, which involved recognizing imbalance in one's life, identifying one's various commitments, flexibly and pragmatically adjusting, weighing and prioritizing these commitments according to circumstances, and developing or drawing upon one or more balancing strategies. This kind of self-reflection was evident, for example, in a study of women at risk of preterm labor, who were observed to be generating a "calculus of salient variables" before deciding how to manage their activity restriction (Durham, 1999). Balancing strategies could vary from individual to individual in ways that could even be classified into typologies of balancing. In a study of healthy people making food choices, for example, Connors et al. (2001) found that all participants employed a "personal food system," and that although eating situations were similar, each had a different evaluation of the situation, with a unique prioritization of his or her values. People then developed individualized strategies to make their overall personal food system workable for them.

In addition to being self-reflective, the internalist balancer needed to be very much in control of his or her life, structuring and orchestrating his or her activities to accommodate the necessary balancing act(s). This required regulation, management, and restraint, as well as flexibility, creativity, and adaptability. In this regard, the internalist balancer appeared action oriented, and although we are unable to confirm this using only secondary data, we suspect a relationship between an internal orientation and a tendency to view balance in procedural terms (see Figure 1, linking balance as a process to the internalist balancer).

The internalist balancer did not exist in a social vacuum, but had a very different way of relating to others. Unlike the externalist balancer, who had a community orientation, the internalist balancer focused on enacting his or her autonomy. Indeed, people could use balancing to actively resist social expectations. Women with gestational diabetes, for example, achieved a balanced sense of control by moving from the point of "strict compliance" to "active self-management" of their diabetic pregnancy (Evans & O'Brien, 2005). People associated these acts of autonomy with assertiveness, reliance on one's own decision-making abilities, and even sometimes overtly disregarding others' advice.

Even the internalist balancer, however, needed other people. Several people noted that balancing involved accessing and accepting help from lay and professional caregivers, as well as from workmates and other social contacts (who sometimes needed to interact with one another to provide the necessary support). People were dependent for their balancing on broader social resources, including information from the media and organizational arrangements. People with diabetes, for example, reported greater ease with their balancing as restaurants and airlines become increasingly conscious of their needs (Maclean, 1991). This dependence on social resources, in turn, necessitated negotiation. Even the internalist balancer observed that balancing involved mutual communication and a willingness to strike compromises with others.

Effects of Balancing

Benefits of balancing. Balance or balancing served many important purposes in the context of health, illness, or caregiving. Most obviously, achieving balance as a state enabled people to experience a sense of health and well-being, whereas balancing as a process enabled people to achieve some, if not all of their often competing commitments. People also associated balance or balancing with resilience, describing it as a means of coping, gaining inner strength, moderating vulnerability, and adjusting to difficult changes. Balancing also helped people to deal with uncertainty, unfamiliarity, and unpredictability. Even when emotional control was not the primary focus, people frequently described balance or balancing as a source of consolation that could

help them deal with adversity. Balancing seemed to improve people's emotional experiences and self-esteem because it provided the necessary stability to prioritize commitments, helped them to resolve ambivalence, provided them with confidence about decisions made, and reduced guilt about value conflicts. Among women at risk of preterm labor, those who successfully balanced competing demands saw themselves as "doing okay," and found the emotional distress and family disruption to be manageable. Those who had difficulty achieving balance, by contrast, felt "on the edge" and experienced emotional distress and, occasionally, significant disruptions to the family (May, 2001). In addition to making people feel better, balance or balancing were also associated with an increased sense of agency and control. Through balance or balancing, people maintained or regained a sense of empowerment, competence, functionality, and the ability to perform daily activities without, or in spite of, challenges such as physical symptoms. This was due in part to the fact that, when balance was achieved, time, attention, and energy for other pursuits returned.

Burdens of balancing. Balance and balancing had many benefits, but efforts to achieve or maintain balance were also a source of anxiety. First, as discussed above, balance as a state was precarious and, particularly for the externalist balancer, difficulty arose when traditional communities were displaced, usually because of migration or colonization. This, in turn, could have profound effects upon communities' sense of health and well-being. For migrant groups, the challenge was finding a way of maintaining community health and well-being while integrating into their new society, as in the case of pregnant Mexican American women who wanted to manage their pregnancies according to both traditional Mexican cultural beliefs and the individualistic beliefs common to Anglo Americans (e.g., Lagana, 2003). For the internalist balancer, the major source of stress seemed to be an inability to muster the personal and social resources necessary for balancing, resulting in a sense of failure associated with uncertainty, tension, stress, strain, and struggle.

Only a few authors provided evidence of people criticizing or rejecting balance or balancing. The few exceptions included some bodybuilders, who described how the desire to be balanced could itself conflict with the desire to be competitively successful (Probert, Leberman, & Palmer, 2007), and some men who have sex with men, who focused not on balancing sexual risk against pleasure but on accepting the consequences of risky sexual behavior (Guest et al., 2005). It was, however, highly unusual for people to express resistance to balance or balancing, and most stress seemed to stem from the inability to succeed in what was assumed to be a desirable and/or necessary process.

