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Health Promotion and the Rural Older Adult

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DEDICATION

This dissertation is dedicated to the rural older adults whose positive attitudes and laughter will forever be with me. I was truly blessed during this journey and owe it all to the rural older adults who radiated warmth, wisdom, and the perseverance to continue their journey with a purpose in life, despite their many hardships.

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ABSTRACT

Older adults continue to live longer, and their desire is to not only live longer but to remain as independent as possible. Therefore, older adults strive to live more productive lives, not to just continue to exist. By living a healthy life, older adults are empowered to take control, not only of their health but of other important life decisions. The purpose of this study was to explore and describe rural older adults' behaviors toward healthy lifestyles. The theoretical framework for the study was Pender's health promotion model, which addressed factors that enhance health-promoting behavior, leading to improved health and quality of life for the older rural adult. This ethnographic study was conducted in West Tennessee, with 30 rural older adults, aged 62 years or older, independently living in a senior center apartment complex. Three research questions guided data collection: What are the barriers to health-promoting behaviors in rural older adults?; What are the health-promoting behaviors in the rural older adult?; and What qualities facilitate healthy aging in rural older adults? Data were collected through two interviews with each participant and participant observation. Key themes that emerged through the analysis process of immersion and crystallization were unhealthy behaviors, self-control, and healthy qualities. This study revealed that some rural older adults felt that the most important factors in aging were being positive about life, having a zest for life, and living

life to the fullest. Some participants had knowledge of healthy behaviors, but through choice or lifelong habits, they continued with unhealthy behavioral choices.

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CHAPTER 1

INTRODUCTION

Chapter 1 consists of five parts: (a) introduction, (b) statement of the problem, (c) background and significance of the problem, (d) research questions, and (e) chapter summary.

Introduction

The world's population is aging. Older adults are one of the fastest growing age groups in the United States; and one of every eight Americans is older than 65 years of age. A person now 65 years of age can expect to live another 18 years on average (U. S. Census Bureau, 2011). Aging is a lifelong process, defined as a progressive, generalized impairment of function resulting in loss of adaptive responses to stress and a growing risk of age-associated disease, which affects the individual's ability to perform activities of daily living. The combination of genetics, environment, lifestyle, and nutrition determine health and disease for an individual (Kirkwood, 1996).

Adopting healthy lifestyle behaviors and avoiding harmful behaviors can help promote health among elderly individuals. Health promotion behaviors may extend the life span, improve the quality of life, and assist in halting some disease processes and promoting some health conditions. Making lifestyle changes is difficult for most people and can be even more difficult for rural older adults, who experience several obstacles.

Concern about unhealthy lifestyles led to the Surgeon General's first report in 1979 (U.S. Department of Health, Education, and Welfare, 1979). This report focused on health promotion and disease prevention strategies that would bring together the

relationship between lifestyle and health. In Healthy People 2000, the health promotion goal for the older adult was to increase the span of healthy living (U.S. Department of Health and Human Services [USDHHS], 2000). Emphasis was placed on quality of life and overall well-being. Healthy People 2010 proposed two goals: increase years of healthy life and eliminate health disparities (Bamm, Hutchison, Dabney, & Dorsey, 2010). The first goal continues the Healthy People 2000 goals by focusing on increasing the quality of the years of life, not just the life expectancy. The second goal emphasizes the Healthy People 2000 goal by reducing health disparities (USDHHS, 2008). Both are consistent with current policies and programs on aging, which increasingly focus on identifying ways to improve the quality of life for the older adult rather than just extending the life span.

Statement of Problem

Life expectancy continues to increase. As older adults continue to live longer, their desire is to live independent and productive lives, not to merely survive. Consequently, older adults are increasingly focusing on quality rather than quantity of life. By living a healthy life, older adults are empowered to take control, not only of their health but of other important life decisions. In this dissertation, I review the extant literature and use an ethnographic design to examine the issues surrounding health-promoting behaviors among rural older adults. The purpose of this study was to investigate health-promoting activities in rural elders, identify the possible barriers that prevent rural older adults from adhering to healthy lifestyle behaviors, and evaluate why some rural older adults experience healthier aging than others.

Background and Significance of the Problem

Promoting healthy behaviors in a population of rural older adults can be challenging because such behaviors as poor nutrition (Dean & Sharkey, 2011; Kennedy, Chokkalinghamk, & Srinivasan, 2004; Souter & Keller, 2002; Zulkowski& Coon, 2004), physical inactivity (Barnes &Schoenborn, 2003; Crombie et al. 2004; Gordon, 2004; Gregg et al., 2003), coping (Sarvimaki & Stenbock-Hult, 2000; Wong, n. d.), socioeconomic issues (Friedman, 2004), and cultural influences (Belza et al., 2004; Gordon, 2004; McAllister & Farquhar, 1992). Health care providers and nurses, in particular, are in a key position to support the health of older adults by promoting a healthier lifestyle and by developing health promotion programs that focus not only on improved health behaviors, but also on eliminating the barriers to health promotion (Clark, 1998; Cunningham, 2004; Easley & Schaller, 2003).

