DOWN HOME:
AN ETHNOGRAPHY ABOUT
COMMUNITY PROCESS
AND HEALTH OF
OLDER PERSONS IN
A RURAL SETTING

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Down Home: An Ethnography About Community Process and Health of Older Persons In a Rural Setting.

Thesis directed by Associate Professor Joan K. Magilvy.

The purpose of this study was to understand how rural-dwelling elderly people describe their health and to gain an understanding of rural community processes as they relate to the health of older residents. Although community health nursing practice supports community-level interventions, the influence of communities upon the health of older community members is not well known.

Ethnographic design and methods were employed to study the health of older residents in a Western Plains farming community of about 500 people. The sample included 104 people. Interviews, participant observation, examination of artifacts, and photography were used to generate data, which included interview transcripts, field notes, and theoretical memos.

Five domains emerged from analysis of categories identified in the data. Five themes crossed the domains and unified data. A metaphor entitled "The Myth of Rural Life" depicted prevailing cultural values and norms. Finally, a theoretical statement developed from the themes and the metaphor.

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Relationship was a key component for understanding life in Farmington. Reciprocal relationships in which older people and the community were mutual benefactors were crucial to the acceptability of help and support, as well as the acceptance of "outsiders" into the community. The community supported older people to maintain independence and to engage in meaningful activity while older community members supported the community through work and volunteer activities. Stressors in the community were a lack of privacy, and isolation for those who did not conform to prevailing community norms.

Implications for the nursing profession include: nurses in rural areas need to foster a sense of relationship and reciprocity within a community since assistance is accepted most easily when older people can reciprocate help. Advocating the use of government supports and programs may not be successful if the programs do not require contributions from recipients.

Close relationships can be stressful as well as supportive, and increasing social support and monitoring for an older person may inadvertently decrease privacy and promote stress. Promoting health for the entire community may require finding a
common goal that both insiders and outsiders agree is important.

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

Signed

Faculty member in charge of thesis
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CONTENTS

TABLES ........................................... xiii

FIGURES ........................................... xiv

CHAPTER

I. INTRODUCTION ....................... 1
   Specific Aims ...................... 4
   Long Term Goals .................. 4
   Definitions ....................... 5
      Health ........................... 5
      Rural ........................... 6
      Elderly Person
         or Older Adult ............. 6
      Community  ...................... 7
      Community Process ............ 7
   Significance of the Study ....... 7
   Summary ........................... 9

II. SELECTED REVIEW
    OF THE LITERATURE .......... 11
    Status of the Elderly
       in America .................... 11
       Demographic Status .......... 11
       Geographic Distribution .... 13
       Economic Status ............. 14
       Health Status ................ 16

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Data Preparation............ 52
Data Analysis............... 53
Rigor........................ 54
Ethical Considerations of the study............ 57
Summary....................... 57

V. SAMPLE DESCRIPTION............. 59
Community Description.......... 60
Summary........................ 66
Participant Description........ 67
Age and Illness................. 68
Economic Status................ 71
Summary........................ 73
Being Older in a Rural Community................. 74
Chapter Summary................ 76

VI. FINDINGS: I'M TOO FIESTY TO GET SICK.................... 77
Domain One: BEING HEALTHY...... 80
Being Active................... 81
Work............................ 81
Social Interaction............. 84
Summary........................ 89
Being Independent............. 90
Hard Core Independence....... 90
Independence with Help....... 91
Having to Move............... 93
Summary....................... 94

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Domain Summary......................... 95

Domain Two: SEEKING HEALTH CARE........ 96

Doctoring............................... 96
Access.................................. 97
Choosing a Health Care Provider........ 98
Choosing a Site......................... 103
Summary................................ 106

Helping One Another.................... 106
Giving Care............................. 107
Family Care............................. 108
Community Care.......................... 108

Domain Summary......................... 110

Chapter Summary.......................... 111

VII. FINDINGS: PEOPLE LIVE IN A SMALL TOWN FOR WHAT A SMALL TOWN HAS TO OFFER.................... 113

Domain Three: KNOWING EVERYBODY........ 114

Insiders............................... 114
Summary................................. 117

Outsiders............................... 117
Time in Residence.................... 118
Cultural Acceptability............. 119
Uneasy Feelings....................... 122

Summary................................. 123

Domain Summary......................... 123

Domain Four: COMMUNITY CARING........ 124
TABLES

Table

1. Population Over Age 65 in the County ...................... 44
2. Age Distribution of Sample Participants ................ 47
3. Overview of Domains and Categories ...................... 78
4. Overview of Domains and Categories ......................... 150
FIGURES

Figure

1. The town of "Farmington"........ 61
2. Typical house in Farmington..... 63
3. Portrait of a "younger-old" man in his garden............... 69
4. Portrait of an older businesswoman........ 83
5. Typical craft projects for older women in the community....... 89
6. Old Louie out walkin' around.... 115
7. Community bus trip.............. 139
CHAPTER I

INTRODUCTION

Never has there been a time when so many people have lived to age 65 and beyond. When the baby boom generation matures into this age category, they will create the largest cohort of people above age 65 who have ever existed (Coward & Cutler, 1989). As the trend for nursing care of the older population shifts from hospital-based to community-based care, the status of elders in the rural community setting must be better understood.

Although community health nursing research supports the impact of health care services on the health of community members, the influence of communities themselves upon health is not well known. Some authors have indicated that community functioning can affect the health status of community members (Goeppinger & Baglioni, 1985; Phillips and Gaylord, 1985). Cottrell, (1976) in his initial work on community competence, concluded that communities may impact the mental health of their residents. Goeppinger and her colleagues believed that living in a competent community may increase health status.
through effective community-based problem solving (Goeppinger, Lassiter, & Wilcox, 1982; Goeppinger & Baglioni, 1985). Although community/public health nurses have been encouraged to intervene at the community level, limited research has been done on the effect of communities upon resident's health.

Older adults living in rural communities can serve as exemplars for a study of the effect of community upon health due to their extensive health needs and the relative isolation of communities in the rural setting. The proportion of older people living in a rural community goes up as the total population decreases, resulting in a high concentration of older residents in rural areas (Clifford, Heaton, Voss, & Fugitt, 1985). Likewise, the number of older people who are living in rural areas will increase as the general population increases. The small number of people living in a rural community allows community study to be undertaken in a more holistic manner.

Basing community nursing knowledge on this exemplar group may allow a greater understanding of the community health needs of other populations. Further, this exemplary rural elderly population can teach us much about how aspects of community life impact health. Knowledge about the effects of
communities upon health will assist in planning for health services and nursing care strategies for health promotion at the community level.

The effect of rural communities upon the health status of older Americans is not well understood, but rural elderly people occupy a greater proportion of the nation's substandard housing (Montgomery, Stubbs & Savannah, 1980; Bylund, 1985) and have lower incomes than their urban counterparts (Lee & Lassey, 1982; U.S. Bureau of the Census, 1987). Older people in rural environments also have less access to health care and fewer available services (Lee & Lassey, 1982). Whether these factors result in a lower health status for the elderly in rural settings is debatable (Krout, 1989).

As a community health nurse interested in the influence of communities on the health of their residents and possible implications for community nursing interventions, I designed a study focused on the health of rural dwelling older people. The purpose of this study was to understand how community-dwelling elderly people describe their health and to gain an understanding of rural community processes as they relate to the health of older residents.
Specific Aims

The specific aims of this study were:

1. to increase understanding about the health of elderly people in rural settings,

2. to investigate rural community processes that affect health, and

3. to explore linkages among community processes and health status of the rural elderly.

An ethnographic design was used to explore these aims and to address the purpose and long term goals of the study.

Long Term Goals

Several long term goals evolved from the purpose and specific aims of this investigation. This study was a basic and necessary first step toward meeting the goals of the long term research. Long term goals were to develop a theoretical model of community health that will guide the intervention of community health nurses at the community level, to develop the concept of community process as it relates to health, to produce an assessment
instrument for community functioning, and to determine the impact of community health nursing on health status at the community level.

Definitions

The following definitions were used in this study.

Health

Although a definition of health was expected to emerge from the study that reflected the older participants' understanding of what health means to them, the beginning definition and assumptions were defined by the researcher. The definition was adapted from Meleis (1986, p. 18). Health was defined as:

a sense of biopsychosocial wellbeing and coherence as perceived by a human being and others and as manifested in efficient and effective capabilities to function, cope, and adjust to life experiences. Health is also manifested in the ability to use internal and external resources in dealing with life experiences.

This very broad-based definition of health was a synthesis of many definitions of health within nursing theory, and was capable of reflecting both individual and community aspects of health. Study findings produced a different definition of health from the perspective of older participants. Health
as defined by older people in the study community was
the ability to be active in the community and to
remain independent. The participants' definition
became the definition of health that was used in
analysis of themes.

Rural

Rural was defined in this study as a community of less than 2500 people in a non-Standard Metropolitan Statistical Area. Standard definitions of "rural" include both "non-metropolitan" areas and places of less than 2,500 people. The U.S. Bureau of Census designation of Standard Metropolitan Statistical Area (SMSA) was used. An SMSA is a county with a city of at least 50,000 or an urbanized area of at least 50,000 and a total SMSA of at least 100,000.

Elderly Person or Older Adult

An older adult in this study was defined as a person over 65 years of age. Sixty five years old was chosen because it was a standard age used to define "older" in the gerontological literature. "Elderly" is used as a adjective interchangeably with "older".
Community

Most definitions of rural communities focus on governmental designations or spatial units. Such definitions ignore the subjective dimensions that are an essential component of community (Cook, Goeppinger, Brink, Price, Whitehead, & Sauters, 1988). In this study community was defined as a locality-based entity, composed of a network of relationships with an expressed intent of meeting a variety of collective needs (Cook, Goeppinger, Brink, Price, Whitehead & Sauters, 1988).

Community Process

Community process was defined as the ways in which a community interacts to identify and solve community problems. Elements of community process include: commitment and participation from community members, communication within the community, methods of conflict management, and interaction of community members within the community and with the larger world in which the community is embedded.

Significance of the Study

With the growing population of older adults in rural communities, it has become increasingly important for community health nurses to understand the interaction between rural community life and the
health status of elder residents. Knowledge about the elderly in rural communities is limited, as is our understanding of the aspects of community that influence health. Static measures of community resources and access to care have not correlated well with the health status of elderly community members. The trend in community health nursing literature is for community health nurses to treat the community rather than individuals within the community (Anderson, McFarlane & Helton, 1988; APHA, 1980; Rogers, 1984; Spradley, 1990; Walker, Akinsanya, Davis & Marcer, 1989). Research on the ways in which communities affect health is needed to guide the practice of nursing at the community level, to develop theory in community health nursing, and to design instruments that assess the health of communities.

The changing status of the elderly population in America has a number of important implications for community health nurses. A tremendous increase will occur in the need for nursing care of older people as an unprecedented number of people live to age 75 and beyond. Much of this nursing care can be provided within a community-focused practice that takes account of the needs of an aging population. As we move into the next
century, community health nurses can take important leadership roles in gerontological health care to prepare people for this increasingly longer stage of life.

Summary

In this initial chapter, an ethnographic study was introduced, the stated purpose of which was to gain understanding of rural community processes as they relate to the health of rural-dwelling older adults. The significance of the results of this investigation lies in the possibility of increased comprehension of the dynamics that affect health of elderly people in rural communities. The results of the study may also enhance the understanding of effective nursing interventions for this population.

In the remainder of this dissertation, the background (Chapter II), the conceptual and methodological framework (Chapter III), the design and method (Chapter IV) and the results of the investigation (Chapters V through VIII) are described. A final chapter (Chapter IX), concludes the study; a description of community process is presented and implications are discussed. The title of the study, "Down Home", reflects the descriptive nature of this ethnography, told in the ethnographic
present in the language of the participants: the older residents of "Farmington", Colorado.
CHAPTER II

SELECTED REVIEW OF THE LITERATURE

The Status of the Elderly in America

Increasing numbers and diversity of elderly Americans have made it difficult to generalize about "the elderly" as though they are a homogeneous group. The population designated as "older" is a group that ranges from age 65 to over 100, with considerable diversity within an approximately forty year span. This diversity is underscored by the changing demographic picture of older Americans. In this chapter, literature relevant to older adults and community is reviewed and presented as a background to the study.

Demographic Status

Americans who are 65 years old or older comprise a group that is growing faster than any other age cohort in the country. In 1989 this group constituted 12.4% of the population as a whole (Fowles, 1990); by the year 2000, the group is projected to encompass 13.1%, and by 2030 it is estimated that 24.5% of the population will be 65 or
older (U.S. Department of Commerce, 1982). The fastest growing segment within the elderly group are those people who are 80 and older (Espenshade & Braun, 1983; Phillips & Gaylord, 1985). The category of those who are 85 or older is 23 times larger in 1988 than in the year 1900 (Fowles, 1990).

Growth in this age group is due not only to a decline in mortality and morbidity, but also to a declining birth rate, so that the relative proportion of older Americans will continue to increase (Ebersole & Hess, 1990). The growth will slow somewhat during the 1990s due to the relatively small number of babies born during the depression years, but will increase very rapidly between 2010 to 2030 due to "baby boomers" who will have reached age 65 (Fowles, 1990).

The majority of the very old segment of the population (those 80 and older) are women. Older women currently outnumber men by 6 million, and they are projected to outnumber men by about 12 million by the year 2030 (U.S. Department of Commerce, 1982). Women not only live have a longer life expectancy, but also tend to marry men who are a few years older. Half of all women over age 65 are widows, with five times as many widows in the older population as widowers (Fowles, 1990). By age 80 only 15% of women
are married, compared to 70% of the men who are 80 or older. Therefore, most of the very old are both female and single. The preponderance of women at advanced older ages has meant that many of the challenges of chronic health problems, limited finances, and changing social relationships are problems that women face alone (Strieb and Binstock, 1990).

Geographic Distribution

In 1988, about half of the elderly population lived in nine states: California, New York, Florida, Illinois, Ohio, Pennsylvania, Michigan, New Jersey, and Texas (Fowles, 1990). This distribution may be affected by migration of older Americans at several times during their later years. Longino (1990) characterizes this geographical movement into three stages: the first migration is at retirement for lifestyle or amenity reasons, often into rural areas; a second migration occurs with the onset of chronic disabilities and is usually towards children and urban areas. The third move is into institutional care when kin are no longer able or available to care for them. This migration trend indicates that geographic distribution of the younger group of elderly is different than that of the frail elderly. High numbers of elderly persons in Florida
have not increased the costs of health care services to the state (Pegels, 1988), perhaps because these individuals are primarily healthier, younger elders. A recent statistic in support of this idea is that a counter migration has appeared in persons over age 75 leaving Florida (U.S. Department of Commerce, 1982).

Migration may also have an effect on the stability and support of social networks. First migration sites may be more supportive to the elderly because these younger, healthier elders are able to interact more effectively with their new communities and contribute more than they consume. Second migration sites may be less supportive for older people who are in relatively poorer health, have an increased need for health care services, and are less able to interact with their communities beyond the immediate family.

**Economic Status**

Assessment of the economic well-being of older Americans can be difficult due to controversy about the appropriate measurements that should be used. Some authors equate well-being with income, while others also use leisure time, possession of durable goods, Medicare support, and home equity (Espenshade & Braun, 1983). Despite the debate as to how economic well-being should be measured, most
people who work with older people agree that the economic status of the elderly population as a whole has improved over the past 30 years and will continue to improve (Kane & Kane, 1990; Pegels, 1988; Smeeding, 1990). The percentage of people over age 65 who live in poverty has decreased from 35.2% in 1959 to 12.6% in 1985. The passage of the Medicare bill and increases in Social Security payments have contributed to this decline, as well as a unique economic situation during the 1960s and 1970s. The next cohort to reach elderly status was in the prime working years during the economically booming 1960s and has, on the whole, gained the maximum increase on mortgage values during the 1970s (Smeeding, 1990).

Striking racial and cultural differences are noticeable for older Americans, however. Only 11% of whites over age 65 live below the poverty level, but 31.5% of blacks and 23.7% of people of Spanish origin live in poverty (U.S. Department of Commerce, 1987; Fowles, 1990). The most economically vulnerable groups within the elderly population are the "near poor" who comprise 12% of the population (U.S. Department of Commerce, 1987), are in the lower middle class and who do not have home ownership (Smeeding, 1990), and women who have been widowed and have no retirement benefits of their own (Haber,
Since most of the very old (80+) are single women, the economic picture for this group is not as good as it is for Americans who are just entering the older stages of life. As more people live to an advanced age, the high costs of caring for a person with a catastrophic or chronic illness drains assets of ill persons and their families. High health care costs for chronic illnesses results in impoverishment for some elderly people (Ebersole & Hess, 1990).

Health Status

While the economic situation is variable for many older adults, the health status of most older Americans is relatively good. The designation of age 65 as "elderly" was made by the Roosevelt administration during the Depression as a means of removing about 25% of the eligible work force from competition for scarce jobs during the Depression. Reaching the age of 65, however, has not been shown to be necessarily correlated with the onset of chronic health problems that are associated with old age. The 65 to 75 year old age group does not generate much demand for supportive and health care services; only 5% of this cohort need help with activities of daily living (ADLs) such as feeding, bathing, and walking (Fowles, 1990). Nearly the same percentage need assistance with instrumental
activities of daily living (IADLs) such as shopping, housekeeping, and transportation (Haber, 1989).

The majority of elders are healthy, but as age increases, so does the need for supportive health care services. While only 1% of elders aged 65-75 are in nursing homes at any given time, 22% of those over 85 are nursing home residents (Pegels, 1988). As greater numbers of people live to advanced old age, they may live with chronic diseases for decades. About 85% of people over age 65 cope with at least one chronic illness (Fowles, 1990; The White House Conference, 1982), with concomitant increased health care needs and costs to themselves, their families, and society (Rice & Feldman, 1983). The most frequently occurring conditions in 1987 were: arthritis (48%), hypertension (37%), hearing impairments (30%), heart disease (30%), orthopedic problems (17%), cataracts (16%), sinusitis (15%), diabetes (10%), and tinnitus (9%) (Fowles, 1990). In summary, while aging itself is not a disease, older people are certainly at increased risk for chronic health problems.

Health Care

The implementation of Medicare programs during the 1960s has gradually improved the ability of elderly Americans to access acute care hospital
and physician services. Unfortunately, most older adults with health care problems need services that address chronic conditions or multiple chronic pathologies (Chappell, 1990) such as arthritis, hypertension, chronic heart disease, Type II diabetes, hearing impairments, cataracts, and combinations of these conditions. Many of the services needed by older people to maintain quality of life, such as hearing aids, dental care, foot care, and glasses, are not reimbursed by Medicare. These costs combined with the costs of health care for chronic and acute illnesses can prove catastrophic. People age 65 or older currently account for 42% of all days of care in hospitals (Fowles, 1990). Medicaid pays for about 46% of long-term care costs, but individual States have a great deal of discretion in reimbursement, with some states providing fairly good coverage and some very little (Ebersole and Hess, 1990).

The elderly who are most at risk for chronic, debilitating conditions are racial and ethnic minorities, those with less education, those living in rural areas, and those with inadequate housing (Phillips & Gaylord, 1985). These categories tend to include, of course, the poorest and most isolated elderly who have little discretionary income
to assist them with medical bills.

**Informal Care**

Much of the care that older adults receive for long-term illness comes not from formal services but from family and friends in the community (Haber, 1989). Formal services are often seen as inappropriate by elders when their symptoms are seen as due to the normal aging process (Branch and Nemeth, 1985). The informal network of family and friends has become the first resort for health care, usually in the form of assistance with IADLs (Chappell, 1990). Informal care also tends to be a substitute for formal health care for the elderly (Fleming, Giachello, Andersen & Adrade, 1984). Thirteen to twenty percent of all elders do not use formal health care services, but it is unknown whether informal services take up the slack (Krause, 1990).

Most family care is provided by women, especially spouses, daughters, and daughters-in-law; 80% of all informal caregivers are women (Chappell, 1990; Haber, 1989). Daughters and daughters-in-law may already be caring for an ailing spouse, in-law, children, or other family member and are more likely
to be employed outside of their homes than in previous generations. Consequently, women may be asked to provide care for both children and older relatives, while also maintaining an income. Research is indicated to understand the changing role of caregivers and their needs, since little governmental or community support exists for the caregivers in the informal care system (Coe, Wolinsky, Miller and Pendergast, 1984). The plight of women caregivers has become so pervasive that a recent newsmagazine made these women the focus of a cover story and coined the term "Daughter Track" to designate the services they provide to parents and spouses (Beck, M., Kantrowitz, B., Beach, L. Hager, M. Gordon, J., Roberts, E., & Hammill, R., 1990). The cost of informal care in economic and personal terms is unknown, although it is probably very high.