Discussion

The concept of balance is a very old one, which has carried meanings about how to trade-off priorities, make choices, and achieve harmony across different cultures and historical periods. This study extends these ideas by synthesizing the existing literature exploring balance in health-related contexts. The studies reviewed showed that balance influenced the conceptualization, experience, and enactment of health, illness, disability, and caregiving across many cultures and health-related contexts. Our chief findings were the importance of understanding balance as both a state (and an ideal state, at that) and a process, and our recognition that the word *balance* sometimes had an internally focused orientation, and sometimes an externally focused orientation.

Practical Implications

Based on our findings, we argue not only that balance is important, but that different types of balance or balancing might be relevant in different circumstances. People from different cultures or within the same culture, individual clients, or whole communities might be more likely to think of balance as a state inhering in their community, or alternatively as a process for which they are responsible. Those who take an externalist/state approach, seeking a state of balance within their community, might feel most unhealthy when they feel that their ordinary balance state is lost, and might seek to conform to or be guided by their community. These people seem most likely to respond to communication and interventions that acknowledge and build communities. Alternatively, those who take an internalist/process approach might want to reflect on and control their own lives, and might seek to balance aspects of their lives, often through considerable effort, using strategies such as varying, moderating, or counteracting one thing with another. These people would be likely to respond to communication and interventions that acknowledge their efforts to weigh multiple commitments.

In addition to respecting people's efforts to achieve balance, it is important for practitioners to bear in mind that some people might be struggling to achieve or maintain balance, and that their perceived need for balance might have become more of a hindrance than a help. People might, therefore, need assistance not only in achieving balance, but also in recognizing the ways in which balance or balancing can be a constraint. Indeed, people might need to be given permission to live—at least temporarily—in unbalanced ways. At the very least, it would be important

to acknowledge that health is tied to notions of "the good life," and that people are who appear to be struggling with health-related decisions or roles are unlikely to be ignorant of or unconcerned about their own well-being. Rather, they are likely to be enacting their complex and expert understandings of the good or balanced life (for them), juggling competing commitments, and/or aiming for subtle balance-related goals.

Strengths and Limitations

Like Campbell et al.'s (2003) metaethnography of diabetes studies, we have demonstrated that the thematic synthesis approach can work with a large number of studies. We believe that we have achieved a true synthesis of the studies we reviewed, in that we have developed new concepts rather than simply collating the results of other studies under preexisting headings. We have identified commonalities and made an otherwise inaccessible literature available to health care practitioners and policy makers, and have provided a heuristic that can be used by those communicating about health and illness. By necessity, we were forced to sacrifice some of the fine detail embedded in some of the individual qualitative studies. This might be viewed as a weakness by those who believe that the main value of qualitative research lies in the detail of individual studies (Flyvbjerg, 2006) or in the detailed synthesis of a small number of studies. We were also unable to distinguish clearly between lay people's and qualitative researchers' understanding of the word *balance*. As noted previously, our synthesis included both studies in which participants used the word *balance* and studies in which participants' accounts were interpreted as being about balance, either because apparent synonyms were used (e.g., moderation, equilibrium) or because balance-like states or processes were described (e.g., being on a seesaw). It would be useful to understand the degree to which balance is a first- or second-order construct in qualitative research, but that was not possible in this study.

Future Directions

We have, to our knowledge, carried out the first comprehensive synthesis of balance in the context of health maintenance, disease, disability, and caregiving. As such, this synthesis should be viewed as a starting point, and more research is needed to both confirm and develop our findings. Obviously, given the wealth of empirical data available and the need to impose methodological constraints to make analysis feasible, there are many issues that we could not explore through this synthesis, nor through analysis of any single article on the topic of balance. We see four goals for empirical work: First, to develop a more detailed model of balance-as-a-process, including by returning to those qualitative studies that explored in detail the steps of balancing process. Second, to develop an understanding of when and how people move between different modes of balance or balancing. Third, to explore the value systems that underpin people's balancing orientations. Finally, to examine how balance or balancing are influenced by or related to social structures like culture, class, or gender.

This synthesis also invites a more theoretically oriented examination of balance. We are curious, for example, about how and where balance has been discursively constructed and deployed. Is it, for example, a key and relatively recent discursive construction that legitimates and manages the reflexivity, uncertainty, and need for acting "entrepreneurially" that characterizes contemporary "risk society" (Beck, 1992; Giddens, 1990, 1991)? If so, what is the relationship between individual narratives of balance and the societal or cultural "grand narratives" in which they are embedded? Can we understand how resisting balance or being deliberately out of balance might be aligned with the governing imperatives of public health (Petersen & Lupton, 1996), and what might be the relationship between balance or balancing, self-government, and autonomy in late modern society?

Conclusion

Balance is a powerful, culturally recognized concept related to living the best possible life, with profound effects on the ways in which people view, experience, and respond to their health-related circumstances. Although understanding balance does not provide a grand theory, or overall explanation, of health, and cannot reduce all the complexities associated with health, risk, illness, and caregiving to a simple model, examination of the concept has provided an important conceptual tool for understanding people's approaches to their own health. If we can recognize the importance of balance and balancing, we will better understand lay people's expertise in managing their own lives. This might assist both patients and public health audiences to be better respected as experts, and to be more willing to communicate constructively with health professionals about the health issues they face.

Notes

1. A complete bibliography is available from the corresponding author.
2. A note on data presentation: The references and examples included in the results section represent only a small number of possible inclusions, and are intended to illustrate the more abstract points.

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