LET THE CIRCLE BE UNBROKEN:

HEALTH OF ELDERLY SOUTHERN APPALACHIAN WIDOWS

by

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The purpose of this study was to facilitate discovery and description of the health experience from the perspective of elderly Appalachian widows. The concepts of health, health beliefs, and health practices were explored using the qualitative research design of ethnography. A purposive sample consisted of ten native women ranging in age from 68 to 90 from a Southern Appalachian county in western North Carolina.

Data collection took place over a six-month period. Data were generated using the following techniques: participant observation, interviews, field notes, health diaries, photography, and document analysis. Ethnographic analysis yielded domains, categories, and themes from the data.

Four domains were derived from the data using ethnographic analysis, including: NO LONGER A COUPLE, EXISTING DAY TO DAY, LIVING THE RIGHT WAY, and STAYING HEALTHY. The domain, NO LONGER A COUPLE reflected the women's experience of widowhood. EXISTING DAY TO DAY encompassed daily life which

included planning, family, and activities. The third domain, LIVING THE RIGHT WAY uncovered moral issues related to values and God. Lastly, STAYING HEALTHY included physical and mental activities and health as related to health beliefs.

Six major themes were revealed from the data and are listed in sentence form. A rebirth occurred with the loss of a husband which required the emergence of inner strength to endure living with loneliness in a crowd. Anticipation of the future and reflection of the past guided the women toward a healthy and competent existence. A strong commitment to God fostered health and prepared the women for their future death. A unity of family and friends nurtured the women. A moral sense of concern for others facilitated one's own state of health. Retaining intellectual faculties was an imperative dimension of health for these older women. The themes were woven into a metaphor found within the Appalachian culture--LET THE CIRCLE BE UNBROKEN--a hymn.

The major findings were: 1) the emergence of a nonstereotypical image of elderly Appalachian widows; 2) the identification of the tacit presence of the women's husbands in their lives; and 3) a new understanding of health from the female perspective.

The form and content of this abstract are approved.
I recommend its publication.

Signed [redacted]
Faculty Member In Charge of Thesis

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CHAPTER I

INTRODUCTION

> I am Appalachia
>
> These mountains and I are One
>
> As the tree-covered slopes strive to touch the heavens so does my spirit strive for freedom from these bonds in which society has placed me.
>
> My spirit likes the old ways of life better than the new; and trusts time-tested traditions more than new-fangled inventions; because its people are plain, ever'day folk who are content to live life at a leisurely pace and love every precious moment of it.
>
> Yes, these are my people, my mountains, my valleys, my animals, and wildflowers. (Reynolds, 1979, p.8)

The United States has been a "melting pot" of diverse ethnic and cultural groups. However, the American dream that diverse cultural groups would blend and assimilate into a common whole has not been fulfilled for the Appalachians. Today members of Appalachia still identify strongly with their cultural heritages (Spector, 1979).

Most significantly, Appalachian women have been ignored in the literature with the majority of research centered around the male mountaineer. The

few references to Appalachian women were often stereotyped and presented in a slanted perspective (Lord & Patten-Crowder, 1979).

In the health care arena, a major challenge for nurses is to recognize and understand cultural diversity to better assist people in meeting their physical, social, and psychologic needs (Chrisman, 1977; Leininger, 1977). An understanding of a culture includes the cultural meanings of health, health beliefs, and health practices of the people. Often subcultures related to age and gender exist within larger cultures. Elderly women's cultural beliefs regarding health are frequently submerged or lost in a larger domain encompassing studies of the elderly.

Since few studies have focused specifically on the health of elderly Appalachian women, lack of knowledge of practices can be problematic for health care professionals. For example, Lewis, Messner and McDowell (1985) stated that health care professionals need to recognize the reason for an Appalachian's lack of eye contact while talking with nurses. Appalachians consider staring and direct eye contact to be impolite. If the nurse is not aware of this cultural practice, she may perceive the patient to be uninterested (Lewis, Messner, & McDowell, 1985).

A thorough review of relevant literature indicates a need to discover the health of the elderly population in general, and Appalachian elderly widows specifically. Since elderly Appalachian women have been under-represented in research, efforts were made to discover whether particular behaviors were associated with health in this subcultural group. Specifically a subgroup of elderly Appalachian women is of special interest. How elderly women who have lost their husbands describe their health and health practices is not evident in research or popular literature. An understanding of the health care practices of these elderly widows will assist in the provision of culturally relevant nursing care.

Genesis of the Study

My particular interest in Appalachia began during the early 1980s when I realized that my family was from an Appalachian county in western North Carolina. This new awareness of my unique heritage encouraged further study of the region. Hence, I took several courses at Appalachian State University in Boone, North Carolina in the Appalachian Studies Department.

During my course work at Appalachian State

University, I worked with the Project on Aging in Watagua County. This work was rewarding and challenging as I discovered the unheard voice of the older Southern Appalachian woman. I wanted to give them the opportunity to be heard through the mist of a patriarchical society.

Purpose of the Study

The purpose of this study was to facilitate discovery and description of the health experience from the perspective of elderly Appalachian widows. The concepts of health, health beliefs, and health practices were explored using the qualitative research design of ethnography. This design was most suited to answer the primary research question: How do elderly widowed Southern Appalachian women subjectively describe and understand health, health beliefs and health practices?

Significance of the Study

The significance of the study relates to several areas of health care. This section discusses the significance of this study relative to women, older women, and widowhood. A discussion of the need to study the Appalachian culture follows.

Women

A subculture of women exists in every society although its exact nature varies from society to society. Margaret Mead (1940) observed that in every known society, the male's need for achievement is recognized. Men may cook, or weave, or dress dolls or hunt hummingbirds. If such activities are judged to be appropriate occupations of men, they are considered by the entire society to be important. "Although women within a given culture may be important, powerful, and influential, relative to men of their age and social status, they typically lack generally recognized and culturally valued authority" (Rosaldo & Lamphere, 1974, p.17).

In American society, despite some recent changes, several core elements of the female subculture persist: marriage, children, and the home; reliance on a man for support and privileges; and an expectation that women will spend their lives nurturing and preserving the health and lives of others. Other elements relate to assumptions that women tend to live vicariously through others and that women are concerned with personal appearances. Further, women do not express "masculine" behaviors, such as aggressiveness, except when they are encouraged specifically in the "female" domain. The

three feminine life themes reflected by these core elements are: maternal, wifely, and sexual (Keller, 1974). These core elements and themes reflect the American feminine subculture.

Subordinate roles are associated with women in American society. Within the historically male oriented health care system, subordinate roles for women are exemplified. Sandelowski (1981) stated that the American health care system demonstrates the belief that women cannot reach the same standard of health as men and that women can be healthy only if they function within narrowly appointed social roles. "Women are believed incapable of controlling their own health destinies; they can not be allowed to aspire to positions beyond the ones they now hold" (Sandelowski, 1981, p.vii). Webster and Lipetz (1986) discussed a move to redefine health for women from an egalitarian stance. Egalitarianism supports viewing women holistically within their context of life and valuing personal experience.

The official concept of health has been developed by men in relation to men and their health. Less attention has been paid to women's value systems, aspirations, or circumstances (Sandelowski, 1981). Women's perspectives of the health concept have not been valued. Women, as a subcultural group,

have not been researched adequately in some cultures. Most specifically, knowledge about the health and health practices of older women is inadequate.

Women as a subculture perceive and classify health problems in specific ways; each cultural subgroup of women has distinctive beliefs about how to stay healthy (Leininger, 1978). One major interest in this study was to discover what behaviors women, especially older women within a specific cultural group, perform in order to maintain their health status. Factors contributing to health status must be examined in detail in order to provide feminine based health care for the future (McElmurry & LiBrizzi, 1986).

Older Women

Women aged 65 years of age and over comprise the fastest growing population segment in the United States. "In 1981, 60% of the 26.3 million persons aged 65 years and over were women; projections show that by the year 2035, 33.5 million women will be in this age group" (Gass, 1987, p.39).

Community health nurses are in a particularly advantageous position to influence the health care of elderly women. However, specific health needs of this older population must first be recognized

through identifying actual or potential stressors that influence health status. Building on this knowledge base, nurses can improve health promotion, maintenance and self-care programs, for example, by developing appropriate programs for the chronically ill, those needing long-term care, and the well elderly. "Nurses must dispel myths about older women by directing attention toward actual health needs and interpreting these to legislators and administrators of social institutions as well as health care providers" (McKeever & Martinson, 1986, p.34).

Weisensee (1986) suggested that past studies of women's health are contradictory and lacking in empirical data. Researchers have traditionally neglected the study of elderly women. Fuller and Martin (1980) suggested that older women have been neglected as research subjects because many studies have integrated data relating to older men and women. Hence, the male/female distinction is lost. Recent attention to the needs of older women in our society has stimulated researchers' interest in pursuing women's studies.

Widowhood

A major factor in the lives of older women is widowhood: in 1981, 51.3% of women 65 years of age

and older were widows. Older women are four times more likely than are older men to lose a spouse. This occurs because of "women's longer life expectancy and their tendency to marry men older than themselves" (McKeever & Martinson, 1986, p.35).

Heinemann (1982) stated that research into the experience of older widowed women is important for the following reasons: 1) women live longer than men and, once widowed, women are less likely than men to remarry; 2) the problems of widowhood are accentuated for women due to lower economic status; and 3) women who become widowed in later life (40 years & older) have more family responsibilities and fewer resources. Research is needed to describe, identify, and understand which, if any, of these factors are related to health in the elderly rural Appalachian widow. The majority of studies on widowhood have focused on urban widows; few relate the experience of widowhood to rural women. No studies were found related to the health of elderly Appalachian widows.

Cultural Significance

Three major reasons for studying health in Appalachia have been identified. First, the health needs of people in Southern Appalachia have been

described as resembling a colorful patchwork quilt of treasured remnants handed down from grandparents and sewn together to comfort new generations. In places "the medical coverage is worn, even ragged; in other places, it is being carefully mended" (Caro, 1986, p.5). This region affords a nurse ethnographer an opportunity to discover health beliefs from Appalachians who have been known historically to avoid health care services as long as possible because they often did not understand medical terminology, laboratory testing, drugs, therapies, and the institution of the hospital itself (Caro, 1986).

Second, there is a need to discover culture-specific health behaviors. Most nurses are unprepared to manage the care of cultural strangers. Leininger (1989) stated that "in a profession that seeks to involve the patient in his or her own care, nothing could be more important than understanding the patient's heritage and traditions" (p.251).

Third, the study of Appalachia can contribute to a better understanding of community life by describing the struggles of the Appalachian work place and the Appalachian community. Discovering the cultural identity of these people and their community life can best be uncovered through an ethnographic

methodology. Michael Agar (1986) summarized this notion when he stated:

> when you stand on the edge of a culture and watch the noise and motion, you wonder, `Who are these people and what are they doing?' Hypotheses, measurement, samples and instruments are the wrong guidelines. Instead you need to learn about a world you don't understand by encountering it first hand and making sense out of it. In order to do this research an intensive personal involvement and an abandonment of traditional scientific control is needed. (p.12)

Summary

In summary, recognition of a lack of understanding of the health and health practices of an ever-growing segment of the population, older widows, coupled with a specific interest in a unique cultural group, elderly Appalachian women, led to the present study. A desire to add to the body of nursing knowledge, specifically community health nursing, was the focus of this study. The research question addressed in this study was--how do elderly widowed Southern Appalachian women subjectively describe and understand health, health beliefs and health practices?

The following chapters in this dissertation describe the research process of this ethnography. Chapter II provides a review of the pertinent literature to ground the development of the

ethnography. The historical-geographical context, the setting of the study, and the values found in the Appalachian region are presented in Chapter III. A discussion of the philosophical perspectives which guided the study and the ethnographic research design that was implemented are reviewed in Chapter IV. In Chapter V, the challenge of gaining access is described and the reader is introduced to the informants. The findings are presented in Chapter VI. Chapter VII concludes the dissertation with a discussion of the findings, implications for nursing, and recommendations for future research.

CHAPTER II

REVIEW OF LITERATURE

In order to understand an historical-cultural perspective of health, a literature review of health definitions, health beliefs, and health practices is reported. The concept of culture and its relation to health is explored. Culture specific studies conducted about health in Appalachia are reviewed. In an overview of women's health the historical, theoretical, and older women's perspective of health are summarized. Finally in order to establish an understanding of the context of elderly women, relevant literature about widowhood is also examined.

Health Definitions

Historical and Traditional Definitions

As health is the major concept to be explored in this study, a review was conducted of historical and current definitions of health found in the literature. Historically, the word paideia was used in ancient Greek thought to represent the idea of health. The word paideia referred to the art of a civilization in which the goal was the development of

qualities in life which increased the human's potential toward self-realization (Smith, 1983).

Partridge (1966) stated that the word health referred to whole which was derived from hole or hale. Hole came from Middle English while hale came from Old English. Many definitions of the word "health" are congruent with the notion of wholism. Health has been associated with the physical, psychological, social, environmental, and spiritual dimensions. All these dimensions must be considered important for a wholistic perspective of health to exist.

Health is both a noun and an adjective. The noun "health" usually refers to a state of being. Health has been used in several instances as an adjective; for example: to describe a philosophy of care such as health promotion and health maintenance; to describe one's practices or behaviors as health behavior or good health practices; and health care costs, health insurance, and health professionals. Roget's Thesaurus (1979) identified the following noun synonyms for the word health: bloom, eudaemonia, euphoria, vigor, pink, prime, trim, and well-being.

The adjective, "healthy" refers to having a state of health. Roget's Thesaurus (1979) identified

the following adjective synonyms for the word healthy: well, sound, hearty, and whole.

The members of the World Health Organization (WHO) defined that health as a state of complete physical, mental and social well-being, not just the absence of disease. The World Health Organization later expanded the concept of health to a level of well being that permits individuals to lead socially and economically productive lives (Mahler, 1988). However, absence of disease may remain the most prevalent definition of health among health professionals.

Definitions of Health from a Sociological Perspective

An indepth review of cultural and sociological views of health is important given that the design of this dissertation was ethnographic. These views accept health as having a unique meaning for each individual or defined by a social group of people. Both Parsons (1958) and Baumann (1961) reflect an understanding of health as the ability of the individual to be functional.

Parsons (1958) conceptualized health as a state of well being that is socially desirable for society. Health was a required state for maintaining integration in a society. Health has been defined by

Parsons from a functional perspective as one's capabilities to perform necessary roles in society.

Baumann (1961) categorized health definitions as follows: (1) feeling state; (2) symptom orientation; and (3) performance orientation. Feeling state referred to a state of well being. Symptom orientation referred to absence or presence of symptoms. Performance orientation referred to activities one can perform when one is absence of disease.

Nursing's Perspective of Health

In looking at health from all potential dimensions, Smith (1981;1983) and Newman (1979) were reviewed relative to their models of health because both view health on a continuum. These models represent directive ideas in the practice of restoration, maintenance, and preservation of health with nursing.

Smith (1981;1983) proposed four categories of health: (1) clinical; (2) role performance; (3) adaptive; and (4) eudaimonistic. These distinctive categories emerged from the ideas of health found in the literature. Each category fits into the health-illness continuum. The clinical models of health referred to the absence of disease. This model was

found primarily in the contemporary writings of the medical profession. The role performance model of health emerged primarily from the writings of Talcott Parsons. Role performance referred to adequate performance of one's socially defined roles. The adaptive model of health referred to the adjustment to the environment. The writings of Rene' Dubos were represented as the adaptive model. The eudaimonistic model of health was represented by the writings of Abraham H. Maslow. Eudaimonistic referred to exuberant well being.

Newman (1979) described a theory of health based on Rogers' model of unitary human beings. Newman's basic assumptions regarding health were:

1. Health encompasses conditions of illness that are accompanied by varying degrees of incapacitation, but each person is still very much a whole person.

2. Conditions of illness can be considered a manifestation of the total pattern of the individual.

3. The patterns of the individual that are manifested precede structural or functional changes.

4. Removal of the illness in itself will not change the patterns of the individual.

5. If becoming "ill" is the only way an individual's pattern can manifest, then that is health for that person.

6. Health is the expansion of consciousness and is the totality of the life process (Newman, 1979, p.56-58).

To Newman, health was an expansion of consciousness. Health constituted the concepts of movement, time, space, and consciousness and was a life process patterned as a synthesis of disease/nondisease. The pattern of expanding consciousness was understood as movement in space-time relationships. The way an individual moved within subjective time and space was determined by his consciousness. Time and space were the context from which the individual expanded himself through movement and consciousness. Newman's conceptualization of health required a different world view. This perspective of health was revolutionary and opened the discipline of nursing to expanding the understanding of health (Kim, 1983).

To further understand the concept of health, the individual's viewpoint of health must be viewed within the context of his/her culture. Health beliefs are contingent upon one's culture. The next section on health belief summarizes this perspective and relevant research which looks at both health and culture.

Health Beliefs

Leininger (1985) discussed the relationship woven between culture and health. She described health as "the beliefs, values, and action-patterns

that are culturally known and are used to preserve and maintain personal or group well-being" (Leininger, 1985, p.196). Hence, health values, beliefs and practices are derived from the culture. Discovery of attitudes and beliefs underlying cultural patterns allows others to understand how individuals of a specific culture foster health.

The concept of culture most congruent with this dissertation is Spradley's (1979) definition of culture. Spradley (1979) defined culture as "the acquired knowledge that people use to interpret experience and generate social behavior" (p.5). This understanding of culture is important because health is culturally defined (Chrisman, 1977; Leininger, 1978). Therefore, culture is related to each person's perception of experience. Culture is important to nursing because it provides the foundation from which to understand people's perception of their experience, most specifically one's health experience.

In many of the reported studies of culturally diverse peoples, folk health beliefs and practices were described as orally transmitted from generation to generation. These transmissions have served to "help the cultural group maintain health, prevent illness, or restore health following an

illness episode" (Hautman & Harrison, 1982, p.50).

Hautman and Harrison (1982) conducted a study of health beliefs and practices in a middle-income Anglo-American neighborhood to determine (1) definitions of health, (2) health maintenance behaviors, and (3) illness beliefs and behaviors. The researchers conducted indepth interviews with 100 subjects in California. The sample consisted of 29 males and 71 females ranging in age from 18 to 88, with the majority of ages ranging from 30 to 64. An interview guide was patterned after that used by Bauwens (1977). This descriptive study found that eighty-five percent of the sample felt that they were in good health and that orthodox and unorthodox beliefs coexisted as an influence in self-care. Unfortunately, only a middle class perspective was captured in this description and the findings were not reported by gender even though the majority of the sample was female.

While few studies have been reported about the health of Appalachian women in relation to health beliefs, two studies are remarkable. Horton's (1984) study was reviewed because of the specific emphasis on Appalachian women. A study conducted by Lang, Thompson, Summers, Hansen, and Hood (1988) described the health belief system and practices of

one mountain community in Tennessee.

Horton's (1984) study focused on the differences between gender-related health problems. This study investigated the incidence of headaches among women and backaches among men in a southern West Virginia town. A need for this study was identified by the local community health center. The sample consisted of fourteen women and fourteen men between the ages of 35 and 45. Home interviews were conducted over one year using open-ended questions about experience with headaches or backaches. Findings suggested that the Appalachian culture was accepting of headaches as a female affliction and of backaches as a male affliction. The family and the belief systems were at the core of the psychosocial factors which operated in health. Religion and the social value system of Appalachia supported the gender difference in illness. A limitation of this study was identified by the researcher when she stated that "the research method was not rigorously controlled" (Horton, 1984, p.647).

Lang, Thompson, Summers, Hanson, and Hood (1988) conducted a door-to-door-survey about health beliefs in eastern Tennessee. Two interviewers questioned every 12th household using a list of homes on the mailing routes supplied by the post office.

No information was given on inter-rater reliability. The questionnaire included questions on the causation of illness, the relationship of religious beliefs and health, and the use of folk medicine. Eighty-one families were interviewed. Seventy-two percent of the respondents were women. The mean age of all informants was 56 years. The results included: 1) fundamental religious beliefs were interwoven with beliefs about the causation of illness; 2) folk medical beliefs play a less significant role than in the past; and 3) a high percentage of individuals believed that the Devil was the cause of disease. This study highlights the importance of health professionals identifying the factors influencing patient's beliefs of causation and treatment to enhance potential compliance of traditional medical treatment.

Health practices are those actions that individuals undertake to prevent disease and promote health. The next section reviews the health belief model and Pender and Pender's (1987) health promotion model derived from the health belief model. These models have helped to explain an individual's actions to avoid illness and have guided our present health care system in Western Society. The findings from this dissertation suggests that other factors such as

religious beliefs may be related to health beliefs of health promotion. Steele and McBroom's (1972) study on rural health practices was selected for review because of it's merit relative to describing rural health practices.

Health Practices

The health belief model (HBM) was developed in the early 1950s by Godfrey Hochbaum, Stephen Kegels, Howard Leventhal, and Irvin Rosenstock. These social psychologists were concerned with preventive health behavior and held a phenomenological perspective of the person. That is, they believed that the world of the perceiver and not the physical environment determined behavior, except as the physical environment was represented in the mind of the behaving individual (Rosenstock, 1974).

The origin of the HBM stemmed from the theories of Kurt Lewin. Lewin believed that the individual existed in a life space constructed of positive and negative regions. These positive and negative regions exerted forces moving the person from one region to another. Life activities were conceived of as a process of being pulled by positive forces and repelled by negative forces (Rosenstock, 1974).

The health belief model postulated that an individual would take action to avoid an illness if he believed (1) that he was susceptible, (2) that the disease had a moderate severity on a component of his life, and (3) that taking an action would be beneficial to reducing the severity of the disease. Taking an action would not require the individual to overcome psychological barriers such as cost, convenience, pain or embarrassment. Hence, the HBM proposed that the likelihood of an individual taking action on behalf of one's health was determined by the individual's psychological state of readiness to act and the perceived benefit of the action relative to the perceived barriers involved. An individual's readiness to take action was determined by his perceived susceptibility and severity of the health condition. A group of factors influenced the individual's perception of susceptibility. These were: (1) demographic variables; (2) structural variables, such as complexity of the action; (3) attitudinal variables; (4) interaction variables, such at patient-nurse relationships; and (5) enabling variables, such as needed resources.

Pender and Pender (1987) proposed a Health Promotion Model that was derived from social learning theory and was organized similarly to the Health

Belief Model. The primary concepts in the regulation of health behavior were cognitive mediating processes. The factors of health promoting behavior "were categorized into cognitive-perceptual factors (individual perceptions), modifying factors, and variables affecting the likelihood of action" (Pender & Pender, 1987, p.60).

The cognitive-perceptual factors included: importance of health, perceived control of health, perceived self-efficacy, definition of health, perceived health status, perceived benefits of health-promoting behaviors, and perceived barriers to health promoting behaviors. An indirect influence on the pattern of health behavior were the modifying factors. These included: demographic characteristics, biological characteristics, interpersonal influences, situational factors, and behavioral factors. In sum, the Health Promotion Model proposed that modifying factors exert their influence through the cognitive-perceptual mechanisms which directly affect behavior (Pender & Pender, 1987).

Steele and McBroom (1972) surveyed nearly one-thousand households of a large rural area in Montana regarding preventive health action of members in each household. Four major indicators of health

behavior: engaging in physical checkups, dental visits, eye doctor visits, and obtaining health insurance were the categories used to identify preventive practices. The findings suggested that the concept of health practices was multidimensional. People were not consistent in their health practices. The study revealed that preventive behavior was correlated with socioeconomic status. This study explored those health practices categorized as preventive behavior unrelated to an illness.

The following section on women's health provides the reader with an historical perspective of issues perpetuating a gender specific view of women. Theories posed by researchers in explaining the phenomena of women's health are discussed. Also included in this section is a review of pertinent literature on elderly women and widowhood.

Women's Health

Historically, in Western society, women generally were socialized to be passive, dependent, accepting of living in a male-dominated society. Men made most of the decisions as women were considered to be delicate and naive to reality. Women were not perceived to have the knowledge base from which to make decisions. The primary role of the woman was to

bear children. A woman was socialized against pursuing an education or doing physical labor (Collier, 1982).

The nineteenth century was a period when the perception of femininity was intertwined with illness behavior. The more pale, delicate and sickly a woman became, the more feminine she was perceived to be. Normal female functions such as menstruation, childbearing, and menopause were referred to as illnesses. It was acceptable for a middle to upper class woman to be in bed for long time periods and to need help from family or servants (Collier, 1982).

During the early nineteenth century, the "conservation of energy" theory was in vogue. A major premise of this theory stated that a given amount of energy existed in each human body. Since women's primary role was one of reproduction, they did not pursue other activities for fear of losing energy needed for childbearing (Collier, 1982).

Collier (1982) remarked:

> although the expectations of appropriate health behavior of (20th century) women were less patterned than they were in the nineteenth century, biases of health care providers, women's lack of information about themselves and about good health practices, and the unwillingness of some women to actively participate in decisions that affect their health status were still factors that limited optimal health behaviors for women. (p.122)

Several facts related to women's health behaviors were prominent in the literature. The first fact was that women use existing medical services more than men. Second, women reported being sick more often than men. Women had more days of limited activity owing to physical or psychological distress than men. Third, "far more pharmaceutical prescriptions were written for woman than men" (Weisensee, 1986, p.20). In summary, women were perceived as the sickest and most frequent consumers of health care in the population.

Woods (1981) stated that women's health is paradoxical. While mortality rates for women were significantly less than for men, morbidity rates and utilization of health services by women were significantly greater. Collier (1982) proposed that the adage "men die and women get sick was analogous to the complex paradox found in women's health" (p.123).

Weisensee (1986) posited seven plausible explanations for women's morbidity which have not been explored sufficiently. These explanations are:

1. Mothers are exposed more frequently to the symptomatically acute illness of their children.

2. Proxy effects in survey may distort the reporting of illness.

3. Bias on the part of the medical practitioners may define women's complaints as hypochondriacal or inconsequential, resulting in palliative treatments or repeat visits for recurring symptoms or both.

4. Normal but exclusively female functions may have been assigned definitions as illness requiring medical intervention.

5. Ways women demonstrate distress may be considered "ill behavior," while ways men exhibit distress are defined as something else.

6. Women misunderstand the nature of their ills and over use doctors.

7. Men are biologically superior to women and therefore, are less susceptible to illness but more to murder and accidents. (p.20)

In summary, a review of the literature around theories posed to explain the phenomena of women's health explains the traditional view held by society. In the next section the importance of researching older women is discussed and research studies conducted with predominately elderly women and widows are summarized.

Older Women's Health

Garner and Mercer (1989) stated that the focus on older women is "an appropriate response to a demographic imperative and the special needs of the majority of our present and future older population" (p.7). Aging is a woman's issue and they suggest that being old and female may be perceived as a disadvantage. Women are beginning to stand up and

make society "readjust its lens and realize that the images of older women are not always of gloom and doom" (Garner & Mercer, 1989, p.8).

Weisensee (1986) argued for "the need to study older women when investigating the variable of health" (p.29). Her arguments center around the fact that women live for an average of seven more years of life than men. Longevity and widowhood are factors which influence the chances of women being left alone to face the effects of health following some of life's major changes and losses (widowhood or divorce, menopause, retirement, economic deprivation, and loss of purpose). Finances, living arrangements, companionship, transportation, social activities, family, the will to live, and many other factors have implications for women's health care in later life. Hence women are more likely to demand a greater ability to care for themselves (Weisensee,1986).