Rural Older Adults

In the United States, 75% of rural counties have populations of fewer than 50,000 people, and 24% have populations of fewer than 10,000 (Rural Policy Research Institute, 2002). The Midwest and South are the most rural regions in the United States (Rural Policy Research Institute, 2002).One of the goals of Healthy People 2010 is health promotion and disease prevention for the older adult (USDHHS, 2008). Effective healthy lifestyle behaviors among rural older adults are essential for maintaining health. Poor health promotion behaviors for some rural older adults, such as poor nutrition, physical inactivity, ineffective coping mechanisms, socioeconomic issues, as well as cultural and belief values, must be explored to gain knowledge related to incorporating healthy lifestyle changes to meet the health needs of the rural older adult.

Barriers

Perceived health barriers may be real or imagined. A barrier is anything that the individual considers to be an obstacle to undertaking a given behavior (Pender, 1996), such as the loss of satisfaction that occurs when an unhealthy habit is given up (e.g., smoking or eating a forbidden food) in the process of striving for a healthier lifestyle. Zimmerman, Olsen, and Bosworth (2000) state that to make lifestyle changes and overcome perceived barriers, the individual must have realistic goals to prevent discouragement, and providers should acknowledge any positive steps the individual may make toward the behavior change. When the individual has lower perceived barriers, the probability of maintaining a healthy lifestyle behavior is more likely (Zimmerman et al., 2000).

Importance of Health Promotion

Health promotion is an essential element in encouraging better health. Unhealthy lifestyles are responsible for a major percentage of the morbidity and mortality in the United States today (USDHHS, 2008). The emergence of health promotion as a vital strategy for improving one's health has shifted the paradigm from simply defining health promotion in traditional medical terms to a multidimensional definition with manifold dimensions. The World Health Organization (WHO, 2008a, 2008b) defines health promotion as a process of enabling people to increase control over the determinants of health and therefore the ability to improve their health. The expanded definition of health promotion is empowering, as it opens up multiple options for improving one's health. Health promotion is often defined as the underlying behavior motivated by the desire to

increase well-being and actualize human health potential (Pender, Murdaugh, & Parsons, 2006).

Health promotion encompasses strategies that allow populations to be healthy and enables them to make healthy choices. It improves the ability of individuals to take action for their health and of communities to influence the determinants of health. The health promotion process provides support for individuals to become agents of their own health by their own actions and choices (WHO, 2008a, 2008b). Lifestyle behaviors play a powerful role in making healthy choices that can prevent, delay, or cope with common diseases and disabilities that may emerge as one ages. It is preferable to adopt a healthy lifestyle at an early age and maintain it for life; however, it is never too late to reap the benefits of healthier living. How an individual maintains his or her optimum physical and mental health will promote important components of successful aging, thus improving the quality of life, regardless of age (WHO, 2008a, 2008b).

Successful Aging

The concept of successful aging has a long and rich history in the discipline of gerontology. Successful aging means something beyond health and longevity; it is rooted in a broader definition of "the good life" in the older adult. It is what the older adult values as significant in the quality of his or her life (Rowe & Kahn, 1997). Successful aging is multidimensional, encompassing the avoidance of disease and disability, the maintenance of high physical and cognitive function, and sustained engagement in social and productive activities (Rowe & Kahn, 1997). Thus, the challenge for young as well as older adults is to discover a positive meaning of life. A good old age does not come about from some special talent or as a secret gift. It comes from within, when individuals set

out to discover a meaningful life for themselves. The common thread of successful agers, regardless of age, is that they have a zest for life and a clear sense of meaning and purpose (Wong, n. d.). The untold story of successful aging is about positive attitudes toward life and about personal growth in wisdom and spirituality (Wong, n. d.).

Ideally, if aging is to be a positive experience for the rural older adult, longer life must be accompanied by a high quality of life as the older adult ages. Maintenance of good health throughout one's life span is essential to extending healthy life expectancy and maintaining quality of life in old age. However, older adults are more likely to acquire one or more of the chronic diseases commonly seen with aging (USDHHS, 2008). Chronic diseases inflict a particularly heavy health and economic burden on older adults due to associated long-term disability, diminished quality of life, and greatly increased health care costs (Bailey et al., 2007; Smeeding, 2001; Zulkowski& Coon, 2004).