Some attempts have been made by formal health care systems to explore options that would allow older persons with health care needs to continue to live at least semi-independently in the community. The motivation for this exploration has been primarily from third-party payers to cut the costs of expensive hospital and nursing home services. Although demonstration projects are usually touted as a way to cut health care costs,
maintaining elders in the community has not been shown either to decrease acute care hospitalization or nursing home use, although an increased quality of life is seen as a result of these projects (Capitman, 1986; Haber, 1989; Kane and Kane, 1990).

Social Support

Social change, which is so pervasive in our culture, may either support or undermine the elderly population (Keith, 1990). Some indication exists in the literature that social support networks are stable and do not appear to change greatly with increasing age (Antonucci, 1990). Although some decline is seen in physical functions, social and psychological abilities show little or no change (Phillips and Gaylord, 1985). Women appear to have larger social networks with greater contacts and support than do men. This support may have a buffering effect on the problems of elderly widows (Antonucci, 1990). Phillips and Gaylord (1985) stated that it is the level of social change that affects the health of the elderly, along with the ability of the community to cope with community problems. They explained:

It is not poverty itself that creates the social diseases of unsanitary and hazardous housing, pollution and inadequate maintenance of streets, buildings, and public facilities. Many poor
communities, both urban and rural, maintain a level of neighborhood pride and identification, are stable and close, and display daily problem-solving competence.

Older adults living in communities that are competent in problem-solving have a better chance of maintaining healthy function through social networking, since social networks are often stable sources of support (Phillips & Gaylord, 1985).

Summary of the Status of the Elderly

More Americans are now aged 65 and older than in any time in history, and the relative percentage of people in this age category will continue to increase. The majority of people who live beyond 80 will be widowed women. Chronic illness health care needs increase dramatically after age 80, therefore these women will require increasing amounts of support from families, communities, and formal health care services.

The next section is a discussion of the concept of community and of community theory. Community theory is used to explore a "competent" or "healthy" community.

Community

The concept of community has had a multitude of definitions (Kirkpatrick, 1986; Lyon, 1987) but
there are many common elements. Common elements in
definitions of community include personal bonds
between members (Lyon, 1987; MacMurray, 1961;
McMillian & Chavis, 1986); reciprocal interaction
between members (Lyon, 1987, McMillian & Chavis,
1986; MacMurray, 1961); integration and fulfillment
of community members needs (McMillan & Chavis, 1986);
and a specific location in time and space (Lyon,
1987). Kirkpatrick (1986) also included a sense of
fellowship, or communion.

These elements of community are similar to
Cottrell's (1976) elements of a "competent"
community. Community competence as an aspect of
community originated with Cottrell's (1976)
experiences in communities that had different
abilities to define and cope with community problems.
Community competence is the ability of a community
and its constituent parts to interact effectively
through appropriate identification and resolution of
community problems (Iscoe, 1974; Rappaport, 1981;
Wilson, 1976). Cottrell's (1976) theoretical
dimensions of a competent community include:
commitment and participation from community members;
good conflict management among community subgroups;
effective, articulate communication within and
without the community; and effective machinery to
facilitate participation within the community and relationships with groups outside the community.

Goeppinger, Lassister, and Wilcox (1982) developed an assessment tool for community competence using a combination of Cottrell's (1976) indicators and expert opinions of community health nurses in practice and research. The tool was further revised by Goeppinger and Baglioni (1985). The tool, however, was not able to capture two of Cottrell's dimensions, and five of the remaining dimensions were represented by only two items. The authors concluded that the dimensions of competence may be overlapping in nature, particularly the dimensions of articulate and effective communication. The researchers concluded that:

Although progress has been made, much work remains both in conceptualizing the major issues and in overcoming practical difficulties. More communities must be studied, and the relationships among the dimensions of community competence and specific problems prevalent in communities must be explored (Goeppinger & Baglioni, 1985, p.520).

Community competence is remarkably similar to a definition of healthy community functioning (Marchione, 1986) that is based on Newman's (1986) theory of health as expanding consciousness. Two key points in Newman's (1986) theory are that health is a function of movement, space, and time, and that increased health is a result of expanded
consciousness. Movement, space, and time are reflections of the consciousness of a community. Consciousness is defined as the capacity of a system to interact with its environment. Each community is a unique pattern of consciousness that is manifested through community patterns that involve space, time, and movement. Health of a community, therefore, is assessed by the diversity and quality of the interactions in space, time, and movement between community members and the larger society of which the community is a part (Marchione, 1986).

A few nurses have analyzed community health from the standpoint of Newman's theory. Marchione (1986) analyzed a community in the midwest that had been totally destroyed by a tornado. The "expanded consciousness" that resulted in a healthier community included an increased awareness of relatedness between members, improved communication, and new and innovative ways of dealing with the problems of rebuilding the devastated town. Expanded consciousness appears to tap similar dimensions as community competence, although this work remains theoretical and has not been tested.

**Summary of Community**

Common elements in the concept of community include a specific location in time and space,
personal bonds between members, interactive relationships, and integration and fulfillment of members' needs. The "competent" or "healthy" community is a community that identifies and solves community problems, has open lines of communication between community groups, and has high levels of participation.

**Interaction of the Community and Health**

An understanding of the community as a determinant of health is just emerging in the nursing literature. "Environment" is considered one of the four paradigm concepts that undergirds all nursing theory. Currently, the paradigm concept of environment is considered to be the setting where nursing care happens and where people live. Chopoorian (1986) discussed the inadequacy of this conceptualization, especially when environment is viewed as if it were a static reality with a comparatively small impact on the health of persons. A common characteristic of community health nursing is that the focus of community health nursing practice is the community and not the individual (Anderson and McFarlane, 1988; Rogers, 1984; Spradley, 1990) with the implication that the community is the client in a dynamic and interactive
relationship with the nurse.

Rural Communities

Most of the current studies on community factors that may influence health treat the community as a static entity. Health has been considered a function of access, available personnel, and options for health care. In a review of the literature on health status of the rural elderly, however, Lee and Lassey (1982) found that while rural elderly have fewer services, less income, and more access problems, subjective measures of health between rural and urban elders did not differ. Possible explanations were that greater social interaction, less fear of crime, and the more gradual nature of the retirement process may mitigate the problems of rural residence. A more recent literature review by Krout (1989) stated that the majority of research on illness in the elderly reports that the rural population is in relatively poorer health. Krout concluded, however, that methodological problems and lack of concise definitions make conclusions about the health status of the rural elderly very ambiguous. His own study of community size and health indicated that community size did not correlate well with health status.
Summary of Literature Review

Health status of older people is not simply a function of resources and access. Dynamic processes involved in community functioning may support or undermine the health status of various subgroups in the community. Rural elders, for example, may rely more on informal networks of support due to a relative lack of formal health care options (Coward & Cutler, 1989). Such informal networks may be characteristic of rural communities. Attempts to relate the size or service options of a community to health status may be too static. The influence of rural community process as it relates to health may be a critical component that is missing from these studies. This study focused on this critical area of community processes as they related to the health of older persons living in a rural community.

In the next chapter, the conceptual and methodological framework is described. Ethnographic concepts are presented that provide the structure for the ethnographic methodology described in Chapter IV.
CHAPTER III

CONCEPTUAL AND METHODOLOGICAL FRAMEWORK

In chapter III the ethnographic concepts are discussed as employed in this dissertation. The chapter begins with an overview of ethnographic paradigms, then proceeds to discuss the concepts of culture, reflexivity, and ethnographic theory. The framework is presented to provide background and context for the methodology chapter.

Ethnography

Ethnography is a means of gaining access to the health beliefs and practices of a culture, and to the social dynamics that underlie those beliefs and practices (Field and Morse, 1985). Cultural knowledge and the assumptions that underlie decisions and actions within a culture are accessible to the researcher through ethnographic methods. Ethnography, therefore, is the design of choice for the investigation of health within the context of culture because it allows the researcher to understand social phenomena. Knowledge about health beliefs and practices can, in turn, guide nurses in
the provision of health care that is acceptable and congruent within a particular setting.

Most ethnographers use a naturalist tradition of science founded on phenomenological principles. Most good ethnography is, indeed, good phenomenology (Bernard, 1988). Several different paradigms within anthropology reflect different orientations toward the purpose of ethnography and the analysis of cultural knowledge. The earliest paradigm in anthropology emphasized holism and field work as the distinguishing marks of ethnography. The holistic approach emphasizes that the whole of a culture is more than the sum of its parts, and must consequently be studied as an integrated unit. Holistic ethnographers also underscore the importance of observation in situ and the avoidance of "artificial interaction" between culture members and the researcher, as such interaction is considered a source of contamination in the observation of a culture (Emerson, 1983). Ethnography in this tradition, therefore, tends to be written from an etic, or outsiders, perspective. The researcher who observes and then theorizes about the observations is assumed to be the "expert" in matters of culture. Researchers live in the culture, but are not expected to interact with the community to any
great extent. Holistic ethnography is characterized by the work of Benedict, Mead, Malinowski, and Radcliff-Brown, although Benedict and Mead tended to emphasize how cultures moved toward consistency, while Malinowski and Radcliff-Brown stressed the functions of various cultural configurations (Sanaday, 1983).

A second paradigm within anthropology is what Sanaday (1983) called "behaviorism". Behaviorism involves the greatest departure from inductive, holistic ethnography. Ethnographers operating within this paradigm seek to uncover universal patterns, or constants, in observed behavior across all cultures. Behaviorism is not holistic or concerned with meaning, but is meant to provide observational data on preselected functional categories that are considered cultural universals (Sanaday, 1983). The approach is essentially empirical, and involves a search for normative data that illustrates how underlying human biological or psychological requirements tailor universal cultural manifestations. Behaviorism is characterized by the work of John Whiting, Robert LeVine, and George Murdock.

In contrast to holistic ethnography and behaviorism, a third paradigm within anthropology
uses a method that Geertz (1983) has called "interpretive" ethnography. Interpretive ethnographers use the emic, or insiders, perspective as the first step in cultural analysis. Participant observation is the main strategy used by these ethnographers to gather data, involving prolonged contact with members of a culture so that:

...you will know when to laugh at what your informants think is funny; and when informants laugh at what you say, it will be because you meant it to be a joke (Bernard, 1988, p. 148).

The goal of interpretive ethnography is to produce an understanding that allows the researcher and the reader of an ethnography to be "in touch with the lives of strangers" (Geertz, 1983, p. 16).

Interpretive ethnography highlights the interpretation and explanation of cultural phenomena. Interpretation involves the sorting of structures and layers of meaning from an emic perspective until it is possible to gain access to the conceptual world from the etic viewpoint. Analysis involves two levels; the surface structure, which uses members' own terminology; and the deep structure, which is the investigator's explanation of social meanings and the actions that lie at the base of social action (Geertz, 1983).

An interpretive ethnographic approach was
used for this study to explore the lived world of rural-dwelling older adults. Culture, reflexivity, and cultural theory are all important concepts that underlie interpretive ethnography as a method. Of these concepts, the most important is culture, since most ethnographers would agree that their research interest is the study of culture.

**Culture**

Culture is a broad ethnographic concept that is generally defined by either a materialist or an ideational ontology (Fetterman, 1989). The materialist perspective focuses on observable patterns of behavior, while the ideational perspective tends to emphasize cognition, particularly language. Probably neither definition is sufficient to describe a culture in depth, since an ethnographer needs to know about both behavior and knowledge to adequately understand a particular culture (Fetterman, 1989).

Interpretive ethnographers define culture as a system of constructed signs, a "web of significance that man himself has spun" (Geertz, 1983). Culture is a context of interwoven meanings which ethnographers interpret (Geertz, 1983). Interpretive ethnographers ask in what ways members of a culture
actively construct their world (Field, 1983). The essential element of culture, therefore, is symbolic action which is constructed by the people who live within the culture. Culture can therefore be fully interpreted only by understanding the emic, or "insiders", viewpoint. Understanding a culture involves the reconstruction of intersubjective meanings. Knowledge is ideographic, and is bound by time and place. The emic perspective is modified by the researcher's analysis from an etic position. Double analysis allows the researcher to see the "underlying forces that make a system tick" (Fetterman, 1989, p. 28) as well as to understand a culture from the insider's view.

Reflexivity

The epistemological emphasis on the intertwined nature of knower and known that is characteristic of interpretive ethnography is known as "reflexivity". Reflexivity derives from symbolic interactionism, and deals with the creation of meaning through interaction. An assumption is made that the researcher is part of the social world that is being studied (Hammersley and Atkinson, 1989).

Symbolic interactionists are well aware that the roles they play in the field are not strictly and exclusively of their own choosing. Subjects can and usually do
reinterpret, transform or sometimes all
together reject the way the researchers
present themselves in favor of their own
interpretation...the mistaken belief that the
researcher's role is unmitigated by those
whom he or she studies remains the

Instead of treating the reflexivity as a
source of bias, ethnographers in this tradition
exploit the researcher's presence (Hammersley &
Atkinson, 1989). The researcher plays an important
part in shaping the interaction, which is central to
the analysis of the culture.

Once we abandon the idea that the social
class character of research can be standardized out or
avoided by becoming a "fly on the wall" or a
"full participant", the role of the researcher as
active participant in the research process
becomes clear. He or she is the research
instrument par excellence" (Hammersley and

Theory

Reflexivity has powerful implications for
the development and use of theory in interpretive
ethnography. The knower and the known are
intertwined; therefore data are always influenced by
the particular nature of the researcher. Developing
theory is close to the events that have been
analyzed, and the theory is related to an
understanding of the processes within the culture.
Ethnographic theory is a theory of what has been
described (Emerson, 1983). Geertz (1983) calls
ethnographic theory "diagnostic" in that it gives a likely understanding of what will happen next based on an observed event. Theory functions within an interpretive science to state what the description demonstrates about the society in which it is found (Geertz, 1973). The task of theory is not to codify abstract realities, but to make deeper understanding possible and to allow for proposals and predictions about relationships within the culture (Field and Morse, 1985). The development of theory which explains how social meanings and cultural biases lie at the basis of social action results in a "thick description" (Geertz, 1983).

Summary

Informed by interpretive ethnography and symbolic interactionism, the framework for this research was an ethnographic exploration of rural culture as a web of meaning that is created by community members. The researcher was guided by an interpretive paradigm of ethnography, in which the researcher sorts structures and layers of meaning to gain access to the conceptual world within the culture. Ethnography in this paradigm is a distinctive way of knowing that results from a reflexive process between the researcher and
community residents; thus the methods included prolonged participant observation, structured and unstructured in-depth interviews, informal interviews, and the examination of cultural artifacts. The next chapter presents the methods that were used in the study.
CHAPTER IV

METHODOLOGY

In this chapter, the design and methods used in this dissertation are presented. The chapter begins with a description of the study design; an interpretive ethnography consistent with the paradigm described in the previous chapter. Study methodology is subsequently described, including setting, sample, and procedures. The chapter concludes with a discussion of data analysis and rigor.

Design

A focused ethnographic design was used in this study to describe the specific aims of the study: 1) to increase understanding about the health of elderly people in rural settings; 2) to investigate rural community processes that affect health; and 3) to explore linkages among community processes and health status of the rural elderly. Ethnography is the design of choice for exploring and describing a culture, in this case the culture of rural community and the health of elder members of the community. In ethnography, the researcher
attempts to discover and describe a culture through the perspective of persons who live within it (Hammersley & Atkinson, 1989; Spradley, 1979). Two primary methods were used to generate data: interviews and participant observation. Ethnographic interviews were used to produce a rich, detailed description of a rural community from the emic perspective of people residing and working in the community. The study was set in a rural town of about 500 people, which is described in detail in the setting and sample description. Both older adults and other residents were interviewed to help develop a detailed portrait that reflected the underlying processes and cultural knowledge that influenced health. The interviews focused on the life of a community’s older residents and how the culture of community life related to health.

Participant observation was the other primary method used to generate data. Observations and participation in ongoing activities took place at the Senior Center, social groups, business meetings, a local cafe, church groups, the clothing distribution site, and town hall. Community celebrations such as "Ag Days" and the Fourth of July picnic were also used as opportunities to participate in community life and observe interactions between
community members.

A variety of data from different sources were used to construct a comprehensive picture of the community. Other sources of etic data that were considered in the analysis were census data, epidemiological statistics, and physical artifacts such as photographs and newspapers. Emic data included transcripts of interviews from community members about their community, and field note observations. Schultz and Magilvy (1988) found that a combination of data provided a comprehensive assessment of the health needs of elders in communities. Analyses that used only one or two of the strategies provided assessments that were less complete and less accurate.

The design employed a reflexive process that operated throughout the developing investigation to guide data collection, management, and interpretation. Following the suggestions of Hammersley and Atkinson (1989), as the researcher became aware of significant themes, the generation of data was guided to check a particular interpretation, or the typicality of the theme, as well as to develop comparative cases.
Study Questions

Study questions were developed from the specific aims of the study. Questions are descriptive, which reflects the nature of ethnographic methodology. The study was designed to answer the following research questions:

1. What is the culture of rural community life for elderly residents?
2. What aspects of rural community life affect health in the elderly?
3. What are the dynamic processes of rural community life that have linkages with health of elderly residents?

The questions were used to guide the selection of a community for the study. A very small community was chosen to allow the examination of an entire community culture and the community dynamics that affect health.

Setting

The study was set in a small rural community called "Farmington" for this report. Farmington was selected for its high proportion of elderly residents and its willingness to participate. The general geographic area was the same as one of the areas used

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in a larger ethnographic study of rural home care for older adults (NIH/NCNR #R01NR2006), for which the researcher was a research assistant. Census data were used to find a rural community in the Northeast or Southcentral area of Colorado that had: 1) less than 2000 members; and 2) a high proportion of residents over age 65. Using a similar area permitted easier access to the research site since the research team was already known and accepted by community members in many of the rural communities. This study also augmented the larger ethnographic study by exploring an aspect of rural communities that was not being considered in the home care investigation: the dynamic processes of community life that have linkages with the health of elderly residents.

Sample

The first choice made for the sample was to pick a community. In concert with the larger study, rural communities were eligible for inclusion in the study if they were located in three selected counties in Northeast Colorado (Washington, Logan or Morgan counties), or in five selected counties in Southcentral Colorado (Conejos, Alamosa, Rio Grande, Saguache, Costilla).
Communities that met the criteria were invited to participate in the study. A letter explaining the study purposes and methods was written to the mayor of each community. An offer was made in the letter for the researcher to speak to the community council or other governing bodies and citizens groups to discuss the proposed research. Eight communities responded to the letter. One community was chosen for the study, and the final choice of the community was made by mutual consent of the community and the researcher, with consultation from the researcher's advisory committee.

Table 1 shows the population breakdown for people over age 65 for the county in which Farmington is situated. Specific breakdowns for the town itself were not available, although Farmington is probably similar except that county towns with residential housing for elderly people and nursing homes would have a higher percentage of very old people. The population aged 65 years and older constitutes 12.7% of the total population in the county.
Table 1

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>912</td>
<td>3.8%</td>
</tr>
<tr>
<td>70-74</td>
<td>743</td>
<td>3.1%</td>
</tr>
<tr>
<td>75-79</td>
<td>575</td>
<td>2.4%</td>
</tr>
<tr>
<td>80-84</td>
<td>372</td>
<td>1.6%</td>
</tr>
<tr>
<td>85+</td>
<td>311</td>
<td>1.3%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2913</td>
<td>12.2%</td>
</tr>
</tbody>
</table>

The second choice for the sample was the selection of community members for interviews. Sampling for the interviews was purposive rather than random. The assumption was held that in a non-probability sample not every member in the setting or population would be knowledgeable about the phenomenon of interest to the researcher (Morse, 1986). Selection of informants was guided by the specific aims of the proposal and was based on field observations, interviews with key informants such as community leaders, and judgement of the researcher and her consultants. Informants were considered to "belong" to the community by self definition; they were part of the population of the study if they considered themselves to be members of the community.
Sampling for this study began with initial interviews with two key informants and proceeded as the investigator determined who would be the most appropriate informants from whom to learn specific types of information.

The sample in ethnography, like the interview questions, was generated during the investigation (Hammersley & Atkinson, 1989). The sample of 104 people included 6 health care professionals who worked with elderly people in the community, 17 leaders of various organizations that involved the older people, 59 older community residents and their families, and 22 community residents who knew about community processes and older residents. Formal, taped interviews were conducted with 36 community residents, of whom 28 were age 65 or older. Informal interviews and participant observations were conducted with 68 people. Most of the formal interviews took place in participants' homes; a few people were interviewed in business or professional settings. Sampling continued until data generated were determined sufficient to address the research questions discussed above.