Widows. Little documentation exists related to the health and health behaviors among elderly widows 65 and older compared to the amount of literature on widowers. However, several articles deserve review because of their significant contribution to understanding elderly women.

Rauckhorst (1987) conducted a study in which adherence of elderly widows to seven basic health

habits was explored. The habits studied were: 1) no smoking, 2) no alcohol use, 3) seven to eight hours of sleep per day, 4) breakfast almost every day, 5) rarely eating snacks between meals, 6) regular physical exercise, and 7) maintenance of weight not more than 10% above ideal weight. The 84 widows in this study had been widowed on the average of 19 years. Findings suggested that elderly widows in this study reported practicing an average of 4.5 of the seven health habits. This study gives the reader insight into those health practices used by elderly women. However, if the researcher had used a qualitative design, the frequency and other health habits could have been discovered.

McElmurry and LiBrizzi (1986) conducted a study of 130 women aged 65 to 86, most of whom were widows. An instrument for evaluating self-reported health concerns focused on the physical, emotional, social, and environmental dimensions of health for older women was used with a convenience sample from the Chicago area. The findings contradicted the traditional stereotype of the older women as being "unhealthy." A profile of a healthy older woman emerged from data gathered using structured interviews. "Independent, active and capable of self care" were descriptors of the population studied.

Health concerns of this group were identified as lack of knowledge in the area of medications, diet, and activities such as pap smear and breast examinations. Developmental complaints of blurred vision, nocturia, and dry skin were reported. This study decontructed the traditional view of the older woman as helpless and dependent. However, the women were predominately middle class and no information was gathered about health behaviors these women use for their health needs.

Ferraro (1985) studied the effect of widowhood on health status. The sample was proportionally representative of the U.S elderly population. The data were collected in a longitudinal design using measures to explore both objective and subjective dimensions of health status. The sample of 2,114 widowed persons consisted of both men and women. The majority of the sample had been widowed over four years. Findings suggested that widows have a decreased perceived health status after the death of their spouse. This study was conducted using quantitative methods. Qualitative techniques could have enhanced the depth and understanding of health status from this population.

Fenwick and Barresi (1981) examined the effects of changes of marital status on changes in

health status of elderly respondents over a 14 month interval. Health status was measured by perceived health, days ill in bed at home and in a medical institution. The sample consisted of a stratified random sample of 18,000 low-income elderly and disabled persons. Respondents consisted of 7,696 individuals who were 65 years of age and older. Results did not differentiate the number of males from females in the study. The participants were interviewed twice, 14 months apart. Findings suggested that respondents who lost their spouses between the first and second interview had significantly lower perceived health at the second interview than those who remained married. These respondents, however, spent fewer days ill in bed than married respondents. Qualitative techniques may have uncovered relevant factors associated with a decrease in perceived health by the widowed population.

In summary, there is a the lack of qualitative research on the health of older widowed women within the discipline of nursing. My study should provide new insight into health from the perspective of elderly widowed women.

Summary

In this chapter, literature was reviewed relative to the concept of health. Definitions of health from historical and traditional perspectives, from cultural and sociological perspectives and nursing's understanding of health were discussed. Significant literature pertaining to health beliefs and health practices were presented. A discussion of women's health and older women's health, most specifically widows health status revealed that the majority of research studies had employed quantitative methodology. Limited research has been conducted using qualitative methods.

Based on the review of literature, the phenomenon of health is a complex experience. For women, especially older women, the phenomenon of health has not been extensively explored from their subjective experience. This dissertation is important because women's subjective experience of health is explored in a culture where women have not historically been given a voice. The purpose of this study was to facilitate the discovery and description of health from the perspective of elderly Southern Appalachian widows.

In the next chapter presents information about Appalachia is presented from a geographical,

historical, and cultural perspective. The setting of the study is discussed and the study site, Western County, is described to enhance understanding of the context of this study. Lastly, the values and relationship with the family and community of Appalachians are summarized.

CHAPTER III

CONTEXT OF THE STUDY

In this chapter the historical-geographical context of the study is presented. Along with the historical context, the study site is described. A description of the Appalachian people documents differences from the main stream culture relative to their values, lifestyles, and linguistics. The major differences have been conceptualized as a cultural difference for the purpose of this study.

Appalachian Region/Geography

The Appalachian population was "federally defined as 24 million people, with more than 6 million living in the poorer Southern Appalachian Region" (Tripp-Reimer & Friedl, 1977, p.41). The Appalachian Region is composed of parts of twelve states and the entire state of West Virginia (Ergood and Kuhre, 1983). The area comprising the federally designated Appalachian Region is shown in Figure 1.

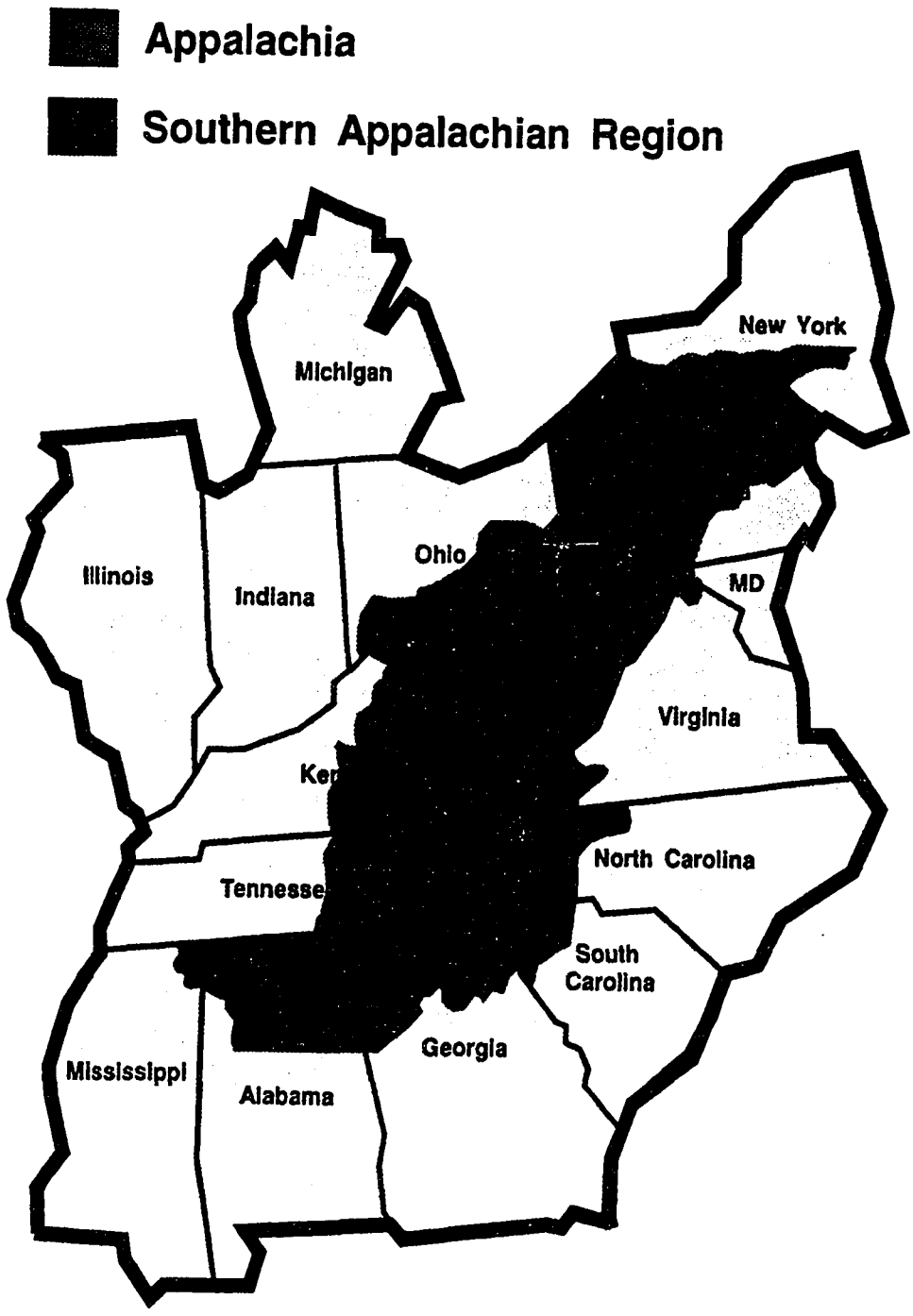

Figure 1. Map of the Appalachian Region

There is no single definition of Appalachia. However, the most commonly used definition is geographical and was written by the Appalachian Regional Commission (ARC), a federal-state agency which administers a multi-billion dollar economic development program under the 1965 Appalachian Redevelopment Act. The Appalachian Regional Commission identified three subregions in Appalachia. Northern Appalachia (Subregion 1) is composed of portions of New York, Pennsylvania, Ohio, and Maryland and all but the nine southernmost counties of West Virginia. This subregion is the most populous, urbanized, and largest geographically of the three subregions.

Central Appalachia (subregion 2) extends diagonally across almost the entire width of the middle portion of the Appalachian Region. This region includes parts of Kentucky, the northwestern counties of Tennessee, seven counties in the southern tip of Virginia, and the nine southern counties of West Virginia. This subregion is the smallest of the three and is predominantly rural.

Southern Appalachia (subregion 3) is an elongated area extending from the highlands of Virginia to the margins of the Mississippi coastal plains. This region includes portions of Alabama,

Georgia, Mississippi, North Carolina, and South Carolina, the eastern counties in Tennessee and 14 counties in southwestern Virginia. The outstanding characteristic of this subregion is its rapid population growth (Ergood & Kuhre, 1983). Possibly the rapid growth of population could be related to an increase in the number of people from outside Appalachia retiring to the region.

This study was conducted in one of the Southern Appalachian counties located in western North Carolina. A map of the state of North Carolina is shown in Figure 2. Twenty-nine counties in western North Carolina have been designated as Appalachia by the Regional Appalachian Commission. Although the name of the county studied has been withheld to protect confidentiality of the informants, the map located in Figure 3 shows the location of the North Carolina Appalachian Region.

The Southern Appalachian Region was selected as the setting for this study because health needs in the states of West Virginia, Kentucky, Virginia, Tennessee, North Carolina, South Carolina, Alabama, and Georgia "are most acute" (Tripp-Reimer & Friedl, 1977, p.42). In addition, I had had previous experience as a nurse with the population in the selected county.

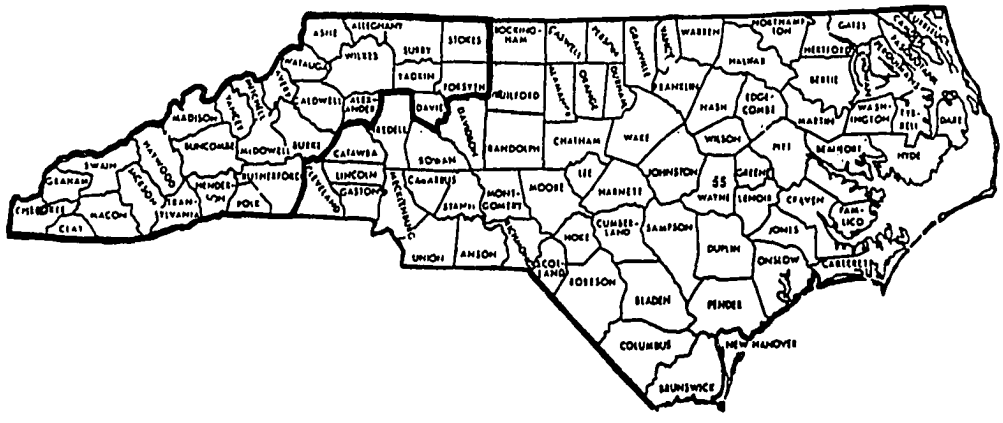

Figure 2. Map of North Carolina with Appalachian Region Outlined

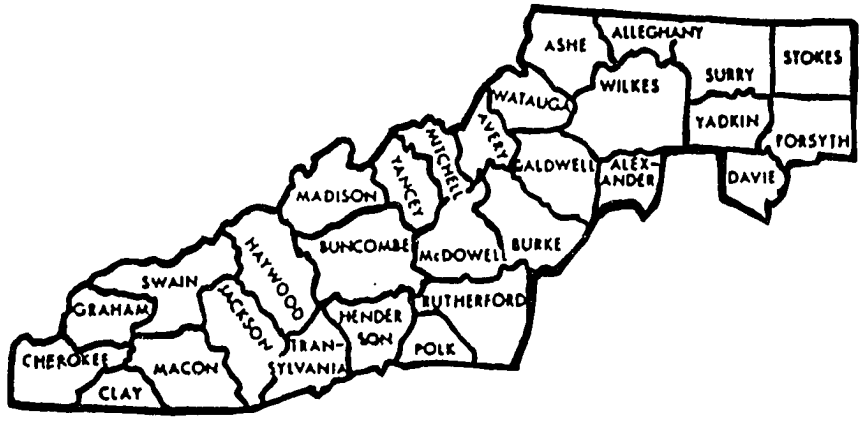

Figure 3. Map of the Designated Appalachian Counties in Western North Carolina

Southern Appalachia

Cratis D. Williams (1972) described the Southern Mountaineer as being of Scotch-Irish ancestry, holding dissenting religious convictions, and being of Whig political preference; the mountaineer was a complex individual. Hence a homogeneity of the ethical and ethnic character of the mountain people was reported in most literature. However, there was no homogeneity of social and economic status as mountaineers live in three groups (Williams, 1972):

(1) Town and city dwellers live in incorporated units of 1,000 or more. Although they may have lived in the town but a generation or so, they resent being labeled mountaineers.

(2) Valley farmers live along river valleys, near the mouths of creeks, or on main highways. Although they are rural inhabitants, like their neighbors in town they reveal the ethical and ethnic homogeneity of the whole mountain population.

(3) Branchwater mountaineers are fewer in number; they live, for the most part, "up the branches," in the coves, on the mountain ridges, and in the more inaccessible parts of the mountain region. They own "poor land" and are akin to the "poor white" who became the mountaineer of fiction.

These people do not refer to themselves as mountaineers. People from Appalachia consider themselves simply as "mountain people." The various terms identifying the Appalachian people have been developed by scholars studying the Appalachian region (Williams, 1972).

County Description

This ethnography was conducted in the homes of elderly widows over the age of 65 who lived in one of the counties located in western North Carolina and designated as Southern Appalachia (see Figure 3). The county and towns have not been identified to protect confidentiality. For purposes of this study, the county will be called Western County. Through document analysis, the following information was discovered and is presented to give the reader an understanding of Western County as the physical context of the study. The domains of land, government, economics, environment, education, and health are described.

Land. Western County is a mountainous county in the western part of North Carolina. A photograph of this county which depicts Southern Appalachia is displayed in Figure 4. The climate has

Figure 4. Photograph of Western County

a relative humidity of 61%; average temperature is 57.8 degrees. The county is rural and supports agriculture as well as furniture manufacturing plants.

Several major shifts are occurring in the county. First, land once farmed is being developed for residential housing. Second, an effort to attract more industry and to develop tourism is a strategy being pursued by the local government.

Government. Five residents of Western County held elected or appointed state government positions and others sit on statewide committees. At the time of the study, these elected and appointed positions were held by people representing the Republican political party. Public decisions for the county are made during public meetings. These public meetings often prove to be a slow process for decision making. However, the meetings are open to all residents of the county.

During this study Western County was faced with dealing with damage from a tropical storm. From September 1989 to the completion of the study in June, 1990, the county had spent $350,000 dollars in relief and clean up due to the storm. Federal disaster aid reimbursement to the county totalled $175,000.

Economics. According to the 1980 census, 29,808 people were employed in Western County. Another 3837 residents of Western County commuted to another county because wages in the adjoining county were more competitive. Based on the 1980 census, the median household income was $14,552 with a median per capita income of $5,653. Non-skilled workers made up the largest employment category. The number of families below the Federally defined poverty level was 7.7 percent.

The travel and tourist industry is increasing in the county. From 1987 to 1988, Western County experienced a 10.7 percent increase in travel and tourism revenue. In North Carolina during 1988, $6.2 billion was spent in travel and tourism; of that amount $7.8 million was generated from this county.

Environment. Western County is heavily dominated by furniture manufacturing plants. These factories pump millions of pounds of toxins into the air each year. Currently there are no standards governing the hundreds of potentially dangerous chemicals that make up those emissions. A set of standards are in the process of being reviewed in the state. Western County ranked number two in terms of the amount of toxic air emission.

Education. In 1989 Western County had seventeen elementary schools, five junior high schools and three high schools. Based on the 1980 census, 53.5% of the adults had not completed high school; 17.2% had some post high school training; and 6.9% had a college education. A new library was constructed in 1988 in the largest town. One room in this library is devoted to the local history of the county.

Health. According to the director of Western County health department, expansion in the area of preventive health care has evolved over the past five years, yet the infant mortality rate was significantly higher than the state average. The county rate was 20.8 deaths per 1000 live births, while the state average was 12.7 in 1989.

The local nonprofit hospital has 120 beds. During 1989, the hospital averaged 70 patients per day. In 1989, 22,000 people received services through the emergency room of this hospital. According to the director of the hospital, 85-90% of the people at sometime in their lives received health care through this emergency room. In 1989, the hospital lost $11,091,857 to free care.

During 1989 Western County was faced with the following emergency situations: a flood, a

chemical fire, a tropical storm, an arson fire, a forest fire and a crime-related hostage situation. The county does not have a 911 emergency calling system. Projections have been made by the local government that a system will be in place by 1991.

Population Description

In 1980 the National Census Bureau reported that Western County had a population of 67,646 people. Four towns, identified with fictitious names, have been incorporated in the county since 1980: Lumber, with a population of 13,748; Heritage, with a population of 2888; Grain, with a population of 2580; and Rocky Mount, with a population of 427. The estimated annual income per capita in 1986 was $11,084, as compared to the $14,567 for the state (N.C. State Census Bureau, 1989).

The population of Western County over 65 years was estimated at 8,136 in 1988. This group represented 12% of the total population. Table I displays the 1988 estimates of elderly males in Western County. There were 3077 elderly white males in 1988, representing approximately 38% of the total population of elderly. Other male ethnic groups represented 1.77% of the total elderly population (N.C. State Census Bureau, 1989).

Table I

1988 Estimates of Elderly Males in Western County

AGE	White male	other male
65-70	1199 (15%)	59 (0.7%)
70-74	851 (10%)	39 (0.5%)
75-79	544 (7%)	32 (0.4%)
80-84	308 (4%)	11 (0.1%)
85+	175 (2%)	6 (0.07%)
Total	3077 (38%)	147 (1.77%)

Table II displays the 1988 estimates of elderly females. Approximately 58% of all the elderly in Western County are white females. Other female ethnic groups are approximately 3.1% of the total elderly population (N.C. State Census Bureau, 1989).

Table II

1988 Estimates of Elderly Females in Western County

AGE	White female	other female
65-70	1512 (19%)	86 (1%)
70-74	1190 (15%)	69 (0.8%)
75-79	965 (12%)	53 (0.7%)
80-84	560 (7%)	34 (0.4%)
85+	423 (5%)	20 (0.2%)
Total	4650 (58%)	262 (3.1%)

Description of the Appalachian People

Several authors have addressed the culture of Southern Appalachia. Weller (1965) wrote of his experience as a minister during thirteen years of missionary work in Southern Appalachia. While a doctoral fellow of the Richard D. Irwin Foundation, Hicks (1976) conducted culturally based research in Southern Appalachia. Beaver (1986) researched aspects of the social organization and system of values of the rural community in Southern Appalachia, specifically western North Carolina. Ergood and Kuhre (1983) have collectively presented ideas and information to demythologize the half-truths of Appalachia. These authors were selected because while they recognized the stereotypes about mountain people, they also made an effort to present a balanced view of this unique cultural group. Specific observation from these four authors are presented in the following section.

Appalachian people are best known as mountaineers or "mountain people." The Appalachian has been portrayed in the general literature, movies and etc. as an ornery, independent, feuding moonshiner or as a proud, honest, God-fearing subsistence farmer. Often the Appalachian man was characterized either as a thin, gaunt, black-faced

mountain miner or a down-hearted, beaten, welfare recipient rocking on his dilapidated porch "just a setten." Frequently, the Appalachian woman was stereotyped as thin, illiterate, and uneducated or as bare-foot and pregnant. These stereotypes "carried a prejudice of ignorance of the true situation" (Ergood & Kuhre, 1983, p.37).

Although there are specific behavioral patterns common among mountain people each person is unique. One characteristic noted about mountain people concerns self-reliance which is often attributed to Scotch-Irish Presbyterian "blood" and to isolated living conditions. This pattern of self-reliance is sometimes referred to as individualism or independence (Beaver, 1986; Ergood & Kuhre, 1983; Weller, 1965).

Another characteristic concerns strong family ties, feuds between families, and a respect for members of "one's own" which are noted in writings about Appalachia. Appalachians are said to be loyal to their kin (family) with much of their identification revolving around dealings with both immediate and extended relatives (Beaver, 1986).

The Appalachian life is lived close to or in harmony with nature. This way of life is viewed as an easiness with life, as well as a spirit of passive

resignation. Yet, living close to the land "is perceived by this population to be analogous to a healthy state of being, envied by the hassled urban dweller" (Ergood & Kuhre, 1983, p.37).

While these three characteristics of self-reliance, clannishness, and life in harmony with nature have been cited over the past seventy years, a close look at the literature on mountain "Appalachian" people indicates that while these features are consistently cited, others are consistently overlooked, such as strong religious beliefs, being stubborn, and the role of superstition in one's life (Hicks, 1976; Weller, 1965).

Using information found in 20 books and articles describing mountain or Appalachian people in general, Ergood (1983) found 11 consistent specific characteristics. In order of "most frequently cited" these characteristics were: independence, religious fundamentalism, strong family ties, life in harmony with nature, fatalism, traditionalism, honor, fearlessness, allegiance to the land, suspicion of government and born trader. "Born trader" referred to the keen sense of bartering among Appalachians. A synopsis of Ergood's (1983) findings related to characteristics of Appalachian people as frequently cited between 1898-1972 can be found in Table III.

Table III

Personal Characteristics of Mountain People as Cited in Selected Studies: 1898-1972

Authors		Family—strong kin ties a—clan loyalty	Independence—individualism a—isolated people	Life in harmony with nature	Honor	Fearlessness	Allegiance	Born traders	Traditionalists	Fatalism	Suspicion of gov't	Religious fundamentalism
Vincent	1898	X	a									
Kephart	1913		X									
Campbell	21	a	X/a			X	X	X				X
White	37			X								
Ernst and Drake	59		X/a									
Griffin	59		X									
Griffin	pre 60		X	X								
Weatherford	62	a	X/a		X	X						
Brewer	62											X
Ford	62		X	X					X	X		X
Weller	65	X	X						X	X		X
Powell	66		X	X								
Caudill	66		X									
Jones	6?	X	X		X					X		X
Ball	68								X			
Ayer	69	X		X								
Photiadis and Schwarzweller	70	X	X/a	X			X		X	X	X	X
Smathers	70										X	
Gerrard	70									X		X
Williams	1972		X									X

Note. From Appalachia: Social context past and present (p.38) by B. Ergood and B. Kuhre, 1983, Dubuque, Iowa: Kendall/Hunt Publishing Company. Copyright 1983 by Kendall/Hunt Publishing Company. Reprinted by permission.

In summary, mountain people have been described as self-reliant or independent, family-involved people whose lives are closely bound to their physical environment. Their activities were customary or historically traditional within the context of life; beliefs were both fatalistic and religiously fundamentalist. This description emerged "from the earliest social science attempts at description to the present" (Ergood, 1983, p.39).

Appalachian Values

Jones (1983) identified seven values associated with the individual, family and community. These values are: personalism, modesty, sense of beauty, sense of humor, family solidarity, religion, and neighborliness. These values influenced both the beliefs and values of Appalachians. Many of the values and behaviors can be traced historically to the emergence of Appalachian communities as frontier settlements in the developing nation. In the following sections, the seven values will be discussed, incorporating idioms and phrases from the region.

Personalism. For Appalachians, one of the main aims in life is to relate well to other persons. Appalachians will go to great lengths to

avoid offending others. This relationship with others could even result in appearing to agree with others when, in fact, they do not agree. For most Appalachians, a good relationship with others is more important than it is to make ones true feelings known. Appalachians respect other persons and they are quite accepting of differences in others. As Appalachians say, "every man ought to have the right to make a fool of himself" (Jones, 1983).

Mountain people tend to accept a person as she/he is. While they may not always like other individuals, Appalachians are able to accept them. They tend to judge others on a relational basis rather than according to how they look, their credentials or accomplishments (Jones, 1983).

Herbert Gans' concepts of person-orientation and object-orientation, which describes opposite patterns of behavior, have been used to discuss the Southern mountain society (Weller, 1965). Weller (1965) believed that mountain people are person-oriented. The person-oriented individual is concerned with being a part of a group and with being liked, accepted, and noticed. The individual is reluctant to separate from a group that accepts him or her. For the person-oriented individual, goals are achieved in relation to other persons and to

group participation. Social relationships which can be fulfilled within a group are central in the life of this individual (Weller, 1965). The person-oriented relationship is often seen when Appalachian patients tell nurses what they think the nurse wants to hear. This happens because the Appalachian does not want to offend the nurse (Lewis, Messner, & McDowell, 1985).

Modesty. Mountain people have a realistic and modest view of themselves. They do not believe in anyone being perfect. They are brought up believing in the concept of "original sin," and are not surprised when "Man fails." These beliefs do not allow the mountain person to pretend to be something he/she is not (Jones, 1983).

Mountain people believed that they are as good as anyone else, but no better. They do not "put on airs," boasting or trying to "get above their raising." Little competition exists among mountaineers. Persons accomplished in a particular area or discipline are hesitant to talk about, or to show their superiority (Jones, 1983).

The characteristic of modesty could dictate an approach that health care professionals should use with Appalachian patients. It is more acceptable to

drop hints of what you would like the client to do than to give direct orders. An outspoken approach is perceived as rude and is offensive to the Appalachian (Lewis, Messner, & McDowell, 1985).

Appreciation for Beauty. Mountain people are known for their sense of beauty. Great pride is taken in good craftsmanship: items carved from wood, stitchery, musical instruments, songs, quilts and a variety of doll making. Some say beauty is evident even in their unique ways of expressing themselves: "He'd cross hell on a rotten rail to get a drink of likker," or "he looks like the hind wheels of hard times," or "She's as tense as a cat on nails," or "She's ill as a hornet." Mountain people have long been masters of simile and metaphor in song, story and speech (Jones, 1983).

Sense of Humor. The mountaineer has a good sense of humor; however, to outsiders it may appear somewhat dour. Humor is tied to their concept of man and the human condition. Humor is related to man's pretensions to power and perfection and to his inevitable failures. "Fun is poked" at pompous people (Jones, 1983). For example, "preachers and lawyers and buzzard eggs--there's more hatched than ever come to perfection" (Jones, 1983). This

statement refers to the notion that education does not make a person perfect even though one can find those with education who think they are more intelligent than anyone else.

Family Solidarity. A central part of Appalachian life is kinship and family. Kinship is "a cultural value that connects people to other people, land, community history and to one's identity" (Beaver, 1986, p.58). These relationships form a homogeneous community. Hicks (1976) stated that the basic kin group in Appalachia is the nuclear family consisting of husband, wife and children. However, Appalachians place a strong emphasis on maintaining close relationships with an extended family network. The extended nuclear family, often determines one's job, church, associates, and helpmates (Tripp-Reimer & Friedl, 1977).