Successful aging may be viewed as the enjoyment of health and vigor of the mind, body, and spirit into middle age and beyond (Wagnild, 2003). Some older adults will adjust to old age in the same way they face all of life's challenges—with tenacity, resilience, patience, and humor. A study by Lang, Rieckmann, and Balkes (2002) suggested that everyday functioning in older adults who are rich in sensory and motor activity and cognitive, personality, and social resources exhibit fewer negative age trends than do resource-poor older people. Although the risk of disease and disability clearly increases with advancing age, poor health is not an inevitable consequence of aging. Much of the illness and disability problems associated with chronic disease are avoidable through known prevention measures.

Key measures include practicing a healthy lifestyle, such as regular physical activity, healthy eating, and maintaining regular health checkups. Limiting alcohol use and not smoking are healthy preventive measures that an individual should follow. Creating a positive, pleasing, low-stress life also contributes to successful aging. Exercise has a huge effect on one's physical well-being; studies show repeatedly that people who exercise are happier and enjoy better health (Bailey et al., 2007; Crombie et al., 2004; Gorden, 2004; Gregg et al., 2003; Lang et al., 2002; Souter & Keller, 2002; & Wilcox, 2002). As individuals age, managing lifestyle as well as behavior will enhance their well-being. Improving health behaviors is possible at any age, and health benefits can be seen in emotional and physical well-being. When individuals feel good about themselves, they want to take care of themselves (Bailey et al., 2007; Crombie et al., 2004; Gorden, 2004; Gregg et al., 2003; Lang et al., 2002; Souter & Keller, 2002; & Wilcox, 2002).

Research Questions

This study identified rural older adults' health promotion behaviors and the barriers to engaging in these behaviors. The research questions were:

1. What are the barriers to health-promoting behaviors in rural older adults?
2. What are the health-promoting behaviors in rural older adults?
3. What qualities facilitate healthy aging in rural older adults?

Definition of Terms

The term *rural* can mean different things to different people, and trying to define it in a nation of such diverse geography is challenging. For the purposes of this study, rural is defined as a town or village with fewer than 2,500 people (Rural Policy Research Institute, 2008; U.S. Census Bureau, 2007). The term *older adult* is defined as an

individual aged 62 years or older. The term *barrier to health promotion* is defined as factors that directly interfere with performing the health-promoting behavior or indirectly interfere by reducing the commitment to the plan of action for changing behavior (Pender, 1996). The term *health promotion behavior* is defined as a person's behavior to promote health status. The term *healthy aging* is defined as the development and maintenance of optimal physical, mental, and social well-being in older adults. The term *successful aging* is defined as encompassing the avoidance of disease and disability, the maintenance of high physical and cognitive function, and sustained engagement in social and productive activities.

Chapter Summary

Chapter 1 serves as an introduction to this study on the health promotion behaviors of the rural older adult. The problem is particularly meaningful because older adults are living longer and require more frequent health care services than younger adults. More research is needed in the area of health promotion to improve the quality of life for the rural older adult. The research questions will aid in the understanding of the rural older adult's health promotion behaviors and the importance of health promotion behaviors.

CHAPTER 2

LITERATURE REVIEW

In Chapter 2, the literature for the study is reviewed. The chapter consists of three parts: (a) the conceptual framework, including the theoretical influences and a review of Pender's health promotion model (HPM); (b) selected key health behaviors related to health promotion, including nutrition, physical activity, coping, socioeconomical issues, and cultural values, and (c) chapter summary.

Conceptual Framework

Theoretical Influences

Health promotion can be traced back to ancient times, when the Code of Hammurabi and the Mosaic Law were set forth. The Code of Hammurabi and the Mosaic Law stressed the importance of taking responsibility for health, dietary practices, pure water, waste disposal, and the isolation of the person with a contagious disease (Moore & Williamson, 1991; Spiegel, 1997). Extensive dietary rules under Mosaic Law are found in the books of Deuteronomy (Chapter 14) and Leviticus (Chapter 11).

The ancient Greeks focused on the personal physical strength and endurance of one’s self. The Romans focused on community health structures, in which the water supply, disposal of waste, and waste systems were maintained such that healthy living among the community dwellers was promoted. Galen perceived health as an interaction between a person and his or her environment and defined health as “a condition in which we neither suffer pain nor are hindered in the function of daily life such as taking part in

bathing, eating, and drinking, and doing the other things we want" (Moore & Williamson, 1991, p. 196).