The use of a self-definition for community membership makes it impossible to enumerate the total
number of people within the conceptual community. Census data indicates a geo-political community size of about 500 people; for the purposes of this study, the community would be larger since many people in the sample from surrounding farms and unincorporated areas considered themselves to be members of Farmington. Comparison of the sample with the census data for Farmington, therefore, is not done. The sample is compared instead to data for the county as a whole. Table 2 indicates the breakdown by age of the participants in the study. The higher percentage of people in the younger age brackets, compared to the population of the country as a whole, is probably due to the lack of residential housing and nursing homes available for older people in the Farmington area. Participant observations took place primarily at community activities for older people in the community; therefore the percentage of "younger-old" people is higher for the informal, participant observation types of interviews.
Table 2

Age Distribution of Sample Participants

<table>
<thead>
<tr>
<th>Age</th>
<th>Formal Interviews</th>
<th>Informal Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>65-69</td>
<td>12</td>
<td>27</td>
</tr>
<tr>
<td>70-74</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>75-79</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>80-84</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>85+</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>68</td>
</tr>
<tr>
<td>Total n</td>
<td>104</td>
<td></td>
</tr>
</tbody>
</table>

Procedure

Following selection of the community and obtaining the town's agreement to participate, I began the study with a preliminary visit to the research site to familiarize myself with the study area. The research was conducted in Farmington, Colorado from September 1990 to August, 1991.

Initial permission to conduct the study was given by the Mayor in response to my letter. The town council formally agreed to participate two weeks later during a town council meeting in which I
presented the study. The willingness of the council and the town leaders to participate in the study was remarkable, and may be a unique feature of Farmington that is not representative of small farming towns in this area of the country.

Introduction to the community of older residents was initially through a woman who I will call "Martha". Martha lived near Farmington for many years, and was the widow of a life-long Farmington resident. She took me to "Meet-and-Eat" (a Senior Citizen meal and socialization program) at the Senior Center in Farmington, introducing me to several people who became key participants in the study.

I visited the Senior Center and Town Hall frequently to do participant observation, and I made appointments to do more formal interviews. People frequently invited me to participate in social events, meetings, church groups, and community activities. These invitations became opportunities for further participant observation. Occasionally I volunteered to help with various organizations, such as Caring Ministries, (a food and clothing distribution center). Radio and newspaper interviews were arranged to allow community members to hear about the study, and to establish my credibility.

The weekly community newspaper agreed to
introduce the study and to publish findings as they were written to seek validation and encourage comment from community members. Newspaper archives became a source of data on historical events in the community, along with historical records from the county museum, community assessments done by other agencies, epidemiological data, demographics, and census data. This examination allowed an understanding of the context of the community.

During the 11 months of the investigation, I lived in the community for one to three day periods during each of 28 site visits. Between visits, I stayed in contact with community members by telephone and by a subscription to the weekly newspaper.

**Participant observation**

Participant observation activities provided an entrance into various settings and allowed an extensive observation of older community members and their interaction with the community. Participant observations included attending activities at the senior center, participating in meetings of agencies that work with older residents in the community, participating in social activities, attending town council meetings, and volunteer work. For example, I attended a "circle" with the women from one of the churches. The circle is a women's Christian group
that promotes fellowship and volunteer help for community needs. The circle meeting allowed me to observe some older women's social activities, and helped me to understand the extent of volunteer work in the community. Participant observations also included brief informal interviews during activities and spontaneous conversations that were recorded as field notes. General observations about the community were made through living in the community, conversation with residents, and "hanging out" around town.

Interviews

Interviews were conducted with the consent of each interviewee and tape recorded with the participant's permission. Detailed field notes were used to record interviews if the participant did not want to be recorded on tape. Decisions about whom to interview came from field observations, recommendations from community members, and analysis of the data. Interviews varied in length due to the unstructured nature of the interview, but they generally lasted about one hour. Appointments were made for formal interviews; they usually took place in homes. Some of the interviews were done in business or professional offices when participants preferred to take time at work. Occasionally I would
ask participants to discuss photographs that they had in their homes, or I would bring photographs that I had taken and ask them to tell me what they saw in the pictures. Photographs often prompted detailed descriptions of participant's lives and community interactions.

The interview process was as open as possible in the early stages of the research as a means of obtaining a comprehensive picture for ethnographic analysis. As data generation proceeded, interviews became more focused as necessary until no significant new information was being generated. Formal interviews were interspersed with informal interviews and participant observations as the data were compiled for analysis. During the course of the study, informants were asked to validate findings or discuss specific questions that came out of the interviews.

Data

Data were generated from interview transcripts, field notes of interviews and participant observations, theoretical memos, and field notes about artifacts. Artifacts included a book about Farmington that was written by several residents; the Farmington Community Plan, articles
from the weekly newspaper, photographs of participants families, photographs of the town and townspeople that I took, and flyers about community activities. Tape recorded interviews were transcribed verbatim by a professional transcriptionist and myself. The tapes included notations about laughter, speech hesitations, and anger, but did not include my verbalizations to let the participant know that I'm listening, such as "uh huh".

Throughout the data collection, field notes were kept to augment the interviews and observations. Memos were written reflecting emerging themes, connections between interviews, ideas about the data, and points to pursue in subsequent interviews.

**Data Preparation**

Prior to analysis, the data were prepared and verified in detail. Each interview tape and transcript was reviewed for accuracy; field notes were expanded and reviewed daily. All of the interviews and field notes were entered into The Ethnograph, a computer program that assists with the mechanical coding and sorting of qualitative data (Seidel, Kjolseth, & Seymour, 1988).
Data Analysis

Analysis of the data did not proceed in a linear fashion, and some activities were done simultaneously. As each interview was completed, analysis began. Following Spradley's (1979) and Lofland and Lofland's (1984) suggestions, during the analysis I looked for common categories and themes within the data that reflected the dimensions of rural community and health for the elderly. An example of this stage of analysis is presented in Appendix A and B. Appendix A is a conversation between myself (CC) and a participant (RH). The codes that are written to the right of the printed text are categories that I identified in the data. Appendix B is an example of part of the coded computer output that resulted from the coded analysis. Each of the categories was placed in a separate file. In the next stage of analysis, entries in each category file were read and analyzed for central ideas. Sub-categories emerged within categories, and were organized within each category. Categories that contained similar data were grouped into domains. An example of the domain SEEKING HEALTH CARE with its constituent categories and sub-categories is presented in Appendix C. Finally, domains were analyzed for themes that crossed the
domains and tied the data together in a holistic fashion.

Toward the end of the analysis, the data revealed a core metaphor that summarized the values and beliefs of the people Farmington, that, along with the themes, became the basis for a "thick description" of the community. Findings resulting from this analysis are described in subsequent chapters.

Rigor

Qualitative research has been criticized for not having the same standards for reliability, validity, approach and objectivity as quantitative research. Qualitative researchers, however, have developed comparable tests of rigor (Becker, 1970; Denzin, 1978; Lincoln and Guba, 1985; Sandelowski, 1986; Strauss & Corbin, 1990). To help clear the confusion, Lincoln and Guba (1985) proposed four factors as a framework for understanding the similarities and differences for rigor between qualitative and quantitative research: truth value, applicability, consistency, and neutrality. This framework was used in the investigation to ensure rigor in the research.

"Truth value" is explained in qualitative
research using the term "credibility". Credibility is similar to "validity" in quantitative research, and is achieved when people under study who have had the experience immediately recognize and validate the researcher's presentation of the experience. Data were presented to community members at all stages of the research process for validation. Community members were asked both individually and in groups to comment about whether findings reflected their personal experience of the community. The results of the study were reported back to the community through articles in the local weekly newspaper, oral presentations at community meetings, and a town council meeting. Appendix D is one of the newspaper articles that reported study findings. Results were usually validated by participants and other community members; occasionally a community member would suggest additions or clarify a point in the presentation.

Credibility is enhanced by prolonged engagement in the setting and persistent observations to ensure that the findings have depth and breadth. I was a participant observer in the community for a period of almost a year to increase the likelihood of credible findings.

"Applicability" in research is related to
whether findings are generalizable to settings or samples other than the one that was studied. Applicability is approached by the notion of "fittingness", referring to how well the data, not the subject or setting, "fit" into contexts outside of the study situation. Fittingness is accepted by the reader of the research report. In this dissertation, demographic and descriptive data about the community are reported so that the reader might compare the findings of this study with similar situations in other contexts.

While consistency is addressed as reliability in the quantitative research paradigm, qualitative research achieves consistency through "auditability". Research is auditable when a clear "decision trail" is presented by the researcher to readers, or decisions are clearly tracked and explained. Logs and memos were used to record the decision-making process in this study. Members of the dissertation committee also followed the decision-making process and provided a check on auditability.

"Neutrality" is known as objectivity in quantitative research. Objectivity is assumed in quantitative research when reliability and validity are established. In a similar fashion,
"confirmability" of findings in qualitative research is assumed when auditability, fittingness, and credibility are established.

**Ethical Considerations of the Study**

All participants were asked for their verbal consent to participate at the beginning of each taped interview. The consent and explanation of the study were tape recorded and transcribed. The informants were told that there would be no risks or benefits to their participation in the study, and that they could withdraw from the interview or request that the recording be stopped at any time. Written permission was obtained from people who could be identified in photographs. To protect confidentiality, all identification was removed from transcribed copies of the tapes. Tapes were kept in a locked file drawer. Neither the community nor any community members were identified in reports. For this reason, the name of the town has been changed and participants are referred to by pseudonyms as necessary in quotations or text.

**Summary**

A focused ethnographic design was used in this study to describe the study aims and questions.
Two primary methods used in the investigation were interviews and participant observation. Data analysis revealed categories that were subsequently grouped into domains. Domains were analyzed for common themes. The last stage of the analysis developed theoretical propositions about community processes that influenced the health of older community residents.

The next chapter begins with an in-depth description of the sample, which provides the contextual setting for data analysis. The results of analysis are then presented in the Chapters VI, VII, and VIII.
CHAPTER V

FINDINGS: SAMPLE DESCRIPTION

The presentation of findings begins with a description of the community and the participants in the study. This description establishes the context for the results of the analysis of the data, which are presented in chapters VI, VII, and VIII. The sample description provides both a framework for the interpretation of the findings and a basis for decisions about applicability and fittingness of the data. As discussed in the Chapter IV, providing descriptive detail about the community and the sample may help the reader to determine whether the findings "fit" into other contexts.

The data and the description that resulted from analysis of the data are presented in the "ethnographic present". The present tense is used to maintain consistency in the text. Use of the present tense also allows the writer to offer a description that is alive and that sustains an active sense of the culture at the time of the study (Fetterman, 1989).
Community Description

Farmington, Colorado, is a small farming community of about 500 people situated on the Great Plains. Like many towns on the prairie, the Farmington grain elevators can be seen from the top of a rolling hill from 50 miles away. The streets are wide and unpaved; the entire town is comprised of fourteen streets that run east to west, and ten streets running north to south. The streets end abruptly in the fields that surround the town. Farm equipment is parked in side yards and vacant lots. Lawns and yards are green and well tended with flower and vegetable gardens during the summer, while the vacant lots have returned to prairie grass and sage. Large shade trees act as wind breaks for winter blizzards and summer dust storms, and provide welcome shade from the hot summer sun. Most of the houses are small, made of wood, and are painted white with high, sloped roofs. Figure 1 shows the town of Farmington from just outside the town limits. The grain elevators and buildings for farm equipment and supplies are the dominant features when Farmington is seen from a distance.
Figure 1. The town of "Farmington".
Railroad tracks bisect the town and separate the original townsite from the "newer" buildings to the south. Some of the houses and commercial buildings are abandoned: the old commercial hotel has been vacant and boarded up for many years; the variety store retains a sign but is no longer in business. Some of the older houses have been vacant for as long as ten years. A new commercial building that was vacant for several years is now partially occupied with two new businesses: a chiropractor's office and a handcrafted saddle/boot shop. The largest buildings in town are the elevators that belong to the farmers co-op. Their profile, with the American flag that flies from the top, dominate the local landscape. Figure 2 is a typical house in Farmington. This house, small but neatly kept with white walls and a fenced yard, is common within the city limits. Many older people live in homes that are similar to this one.
Figure 2. Typical house in Farmington
Farmington is about the same size as it was 50 years ago. A dispute occurred with the 1990 census over the official count of 499; the town claims that a more accurate population figure is 561. Net change over the past few decades is essentially zero. The demographic research division for the state, however, forecasted declining population numbers for the town unless a slow downward trend due to outmigration of younger people is reversed by economic development.

Farmington was founded when a land swindle attracted 1,000 would-be homesteaders to an unirrigated section along the Overland Trail, a popular wagon trail used by settlers moving to Oregon and Northern California. A promised irrigation system never worked, and many families moved along. In the late 1880s the railroad came through, and the improved transportation brought in new families who had been farming further East. Many of these people were European Caucasian immigrants, primarily Germans and German-Russians who had first emigrated to Russia and then immigrated again to the United States when political unrest began to spread. These farmers proved to be more tenacious, and many families with German names remain in the area today. The settlers were cattle ranchers and dry land farmers.
who grew primarily wheat. Once irrigation was installed in the 1930s, the principal crops became sugar beets, corn, grain, sorghum, and pinto beans. A majority of people in the community today are farmers or work in farm-related businesses; the only large non-farm employer is the school system.

More recent immigrants have been Spanish-speaking people from Mexico and Central America. An old motor hotel rents apartments to migrant workers and other Spanish-speaking residents who live in Farmington on a semi-permanent basis. More permanent residents live in a small section of town, primarily in trailers. Spanish-speaking older adults do not comprise a large minority. Census data for the entire county showed only 120 people Spanish-speaking people over age 65 out of a total population of 22,700. Approximately 20 permanent Farmington residents are from a Spanish-speaking background.

Farmington is situated in a flood plain of a large creek. Several major floods have inundated the town. Partly due to concerns about emergency response and economic consequences of the last flood, the townspeople voted to incorporate in the mid 1970s. Town members formed their own water and sanitation district, as well as an emergency response system. In the late 1980s, the town completed a
levee that will prevent any further flooding.

Life in Farmington is regulated by the seasons. Winter is a slow time, when people make social visits and take vacations. Life speeds up in the early spring with the advent of plowing, then grows busier as the planting season begins in mid to late spring. Once summer arrives, farmers are in the fields during the daylight hours and the streets are busy with farm equipment moving from field to field. "We won't sit down until after the harvest", said one resident.

The farm crisis of the 1980's had a major impact on Farmington. Many smaller farmers sold out; farms that once could support a family of eight now barely support one couple. "This is a farming town, said one community member, "and farming just isn't making it". Some people have switched to custom farming, (doing only one aspect of farm business such as plowing or haying); others to agriculture-related businesses. General conditions have stabilized and improved in the past few years, but the future of Farmington remains uncertain.

Summary

Farmington, the community selected for this study, is a small farming town that has remained
about 500 people for several decades. The town has always relied on farming as an economic base. People who live in the community are predominantly farmers of Northern European ancestry, with a small minority of Spanish-speaking people. Recent economic changes in agriculture have precipitated an economic crisis that may have a permanent effect on the community. This community was selected for its small size, number of residents above age 65, and willingness to participate in the study.

Participant Description

As described in Chapter IV, the size of the total sample of participants was 104 individuals who lived or worked in Farmington. In this section, participants are described in-depth to provide the social and community context and to aid in decisions about sample applicability. "We're farming people", said one of the study participants, emphasizing that their identification with farming is strong. Most people live the majority of their lives in and around the Farmington area, and this finding is especially true for people age 65 and older.

Even within a community as small as Farmington, it is not possible to discuss "the elderly" as though they are a homogeneous group.
Factors which describe the diversity of older residents are age, presence of chronic illnesses, and economic status.

**Age and Illness**

The older population of people in Farmington are a diverse group of individuals who span 31 years from age 65 to 96. On the whole, people between age 65 and 75 in the community describe their health as "very good". Residents in this age group are extremely active in the community. They are often in positions of leadership in church or community groups, and they organize and participate in community activities. It is not unusual to hear people say "I just don't feel old", or "I know I'm old by the calendar, but it doesn't seem old to me". Many people in this age group had expected to be "old" as their parents were old at the same age; instead they find themselves feeling well and actively engaged in their community. Figure 3 is of a man in the "younger-old" category. He is standing to one side of his extensive garden, where he works every day from spring to fall.
Figure 3. Portrait of a "younger-old" man in his garden.
As age increases, the number and severity of chronic illnesses increases for most people. People over age 75 are more likely to say that their health involves "doing the best I can". These individuals eventually stop driving, asking family or friends to drive them to activities in the community or to appointments. It is not uncommon to hear people discuss being slower than they once were, and to experience more difficulty with sight and hearing. They remain active, although they are less likely to hold leadership positions in the community.

Those in their eighties and older begin to appear frail. They may withdraw from activities until their world encompasses only church services and family get-togethers. They often speak of chronic pain and describe their lives as "getting by". Even the very frail, however, contribute to family or community activities by endeavors such as clipping coupons for the food bank or by doing craft projects for family or charity.

Broad diversity exists within age groups. Some older people in their late sixties are incapacitated by chronic illness, requiring 24 hour care. Others in their eighties are very active and unbothered by physical problems. The categories are intended to provide a basic understanding of the
aging experience for the majority of older people in Farmington, with the caveat that variation from these general categories is not uncommon.

Economic Status

The economic status of older people in the community is determined for the most part by the economic status of farming. Dropping land prices combined with rising costs for fertilizer, seed, and water precipitated the farm crisis of the early 1980s. The crucial factor for the current economic status of older residents is when, or if, they retired and sold their farms. Those who sold their farms before land and crop prices plunged made large profits, and consequently are "comfortably well-off" today. They are considered "wealthy" by community standards, although most would not be in an upper socio-economic level on a national basis.

Those who retired somewhat later found that their land had lost as much as a third of it's value; these people have either sold their land at a loss or the property remains unsold. The low crop prices and high overhead that characterized the 1980s drove many farmers into bankruptcy status. Even if the land was not lost, many older people now find themselves with land that cannot be farmed at a profit. Those people
who took maximum depreciation writeoffs in order to pay lower self-employment taxes had counted on income from their farms during their retirement years to supplement social security payments. The result is that some older people have a retirement income comprised of small social security payments that cannot be supplemented from their farms.

People who were not farmers, but who had worked at the school or for a business generally retired on small pensions and social security payments. Even those who owned businesses found it difficult to sell them when they retired, since most commercial activity also suffered when farm prices dropped. Older business owners said that their businesses would support a family but "not very well".

Abject poverty, however, is not widespread. Despite economic problems within the community, the percentage of people over age 65 who lived in poverty is 9.8%, compared to 12.6% nation wide (U.S. Department of Commerce, 1983). As age in the county increases, the poverty rate also increases: 7.0% in the 65-74 year olds; and 12.6% of those over 75 live in poverty. Census data indicate that people in Farmington have an estimated per capita yearly income of $7,361, which is about $1,200 less per year than
the average in the county as a whole. The poorest members of the community are the Spanish-speaking migrant or semi-migrant workers, but few elderly people were among this group in Farmington. The effects of poverty for older people, however, are mitigated by community help. As discussed in Chapter VII, the community as a whole provides a "safety net" for older members.

Summary

Older people in Farmington are a diverse group. Seniors in the community run an economic gamut from "comfortable" to "really just scraping by", as described in the words of residents. An equal diversity exists among various age groups, with "younger-old" people who feel well and are very active, to the "oldest-old" people who are more frail. Recognizing these differences, it is still possible to draw a composite portrait of an elderly woman in her eighties that describes a "typical" older person. This portrait is used both to highlight and contrast the various subgroups among elderly people in this rural community.
Being Older in a Rural Community

"Esther" was born in the county 84 years ago to immigrant parents who settled first in Nebraska. Her family migrated to Farmington when the railroad opened up new land for farming. Life for people in the county has changed profoundly since Esther was young: she can remember going to town by horse and wagon, hauling water, and cooking with a wood-burning stove. Farms were isolated enough that families had to fend for themselves much of the time. People often treated illness at home with folk remedies. "Mother had to do an awful lot of the doctoring herself. She used to use "Denver Mud": it's a clay-like stuff that you heat up and put on your chest which would act as a poultice". She married during the thirties, and she and her husband dry farmed land about six miles from town. Times were hard during the Depression, but she remembers the period in which she raised her children as some of the best times of her life: "I loved living on the farm; we always worked together and though we didn't have much we always had a good time". She was involved in the community despite the demands of farm life: she worked with the Parent-Teachers Association, the Future Farmers of America, church groups, and 4H.

Her father died suddenly in his early
sixties, but when her mother grew older, Esther took care of her mother until she died. When her husband became ill in his early seventies, Esther cared for him during his long illness. With her help and the help of their two sons and daughters-in-law he was able to stay at home until the last month of his life. She stayed on the farm for a few years after his death, then decided to move into town and let one of her sons live in the old farm house.

Now that Esther is in her eighties, she has "slowed down somewhat", but she remains involved in community life. She no longer drives, but her children who remained in the area and their families help her get around. "I don't have any trouble getting where I need to go", she says, "but I hate to ask too much because I know they're all busy". She remains active in church groups, and is often found doing projects for both community groups and her family. "I'm just too busy to bother with being sick", she often says.