Obligation and loyalty to family is interpreted in several ways. Appalachians would agree that one should be loyal to one's family before he or she is loyal to anyone outside the family. Loyalty runs deep among family members; a sense of responsibility extends to cousins, nephews, nieces, uncles and aunts and to in-laws. A general rule of loyalty entails patronage of stores or businesses owned by kin. Cooperative projects, such as

splitting the cost of butchering a cow, are reserved for "kin before others." One is expected to support one's kin in any political race (Hicks, 1976). The family provides a caring and secure atmosphere. During a crisis, such as hospitalization, the members usually stay with the sick person and often refuse to transfer their loved one to a distant hospital. This togetherness produces a strength that withstands any problem (Hicks, 1976; Jones, 1983).

Religion. Mountain people are usually religious. This does not mean they all participate in a formal, organized religion; they are religious in the sense that their values and the meaning they see in life arise from religious sources.

Historically, organized churches were impractical in the wilderness because preachers often moved on to other settlements. Hence, churches were formed in various ways, often without a strict organized structure or religious leader. These early churches stressed fundamentals of the faith. Life on the frontier, where people lived off the land, provided a context that did not allow optimism. One was "lucky" if he or she endured. As a result, religion was fatalistic and deterministic and stressed rewards in another life. The importance of accepting Christ and salvation was emphasized within

the fundamentalist churches. The fatalistic attitude supported the belief in predestination; life was predetermined for the person at the moment of conception. Hence, one moved through life on a determined road designed by God (Hicks, 1976; Jones, 1983).

Neighborliness. Historically, the frontier provided a context which required people to help each other in order for work to be accomplished. The mountaineer's self-reliance was tempered somewhat by his neighborliness and hospitality among kin. Two examples of hospitality were characterized by the quickness by which people invite one in, and the generosity in offering someone their food. Women often met for the purpose of canning food or sharing work, however socializing was often the major focus of the gathering (Hicks, 1976; Jones, 1983).

Appalachian Women

Southern Appalachian women can better be understood by reviewing the historic-socio context. Appalachian women are descended from a variety of backgrounds. A woman may have come from a Scotch-Irish, English, German, and/or French Huguenot background, but she may also have been descended from that "bunch of Italians" who settled in Valle Crucis,

North Carolina. She might be Melugen, one of those mysterious people who lived in Hancock County, Tennessee. Her people may have come to Appalachia long ago and identifies themselves as a "Native American Indian." She may have moved into the region recently and decided to adopt the mountain style of living, or maybe of mixed ethnic heritage.

Despite their different family backgrounds, Appalachian women are unique because they share an Appalachian heritage and culture. The women are consciously aware of their differences from outsiders; for example, the dialect of the language, beliefs about male and female roles, and the strong connection to family. "Sharing a common but different culture from the dominant culture makes the Appalachian mountain woman significantly different from women of any other segment of the American population" (Weeks, 1980, p.22).

Female children are expected to become mothers; boys are given the freedom to be whatever they chose. Girls have less freedom than boys because of chores and familial protectiveness toward them. Yet, a close feeling exists between brothers and sisters. Tacit cultural knowledge includes the feeling among siblings that a responsibility exists of "looking after" each other (Weller, 1965).

Girls are brought up in a social environment fostering learning skills in sewing, cooking and housekeeping. These skills help women in a male dominated society. As a result, the mountain male often retreats when confronted with a "good talkin" woman; he is inadequate when competing with the verbal skills of a woman. This verbal skill is the mountain woman's major weapon in a patriarchal society. Although historically, she was not able to fulfill a leadership role, i.e., newspaper editor, or local governmental office because of societal rules, she could "talk her way to what she wants" (Weller, 1965, p.76).

Women are expected to regard the household as their domain; cooking, cleaning, and tending to children are regarded as appropriate female activities. Flower gardens are also the province of women. Men are responsible for shrubbery, or home repair, and maintenance. Both women and men work in the vegetable garden.

Women, more than men, are expected by the culture to attend church and to accept the rules of fundamental Christianity as a serious guide to daily activity. Women are the protectors of the morality in their homes. A "good" woman does not drink alcoholic beverages nor does she allow drinking in

her home. In public, cursing is forbidden in the presence of women and children. In general, traditional male and female roles are strongly accepted in the Appalachian society. When a person does not fit into a traditional role, the community spends a great deal of time gossiping about the reason for such deviant behavior. Often it is concurred that role changes occurred out of necessity. For example, a role change may have occurred out of a need to provide for one's family or self (Hicks, 1976).

Women frequently become close friends. This sense of friendship is often referred to as being "like a sister to me" or being "like a mother to me." Terms such as "aunt" and "uncle" are used as a means of incorporating people into a contrived kinship relationship. The use of kinship terms underscores the importance of kinship feelings within relationships (Beaver, 1986).

Among Appalachian women, uniqueness stems from the characteristics brought by the first settlers. A conscious desire to remain independent and outside the mainstream of American society's values prevents a change in the attitudes of many women. These women claim a world view that includes a strong sense of family and kinship, an attitude

toward religion that allows acceptance of life as the way God meant it to be, a love of land that approaches spiritualism, and an independence and self-pride. The pride of Appalachian women precludes their being "beholding" to anyone.

What is the essence of an Appalachian woman? Fitzgerald (1980) stated that this essence stemmed from a deep personal God-centered faith through Christ that molded the woman and held her family, church, and community together. This religious faith was often comfortable, but confining. Being part of the silent majority was accepted and at times confining; yet, this sense of belonging provided a deep comfort.

Today, one finds that the Appalachian woman seeks to be accepted as an individual in her own right without disrupting the family. She tries to establish a sense of partnership and equality with her "men folk." Historically her skills in diplomacy and her willingness to cooperate with others are beginning to help her gain roles in the community. These new roles such as owners of small businesses, promote further changing of culturally prescribed roles (Fitzgerald, 1980).

Elderly Appalachians. The elderly Appalachian holds a position of honor. Elderly is the preferred term in the culture for persons over the age 60 or 65. This term is used in this study out of respect for the cultural language. The Appalachian's attitude toward the elderly is one of great respect and caring. Older adults are "more likely to be kept at home, and cared for by their families than placed in nursing homes" (Lewis, Messner, & McDowell, 1985, p.22). Elderly Appalachians are person-oriented and have an easy-going pace sometimes perceived by outsiders as "lateness" or lack of time consciousness. Related to health care situations, Appalachians often arrive for medical appointments when they feel ready, according to Lewis, Messner and McDowell (1985). This easy going pace can be difficult for health professionals who are time conscious. Before proceeding with a physical examination, it is often necessary to "sit down and visit a spell."

Elderly Appalachians have also been noted for their erratic behavior toward taking prescribed medication. A tendency exists to take medicine only when they feel sick. Also, a belief exists that if one pill is good, two will be better (Lewis, Messner, & McDowell, 1985). To fully understand the meaning

of health behaviors of elderly Appalachians, the nurse must be open to considering all behaviors within their cultural context. "Utilization of the personal approach is essential in meeting the health care needs of the elderly Appalachian" (Simon, 1987, p.35).

Summary

In summary, Appalachia represents a defined geographical area of the United States. Southern Appalachia has been identified as a distinct area of the region. The study was conducted in Western County, a Southern Appalachian county in western North Carolina.

Values of Appalachians provide the reader with a description of the social/cultural context for this study. The roles, values, and lifeways of elderly widowed Appalachian women have not been addressed in current literature. Hence, there was a need to conduct research focusing on the elderly widowed Appalachian woman. The term elderly is used throughout this chapter and dissertation to represent older adults in this culture.

This study was initiated to further nursing's knowledge of the subjective experience of health by elderly widowed Appalachian women. Chapter IV

describes the methodology of the dissertation research. The methodology is discussed in terms of the philosophical perspectives and the ethnographic design which guided the study.

CHAPTER IV

METHODOLOGY

This chapter gives the reader information about the epistemological, philosophical, and methodological perspectives of this qualitative research on elderly Appalachian widows using an ethnographic design. A phenomenologically-oriented philosophy provided the paradigm to guide this dissertation.

Philosophical Perspectives

The phenomenologically-oriented paradigm is concerned with understanding human behavior and the meaning of human experience. Phenomenologically, a lived world experience is understood without concern for how the experience came to be. Munhall and Oiler (1986) discuss two themes inherent in phenomenology that elucidate a framework for nursing research. These two themes are: one's presence to the world and modes of perception. This framework supports a need to understand human experience as involvement in a world and perception as original awareness of that involvement.

Man's presence to the world is recognized by Merleau-Ponty (1974) as consciousness (Man is used in the generic sense). Bernard (1981;1987) suggests that the female world differs from that of the male world. These separate worlds have varying degrees of spatial separation depending upon the extent the two worlds are integrated. Hence, consciousness for a female is the simultaneous contact with the world (male and female world) and with herself. Knowledge of the world and self are contingent on one's presence in the world. Reality for women emerges as the subjective (Munhall & Oiler, 1986).

Another aspect of a phenomenologically-oriented paradigm is perception. Merleau-Ponty (1974) stated that perception is understood through the lived experience of the other. The perceived world defines one's reality. Perception of an experience is the moment the world is constituted to each human being (Munhall & Oiler, 1986). The important reality is what people imagined it to be. This philosophical perspective embraces both a multicultural and gender perspective because it accepts multiple realities. "People act on their individual perceptions, and those actions have real consequences--thus the subjective reality each individual sees is no less real than an objectively

defined and measured reality" (Fetterman, 1989, p.15).

Congruent with a phenomenological perspective, cognitive theory within anthropological ideational theory supported my valuing the subjective experiences of informants. Ideational theories describe change as the result of mental activity--thought and ideas. Classic ideational theories in anthropology include cognitive theory, culture and personality theory (Kaplan & Manners, 1972), sociolinguistics (Cazden, 1979; Gumperz, 1972; Heath, 1982), symbolic interactionism (Blumer, 1969) and ethnomethodology (Bogdan & Taylor, 1975; Garfinkel, 1967; Mehan & Wood, 1975).

Fetterman (1989) states that cognitive theory is the most popular ideational theory in anthropology. Cognitive theory assumes that people as a group can be described by listening to what they say. The human world is viewed from the perspective of ideas, beliefs, and knowledge of human beings. The perspective of human beings is organized into patterns of meaning. Reality for each human being is understood as his/her subjective reality. Thus for the present study, the tenets of phenomenology and ideational theory guided the ethnographic research process and were the source of my assumptions.

The concepts of culture, emic and etic perspective, nonjudgemental orientation, and symbols provided the framework of this study. This framework provided an open and balanced approach for data generation.

Culture

Culture can be viewed from either a materialists (Harris, 1971) or an ideational perspective. The classic materialist interpretation of culture focuses on behavior. From this view, "culture is the sum of a social group's observable patterns of behavior, customs, and way of life" (Harris, 1968, p.16). Fetterman (1989) stated that "the most popular ideational definition of culture is the cognitive definition" (p.27). From this perspective, the concept of culture includes the ideas, beliefs, and knowledge as characteristics of the group. Cultural behavior and knowledge are essential to understanding a culture. Hence, Spradley's (1980) definition of culture has been adopted for this study. Spradley (1980) stated that "culture is a way of being and knowing that is used by the individual to interpret experience and generate behavior" (p.6).

Emic and Etic Perspective

The emic perspective is the native's perception of his/her lived world. The native's perception of the phenomena of interest is significant for understanding the meaning of situations and behaviors. In traditional anthropology, the native was called an informant (rather than a research subject), one who informs the researcher about his or her culture. Acceptance of multiple realities is central to the emic stance. To understand why people think and act the way they do, the ethnographer must document multiple perspectives of reality. "Differing perceptions of reality can be useful clues to individual's religious, economic, or political status" (Fetterman, 1989, p. 31).

An etic perspective is the researcher's or the "scientific" perspective on reality. Some ethnographers describe only the emic view while others describe only the etic perspective. Historically, those who described only the emic perspective were guided by the phenomenological paradigm. Anthropologists who preferred to rely primarily on etically derived data were philosophically logical positivists (Fetterman, 1989).

In this study, data were generated from the emic and etic perspective. Fieldwork required an insightful and sensitive cultural interpretation combined with rigorous data collection techniques. Fetterman (1989) stated that "good ethnography requires both emic and etic perspectives" (p.32). Fieldwork also requires a nonjudgemental orientation.

Nonjudgemental Orientation

Following the suggestion of Fetterman (1989), I held a nonjudgemental orientation to the Appalachian culture and its people. This orientation helped me to explore new directions, ensure valid data, and to prevent data contamination. This stance helped to prevent me from making value judgments and stereotyping the informant. All cultural practices were viewed nonjudgementally. In the conduct of this study, I had to hold my values in abeyance and remain open to the native's reality. Suspending disbelief of the native's behavior or belief required me to have a great deal of control over nonverbal behavior.

Symbols and Rituals

Symbols help an ethnographer to understand and describe a culture. Symbols are "condensed

expressions of meaning that evoke feelings or thoughts" (Fetterman, 1989, p.36). Once symbols are identified, they can become tools for the ethnographer. Identification of symbols explicate the meaning of various cultural beliefs and practices. Symbols often function within the role of rituals. Rituals are repeated patterns of symbolic behavior (Fetterman, 1989). Together, symbols and rituals provided an understanding of the culture.

Design

This research was conducted within the framework of assumptions and characteristics of the naturalistic paradigm of qualitative research outlined by Lincoln and Guba (1985). This framework views the researcher as instrument conducting research in a natural setting. Ethnography is a research design that requires the researcher's use of self and is conducted in the natural setting of the culture.

An ethnographic research approach was chosen for this investigation because this design was most suited to answer the primary research question: How do elderly widowed Southern Appalachian women subjectively describe and understand health, health beliefs and health practices? To discover these

elderly women's perceptions of health, an ethnographic design facilitated uncovering the meaning of an experience lived and perceived by members of the identified culture. In this study, the following qualitative techniques were used to generate ethnographic data: participant observation, interviews, field notes, health diaries, photography, and examination of documents. These techniques are more adaptable to dealing with the purpose of the study. Such techniques exposed more directly the nature of the transaction between investigator and informant and hence made easier an assessment of the extent to which the phenomenon was described in terms of (is biased by) the investigator's own posture (Lincoln & Guba, 1985). A diagram of the fieldwork techniques are displayed in Figure 5.

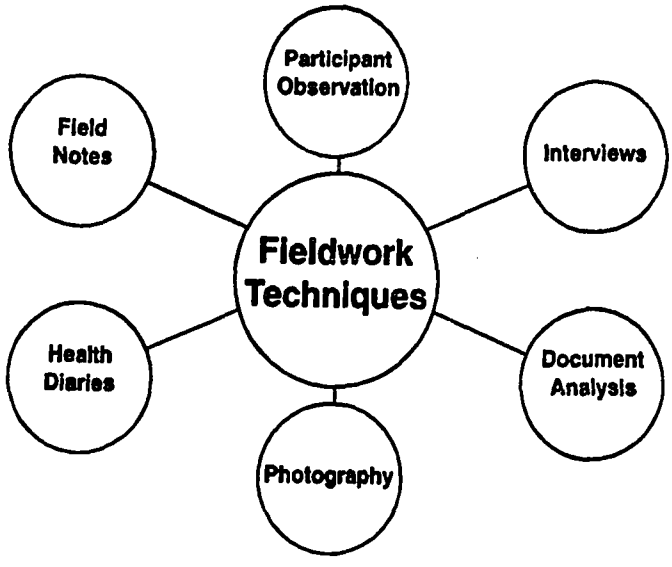

Figure 5. Diagram of Fieldwork Techniques

Participants

Purposive sampling is characteristic of ethnographic research when the goal is to yield a rich description rather than generalizable findings. A purposive sampling procedure was used in this study for selection of informants. The term "informants" is used instead of concepts like subject, respondent, friend or actor because a complex relationship exists between the researcher and informant. This relationship has been described by Spradley (1979) as placing the informant in a teacher role and the researcher in a learner role. Informants provide an emic viewpoint about their life.

A characteristic of purposive sampling is "selection to the point of redundancy" (Lincoln & Guba, 1985, p.202). In purposeful sampling the size of the sample is determined by informational considerations. If the purpose is to maximize information, then sampling is terminated when no new information is forthcoming from newly sampled units: thus redundancy is the primary criterion (Lincoln & Guba, 1985).

In this study the sample evolved as I recruited informants who added information relevant to the research questions. The size of the sample

was determined when no new information was obtained from newly sampled informants. Sampling was determined to be complete when I heard repetition in the data of each domain identified for indepth analysis. This process occurred when ten women had entered the sample.

The ten informants for this study were elderly Appalachian widows. The widowed population was selected as representative of the typical case of older women. In 1981, marital status statistics for women age 65 and older "revealed 5.7% were single, 38.6% married, 51.3% widowed and 4.4% separated or divorced" (McKeever & Martinson, 1986, p.35). Hence, elderly widowed women represent the majority of the older female population.

The sample was selected according to the following criteria: 1) aged 65 years and over; 2) widowed for at least one year; and 3) native to the Southern Appalachian Western County, North Carolina. A native was defined as an individual born, raised and a resident of the county for most of her life. For the purposes of this study, the informants were self-identified as native (and self-identified as "elderly"). Demographic data were collected using the data collection form developed for the study, shown in Appendix A.

After a potential informant met each of the three criteria, I evaluated her for the qualities of being a "good informant." My criteria for a "good informant" included that a woman: (1) was able to reflect and provide detailed information about her understanding of health, health beliefs and practices and (2) was willing to share her health experiences and examine them critically (Morse, 1989). Each of the ten informants selected for the study met the criteria of "good informant." In Chapter V the process of gaining access to the informants is discussed with an indepth description of each woman.

Data Generation

The following section summarizes the ethnographic techniques used in this study. "These techniques lend themselves to being more sensitive to the many value patterns that may be encountered" (Lincoln & Guba, 1985, p.40). In an ethnography, data are said to be "generated" rather than "collected," a term which implies a static, available, quantifiable set of data.

Participant Observation

A specific technique integral to the ethnographic method is participant observation. Participant observation is a strategy of observing

the culture and interacting with the people (Spradley, 1980). During this study, I did not use participant observation in the classical sense of full immersion into the culture. The degree to which I participated varied from one social situation to another. Initially, I spent time observing at local sites throughout the community. For example, I would go to grocery stores, local shopping areas and restaurants to observe elderly women. I attended the county fair and local events in the community.

During the six months conducting the study, I was invited by the women in the study to many social situations which offered opportunity for participant observation. These invitations did not happen immediately. I frequently spent half days at the women's home to build the trust and rapport that was needed for them to feel comfortable enough to invite me to social gatherings. Only after several meetings with the women did they invite me to participate in their lives. I participated as an invited guest with widows during in-home and community social gatherings in order to observe the widows in their familiar environments. Observations during these occasions were recorded in written field notes.

With the women, I attended church services, homecoming (a ritual in the church when former

members return to the community) and a women's circle of a Methodist church. I participated in a community picnic for volunteers, went shopping with the women, accompanied the women for meals eaten "out" in restaurants and spent all day outings with some of the women. These outings gave me the chance to see the activity of women during everyday life. The participant observation experiences enhanced my understanding of the context.

Negotiated fair return for interview time provided additional opportunity for participant observation and the establishment of trust and rapport with the informant (Bernard, 1988). Fair return is a concept frequently employed by the anthropologist doing fieldwork. The anthropologist often offers a "fair return" for the informants time in interviewing. For example, a ride to the grocery store, running errands, and even odd jobs around the house may be offered.

In this study, the widows were hesitant at first to accept my offers of fair return, but with time they viewed my fair return as generosity. Some examples of fair return that occurred during this study included: running errands, driving the women to visit their neighbors, and helping them in their volunteer activities.

Interviews

Interviewing is the predominant mode of data generation in this ethnography. Unstructured and semi-structured tape-recorded interviews were employed to discover the informant's subjective experience. May (1989) defined unstructured interviews as:

> those which do not reflect preconceived ideas about content and are done with little or no organization; semi-structured interviews were defined as those organized around areas of particular interest while still allowing considerable flexibility in scope and depth. (p.173)

Spradley (1979) described thirty types of ethnographic questions in his book The Ethnographic Interview. The three major types are: descriptive, structural and contrast questions. During this ethnography, I used all three types of questions. Descriptive questions were used to elicit a sample of the person's language. For example, I asked each woman a descriptive question such as "Tell me about your day." Each woman's response resulted in a verbal description of the cultural scene.

Structural questions were more specific; they allowed me to uncover information about domains. These questions elicited information about the organization of cultural knowledge. For example, I asked my informants "What do you do to stay healthy?"

Their responses provided data about health beliefs and practices.

The third major type of ethnographic question was the contrast question. Contrast questions enabled me "to discover the dimensions of meaning by which my informants distinguished objects and events in their world" (Spradley, 1979, p.60). A typical contrast question that I asked was "What is the difference between sickness and illness?" Consistently the women defined illness in a similar way. A mixture of the three types of ethnographic questions were used throughout the study as I deemed necessary. Appendix C displays examples of the types of questions that guided the interviews.

Since establishing trust and eliciting information were goals of the ethnographic interview, interviews were non-structured or semi-structured and free flowing. In this study some questions to initiate researcher/widow conversation included: "Please describe a typical day in your life." "Tell me what health means to you." "Please describe how you stay healthy or tell me about your health practices."

To further focus the interview around health, some additional questions were asked. These questions elicited a contrast between health and

illness. For example, I asked "have you been sick in the past month? If so, what were your symptoms?" and "how did you treat yourself?" "When was the last time you sought care from a doctor, nurse, healer, or other caregiver?" In ethnographic interviews, the researcher does not follow an interview guide. The flow of interviewing is guided by the response of the informant to previous questioning.

Additional questions were then generated depending upon the responses of the widows. Sometimes the entire conversation took a different turn depending upon the context introduced by the informant. In this study the ethnographic interview was flexible and I was an active listener and responder. Several interviews with each informant were necessary to clarify and expand the data. Each woman was interviewed a minimum of three times and a maximum of six times in her home. Interviews lasted one to four hours.

Recording Field Notes

After each observation and interview I documented descriptions of observations that were perceived as pertinent for the study. The field notes were continuous descriptions of events and conversations with people during the course of fieldwork. Occasionally I would use a tape recorder

to document external observations. These tapes were then transcribed for analysis. A separate journal was used to document thoughts, ideas, mistakes, confusion, problems, and feelings about the observations in a journal. The notes were used to help me recognize personal biases. This journal represented a personal side of the fieldwork and became an invaluable tool to reflect upon during analysis. Three forms of field notes represented data generated in this study: the transcriptions of interviews; notes of participant observation; and a reflective journal with feelings about the experience.

Health Diaries

Health diaries were a rich source of data. Each informant was asked to write in a health diary each day during the study (see Appendix B). Six of the women were able to keep a health diary. Four informants were not able to write for health reasons, (i.e. arthritis or vision). These women verbally recounted weekly events during their interviews. For the six diary writers, their entries served as a source to elicit questions for my formal interviews. The diaries were often detailed and provided description of their perceived experience of the health phenomena. The health diary was kept for a

three week period. Two major questions were answered each day:

1) How was your day today? a) Any problems or concerns?

2) What did you do today to stay well or healthy? a) Any positive things?

The purpose of the daily diary questions was to identify day-to-day problems or health maintenance carried out by the informants. The informants were instructed that the questions were broad to allow for a wide range of possible answers. I retrieved the women's diaries once a week. At that time, I tape recorded an interview with the informant. Informants were asked one or two questions to support the consistency of the diary. Several of the women stated that the health dairy had given them greater insight into their own health. This technique could be considered therapeutic for some women.

Roghmann and Haggerty (1972) found the health diary to be an efficient and reliable record of a wide range of everyday events for a sample of 512 families in a New York community. The health diary provided time series data for a short term study. Health diaries served as a source for probing questions to be used during taped interviews because diaries were detailed and they could provide a

reasonably accurate description of health phenomena. Because recall of minor events was often poor during retrospective interviews, diaries often provided a level of accuracy not attained with interviews alone (Roghmann & Haggerty, 1972). Quinn (1988) successfully used health diaries in a study about perimenopausal women. In her study, the health logs provided a rich source of data.

Photography

Photographs provide detailed information about the context of a study. The images of photographs are essentially a visual diary. This form of document may be analyzed much like the tape recordings of interviews (Highley & Ferentz, 1989).

In this study, photographs were used as a supplemental primary data source to illustrate the lifeways of the culture. Aspects of the womens' lives were photographed using black and white and color film. Photos included: landscape, buildings such as churches, artifacts in the home of the informant such as the family Bible, the homes of the women, and rooms such as the kitchen. The informants were initially hesitant about the use of photography but gave their written consent. To overcome this dilemma, I included the informant in decision making about the use of the photography.

The informants were asked to help identify special aspects of their home that they thought other people would like to see or that they would like other people to see. The technique of including the informant in decision making rather than the researcher making all the decisions about the photographs facilitated the use of this technique. Rapport was enhanced with the use of photography.

Document Analysis

Documents offered additional data for analysis toward understanding the culture. Examples included mass media products, local newspapers, autobiographies, historical documents, family Bibles and genealogies. Hammersley and Atkinson (1983) discussed the potential for bias or distortion that may be inherent in the data. Documents are social products and must be closely examined, not simply used as a major source of data.

In this study, several of the women shared their family genealogies with me. In some cases, ancestors had been traced back to the 1600s. The majority of the women, however, could only trace their heritage back two generations. Family Bibles listed births and deaths of relatives by date. No information was found explaining the cause of death. A ritual noted among the women was cutting out

newspaper articles and saving them in the family Bible. These articles were a source of historical importance in the lives of the women. Artifacts, such as family Bibles never left the womens' homes. Clipped poetry and articles were often found in their Bibles.

A book documenting the history of the selected county site was written by the county's Women's League. This book was reviewed as well as other relevant historical books on Appalachia. Material from the Chamber of Commerce depicted the county as being a place with "quality of life." Document analysis revealed that the county officials wanted to project an image of an industrialized county with traditional values. Analysis of the material from the Chamber of Commerce, daily local newspapers and local history books provided the county description in Chapter III.

Analysis

The purpose of ethnographic analysis is to yield a "thick description" of the culture (Geertz, 1973). Spradley (1979) defined ethnographic analysis as "a search for the parts of a culture, the relationship among the parts, and their relationship to the whole" (p.142). Participant observation,

interviewing, field notes, health diaries, photography and document analysis combined with ethnographic analysis led to the discovery of cultural meaning. Ethnographic analysis involved identification of domains, categories, and recurrent threads (subsets) within the domains which led to the discovery of cultural themes.

Initially, transcriptions of the interviews, photographs, field notes of observations and health diaries were transcribed onto a micro-computer using a word processing software. The data were transcribed onto the computer to facilitate readability and to save as files to be used with The Ethnograph, a software package which assists in the mechanical aspects of data management.

Once the data were transcribed onto the computer, I dwelled with the data by reading and rereading it. As I dwelled with the data I looked for similarities to guide me in the decision to select those domains which appeared repeatedly in the data. I selected four domains to be studied indepth. These domains were circumscribed realms of human concern that the women continuously talked about and, thus, reoccurred in the data. The domains of widowhood, daily life, morality, and health were studied indepth.