Of more direct relevance to modern nursing practice, health promotion was acknowledged by Florence Nightingale, who felt it was the nurse's responsibility to ensure that the environment was well suited to promote healing and wellness for the patient (Nightingale, 1898; Swanson &Wojnar, 2004). The concept of positive lifestyle practices and health promotion became prominent in nursing during the mid-1970s, as fitness centers, stress-reduction activities, promotion of self-care, and taking responsibility for one's own health paved the way for a prevention perspective rather than a cure perspective (Pender, 1996).

Health promotion is oriented toward health rather than illness and is receiving increased attention for the prominent role it plays in health care. It draws its conceptual framework from a variety of sources, such as the theory of reasoned action (Ajzen, 1991; Fishbein & Ajzen, 2005), health belief model, HPM (Pender, 1996), and high level of wellness theories (Eason, 2003; Pender, 1996). Health promotion behavior is based on cognitive, reasoned, purposeful behavior, which expands the person's potential to attain the highest level of wellness (Eason, 2003; Pender, 1996). The older adult life span continues to increase, and participation in health promotion lifestyle behaviors is essential for maintaining one's health and is particularly important for the rural older adult (Frenn & Malin, 1998; Pender, 1996; Pender et al., 2006).

As Americans live longer, a health-promoting lifestyle is important because individuals will have more years to benefit from adhering to a healthy lifestyle, resulting in greater independence and improved quality of life (Resnick, 2003). Health promotion

is fundamentally about one's empowerment and the ability to take one's options in any given situation and react appropriately. How individuals address their health promotion options is based on effective communication skills (Kelleher, 1996). Promoting health is a reflective and complex activity, often involving decision making based on one's needs and knowledge base (Davies, 2006).

Pender's HPM

Pender's (1996) HPM is one of the predominant models of health promotion in nursing. It originated from expectancy-value theory and social cognitive theory. Expectancy-value theory was based on behavior that is rational and economical, which means that if a person engages in a given action and persists in it to the degree that the outcome of taking action is of positive personal value, this action is likely to bring about the desired outcome (Pender, 1996). A person will not invest effort and personal resources in working toward a goal if it has little or no personal value. Social cognitive theory focuses on beliefs that are formed through self-observation and self–reflection, both of which greatly influence human functioning. This theory places major emphasis on self-direction, self-regulation, and perceptions of self-efficacy. Pender developed her model to provide a framework for predicting health-promoting behaviors. The model focuses on how behavior-specific cognition and affect influence behavioral outcomes (Pender, 1996).

The initial version of Pender's HPM was introduced in the early 1980s (Pender, 1987). The model provided a framework for nursing and behavioral sciences perspectives on factors that influenced health behaviors. This framework offered a guide for exploring the motivating factors that directed an individual to engage in health promotion

behaviors. The initial HPM described the potential of seven cognitive-perceptual factors and five modifying factors to explain and predict health behaviors. The cognitive-perceptual factors were: importance of health, perceived control of health, definition of health, perceived health status, perceived self-efficacy, perceived benefits to health-promoting behaviors, and perceived barriers to health-promoting behaviors. The modifying factors were: demographic characteristics, biologic characteristics, interpersonal influences, situational influences, and behavioral factors. Participation in health-promoting behavior entailed the likelihood of engaging in health-promoting behaviors and the presence of cues to action. The HPM represents a theoretical perspective in that it explores the factors and relationships that enhance health-promoting behavior, thus leading to improved health and quality of life (Adams, Bowden, Humphrey, & McAdams, 2000; Callaghan, 2005; Galloway, 2003; Gillis, 1993; Johnson &Nies, 2005; Pender, 1996; Resnick, 2003; Simmons, 1990). The 1996 revision of the model added three new variables that serve to influence the individual to engage in health promotion behaviors: activity-related affect, commitment to a plan of action, and immediate competing demands and preferences (Pender, 1996; Pender, Murdaugh, & Parson, 2011).

Pender (1996) defined health as having a positive, comprehensive, and humanistic focus without concentrating on a disease as the principal component. Pender's definition of health includes the whole person, taking into account one's lifestyle, strengths, resiliency, potential, and capabilities. The major strength of Pender's definition of health is that it increases opportunities to improve the client's health because it encompasses the whole person. Health-promoting behaviors are desired outcomes defined as actions

directed toward attaining positive health outcomes such as optimal well-being, personal fulfillment, and productive living (Tomey & Alligood, 2002).

The model concepts in the HPM are divided into three areas: individual characteristics and experiences, behavior-specific cognitions and affect, and behavioral outcome (Figure 1). Each person has unique personal characteristics and experiences that affect subsequent actions. Individual characteristics and experiences are defined as: (a) prior related behavior and (b) personal factors (Pender et al., 2011).