She has chronic "aches and pains", but she says that she doesn't let that stop her from doing what she wants to do. "You just have to take things as they come", she says, "I don't ever want to be a burden to anyone, so I manage". She would like to stay in town, in her own home, for the rest of her
life. "I can't imagine wanting to live anywhere else: this is my home and I want to stay".

Chapter Summary

In this chapter, the setting and people of the study are described. Farmington is a small farming community in which the economic fortunes of both the town and the townspeople have risen and fallen with agricultural economics. Older people in Farmington are a diverse group that span many years. The description of Farmington and "Esther's" composite portrait provide the context for the detailed description of older people, the community, and health that follows in the next three chapters. As described in the following chapters, the active life that is characteristic of older people in Farmington is a component of health, and the community itself plays a vital part in maintaining health for older people.
CHAPTER VI

"I'M TOO FIESTY TO GET SICK"

A detailed description of health and community life for older people in Farmington is presented in the next three chapters, based on the results of analysis of ethnographic data. Three main ideas are discussed: the lived experience of health as it is perceived by older people in Farmington, elements of community life that influence the health of older residents, and links between community and health.

As previously mentioned in Chapter IV, in the first level of analysis data were examined as a whole until domains emerged. Domains are groups of related categories that address a central subject. Each domain was subsequently analyzed on a second level to identify categories and subcategories which comprise the internal organization of the domain. Categories were added or removed from domains until each domain spoke to a consistent and logically related idea. These domains contain material that overlap with categories or subcategories in other domains, and none of the domains or categories are
considered mutually exclusive. Ethnographic data are overlapping in nature and may be pertinent to more than one area of a culture. Five domains emerged from ethnographic analysis of the data. These domains and their major categories are presented in table 3.

TABLE 3
OVERVIEW OF DOMAINS AND CATEGORIES

Domain 1: BEING HEALTHY

Categories
Being Active
Being Independent

Domain 2: SEEKING HEALTH CARE

Categories
Doctoring
Helping One Another

Domain 3: KNOWING EVERYBODY

Categories
Insiders
Outsiders

Domain 4: COMMUNITY CARING

Categories
Crisis Support
Personal Safety
Daily Caring
Networking

Domain 5: INSIDER PROBLEMS
Categories
Privacy
Leadership Problems

The titles of domains are written in capital
letters to increase clarity. Each of the domains and categories in the text is headed by a representative quote from a participant in the study. The quotes are chosen to highlight information within a domain or category in language used by community members. The intention of the quotes is to present data in emic terms, and to maintain a focus on lived experience from an emic perspective. As in previous chapters, the results of data analysis are presented in the "ethnographic present".

The first aim of this ethnography was to increase understanding about the health of elderly people in rural settings. Understanding health for older people in Farmington requires more than knowing the statistics for morbidity and mortality, access to health care providers, distance to health care services, or numbers of health care providers. Elderly people's health in this very small, rural community is a complex and dynamic process of interaction between people, the community, their values, and the health care system.

In this chapter, two domains which describe the experience of health for older persons are presented. The domains reflect the lived experience of health and health care from the perspective of older residents. The domains are: BEING HEALTHY and
SEEKING HEALTH CARE. BEING HEALTHY describes older participants' definitions of health, and their strategies to maintain health. SEEKING HEALTH CARE discusses the participants' experiences with formal and informal caregivers.

Domain One: BEING HEALTHY: "If I Slowed down, I'd Prob'ly Drop Dead"

When older people in the community are asked what determines their health, the most common answers are that modern medicine keeps people healthier, or that they inherited good genes from their ancestors. "Medicine makes all the difference", said a man in his seventies. "It's all those pills that our parents didn't have that make you healthy". When asked what "being healthy" involves, however, the participants answer in action terms. Health for older people in Farmington is the ability to be active, to contribute, and to be independent. BEING HEALTHY contains two categories: Being Active and Being Independent. Each category is analyzed in turn, using quotes from community members that illustrate the experience of being healthy for older people in Farmington.
Being Active: "I Don't think of Myself as Old Because I've Got So Much to Give"

Many tales circulate in the community about people who are very old and still active. One resident who is in her nineties is often mentioned as an exemplar of the ideal active older person. One of her neighbors said:

She's the toughest old lady you'd ever hope to meet. She lives by herself and she's out there every day working in her yard and she's ninety some odd. Someday I'm gonna find her dead out back with a spade in her hand.

Working and being socially active are the two ways that people describe being active.

Work. Many older people in Farmington worked hard for much of their lives, often as farmers or farmer's wives. People are proud of their ability to remain in the work force. A woman in her late sixties said:

For forty years I was up at four to milk and I'd be on my feet until way after dark. I've slowed down some, but I'Ve been workin' all my life and I'd hate to quit now. I'd get bored just watching TV like some folks do.

Many people who are in their sixties, especially those who are farmers, still work on their farms. They frequently share the work with adult children, but still put in long hours. A woman talked about her husband in his sixties:
He may have slowed a bit, but Lord knows, I still can't get him off that tractor!

Few people continue to work full time into their seventies, but often continue to help adult children with less strenuous farm or business activities. Several older people who owned or operated businesses in the community work part-time with their adult children who have taken over full-time operations. "Well, I like to keep my hand in, you know", said one woman who ran a business for thirty years. "It keeps me goin', somehow". Figure 4 is an example of an older woman who has continued to work in her own business in the community with other family members. This woman is a leader in her business and in the community, which is not unusual for older Farmington members. Along with other older residents, she has brought computers and modern business equipment into her work place.
Figure 4. Portrait of an older businesswoman.
Social Interaction. Social participation for older people encompasses a wide range of activities. Older people, like Farmington residents in general, are very active in the community. Three means of social interaction that were commonly mentioned by older people are church, volunteer work, and visiting.

The largest of the four churches in town has a membership of 350 people, and the other congregations together have approximately 100 members. Church members come from a 50-mile radius around Farmington to attend church. Most of the older people attend one of the four churches regularly, often with adult children and grandchildren. Church groups meet frequently to conduct the work of the church and to provide social gatherings. One minister said:

The backbone of our church committees are the older people. It's usually the senior citizens who carry on the men's and women's fellowship groups and who do the majority of the tasks for the church.

The churches are a center of social activity in Farmington, organizing support for both individuals and the community in times of trouble, and providing a center for celebrations. Older people maintain an active presence in most of the churches' groups and projects. "I get a lot from the church", said an
older woman, "and I give a lot, too. Makes me feel good".

Many of the older people volunteer their time to different community groups. The amount of volunteering became apparent when a new program called SHARE was introduced into the community. SHARE is a food co-op for anyone in the community who wishes to participate. In order to qualify for a package of food that is worth about $30, a person must contribute $13 and volunteer in a community activity for two hours each month. The older people at the Senior Center laughed when the program was introduced to them last winter. "None of us will have any trouble making it (the volunteer requirement)" , said an older woman, "Our only problem will be adding up all those hours!" One of the women at the Center listed her activities for the past two weeks:

Last week we made aprons at STRING (a church-related group) for the Sheltered Workshop, (a workshop for the mentally handicapped in a city 15 miles away) and that was two nights and I've still got to finish two afghans for Valley View (a nursing home in the same city as the workshop), and then I spent one morning at Caring Ministries this week( a food and clothing distribution center) helping sort clothes, and I suppose I should count doing cleanup here at the Center both weeks, and how many hours does that come to? I'll bet it's 30 and I'm not sure I remembered everything!

As the quote above illustrates, older people
in Farmington contributed to the community in a number of ways. Social groups often have a volunteer aspect: the Women's Circle collects baby items for impoverished mothers; other groups collect canned items for the food locker. The volunteers who run the clothing and food distribution site are comprised almost entirely of retired people. Even very frail people in the community contribute by activities such as clipping coupons for use at the food site or by making small needlework items to be sold at fund raisers.

"Visiting" refers to the frequent informal social interaction between neighbors and families. The extent of visiting between older members in the community can be seen in a column in the local weekly newspaper, written by one of the older residents of Farmington. The column records get-togethers with friends and families, frequent extended visits, and social meetings. A paraphrase of a typical column entry during the past winter might read:

Eliza Johnson, Mary Hogan, Blanche White were Friday afternoon and evening guests of Myrtle Jenkins. (all older women in the community). They visited all afternoon, had dinner at the Country Cafe, then played cards in the evening.

This same column also recorded a Women's Fellowship meeting, a pancake supper at the American Legion Hall, a baptismal party, a program at the
Senior Center, a visit by five older people to the school to talk about the Depression, and eight other informal social gatherings.

Family visits are frequent and warm. Grandparents habitually babysit for their grandchildren, sometimes staying while parents are working and often providing child care during school vacations. Babysitting on a regular basis is an important contribution to family life when both parents work outside the home. "We wouldn't want our grandkids with strangers" said an older couple. "And besides, there's nobody who babysits in town anyway".

Older women often make things for their families such as afghans, painted china, or clothes. One older woman spoke of making baby quilts for all twelve of her great-grandchildren. "And just as I got done", she said, "my granddaughter called me up to say it was time to make another one!". Another woman in her seventies wanted to heal quickly following surgery for cataracts. She frequently paints pictures and crochets for family members.

I told the doctor that I need to get my new glasses as soon as possible. Here I am at this age, and I've got at least 25 years of projects to get finished, so there's no time to waste!

All of the items in Figure 5 were made by the woman sitting on the couch. When a family member admires a
painting, she frequently writes their name on the back, so they can inherit it when she dies.

Figure 5. Typical craft projects for older women in the community.
The family home in which many older people still live is the focus for family gatherings and celebrations. It is not unusual for twenty people and more to be present for a holiday dinner or a birthday. One woman in her eighties described her birthday party:

They all came over, since I have the biggest place, and there must of been twenty-five people with kids and grandkids and greatgrands plus my sister's people. My land, we nearly overflowed the house.

Summary. Activities are an important component of health for older people in Farmington. An active life includes work and social interaction. Church groups, volunteering, visiting, and family life are all activities which contribute to health as defined by older people and also contribute to community life. These activities allow older people to give as well as to receive from the community. Their work makes an important contribution to the overall community which tends to balance the contributions of the community to older members. "I expected to be slowed down and old by now", said a woman in her seventies. "But I don't think of myself as old because I've got so much to give".
Being Independent: "I Don't Want to Be A Burden to Anyone"

The second category in the domain BEING HEALTHY is Remaining Independent. Independence is the second major determinant of health as defined by older people in the community. Older Farmington residents describe independence in three ways: Hard-Core Independence; Independence with Help; and Having to Move.

Hard-Core Independence. Hard-core independence is the stance taken by older people who refuse to accept help from any source. A professional who works with older people in the community told a story that is characteristic of an older person who takes a hard-core independent stance:

I have this one lady: it was in a cold snap and so I was concerned about her, it being so cold. When I went to the place I went in and it looked like she dropped in from Baby Doe. I mean she had layers and layers of clothing, no heat in the house, water froze...She was perfectly contented with the way things were...She told me to get out and leave her alone.

Older people who wish to remain independent from any help sometimes do so at the cost of their health and comfort. An older woman in her eighties said:

Sometimes I wish I wasn't so damned independent. I could get more of what I needed, but it just goes against my grain.
The hard-core independents are those older people who refuse to ride the county bus service or to accept food commodities. For this group, there is a social stigma about using a service that is supported by government funds. "You should pay your own way" is heard often in the community, and very independent elderly people took care that no one could consider themselves to be what one older man called "a freeloader: somebody who takes handouts". He would sometimes eat at the Senior Center, and he assured me that "I always pay for the meals, you know, I don't get them free".

Independence with Help. Most of the older people in Farmington are not as fiercely independent as the hard-core group. Although most older people do not want to live in the same household with their families, they rely on their families for a great deal of informal help. Help from family members is a comfortable and acceptable idea for most of the older community. "I'm so glad my kids are here", said a widow in her seventies. "They're a real comfort to me, and I know I can rely on them". This group is not as adamant about using county-supported transportation or participating in programs to support elderly people.

Support from family members becomes
increasingly critical in Farmington as people grow older. When people no longer drive, it is usually family members who take them to doctor's appointments, shopping, church, and recreational activities. These trips sometimes involve driving 45 miles one way to an appointment. A small bus is available in the community, but it is not used to a great extent. A bus rider said that:

People here have so much family to take them places that I don't see the bus being active once the current riders have passed away. We don't really need it that much because family takes the place of public transportation.

Family members also stop by stores in the larger towns to pick up refills for prescriptions, groceries, or other items not available in Farmington. An older woman in the community commented:

There's several people here, especially my daughter and son-in-law, that I could contact and say, "Hey, I need this prescription filled, will you go and get it? So I call it in, and then the pharmacist fills it and it gets picked up and I send them the money, no problem.

Social life and daily social contact for frail elders who are unable to leave their houses without assistance is provided primarily by families. Independence for home-bound older people is the ability to remain in their own homes. Typical social contacts center around meals, which are often eaten
with family members several times a week, church activities, and holiday or personal celebrations.

People see family support as a critical resource in the lives of older people in Farmington.

A community member said:

There's a lot of people who move, but there's still a lot of family structure stuff here where two or three generations still live in the county. I think that's what makes it so supportive and caring.

Having to Move. Family is so critical that older people sometimes leave the community in order to be near family members who can provide support. When chronic illnesses become severe enough to hamper mobility and activities of daily living, it is sometimes difficult for older people to find enough supports in the area from family and community. Moving to a larger town in order to access supportive housing or more medical care was not uncommon. Those who stay in the community are apt to have more family and community support than those who leave. Long-term residents of Farmington who moved into the larger towns nearby often say that they did so to increase their feelings of security, or to be less of a burden on their spouse and extended families. Those who move often have more economic resources than those who stay, since it is more expensive to live in the larger towns than to stay in Farmington.

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Older people say that they would prefer to remain in the community, but during the course of the study, two couples left the community to be near family in other parts of the state. Others plan to leave when they become too frail to manage on their own. One woman in her eighties will join her daughter in another city once her very ill husband has died.

Once he's gone, why I'll head off. I'll live near her house and she and her family will take care of me.

**Summary.** Older people in Farmington described two ways to stay independent. Some older people refuse to accept help from either family or the community, believing that to do so would compromise their independent status. Most people, however, are willing to accept help. For the second group, independence means being able to maintain a separate household with family nearby. A woman in her seventies was asked if she wanted to live with her children if she became ill or frail. "Oh no", she said. "I'd rather stay in my own house and have a little help. I don't want to be a burden to anyone".
Domain Summary

Health as it is defined by the older members of the Farmington community was discussed in the domain BEING HEALTHY. Health is defined by the older people of Farmington in active terms: staying active at work and participating in social activities, and remaining independent. A woman in her early seventies laughed when asked if she ever felt too busy. "If I ever slowed down I'd prob'ly drop dead", she said.

Older people contribute a great deal to the community in the form of volunteer work and family support. A community member summarized many healthy older people in Farmington when he talked about his wife's grandmother:

She's 78, she takes care of the church, she shovels the snow, she sets up for meals, she bakes, you name it, she does a lot of crafts, she's always ready to help. She probably puts in a longer day than I do. Always doing somethin, she doesn't drive, but she gets around. She doesn't want you to help her but she's always ready to help you....you'd never know how old she is. She's about done and seen it all.

Families and the community in turn support older people to maintain their health status, which will be described in depth in the next chapter.
Domain Two: SEEKING HEALTH CARE: "You Can Tolerate A Lot If You Have Family and Friends"

The second domain which addresses the experience of health for older people is SEEKING HEALTH CARE. This domain has two categories: Doctoring and Taking Care of Our Own. SEEKING HEALTH CARE describes the experience of both formal care (Doctoring) and informal care (Helping One Another). Health is often considered by health care researchers to be related to available resources such as numbers of health care providers, access to formal care, and available informal care. In Farmington, health is related to personal and community values as well as provider characteristics and access to care.

Doctoring: "She Was Doctoring, But She Died Anyway"

"Doctoring" is a general term used by older people in the community to mean visiting a health care practitioner (usually but not always a physician), or following a health care practitioner's advice. The word is used as a verb. An example is in the title of this category. An older woman was telling me a story about her niece who had died suddenly. The entire passage shows how the concept of "doctoring" is used in Farmington:

And she was doctoring, you know, but her doctor thought she had the flu and he gave her some pills of some kind. But the pills didn't work
and she was dead the next day.

The category of Doctoring is described with three attributes related to obtaining healthcare: Access; Choosing a Health Care Provider; and Choosing a Site.

Access. The lack of health care services within the town limits is not considered to be an important problem by the older people in Farmington. Although the closest medical services are 15 miles away, they are often bypassed by older citizens for a larger regional hospital with specialist physicians forty-five miles away. People sometimes travel even farther for health care on a regular basis. One older woman drives 80 miles each way on a monthly basis to visit a chiropractor who has treated her back for 20 years. Another visits her dentist in the next state twice a year; the round trip is over 200 miles. "Distance don't mean anything out here", said an older woman, "We're likely to go forty miles just for lunch. We're used to it".

Distance is only mentioned as problematic when people needed to drive to cities 45 to 60 miles away on a daily basis for treatment. One woman who had recently lost her husband said:

It was so hard with the drive. I drove every day and stayed with him and I'd come home in the evening. And he was in the hospital over a month before he passed away. It was hard.
Choosing a Health Care Provider. Four different aspects describe Choosing Health Care Providers by participants in the study: Taking Time, Referrals, Just Checking, and Other Ways.

Taking Time depicts the importance that older people place on a provider's ability to establish a relationship and willingness to listen. Health care practitioners are often judged by older people as "good" by the amount of time that the provider is willing to spend with them. This belief is especially true related to physicians. "It takes me such a while to explain what's wrong", said an older woman, "and I can't stand it when the doctor rushes in and out". Once the person finds a doctor who is willing to sit and listen, they stay with that physician. "People are kind of funny about doctors", said one man in his eighties, "they just keep on going to see the ones they know, no matter who comes in new". When a physician retires or moves, the process of finding a doctor begins again, and is often a traumatic event for the older people in the community. A woman at the Senior Center told me about her latest attempt to find a new physician who suited her:

First I waited for half an hour and then he came in and looked at my big toe for 30 seconds and off he went. And the nurse behind the counter said that will be $50,
Mrs. H.: How could he possibly know what was wrong with me when I never got to tell him about it?

Another facet of spending time with patients is willingness to call directly with test results. Older people in the community want to hear from the physician about tests, and they expect a physician to take the time to explain results. A woman who knew many of the older people in the community said:

Most of the older doctors would call you back with the results and everything. The new doctor moved here from back East, and he figures that if there's nothing, he won't call and you shouldn't worry about it. And here you are being tested for you know, maybe something scary, and you want to know either way. And the older people think that he doesn't care enough to call you. If he would take the extra moment it would make a big difference.

When a specialist is needed, doctors are frequently chosen on the basis of recommendations from family members who have had a similar problem. Surgeries, therefore, are sometimes done in other states, as well as in a variety of places around the state. If no relatives or close friends had similar problems, recommendations are sought from relatives who are health care professionals and, as an older woman said, "in a position to know who you can trust".

Referrals from physicians are accepted only if there is a good relationship with the referring
physician. One man in his seventies said that he would never accept a referral from a doctor who had died recently.

We had an old doctor here who was here for a long time and he was a poor doctor when he graduated, but he practiced medicine until he was so old he couldn't know anything. He wouldn't know good from bad in another doc.

Just Checking is a term that older people use to describe health monitoring activities such as blood pressure and blood sugar checks. While most of the primary health care is provided by physicians who are located about forty-five miles away, monitoring and prevention services are done by nurses who come to the community. Prophylactic health care is utilized by older community members if it is done in the community. A home care nursing service provides monthly blood-pressure screening at the Senior Center. The screenings are well attended by older people in the community. Even people who are not regular participants in Center activities come in to have their blood pressure taken. The nurse also monitors medications and checks that they are taken correctly. "It's reassuring", said an older woman at the Clinic. "I like to know I'm OK".

Flu shots are given by the same home care nurses, and many older people get the shots annually. People who are using oxygen at home are checked on a
monthly basis by a nurse employed by the company who sells the oxygen. She checks for possible pulmonary complications and also discusses medication use. Older people are interested in monitoring their health for possible problems, but most health care visits are prompted by specific problems rather than prophylactic care. One older woman in the community summarized the feelings of many, saying:

I know I should get a mammogram every year, but I've never had one, and that's just not the way it was when I was younger. Medicine changed but I didn't!