Analysis and data generation were a simultaneous process. As the data were collected I repeatedly went back and forth through the data to code "pieces" of raw data (pieces of data could include one line to several pages of typed transcripts). After I coded the data for categories and recurrent threads, I used The Ethnograph software to assist with data management: storing, sorting, and organizing the coded data (Seidel, Kjolseth & Seymour, 1988).

Next I searched for and identified categories within each of the domains. Categories uncovered the internal domain structure. I noticed that each category identified was composed of recurrent threads or subsets. The threads differed across categories, although some overlapped (for example, family). When these recurrent threads were woven together, they explained the categories. The three foci of analysis: domain, category, and recurrent threads provided the basis for an indepth analysis of the data. I reflected upon the domains, categories and recurrent threads until several cultural themes became apparent.

A theme is a phrase that captures the main significance of the text as a whole. Cultural themes were identified as a synthesis of several patterns

which could be applied to numerous situations and/or which reoccur in two or more domains. Six themes pulled together the major aspects of the health experience of older Appalachian widows. The discovery of the cultural themes allowed for the construction of a more wholistic view of the phenomena of the study (Spradley, 1980). For example, the first theme describes the phenomenon of widowhood in the form of a rebirth. These cultural themes formed the basis of a description of cultural knowledge, behaviors, and/or meanings of the health of Appalachian widows.

Lastly, a metaphor emerged which describes the gestalt of the lived experience of the widows. This process was accomplished by looking within the culture to find words which were symbolic of the women's experience. The metaphor was immersed in the data and the culture. Yet stood out as a unifying entity.

In sum, ethnographic analysis involved a systematic examination of data in order to determine the parts, and relationships of the parts to the whole. Ethnographic analysis is a continuous process and begins with the initial pieces of generated data. In this study, the analysis yielded a description of the health experience from the perspective of

Appalachian widows. The product of this ethnography is a rich description of the health, health beliefs, and health practices among older Appalachian widows.

Rigor

Traditionally, the researchers within the positivist paradigm identified internal validity, external validity, reliability and objectivity as criteria for a rigorous study. In contrast, within the qualitative paradigm the researcher uses credibility, transferability, dependability and confirmability as criteria of rigor as defined by Lincoln and Guba (1985).

This study employed three major techniques to meet the credibility criteria: prolonged engagement, persistent observation and member checking (Lincoln & Guba, 1985). The purpose of prolonged engagement was to build and establish trust with informants. Also, prolonged engagement ensured that I was involved in the local site long enough to detect and identify regional, parochial traditions or values that might influence the data. Toward this goal, I gathered data in the field for over six months. This prolonged engagement with the community allowed me the opportunity to build trust and to identify culture specific behavior.

Persistent observation was another technique that provided an opportunity for me to see each informant more than once and repeatedly over time and circumstances. After the seventh informant had participated in the study, I began to hear repetition in the data. Three more informants were then interviewed to ensure persistent observation for indepth analysis.

Credibility of a study is enhanced when a faithful description of a human experience is recognized by other researchers, readers and informants. A researcher and colleague, Dr. Linda Reece, a native of the Appalachian region confirmed and acknowledged the findings as faithful and true. Another colleague, Mary Jo Danner, R.N., M.S.N. reviewed the manuscript to reconfirm the findings. Several informants were then asked to review the credibility of the findings. The informants validated my descriptions of the domains and themes. This process was called member checking for confirmation of credibility. The informants acknowledged a sense of comfort with the final step of analysis of selecting a cultural metaphor which captured their life.

Transferability is an indepth description that has evolved from the widest range of data

sources possible. As the researcher, I "bear the responsibility to provide a data base that makes transferability judgments possible on the part of potential appliers" (Lincoln & Guba, 1985, p.316). In this study I attempted to document closely the sources of data that lead to the conclusions. I have worked toward enhancing transferability of the study by providing as thick a description as possible for conclusions to be drawn by the reader.

Dependability of the study is established when credibility is present. I have provided a detailed decision trail of the decisions made during the study. The description of methodology and analysis provides enough detail that a reader would be able to follow my path of data generation and analysis. The dependability of my study was further enhanced by my consistent adherence to the procedures for data collection and analysis. All techniques were conducted by me as the only researcher which ensured a consistent methodology. Replication of this type of study is impossible because of the researcher's unique use of self as instrument. Although unlikely, a similar approach by another researcher could produce some common findings if steps were followed closely. Finally, I kept a personal diary of all judgments and decisions made

during the study which could be used if necessary by another researcher who wanted to follow a similar path.

Confirmability is enhanced in this study because I used multiple data generation techniques (i.e., participant observation, interviewing , photography, and document analysis), a decision trail and my reflexive journal. In the journal I described experiences which substantiated that the conclusions were grounded in the data (Lincoln & Guba, 1985). In summary, I believe that rigor was enhanced during this study by my use of the criteria of credibility, transferability, dependability and confirmability and related techniques suggested by Lincoln and Guba (1985) to ensure trustworthiness of the findings reported in this and subsequent chapters.

Ethical Considerations

A human science paradigm ensures that the human realm will be treated with respect. A respect for persons is a tenet of the human science paradigm that was integrated into the research process. The discipline of Nursing has brought to human science research a unique way of viewing persons. Nursing brings a humanistic approach and value of health and health related concerns to the ethnographic

techniques employed in this study.

An example of nursing research using ethnographic techniques was demonstrated by Rena Gazaway (1969), a nurse ethnographer, who described a "hollow" in Appalachia. Her humanistic approach supported the premise that nursing is a caring profession. A sense of caring can be felt as one reads of her experience with a group of people she has come to love. With respect to persons as unique individuals she wrote:

> no matter how noble our motives, can we in all good conscience impose our will on the hollowers and arrange their lives according to our blueprint? If so, then let us proceed slowly...Let us not regard them as resources, but rather as people whose most urgent need is to be understood and to know that someone cares (Gazaway, 1969, p.316).

In this study I tried to follow Gazaway's poignant example of the ethical researcher.

Because ethnographic techniques bring the researcher and informant into a very close, personal and intimate relationship many anthropologists consider the four ethical criteria employed in the present study when conducting an ethnographic study. These criteria are confidentiality, honesty, responsibility, and fair return for time utilized (Dobbert, 1982). Applications of these issues are described below.

Confidentiality

The women who agreed to participate in my study were informed about the nature of the research study and were guaranteed anonymity. The names of informants, community and county assured confidentiality in the following ways:

1. Fictitious names appeared on transcripts and audiotapes.
2. Health diaries were coded by identification number.
3. Field notes, diaries and tape recordings were locked in a file cabinet at my home.
4. A fictitious name was given to the county and towns.
5. Written and/or verbal consent was obtained from each informant.
6. The location of the study was kept confidential so that only the researcher, key informants and dissertation committee members were aware of the study site.

A written consent form was given to each participant which included a description of the study, my name and telephone number in case an informant need to contact me (Appendix C). If the informant felt uncomfortable signing a consent form, a verbal consent was taped at the beginning of each

interview. Six of the women signed consent forms and four gave verbal agreements.

Potential Problems and Limitations

Doing fieldwork within one's own culture can be both a strength and a weakness. "Nurses who use qualitative methods that involve fieldwork techniques to address nursing research questions must be conscious of the unique problem of solving questions in one's own culture" (Morse, 1989, p.79). The major advantage of doing research in one's own culture is that being perceived as an insider may enhance one's ability to gain entry. While some researchers believe students "should not be allowed to do research in their own subculture, other experienced researchers believe research in one's own culture is valuable to allow students to study problems that arise from practice" (Morse, 1989, p.89).

In reference to this study, I have had previous exposure to the selected Western County, North Carolina. My past experience enhanced my access to gatekeepers, the people who facilitated my identification of and introduction to informants. The establishment of trust and rapport with the informants was not obtained easily. Although I did

not previously know the informants, I was viewed as a native of North Carolina but as an outsider to this county. My being a nurse held much influence with the informants. Occasionally, I could hear disappointment in the voice of the informants when they realized I was not born and raised in Western County. This experience reminded me that I was not totally immersed in their culture and could maintain a more neutral perspective.

Another problem that must be addressed in this type of research is the role of nurse researcher. Occasionally a nurse researcher is confronted with an informant asking, needing or demanding intervention. Archbold (1986) stated that at these times the nurse role becomes salient. Ethically, the researcher cannot be separated from the nurse. Swanson (1986) suggested "unless the health of the respondent is threatened, the best way to deal with the nurse's need to intervene is to carry out any interventions at the end of the interview in order to avoid altering the respondent's response" (p.69).

Once during the study, an informant stated that she had chest pain the night before and had not told her family. She stated that the pain had lasted longer than usual. The informant was not on

medication for this health problem. At the time of the interview the informant denied having chest pain. At the end of the interview, I suggested that she should let her daughter know she had chest pain. The informant agreed and asked me to call her daughter and explain her chest pain. I called her daughter and discussed the importance of having the informant evaluated by a physician. The daughter agreed that if her mother had anymore chest pain that she would take her to the hospital. The following week, a fourth interview revealed that the informant had not had any further chest pain. Following my reflection on the ethics of the situation, I did not judge this intervention to be a threat to the study and believe I operated according to my nursing code of ethics.

Summary

In this chapter I discussed the philosophical perspectives that guided the study. A qualitative research design, ethnography was described. The six ethnographic techniques used to conduct and produce this ethnography were identified. The steps for data generation and analysis were outlined. Description of the sampling procedures were presented. Rigor was discussed using Lincoln and Guba's (1985) criteria for qualitative research. Ethical and

confidentiality considerations were reviewed. Potential problems and limitations were addressed.

In the next chapter the first step in fieldwork is described: gaining access. The reader is introduced to the informants through the use of quotations and their self descriptions. Demographic information obtained from the women is also reported.

CHAPTER V

GAINING ACCESS

Gaining access to the informants of this study proved to be quite challenging. A photograph that symbolizes the process of gaining access is shown in Figure 6. This process was often a long and rocky journey. Many roads were traveled to obtain access to the informants.

I began the process by contacting colleagues in the selected county. These colleagues were nurses who were native to the county whom I identified as "gatekeepers." Gatekeepers are people who can facilitate opening the gate behind which informants exist. Gatekeepers can control or facilitate researcher access to good informants.

The gatekeepers in my study were nurses who had attended the local community college and had furthered their education by completing Bachelor of Science degrees in nursing through an educational institution approximately 200 miles away. Although I had had a prior relationship with the gatekeepers, gaining their support and trust required several conversations by telephone and in person. The

Figure 6. Photograph of Gaining Access

purpose of the research and the criteria for informants were discussed with each of these women. Four gatekeepers then facilitated the participation of the ten informants. Once committed to the project, the gatekeepers worked very hard at trying to secure participants for the study. They reported feelings of "being overwhelmed" and "let down" when one of the potential informants refused participation in the study.

On the first visit with each potential informant, I was accompanied to the woman's home with the gatekeeper who had identified her. During the first visit I discussed the nature of the study. Each informant was told that participation in the study would require several interviews and construction of a health diary. The women were assured that all information would be held confidential. For each informant who agreed to participate another refused. Those who refused did not appear to have any physical health conditions; they lived alone and near the women who did agree to participate.

Most of the women who refused to participate in the study did so in the traditional manner. Reasons were given which identified overwhelming responsibilities to the family and community. The

gatekeepers confirmed that these excuses were considered valid within this culture. However, I frequently felt as though the women looked upon me as a threat. One potential informant told a gatekeeper, "don't sic her on me" (send her to my home). I learned that once a woman agreed to participate, her word was honor and she would never miss an appointment (field notes).

Only through the influence of the gatekeepers did the women hesitantly agree to participate. All of the women in the study were previously unknown to me. The informants met the criteria for sample selection discussed in Chapter IV. I trusted their participation and I perceived them to be "good informants."

After my initial introduction to each informant, and obtaining her agreement to participate in the study, a time was specified for my first formal interview. Arrangements for subsequent interviews were made at the end of the previous interview. Upon initially interviewing each of the ten older widows who participated in this study, I conveyed verbally that their thoughts, feelings, and way of life were significant. Frequently, the women expressed concerns about being a "good" informant. Such comments as, "I really don't know what I could

tell you that would be important" or "my life is the same everyday, nothing new ever happens" were heard frequently (field notes). The women were assured that I was learning a great deal from our time together. Conversations with colleagues verified that this behavior was not uncommon among informants and should be expected (Magilvy, personal communication, 1989; Quinn, 1988).

The first interview was conducted in the home of the informant. At the beginning of the first interview, a written or verbal consent for the tape recorded interviews, release of daily health diary for a three week period and permission for photographs to be taken were obtained. At this time I offered a "fair return" in exchange for their time in interviewing. Initially, all of the informants said that was "not necessary." However, by the third or fourth interview the women accepted my offer, for example to run an errand or to help them with a specific project.

All of the women in the study were very interested in gathering information about me. I was frequently questioned about my work, family, values and religious preference and had to be careful about the data I disclosed to my informants. The women were very clever in trying to find out if I agreed or

disagreed with their way of life. For example, statements like "I never lock my doors, no siree, I don't believe in it," were followed by a look from the woman to see if I approved of their behavior (field notes). My background as a nurse was found to be helpful in such situations. As a nurse, I had been educated to use therapeutic communications; most of my responses took the form of reframing the statement or nodding to lead the informant further.

Introduction to the Sample

The final sample consisted of ten informants, all Caucasian, older widows who live in and are native to Western County, North Carolina. These Southern Appalachian women identified their ethnic heritage as Scotch-Irish, English, or a combination. The demographic background of my informants were consistent with most women in the county. Their ages ranged from 68 to 90 and they had been widowed from 3 to 26 years. Although a redundancy of categories and domains occurred after interviewing seven informants, I interviewed three additional women to enrich the thick description of the culture and to support ongoing data analysis.

Each informant was coded initially with an identification number 01 through 10 to ensure

confidentiality. The women were then given a fictitious name to humanize the data analysis and description. The name used for the women were: Louise, Reba, Cora Lee, Edna, Myrtle, Mary, Anne, Laura, Lilly, Helen, and Dottie. A short introduction is presented by each informant in her own native language. The language of the Appalachian culture dates back to the Chaucerian and Spencerian period as is often reflected in the actual pronunciation of the words. The language used by each informant gives the reader a flavor of the culture. A glossary was developed from the native language used by the women. Terms were identified, defined, and checked with the informants. The glossary reflects the dialect or native Appalachians and is presented in Appendix E.

Ten Appalachian Women

Louise. Well, I would have never thought in a million years that I would be participating in such a study...and I...probably wouldn't have if my neighbor hadn't ask me to help her out. I'm always willing to help a friend out. My name is Louise and I'm 76 years old. I was married to the town's fire chief for 55 years. I've been a widow now...for 5 years. My husband died of high blood and poor

thing...he never did knowed nothing the last week he lived. After my husband died I spent one night by myself in our trailer and I couldn't stand it so I moved in with my daughter...and I've been here ever since. I went up 'til the seventh grade of schooling and then went to work in a cotton mill. We needed the money. I worked all my life in the cotton mill. I had four children and worked 'til I retired.

Cora Lee. My name is Cora Lee and I have lived on these 150 acres ever since I married. We bought this land for $1200 in 1945...but we didn't have one thousand two hundred dollars. But we some how over the years paid it off. I finished high school--went through the eleventh grade. I married a teacher. But when the war happened he lost his job and worked a milk route for awhile...things got better over the years and he went back to teaching. I'm 76 years old and been a widow for 9 years. My husband died in 1980 of emphysema. I hate to tell you...he smoked...but he couldn't quit. He had emphysema and heart problems and about two weeks before he died the doctor found a spot on his liver...a liver spot...what is it they say people have when they drink?...they have cirrhosis of the liver. But I say my husband didn't drink. The doctor said he didn't have to drink...most likely

cancer. And the doctor didn't find that liver spot until just before he died---maybe two weeks. But he was never a person with a strong constitution, he...I mean I could work circles around him. He was slow and easy going. But he was dedicated to the kids and grandchildren. They had to be here on Sunday to eat dinner. Eating Sunday dinner with the family is tradition, you know. I've worked several jobs over the years. I worked 17 years in a sewing factory and several in a knitting mill. I raised five girls and one boy. I live alone in the house that my husband had built on this 150 acres. My daughter lives just up and over the hill on this ol' dirt road. My favorite past time is doing crafts,...making baskets, crocheting, quilting, caneing chairs, and oh just about anything.

Reba. My name is Reba and I've lived in this county all my life and my parents lived in this county. We mostly farmed. I had two boys, one lives in Florida and the other one lives around here, he's the oldest. He looks after me and I'm thankful for that. I was talking to Mr. Craig yesterday and I told him that I was ninety and as I was walking away I heard him say to Mr. Strong...that I wouldn't have thought she was over seventy-five...so that really gave me a lift. I'm a Presbyterian...but rarely get

out much any more. Occasionally I get to the monthly women's circle at the church. I have heart trouble and that's what my husband died of three years ago. We sold the ol' homeplace and we moved into this apartment some years back. The only work I ever did was work as a telephone operator. I use to know everybody's telephone number and even their dogs name...and practically everything else about them. All the education I ever got was just through high school.

Lil. Lord honey...I was so nervous about talking to you. I'm not use to having visitors except for my kids and grandkids. Let's see...my name is Lilly Mae but folks call me Lil. I'm 82...but the social security place got me as 83...so according to them I'll be 84 in September...but my mama told me I was born in 1906 and it's in the Bible. My oldest child is 64 and my youngest is 44. My youngest is a girl and she is the only one that never married. I had eight children. I never miscarriaged or nothing honey...I carried 'em 'til their time. I've been living here in this trailer behind my daughter's house for four years...ever since my husband died of a stroke. I worked five years in a hosiery mill and I worked two years in the shop (furniture factory) and I worked a little at a

sewing factory doing piece work, but it went out of business. I paid into social security and I drawed a little after I got sixty two...I drawed $40.00 a month. My husband waited so long before he signed up and I signed up on him and I got more. He worked all his life in furniture. I never had to pay no bills my husband always gave me the money and I paid them. We gave our house to our daughter because she looked after us. I finished the sixth grade and my husband only went to the third grade and did you know honey we only went to school three months back then...when I was a young girl.

Edna. I'm Edna...and I live here with my son. I went to Appalachian State University to become a school teacher and taught at a two teacher school here in the county. I quit teaching after the children started coming. I have 11 children and I've seen them all marry and have kids. That's a pretty feat at my age. I'm 90 years old. My husband has been dead since 1966 and it fell my lot to go stay with Aunt Nell. I lived with her until she died and then moved in up here with my son. After my husband died we divided the homeplace and land amongst the children and they each own land up here. My husband farmed and then did some survey work. He surveyed off the graveyard up there at the Baptist church and

they wanted to pay him but he said no just give me them two plots for me and my wife. So he is buried there and I guess that's where I'll go too. I still can vegetables and make quilts. But I'm not too good at remembering to take my medicine...usually my son puts it out on the table or one of the kids. But besides that I still have a good mind.

Laura. My name is Laura and I moved into town 3 years after my husband died. I've been a widow for 16 years. We lived on a farm and he worked and owned a service station. Now the boys run it. I have four children...two boys and two girls. They all live around here except the one girl that lives up North. I'm 72 years old and I don't dress every day...I like to just wear ol' clothes around the house. My favorite past time is reading. I read at least two books a week and I do hand work. My life is pretty nothing. I like to be by myself...I stay home a lot because I love to watch a couple of the stories (soap operas) ...if I'm knitting I'll watch every one of those darn stories. I do a lot of yard work. I've always done my whole yard until this past summer and then I had to have some help. I'm into my family...it's wonderful.

Helen. I live up here on the hill. The same house my husband built when we got married. My name is Helen. I'm 68 years old and been a widow for 17 years. My husband worked in an elected law enforcement position. I taught 32 years at the middle school...the fourth grade. My husband use to say I had the brains and he had the looks. I have five children and six grandchildren. My youngest son still lives here with me. He works at the local hardware store as one of the managers. I'm very active with the Methodist church, senior citizens, and several volunteer organizations. My sister lives next door and one of my daughters lives behind me. I love to cook. I do a lot of canning every summer. I also travel occasionally with the local tour group...and some people would say I'm adventurous. Next month I'm going on a four day tour that is a surprise tour. You pay your money and you don't know where your going until you get there. I'm really looking forward to that.

Myrtle. My name is Myrtle and I'm 75 years old. My husband and I lived in this trailer for many a year. He's been dead 17 years. He died from viral meningitis and he was a diabetic but we didn't know it at the time. Well he was sick for about six months. But he didn't give up, he kept going and

when he got really ill we took him to the hospital on a Sunday night and he died on the following Monday night. After my husband died one of my sons came over after his wife left him and he brought my granddaughter for me to raise. No I never had to live alone after my husband died. I always had someone in the house. I started working after my kids were grown and the two grandchildren I was keeping were in school. And I was in my 50s before I ever started working. I worked in the cotton mill about seven years and then it got to be so hard getting my granddaughter to stay with anyone that I took to babysittin'. I did babysittin' for twelve years and I kept fourteen at one time the one's in the crib to those toddlin' around. Now I live in this trailer up above my daughter's and the granddaughter and grandson I raised are over here most of the time. I do some sewing from time to time and sell it or make cushions. I watch a lot of TV.

Anne. My name is Anne and I'm 80 years old. I've been a widow for 26 years. I taught school 43 years and married when I was 30 years old. We didn't have any children and I'm sure we missed a lot but...my life has always been full. I was the oldest one in my family and took on the majority of the responsibility. I went to a two year girls college

and then I had to send my other brothers and sisters through school. As soon one would get through school then we would all start paying for the next one to go. I lived out in the country until my husband died and then I moved into town, it was closer to things and to my job. I rented the house across the street for a while and then when this house went up for sale I bought it. I've lived here for 26 years and my best friend moved in up the street from me and my other neighbors and I went to school together and the other lady across the street...well we worked together in a department store when I was in school. And the Harris's, well I taught all their children...so I moved into an area were I knew just about everyone. It was the right decision to move but I hesitated about buying this house because it didn't have a basement. I moved over here on my 25th wedding anniversary by myself. I go to the church where my mother's mother organized the church. It has been here for 200 years and the property that church is on, my mother's family owned. My roots are so deep...some of these new people that have moved in are good people but I know that they don't feel the same as those of us that have been here all our lives.

Dottie. I graduated from high school in 1927 so I'm 78 years old. I went to business school for one year. My name is Dottie and I worked in the Chamber of Commerce and the clerk of court office until the 1960s. You see my husband had a light stoke and I had to quit work to drive him on his route. He was a pharmaceutical salesman. Well, he died in 1977. I have lived in this house since 1952...back then there were hardly any houses out here. I'm very involved with my church and of course the bridge club. I still drive but I don't drive at night. I can drive at night but if I plan to go to church or the funeral home I look for a ride. Now for instance tonight...we have the women's society meeting at the church and there is this girl in my circle that has been real good all this past year and she calls me every time to see if I have a ride and it has worked out real well. You see, I don't have any children and my closest family is aunts, uncles, nephews, and nieces.

Summary. Each woman is unique, but common patterns emerged from their stories. Each of these womens' stories will unfold as the domains and categories are discussed. The language and stories of the women are documented throughout the text to

help the reader discover the culture of elderly Southern Appalachian women.

Demographics

During the first interview, a Demographic Form (See Appendix A) was completed on each informant. I explained that this information would be used for descriptive purposes. A summary of this information is presented in Tables IV and V. Each table lists the informants by a fictitious name.

Table IV includes age, years widowed, level of education and number of children. The ages of the women ranged from 68 to 90 (mean age=78.7). The length of time of widowhood ranged between 3 to 26 years (mean=13.2). The majority of the women had been a widow more than 15 years. Level of education among the women ranged from 6th grade to 4 years of college education. Three women had an educational level between sixth and seventh grade. Three had completed high school (11th grade). Three women had attended one or two years of community college and one woman had completed four years of college.

Eight of the women had children. These eight women stated that the majority of their children remained in the county. The two women who did not have children stated that they had brothers, sisters,

nieces and nephews, as well as other relatives living in the area. Analysis of health diaries supported the importance of extended family in the lives of these women.

Table V includes occupation and the ethnicity of the women. Only four of these women stated that they had worked all their lives: Louise, Helen, Anne, and Dottie. The other six women had spent the

Table IV

Demographics of the Informants

Fictitious Name	Age	Number of Years Widowed	Education	Number of Children
Louise	76	5	7th Grade	4
Cora Lee	76	9	11th Grade	6
Reba	90	3	11th Grade	2
Lil	83	4	6th Grade	8
Edna	90	23	1 yr College	11
Laura	72	16	11th Grade	4
Helen	68	17	4 yrs College	5
Myrtle	75	17	7th Grade	6
Anne	80	26	2 yrs College	0
Dottie	78	17	1 yr College	0
Mean = 78.7		Mean = 13.2		

Table V

Demographics of the Informants

Fictitious Name	Age	Occupation	Ethnicity
Louise	76	Cotton Mill	Irish
Cora Lee	76	Factory	English
Reba	90	Telephone Operator	Irish
Lil	83	Furniture Shop	Scotch/Irish
Edna	90	Teacher	Irish/English
Laura	72	Homemaker	Scotch/Irish
Helen	68	Teacher	Scotch/Irish
Myrtle	75	Cotton Mill	Scotch/Irish
Anne	80	Teacher	Scotch/Irish
Dottie	78	County Office	Irish

majority of their lives raising children and had accepted employment after their children were grown. Only one woman did not hold a full time job. The Appalachian mountains are predominantly Scotch-Irish, however other European heritages can be found such as English, French and Dutch.

Summary

In summary, gaining access was a difficult and time consuming endeavor. Finding key informants willing to share their thoughts and time with a researcher can only happen with the help and trust of gatekeepers. An introduction to the informants provided the reader with a sensitive understanding of the uniqueness found among the individuals. The demographic data were summarized on Tables IV and V. These profiles of the women presented in this chapter can give only a glimpse of their way of life. The lived experience of the women unfolds to the reader in the presentation of the findings, which are described in the next chapter, Chapter VI.

CHAPTER VI

PRESENTATION OF FINDINGS

The purpose of this ethnographic research study was to facilitate discovery and description of the health experience from the perspective of elderly Southern Appalachian widows. The description of these perspectives is facilitated by illustrations of informant quotations and stories in their native Appalachian language.

With ethnography one can elicit description of the lifeways and experiences of being part of a culture, in this case Southern Appalachia. The description uncovered in this study can be understood as a blend of cultures and subcultures: rural life, aging, women, and Appalachia. In this chapter I describe the lived experience of Appalachian older widows viewed in the context of these blended cultures. The results of domain analysis, category analysis, analysis of threads, and finally theme analysis are woven into this description.

Domain Analysis

The first level of analysis began with the emergence of domains. Four domains were derived from the data for indepth analysis. The domains of widowhood, daily life, morality, and health are labeled in the language of the women:

1. NO LONGER A COUPLE,
2. EXISTING DAY TO DAY,
3. LIVING THE RIGHT WAY,
4. STAYING HEALTHY.

Each woman's perception of health was unique but these domains continuously emerged as the women described their life and health. The reader will find that the domains have aspects which overlap. The domains are therefore not mutually exclusive.

During the second level of analysis I focused on each domain separately. This indepth study allowed categories to be discovered within each domain. Categories were identified to explain the internal organization of the domain as reflected in the data.

In the next level of analysis I examined the different ways in which each category was described by the informants. In addition, I validated with the informants their experiences as congruent or incongruent with the categories of each domain. The

four domains are discussed in detail in the following sections.