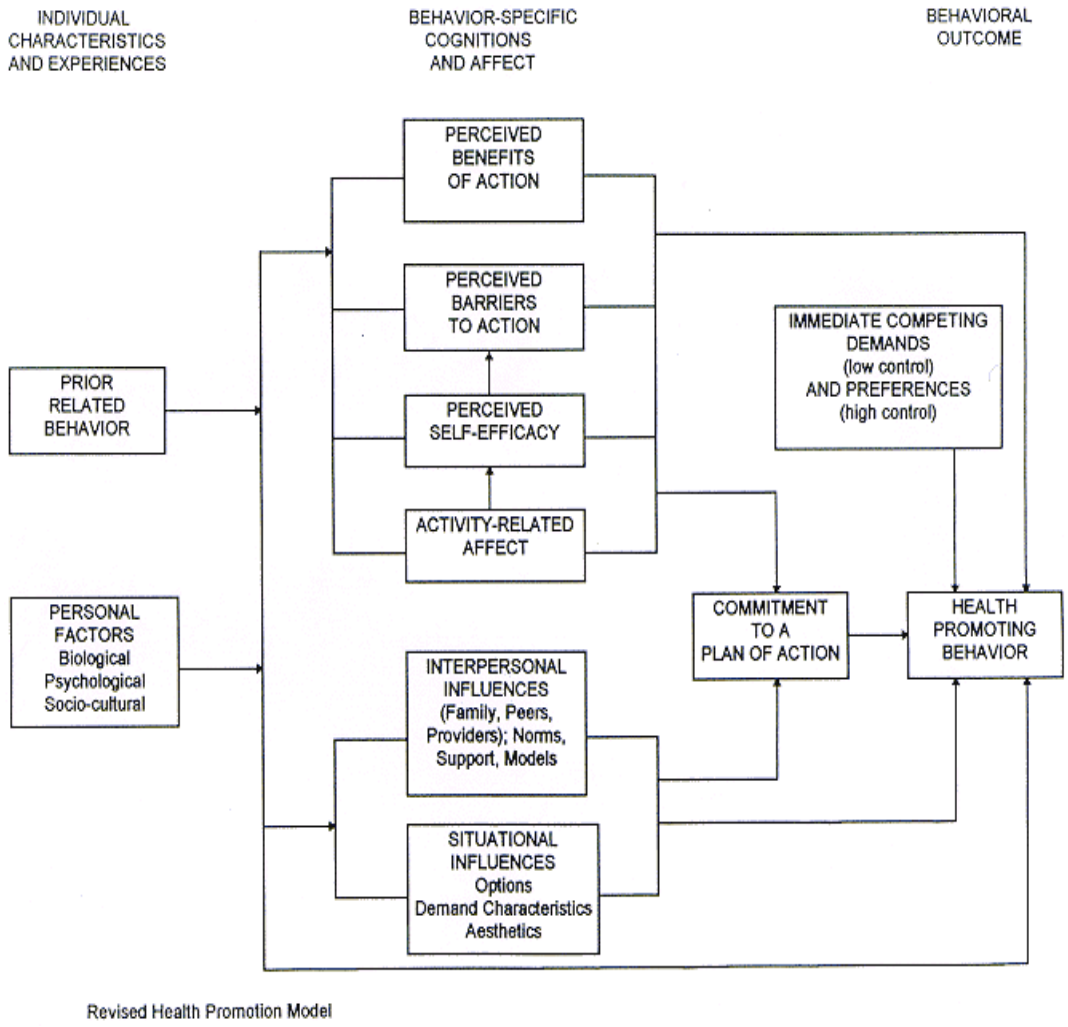

Figure 1. Pender's Health Promotion Model (Pender, 1996; Pender et al., 2011).

A prior related behavior is often the best predictor of behavior because the focus is on the frequency of the same or a similar behavior performed in the past. It is consistent with the focus on perceived self-efficacy, which maintains that one's future behavior is influenced by the success or failure of prior attempts at similar acts. Habit strength accrues each time the behavior occurs and is augmented by concentrated, repetitive practices of the behavior. If desired short-term benefits are experienced early in the course of the behavior, the behavior is more likely to be repeated (Pender, 1996; Pender et al., 2011). For example, a person may begin a dieting program, with quick weight loss results in the first few months. This person will be more likely to repeat this behavior again due to the short-term benefits received from the prior behavior.

One's cognitive and health behaviors are influenced by modifiable (e.g., smoking, physical inactivity, obesity) and non-modifiable (e.g., age and sex) interpersonal, demographic, situational, and behavioral factors (Lannon, 1997; Pender, 1996; Pender et al., 2011; Sitzman & Eichelberger, 2004; Wang, 2001). Personal factors (age, gender, body weight, balance, strength, agility), psychological factors (self-esteem, self-motivation, perceived health status), and sociocultural factors (race, ethnicity, socioeconomical status, education, and acculturation) play a role in predicting the nature of health behaviors (Lannon, 1997; Pender, 1996; Pender et al., 2011; Sitzman & Eichelberger, 2004; Wang, 2001).