Older people in Farmington described other health care providers that they use for care. The most frequent non-physician providers are nurses from a home health service based 15 miles away. The agency usually has two or three patients in Farmington. The nurses provide a wide variety of care. Typical cases include: teaching newly diagnosed diabetics to monitor blood sugar and to maintain a diabetic diet, giving intravenous antibiotics, monitoring patients who have recently been discharged from the hospital, and dressing changes. Older people are usually referred to the service by their primary care physicians, but a few who used physicians in cities far from Farmington contacted the agency themselves when they needed nursing care at home. The agency tries to assign a
registered nurse who lives just outside of Farmington to patients in the area. Some of the older people consequently refer to the nurse as "the Farmington nurse". The nursing service is well accepted in the community. One older man had used the agency at intervals for several years. He made a typical comment when he said:

She helped so much. It was through her help that I learned that the drug I was taking was really hurting me, and she got the doctor to give me something else. I could sit and talk to her about all the questions that were puzzling me, because it was just in my home. And in the doctors office you know how many people are waiting! So (the home health agency) was very, very helpful.

Many older people see a chiropractor for chronic back and joint pain, along with muscle aches and arthritis. During the course of the study, a Farmington resident who had gone to chiropractic school returned to establish a chiropractic clinic. His business is doing well, and he believes that it is due to his patient's familiarity with chiropractic care. He said:

I'm surprised that of the 70 some patients I've had just startin out, that only two of them had never been to a chiropractor before. Most of them are actively going to a chiropractor within the last six months or so.

Other alternative health care practitioners are used only by a few older people in Farmington. A few people use "naturalist" pills and herbs, and a
few believe in spiritual healing. People who use herbal cures and spiritual healing, however, also utilize the services of more traditional health care providers.

**Choosing a Site.** Two issues were mentioned when older people discussed choosing a site for health care: Horror Stories and Other Needs. Negative anecdotes and rumors that circulate around the community are described as influential to decision making, along with reasons other than those that pertain directly to health care.

Local health care providers, hospitals, and clinics are subject to "horror stories" that circulate around the community. Horror stories are negative perceptions that resulted from the use of local health care services in the town that is fifteen miles away. Some of these stories can be traced to the time that preceded the current hospital administration and many of the currently practicing physicians, but the stories maintain their power. People are slow to change their minds about local health care. Incidents that occurred as much as ten years ago are still important determinants of a person's choice of health care. A woman in her eighties talked about a doctor who had been practicing in the community area several years ago.
There was a scandal back with the last doctor. The doctor didn't behave himself. (Long silence). And in a small town the word usually gets around.

An older man described an incident that happened to his brother-in-law:

My brother-in-law Bill crashed the car down towards Bradley (The town 15 miles away). So the ambulance took him to Bradley hospital and that doctor never saw his hip was broke. He kept tellin' Bill to walk. After two days I said "I'm takin' you out of here to Meyers (a hospital 45 miles away). And first thing they find is that his hip's broke. If I ever get hurt I'm goin' to Meyers, that's no joke.

Although many people use the closest hospital that is 15 miles away for emergency or minor care, people travel elsewhere for primary care and more complex problems such as heart disease, cataract surgery, and cancer. A woman who had worked in the local health care system and who lived in the community said that:

It's hard to change people's minds once they have a certain view. Somebody says "Well, this place treated me badly" and someone else will hear that and from then on it's written in gold and you can never erase it.

Horror stories seem to be a part of the general perception about local health care in the county. Conversations with older people who live to the east of Bradley in Creekside revealed that they preferred to "doctor" in Bradley because of negative stories about their local hospital. The negative stories about Creekside Hospital are very similar to
those told about Bradley Hospital in Farmington.

The addition of specialist physicians who traveled to the closest hospital at regular intervals did little to change people's minds about traveling farther for health care. Part of the reason is due to the horror stories, but another reason is because it is convenient to combine health care trips with services available in larger towns. Although Farmington once supported a doctor in the community, the advent of good roads and automobiles meant that people could easily travel farther for care and combine other needs for goods and services. An outreach clinic from the local hospital in recent years closed for lack of business within two years. People want to combine health care appointments with shopping at markets with senior discounts and volume prices. People get a wider variety of goods and services in the larger cities than they can in the town 15 miles away. Since medication costs are not covered by Medicaid, and they are often very expensive, "doctoring" in the larger cities also means access to cut-rate drug stores. A frail woman in her eighties talked about why the local clinic failed.

When I first got here, why there was doctors that came here three days a week. And of course, that was very nice, but you still had to go to (the town 15 miles away) to get a
prescription filled. And if I doctor in the next county, why I can get a five percent discount, too, on the same medicine.

Summary. In the category of "Doctoring", health care choices made by older people in Farmington are described. Access is not problematic for older people, even though a preferred site for care is 45 miles away and no physicians practice in Farmington. Physicians preferred are those who take time with patients and have a good reputation in the community. Formal health care is sought for specific conditions, but many older people use monitoring services that take place in the community. Prophylactic health care is well utilized when it is available within the community, but specific health care problems prompted most visits to health care providers outside of the community. Home health nurses and a chiropractor provide most of the other formal health care that is used by older people in the community; both services are well accepted by older community members.

Helping One Another: "We Take Care of Our Own Here"

In the category "Helping One Another" informal care is examined. Most of the health care for older people in Farmington is informal and is given by family and friends. Informal care is preferred to formal care for long term illness. No
one in the community wanted to be placed in a nursing home and few were interested in moving to Senior Housing; people want to stay at home with their families near by. As one woman in her eighties who was quite frail said:

I've lived here all my life and I can't imagine wanting to be anywhere else. All of my family and friends are here. It wouldn't be home in some other place.

Helping One Another is described by three activities: Giving Care, Family Care, and Community Care.

**Giving Care.** Older people commonly give informal care to one another. Since women have a longer life expectancy than do men, wives usually provide the care for husbands. Wives with mild chronic health problems sometimes are primary caregivers for husbands who are even more ill. Care giving takes a toll. "It's the hardest thing in the world, sometimes", said a woman in her seventies with chronic obstructive pulmonary disease. She provided care for her husband for the past ten months. "I never have a day free and I get so tired".

Furthermore, these women are often too involved with care to participate much in community life. One married woman who came to a special event at the meal site said:

I don't come very often because I'm busy taking care of my husband, and that takes up
most of my time. If I were a widow, like most of the women here, I'd be down here all the time, and back in church, too.

Only after older women who are primary caregivers become widows are they able resume active participation in community life.

**Family Care.** Care giving by spouses in Farmington is usually not done alone. Families help by assisting with transportation, shopping, and providing social contact. One older woman who had three adult children in the area talked about how her family supported her during her husband's last months of life:

> The girls came and cooked when I was just too tired, and sometimes they would feed their Dad. And my oldest boy would change his catheter and help me lift him. Oh my, I couldn't have done it without them.

When people live alone and become frail, families provide increasing amounts of informal nursing care. Sometimes family members would do twenty-four hour care during the last months of life. Several examples were observed where families have provided this care for several years.

**Community Care.** Few people in Farmington do not have family members who live close by, since those without family connections often move out of community to live elsewhere. For those few who never
married, had children, or were otherwise without family, other community members sometimes acted as family. A very frail man in his eighties who was unmarried and who had no family other than a nephew in another state became housebound and unable to provide much self care. Members of his church and the community cleaned his house, visited on a regular basis, provided informal nursing care, and took him meals. A community member and his family who had adopted the older man into their family as a "grandfather" also said that:

Plenty of people here wanted to help...there was a man who used to be the postmaster here, who retired and moved elsewhere. He used to stop probably at least once a week and visit. He did a lot of things for him; washed dishes every time he went. A lot of people kind of checked in on him...his skin got dry and he itched a lot, and during that last year he'd con somebody or other into lots of back rubs.

Without this community "family" and frequent visits from a home health nursing service, he would have been forced to move into a nursing home. The home health nurse who was involved in his care said that:

The nursing service alone couldn't have kept him at home without the tremendous amount of support from the community.
Domain Summary

Choosing a health care provider is a decision based on establishing a comfortable relationship with the provider, referrals from family members, and with other amenities in the site where the practitioner is established. The recounting of stories about both practitioners and clinics in the rural area has a powerful influence over the choice of providers. Beliefs and stories may persist for long periods of time and may have an effect on the ability of health care providers to maintain viable practices. Health monitoring and prophylactic care was well accepted and utilized when services were provided within the community. Trips to health care providers outside of the community were primarily for specific health problems.

Informal care provided by spouses and families is preferred to formal care for long term problems. Families are both primary caregivers and assist spouses in providing care. Family support is so critical that couples without extended family in the area may relocate to be closer to their adult children or other supports.

"I know I'm not the healthiest person in the world", said an older man. "But you can tolerate a lot if you have family and friends".
Chapter Summary

Results of ethnographic analysis revealed two domains which capture aspects of community that influence health. These domains, BEING HEALTHY and SEEKING HEALTH CARE, were discussed in this chapter. First, health was described from the perspective of older residents of Farmington. A balance of activity and independence forms the basis of the definition of "health" for older people in this community. "I'm too fiesty to get sick", said a man in his seventies, by which he meant that he was both too independent and too active. "If I get sick", he added, "I'd have to come in the house and sit and that's not me".

Informal care, preferably by family, is preferred over formal health care by older people in Farmington. When formal care is sought, family remains important in providing referrals. Older people value health care providers who will spend time with them and give them time to ask questions.

Relationship undergirds the domains within these data. The maintenance of health and the mitigation of health problems is based on a web of relationships that are critical for older people in the community. At the same time, older people make important contributions to the community through their work and volunteer efforts. The ability to
give to the community as well as to receive help is an important factor in the acceptability of help, as will be discussed in the next chapter. Chapter VII is concerned with three domains of community life that influence the health of the elderly, and the web of relationship present in these data.
CHAPTER VII

"PEOPLE LIVE HERE FOR WHAT A SMALL TOWN HAS TO OFFER"

Relationship is important to community life in Farmington. In this chapter the second aim is addressed: the investigation of rural community processes that influence the health of elderly people. Exploration of these processes led to the discovery of three domains. These domains all deal with relationship in some form, and are about living in a rural community: KNOWING EVERYBODY, COMMUNITY CARING, and INSIDER PROBLEMS. Results of the analyses of these domains are presented in turn by discussing categories that relate to each domain. Although relationship is discussed in detail in the first domain, this concept is also found in the other two domains. "People live here for what a small town has to offer" is a quotation which reflects the positive feelings older people have for their community, as described in the domain KNOWING EVERYBODY.
Domain Three: KNOWING EVERYBODY: "The Obvious Thing Is That Everybody Knows Everyone Else"

KNOWING EVERYBODY examines the pervasiveness of relationship within Farmington. People are often related by blood or marriage; they also feel an extended relationship with the community as a whole. People are categorized as "insiders" or "outsiders" by the people who live in Farmington. KNOWING EVERYBODY has two categories: those who are Insiders and those who are Outsiders.

Insiders: "We're Like a Big Family Here"

"Insiders" are those people who have lived in the community for extended periods of time and who uphold community values. Not infrequently, people are related by either blood or marriage to nearly every other resident. As a consequence, people know one another very well. They often grow up together, attend the Farmington school for their entire educational career, and marry someone from the community. Even when teenagers leave Farmington for college, they often marry someone from the community and return there to work and raise a family. The depth of the knowledge of one another held by community members is illustrated by figure 6. When community members saw this photograph, an immediate comment from several people was: "There's Old Louie
"out walkin' around". When asked how they could tell who it was from the extremely small figure in the picture, a woman said:

Well, it just seems obvious. He always wears that hat, and there's his vest and he's walkin' back towards his house the way he always does. That's him all right.

Figure 6. Old Louie out walkin' around.
Relationships are so tangled that people who have lived all of their lives in the community are sometimes surprised to find out that someone is related to someone else. One man who is a life-long resident said that:

There's some people I didn't even know were related to people; you'd think in a small town you'd know that. But we'll get to talking and I found out that they're married to so and so's cousin. You have to be very careful what you say about someone, because some way or the other, they're related to the person you're talking to.

A sense of relationship spills over to encompass the community as a whole. The community is, in some sense, "family". "We're like a big family here", is a frequent comment from community members when they talk about Farmington.

Relationship appears to be crucial in community response to people who move to Farmington to live. Entering into the community is made more easily when a sense of relationship can be established for the "outsider". As an outsider and researcher, I was welcomed into the older adult group within the community because I was introduced by a woman who has lived there for many years. The woman's niece through her marriage is a faculty member at the University, and I worked for her as a Research Assistant. "Why, that makes you something of a relation, doesn't it," said one of the Senior...
Center members. I was introduced during my early visits to Center members as "the person who works for W.'s niece", and occasionally as "the nurse who is related to W.'s wife". I quickly became "family" and was introduced as a "sort of relation" from then on to prospective participants in the study. As a "sort of" family member, I was quickly included in activities in the community and people readily agreed to participate in the study.

**Summary.** Insiders are those who are treated as "family" within the community whether or not an actual family relationship exists. It is common to find that people know one another and their habits in detail. "People treat you like family here" is a compliment that community members often pay to their community. The warmth and positive regard towards family life is reflected in the language which symbolizes a sense of extended family that is applied to the community at large.

**Outsiders: "I Was the Raisin in the White Bread"**

Not everyone is welcomed as easily as I was into the community. Two basic reasons are given for why people are considered outsiders: the amount of time spent in the community, and cultural acceptability. The general feeling expressed by the
community towards outsiders is uneasiness.

**Time in Residence.** The local paper printed an anonymous letter from someone who called him or herself "Outsider". The writer wrote about trying to become a member of the community for the past four years without success. The perception was that the community had never welcomed the person or treated him or her as an "insider" in community life. While the next week's paper had two letters in defense of the community, other people sometimes mention an element of exclusion in Farmington that relates to the amount of time spent living there. A joke told at the Senior Center illustrated the situation: it takes "at least" fifty years to become a "true" member of the community if you aren't born there. Another resident who had lived in Farmington for twenty-two years quite seriously said that she hadn't been there long enough to be considered a "real" member of the community. One woman who had lived most of her life within a twenty mile radius of the town said that the people in Farmington were more "clannish" than in other local towns. She doesn't consider herself a community member because she hadn't lived within the town limits all of her life.
Cultural Acceptability. People who do not conform to community social or cultural standards are also "outsiders" in community life. The largest group of outsiders in Farmington are the Spanish-speaking migrant and semi-migrant people who live primarily in one area of town in a small area of trailer homes. This group also includes an extended family who lives in the trailer homes on a year-round basis. Community non-acceptance stems from the perception that the Spanish-speaking people make extensive use of government-supported services. A wide-spread belief in the community is that some Spanish-speaking people have remained on welfare support for several generations. Farmington's older adults perceive that this population, which townsfolk call "the Mexicans", fight and drink alcohol more than is acceptable by community standards. A nearby tavern was avoided on Saturday nights because "that's where all the Mexican fights happen". The community believes that much of the petty crime in town is attributable to this group. Many of the people who appear on the Farmington police records have Spanish-speaking surnames, and the community assumes that much of the crime can be attributed to Spanish-speaking migrant workers. Several people told me to "watch out for what you leave unlocked when spring
comes" because migrant laborers come to Farmington to work in the fields when the spring plowing and planting begin.

As a result, little interaction takes place between the English and Spanish speakers. "The separation is pretty deep", said one man. "Even the kids don't play together at school". Groups within the community are rarely attended by Spanish-speaking people. When someone encouraged a Spanish-speaking man to attend a community function, he said:

I don't think I'll be welcome there....I'd feel like a fly in the milk because here are all those white faces and I'm the only minority.

When a Senior Center was situated near a settled-out migrant settlement in a nearby community, the Caucasians did not attend because, as one older woman said, "they thought it might be somehow connected to welfare, and they just weren't comfortable".

Although cultural differences are part of the uneasiness between groups, the community is more willing to accept people who share community values. Several families of Spanish-speaking people who settled in the United States about four hundred years ago own their own farms. These families are spoken of with approval by community members. Although they are referred to as "Mexicans" by most townspeople, they are considered to be good community neighbors.
Caucasian outsiders are usually those who violate community standards by accepting welfare for extended periods of time, by being unwilling to support their families, or those who refuse to contribute to the community as a whole. A prevailing cultural norm that determines the acceptability of help is whether the helping relationship is reciprocal in nature. A food bank program in which volunteer work is traded for reduced prices on food was readily accepted by the community. Government programs with no opportunity for people to give something in return are generally not acceptable.

People who are perceived as withdrawn from community life and unwilling to participate in community activities are not accepted as "real" members of Farmington. "People who live like there's only them in the world just don't fit in here", said an older man.

Outsiders sometimes said that they feel as though the community is not willing to accept them as they are. "People put us into pigeonholes", said someone who calls himself an outsider. "God help you if you try to be something different".
Uneasy Feelings. A general uneasiness about outsiders extends to several aspects of life in the community. When the ambulance responds to a traffic accident that involves someone from outside the county, the crew express more concern about the possibility of law suits than if the victims are local people. An ambulance volunteer said that people he knows are not likely candidates to bring suit, but:

If we roll to the scene and it's someone from New York, why along with the injuries they've got dollar signs in their eyes. We always document those real, real well.

People from a large city about 70 miles away are sometimes viewed with suspicion. One community member said that a visitor to the town council meeting was not popular. "He's a suit", (an expression used to differentiate a man who works in a suit as opposed to the work overalls or jeans that most Farmington males wear) she said. "He thinks he's telling us something that we don't know because we're hicks". Another man who was dealing with an engineer from the city said:

He used a lot of big words, but he didn't really know what he was talking about. He just wanted to sound smart. But he didn't know nothing about our situation here.
Summary

People are labeled as insiders or outsiders depending on their length of residence in the community and shared cultural values. Outsider labels occur in this small rural community because people know each other well and have strong values about "appropriate" behavior. Those who have not lived in the community for many years, or who violate community standards, are relegated outsider status. Insiders express feelings of uneasiness toward outsiders, and outsiders feel as though they are "different" than insiders. A man who referred to himself as an outsider in Farmington said:

Did you ever feel like you didn't fit in somewhere? That was me: I was the raisin in the white bread.

Domain Summary

"The most obvious thing here", said a study participant, "Is that everybody knows everyone else". The knowledge that people have about one another is deep and intimate. "Insider" status can be difficult to achieve in Farmington. Those who are born and live their lives in town are automatically insiders unless they violate cultural norms, but the process is slower for those who move in. Establishing a sense of relationship helps, as does contributing to
the community. Farmington has a stable population that is interrelated by birth and marriage; there are no mechanisms to easily assimilate newcomers into the community.

Insider status has both advantages and disadvantages for the health of older adults. These advantages and disadvantages are discussed in the next two domains, COMMUNITY CARING and INSIDER PROBLEMS.

Domain Four: COMMUNITY CARING: "We Take Care Of Our Own"

The community may exclude newcomers who have no relationship ties except when a need occurs. When one life-long resident was asked how the community treats people who move to the community she said:

People here will leave you alone and not bother much with you until something really bad happens. Then they will give you all the help in the world.

Stories abound about community support during times of need. Even those who tend to disparage an idealized picture of rural life agree that Farmington provides tremendous help to anyone who is experiencing difficult times.

Four categories comprise the domain of COMMUNITY CARE. The categories describe community programs and actions that help people personal and
community-wide crises, promote safety, assist older people in their daily lives, and in networking with groups outside of the community.

Crisis Support: "We're At Our Best in A Crisis"

Crisis Support examines community assistance for individuals and the community as a whole during serious crises. Emergency services and emergency helpers are necessary for community support.

Emergency Services. The perception of emergency services within the community is that the fire and ambulance services are excellent. A man in his seventies talked about what happened one day when he fainted:

I got up to walk down the hall when everything went black. And my wife, she dialed 911 and they were here in about two minutes. I don't worry too much about emergencies because I know they'll be here quick.

The ambulance and fire crews are staffed entirely by volunteers except for the Chief's position. Both crews require large amounts of volunteer time: the fire engines go out almost daily. A position on either the fire crew or the ambulance requires many hours per month of training time. The ambulance crew must complete one semester of training at a community college twenty miles away. Crew
members average eight hours per month of additional training activities along with their ambulance runs. When an emergency happens in town, response is fast and efficient. "When we have an emergency", said one volunteer, "we get so many people on the scene sometimes that it's almost too much help!" The dedication of the volunteers is impressive: all of them also work as farmers or at other jobs in the community. Their volunteer time, therefore, is always given in addition to their full-time work. Volunteers are deeply appreciated by the community. Community members often refer to the excellent job done by the crews, and community perception is that both fire and ambulance services are excellent.

Emergency Helpers. The presence of a crisis requires helpers to deal with community response to individuals requiring help. Two topics running through the concept of helpers were Personal Crisis, and Community-Wide Crisis.

Personal crises occur when individuals are in need of help from the community. Since everyone knows everyone else, misfortune or need is felt in a real and personal way by nearly everyone in the community. "The same bad things happen here as happen anywhere else", said a community member. "The difference is that when it's someone you know, you
just can't ignore it. It's like it happened in your own family".

When people are hospitalized, others in the community offer assistance in meal preparation, child care, transportation, house cleaning, and yard care. When a child was hospitalized for a major illness, people in the community organized a fund raising drive to help pay for the hospital bills and a blood drive to replace the blood that the child had used from the blood bank. The blood drive produced a surplus of blood that was credited to future needs in the community. A study participant said that the surplus was not surprising. "People come out of the woodwork when somebody needs help", she said.