NO LONGER A COUPLE

During analysis of the domain, NO LONGER A COUPLE, four categories were identified: coming back, enduring, being prepared and constant contact. I analyzed each of these catagories and found recurrent threads that occurred in the lives of the women. NO LONGER A COUPLE portrays the experience of widowhood.

Coming Back

The women talked about the first year of their husbands' deaths as a time when they often thought about their husbands returning. Whether habit or an unconscious process existed, the women experienced thoughts of their husbands returning. The women had to reinforce in their minds that their husbands were not coming back. Cora Lee and Dottie had the following thoughts:

> Cora Lee: The thought started in my head that he was coming back, and then I'd say no, he's not coming back.

> Dottie: When you lose your husband there are days that it is so hard to believe that he isn't coming back. When you're set into a routine you just expect him to come through the door.

Expressions of coming back took three forms: dreams, reminders, and mementos. The tacit presence of their husbands existed in the lives of the

informants through these forms conveying a metaphysical connection. The womens' lives contained symbols that reminded them of their husband's existence. This connection weathers the nonexistence of the physical. The women acknowledged this tacit presence as an authentic reality which must be integrated into being in the world. Dreams, reminders and mementos were the bridge for a metaphysical reality, according to my informants.

Dreams were described as occurring in two ways: daydreaming and nightdreaming. As the informants reflected, they realized that the majority of day-dreaming took place within the first year after their husbands' deaths. While most implied that they still continued to have nighttime dreams, the daydreaming emerged as a disruptive pattern of daily life. Difficulty surrounded the sharing of daydreaming. The women did not want to think that day dreaming was synonymous with "going crazy." Daydreaming about their husband was when they had moments of "being here but not here." "Being here" referred to having a consciousness of being in the real world (field notes). Both Helen and Cora Lee can recall precisely the experience of daydreaming.

> Helen: Once, while I was teaching, I actually thought I saw him coming down the hallway. He use to come by around noon and tell me that he had to run over to another county and that he

> would be home late. When I realized that I must of been dreaming I just bawled. I bawled in front of a class full of fourth grade students.

Tension existed as the women tried to deal with the real and unreal experiences surrounding their husbands' deaths. Helen used the word "thought" as indicating the experience happened in her imagination. Cora Lee discussed her experience with daydreaming.

> Cora Lee: It would be early in the morning and I would be tired and sleepy and I couldn't get my husband off my mind enough to get everything else straight. Some mornings I would drive to work, get there and not remember how I got there. I guess I was just dreaming. And then there were mornings that I would get in my car and not even know where I was going.

Daydreaming was a painful event. The pain occurred when the women tried to discriminate the real from the unreal world. Paradoxically, daydreaming functioned as a method of escape and then as a method of having to face the death of their husbands. The dialectical stance taken in daydreaming functioned as a coping strategy in their lives.

The women reported that although many years had passed since their husbands' deaths, they still had nighttime dreams about their husbands. The women did not feel the dreams were either disturbing or helpful; they just happened. Helen, Edna, and Myrtle discussed nighttime dreaming.

Helen: I still dream about him. Just the other night I dreamed that I was coming into the kitchen and that he was standing at the refrigerator eating some fresh vegetables from the garden.

Edna: I think I dream more about my husband when it gets close to his birthday or our anniversary.

Myrtle: One night, a cold night, I was in bed sound asleep and my feet were cold. Well, I moved my feet over to warm them up against my husband like I use to do. It felt so warm and good. I suddenly woke up and realized that I must have been dreaming because he wasn't in bed with me. He was dead. It was the strangest thing.

Initially, after their husbands' deaths, the women strived for harmonious reconciliations of their dreaming. Each of the women came to accept this metaphysical phenomenon as a natural aspect of widowhood. They told stories in a matter-of-fact manner indicating their acceptance.

The women discussed different ways in which the memories of their husbands emerged on a day to day basis. Reminders kept their husbands' presence in their lives. Reminders are items that awaken one's memory. Three reminders were identified: mail, home and grave. Several of the women discussed mail coming to the house in their husbands' names. Cora Lee in a comical tone of voice talked about her experience.

Cora Lee: I guess one of the most annoying things was that the light bill continued to come in my husband's name for several years and the University still sends junk mail. My husband

> made a little contribution, I think $25 one time and let me tell you if it had been $25,000, they wouldn't have sent him any more mail. The first time they sent me something that he was supposed to send back, I just wrote on there, he has been deceased since 1980 and I cannot get this mail stopped. And I believe it has slowed down but not completely stopped. I got some tickets to a football game the other day in his name.

Cora Lee's experience with the mail was portrayed as a comical expression of life. Typical of the culture was reflecting upon the humorous aspect of their loss.

Myrtle shared her story of a similar experience. The difference in Myrtle's story is that she telephoned and even showed up in person trying to be recognized as the person who was actually using the company's service.

> Myrtle: I use the mail order catalog a lot, and naturally when my husband was alive, we always ordered everything in his name. Well, it seems that when you place an order you have to give your telephone number for pick up purposes. Anyhows, it took me five years to get the company to finally change that telephone number to my name, so that when I go to pick up something at the catalog area I can ask for it in my name. You wouldn't believe the number of times I tried getting that changed.

Home is a place that merges a husband and wife in a single dimension. This dimension takes on qualities of both individuals. Aspects of the house stand as reminders for the people who live there. Cora Lee talked about her feelings when she views the kitchen. The kitchen takes on a new meaning with the

death of her husband. It is now a nostalgic reminder of the past.

> Cora Lee: Right after my husband died I just bawled all the time and didn't even want to go into the kitchen because I was so use to seeing him sit at the kitchen table. I didn't want to cook or eat anything.

Entering the kitchen meant facing reality--the reality that her husband was dead. While visiting Cora Lee, we ate lunch in the kitchen as well as on the porch on many occasions. A different mood seemed to be present when eating in the kitchen. The chair that her husband sat in remained empty throughout our meal. Even after nine years of widowhood, Cora Lee can sense the presence of her husband in that room (field notes).

Visiting the grave is a ritual that each woman identified as important. Keeping the grave clean and providing new flowers on a regular basis were identified values. A belief was expressed that all people were suppose to care for the grave out of respect for the deceased. Graves that were unkept indicated that the deceased has no family living in the area, or that all family members were dead, or implied that family members were disrespectful. Visiting the graves was a reminder of the presence of their husbands as well as an expected behavior of the culture (field notes). In one respect the women were

continuing to care for their husbands. Louise and Anne talked about time spent going to the grave site.

> Louise: My daughter and I went to the graveyard this morning and she cleaned off the head stone (referring to her husband's). We sometimes just go over and drive around and look at all the graves. We can see if anyone new has been buried and see those who have already died.
>
> Anne: I went downtown today and bought a fresh wreath to put on my husband's grave. I got some red ribbon from Woolworth's and made a big bow. It really looks nice on the grave. Since I have no children, I'm the only one that puts anything on it. But, you know that people always try to get something on right after Thanksgiving.

An understanding exists within the culture as to the appropriate way to display flowers on the grave, the time of the year to replace flowers, and the ritual of caring for the grave site. The grave sites are no longer the family graveyards so often written about in the history books. The graves are at local churches or at large company owned cemeteries. Only on rare occasions does one see a family cemetery near a farm house in this county.

A memento is a token or keepsake that one collects to serve as a token to appreciate someone. For these women the mementos were cherished as extensions of a person, their husband. The women discussed mementos that they had kept in their lives to keep their husbands' presence forever with them. Sometimes mementos were left out to be viewed or tucked away as a keepsake. Cora Lee, Anne, and Reba

had items in their lives that represented their husbands' presence.

> Cora Lee: I saved only one pair of pants, a checked pair, those were his favorite. Somehow I just couldn't give them up. I still have them and it has been 9 years. After my husband died I got rid of his lounge chair. I put it down in the basement. I didn't want to look at it because it reminded me of him.

Cora Lee had to give up the physical presence of her husband but not the physical tokens of his existence. I believe having the physical tokens gave her a sense of power over the experience of widowhood. She had made the decision about these mementos.

Anne found comfort in various articles which called to mind her husband. She shared many stories of precious artifacts, such as the story about the grandfather clock which stood in the living room.

> Anne: Do you see that clock over there, well my husband had a man who worked in the shop (furniture factory) make it from looking at a picture. He gave that to me as a gift. It reminds me of him.

Reba discussed furniture within her home as belonging to her husband. The notion of having a designated chair for both spouses was evident in the majority of the womens' homes.

> Reba: That's my husband's chair and this one is mine. I never sit in his chair. It's odd how you think that it still belongs to him.

The category of coming back refers to the metaphysical experience of one's husband lingering in

this world. The dreams, reminders, and mementos create the context from which a woman experiences her husband coming back to her in this world. He continues to exist as a pattern in her life. The woman deconstructs the physical reality and perceives the world in a way which includes the tacit presence of her husband.

Enduring

Enduring is the second category identified in the widowhood experience. Enduring means getting through an experience. To endure NO LONGER A COUPLE, several threads are important: work, inner strength and daily strife.

Work was a way of enduring and provided a focus in life. Cora Lee stayed home by herself for three months until her daughter influenced her decision to work. For a short time, the job filled the emptiness she felt. This form of distraction was only a quick fix until she realized that she must attend to her husband's death. The following is Cora Lee's understanding of how work was woven into her coping with widowhood.

> Cora Lee: After about three months one of my daughters that lives west of here called and said there was job in a knitting mill up where she lives and asked me to come work during the week and stay with her. She said I could come home on the weekends. So I did. I think I worked 6 weeks. I could work all day, and I enjoyed it

> and it was a nice place to work. Then about 3 month later it was hot, it was afternoon, I said, I'm going home, and I'm not coming back up here no more. I didn't really like staying there all week with my daughter. I felt like I was imposing on her. So I went home and worked around the house and on my garden.

Work was a distraction for Myrtle as she faced the death of her husband. Work filled her time during the day, but as night set in she had to accept the inevitable darkness of loneliness. Myrtle talked about being alone in a dark room as "the worst of times." A time when the reality of a life without the physical presence of her husband emerged. Myrtle told her story.

> Myrtle: I was working and had a granddaughter to raise, so I didn't have time to set down and grieve all the time like some women. The worse time for me was at night. At night is when you got time to go to bed and study, (think) that was the worst. There wasn't no one to talk to or nothing...it was hard. But having family responsibilities helped me get through it.

Some women discussed the presence of an inner strength that helped them survive widowhood. Inner strength was a power within that was fostered by the power of God and the family. God and family provided a spirit of love and support for the women. Laura, and Lil reflected on their inner strength.

> Laura: What saved me after my husband died was my four children and grandchildren being born. And there is just a power or strength that gets you through it all.

> Lil: There is just a power that will take care of you...and help you to get over the hard

> part...if you will let it. You can't give in to depression. To keep busy is the main thing. Do for other people and always think of other people that are worse than you. And you can always do that. There will be loneliness, depression and days when you just don't know what to do.

Inner strength was nurtured by friends and the church. Facing the loss of their husband with a strong support system was a lifeline for endurance. Anne voiced the importance of friends and church.

> Anne: I just don't see how people do it (endure widowhood) without a church to depend on. I had a good church, a good minister and good friends that helped me get through it.

The daily strife of enduring was centered around loneliness and the path of overcoming the inherent suffering that is experienced with the loss of someone you love. Loneliness was understood to be multidimensional. Edna, Laura and Myrtle talked about loneliness as a depression emerging from solitude.

> Edna: After my husband died I tried staying alone, I even rented out one bedroom to boarders, but I was so lonely. My son built me a house next to his so now I'm not as lonely.

> Laura: Back when I was in school we jumped rope at recess and we entertained ourselves. I think that's why sometimes I don't mind being alone. I can always entertain myself.

> Myrtle: After my husband died, I never stayed alone. My son moved in with his daughter and I had family responsibilities.

For Reba, loneliness can be viewed from another angle, that of emptiness. She felt barren.

Life was no longer rich and full. A vital force had been drained from her. Reba found difficulty in trying to describe an experience for which perhaps there were no words.

> Reba: It's lonely when you've shared all your life and then there is no one to share with. There is an emptiness. Its a hard thing to describe. We lived together 67 years. And that's sorta like takin' a leg or a arm. You'd think that you would get to where you don't miss 'em, but you don't. Oh, I cry about it yet, sometimes. There aren't words that can explain it I don't think. You have to feel it. And I never realized what it would be until it happened. I fill my loneliness with watching TV and listening to music.

A third dimension of loneliness was the loneliness one experienced in a society arranged for couples. Look around, when you go into a restaurant there is not a table for one but for two. Cars do not have one front seat but two. These things do not occur to you until you are companionless. Couples represented a pattern of connectedness in the world. This dimension of loneliness was described by Anne, Dottie, and Reba.

> Anne: There is loneliness even yet and it's been 26 years. There is a kind of loneliness that you won't understand until it happens to you. Your whole life changes. Your social life changes because women and couples don't do things together and they try their dead level best to bring you in...but gradually it doesn't work and you have to find yourselves a new set of friends and it will be women instead of couples.

The women that Anne referred to were other widowed women. An interconnected alliance of sisterhood

evolved for which widows were the members. A spirit like force resided among the web of widows.

Forging beyond the reality of couples was a new journey for the women. Dottie and Reba discussed the feelings of loneliness of this journey.

> Dottie: I've always dreaded to go where there is couples...you know...you can be lonelier in a crowd than just sittin talkin to someone at home.

> Reba: When you're alone like that. Where you would be invited as a couple. You're not invited as a single, cause you really don't want to be, but still there's that, I don't know, loneliness there. Loneliness is the part that hurts.

As the days pass a vital energy must surface within each woman to deal with the worst days. Anne talked about loss after loss she experienced. An old saying that "bad things happen in three's" was an episode in Anne's life.

> Anne: I had a pretty hard time of things. You see my husband died in March, and then mama died in November and then my dad died the following June. But of course you've always heard things come in three's. (This is an "old-time saying" that when disaster strikes expect it to hit at least three hard blows before your bad luck will pass). This had to be the loneliest time of my life. I had days when I wonder what would be next.

The women courageously continued on their journey knowing that the worst of times will pass away. Laura described widowhood.

> Laura: It will be one of the hardest things beside losing a child that one ever goes through. It is just phase after phase after phase that you go through. And the best way to do it is to remember that this too will pass away. The worst

> days, the saddest days of it, the most horrifying days, they will pass and everyday will get better. And maybe you will start a new project, that's what I did. I did all kinds of things. You'll be doing fine one day and then the next day you just want to throw it (the new project) because you say I'm not interested in this. What good is it? But you have to, you just have to make yourself do all these things and know that it is going to get better, that is the main thing, to know that it is going to get better.

As each day, week, month passed, healing took place. As Laura attested, life gets better. The women endured with a courage that could only be understood by experience. Words can at best mirror their experience of endurance. In their language, enduring was a time of "getting through it."

Preparing

The women talked about how other women should prepare for widowhood. Preparing was the third category in the domain of NO LONGER A COUPLE. Different ways to prepare one's self focused around learning to manage the traditional roles of the husband. Subjects such as money, taxes, cars, banking and gaining a level of independence were discussed. Laura and Anne shared their advice.

> Laura: Everybody should prepare themselves for widowhood. Don't be like me. I didn't a bit know how much money we had. Or what you do when you pay taxes or anything. Every month my husband gave me money to pay monthly bills and to pay the groceries and if I ran short, all I had to do was tell him. Law, he bought the cars and when he died I was lost. The worst part was the bank being the executor of the will and the money

> he had put in a trust. It was a bad thing and my husband should never had done me like that. The bank just eats you up and charges you so much for signing just one check. Don't ever let your husband do that. Don't let your husband let the bank be your trustee. If you do the bank will take everything you got. We have fought it in court and tried everything we can to get it out of their hands, but it is hopeless.
>
> Anne: You need to be as independent as possible while you're married. I don't mean to be an ornery woman I mean to seek knowledge about your affairs. This helps you survive widowhood.

Preparing for widowhood means being unconventional during one's married life. Seeking the knowledge of which men are the guardian could be viewed as an extraordinary task for elderly women in this region. How to inspire other women to seek such knowledge remains perplexing.

Constant Contact

Constant contact with family, friends and the church have made widowhood much easier. A support system was found to be one of the most important ways of dealing with loneliness. Anne and Reba discussed the important role their family played in dealing with widowhood.

> Anne: And keep close contact with your family, because if you are left alone without children like I was you need that closeness that you can only get with a family. Women who don't have a closeness with their family are lost. In this county the widowed women keep a constant contact with their family...and it's one of our major topics of conversation. If you don't have that close contact with your family I don't know if one could ever learn to live alone. No matter

> how deep in grief I got my family was there for me and they still are there to help me.
> Reba: There's a lot to life even without your partner. There are the children and also the grandchildren and both of my boys have been so good to me.

Being connected with one's family through constant contact is the elemental root in the life of the women. Knowledge that one's family is everlasting provides a context from which the women walk the path of widowhood.

Summary of NO LONGER A COUPLE

The domain of widowhood had four categories: coming back, enduring, preparing, and constant contact. Recurrent threads were woven into an understanding of each category. The threads reflected the pattern of each category. Table VI summarizes the categories and recurrent threads of the domain NO LONGER A COUPLE.

The domain, NO LONGER A COUPLE, is captured in a poem that Reba had clipped from a newspaper.

> Until that time....the golden sun has disappeared, sky is dull and gray... and I am lonely in my heart because you went away. Not just around the corner or a measurement of miles but to the vast eternity beyond our tears and smiles. I miss you more each moment love, and oh how I long for you, then while my life goes on, there is nothing I can do. Tomorrow is an empty word and if I say goodnight, it seems to have a hollow sound that switches off the light. And I can only wait and pray until the time when we can look upon each other in the vast eternity.
>
> Author & Source Unknown

Table VI

Analysis of Domain: NO LONGER A COUPLE

Categories	Recurrent Threads	
Coming Back	dreams	daydreaming
		nightdreaming
	reminders	mail
		home
		grave
	mementos	personal
		household
Enduring	work	job
		home
		garden
	inner strength	within
		God
	daily strife	phases
		loneliness
Preparing	money	amount
		management
	taxes	amount
		management
	cars	purchase
		service
	independence	
Constant Contact	family	
	friends	
	church	

EXISTING DAY TO DAY

The domain of EXISTING DAY TO DAY uncovers the daily life of the women. This domain includes three categories: planning, family and activities. Each category is described in relation to the recurrent threads which provide a pattern.

Day to day life was very important to these women. In some ways existing day to day was ritualistic. During the days I spent with these women the initial conversation would center around what had taken place during the week. In their health diaries I asked each woman to respond to the question "What things did you do today to stay healthy?" Analysis of their responses to this question elicited three categories that depicted daily life: planning, family and activities.

Planning

To exist day to day, these elderly widows believed that planning and organization were essential. Planning can be understood from a daily and a futuristic perspective. The women felt comfort in knowing what the next day would be like (field notes). Dottie talked about two ways of planning her day: laying out her clothes the night before and using a list to organize herself.

> Dottie: I didn't start planning my days until about two years ago. I told somebody that I wasted more time and she told me that she planned what she was going to do the next day before she went to bed. So I started doing that. I set my clothes out for the next day and I write down the list of things I have to do. It really makes a difference. And there are days that I think I don't have anything to do but when I started thinking about who I hadn't visited in a while, then it comes to me that I do have something to do.

A sense of purpose was found when the day was planned. But planning did not mean that the women had to accomplish each item on the list of things to do. Anne acknowledged this belief.

> Anne: I get up every morning, planned with what I want to do and some mornings I don't get it all done and some I do...but I would be very unhappy if I got up mornings not knowing what I was going to do and living from one day to another, that would be miserable life.

Planning was not just undertaken on a day to day basis. The women talked about planning ahead for the future. These plans focused on setting up future conveniences. Being prepared for anything that life might throw in their direction was important emotionally. Thoughts of next month or next year guided the women in their plans. These plans were considered a way to maintain their health. The women wanted to prevent distress or depression that might occur if they had not planned ahead. For example Edna was not going to be inconvenienced by cold weather or a possible power outage during the winter

months. A sense of security emerged within the women by knowing that they had planned ahead. Edna shared her message on this issue.

> Edna: I got a little heating stove in my bedroom, you know a wood stove. My son made me a wood pile in the back but I usually go out and get my own firewood. I can cook on it if the power goes out.

The women shared many stories of superstitions which prepared one for the future or identified a sign which could indicate the future. The women recounted many stories that indicated what one should or shouldn't do to prevent things from happening in the future. One may say that these accounts are superstitious, coincidences, or truths depending upon the reader's world view. Within this study, these accounts are considered a different way of thinking about the future. Laura gave several examples of superstition.

> Laura: Well you have to be careful about not marking your baby. I mean you can't think or do something that might mark your child. Like this one woman saw a child with a cleft lip and cleft palate and she must have marked her child because she had a child with a cleft palate. There was a child in the neighborhood that had a strawberry mark on her face and her mother said she marked her child because she wanted strawberries and it was February and she couldn't get them. They were out of season.

Many stories of death omens were described by the women in this study. The beliefs were usually accompanied by a story which supported the belief.

For example, Myrtle and Lil described the nature of an animal's ability to predict death.

> Myrtle: You can tell when there is goin' to be a death in the family. That's right. You can. My sister...well, before her husband died and they live out in the country...they have this front porch and whippoorwills came up out of the fields and cried all night long. Yes it was a sign.
>
> Lil: Dogs howling at night in the neighborhood is a sure sign that there is going to be a death. But I do remember once when I was younger that a lady that lived a piece down from us lost her husband...and it was a rooster that came up on the porch and looked in the front door turned and looked out. That's a sign that death is coming. Lord, honey, those animals can just sense death.

These are just samples of superstitions that emerged as the women talked about life in general. The superstitions represented a way of understanding the future or explaining the unknown or undesirable.

Anticipation of the future required that the women think about a time of total dependency. These thoughts of the future were sad but accepted. The women talked about their concern of being a burden to their families. They suggested that all women should discuss openly with their families about planning for care in the future. Anne, who is 80 years old, felt that as she aged she should think about the day when she would need help to live.

> Anne: When I get to where I can't do for myself I'll make arrangements for a retirement center or nursing home. I don't mind thinking about that. I hate to give up my house and my things. Things that I have had all my life. I don't worry about it though, I just want to grow old gracefully.

Lil approaches the future in a pragmatic manner; plans should be made. Her perspective identified children as having that responsibility.

> Lil: People my age should make some arrangements about themselves, or if you have children...your children should. I'm looking into the future and when you're 83 you know that by the law of averages that you are not going to be around here long...and I don't even worry about growing older.

The future of the women may represent a burden to their children. Laura found this thought troublesome. A loss of health was interfaced with thoughts of being a burden.

> Laura: As you get old, what you worry about the most is being a burden. But you are so afraid that you are going to be. You know, that as you get older that you are going to lose your health and nobody wants to be a burden. You don't want to insult yourself by loosing your mind. I'm afraid of getting old. I have a horror of getting five years older. I hope I can gracefully bow out if I need to go to a rest home...and not be a burden anymore than I can be. That's one way I look at old age. But the main thing that bothers me about growing old is health. I hope I don't get mean and hateful and just an old hag. I want to keep my young ideas. I hope I can do that.

Growing old meant planning for each day and the future. Planning included considering one's health. As Laura so nicely stated, "the main thing is health." Aging can be a wonderful experience but with this experience comes the knowledge that one day health may not be present. One aspect of staying healthy for Laura was keeping young ideas. For

example, Laura stated, "I understand my grandchildren and enjoy doing some of the activities they like" (field notes). Laura as well as the other women were not closed minded, if anything they were the most up to date women I had ever met. They were insightful and reflective on many issues.

Activities

Activities is the second category of EXISTING DAY TO DAY. Many activities were discussed in the health diaries and during interviews. The women reported watching TV, visiting neighbors, doing crafts or projects, and community work as regular activities in their lives. For women such as Louise and Lil, who do not drive, watching TV was an important part of their day. Game shows and "the stories," (soap operas) were among the major attractions.

> Louise: I guess I sit in this chair the biggest part of the day. I watch TV most of the day. I enjoy the Price is Right and baseball games.
>
> Lil: Oh lord yes, I watch a lot of TV. I just watch channel 3. That's the channel with all my soap operas. I have to watch TV because from this here trailer you can't see the road. So you don't have much of a choice.

The television was viewed by the women to be a link to the rest of the world. The women spoke of the embarrassment that would be occur if they did not keep up with the news. Anne said, "Oh it would just

be awful to go visit someone and them mention something in the news and I not have an idea about it" (field notes).

Most of the women had a hobby which occupied a good deal of their time. These hobbies were viewed as healthy behaviors, stimulating both body and mind. Cora Lee worked for a craft store on consignment. She was very artistic and could do everything from make baskets to cane chairs. During the months that I participated in her life, she was very generous in teaching her crafts to me (field notes). She told me that she felt a tremendous sense of peace while working on her projects.

Edna was usually involved in cutting squares or doing some form of quilting when I visited. An example of these quilts are shown in Figure 7. She talked about quilting parties as a way of getting the work accomplished on the quilt and having fun at the same time by being able to socialize. She said the custom was that whoever did the inviting would prepare food and drinks. Since she did not drive, a ride was provided by the person holding the get together. An invitation would be extended through a phone call. A person might say, "let's do some quiltin' tonight?" Edna shared her thoughts with me about her handiwork.

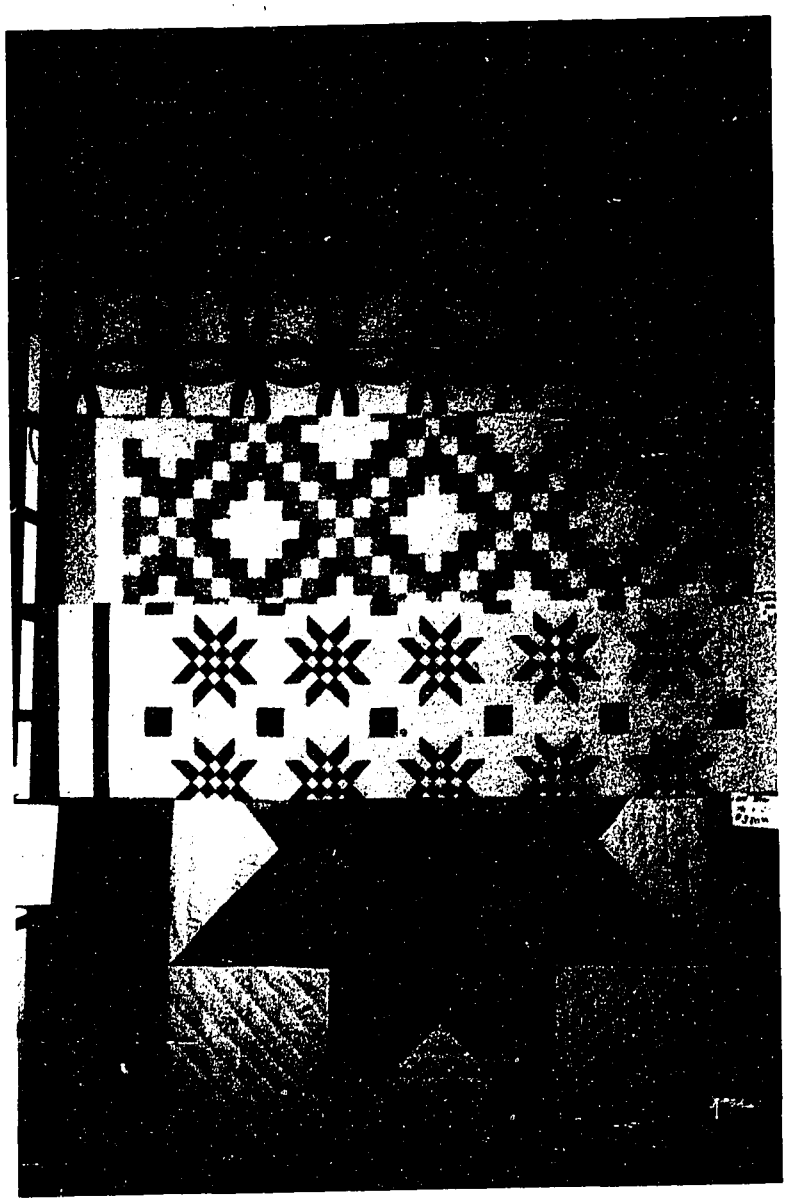

Figure 7. Photograph of Quilts

> Edna: I can always find things to do in my house like I do a lot of crocheting work. I crocheted this cover for my family Bible. I make quilts too. I've been making quilts every year ever since I can remember. I piece the pieces on the machine and then put'em in a frame and quilt em. I put four chairs together to sit the frame on but some folks have hooks in the ceiling that they hang the frame from. Usually several of us will come together and quilt in the evening. Now my frames were my mother's and I don't know where you would get them now a days. It takes about three days of my spare time to get one quilted. Different people in the community know that I quilt so they just drop off left over material from their sewing work for me to use. So I always have plenty of material.