Behavior-specific variables within the HPM are considered to have major motivational significance in determining whether a change in behavior results from the intervention proposed, and whether behavioral changes become a long-term commitment.

Behavior-specific cognition and affect variables are (a) perceived benefits of action, (b) perceived barriers to action, (c) perceived self-efficacy, (d) activity-related affect, (e) interpersonal influences, and (f) situational influences (Pender, 1996; Pender et al., 2011).

Perceived benefits of action are the expected positive outcomes of the proposed health-promoting behavior. The perceived benefit is directed toward motivating the desired behavior to a plan of action to engage in the behavior from which the anticipated benefit will result. Individuals tend to invest their time and resources in activities that have a high likelihood of increasing their experiences of a positive outcome. For example, a message that smoking causes teeth to become discolored and that after quitting, the teeth will remain whiter and healthier may be more salient to a teenager than a message focused on the risk of cardiac or pulmonary disease many years hence (Pender, 1996; Pender et al., 2011; Sitzman & Eichelberger, 2004).

Perceived barriers to action are the real and imagined barriers to health behavior change. These barriers consist of perceptions concerning the unavailability, expense, difficulty, or time-consuming nature of a particular action. Barriers are often seen as mental blocks to undertaking a given behavior. When readiness to act is low and barriers are high, action is unlikely to occur. When readiness to act is high and barriers are low, the probability of action is much greater (Pender, 1996; Pender et al., 2011). For example, a young man may believe the only way to lose weight is to purchase a costly membership at a gym, which he cannot financially afford. The young man's perceived barrier is due to financial issues, and the health behavior change will not occur.

Perceived self-efficacy is the personal judgment about individual capability to organize and consistently perform new behaviors. Higher self-efficacy results in lowered

perceptions of possible barriers to positive health behavior change. Feeling efficacious and skilled in one's performance is likely to encourage one to engage in the proposed behavior more frequently than is feeling inept and unskilled (Pender, 1996; Pender et al., 2011). For example, if individuals perceive themselves as being well organized and motivated toward self-betterment, they are less likely to encounter significant barriers to behavioral change.

Activity-related affect refers to negative and positive feelings associated with actually performing the health-promoting behavior, which influences the probability of repeating the behavior and maintaining the behavior as a long-term commitment (Pender, 1996; Pender et al., 2011). For example, a faculty member walks a mile during lunch break every day at work and finds that it results in unpleasantly sweaty work clothes and windblown hair; therefore, negative feelings may be associated with the actual activity of walking a mile a day at work.

Interpersonal influences are related to how significant others around the client affect motivation for positive change. Interpersonal interaction influences health-promoting behavior directly as well as indirectly through social pressures or encouragement to commit to a plan of action. Individuals vary in the extent to which they are perceptive to the wishes of others. However, given adequate motivation to behave in a way consistent with interpersonal influences, individuals are likely to undertake behaviors that will be socially reinforced and admired (Pender, 1996; Pender et al., 2011). For example, if a client lives in a household where all the adults smoke, smoking cessation will be more difficult than if the adult household members do not smoke and they prefer the client to quit.

Situational influences are related to the external factors that affect the client's perception of the proposed health-promoting behavior, such as when, where, and how the activity will take place. Individuals are drawn to and perform more competently in situations or environmental contexts in which they feel compatible and safe rather than incompatible and unsafe. Environments that are interesting are desirable contexts for the performance of positive health behaviors (Pender, 1996; Pender et al., 2011). However, if the environment is distracting, it might make it difficult for the client to commit to the health-promoting behavior. For example, if a client is asked to attend a nutritional education class in the lobby of a candy store, the smell and inviting appearance of the candy might make it difficult for the client to commit to a nutritional diet plan unless the competing demand of the smell and visual aspects of the irresistible candy is removed.

A behavioral outcome is the endpoint component of the HPM. The health-promoting behavior is directed toward attaining positive health outcomes for the client. When integrated into a healthy lifestyle that embraces all aspects of living, health-promoting behaviors result in improved health, enhanced functional ability, and a better quality of life at all stages of development (Pender, 1996; Pender et al., 2011). Behavioral outcomes entail the variables: (a) immediate competing demands and preferences, (b) commitment to a plan of action, and (c) health-promoting behaviors (Pender, 1996; Pender et al., 2011).