Help is extended to newcomers and transient community members as well. The community clothing and food site is always well-stocked with donations and volunteers. A worker at the donation site told of an unemployed young couple with children who moved to town. Volunteers at the site were active in supplying them with warm clothing, food and job hunting ideas. When a sympathetic neighbor learned that this family did not have running water or electricity in the house, the neighbor allowed the couple to run an electrical cord across the alley and to use his sink for water. The family received

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help when it was needed, but by no means were they considered "insiders". Help to "outsiders" who live in the community is part of community tradition, but the recipients remain outsiders until they have spent considerable time in the community and begin to make contributions to community life. Community disapproval of "taking something for nothing" is so strong that ride the community bus or participate in the Senior meal program are often quick to point out that they pay for these services.

The community response to larger problems within Farmington is handled differently. An excellent example of community spirit in times of community-wide need transpired when people were called onto active military duty to participate in Operation Desert Storm. Several of the Farmington community members participated in Desert Storm, including the High School biology teacher. A total of 52 people were called to active duty in the county. The large number of community and county members who were activated meant that few families were unaffected by the war. Within a few weeks, community members had organized a support group, a prayer service, and a rally to support families and troops. The town council dedicated the annual "Agricultural Days" parade and activities for support.
of the service members and their families. The quick response was typical of the community, as one man stated:

It was really informal...It was just people knowing other people in the community and saying: "hey, we need to let these people know we're thinking about them" rather than a vote of the town council or anything else. It lets things happen quickly, rather than being dragged out through a formal system.

Summary. The community responds quickly and efficiently to both insiders and outsiders who are in need. Emergency response is well supported by volunteers from the community and by informal help from neighbors. When personal tragedy or community disaster occurs, the community responds through informal means to meet people's needs. A community member summarized the community's perception of itself when she said: "I think we're a pretty caring community, but we're at our best in a crisis". Day to day help, however, is primarily given to insiders.

Daily Caring: "Folks Help Out In Small Ways"

The category of Daily Caring addresses the community response to people in need of help in non-crisis situations. Although a perception is held in Farmington that the community responds best in a crisis situation, substantial help is given to meet personal needs of older people in the community,
especially those who are insiders. A consensus exists in the community that members are extended "family" who are a part of an individual's responsibility.

Many elderly people speak of their neighbor's help and support in small ways. One elderly woman reported that her minister stops by occasionally with meals that he knows she enjoys. The woman who cleans her house is willing to do more than just the housework. She explained:

The cleaning lady does so much. When I couldn't drive she went over to the American Legion hall and she got a wheelchair for me, and she went to the store for me. And if I need to go to the doctor she will skip the cleaning and take me there instead.

Another older woman realized that she has not needed to clear her sidewalk of snow for the past 10 years. One neighbor or another simply shovels her walk and driveway when they were out doing their own. When a large snowstorm hit the community one morning, the family I was staying with sent their son out to shovel the sidewalk. "When you're done," said his mother "go check up and down the block to see if any of the older people need to be shoveled out". When he returned an hour later, he had cleared the sidewalk for two widows who lived nearby.

An older woman mentioned that she has never been snowed in, no matter how large the storm was,
for more than a few hours:

When we have a big blizzard, good land, there'll be seven or eight farmers in here from out in the country with tractors and blades so you never have to worry about gettin' out of your driveway.

Community members don't neglect the social needs of their older residents, either. Visiting with one another is a commonplace activity for everyone in the community. When people are alone, neighbors visit or invite the person to join them. One older woman who had moved into the community only a few years ago told a story about another woman who worked in a business in the community.

She would be there all the time and she would call me sometimes and say "I'm lonely, why don't you come on down" so I'd go there. And I would stay down there a lot. She just wanted to help me out.

Summary. Community help extends to older people in small concerns as well as in times of crisis. Neighbors provide help with such things as yard care, shoveling, and social interaction. An woman in her early seventies talked about how she managed to live alone. "It's not too hard", she said. "Folks help out in small ways and it makes all the difference". 

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Personal Safety: "This is Really a Safe Place to Live"

Personal Safety is a category in which the general perception of security and safety is identified by people in Farmington. Community action in the form of safety programs and "looking out for one another" plays a part the feelings of safety for older people in the community, and the low crime rate reinforces a feeling of security.

Crime. Although reportable crime (homicide, rape, robbery, assault, burglary, theft, and arson) occurs, no one believes crime to be very prevalent. This perception is accurate, according to crime statistics kept for the town. No homicides or rapes have occurred in the past two decades. Last year only three reportable crimes were recorded in Farmington, all of them non-violent. A similar low number has occurred for the past few years. The crime rate has been rising in the state as a whole, but has not increased in Farmington. Furthermore, the percentage of "cleared" or solved, crimes is over 50%, which is much higher than the statewide average of 27%. Older people often say that they would be afraid to live in a big city, but that here in Farmington "people watch out for one another". Few people lock their doors, and almost no one locks
their cars when they are parked in town. A typical story told by a community resident is:

When this eighty year old fellow wasn't seen around town in his usual places, nobody's seen him, by that evening they'd called the cop to go look and find out if he's died in his bed or is he OK or is it just that we haven't seen him.

A common belief is that when a crime is committed, someone from outside of the community is the perpetrator. "When something really bad happens here", said an older man, "it's usually somebody from somewhere else who's responsible". One major crime, which occurred during the course of the study, was a robbery of the local liquor store. The thief was a young man who had attended school in Farmington, but he and his family had lived about forty miles away for the past five years. The perpetrator was caught within a week because the local law enforcement recognized his distinctive habit of stealing a pickup truck and then using it to commit a robbery. Community members considered this to be an good example of their assertion that crimes are committed by "outsiders". A bank robbery that occurred three years ago was also committed by someone who grew up in town, but no longer lived there. He was recognized by the bank manager and quickly apprehended, but once again this crime was committed by someone who was not considered a genuine member of
the community.

Safety Programs. The community participates in a program called "Are You OK?" Older people who live alone can have a computer-generated telephone call to their homes at the same time each day. If the call goes unanswered, someone comes to the home to see if the person is safe and well. The service is a part of the county-wide 911 system, and is offered as a free service to older people.

Safety programs are a part of the ambulance crew's regular lectures for senior citizens in the county. The classes concentrate on basic first aid and home safety. "It's so surprising", said an ambulance volunteer, "Some of these people are eighty years old and they don't know how to stop bleeding. So we teach them how to stay alive until we get there". Older people are also taught home safety ideas such as placing their telephone within reach of the floor in case they fall and are unable to get up.

One woman in the community teaches CPR classes on a regular basis, and many of the community members have taken the class. A number of registered nurses, licensed practical nurses, a physical therapist and a chiropractor live in town and provide care on an informal, as-needed basis. A frail older woman said that "when I cut my arm on the
garage door, why I just called my neighbor the nurse, and she came right over and bandaged me up".

A major safety issue that is not well addressed in Farmington is the provision of shelters for the tornados endemic to the Great Plains. Many homes in town do not have basements, which are considered the safest place to be if a tornado strikes. Although the community hall has a basement, it is usually locked. Older people are invited to share the basements of neighbor's homes, but there is no guarantee that a neighbor will be home during a tornado warning. An older woman told a story at the Senior Center the day after a severe spring windstorm triggered a tornado alert.

Both of my neighbors said I could come to their house, but the last time we had a warning, wouldn't you know, they were both gone! So I went into my bathroom and shut the door, but it didn't feel very safe.

Summary. Older people feel safe in Farmington. The community perception is that what little crime occurs is committed by outsiders. Since most older people know their neighbors well and watch out for one another, a general feeling of security prevails. Safety is addressed through community concern, formal classes, and informal care by professionals in the community. A woman in the community expressed a common conviction when she
said:

I'd be so scared to live in the city with all of the crime there. But here I never lock my doors; this is really a safe place to live.

Networking: "We're Looking Ahead"

The fourth, and last, category in COMMUNITY CARE considers community interface with groups outside of the local community. Farmington is remarkably successful in dealing with the network of county, state and federal governments of which they are a part. The most notable achievement was the construction of a levee to control the flood waters of a nearby creek. The town had been prevented by federal regulations from any new building within most of the town limits because it was situated in a thirty-year flood plain. The mayor and town manager spearheaded the writing of two grants, one to study solutions for the problem and one to build the dike. The grants were funded by the state and federal monies, and the town council successfully petitioned the federal government to lift the building restrictions. The entire project took six years and repeated grant proposals to accomplish.

Smaller projects are also quite successful. The community sponsors a summer recreation program by recruiting summer interns from a Recreational Therapy Program to live in the community and run various
recreational groups. The program changes from year to year depending on the intern's interests, but during the summer that the study was conducted, there was an exercise program for the elderly, art projects for all ages, activities for school age children, and a softball tournament for the adults. The intern also organized a "Summer Recreation Day" and a "Community Camp Out" in which the entire community was invited to participate in outdoor activities.

Farmington successfully taps into county resources to achieve some of their goals. A summer library and swimming program at the county seat is well attended by the younger school age children, and the community is able to use the services of the county bus. The emergency dispatch system that includes Farmington resulted from successful input from the town and the county at the state level. It includes a 911 dialing system, trained Emergency Medical Technician dispatchers, and the previously mentioned "Are You OK?" telephone program for seniors.

Finally, the Area Agency on Aging (AAA), which is a six-county wide Federally funded agency that sponsors programs for older people, developed a number of approaches used by people in the community to maintain their health. The county AAA coordinator
lives in Farmington, and older people in the community frequently contact her directly for services. Programs sponsored by the AAA include: "Meet and Eat" site where older people share their noon meal twice a week; a Painting Program in which volunteers paint older people's houses with donated paint; dental and vision programs to provide low-cost services to Seniors; and a food distribution program.

A small van which provides very low cost transportation for anyone in the county who requests the service is available to older people who no longer drive. The bus picks up people at their house in town or at their farm in the country. People plan their day around shopping and appointments, eat lunch together at a restaurant in town, and then are driven home. An average of six or seven people ride the bus each week. Figure 7 shows a group of older people on "Shopping Wednesday", which is a regular shopping day in a larger town 15 miles away from Farmington. Although a some of the women in this photograph have difficulty walking, the other bus riders help them with packages and in getting on and off the bus.
Figure 7: Community bus trip
A community need that has not yet been addressed in Farmington is a lack of low-cost, easily maintained housing. Older people in the community frequently say that they would like to stay in the community: "I've lived here all my life; this is my home", said a woman in her seventies. "I just wouldn't want to live anywhere else!" Maintaining a separate household is an important part of independence, but older people often prefer a smaller home than the one in which they raised their families. Unfortunately, it is almost impossible to sell a home in Farmington, due both to depressed economic conditions and a lack of interest in the predominantly older homes that elderly people often own. When houses and yards become too large and too difficult to care for, they cannot be sold. Furthermore, no small homes are available in the community that are in good condition and easily maintainable. As a result, many older people remain in homes difficult to maintain and more costly than they can afford on retirement incomes.

Farmington continues to plan for the future. The town bought a farm close to the town limits that will provide a new well to maintain adequate water supplies. A successful grant application funded a comprehensive plan that was finished in 1990. The
plan provides the planning basis for economic development, public services, and overall land uses.

Summary. Farmington has been successful in meeting community needs through networking with larger political entities. The community maintains a planning perspective which was summarized by a community member:

We're looking ahead, to the future, to what we can do to improve streets, utilities, zoning, doin' some utility projects. I don't know how much of the plan we'll be able to afford, but it's a good way to look ahead.

Domain Summary

The domain, COMMUNITY CARING, illustrates community response to both crisis and daily needs. Problem identification is rapid and problem solutions are usually done through informal channels. Community members perceive their emergency services to be excellent, and many community members volunteer long hours to maintain emergency skills. People feel safe in Farmington, and believe that when bad things occur, an Outsider is responsible. Neighbors and friends, therefore, are to be trusted.

The community has networked with outside groups and agencies to provide services for older people and the community as a whole. Community planning documents are planning for future
improvements in services over the next two decades. The community newspaper ran an article two years ago in which a resident talked about the community as a place to live. "One of the things I like best", he said, "is how we take care of our own".

Domain Five: INSIDER PROBLEMS: "It Can Be Tough To Be An Insider, Too"

Although the community assists older people to achieve and maintain health in a number of ways, there are also stressors and problems in the community that are detrimental to health. The domain, INSIDER PROBLEMS, centers around the problems that happen when people are deeply intertwined in relationship with one another. The closeness of rural life, perceived as an asset in the preceding domains; in this domain is a detriment. Two categories are found in INSIDER PROBLEMS: lack of privacy, and leadership problems.

Lack of Privacy: "Everybody Knows Your Business"

A lack of privacy and a sense of always being monitored by others is frequently mentioned by people in Farmington. One younger woman mentioned that she had gone out for a cup of coffee with a male co-worker one evening at the local cafe. "People came up and said they intended to let my husband know", she said. "They were joking, and what's more my husband wouldn't care, but it
still gets to you".

One older woman had recently moved to town from a farm in the country, and her most difficult adjustment was to the lack of privacy. She had never thought about maintaining privacy when she lived a few miles from town, but she soon realized that she would need some barriers from her neighbors now that she had moved.

On the farm, I never pulled a drape and I could just look out and see everything. So the first month I was here I didn't have anything on my windows, and my neighbors were always asking me: Well I seen your light on at 11 o'clock and you still weren't home, what time did you get home? Then I knew it was time to get the drapes up.

Other examples illustrate the inability of people to keep their lives out of the public eye. A scandal of any nature rarely goes undetected, and very public discussions of impropriety are observed. Stories are rampant about people who are having affairs, are pregnant out of wedlock, can't pay their bills, or who drink to excess. "Be careful where you park your car", one man said half jokingly to me, "or everybody will say you're carrying on with whoever lives there".

Furthermore, it is impossible to use government supported services without everyone knowing. A man in the community said that he would never accept any help because "People always know even if they don't publish it in the newspaper; everybody knows your
business". The lack of privacy contributes to a reluctance to use community services even when a real need exists.

**Summary.** Privacy does not exist in Farmington to any extent. People know one another's private lives in as almost as much depth as they know their own. Consequently, those who would use certain services are deterred by the knowledge that their neighbors will discuss it. "Don't think you can get away with anything", said a community member. "When you live in a town this small, everybody knows your business".

**Leadership problems: "You Don't Get Much Thanks"**

An unspoken expectation is held that people in public positions are unblemished in their personal lives. People who hold public office or who are in a position of authority in Farmington can lead very uncomfortable lives even if they maintain a strict propriety. Teachers, school board members, town council members, ministers, and business leaders sometimes have difficulty in such a small community in separating public functions from private activities. Everyday activities such as shopping or going out to eat or even just gardening in the yard provide opportunities for neighbors and friends to comment, sometimes very unfavorably, on policies and decisions. People in these positions often comment on
how startling it is to have a constant critique. One man who had been in a public office for several years said:

"There's nothing more demoralizing than when your communications are taken to a personal rather than a professional level...you alienate some of the members of your community by some of the decisions you make and you need to be prepared to deal with the anger...and you can't even go to the grocery store in peace the way you can in a big city".

People in public positions sometimes handle the stress of public criticism by remaining slightly withdrawn from close personal friendships. Several officials said that they were careful about confiding in anyone outside their immediate family. One man said that the best advice he was given when he took a public position was to "make friends, but not be friends" with people in the community.

Compounding the problem is the fact that people often grow up together, and bad feelings may extend back to grade school. Dissent within the community is often deeply felt because of the extent of interrelatedness between community members. Quarrels between families may continue for many years, with subsequent disagreements adding to the estrangement. Since relationships are extensive in the community, it sometimes happens that people who own businesses find their business is hurt by boycotts of family groups. Most of these quarrels are rather short-lived in duration, but it is still painful for people to deal with
disagreement from neighbors and friends. Another woman spoke for many people when she said:

What killed me is that we were friends this morning, and now all these people are shootin' me daggers.

Active community members sometimes believe that their efforts are both unseen and unappreciated. "I never hear about what I do unless someone didn't like it", said one long-time resident. "There are times when I'm ready to just give it all up since you don't get much thanks".

Summary. Public life can be difficult in Farmington. Quarrels and dissent over public issues spill over into private lives. Older people who are now or had been community leaders in the past sometimes draw back from close relationships with all but their immediate families in an attempt to escape community criticism and pressure. One woman who had worked in a public position for some time said: "You hear a lot of complaints, but you don't get much thanks".

Domain Summary

Insider status can be difficult because of a lack of privacy. The community is so small that it is difficult to vary from community norms without being discussed at length. Some people feel constrained and
hampered by the public scrutiny. A woman who had spent a number of years in public positions said that "People talk about how hard it is to be an Outsider. Well, it can be tough to be an Insider, too!"

Chapter Summary

Relationship is central to life in Farmington. The community supports its members in crisis and in daily life due to a sense of relationship with one another. Knowing one another well contributes to a sense of safety and well being for community members, as well as providing a "natural neighborhood watch" for one another. Reciprocity is a key ingredient within relationships. The ability to give as well as receive help is crucial to program and personal acceptability. Programs and that do not allow people to contribute to the community and people who do not provide for others do not gain community acceptance.

Farmington maintains a number of activities that contribute to safety and health of the older population. People are involved in community-sponsored activities that range from recreation classes to Bible studies. The ability to contribute to the community is valued. Participation is active in all age groups, although older people are often especially active in church and charitable activities.
Community problems also revolve around relationships. The small and close-knit relatedness within Farmington can be overwhelming. People who take leadership positions are unable to get away from community criticism. Those who choose not to conform to community social standards are not well accepted into community life.

The community is planning oriented, and is successful in using larger government agencies to assist them in their goals. Removing Farmington from flood-plain classification was a major achievement, and extensive planning is occurring for future utility needs and zoning codes. On the whole, the community is able to assist older people in maintaining their independence and remaining active.

Residents often say that they live in Farmington because it offers a way of life that isn't available in larger towns. Elements of this way of life relate to health: little pollution, a community that "supports you in times of need", little crime. People often say that they feel privileged to live in Farmington. A resident said:

I've learned that you can't do the same things in a big city that you can in a small town. For instance, there's maybe farm machinery parked around town. It's a farm community; it's a way of life. If you did that in a town of even 10,000 people, your neighbors would want it removed. We've got dirt streets and we've got tumbleweeds blowin' down the streets and yet
we've got fresh air and we don't have much traffic. And I think it'll always be that way. People live here for what a small town has to offer. If they didn't they'd probably want to live somewhere else. I think they should.

The links between community processes and the health of the older residents of Farmington is the basis for the next chapter. The links are based on five themes derived from the domains. Table 4 is a summary of all of the domains that were presented in the Chapters VI and VII. These domains are analyzed for themes that cross domains and provide a more holistic picture of the data.
## TABLE 4
OVERVIEW OF DOMAINS AND CATEGORIES

<table>
<thead>
<tr>
<th>Domain 1: BEING HEALTHY</th>
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<tbody>
<tr>
<td><strong>Categories</strong></td>
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<td>Being Active</td>
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<td>Being Independent</td>
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<th>Domain 2: SEEKING HEALTH CARE</th>
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<td><strong>Categories</strong></td>
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<td>Doctoring</td>
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<td>Helping One Another</td>
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<th>Domain 3: KNOWING EVERYBODY</th>
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<td><strong>Categories</strong></td>
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<td>Insiders</td>
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<td>Outsiders</td>
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<th>Domain 4: COMMUNITY CARING</th>
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<td><strong>Categories</strong></td>
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<td>Crisis Support</td>
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<td>Personal Safety</td>
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<td>Daily Caring</td>
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<td>Networking</td>
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<th>Domain 5: INSIDER PROBLEMS</th>
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<td><strong>Categories</strong></td>
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<td>Privacy</td>
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<td>Leadership Problems</td>
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CHAPTER VIII

THEME ANALYSIS

Cultural themes are the third level of ethnographic analysis. Themes are larger and more holistic than domains because they contain information found in two or more of the domains. The themes transcend the domains and clarify the lived experience of health for older people who live in Farmington. Five themes emerged from the domain analysis. In this chapter, each of the five themes is presented as a statement that describes a part of the rural culture in Farmington that influences health. The five themes are subsequently woven into a metaphor that exemplifies the cultural values that underlie the themes. Themes, like domains, overlap in subject matter and material. The overlap results from the holistic nature of the data, which resists being compartmentalized into discrete categories. The final metaphor is that of myth. This metaphor brings all of the themes together to capture the values and cultural beliefs that operate in the community. The five themes and the metaphor provide an overall sense of rural life and health for older people in this culture. A description of the community based on
the themes and the metaphor of myth concludes the chapter.