Most of the women talked about visiting neighbors on a routine basis. Visiting was consistently identified as a health behavior. During participant observation and conversations with Anne, I found that visiting was scheduled into daily activities. She felt that on days when she thought she had nothing to do, those were the days she would make her rounds in the community to visit (field notes). An importance was placed on keeping up to date on the happenings of other families in the community.

Laura and Anne lived on the same street and both talked about their excitement with a new baby in the neighborhood. Holidays, births, birthdays, and sickness were reasons for making a visit.

> Laura: My neighbor had a baby and I ran across the street yesterday to visit. They are so happy. You just don't see happiness like that much these days. They are the happiest couple I

> think I have ever seen. I got the baby one of those hallmark Christmas balls that says Baby's first christmas.

Events in the community kept the women active. The majority of community activities were supported by the women in the county. Occasionally events in the community were more important than visiting.

> Laura: We are having a good program at church so I'm not going to the neighborhood party. I'm chairman of the pulpit committee. So I need to be at this program and the neighborhood party was planned after I had decided I was going to the church. Then Monday we are having a luncheon at Joyce's. And this Sunday I'm going to an open house at a neighbors.

The recurrent threads of the activities in the lives of the women formed a multicolored quilt. Each patch gives the reader one of many dimensions in the daily life of the women.

Family

Existing day to day would not be complete without the family. The lives of the women were tightly woven with their families. Not a day went by that these women were not in contact with at least one family member and it was usually more than one member of the family.

The family can be viewed as interdependent. The women were dependent on the family and the families were dependent on the women for certain

aspects of their lives. For example, on each of my seven visits with Myrtle one of her sons and usually one or two of her grandchildren would stop by to visit. There was always at least one telephone call that occurred during the visit, usually a family member inquiring how she was and asking for advice. In her diary, Myrtle discussed activities with her family as a way in which she stayed healthy. Myrtle was dependent on her children for many things. She stated this quite eloquently.

> Myrtle: Well, I never learned to drive so I have to rely on my family. Usually my son takes me to the grocery store and around to pay my bills and my daughter takes me to church.

During hours of participant observation with her, I found that the family members were also dependent on her. Myrtle was the one who listened to their problems and gave advice. She was the stabilizing force for the family. In times of crisis, such as death or illness in a family, an interdependency existed as they would all rally together. The life of each person in the family related to the health of other family members.

Another example of interdependency was seen in Louise's life. Louise moved in with her daughter only a day after her husband's death and has been living with her daughter for five years. Louise had debilitating arthritis and used a walker. Her

eyesight was failing due to cataracts. Again I saw a similar pattern. The family would make decisions based upon Louise's advice or suggestions. The telephone was a tool for staying connected with the rest of the family. Louise described her dependence upon her daughter.

> Louise: Oh, my daughter takes me out every now and then and rides me around. We go to the grave yard and check on the flowers and such. See, if it wasn't for my daughter I don't know what I'd do. She baths me every morning, fixes all my meals and snacks, gives me my medicine...just everything. I usually wait to get up after my daughter's husband leaves for work, that way I'm not in the way. My daughter will come to my bedroom door and ask if I'm ready to get up...I know then that she has time to work with me.

In talking with Louise's daughter, she felt that she gained a great deal of advice from her mother during difficult times. Her mother's words were a source of inspiration for her. The love for her mother was present in each word that she used to discuss their relationship.

Summary of EXISTING DAY TO DAY

The domain of EXISTING DAY TO DAY had three categories: planning, activities, and family. Recurrent threads that facilitated an understanding of each category are listed in Table VII. The category of planning had two recurrent threads: daily and future perspectives. Activities were described as consisting of TV, crafts, visiting and community

work. The family was reflected as an interdependent pattern.

Table VII

Analysis of Domain: EXISTING DAY TO DAY

Categories	Recurrent Threads	
Planning	daily	clothes list
	future	convenience nursing home burden health
Activities	TV	stories game shows
	visiting	family friends
	crafts	quilting
	community	gatherings
Family	interdependence	children

LIVING THE RIGHT WAY

Analysis of the domain, LIVING THE RIGHT WAY, encompassed two categories: values and God. The two categories represent the moral presence within the lives of the women. Morality, or living the right way was identified by the women as intertwined with life and health.

Values

The women had a way of looking at values: right or wrong. They identified things in their lives that were right and things that were wrong. Aspects of society and individual behavior were discussed in terms of the right way and the wrong way life should be lived. The women had consistent views on what was morally right and what was morally wrong. Many different ways of doing and being "right" in the world were discussed. Initial discussion will center around what "is" morally right. One's behavior was judged based upon several qualities: unselfishness, God-fearing, moderation and hard work.

Unselfishness could be identified when people were willing to help them out...willing to work together. For example, one day while visiting Helen, I offered to drive her up the road to visit a neighbor. She planned to get a gallon of beans and a watermelon. She said that the man that she was getting the food from never charged her, but that she always tried to pay; he would not accept the money because she had been such good friends with his deceased wife (field notes). Sharing and being there for another person when they were in need was "right."

The women wrote in their diaries and

commented in interviews that doing "right" helped them to stay healthy. Myrtle shared her thought on this matter.

> Myrtle: I go visiting to my neighbors and just do something to help other people out...do little things like I'll go thread my neighbors sewing machine or I'll go to the mailbox and bring her mail back, just things like that makes me feel good and stay healthy.

Cora Lee identified other informants within the community for the researcher. Her view of a good informant was a generous person. During an interview she said:

> Cora Lee: There is a lady I want you to have in your study. It will be good for her to have company. She's the type that always gives you a Methodist Bushel. A Methodist bushel? Well that's a bushel and a half. She is a giving and good-hearted woman, that lady is.

Being unselfish meant being generous. This was a trait highly valued among the women. By giving of one's self you were surely helping someone in need and doing the right thing and reaping benefits too.

The women all professed to be God-fearing people. They considered themselves Christians and church-going people. Again, this was thought to be the right way to live one's life. Laura described being a Christian.

> Laura: Going to church and being a good Christian will help keep you healthy. A good Christian believes in God, a higher power than we are to help your fellow man to be understanding and to love everyone no matter what, and to try to keep your conscious clear...not to harm

> anybody, always to think of the best in everyone. I've heard people say well it will come home to them and their time is coming....people who haven't been a Christian, you know.

Living a moderate life was observed in the lives of the women of this study. The women did not live in lavish homes or discuss their finances. However, several of them would discuss ownership of land. Many of the women lived in $20-40,000 homes and owned over a hundred acres of land. Yet, they would not realize such wealth was part of their daily lives. For example, Anne's husband owned one of the few gas stations in town for over twenty years and people in the community considered her "well off." However, she would attest to the value of a moderate lifestyle.

> Anne: I try to live a moderate life, not go to extremes one way or the other. That is the right way.

A moderate life meant not overindulging in material items. A simple life was considered a better way of life. Reba shared her beliefs.

> Reba: And people got too much now a days. Back when we didn't have things, we cherished what we did have and now we have so much that we don't appreciate what we do have.

An individual who was hard working was living the right way. Idleness was not valued. The women believed that hardwork was a way to go far in life or do well. Edna shared thoughts about her family.

> Edna: My family believes in using what talents they have and to helping others. We got through hard times by helping others. My children are hard working and that's why they did so well. They just have that get up and go. You can't get them down, the good Lord was with them. And if I could be of help to any of them I would.

The women quoted a phrase "things will come home to you," meaning that if you don't live the right way, God would see to it that a time would come when one would wish one had done differently in life. Another phrase that represented the same notion was "your time would come." This phrase was associated with death or a time in which one might need to ask the Lord for forgiveness. Several of the women shared their thoughts about these phrases.

> Dottie: I've said that things will come home to you. What does that mean? Well, I know a lady that doesn't drive and if I don't offer to take her places then it will come back to you and you'll be sitting here one day and nobody will offer to take you somewhere.

> Reba: I do think that we get paid back for things that we say or do. If we don't get paid back it comes a time when we will be sorry. I don't believe that I've ever done anything wrong that sooner or later I was sorry. But when it comes back home to you, you are sorry.

Living the "wrong" way was a route to having things come home to you. Several of the women shared concerns over people living a fast life and children being raised wrong.

> Lil: Law honey, people just live such a fast life now a days. I think of the Bible a lot and the Bible says that before the end of time you can only tell the summer by the budding of the

> trees...and a warm winter and a cool summer. But he said he wouldn't leave no signs that we would have to guess toward it. But people are living too fast honey. No wonder that disease (AIDS) has been put on this earth. He is going to put something on this earth to kill out people.

Lil looked to the Bible for guiding her rationale in life's sufferings. God was the deity to which the women looked for answers. Health and heaven were interfaced in the belief system. Louise integrated her idea of living right into her thoughts about what must be done to maintain her health and to get into heaven.

> Louise: I say the best way to keep your health is not to do things to make you not have good health. Like getting out here and drinkin' ol' beer or liquor or wine or something like that. I know there are a lot of people that do that and they won't make it into heaven either. Not get out here and run around and lay out at night (stay out late) or do things you shouldn't do. You can't do that and live right.

The moral deterioration of society was troublesome to many of the women. Edna and Reba supported this belief.

> Edna: I must say I don't enjoy reading the newspaper like I use to. There is nothing I can do about it but I don't like to read disturbing things and all those killings. I think we are better off to not know about them.

> Reba: I think that we have just deteriorated in our values. I think the whole country has the things that we use to value and we don't anymore. Children use to be happy playing with nothing or just a paper doll. Children use to use their imagination. Now people buy children everything. I think children lack imagination.

Reba's concern was extended to the children. An unhealthy behavior was giving material items to children. Reba questioned the ability of children to develop their mental capabilities, i.e., imagination. Learning to develop one's imagination was considered an important aspect of life.

Lil talked about the discussions presented on television. A belief emerged that sex was not an item to be discussed on national television.

> Lil: I was watching that talk show, but all it ever had on it is sex and stuff. It was talking about castrating men because they rape women. I don't know why they want to talk about such things on TV.

These women have lived through several generations of change within society, a time in which values have changed. The changes within society were disturbing to the women. LIVING THE RIGHT WAY involved retaining the values that were passed down from generation to generation.

The women voiced a deep concern about the country. Life is changing and the time when people were safe within their own community is disappearing. During interviews, the women indicated that they believed that children were overindulged because parents do not take the energy to discipline them. The women were concerned about the future being in the hands of the children (field notes).

God

The domain of LIVING THE RIGHT WAY also included the category of God. God was discussed relative to their beliefs about a spiritual being. The women talked about being alive because of the will of God, hence He was the one to thank for life. Some of the women performed a daily ritual of thanking God for being alive. Edna and Anne attested to this belief.

> Edna: I'm able to stay well because I thank God every day I'm here on earth. I just have a wonderful life. It is so good to be living. I feel like there is so much for me. I don't want to leave.

> Anne: In the spring I often walk out on my back porch and I say thank you Lord, you're going to let me enjoy one more spring. And I just love to see it come and I'm so grateful to be able to do as much as I do.

Reading the Bible was considered a traditional ritual. Within the diaries and during interviews, they shared their thoughts about how the Bible was the text through which a sense of peace was derived. During a visit with Myrtle, she showed me her mother's Bible, a symbol which had been passed down to her as the oldest child. Inside the Bible she had a certificate, another symbol that she had received from her church for having read the Bible completely through. She was very proud of this certificate. With tears in her eyes she said:

> Myrtle: The one thing that helps to keep me healthy is believing in the Lord. I have read the bible all the way through. Some evenings I just sit and read it.

Edna had her Bible on a small coffee table when I entered her house. The wrinkled and worn pages had been touched many times. Edna at the age of 90 felt that her time left on earth was drawing shorter each day, even though she was able to provide all her own care. She said her favorite text in the Bible was Psalms.

> Edna: I read the Bible every day. I've read it through a time or two. I like going back to the psalms because I believe they have a special meaning for us. They have a message for me.

"Being ready or prepared for your time of going home" was a phrase frequently spoken by the women. A strong belief among the women existed that one should always be ready for the Lord to call down and take one to heaven. Edna and Louise talked about living the "right" way as a prerequisite to being ready.

> Louise: You know, I'm just gonna live till my time and then I'm goin'. And the best thing's to be ready. We should be ready. I mean you shouldn't be mean or do things that you oughtn't to do. I think that I try to live as good as I can.

> Edna: I'm not ready to go. I hope I'm prepared but I'll stay here as long as the good Lord wants me too. But I'll go when the Lord calls me. And I've tried to live the kind of life that is good. I adhere to the things that the Lord has told me in his book.

A common corallary among the women and community was that if one believed in God, then one went to church. Anne was proud to discuss her church-going affairs. Her family had been influential in the establishment of the church.

> Anne: I go to the church where my mother's mother organized the church. It has been there for more than 200 years and the property that the church is on, my mother's family owned.

Going to church every Sunday was very important to the women. If they were unable to go to church, they talked about a sense of not feeling quite right. They all agreed that they enjoyed going to church. Going to church afforded the women the opportunity to visit with people as well as to hear the Lord's word (diaries). Dottie shared her thoughts on this subject.

> Dottie: I go to the Methodist church every Sunday and I'm on several committees at the church. I feel better by being a part of that. If I miss a Sunday then I can not get my week started right.

Another aspect of church life for the women was the network of women that meet in what was called a "circle meeting." During participant observation, I found that these meetings were very ritualistic. Prior to the meeting, the women spent a great deal of time talking to each other about the happenings in the community as well as gossiping. Once the meeting was over people did not linger long. Quick

good byes were exchanged and offers for a ride home given (field notes). Reba described this function in her own words.

> Reba: I've managed to get to circle meetings (women of the church meet once a month), a few times in the last year. Usually we have one person that presents a program. Then there is a collection (collection for money). And we have a box that we pass for the least coin. You put in whatever you have that is whatever your least coin is, a penny, a nickel, a dime, or whatever. Then we have another one called the yearly dues. We have about 15 or 20, members. The meeting usually lasts about 1 1/2 hours.

Several of the women talked about televised church services as an alternative to stepping inside the physical structure of a church in the case that they were physically unable to attend. The same sense of commitment seemed to exist among the women who stayed home and watched their church service.

> Louise: I watch church TV on Sunday mornings because it is just too hard to walk and get ready for my daughter to take me to regular church. I really enjoy watching TV. I watch Jimmy Swaggert.

> Reba: I went to church on the TV this week. It's the First Presbyterian. I really enjoy that show on Sunday mornings.

Whether a person was homebound or able to go to the local church, everyone attended "homecoming." Homecoming was a ritual that occurred once a year at the majority of churches in the county. Homecoming was a time of coming home or a returning to the church of all people and families who have ever been

members. The returning celebration included a luncheon, usually in a fellowship hall or on the grounds of the church. Helen talked about homecoming at her church.

> Helen: We had homecoming Sunday...that's when all the people who are members and their family come for preaching and then dinner afterwards. We sat up tables outside and everyone brings something to eat. It is great fun to see people that perhaps you haven't seen in a year or longer. Everyone that could brought card tables and chairs so that we would have enough room.

During participant observation, I observed that this social occasion was well prepared by the women of the church. Each family was responsible for bringing food to put on the table. The meat for the dinner was donated by the women's circle group. Tables were lined in a long row. Some of the delicacies included turkey, ham, fried chicken, every casserole that one could imagine and desserts. There was a wide variety of choices. The only drink was heavily sweetened iced tea, a customary drink. Children played throughout the afternoon. Groups of families formed the boundaries designated for eating. People spent a great deal of time sharing stories, laughing and complimenting each other on outfits, and food (field notes).

Within personal notes, I reflected upon the acceptance of my presence during the church event. An informant always introduced me as a friend or as

her second daughter. This form of introduction signified that I was truly within the culture. Such terms of endearment were acquired after many days of establishing rapport and gaining trust (field notes).

Summary of LIVING THE RIGHT WAY

Many of the women had strong fundamental religious beliefs, and these beliefs were interwoven with beliefs about morality, life and health. All of these women indicated that they would use or seek professional medical help. A belief that God's will would take care of them did not encompass the healing of all health problems. The women accepted those who they believed lived the right way. Living the right way involved unselfishness, moderation, and being God-fearing and hardworking. Table VIII displays the categories and recurrent threads of each category related to the domain, LIVING THE RIGHT WAY.

STAYING HEALTHY

The fourth domain represented the major focus of the study, STAYING HEALTHY. The women referred to their perceptions of health as "staying healthy." During the analysis of this domain, three categories emerged: Physical Activities, Mental Activities and Health. Within each of these categories, recurrent

Table VIII

Analysis of Domain: LIVING THE RIGHT WAY

Categories	Recurrent Threads	
Values	right way	unselfishness
		God-fearing
		moderate
		hardwork
	wrong way	fast life
		overindulgence
God	beliefs	giving thanks
		your time
		Bible
		being ready
	Church	local
		TV

threads are woven to explain the different physical and mental activities that were related to the women's health. The category of Health included four threads: definition, experience, family and community. The category of health brought to light how the women defined the words health, illness and sickness. They felt that the words illness and sickness must be explained to truly understand health. Health was therefore discussed in light of previous experiences of not being healthy such as having surgery or falling. Further analysis found that the community and family were interwoven into the women's subjective understanding of health.

Physical Activities

Three different threads of physical activity were identified by the women as being important to their health. These were: staying busy, exercise and eating.

Modes of staying busy were often planned the night before retiring. These plans included visiting family, friends and neighbors. Getting out of the house was defined as a health practice by the women. Working on crafts or projects within the home or in the community was identified as healthy and another means by which the women stayed busy. To be idle all day long was considered a wasted day (field notes).

One's health could be enhanced if one was willing to stay busy. Dottie and Edna talked about staying busy.

> Dottie: I think staying busy is the secret to many things in life. Being healthy and happy come your way when you are busy. And that keeps your mind active too.
>
> Edna: Well, I always managed to stay busy. I wanted to do something or help someone and I never got idle and that's the best way to be.

Visiting people in the neighborhood or family members was documented in each woman's diary as a way health was maintained. Having a support network within the family and community was identified on a day to day basis with the diaries, field notes, and during participant observation. Edna talked about the closeness she experienced with her family. Visiting the family was often just a matter of walking next door. Physically and emotionally this activity was important to the health of the women.

> Edna: Well, my daughter-in-law lives next door and visits me more than anybody else. She keeps up with my medicine and brings it over here three times a day. Sometimes I go over there to get it. Then I visit this woman that lives up on the hill. She use to come visit me every day but she is sick and has been sick for seven years.

A purpose for being had to be established daily. Often this took the form of a craft. Finding something to help pass the time when living alone was important to one's health. Laura did a lot of sewing. Cora Lee, who worked on consignment for a

craft shop, taught classes in the community. Both women found that working on a project afforded them the opportunity to feel useful.

> Laura: I have times that I feel depressed and I realize it and I fight it. I do something...I'll get in my car and go shopping or I'll call someone on the phone to talk...dig into my sewing box.

> Cora Lee: Occasionally I'll teach people in the area how to weave baskets. Let me tell you, you don't have to be educated to learn to make baskets. One time I taught this group of school teachers and before the session was over they were just a throwing baskets. No patience at all. Seems like when people get educated they can't stand not to do something perfect the first time. And you know with basket making it takes a lot of practice.

Another way of staying busy was through volunteer work. Volunteering throughout the community required physical energy but also fostered one mentally. Volunteering was a moral obligation and was perceived as doing a good deed for another. Most of the women did some form of community work. Whether the volunteer work was with a church or another organization, the women found the activity wonderful and healthy. Anne and Laura talked about their volunteer work.

> Anne: I stay involved in activities where you have to think like the volunteer work I do. I stay busy. I just don't sit and do nothing. You must keep dealing with people to keep your mind active. I think that is why so many people are depressed, because they don't stay busy. You have to stay interested in other people as well as yourself.

> Laura: At the age of 72 I do a lot to stay busy. I'm very involved with my church. The biggest thing is that the church provides things for people to do. We have a list of shut in's from our church and we take turns calling them every week.

Exercise was viewed as a healthy activity. Most of the women considered their housework and yard work a form of exercise. For example, Edna, a short, frail lady, was always up doing something in or around the house. Her house had two bedrooms. Once inside the house there were no doors only curtains hung over the entrance of each room. She told me that she didn't need to be opening and closing doors that she needed to save her strength for other activities. During our time together she shared her love of plants with me. Her kitchen small and crowded with antiques, pots and pans, had plants dotting every corner and nook that could possibly hold an item. Edna talked about the ways she got exercise on a daily basis.

> Edna: I picked some peas outside. Then washed some things, hung them out to dry and then ironed them. And of course I did my routine morning stuff, made two beds because my daughter-in-law spent the night. I do vacuum every other day and go to the mailbox everyday. I did all my plantin' this year. My son makes the rows and then I plant, weed, and pick and then can the food. I've got canned food in cabinets, in boxes under beds, just about everywhere in the house.

Some of the women scheduled morning or afternoon walks. Laura and Anne each tried to do

extra walking each day. For example Laura talked about a creative way to get a little more exercise in during the day.

> Laura: I parked my car just as far away from Belk's (a clothing store) this morning so I'd have a ways to walk so that is a little extra walking for the day.

Anne saw the benefit of routine walking on a daily basis both physically and mentally. Walking was an outlet for networking with a support system.

> Anne: I walk every morning...for years I walked rain or shine for two miles. Now, I don't care a thing about walking in the Mall, and now a lot of people go down there to walk. My neighbor across the street goes every morning but I prefer to get outside. I always do three or four blocks a day. I started walking after I lost my husband. Chiefly to be outside and for my health. It keeps my weight down...emotionally I think it did more for me than anything else because you can get sorry for yourself and being I usually walk with neighbors...and association with people in the neighborhood did as much for my mind as it did for my body...and emotions (mental health) are good for your body. In the evening when we walk it is a social walk. Mentally it is good to help you relax. It seems to me like I have a hard time getting to sleep if I don't take my evening walk.

The local "Mall" was used by older people for walking and socializing. People would arrive at the mall before the stores opened, usually around 8:00 a.m. Older people could be observed walking from 8:00 a.m. to 10:00 a.m. on a regular basis, Monday through Saturday. The majority of the participants were women. This finding was later affirmed in field notes as the women identified walking as an important

health behavior.

Laura made a point that she thought was inherent with aging, "the older you get the slower you get." Laura had developed arthritis in her hands and found difficulty in accomplishing housework. One of her greatest loves was working in the yard. She did all her own yard work, which included mowing, weeding and clipping.

> Laura: I can't accomplish things like I use to. It takes all day to do what I use to do in half a day. As I get older I slow down. Now I have to give myself plenty of time to get ready to go out. Changing my bed took me an hour this morning. I like to never get the bottom sheet on. I despise to make a bed, it takes me forever. I love to work in the yard and I spend hours just working in the yard. Having a nice yard is very important. We believe in mowing our grass every week or you are a sinner and you just die if you don't get your grass mowed every week.

Consuming food was also discussed in relation to health. The women believed that eating a balanced diet was more important than eating foods low in cholesterol or low in fat or in fact low in anything. Their definition of a balanced diet was foods taken from the four major food groups. Consuming a balanced diet and maintaining their weight were ways to stay healthy. They seemed to be well informed about low cholesterol diets from the media and physicians in the community. Some of the women shared their thoughts.

> Anne: Eat correctly...I don't mean not to eat a lot of things that aren't good for you. I mean see that you have a well balanced diet. It doesn't hurt to have something every now and then that's not healthy.
>
> Helen: Well When I say good I mean tasty. I am a good cook. When I cook for myself I usually have a balanced meal. I have a meat and vegetables. I've weaned myself down to skim milk too.

Thoughts about preservatives found in store-bought food was a concern for these women. They perceived foods with preservatives to be unhealthy. The majority of the women had gardens or bought produce from people they knew. Canned food from the garden was considered healthier than buying food from a grocery store. Lil and Edna shared this belief as well as the others.

> Lil: I can taste but my tasters aren't as good as they use to be. But I know when it's home cooking and when it's store bought. I think that stuff that is preserved and that you can fix so quick can kill you with all those preservatives. All that canned food from the grocery store just doesn't taste the same as what comes out of the garden. I don't think it is good for you. There are too many chemicals in it. And I heard on TV that they are putting something in our water. Now that's gonna hurt us. Well, there will always be something to take us away from here.
>
> Edna: I can food a lot because I believe that food you grow yourself is safer to eat.

Drinking water was viewed as a healthy behavior. Edna talked about a remedy passed down from her mother concerning the drinking of hot water on a daily basis.

> Edna: And drink hot water when I get up. My mother always did that. I've been doing that for years. It's good for flushing out the stomach. But I'm 90 years old and I should be able to eat whatever I want.

The women who were over 80 agreed about being able to eat what they wanted. Some of them had doctors who told them to eat what they wanted, while others had doctors who instructed them to follow a specific diet. The latter group reported that they listened to their doctors but ate what they wanted. Louise summarized this belief quite well. She said she'd be ready to go if the Lord called. She continued:

> Now there's certain things that doctor told me not to eat, but I'll tell you what I told my daughter. I'm gonna live till I die.

Throughout the county, I found that a certain group of people went to specific restaurants regularly. For example, eating fish on Friday night was a ritual with the older people of the county. People went to "Fish Camps," an informal restaurant throughout the week, but Fridays were the busiest with the majority of the clients being elderly. Fried fish, french fries, cole slaw, and hush puppies were usually the main course. Hush puppies were a mixture of cornmeal, egg, milk, and occasionally onions. These restaurants provided the older women an opportunity to socialize with young waitresses,

older friends, and family. Usually a table consisted of four or more people (field notes).

The category of Physical Activities was woven together by the threads of staying busy, exercise and eating. Each of these threads is related to a form of physical activity that promotes health.