Immediate competing demands and preferences are behaviors of which the client has little control because they are associated with necessary life activities, such as work or family care responsibilities. Both competing demands and preferences can derail a plan of action. Competing demands are differentiated from barriers in that the individual

must carry out an alternative behavior based on an unanticipated external demand. Competing preferences are differentiated from barriers such as lack of time because competing preferences are last-minute urges based on one's preference hierarchy (Pender, 1996; Pender et al., 2011). An example of a competing demand is if a parent has to choose between leaving a child alone at home to go to the gym or stay at home with the child; most parents would choose to stay home rather than to leave the child alone. In this example, exploring exercise options at home would be more effective for this individual than attempting to complete an exercise regimen at a gym. A competing preference example is when a client selects a food high in fat rather than one low in fat because of taste or flavor preferences, or driving past the recreation center where one usually exercises to stop at the mall instead. The client is acting on a competing preference for shopping rather than for physical activity.

Commitment to a plan of action refers to the client's intention to change and the creation of a plan of action to accomplish the implementation of a health-promoting behavior. Clients are more likely to engage in health-promoting behaviors when they anticipate benefits from the activity (Pender, 1996; Pender et al., 2011). An example is a client who joins a gym for toning and weight loss after observing that a friend achieved positive results by adhering to an exercise regimen at the gym.

Health-promoting behaviors are desired outcomes of the HPM, such as attaining positive health, optimal well-being, personal fulfillment, and productive living (Tomey & Alligood, 2002). Health-promoting behaviors are important for clients to assume more responsibility for their health and to begin to make changes toward more healthful

behaviors. Examples of health-promoting behaviors are eating and maintaining a healthy diet, exercising regularly, obtaining adequate rest, and building positive relationships.

Knowledge of the assumptions that shape health promotion facilitates understanding the overall force and significance of the theory. Pender's HPM is based on the following assumptions: (a) persons seek to create conditions of living through which they can express their unique human health potential; (b) persons have the capacity for reflective self-awareness, including assessment of their own competencies; (c) persons value growth in directions viewed as positive and attempt to achieve a personally acceptable balance between change and stability; (d) individuals seek to actively regulate their own behavior; (e) individuals in all their biopsychosocial complexity interact with the environment, progressively transforming the environment and being transformed over time; (f) health professionals constitute a part of the interpersonal environment, which exerts influence on persons throughout their life span; and (g) self-initiated reconfiguration of a person–environment interactive pattern is essential to behavior change (Pender, 1996; Pender et al., 201).

Based on these assumptions, health is conceptualized as a positive high-level state. The focus of the model is the individual who has a drive toward health. Each person is expressed by his or her pattern of cognitive–perceptual and modifying factors. The model represents interrelationships between cognitive–perceptual factors that influence the occurrence of health-promoting behaviors. The HPM has been used in a variety of settings, including schools, workplaces, rehabilitation centers, ambulatory treatment facilities, health care facilities, and prisons (Bolio, 1999). The HPM model has been used among older adults (Peterson & Bredow, 2004) and in culturally diverse groups, such as

Thai-, Japanese-, Korean-, Taiwanese-, and Spanish-speaking individuals (Hulme et al., 2003; Peterson & Bredow, 2004).

Review of Literature

Numerous studies have been conducted using older adult populations and exploring the importance of health and healthy lifestyle behaviors. The HPM has been used in many diverse populations, settings, and countries, including in older adults in Taiwan (Huang, Chen, Yu, Chen & Lin, 2002), Spanish-speaking adults in the Midwest (Hulme et al., 2003), women in active-duty military service (Agazio, Ephraim, Flaherty, & Guerney, 2002), and parents of school-age children concerned with bicycle safety (Lohse, 2003). Researchers have also examined the importance of health promotion behaviors in the workplace (Lusk, Kerr, & Ronis, 1995; Lusk, Kerr, Ronis, & Eakin, 1999) and in prison (Bolio, 1999).

According to Galloway (2003), the importance of health is clearly defined through the client's value scale; if health is valued highly, the client is more likely to act and adopt a new healthy lifestyle behavior. However, if the client does not view health as a priority, adopting healthy behaviors will be less likely to happen. Galloway also summarized how cues operate within the HPM theory. The cues to action are indirectly linked to the likelihood of action. Cues are more challenging to articulate and measure due to their subtle and complex nature. The intensity of cues may vary depending on the level of readiness to act and locus of control of the participant.

Huang et al. (2002) explored the effectiveness of health promotion education programs for a group of elderly residents in a community in Taipei, Taiwan. The course content consisted of healthy lifestyle and health promotion, disease prevention, nutrition,

and exercise. A total of 140 elderly participants took part in this study. Ninety-seven subjects attended all of the education programs. Information about demographics, health status, health promotion knowledge and health-promoting behaviors was obtained. Health promotion knowledge was assessed with a pretest and posttest in the second, third, and fourth sessions. The research findings revealed that the education programs were effective in improving health promotion knowledge and behaviors. The scores for health promotion knowledge and positive health behaviors were high among participants who were aged 65 to 69 years, were married, lived with family members, and had higher education levels.