Farmington influences the health of the older people who live there in a number of ways. Five cultural themes address those influences: 1) Relationship is central to life in Farmington and influences people to support their families and their community; 2) Reciprocal relationships between the community and older people provide benefits for both groups and determine the acceptability of programs and people; 3) Community values support a balance between independence and interaction for older people that fosters health; 4) Community programs and individuals work together to support the health of older members; and 5) Close relationships are sometimes detrimental to the health of older community members. Each of the themes will be discussed in turn.

Theme One: Feelings of Relationship are Central to Life in Farmington, and Influence People to Support Their Families and Their Community

As mentioned in the previous two chapters, a theme of relationship is present in every domain in the data. A sense of relationship underlies the contributions of older people to their community, and the support of the community for older people. Relationship partly determines "insider" or "outsider" status in the community. Family relationships support health for older
people, and a sense of being "all one big family" promotes community support. Over-involvement in relationship contributes to the stress of living in a small town. The centrality of relationship to rural life is the focus of the first theme. Each of the following themes continues to incorporate an aspect of relationship.

**Theme Two: Reciprocal Relationships Between Older People and The Community Provide Benefits to Both Groups**

Farmington values the contributions of older people to the community in the form of volunteer help and charitable projects. Older people often define "health" as the ability to stay active and to contribute. Older people form the backbone of many community groups. Volunteer work done by older people contributes to the community as a whole by assisting with individual and community needs.

At the same time, community organizations and activities help to keep older people involved in community life. The recreation program, community celebrations, and classes within the community involve older people and welcome their presence. The safety programs within the community such as "Are You OK?", the CPR classes, and the safety classes contribute to a feeling of safety and security for older people, which in
turn adds to feelings of well-being.

Acceptability of people into "insider" status and the acceptability of assistance programs depend on reciprocity within relationships. People who isolate themselves and do not contribute to community life are not accepted into community life. Programs that do not have a component of volunteer labor in exchange for help also violate community standards; it is not acceptable for "insiders" to utilize those services. "Insiders" who use government supported services such as the county bus often point out that they pay a fee for the services.

**Theme Three: Community Values Support a Balance Between Independence and Interaction That Fosters Health for Older People**

Older people in Farmington value their independence. Independence is defined as maintaining a separate household and taking care of oneself and one's family. Independence is a large part of "health" to the older people in Farmington. At the same time, older people are an integral part of community life. They interact with their family and community both socially and in volunteer activities that contribute to community life. This interaction is a large part of the active lifestyle that is another aspect of "health" for older people.

As people grow older, a balance between
independence and interaction is supported by families and the community. Older people are supported in maintenance of a separate household by family help such as shopping, and by community help such as shoveling snow. Interaction is supported by family social life and by community social and volunteer groups. Older people are able to maintain health as they define it even if they experience problems with chronic illness and frailty.

**Theme Four: Community Programs and Individuals Work in Together to Support Older People**

Families care for older people in Farmington by assisting in many activities of daily life such as transportation and heavy housework. As people grow older, families provide informal health care and help older people to remain at home despite debilitating illness. The community assists older people through informal and formal mechanisms. Informal help is provided by neighbors who assist with yard work, heavy lifting, and social interaction, and household chores when people are ill. Formal programs include the county bus, the "Meet and Eat" meal site program, and the Recreation Program.

The community also promotes a sense of safety and well-being. Farmington is successful in using resources at other levels of government to accomplish civic goals. Building the flood control dike insured
that the town will never again be threatened by floods. Current plans to increase and improve water supplies, provide better streets, and attend to zoning will continue to sustain the general quality of life. Fire and ambulance services provide excellent help in emergency situations. Older people in Farmington are supported in their belief that the community is a healthy place to live, and that community leaders are concerned about environmental quality.

**Theme Five: Close Relationships are Sometimes Detrimental To the Health of Older Community Members**

Little privacy exists in the very small rural town of Farmington. The lack of privacy contributes to a reluctance on the part of older people to use government services. Some older people hesitate to use services because their neighbors will know. A social stigma exists against using what might be construed as "welfare".

Close relationships sometimes mean that older people feel overwhelmed by the closeness of community life. People in public positions are especially subject to the stress of constant scrutiny and critique. Older people in the community who had been community leaders sometimes speak of feeling isolated, and being unable to develop close friendship networks with others in the
community.

Being "different" is difficult in Farmington. Close social networks in the community are based on people having similar cultures and values. Those who are not life-long residents, who are from a different culture, or who have different values can be isolated in an "outsider" status. Outsider status can be detrimental to the health of older people when they are isolated from the social support and friendship that insiders enjoy.

The Myth of Rural Life

The cultural values and beliefs that underlie the five themes are expressed in the metaphor of myth. The myth was first mentioned to me by a study participant who said: "you have to be careful not to be caught up by the myth of rural life. People will tell you that everything is perfect here, but that just isn't so". The community member who told me about the "myth of rural life" was using the word myth to denote a falsehood. He believed that the myth was a distortion of the truth about life in a small town.

Myth, however, has another meaning that is used in contemporary anthropology, sociology, and some divisions of theology. Myth in the anthropologic sense is a story used by people in a culture to discuss a universal truth or ideal that lies at the heart of the
culture (Elaide, 1963; Shapiro and Hendricks, 1979).

Myths are used to explain social traditions and customs in a way that gives life value and a sense of security (Aldington & Ames, 1984; Shapiro & Hendricks, 1979). A myth is a living story in that it supplies models for human behavior and makes a working hypothesis about the world (Elaide, 1963).

A myth is capable of saying several things at the same time and on different levels of meaning. The "myth of rural life" contains many of the cultural ideals and values that the residents of Farmington espouse about their personal lives and their community. The values in the myth are used by community members to enhance and support the health of the older people who live there. The myth is also a "living story" in the presentation of models of appropriate behavior. The myth is a positive picture of life in Farmington because it expresses community ideals and values.

The essential elements of the myth as told by the residents of Farmington incorporate both individual and community life. These elements are sometimes in opposition to one another in the community, but the ideal expressed in the myth are that they work in concert.

Individual aspects of the myth speak to independence and individual pride. The myth says that people in Farmington value their independence, taking
care of themselves and their families without interference from governmental regulations. People care for themselves and their extended families when problems arise. By the same token, children work with their parents to maintain the family farm or business and contribute to the family needs. When parents become infirm, families help them remain as independent as possible. Families remain geographically as well as emotionally close.

Community aspects of the myth address the responsibilities that individuals have to the community as a whole. People are responsible to their neighbors, and when someone is having trouble, the entire community helps out. People take pride in their community and work towards the common good. The combination of individual independence and communal obligations is what creates the characteristic myth of rural life.

Summary

The myth of rural life states that life in Farmington is characterized by independent people who care for themselves and their families while at the same time responding to community needs when they arise. Peace of mind stems from both caring for your own and knowing that others will look out for you. Rural life in the myth is a special way of life, including a belief that people are healthier and happier than they would be.
living in an urban environment.

The myth of rural life can be heard in many things said by community members; for example: "This is a special place to live", "People really value their independence here", "It's much safer to live here than in the city", "We're all like one big family", and "The town takes care of itself". These thoughts reflect different aspects of the myth. The "truth" that lies within the myth is not the reflection of actual life, but reflects beliefs about life in Farmington. The importance of the myth is that it incorporates the values that people hold about their lives in Farmington. The myth provides a standard of behavior that guides individual and community response to people in need.

The five themes found in the data fit into the Myth of Rural Life. The themes, like the myth, speak to the importance of family, communal responsibility, and independence. The fifth theme, which discusses the problems that occur when relationships are too close, is represented in the myth as the tension between being independent and supporting the community and also between insider and outsider status. This theme reflects the problems that occur when people are overly dependent on the community or who do not contribute to community life in the way that is specified by the values expressed in the myth.
Thick Description

The cultural themes and the "Myth of Rural Life" reflect a holistic presentation of the data. The themes provide a working hypothesis about rural life, while the myth incorporates cultural values that shape the community. A description of the community that is based on both the themes and the myth provides a "thick description" that interprets life in Farmington. The description provides a working hypothesis that can serve as the beginning of an ethnographic theory. Although the description is not developed enough to be a theory, it is the foundation of a theory that could be generated through further research.

Older people in the community define health as an active, independent lifestyle. Community standards promote a balance between individual independence and community responsibility. The community supports health for older people by supporting independence and interaction with the community in meaningful, valued ways. At the same time, older people in the community make valuable contributions to the community through their work and volunteer services. The cultural acceptability of community help depends on this reciprocal exchange, as does the acceptance of people into "insider" status.
People in the community know one another intimately, leading to a sense that the community as a whole is an extended family. The sense of relationship results in individuals and the community feeling responsible for one another, and therefore working in reciprocity to support individual and community needs. Tension in the balance between individual and communal responsibility sometimes results in "insider problems: a lack of privacy and exclusion of those who do not support community values and norms.

Chapter Summary

The five themes and the values expressed in the Myth of Rural Life help to explain "how things work" within the community. The themes provided the substance for a deep description of the community, while the Myth of Rural Life summarized community values and beliefs. Together they provided insight into processes within the community. Violations of the deeply held values within the myth were responsible for much of the dissent and some of the most bitter quarrels within the community, for these values were deeply held. The themes and the myth can be used as a framework for understanding the cooperation and support that community members offered to one another. Community processes could mitigate the effects of chronic illness, the relative lack of money

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for most older people, and even provided surrogate family
for those who were alone.

In the final chapter the study findings are
compared and contrasted with other related research. The
discussion ends with the implications of the study for
the nursing profession and recommendations for further
research.
CHAPTER IX

DISCUSSION AND IMPLICATIONS

The findings of this study reflect, but go beyond, the three study questions: 1) What is the culture of a rural community and the experience of health for older residents? 2) What aspects of rural community life affect health in elderly people? 3) What are the dynamic processes of rural community life that have linkages with the health of elderly residents? In the first two domains presented in the findings, BEING HEALTHY, and SEEKING HEALTH CARE, rural culture and the experience of health for older residents are discussed. In the last three domains, KNOWING EVERYBODY, COMMUNITY CARING, AND INSIDER PROBLEMS rural culture and the influence of the community on health are explored. Discussion of the findings is constructed around these domains, followed by comparison of a description of the community with two theories about communities and health.

Comparisons between rural areas are difficult due to cultural differences and varying definitions of "rural". Historical patterns, local and regional values, and behavior systems may vary greatly from national norms (Krout, 1988). Regional and local diversity is a theme.
that runs through any data about rural areas and rural life (Fugitt, Brown, & Beale, 1989). Farmington culture reflects the Northern European background of the early settlers, as well as farm and small town life. Comparison with other rural towns which may have different economic bases and townspeople from other cultural and social origins would not be appropriate.

Diversity in areas designated as "rural" may also result in large differences among populations of elderly people. The rural-urban dichotomy found in much of the literature is probably a rural-urban continuum ranging from frontier conditions to semi-suburban (Fugitt, Voss, & Doherty, 1979; Krout, 1988). Comparisons between rural areas and populations of older people must therefore be done cautiously.

**BEING HEALTHY**

Older people in Farmington defined health as the ability to be active, to contribute, and to be independent. Older Farmington residents were very active, and they reported that their activities were meaningful and enjoyable.

In a review of literature about community participation and rural-dwelling older adults, I found that information on participation in community activities is limited and characterized by contradictory findings.
(Kivett, 1985). Kivett stated that it is unclear whether participation in community activities is high or low on the part of rural adults, and whether such participation contributes to well-being. Kivett states that measurement discrepancies, overlapping categories of activities, and methodological problems account for part of the ambiguity in the data. As mentioned in the introduction to this section, wide differences in older populations in various rural areas make comparison between findings difficult.

In other studies, however, investigators have found that older people in a variety of settings define health as activity. In a series of rural studies done by students and faculty at Montana State University (Long and Weinert, 1989) health was related to work and role activities. In an ethnographic study of six urban elders exploring the meaning of wellness, the researcher found that people in the sample identified activities and relationships as the main reasons for their "vibrant wellness" (Miller, 1991, p.49). Although Miller's sample was drawn from politically active, urban, primarily Jewish elders, activity was part of the definition of health as it was for older people in Farmington.

In a study of over 13,000 people over 60 years of age in urban and rural settings, rural residents were more active than urban residents in church groups,
social, political, and recreational organizations. Activities were part of health for the older people in this sample. Rural residents reported themselves to be healthier than their urban counterparts. Activities were a part of health for the rural residents in this sample.

Independence as a part of health was mentioned in other studies of rural life (Erikson, Erikson, & Kivinck, 1986; Long & Weinert, 1989; Magilvy, Congdon, Craig & Nelson, 1991). In a description of an Appalachian rural community, residents had a strong sense of independence that was important to the explanation of health behaviors and health care choices (Lozier & Althouse, 1980). Independence was also identifies as a component of health in an ethnography of nine Appalachian widows (Hardin, 1990). Farmington's older residents, like the rural elderly described in these studies, valued independence as a part of health.

Family support was critical to the maintenance of both independence and activity in Farmington. People in Farmington did not grow old alone; they were supported by a network of family relationships. Several studies in the literature supported this finding for older people. Family care was shown to prevent or delay institutionalization for elders in a survey of 300 primarily urban elderly people (Newhouse & McCauley, 1987). A recent study indicated that family caregivers,
particularly a spouse or adult child, are extremely important in the maintenance of independent living arrangements for elderly people who need some assistance with personal care (Soldo, Wolf, & Agree, 1990). Although Soldo, Wolf, and Agree's study is not based on a rural sample, the analysis of 2,328 unmarried women aged 65 years or older showed that the availability of adult children is an important variable that influences the probability of living alone.

In a literature review of informal and formal health care systems for the rural elderly Coward and Cutler, (1989), found that rural elders are cared for by families to a greater degree than their urban counterparts, but that greater levels of care may be due to relative unavailability of formal services in rural areas. In a recent study, Krout, (1988), found that older people in rural areas do not have especially strong family ties as measured by frequency of contact. Krout's sample of 600 people over age 65 who resided in Western New York State. Differences between the strong, frequent family contact and support in Farmington, and limited family support in Krout's study may be due to the differences between a rural farming culture on the Great Plains in contrast to the rural culture on the East Coast.

In summary, activity and independence as part
of health, if not always the actual definition of health, is a common finding in the literature for older people in rural settings. Family support to maintain independence is also frequently mentioned, although the amount and meaning of the support is disputed. This study adds to a view of older people who define health in active terms, and are supported by families to maintain health.

SEEKING HEALTH CARE

Formal health care choices by older people in Farmington were made on the basis of positive relationships with providers and sites, referrals from family, and the availability of non-medical services such as full-service grocery stores and large discount stores found in larger towns and cities.

Distance as a barrier to care was not problematic in Farmington. In several studies, traveling long distances was not considered difficult by many rural residents (Magilvy, Congdon, Craig & Nelson, 1991; Long and Weinert, 1989). Some studies, however, report that distance can be burdensome to older people. In a review of health care and the rural elderly, Boeder (1988) stated that young adult and adult rural populations were very mobile and they prided themselves on traveling long distances. Rural elderly people, however, were unable to travel as easily as younger community members and had
difficulty with access to health care. Distance was found to be a barrier to access in other studies as well (Coward & Cutler, 1989; Parkinson, 1981). A possible reason for the discrepancy in findings could be the degree of support available to Farmington residents to provide transportation.

Health care providers were chosen by older people on their ability to relate with their patients, and by referrals from family. A number of studies have focused on older patient-physician relationships, but none were found in which family were identified as a source of referrals for care.

Analysis of conversations between 550 patients on return visits with 127 physicians in a nation-wide sample (Bertakis, Roter, & Putnam, 1991) concluded that physician communication style is related to patient satisfaction with visits. Having physicians who discussed psychosocial topics and counseled patients on concerns was positively related to patient satisfaction. Patients were less satisfied when physicians dominated the interview and only discussed physical problems. In a similar analysis of 359 elderly patients in Great Britain who were treated by the same physician people preferred "directive" care to a more "sharing" style (Savage and Armstrong, 1990). Differences in findings may be attributable to age differences in the samples or
cultural differences in the health care systems between the two countries.

Anecdotal accounts from a physician who maintains a geriatric practice (Anderson, 1990) confirmed the need for older people to be heard by their physician. Anderson had found through his practice that older people required more time per appointment to discuss problems. Although Anderson's conclusions are not research based, his stories reflect the same concerns with physicians that older people expressed in this study.

Health care provider sites were avoided when older people, their families, or their friends had negative experiences. Health care sites were often chosen for their proximity to other services. In a study of rural consumer satisfaction with medical services Andrus & Kohout (1985), dealt with the reasons that rural-dwelling people chose medical care. They found that "outshopping" (going outside of the local area) for medical services was high for their Iowa rural-dwelling sample. The outshopping site was 45 miles away, which was the approximately the same distance that older people in Farmington often traveled for medical services when they did not use local care.

Outshopping for physicians and other medical services in the Andrus and Kohout study was tied to the perception of inadequate equipment at the local
provider's site, and the inability of people to see the same doctor on successive visits. Non-medical services was not associated with medical outshopping. Medical outshoppers in this sample were more dissatisfied than inshoppers with local medical services, the competence of the local physicians, fees, waiting time in the doctor's office, and experiences with office personnel. Dissatisfaction with local services in the form of questions about the doctor's competence and concerns about the local hospital was found in both samples. In this study the age-distribution of the sample was not reported; however, the respondents were healthy and had no major medical problems. Therefore, the sample probably consisted primarily of people below age 70. Older people may outshop for medical services in conjunction with non-medical services due to a greater relative difficulty in getting to the outshopping site.

In a survey of factors affecting use of four rural clinics in Mississippi, positive past experiences with the clinic and the availability of other goods and services were associated with continuing use of the clinics (Banahan & Sharpe, 1982). Findings indicated that distance, cost, and waiting time all affected clinic use. Waiting time and fees were problematic for some of the older people in the Farmington sample, but these dissastifiers were not mentioned as strongly as were
negative experiences with the local physicians and hospital.

In Farmington, informal care was preferred to formal care. None of the older study participants wanted to be placed in a nursing home, and few preferred placement in supportive housing. Families provided most of the informal health care for older people in the community. Older people themselves were caregivers for spouses. Adult children provided support for activities of daily living such as transportation and shopping. As people grew more frail, families became primary caregivers, sometimes providing 24 hour care. Low utilization rates of formal services by the rural elderly has been reported in other studies (Krout, 1983; Scott & Roberto, 1985; Stoller & Earl, 1983). It has been suggested that low utilization is a consequence of a lack of perceived need, negative attitudes toward receipt of assistance, and fear of loss of independence (Coward, 1980). Dislike of formal assistance and a preference for independence were prevalent attitudes in Farmington among older people. People preferred to stay in their own homes and "take care of their own". A longitudinal study of 635 frail elderly people found that formal services were used consistently only by older people who did not have a spouse or other family caregiver available (Tennstedt, Sullivan, McKinlay & D'Angostino, 1990).
Some researchers have suggested that informal and formal services play complementary roles (Brownstein, Dillon, and Hyman, 1983; Scott & Roberto, 1985). Formal care supplemented, rather than replaced, informal care as people grew older and their needs increased in a survey of 313 urban elderly people over age 60 (Edelman and Hughes, 1990). Scott and Roberto (1985) reported a similar finding for rural elderly people when children were in close proximity and the older person was widowed. Formal care was used in Farmington when family could not provide all of the help that was needed.

In summary, the findings in this study support an idiosyncratic view of health care choice. Older people relied on personal experience, local stories about providers, family referrals, and the availability of non-medical services when making health care decisions. Positive experience with providers was a factor found in the literature, but the impact of "horror stories", family relationships, and non-medical services in health care decisions was not discussed in any detail.

In the next three domains, KNOWING EVERYBODY, COMMUNITY CARING, and INSIDER PROBLEMS community factors that influence health are presented. A review of the literature uncovered little information on aspects of community that influence health. The study of older people within the context of culture has been largely
ignored by social scientists until the past few years (Hess & Markson, 1986; Strange & Teitelbaum, 1987); the study of community influence on health is in its infancy (Fry, 1981). The scarcity of comparative studies is reflected in the discussion of the following three domains.

**KNOWING EVERYBODY**

People knew everyone else very well in Farmington, which in turn fostered a sense of relationship and responsibility. People were classed as "insiders" or "outsiders" by community members on the basis of interconnectedness and acceptance in the community. In a focused ethnography of a farming community, (Magilvy, Stoner, Campbell, Campbell, Candela, Chwasz, Garratt, Hummel, Johnson, Kotthoff-Burrell, Ortega, Schultz, & Wilson, 1985), older people who had moved to the town were called "newcomers" by the community. "Newcomers" there had experiences similar to "outsiders" in Farmington.

Weinert and Long (1987) found in a survey of rural dwellers that those who had lived in rural communities for less than twenty years still saw themselves as "newcomers" to their communities. Outsiders were viewed with some suspicion in Weinert and Long's study, as they are in Farmington. Insider status
was related to a feeling of "family" relationship with others in the community.