Mental Activities

The category of mental activities included thoughts about enjoying life, not worrying and keeping one's mind. These different mental activities were considered important to the overall health of the women. Enjoying life meant that you get out and experience it. Dottie succinctly stated:

> Dottie: I think that a healthy person likes to get out and go, enjoys life. They don't just sit, they get out.

Maintaining an attitude absent of worry was a key to health according to the women of this study. There seemed to be no purpose in the behavior of worry. The women reported that to worry about something did not correct the problem. To correct the object or focus of worry one must act. To sit idle and do nothing but worry was considered a waste of energy (field notes). Edna and Anne explained their views on worry as a detriment to one's health.

> Edna: I don't worry. I don't think the good Lord wants us to worry. If things happen to us I think the Lord has a plan for us. You know I

> have no worries or cares. I don't let things of the world worry me you know, and if we did we'd all be worried all the time.
>
> Anne: Well the one thing is not to let anything worry you to death if you can help it...stay as free of worry as you can...that will help you stay healthy. Keep a good outlook on life, will keep you healthy. One of the things that I always try to remember when I start to worry is that whatever comes, this too shall pass away.

The most important aspect of aging that concerned the women was the importance of "keeping one's mind." Being aware and understanding the people around you were the most cherished aspects of health. The greatest fear in aging was losing one's ability to make appropriate judgments. As Laura stated, "having a good mind is the most important thing. I just pray that I can always have a good clear mind" (field notes).

All of the women shared ways in which they worked at keeping a functional mind. Dottie found that her bridge club was stimulating and made her think critically as she played cards (diary). Reba and Laura discussed reading as a mechanism to use your mind. Thinking deeply about something such as the text of a Bible, a library book, or even the Reader's Digest was thought to be helpful. Lil stated "most weekends I work on my puzzle book or do picture puzzles, both of these things helps your mind" (diary). Cora Lee found that playing Scrabble

with the neighbors was a good way to keep one's mind active. She shared some humor about this activity.

> Cora Lee: Our big joke is that we will never have Alzheimer if we play Scrabble (a board game). So now if I forget something or burn something I say the Scrabble isn't working. I just go nuts if I lost something but now I just come to the conclusion that if you don't look for it, it will show up.

Lil told me that as one gets older, people just naturally think that you are losing your mind. This stance toward older people upset her. She shared with me an experience of how a trained health care professional had treated her.

> Lil: Now this one doctor wouldn't give me a prescription for some cream that I was putting on my face for skin cancer. He made fun of me and said that stuff didn't work. He thought that because I was old that I was crazy, but honey I tell you I'm not crazy. My mind is pretty good its just my body is wearing out. I'm not crazy. I'm able to keep my check book and I don't like for no one to make fun of me.

She spoke in a very proud manner as she described her ability to balance her check book. She stated that even though her social security check was just over a couple of hundred dollars a month, she had been "putting back" ten dollars a month. The ability to save money indicated that she had a good mind.

Mental Activities were related to one's overall health. The ability to enjoy life was a tenet of good health. But having a mind which could rationalize could allow the women control of their

lives. Not losing one's mental faculties was of the utmost importance in the process of aging. A strong value was placed on maintaining a worry free context for life. Again the pattern of being worry free was interfaced with God, an aspect of the domain of LIVING THE RIGHT WAY.

Health

The category of health uncovered an understanding of the women's definitions of health, illness and sickness. Stories of their experiences in the health care system were fascinating. They discussed doctors, nurses, and the hospitals in the county as well as in the county west of their home. The family was a source of strength for their personal health. Many home remedies were shared and they described the treatment for sicknesses within their family. Again, participation in the community was discussed as a resource for maintaining or increasing one's health.

The women described health as a state of well being. Maintaining their health was very important to them. Anne told me that she wanted to live just as much today as she did when she was sixteen. Growing older does not mean one is ready to die. Each day one ages, health becomes more valuable to the person as an individual (field notes). Dottie

talked about the meaning of health for her.

> Dottie: Well, health means a hundred times more to me now than it did even five years ago. As you get older you see your friends die and you know that health may be with you one day and gone the next. It is harder to do some things as you get older, but then I can do some things easier than a young person.

One's degree of health was associated with one's level of independence. Anne described what being healthy meant.

> Anne: I guess that if you felt well for your age and that if you were able to take care of most of your responsibilities that you were able to enjoy life, that is what I would call good health,... just being able to do the things that you need to do and not feeling life is a burden. I'm not one of these people that believes that you have to be happy all your life. I think a healthy person is someone who can take hard things in life and snap back. It is more than just the physical aches and pains. I mean the physical aches and pains are not your problem when you get my age..truly it isn't. It is the responsibility of looking after yourself.

Maintaining independence or appearing as though you are maintaining independence was one way to "beat the system" (fool people). Lil told me that the most important thing was to try to appear healthy and to act like you felt good when your family came over to visit. If they found out that she didn't feel well the first thing they wanted to do was take her to the doctor (field notes). Hence, the importance of appearing independent could explain that when the women finally seek health care they are really sick.

The terms sickness and illness had different meanings for the women in this study. Sickness was consistently discussed in terms of a short term situation while illness was more life threatening and long term. The word ill can have several definitions depending upon its semantic relationship within a sentence. For example, Dottie stated:

> I think ill can mean being mad, like ill as a hornet and illness is when you are really sick and need medical attention. Sickness is something you can get over.

The women agreed that to be sick would probably not necessitate a visit to a doctor but an illness would. Edna gave these examples:

> Edna: Sick is just a stomach ache or just plain sick, but illness I think is something like you can't get over. You usually die.

The women were eager to share stories about their health. The stories often involved beliefs about their sickness, doctors, nurses and even the hospitals.

If the women got along with their doctors, then the hospital which treated them was considered a "good" hospital. Likewise, the women who felt that their doctor had not given them the best care extended their concern with the doctor to negative feelings about the hospital. The women would tell me that they did not want to return to a hospital because of the care they received from a particular

doctor. When asked about the nursing care received at the local hospital, the answers were always the same. The nurses were very kind and caring. They did a good job. This could be a biased response because I was known to be a nurse.

Lil is 83 years old and has been in the hospital several times. She stated that the surgeon who had performed gallbladder surgery on her was mean. She had no intention of ever going to him again or to the county hospital where the surgery was performed. Since that surgery she recounted other health problems which had required hospitalization. In one case she had her family take her to a county west of her home and in another instance to the county north of her. Lil related her health experience through a story:

> Lil: Well, I had gallbladder surgery once. Honey, that doctor hurt me. He cut me plum across my belly. I don't know why in the world he done that because I asked some of them nurses and they just pulled downed their shirt and showed me their little scar. In three days it got infected and bursted and run down like a big boil. I had to take back to the hospital and stay five more days. I've also had those ol' hernias that come up like little banty eggs. I had to have them fixed. I had that done west of here. And then I broke my hip because I slipped on one of those throw rugs as I was going to the bathroom one night. I got that fixed in the county north of here. Now I have a potty chair at my bed. Now I'm afraid of falling. Also ever now and then I have this one leader (tendon) that draws up and it really hurts me, honey. I think it started after I fell. I usually just rub it with my hand until it goes away.

Fear of falling was a health problem for many of the women in the study. As one ages, being unsteady on one's feet was expected leading to a fear of falling and breaking a hip. Some women had experienced failing eyesight due to cataracts which made walking even more difficult. Louise shared her experience.

> Louise: I have to use a walker to get around in the house. You see I have terrible arthritis. I usually just take Tylenol for it when it gets real bad. I have to be real careful walking because I'm afraid of falling and breaking a hip. And I've had a cataract removed. I still don't see as good as I once did. But I do read the paper and watch TV.

Anne walked daily for exercise. During a morning walk she stumbled and fell to the pavement. For Anne, this was her first experience with falling. She shared her story:

> Anne: I had a fall two weeks ago. I had an appointment with the doctor for my yearly physical and so I decided to take my walk around the block and up here on the hill I fell just as flat as anything you've ever seen. Have you ever heard of anyone falling flat on their face? Well that's exactly what I did...I fell flat on my nose. The first thing I did was to see if my nose was broken and it wasn't, so I got up and kept walking and as I got back to my house a neighbor was standing there and she put cotton across my nose to catch the blood and I went on over to the doctor. That really did jar my body. You talk about being sore. I really have been sore. That's the first time I had fallen and the doctor said he just thought I had stumbled.

Falling was frequently discussed by the women. During my first interview with Myrtle, I noticed a

bruise on her arm. I asked her about the bruise and was told that she had slid in the tub. She thought she had been lucky to have not broken her arm.

Helen shared a story about health that occurred over a year ago. Helen had been diagnosed and treated for an ulcer. Her diagnosis occurred after she got so weak she could not stand. She told me that she knew that she had been passing blood in her stool but that she had planned to go on a tour for a four day weekend. She explained that she hoped to make it through that weekend before going to the doctor.

Several women talked about how health knowledge was transferred throughout the community. People discussed their health experiences in great detail and often reached conclusions through these discussions. This example was given by Helen:

> Helen: I was telling the man that came to fix my oven about my ulcer and I said I didn't know why I had an ulcer and he said that he knew someone that had one and it was from taking a certain kind of medicine and it had eaten a hole through the stomach. I told him that the doctors had asked me if I had been taking a lot of aspirins and I said no because I rarely have a headache. Sometimes when I have a headache I can just take a walk and that takes care of it.

Over half of the women in this study told me that they had high blood pressure. All of them had medication to take for their high blood pressure. Edna said that she had had high blood pressure for

many years. Her daughter-in-law monitored her medicine on a daily basis and her son was in charge of taking her blood pressure. Edna commented on her beliefs about high blood pressure.

> Edna: I go to the doctor occasionally for a checkup cause I'm bothered with high blood pressure. My son checks if I start to feel bad. I know I'm feeling bad when my head feels heavy. And you wouldn't be exactly dizzy, it'd just feel it's too heavy up there. Most people, a lot of people, when it runs up they get dizzy. Sometimes it gets hard to walk. But I never get that bad since I take medicine now. I've heard people say "I didn't know my blood pressure was up." But you can tell when it runs up. It just doesn't feel right.

During the month of September, Helen discussed her high level of cholesterol with me. One week prior to my visit she had decided to stop taking her medication. Helen hoped to control her cholesterol level with her diet. Helen stated:

> Helen: I went off my cholesterol medication because I want to see if I can't just control it with my diet. I didn't tell my doctor..I just thought I'd do it myself. I hate taking medicine. That's why I walk a lot to lower my cholesterol.

The following February, Helen was seen by her doctor. Her cholesterol was elevated and she agreed to take her medication.

Going to the doctor was a difficult decision for these women. Often a family member influenced a woman's decision to go to the doctor. Anne told me that people her age were raised not to go to the

doctor unless they were dying. While growing up in a rural county, a doctor was not always close by and even if one were, a person should be extremely "bad off before going to see him" (field notes). Anne explained how older people think.

> Anne: Well, it's a hard decision to make to go to the doctor. To make your mind up to go to the doctor...especially for us older people who didn't grow up going to the doctor a lot...we keep thinking that if we just wait and use some of these remedies like bedrest, aspirin, and fluids this is going to pass...and it generally does and when you get so you've been sick a couple of days...then it is time to go. I know us older people do have a tendency to prolong going to the doctor because we keep thinking it will ride itself out. When you start running a temperature or want to stay in bed all day, then it is time to go to the doctors.

The women seemed to consistently identify that a doctor was needed if someone had a high temperature. I found Anne's comments about running a temperature to be a definite symbol of being sick. A high temperature could be intuited or actually measured with a thermometer.

Another health problem that emerged as a pattern of concern for the women was deteriorating eyesight. This was often due to glaucoma or cataracts. Several of the women discussed their experience with cataract surgery. Dottie shared her experience.

> Dottie: I had cataract surgery a few years ago and after the surgery colors looked so different. I had a pair of shoes that I thought were navy.

> And I had been wearing them with different outfits. Well, they really weren't navy. Can you imagine what people thought? They were a bright blue. I told the doctor and he said that the color blue seemed to be the most different after surgery.

Dottie discussed a common problem for people who have outpatient surgery. The problem was having no family or significant other to help a person when returning home.

> Dottie: I was really dreading this surgery. It was done on outpatient. There wasn't much pain, but you have to go back home the same day and when there is no one at home, what is a person to do? Well, the doctor said he couldn't let me spend the night, so I had to stay with a first cousin. But what do people do who don't have family willing to take them?

Family was the center of life for the women in this study. For them there would always be family to step in and help. Within this culture, great value was placed on keeping in constant contact with one's family.

Dottie tried to explain the connected relationship within "the family." The family was not just a nuclear family but also an extended family.

> Dottie: I know my first cousins, like you would know your sisters. And there is never a thought given that I don't know that one of them will give me a call and ask if I need a ride to a function, like a funeral or church. They do it because they know I'm going and we are family.

Edna proudly discussed her family's ability to "stick together." A belief system existed that blood was thicker than water and therefore family

must "be there" for each other. Edna's comment supports this belief.

> Edna: I know my children will stick together when I'm gone. They are that kind of children. That is their very nature. There has never been a sweeter family. If one person in our family hurts, then everyone in the family feels the same hurt. And if anyone of them could take and share any pain they would. My son makes me do what needs to be done for staying healthy. But it is his sense of humor that keeps me going. If I get down or blue his sense of humor comes right in and helps.

Even though the women were tightly connected to their families they shared insights about how they understood their children. Of the children, usually a daughter had the strongest connection with the woman. The children had difficulty understanding that as one got older, life changed and health changed. The women talked about not being able to move as fast as they used to, and not being able to get well as quick. There were times when the women did not share their health with the family, if they did try to share it, they were not understood. The women considered this form of expression as preventive. Lil and Laura discussed this issue.

> Lil: My daughter, well she is funny, she wants you to get better and to go to the doctor and to get better fast. But at my age it is hard to get better fast. That's why I don't always tell her when I'm sick.

> Laura: I realize that when I don't feel good and I complain to my daughter and say I don't feel well she turns me off. She will interrupt me. She doesn't want me to think about it.

The majority of the women lived near their families; for example, the next door neighbor was usually kin. In one instance, Helen had kin living beside and behind her house. This close proximity of living facilitated the family closeness. Family members worked, played, and socialized together on a daily basis. Helen described being with her family.

> Helen: Well my sister and her husband lives two doors from me. Every time they go out to eat I go with 'em. On Friday night we always go out to eat supper. Today she wants to run to the library in town and she has asked me to go with her today. And when we go to church, like one Sunday I'll pick them up and the next Sunday they pick me up. We go to choir practice and take time about. We've taught a lot of people how to play Pinochle. We can play three or four nights a week.

Some of the women had children living out of the county or state. When asked about this, they described how they maintained their connection. For example, all of Laura's children lived in Western county except for one daughter who lived in the state of Connecticut.

> Laura: I'd much rather be with my family than anything else in the world. My family makes up my life. Every Saturday morning my daughter calls from Connecticut and we talk for 45 minutes. We see each other about 4-5 times a year.

The families arranged for their vacations to be at the same time every year. Both of her daughters owned beach houses on the North Carolina coast which made an excellent place for the families

to come together for their vacations. Each year the entire family had several outings at these homes.

For Lil, Edna, and Louise being with the family often meant being cared for by the children. Each of these women relied on their children for care. In Lil's situation, all of the children pitched in to help her. One son who lived in Virginia sent a monthly check. Lil stated:

> I have eight kids and they follow a schedule for helping me. One week my granddaughter will help me clean my house and then another week someone else will. My daughter owns a restaurant and someone always brings me a hot meal every evening (diary).

The women in this study had a strong support system in their families.

Recipes for home remedies for various ailments were shared by the women of the study. I was told that home remedies emerged because of a lack of money and/or professionally trained doctors being in the area. The people often "made do" with what they had available. Knowledge of home remedies was passed down from generation to generation. The majority of the remedies are still used. Those no longer used were the result of an increased number of drug stores, insufficient knowledge of the outdoors to find ingredients and just from the thoughts of what was actually being swallowed such as sheep manure tea. Table IX summarizes various home

remedies described to me by my informants.

The women use home remedies that are perhaps acknowledged throughout the United States. For example, Reba talked about having cystitis. She used fluids as her primary mode of treatment. The sharing of medication among family members seemed to be a common practice among the women of this study.

> Reba: I had an attack of cystitis this weekend. I haven't taken anything for it except fluids and I use cranberry juice. My son brought it over, about two quarts, and it is a good medicine for it. I've drank milk, coffee, water all day for it...and I haven't had anymore cystitis. It is a peculiar thing. It's not anything that you can hold or touch. If my heads hurts I can hold it. But that hurting that you get there...there is no touching it. My daughter brought me some medicine that she had used and told me that if it got real bad to take one of those pills (antibiotics).

The role of the community in the lives of these women was paramount. Every diary had information about activities in the community. During the days I spent with these women, I was kept up to date on their participation in the community and local events. During months of participant observation I attended many local events and observed the women participating in the community. The sense of community was strong. Anne shared her comments:

> Anne: My roots are so deep. Some of these new people that have moved in are good people but I know that they don't feel the same as those of us that have been here all our lives.

Table IX

Home Remedies

Cough	Cough Syrup made from Corn Whiskey and Horehound candy.
	Vicks Rub put it on a cloth and then on my chest that way the vapors from it come up. A flannel cloth is the best.
	Poultice of mustard or onions.
	Kerosene (on cloth) to chest.
Ulcers in mouth	Chew on Yellow root.
Boils	Put fatback on boil to draw out.
	Cut a potato in half and put over boil to draw out.
Ring worm	Mix turpentine and lard together and put on ring worm.
Poison Ivy	Take the petals of the flower called Touch me Nots and make a salve.
Measles	Rub chicken manure over body to draw out the measles.
Sting	One-half teaspoon of baking soda and one-half teaspoon of honey were mixed to form a paste.
	Place tobacco or snuff on a cloth and moisten and put over sting.
Colic	Catnip tea.
Earache	Heat a bag of rice and put on ear.

While participating and observing in the community I frequently heard the words "outsider" and "foreigner." This form of segregation was stronger in Appalachia than the racial/ethnic issues described in other areas of the country. I was in a local store one day and saw a large sign that stated "No Public Bathrooms." Two older couples, who appeared over the age of 65 entered the store. One of the men asked the counter clerk where the bathroom was, and the store clerk said, "we do not have any facilities available." The man who spoke with a northern accent did not accept this answer and asked where the help went to the bathroom. Again the clerk just replied, "we do not have public bathrooms." After the two couples left, I overheard the clerk and manger talk about those foreigners coming down here and being so bossy (field notes). In the community a bias exists toward people who are not from the area. Being from the local county or a nearby county is helpful when one wants to enter this culture.

People who lived in the community were very dedicated to helping others and working toward a better community. Anne, who taught school for many years often did volunteer work at the local school. She shared her thoughts.

> Anne: I have went back to the school and did some tutoring in reading. I monitor tests in the high school and I do as much as I can. The school helped me. I always had a good job and people in the county have been nice to me and if I can give them anything back I will.

Volunteering in the community was seen as a healthy endeavor. This activity demonstrates community commitment. Anne volunteered at the reception desk in the local hospital. This community work helped the local hospital but it also helped her mentally, or as she referred to it "gives her a lift." The phrase of "getting a lift" out of something was used throughout the study by the women. This phrase means feeling good or happy. Anne commented on the opportunity to be around people.

> Anne: I see people that I have taught and some people I don't recognize until they come up and say I'm so and so. I wouldn't ever have the opportunity to see them because we don't go to the same church or do the same things...it gives me a lift...it helps keep me connected and especially the children I have taught. I'm so delighted when they see me.

Being active in the community is equally rewarding for the people that the women help as well as for themselves. The community work provided an opportunity for the women to socialize. Several of the women delivered meals to people who are not able to get out of their homes. The women referred to these people as "shut-ins." Cora Lee and Helen discussed their work.

> Cora Lee: I deliver meals on wheels to people in this area of the county every Thursday. They like to hear the news of the community, so I spend a lot of time talking and catching them up on things.
>
> Helen: I have been delivering meals to shut ins for about 4 years. It takes about an hour and 15 minutes to deliver all the meals but of course we do a lot of visiting when we deliver meals.

These women delivered meals in the area of the county in which they live. I found that the people "look after their own." Dottie explained that everyone in the neighborhood looks after everyone who needs help.

> Dottie: Yes, everyone looks after everyone else. When they were talking about organizing hospice in the county, one doctor spoke up and said that's what people in the neighborhoods had been practicing for years. That's what we have done.

Even though people have family, the neighbors helped in various ways. If someone had to go out of town to a hospital, a collection of money was taken up in the neighborhood to give the family some extra money for things that they might need. Myrtle recalled that the furniture shop where her son-in-law worked took up a collection of money for him. She said, even though her son-in-law was a "boss man," the extra money helped buy his meals while he was at the out-of-town hospital with his wife. Help from within the community was given to people who were having a crisis, yet not necessarily poor. Anne shared similar thoughts.

> Anne: I think that we should help as much as possible and I think that we miss a lot if we don't help people who are ordinarily makin' it. I think it really gives them a lift to know that someone cares.

The women talked about washing clothes, straightening up a house, just about anything that someone needs as a way of helping someone in the neighborhood. Dottie shared her thoughts.

> Dottie: We might go and sit with them for hours to help pass the time or even eventually nurse them around the clock, whatever it takes to keep them home.

Providing food within the neighborhood was a common practice. When people in the neighborhood were sick, the women baked food and took it to them. And after a death was announced in the community, food was always taken to the closest family member's house. Family members do not cook when there has been a death in the family. Cora Lee shared an experience that happened in her neighborhood.

> Cora Lee: When Joe (neighbor) was down sick, the Methodist church called me and said that they were taking food on Wed.-Sun. and then they wanted to know which neighbors were going to pick up the rest of the days.

Summary of Staying Healthy

The domain of STAYING HEALTHY, revealed the Mental and Physical Activities that the women believed influenced their health. The Mental Activity of "keeping one's mind" was considered most

important for health maintenance. The category of Health showed the language of health among these women. The definition of illness and sickness must be understood from the emic perspective for culture-specific health care to take place. Women were interested in the welfare of others. Their willingness to share strengthened the interconnectedness of the family and community.

Table X summarizes the major categories and recurrent threads found within the domain STAYING HEALTHY. This outline helps to organize the experience of staying healthy for the women in this study.

Summary of the Four Domains

The indepth analysis of the four domains provided a description of the lives of these ten elderly Appalachian widows. The domains are not mutually exclusive and must be viewed as fluid and open. The four domains, NO LONGER A COUPLE, EXISTING DAY TO DAY, LIVING THE RIGHT WAY, and STAYING HEALTHY reflect the symbolic categories of the lifeways for the women in this study.

Table X

Analysis of Domain: STAYING HEALTHY

Categories	Recurrent Threads	
Physical Activities	busy	visiting
		crafts
		volunteering
	exercise	walking
		yard work
		housework
	eating	balanced diet homegrown
		preservatives
Mental Activities	enjoy life	socialize
	worry	
	mind	activities
Health	definition	illness
		sickness
	experience	doctors
		nurses
		hospitals
	family	being with
		remedies
	community	

Themes

The next level of analysis was the search for themes. Cultural themes were uncovered through a process of being totally immersed in the data. Extensive time was spent with the data, referring to the process as an "intensive dwelling with the data." I was engaged in a dialectic process with the emic and etic perspectives and analyzed and represented the data in a scholarly manner. This phase of analysis illuminated cultural themes. Themes are the phrases that capture the major aspects of the text as a whole. Then analysis was taken one step further by interweaving the themes into a metaphor.

Six themes emerged as all the data were reviewed again. These themes are:

1. A rebirth occurs with the loss of a husband; a widow lives with loneliness in a crowd and finds the inner strength to endure.
2. Anticipation of the future and a reflection of the past guides a widow toward a healthy and competent existence.
3. A strong commitment to God prepares women for the impending time of death and fosters health.
4. A moral sense of concern for others facilitates one's health.

5. Retaining intellectual faculties with aging is an imperative dimension of health.
6. The unity of family and friends woven around the women nurtures health.

After reviewing the data and working to understand fully each domain, these themes became clear. The themes transcended the domains and clarified the lived experience as described by the women. A discussion of each theme uncovers the depth and reflected nature found in the themes.

The first theme: A rebirth occurs with the loss of a husband; a widow lives with loneliness in a crowd and finds the inner strength to endure. This theme is mirrored in the writings of Emma Miles (1975) about a fictitious character called Geneva Rodgers. Miles (1975) wrote:

> For all her gentleness and courtesy, at an age when mothers of any but a wolf-race become lace-capped and felt-shod pets of the household...she is able to toil almost as severely as ever. She is able to do battle upon occasion to defend her own. Her strength and endurance are beyond imagination to women of the sheltered life. The range of her experience is wonderful; and her wisdom commands a respect of all. (p.37)

Living with loneliness in a crowd was an experience that was shared among the widows. The tacit presence of their husbands rooted the loneliness that was experienced daily. Margaret Flanagan (1987) captured a dimension of this tacit

presence in a poem.

> Now his absence was a constant companion:
> his hairbrushes, his keys,
> his clothes still smelling of him
> in his closet, covered, like museum artifacts.
>
> All the things he had handled,
> used, inhabited, and finally left
> were covered or lying about
> like the frames of stolen paintings left behind.
> (p.103)

The second theme: anticipation of the future and a reflection of the past guides the women toward a healthy and competent existence. Life is rich. A healthy and competent existence comes from the mystery of life. Louise Mattlage (1986), an eighty year old woman captured the essence of this theme in her writings. She wrote:

> The mystery that awaits us is near. Tomorrow is never there. Now is the most marvelous thing in the world. The future is delicious conjecture. And the absolutely sure, unshakable conviction that life is only part of being. The continuing certainty that the beyond is full of marvelous surprises. (p.81)

The third theme: a strong commitment to God prepares women for the impending time of death and fosters health. The women sought answers about the mystery of life from God. God's will was accepted complacently. Some would say this was a fatalistic perspective on life while others would say that this belief was part of the unquestioning acceptance of faith. Faith is a conviction to a belief with or without an empirical perspective.

The fourth theme: a moral sense of concern for others facilitates one's health. This theme was apparent throughout the data. The women felt that caring for others enhanced their own health. In Wilma Dykeman's 1962 publication The Tall Woman she presented the epitome of mountain mothers. This presentation showed that mountain women were caring as illustrated in the following quote. Dykeman (1962) wrote:

> Surely a woman has strange ways. The heart makes its logic, I reckon; nothing like the logic your papa talks about from all his books. It's made known to anybody who can give herself to being loved. And who can ever tell what it means to have given yourself in these mountains? (p.137)

The women in this study were giving and caring among their family, neighborhood and community. A concern for others was not a submissive behavior but a genuine love for people: a humanist behavior.

The fifth theme: retaining intellectual faculties with aging is an imperative dimension of health. "Keeping one's mind" was a central concern out of the fear of becoming "crazy." Being human and alive meant being creative, adaptive and engaged with the world. Life was cherished and precious. The women did not want to live a life without the meaning that "keeping one's mind" held for them.

The last theme: the belief that the unity of family and friends woven around the women nurtures

health. This theme emerged in the interviews, diaries, and during participant observation. Life for these Appalachian widows would have little meaning without family and friends. Their lives were organized around their families. A belief that a person was always there for a family member was seen as an aspect of life which nurtured a woman's inner being. Friends were usually treated as extended family members. Together, family and friends provided a never ending circle of life.

Let the Circle Be Unbroken

The last step in the analysis was to crystalize the themes together into a metaphor. This process was accomplished by looking within the culture to find words which allegorized the women's experience.

A metaphor identified within the culture indicated that health for the women in this study was represented by a complex circle. A prominent symbol within the culture was hymns, that is a song of praise or thanksgiving. Ready (1990) stated that for "the Appalachian woman, her refuge lay in church, in her fellow sisters and in the hymns" (p.4). The words of a hymn, popular in Appalachians, "Will the circle be unbroken, by and by, Lord, by and by...."

represents the essence of the women's stories. This essence is expressed by the importance of staying connected to all things precious in life in both the physical and metaphysical world. All of the women gave thanks to God as a power instrumental in their health. Their inner strength was fueled by their belief in God, and they had an unmovable faith in God and life everafter. Death was accepted as inevitable. While death was recognized as inevitable, it was accepted with equanimity.

The women were continuing a journey through life without their husbands, who, even in death, were a continuing presence of themselves. This journey was represented by the unity of a circle. The unity of the circle was family, friends, the church and the community. This unity intertwined with the women's health. The women believed that one must stay connected and give of self to others to survive. This connection included aspects of doing for others. Surrounded by family and friends, the women continued to look toward the future. The future was described as aspects of life and death. Life was lived to the fullest potential. This potential encompassed the act of caring for others.

Health can be understood as an unbroken circle. A circle being symbolic of the whole. This

whole refers to the total human condition--life. The women held a belief system that aspects of their lives facilitated health. A key dimension of this circle was expressed by the women as "keeping their minds"--mental health. For these women independence and a sense of self can not exist without mentation. Health was perceived to be present when all the analyzed domains were in harmony within the enclosed circle. As the circle of life evolves, the metaphor of Let The Circle Be Unbroken expressed the life experience of widowhood and health for all of the women in this study.

Summary

The purpose of this chapter was to describe the experience of health of the elderly widowed women in my study. During the process of analysis, four domains were chosen for indepth analysis. These domains are NO LONGER A COUPLE, EXISTING DAY TO DAY, LIVING THE RIGHT WAY, and STAYING HEALTHY. The major themes which surfaced highlight the major aspects of the lives of Appalachian widows.

These themes were woven into an ornate human tapestry, a colorful quilt referred to as "Let the Circle Be Unbroken." This cultural metaphor captured the experience of these elderly women's

perspective of health. Health was one's total life process which surrounded and completed the circle of life. In the last chapter, a discussion of the findings, implications for nursing, and recommendations for future research are presented.

Chapter VII

DISCUSSION AND IMPLICATIONS

This chapter includes a discussion of the findings, implications for nursing, and recommendations for future studies. Information gained from analysis is contrasted and interfaced with previous knowledge about widowhood, aging, morality, health, and Southern Appalachia.

Discussion of the Findings

The major findings of this study included: 1) the description of the tacit presence of husbands in the lives of these elderly Southern Appalachian widows; 2) the emergence of a nonstereotypical image of the elderly Appalachian widow; 3) identification of inner strength experienced with widowhood; and 4) an understanding of health from the female perspective within this culture.

The discussion of the findings is organized in relation to the four identified domains:

1. NO LONGER A COUPLE,
2. EXISTING DAY TO DAY,

3. LIVING THE RIGHT WAY,

4. STAYING HEALTHY.

NO LONGER A COUPLE

The elderly widows in this study have broken the mold of the stereotype of older women, especially Southern Appalachian women. Traditionally, women have been viewed as having the attributes of passivity, emotional dependence, capacity for empathy, altruism, and submissiveness (Mowbray, Lanir, & Hulce, 1985). The women of this study possessed the characteristics of self-discipline, strong will, independence, activity, and caring. They are a stabilizing force within the family and take responsibility for their own health.

The Appalachian women I interviewed have managed to survive widowhood instead of being perceived as stoic mourners. Although they were dependent upon their husbands, the informants emerged as women capable of managing self, the family, and its finances. A few of these women, however, never had a chance to become independent. They had fathers, then husbands, and then sons who took over. Overall, the women described their perceptions of the proper woman's role: dependent on the man as long as he is there, but capable of taking control when they finally must become independent.

Nationally, approximately two-thirds of the women over sixty-five are widows and many live alone (McElmurry, Glass, & Egan, 1981). Widowhood is an aspect of the life cycle for women which usually results in living alone. Living alone often results in social isolation. Lopata (1979) found that the widows living in the Chicago area experienced isolation due to lack of skills, money, health, and transportation needed for reestablishing connections in the community. In this study, transportation was not a deterrent to staying connected with others. Loneliness was experienced by all the women and social isolation was identified as existing even in a crowd. No longer were the women seen as part of a couple; they were now widows. Other widows became part of their social network. The women experienced social isolation relative to no longer being a couple but their family ties remained strong following the death of their husband. Peterson (1990) conducted fieldwork among elderly black urban population and found that black women survived widowhood with strong kinship ties. This characteristic of strong kinship ties was observed among the Appalachian widows in this study.

A major discovery of this ethnography was the identification of inner strength experienced with

widowhood. An inner strength helped these women survive. Rose (1988) conducted a phenomenological study on inner strength among women and found nine essential themes that formulated the meaning of inner strength.

Several strands of Roses' (1988) findings are demonstrated within this study. Evidence of one of Rose's essential themes was seen in this sample: quiescencing - availing oneself of quiet and calm. The women were able to draw inner strength from God and from a calm, quiet, peaceful approach to everyday life. Introspection, another of Rose's themes was cultivated by these Appalachian widows faith in God. Rose's theme of using humor was also observed in this sample. The women were able to laugh at themselves and at life's day to day situations. Finally, Rose's theme of having capacity can be understood within the lives of these women as they look toward the future and reflect upon the past during decision making.

All of the women, whether widowed 3 or 26 years, experienced the tacit presence of their husbands. The tacit presence included more than memory, reminiscing, or a nostalgic reflection. This tacit presence is an inner embodied experience of their husbands being there but absent physically.

The tacit presence of one's husband during widowhood has not been documented in previous nursing research.

The article by Moss and Moss (1984) deserves review because their discussion about the existence of the marital bonds after the death of a spouse is consistent with the findings of this dissertation. Moss and Moss (1984) stated that marital ties persist after death as "pervasive and persistent memory" (p.197). Five themes of marital bond were identified which exist throughout widowhood. These themes are:

> 1) caring-an affirmation of continuing affection;
>
> 2) intimacy-a unique sharing and sense of mutual importance;
>
> 3) family feeling-a deep sense of biological kinship and bondedness;
>
> 4) commitment-intended continuity of the relationship;
>
> 5) reciprocal identity support-each is defined and confirmed by the other (Moss & Moss, 1984, p.195).

Moss and Moss (1984) suggested that these themes may provide comfort and support to the surviving spouse. Memories were discussed in terms of normality, meaning that persistent and positive memories of a widow's husband is considered to be normal behavior. This dissertation generated similar data; the existence of a tacit presence of the informant's

husband in her life was normalized in the Appalachian culture.

EXISTING DAY TO DAY

Among the variety of theories reported in texts and literature on aging, no one theory adequately explains the multidimensional nature of aging. The reality of the aging woman must be discovered from her subjective experience. An advantage of using qualitative methodologies includes the ability of the investigator to discover the multiple realities of aging (Lincoln & Guba, 1985).

A major psychosocial theory appears to be congruent with the voices of the women in this study. Activity theory of aging (Cox, 1984) emphasized the stability of the personality system as a person moves from middle-age into old age. Old age is viewed as a continuation of life. Within this theory a person who ages successfully is the person who remains active, productive and engaged in a viable social network (Logan & Dawkins, 1986). In this study, the women believed that their health was influenced by staying busy, the ability to keep their mind, and staying connected with other people. The Appalachian women represented successful aging through their activities and engagement with others.

LIVING THE RIGHT WAY

Gilligan (1982) argued for the integration of the "feminine voice" into developmental theories of morality. Three levels of moral development among women were identified by Gilligan. The first level predominately focuses on care for self. The second level of judgment is characterized by the concept of responsibility or care for others. Characteristics of this level include the maternal concept of morality which equates good with caring for others. The third level of judgment is based upon the moral principle of nonviolence, or care for self and others equally.

Gilligan's second level of judgment was found to be exhibited by the women of this study. Their conceptions of self included doing or living the right way. In the second level, moral judgment emerges from shared norms and expectations (Gilligan, 1982). In this study, the Appalachian women were seen to be connected to family, to each other, and to the community. Morality dictated that care be given to neighbors in need; the ability to care for and protect others was deemed "good." The expression of concern for others and the interest in caring for others were viewed as an obligation to care by the widows. They were fulfilling society's expected role

for the "good" woman. Sacrificing themselves for their husbands, children, and grandchildren, neighbors and friends was accepted as what a "good" woman does.

Gilligan's third level of judgment is based upon the moral principle of nonviolence, or care for self and others equally. The elderly widows in this study shared stories about self-care and caring for others in the community.

Christenson (1977) studied value differences among various generations. Findings suggested that attitudes and values shift as one moves from the younger generation to the older generation. Christenson found that moral integrity peaked in importance between ages 30 to 39 and 60 to 69. This characteristic was not found in this study. The widows in this study considered moral integrity to be very important for their health. Christenson also found that helping others is highest between ages 50 to 59. In contrast, the women in this study were very active in caring for others in their family and community. In these older Appalachian women, the values of doing right and doing for others are strongly held through the later years.

Similar beliefs of the women in my study are congruent with Sullivan's (1979) findings. Sullivan

found that people over the age of 65 in a metropolitan area believed in: religion and prayers as sources of peace of mind; unselfishness and dictates of conscience; and maintaining contact with relatives. This research group identified several practices such as helping others, and participating in church activities as being important in the lives of the informants. Both of these practices were identified by the women in my study as important health behaviors. Sullivan stated that the sample of both men and women over 65 years old rated their health fair to poor. All of the women in my study perceived themselves to be in good or very good health, even those who had obvious/known chronic illnesses. A difference in perception of health of the women in my study might be explained by the culture or they might be gender-specific. Another possible explanation is that those informants who agreed to participate might tend to be more active and healthier than those widows who refused to be interviewed.

In contrast to Sullivan's (1979) findings of a present-oriented perspective, the women of this study had both a present-oriented and a future-oriented perspective. Thinking toward the future enhanced their sense of security. Only if one thinks

about the possibilities, can one be prepared for the future. A belief was expressed that both a present and future oriented perspective were necessary for a healthy way of life.

The study of older people is anthropologic in that older people eventually vanish. A civilization disappears each year with the death of the elderly. Preserving the heritage and understanding the wisdom of elderly women become more difficult tasks as technological advances move society forward with increasing speed. Ebersole and Hess (1985) described this process as the human Doppler effect.

> Society is on a fast train called progress, and the voice of the people moving less rapidly is diminished by the speed of progress. This thought emerges from the understanding that the motion of a body will diminish the number of sound waves from another body in proportion to the speed of the receding body. (Ebersole & Hess, 1985, p.709)

The experience of aging for the women in this study was congruent with the human Doppler effect. Several of the women perceived living a fast life as incompatible with their way of life. A negative value was placed on overindulgence of material wealth. A moderate life was viewed as a healthy way of living. The women's understanding of progress may be explained by the human Doppler effect.

STAYING HEALTHY

The experience of health from the perspective of the elderly widowed women in this study coincided with Smith's (1983) explanation of the eudaimonistic model of health. The women stated that health was a way of being well, hence general well-being.

The women of this study demonstrated a tremendous vitality for life. Health was considered to be at the center of the life process. The process of maintaining or fostering one's health was considered important for living. The will to continue living was significant. These women accepted death as inevitable but wanted their life to continue. These women accepted responsibility for their own health and wellness. They identified self care measures that help to improve their physical, psychological and social well being.

The ethnographic findings interface nicely with the findings of a descriptive study of older women (McElmurry & LiBrizzi, 1986). The predominantly middle class American women in that study identified a need for education in various health related areas although they were described as healthy, independent, and capable of self care. In contrast, the Appalachian women of my study could list appropriate foods for low cholesterol diets and

identify appropriate health behaviors such as breast examination but did not practice the behaviors consistent with the knowledge. Even when the women were aware of health problems, prevention was not taken. Hence, education may not increase health behaviors among this group of older women.

Retaining intellectual faculties was considered imperative to health for this group of women. One must be mentally alert and capable of exercising the skill of problem solving to be self sufficient. Within this culture, a belief existed that the family members were responsible for each other. Yet, the women did not want to experience a loss of being self sufficient. They believed that if they were not self sufficient then they would be a burden.

The women professed an attitude of "don't worry" as a way to cope with stress. This attitude was a strong belief within the culture. Warheit (1979) identified a progressive pattern of resources that people use to cope with stress. These resources are: 1) inner strength; 2) family assistance; 3) friendships; 4) assistance from professionals; and 5) cultural beliefs, values, symbols, and myths. An attitude and behavior of not worrying was a cultural belief. The women of this study used all of these

resources except assistance from professionals. Emotional illness was viewed as a weakness by this group (field notes). Carlton (1974) stated that Appalachians believe one should deal with mental problems oneself. A mental health clinic was available in Western County, but the women in this study did not perceive this as a resource. The strong friendship that connected various groups of widows in the county formed the support network for sharing problems.

The unity of family and friends, like a quilt pattern woven around the women, nurtures health. These relationships were viewed as healthy. Harris (1975) demonstrated the significance of friendship among the elderly. Relating with friends was identified by these women as a significant aspect of maintaining their health.

Family ties with children and extended family members were also strengths of the women in this study. The data from the daily health diaries frequently documents aspects of their lives with kin. The connection with kin was perceived as healthy by the widows. Johnson and Bursk (1977) affirmed that emotional support of the parent is more salient than physical support or care. Parents identified emotional support from their children as more

important than physical care.

Webster and Lipetz (1986) called for allowing informants to describe their experience of health and illness in the context of their daily lives. In this study, three major health problems were identified by the women as concerns of everyday life: falling, hypertension and diminished vision.

Ebersole and Hess (1990) stated that falls, the majority of which are due to environmental factors, are a significant problem for the elderly. A study by Bruno and Craven (1983) found that being female and living alone were risk factors for falling. The widows I interviewed, like many older women, expressed a fear of falling and loss of independence.

Over half of the women in this study had hypertension. All of these women were on medication and sought medical care on a regular basis. They could discuss an appropriate diet for high blood pressure but did not adhere to a specific diet. Each woman had devised a method for adhering to her medication schedule, demonstrating some acceptance of her health problem.

Deterioration in vision is normal with aging. Several of the women had a form of visual difficulty. Three of the women had had cataracts removed and one

informant had glaucoma. All of the women wore glasses. Night vision decreases with aging, and was identified among the women as the major reason for discontinuing driving at night. Those women who drove cars did so only during daylight hours. All shopping had to be taken care of during daylight hours. More lighting was required for reading. Addressing envelopes or writing letters had to be carried out by family members. Reading had become difficult for some women (field notes).

The sharing of health experiences among Appalachians has been referred to by Crase (1978) as an obsessive behavior which he called the illness syndrome. This study found that the women communicated frequently by word of mouth about the health of members of the community. However, I would not label this form of communication illness syndrome. Instead, a sense of concern for others was at the center of this behavior.

In this dissertation, rural is understood to mean a county with less than 100,000 people. Rural applies to the county selected for the context of this dissertation, with a population of 67,646 and no town over a population of 13,748. The county is large and distant from cities with metropolitan services. Several areas were identified as being

problems in Western County. First, transportation remained a problem throughout the county. Dirt roads were difficult to travel due to snow and the mud during rain. Second, health hazards of Western County have been identified by the state. Western County ranks second in the state of North Carolina for emission of toxic pollution.

Third, the resources that are available in the community were not used adequately by the elderly. For example, I found that some individuals refused the program delivering meals to home bound individuals. Possible reasons for this included: the layers of bureaucracy that require paperwork, the lack of personalized interactions, and the trait of independence seen in the people. The Appalachian culture has a negative perspective toward anything that resembles charity. There are people in the county who refused services from the health department because of the perceived view that the care was charity. Charity care was considered to be a stigma or unacceptable.

Lastly, educational programs aimed at teaching self-care measures for the elderly population could be offered through the churches with public or private funds. Former President Carter challenged the churches to deal with human health

within the community and globally. The concern for human health would seem to flow naturally from the church since one-third of the biblical text of the four Gospels was devoted to acts of healing by Jesus (Carter, 1990). Carter further suggested that the church could "provide a constant flow of information about health issues to be used in church bulletins and denominational periodicals" (1990, p.35). Within Appalachia health models could be developed with the support of the churches.

William Foege (1990) stated:

> The church can teach us about the unity of body and soul and about the damage caused by our inability to see people as wholes. There is a unity to the idea of brokenness, whether we are talking about sin or disease or depletion of the ozone layer or the homeless. There is also a unity to the idea of redemption, whether we are talking about forgiveness or healing or environmental improvement. (p.36)

Both Carter and Foege support the need of church involvement relative to health promotion. Within the culture of Appalachia, the church has a strong influence with the people. The church could bridge the gap between the ideals and practice of health.

Implications for Nursing

The results of this study add breadth and depth to the limited body of knowledge describing health in Appalachia and these women add a new

understanding from the female perspective within this culture. The descriptions and interpretation of the lifeways of Southern Appalachian women add to the knowledge of cultures. The findings document the value of an ethnographic study as an important approach for generating knowledge. The results from this study have several implications for nurses working among the Appalachian culture.

An understanding of the Appalachian life way will enhance the delivery of care given by the nurse. Effective nursing care is facilitated by "(1) avoidance of ethnocentrism, i.e., the belief that one's own culture is right and better than other cultures, and (2) avoidance of stereotyping" (Logan & Dawkins, 1986, p.116). Avoidance of these behaviors may allow the nurse to be perceived as being more flexible by the Appalachian culture.

Nurses working with the Appalachian culture should incorporate the family into planning for health care. Within the Appalachian culture, family involvement is key to compliance. Family members must agree on preventive health measures to ensure compliance. Finally, the nurse should integrate new ideas into the existing belief system and explore the client's ability to comply. Within the Appalachian culture, this strategy could be successfully

accomplished by having other community members share their positive experiences of a new health idea.

Nevertheless, the Appalachian culture is complex and introducing health practices to this community is a challenge. Church leaders, community leaders and/or family members can influence health care in the region. Health professionals must work to facilitate cooperative relationships with individuals who might help to influence health behaviors.

Recommendations for Future Studies

This dissertation indicates a need for research to be conducted from the perspective of the elderly, and most specifically elderly women. Four areas should be explored further within the Appalachian culture: 1) identification of the difference between the health needs of middle aged women and those of older women; 2) exploration of the ways community health nurses can support non-kin networks of elderly women; 3) identification of elderly women's perspective of health in various cultures; and 4) clarification of self care and caring behaviors that women perceive as promoting health.

Additional areas for further study include:

the use of humor and reminiscing as a health promoting behavior among elderly women within the Appalachian culture; and women's perception of the tacit presence of their husband as a lived experience. Lastly, life satisfaction and happiness among the elderly in Southern Appalachia needs to be explored further in comparison to other cultures. All of these proposed studies could be conducted with ethnography or other qualitative designs.

Summary

The purpose of the ethnographic study described in this dissertation was to facilitate discovery and description of the health experience from the perspective of a group of elderly women in the Southern Appalachian region of North Carolina. Several techniques were used to gather data: participant observation, health diaries, document analysis, photography, and in-depth unstructured interviews. Data generation was directed toward gaining a thick description of the lived experience of the women.

Four domains were derived from the data to lend structure to indepth analysis. The four domains included: NO LONGER A COUPLE, EXISTING DAY TO DAY, LIVING THE RIGHT WAY, and STAYING HEALTHY.

Categories were identified within each domain, each illustrated by threads of meaning. Analysis of the domain, NO LONGER A COUPLE, produced four categories: coming back, enduring, preparing, and constant contact. The second domain, EXISTING DAY TO DAY, encompassed planning, family, and activities. The third domain, LIVING THE RIGHT WAY unfolded two categories: values and God. The last domain, STAYING HEALTHY, embraced physical activities, mental activities, and health.

Six major themes were revealed from the data, stated in the form of a sentence. A rebirth occurred with the loss of a husband which required the emergence of inner strength to endure living with loneliness in a crowd. Anticipation of the future and reflection of the past guided the women toward a healthy and competent existence. A strong commitment to God fostered health and prepared the women for the future-death. A unity of family and friends nurtured the women. A moral sense of concern for others facilitated a state of health. Retaining intellectual faculties was an imperative dimension of health for these older women.

These themes were woven into a metaphor found within the culture--LET THE CIRCLE BE UNBROKEN--a phrase taken from a popular Appalachian hymn. The

description of this metaphor captures the experience of these elderly widows. Health was a complex circle that connected family and friends. As the women told their stories, this circle was woven in and out of the domains and themes. Health represented their life process. Health was the unbroken circle of the physical and metaphysical aspects of life.

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Appendix A

DEMOGRAPHIC FORM

NAME:_____

ID NUMBER_____

ADDRESS:_____

PHONE:_____

DIRECTIONS TO HOME

_____

_____

_____

AGE:_____ NUMBER OF YEARS WIDOWED_____

EDUCATION:_____ ETHNIC HERITAGE_____

PREVIOUS OCCUPATION_____

GENERATION_____

DATE OF INTERVIEWS_____ PLACE_____

_____

_____

_____

_____

_____

Appendix B

INTERVIEW GUIDE

Descriptive Questions:

Tell me about your day.

Please describe what you did yesterday.

Tell me about the last time you were sick.

Structural Questions:

Tell me what health means to you.

Please describe how you stay healthy.

What health practices do you consider important?

Contrast Question:

What is the difference between sickness and illness?

How do you decide which health problem is important for the doctor?

Appendix C

HEALTH DIARY

ID_____

Date_____

1. How was your day today? a)any problems or concerns?

2. What did you today to stay well or healthy?

a) any positive things?

Appendix D

SUBJECT CONSENT FORM
FOR
PARTICIPATION IN CLINICAL INVESTIGATION PROJECT
UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER
VETERANS ADMINISTRATION MEDICAL CENTER

Project Description:

You are being asked to participate in a study about the health beliefs and practices of Appalachian widows. You have been selected because you are a widow and in this state.

If you agree to participate, you will be asked some questions about your health practices and asked to keep a health diary for one month. The researcher, SONYA HARDIN, will visit your home to conduct several one to two hour interviews. The interviews will be taped recorded and the audiotapes will be erased following completion of the research. You may refuse to answer any question at any time. In addition, the researcher may accompany you to various activities (e.g. church, meetings) if invited by you. She may also ask your permission to photograph the setting in which these activities occur or artifacts found in the setting.

There are no risks or benefits to you from participating in the study. The researcher will offer you a fair return for the time you are involved in the interview. For example, a ride to the doctor or grocery store, running errands and doing odd jobs around the house may be offered.

The information obtained in this study may be published in professional journals, but your identity will not be revealed.

Appendix D (Continued)

If you have any questions please feel free to ask them at any point during the study. If you have questions regarding your rights as a human subject participating in this research project, please call Mrs. M. Peratt, secretary of the UCHSC Human Subjects Committee at ([redacted] A copy of this consent form will be left with you.

My name is: Sonya Hardin, RN, MSN
Office phone [redacted]
Home phone: [redacted]

AUTHORIZATION: I have read the above and understand the discomforts, inconveniences, and risks of this study. I agree to participate. I understand that I can refuse to participate or withdraw at any time.

SIGNED:_____

WITNESS:_____

DATE: _____

Appendix E

GLOSSARY

A

A Body: a person.

Act the fool: act silly.

Addled: confused.

Ailin': sick.

Aim to: intend.

Airish: cool.

Alkyholic: alcoholic.

All to pieces: torn apart.

Amongst: among.

Ary: any

B

Bad off: a serious health condition.

Bantam: a small variety of chicken.

Banty: term used to describe something small, or a person with an aggressive personality.

Bedfast: confined to a bed due to an illness.

Beholden: obligated.

Big Headed: conceited.

Bitch: Mean woman or to complain.

Blowed: blew.

Bring down a notch: deflate one's ego.

Bone yard: cemetery.

Bound to: certain.

Burying: funeral.

C

Carry: take.

Cheer: chair.

Choicey, or Choosey: particular.

Clever: good-natured.

Coming up a cloud: a thunderstorm.

D

Damn: very.

Dead level best: the best one can do.

Decoration day: a day to put flowers on the grave; now called Memorial Day.

Die out: die.

Dinner: noon day meal.

Dips: use snuff.

Directly: soon.

Doesn't differ: makes no difference.

Done: finished.

Dope: a soft drink, usually refers to Coke.

Dremp: dreamed.

Druthers: preference.

Dying out: vanishing.

E

Easing powders: pain killers.

Er: or.

Except: accept.

F

Fell off: weight loss.

Figured: thought.

Fitten: suitable.

Fit to be tied: enraged or extremely upset.

Fixin' to: preparing to.

Flair: flour or flower.

Foreigner: one living outside the mountains.

Fur piece: long distance.

G

Git away with: embarrass.

Git on: accuse.

Git shed of: rid.

Give out: exhausted.

Give up one side and down the other: scold.

Go to the bad: spoil.

Gracious plenty: enough.

H

Hear tell: know.

Hog wild: overly excited.

How come: why.

I

Ill: bad tempered.

Illness: serious condition.

K

Kaint: can not.

Kaint kumplain: healthy.

Keer: care.

Kiver: cover.

Knowed: knew.

L

Laid out or laid to rest: a person in a casket.

Law/ Law-mercy/ Lord have mercy: exasperation or surprise.

Let on: admit or even hint.

Lift: a feeling of wellness.

M

Make out like: pretend.

Mend: improve physically.

Mess: a sufficient amount.

N

Not about to: by no means.

Not got a lick of sense: not very bright.

O

On: about.

Ornery: worthless.

Own up to: acknowledge.

P

Pank: pink.

Pay no mind: give no attention.

Peaked: tired.

Pester: bother.

Play possum: act dead.

Plum: totally.

Pocket book: purse.

Poorly: not well.

Puke: vomit.

Puny: not well.

Purt' near: almost.

Purty poorly: bad health.

Puttin' back: saving money.

Q

Quare: peculiar.

R

Raise: to rear.

Right: very.

Right smart: a lot.

Rising: boil.

S

Sair: sour.

Sartin: certain.

Shop: furniture factory.

Shucky beans: beans dried in the hull for winter.

Shut ins: people who are homebound.

Sic: chase away.

Smidgen: small amount.

Sorry: worthless.

Stories: soap operas.

T

Tad: small amount.

Taint: it is not.

Take off: leave in a hurry.

Take on: crying.

Tared: pronunciation of "tired".

Tell: distinguish.

Thar: pronunciation of "there".

Time about: to take turns.

Took down: sick.

Took a notion: decided.

To saucer: pour hot coffee into saucer to cool and then drink from the saucer.

U

Up bringing: the way one was reared.

W

Wauter:water

Well, I've never: You don't say.

Wimmen: ladies; females.

Without Rhyme nor reason: no known cause.

Worn out: tired.

Y

You-uns: you.

Phrases

I want off: to disembark from an automobile.

It poured the rain: the rain came hard and loud.

I don't care to: means I will do it.

I felt like a cat on nails: feeling stressed.

That's your tail, I'm sitting on mine: You must be lying.

A body can get sick as a dog if they're out in the rain: A person will get sick to their stomach if they stand in the rain a long time.