COMMUNITY CARING

The community provided support to older people that allowed them to maintain their independence and to interact socially. A community can view itself as powerful or powerless; self-reliant or dependent (Cook, Goeppinger, Brunk, Price, Whitehead, & Sauter, 1988). The people of Farmington had a common image of their community as self-reliant, capable, and peaceful. This image, in conjunction with values of independence and communal responsibility, enhanced the health of older residents.

In an ethnography of older people in a Minnesota housing project, objective health was related to the ability of older people to maintain their roles and activities, which in turn influenced health perception (Boyer, 1980). Older people who felt healthy in Boyer's study were those who were able to maintain meaningful roles and activities within the housing development project. Although one participant was in her eighties and wheelchair-bound, she felt "healthy" because she maintained an active social and volunteer life. The housing projects provided many leadership roles for older people, which Boyer believed were supportive for health
of the residents.

Farmington responded well to people in need. Very little information was found in the literature that spoke to rural community response to people in need. Anecdotal accounts discuss how rural communities help community members, but a literature search revealed few studies that addressed this phenomenon. In a focused ethnography set in a farming community, (Magilvy et. al, 1985), people helping one another was called "neighborliness". Older people who had lived in the community for an extended period were assisted by the neighborliness of their peers and nearby residents. Farmington community members felt responsible for one another, especially those who were considered "insiders", and to the community as a whole. "We take care of our own" was a community value that underlay community response to those in need.

Reciprocity in relationship as a basis for acceptance of help was not found in the nursing literature. The importance of giving as well as receiving help in Farmington was an important factor in the acceptability of government and community programs to provide support. Reciprocity also partially determined those who were accorded "insider" status by the community.

People felt safe in Farmington. The general
perception of older people was that the community was a safe and secure place to live. Other reports about older people and crime indicate that residence location may influence whether older people feel safe. In a study of 224 adults aged 65 and older who reside in the community, the most important antecedents of fear of crime were living in an urban setting with a high crime rate. (Chapman and Beaudet, 1983).

Hearings before the Select Committee on Aging indicated that urban-dwelling elders were often living in great fear of crime and victimization (Tauke, 1983). Witnesses to the committee indicated that crimes committed against the elderly are very high in some urban areas. Crime rates were very low in Farmington, and few older people had been victims, which may partially account for why elderly people felt safe in the community.

Community stability may also play a part in feeling secure. In a recent survey of rural communities in Wyoming, older people were very concerned about safety, and a large number of respondents rated crime as the number one problem in their community (Ide & Wolff, 1991). These communities were similar to Farmington in their size and Plains environment. The authors concluded that the concern for safety may be due to the disrupted nature of the communities: their rural sample was drawn
from mining communities that were economically very depressed. People within the communities were highly transient, and the cycle of economic boom and subsequent collapse had severely disrupted lives in the study communities.

**INSIDER PROBLEMS**

Little privacy existed in the community. The lack of privacy led to a reluctance to use services. Lack of anonymity was also found in a series of studies by Montana State University (Long & Weinert, 1989). Long and Weinert did not discuss, however, how the intense nature of relationship within their communities may have affected the health of residents, although they did mention the stress placed on health care providers.

Some of the older people who had been in leadership positions in Farmington felt isolated due to the older person's withdrawal from close friendships. A literature search did not uncover any information about conflicts stemming from the interrelatedness of public and private lives in other communities.

Every culture, however, produces a particular configuration of stresses (Clark and Anderson, 1967). The older people in Farmington did not have some of the stressors of urban life, such as high crime rates, traffic, and isolation. They did experience stressors in
the form of little privacy, criticism in leadership roles, and isolation from mainstream culture if they did not conform to prevailing cultural norms.

In a study of community differences in perceived stress among elderly people Preston & Crawford, (1990), found that rural-dwelling elders reported less stress than those in urban settings. The authors concluded that experience of stress for elderly people differs according to the social context in which they live. Lower perceived stress levels in rural subjects, however, may reflect an urban bias in the measurement of stressors (crime, pollution, noise levels, etc.). Small-town stressors may not be well documented or measured by standardized tests.

Themes and The Myth of Rural Life

The cultural themes and the "Myth of Rural Life" reflect a holistic presentation of the data. The themes provide a working hypothesis about rural life, while the myth incorporates cultural values that shape the community. A description of the community that is based on both the themes and the myth provides a "thick description" that interprets life in Farmington. The description is the foundation for a theoretical statement about life in the community, and could provide the basis for a beginning theory of rural life through further
Older people in the community define health as an active, independent lifestyle. Community standards promote a balance between individual independence and community responsibility. The community supports health for older people by supporting independence and interaction with the community in meaningful, valued ways. At the same time, older people in the community make valuable contributions to the community through their work and volunteer services. The cultural acceptability of community help depends on this reciprocal exchange, as does the acceptance of people into "insider" status.

People in the community know one another intimately, leading to a sense that the community as a whole is an extended family. The sense of relationship results in individuals and the community feeling responsible for one another, and therefore working in reciprocity to support individual and community needs. Tension in the balance between individual and communal responsibility sometimes results in "insider problems: a lack of privacy and exclusion of those who do not support community values and norms.

This theoretical statement is compared to two theories about community in the nursing literature: Community Competence (Cotrell, 1976) and Health as
Expanding Consciousness Newman, 1986). The theories and the ethnographic description are not on the same level: Community Competence and Health as Expanding Consciousness are Grand Theories that explicate the elements of successful communities and how they promote health; this study provides an explanation of how one small rural community affected the health of its older members. The comparison between the two Grand Theories and the description based upon findings in this study is done to confirm similarities and differences between this small rural community and communities in general. Further, this study can be useful to point out possible additions to theoretical knowledge about communities and health.

As discussed previously in the Chapter II, community competence was defined as the ability of a community and its constituent parts to interact effectively through appropriate identification and resolution of community problems (Iscoe, 1974; Rappaport, 1981; Wilson, 1976). Theoretical dimensions of a competent community include: commitment and participation from community members; good conflict management among community subgroups; effective, articulate communication within and without the community; and effective machinery to facilitate participation within the community and relationships with groups without the community.
(Cottrell, 1976). An assessment of these dimensions concluded that the nature of Cottrell's theoretical dimensions may be overlapping in nature (Goeppinger, Lassiter, and Wilcox, 1976).

The five themes that were found in this study support several of Cottrell's dimensions. Community values supported both commitment and participation in the community. Participation of older people within the community was facilitated by families and the community. Communication was not problematic in Farmington, perhaps because the community was extremely small and the weekly newspaper, which was read by nearly everyone in the community, kept people informed about local events. The community interacted effectively with larger governmental entities to meet needs in Farmington. The community was also effective in identifying and meeting people's needs.

Dimensions of community found in this study but not discussed by Cotrell or Goeppinger's group were a sense of relationship, the balance between participation and independence, the interaction between individuals, family and community that supports health, and privacy problems. Farmington provided a setting in which older people had avenues for meaningful participation, and mechanisms by which older people could remain independent.

Marchione (1986) based her definition of
healthy community function on Newman's (1986) theory of Health as Expanding Consciousness. The factors of a community with expanding consciousness were an awareness of relatedness between members, good communication, and new and innovative ways of dealing with community problems. Marchione's work captures the element of relationship that was found in the present study, but not the interactive processes that were important to health of elderly people in Farmington.

Elements of community competence in Farmington included commitment and participation by community members, and effective networking with groups outside of the community. The community effectively identified problems and met both individual and community-wide needs. Conflict between sub-groups in the community in the form of "outsiders" and "insiders" was not addressed in Farmington; cultural outsiders were not considered part of the community.

Expanded awareness of relationship between sub-groups in the community is an element of health as expanding consciousness postulated by Marchione. Although the Farmington community felt like "one big family" to many members, some groups were excluded. Problem identification and innovative problem-solving were strong skills within Farmington.

Neither Grand Theory incorporated the several
interactive elements found in the current study. Feelings of relationship between members resulted in a sense of responsibility for one another. A dynamic balance between independence (taking care of yourself and family) and interaction (taking care of one another) in the community assisted older members to maintain health. The tension between knowing people well and invading privacy was a dynamic that was not well resolved. Process elements may be missing from both Grand Theories to address the active interrelations that influence health. This ethnography describes one, very small, rural community, but interactive elements may be important to other healthy communities in general.

**Summary**

Findings in this study support a link between community values, community processes, and the experience of health for older people, as expressed in the five cultural themes and the Myth of Rural Life. The major findings were:

1. A sense of relatedness was central to community life.
2. Close relationships may have negative implications for health when they interfere with privacy and individual needs.
3. Reciprocal relationships between older people and the community resulted mutual benefits to both groups.
4. Reciprocity in relationships determined the acceptability of community and governmental help and support.

5. Reciprocity in relationships partially determined "insider" and "outsider" status in the community.

6. A balance between independence and community responsibility supported health as it was defined by older community members.

7. Health care choices were frequently based on relationship factors.

The results of this study add to the body of knowledge about communities and health. The study supports a community-level view of health for older people.

**Nursing Implications of the Study**

Implications of this study are related to the cultural themes and values. Community health nurses are just beginning to identify their scope of practice as the community as a whole. An emphasis on community characteristics that affect health guides community practice and interventions by the nurse on a community level. This study supports assessment of community processes that influence health and community-level intervention. Specific implications for the nursing profession include suggestions for assessment and
To be most effective, community health nurses in rural areas need to foster a sense of relationship and reciprocity within the community. The ability of older people to contribute is an important basis for the acceptance of assistance. A working partnership with a rural community may require a reciprocal relationship between a nurse and community members. A community health nurse who lives within or nearby a rural community would enhance the ability of community members to "give" in the form of advice or community knowledge. Approaching older people with an intent to learn would allow older people to give to the nurse in a way that is helpful to both.

An important consideration for rural practice is to assess the social networks for individuals in the community. Close relationships can be stressful as well as supportive, and it may be that increasing social support and monitoring for an older person may inadvertently decrease privacy. Nurses who advocate the use of government supports and programs might do well to remember that a lack of privacy may lead to a lack of acceptance by older clients.

Enhancing health in a rural community requires detailed knowledge of idiosyncratic patterns and processes within the community. Every community has a
culture that is unique to that particular setting. Knowledge of particular patterns and processes within a community allows a community health nurse to plan interventions acceptable to the community and more likely to be effective.

Working within a rural community could also require a nurse to find a common goal that both insiders and outsiders agree is important. Working together on a project might provide reciprocity between groups and perhaps allow greater acceptance of outsiders into community life.

Finally, a community health nurse needs to encourage a balance between independence and interaction for older people. Supporting meaningful contributions by older people to the community may enhance feelings of health and well-being for older clients, as does the maintenance of independence. "Health" as defined by the older adults and community values sought this balance. Health in this community meant being able to both care for yourself and care for your community.

Recommendations for Future Research

This study represents a beginning toward needed research about rural-dwelling older people. Review of the literature indicates that rural communities may vary widely, with findings from one area bearing

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little similarity to findings from another area. While replication is impossible in ethnographic research, similar studies in other rural communities would allow findings to be compared and contrasted. A community that is more disrupted by change or less able to care for older members would provide a good contrast to the stable, supportive environment found in Farmington.

Long term goals of the study were to develop theoretical models of intervention at the community level, and to develop the concept of community function as it relates to health. Further research based on the findings of this study is needed to proceed with development of the concept of relationship and toward a model of nursing interventions for the community. Community function and health could also be a part of that model.

Study Limitations

The use of one small rural community limits applicability of the data. The community's willingness to participate may be a unique feature. The reader will need to decide how, and if, the Farmington sample is similar to other rural samples.

The Spanish-speaking people in Farmington were not a part of this study. Inability to access this population limits the discussion of community dynamics.
for the entire population. The lack of Spanish-speaking participants also limit the discussion of "outsiders" within the community. Community participants were primarily "insiders", and this study was not able to discuss the full range of experience of "outsiders" within the community.

Summary of the Study

The purpose of this study was to increase understanding about the health of older people in rural settings, to describe community processes that affect health, and to explore linkages between community processes and health status of rural-dwelling elderly people. Although community health nursing practice supports health care interventions at the community level, the influence of communities upon health is not well known.

Large numbers of older people live in rural settings. As nursing care of the older population shifts from hospital-based care to community-based care, the health status of elderly people in rural environments must be better understood. Knowledge about the health of older people and the effect of rural communities upon health will assist with planning for health services and nursing care strategies for health promotion at the community level.
The study employed an ethnographic design and method, and was set on the Great Plains in a small farming community of about 500 people. The community was chosen for its size, proportion of older residents, and its willingness to participate in the study. Thirty-six residents participated with in-depth, formal interviews. Participant observations and informal interviews were conducted with 68 people. The total theoretical sample consisted of 104 people. The older participants ranged in age from 65 to 96 years old. Data included verbatim transcripts of interviews, field notes reflecting participant observations and examination of artifacts, and theoretical memos. Five domains emerged from analysis of categories within the data. Five themes crossed the domains and tied the data together. A metaphor entitled "The Myth of Rural Life" described cultural values and belief. The themes and the myth provided a description of community processes that influence health.

The five domains which emerged from ethnographic data analysis were: BEING HEALTHY, SEEKING HEALTH CARE, KNOWING EVERYBODY, COMMUNITY CARING, and INSIDER PROBLEMS. The first two domains described rural culture, and the experience of health and health care for older residents. Health was defined by the older residents as independence and an active lifestyle.
Health care choices were primarily made on the basis of positive relationships and experiences with health care providers.

KNOWING EVERYBODY, COMMUNITY CARING, and INSIDER PROBLEMS explored rural community culture and the influence of the community upon health. Relationship was a key component to understanding community processes. Reciprocal community relationships in which older people and the community were mutual benefactors were crucial to understanding the acceptability of help and support, as well as the acceptance of "outsiders" into the community. Close relationships led to a sense of extended family responsibility among community members. The community supported older people to maintain independence and to engage in meaningful activity within the community through help in daily life, crisis support, personal safety, and planning activities that emphasized community well-being. Older community members supported the community through work and volunteer activities. Stressors in the community were a lack of privacy, and isolation from community life for those who did not conform to prevailing community norms. When cultural norms such as reciprocity were violated, people remained in an "outsider" status.

The five domains were the basis for five cultural themes. The five themes were: 1) Relationship
is central to life in Farmington and influences people to support their families and their community; 2) Reciprocal relationships between the community and older people provide benefits for both groups and determine the acceptability of programs and people; 3) Community values support a balance between independence and interaction for older people that fosters health; 4) Community programs and individuals work together to support the health of older members; and 5) Close relationships are sometimes detrimental to the health of older members.

A metaphor entitled "The Myth of Rural Life" depicted prevailing cultural values and norms. A "thick description" developed from the themes and the myth that describes how community processes influence health.

Older people in the community define health as an active, independent lifestyle. Community standards promote a balance between individual independence and community responsibility. The community supports health for older people by supporting independence and interaction with the community in meaningful, valued ways. At the same time, older people in the community make valuable contributions to the community through their work and volunteer services. The cultural acceptability of community help depends on this reciprocal exchange.

People in the community know one another
intimately, leading to a sense that the community as a whole is an extended family. The sense of relationship results in individuals and the community feeling responsible for one another, and therefore working in reciprocal ways to support individual and community needs. Tension in the balance between individual and communal responsibility sometimes results in "insider problems: a lack of privacy and exclusion of those who do not support community values and norms.

Comparison of this description and two other community theories, Community Competence and Community Health as Expanding Consciousness, was made. The description supports theoretical concepts in the two Grand Theories. Community commitment and participation were important elements of community in the two theories and in the description. Interactive elements in the description were not emphasized in the two theories that were discussed.

Contributions of this study to nursing knowledge and implications of the study to nursing practice were discussed. Recommendations were also made for future research on the health of community-dwelling older adults.

The significance of this study lies in the focus on health of elderly people in a rural setting and on community processes that influence health. Knowledge
of ways in which rural-dwelling older people define health and seek health care, and knowledge of how a rural community influences the health of its older members, may assist nurses and other health care professionals to develop effective community-level interventions to maintain and restore health for older people.
REFERENCES


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APPENDIX A

SAMPLE OF CODED TRANSCRIPT


she was in the nursing home with depression. And then she had a hip replaced, but she hasn't done much since. He does all of the work in the house. She goes for short walks with him, but that's about all. She used to go to the Center, but not since she fell.

CC: But you haven't seen them since?

RH: No, some people believe that meet-and-eat is a poverty program! They think that it's charity. They avoid it sometimes because they don't want to be seen as poor. But there were quite a few of the people who gave 500 dollar checks for the new dishwasher. So it's not really a program for the poor.

CC: That's interesting. I should ask people if they think that meet-and-eat is for poor people.

RH: Well, I think that to begin with I had that idea. The first center was over by the Mexican colony, that was where it was held, and the Mexican people never did take to it.

CC: I don't think I've ever met any Mexican people at either site.

RH: They just don't go. There was one little old man that had a wooden leg, I think, that used to come but maybe he didn't feel welcome. He was the disreputable looking type. He wore a sign that said "I can't talk", maybe he couldn't hear, so that discouraged communication. There was one poor little lady there that had a jaw that constantly trembled and shook and she didn't seem comfortable.
APPENDIX B

SAMPLE OF CODED COMPUTER OUTPUT

SORTED OUTPUT FOR FILE CAC11 1/23/91 01:47
SORT CODE: IMAGE

CAC11 RH + cac11 interview 1/23/91

SC: IMAGE

#$IMAGES
: RH: No, some people believe that meet-and-
: eat is a poverty program. They think that it's charity. They avoid
: it sometimes because they don't want

$-MONEYSTAT
: to be seen as poor. But there we're quite a few of the people who gave
: 500 dollar checks for the new dishwasher. So it's not really a program for the poor.
: CC: That's interesting. I should ask people if they think that meet-and-

CAC11 CC + cac11 interview 1/23/91

SC: IMAGE

#$IMAGES
#$CULTURE
: eat is for poor people.
: RH: Well, I think that to begin with I had that idea. The first center was
: over by the Mexican colony, that was where it was held, and the Mexican
: people never did take to it.
APPENDIX C

Complete Analysis of Domain: COMMUNITY CARING

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<tr>
<th>Categories</th>
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Nurse Craig depicts "typical" older resident

Requesting response to her findings

Special to the Courier
by Carol Craig

I am a nurse who is studying the town of Wiggins and the surrounding area for my PhD in community Health; you may have met me when I've been in town. I've begun analyzing my data, and I'd like to share with you some of my early description of rural life for older residents. The following is the story of a "typical" older resident. While I recognize that there are many differences in the lifestyle and life histories of older people in this area, there are some common threads that seem to run through many people's lives. I would like to hear from anyone in the Courier readership about the following description. Does it seem familiar to you? Are there things in this story that don't ring true? Is there anything else that you would add if you were writing this story? The topics in this story will form the foundation of an analysis of what it is like to be older in a rural setting, and how the community in general affects the health of older residents. Please give any comments that you might have to Val Loose at the Town Hall, or leave your phone number with her and I will give you a call. As the analysis proceeds, I'd like to talk about my findings with anyone in town who is interested. Thanks!

"Esther" was born in the county 84 years ago to immigrant parents who settled first in Nebraska. Her family migrated to Farmington when the railroad opened up new land for farming. The changes in the way people in the county have changed profoundly since she was young: she can remember going to town by horse and wagon, hauling water, and cooking with a wood-burning stove. Farms were isolated enough that families had to fend for themselves much of the time. People often treated illness at home with folk remedies. "Mother had to do an awful lot of the doctoring herself. She used to use Denver Mud: it's a clay-like stuff that you heat up and put on your chest which would act as a poultice". She married during the thirties, and she and her husband dry land farmed about 6 miles from town. Times were hard during the depression, but she remembers raising her children as some of the best times of her life: "I loved living on the farm; we always worked together and though we didn't have much we always had a good time." She was always involved in the community despite the demands of farm life: she worked with the PTA, the FFA, church groups, and 4-H.

Her father died suddenly in his early sixties, but when her mother grew older, Esther took care of her mother until her mother died. When her husband became ill in his sixties, Esther cared for him during his long illness, and with her help and the help of their children he was able to stay at home until the last month of his life. She stayed on the farm for a few years after his death, then decided to move into town and let one of her sons live in the old farm house.

Now that Esther is in her eighties, she has slowed down somewhat, but she remains involved in community life. She no longer drives, but her children who remained in the area and their families help her get around. "I don't have any trouble getting where I need to go", she says, "but I hate to ask too much because I know they're all busy." She remains active in her church groups, and is often doing projects for both community groups and her family. "I'm too busy to bother with being sick."

She has chronic aches and pains, but she says that she doesn't let that stop her from doing what she wants to do. "You just have to take things as they come", she says, "I don't ever want to be a burden to anyone, so I manage." She would like to stay in town, in her own home, for the rest of her life. "I can't imagine wanting to live anywhere else: this is my home and I want to stay."