In addition to studies that target the health promotion behavior of older adults, several studies have been conducted on working-age populations as well. Pender, Walker, Sechrist, and Frank-Stromberg (1990) explored a multivariate model of HPM in evaluating the health promoting lifestyles of 589 employees (aged 20-65 years) enrolled in an employer-sponsored health promotion program. One's definition of health, one's perceived health status, and personal competence accounted for 31% of the variance in health-promoting lifestyle behaviors. The employees who perceived themselves as competent in handling life issues and who defined health as a high level of wellness reported healthier lifestyles.

In a study of 18- to 66-year-old adults, the perception of good health positively correlated with health-promoting lifestyles (Pender, 1987). The perceived health status of these adults was based on their self-evaluation of their current level of health and well-being, and their self-report of being healthy.

Lusk et al. (1995) examined the health-promoting lifestyles of blue-collar and white-collar workers and found that the white-collar workers scored higher in areas of self-actualization, exercise, and interpersonal support. Self-actualization, exercise, and interpersonal support scores ranked higher among younger workers, whereas older workers scored higher on health responsibility and nutrition. Women scored higher on the lifestyle profile and in the areas of health responsibility, exercise, and interpersonal support, and individuals with higher education levels consistently scored higher, particularly in the areas of health responsibility, exercise, nutrition, and stress management.

The HPM has also been used in school-aged children. Lohse (2003) used the HPM in a study of parents whose children received a safety education intervention. Results showed that the parents of the children who participated in the intervention had significantly higher knowledge-level scores and that the majority of parents were in favor of bicycle helmet legislation for children. The implications from this research point to the importance of bicycle safety education interventions for students and parents and the need to implement bicycle helmet legislation.

The HPM has guided researchers in identifying predictors in the use of hearing protection and designing theory-based interventions to promote the use of hearing protection. Lusk et al. (1999) explored the effectiveness of an individualized intervention to increase the use of hearing protection devices that decrease noise-induced hearing loss. Pender's HPM provided the theoretical framework for this study and guided the process for individualized intervention development to change workers' health promotion behaviors regarding the usage of hearing protective devices in the workplace. Workers

who received the individualized intervention increased their usage of hearing protective devices significantly. However, in a subsequent randomized controlled trial (Lusk et al., 2003), the individually tailored intervention was not superior to a control intervention consisting of a commercially produced safety video on hearing protection.

A primary assumption of the HPM is that individuals will value growth in directions that they view as positive. Kerr, Lusk, and Ronis (2002) utilized the HPM in research involving Mexican American industrial workers in the workplace and their use of hearing protection. Factors that influenced the use of hearing protective devices were a definition of health, self-efficacy in the usage of the device, and the benefits or barriers to the usage of the device.

Pender's HPM is flexible and adaptable for individuals, families, and community applications in all age groups and diverse populations. Future research has the potential to enhance the quality of health promotion and preventive care in diverse groups of people. The HPM may be used as a framework to identify health-related needs, as well as to plan and implement specific health-related programs in diverse populations.

Theoretical Assumptions

HPM is based on understanding the cognitive psychology of the individual and factors such as motivation, intentions, and behaviors. This theory reflects a long connection with psychological and social aspects that are necessary components of health behaviors in individuals. Within the HPM, the main theoretical proposition is that previously related behaviors influence beliefs, affect, and enactment of health-promoting behaviors. Perceived competence in a given behavior increases the likelihood of a commitment to action; a positive affect toward a behavior results in greater perceived

self-efficacy, which in turn results in increased positive affect; and the greater the commitment to a plan of action, the more likely health-promoting behaviors will be maintained over a long period (Pender et al., 2006).

The HPM does not rely on personal threat as an inducement to perform or enhance motivation for the health behavior. Instead, it focuses on the person's expectations to engage in a particular behavior. The expectations are proposed to directly motivate the behavior into a plan of action. Anticipated benefits of action are mental representations of the positive consequences of a behavior. Thus, individuals will tend to invest time in activities that have a high likelihood of increasing their experience of a positive outcome. An example of this theory in action would be a person who resolves to walk a mile during lunchtime every day because in the past this behavior resulted in positive results or because a friend walked every day with visible positive results. This anticipated benefit of action will result in a positive situation for the individual (Leddy, 2006; Pender et al., 2006; Peterson & Bredow, 2004). To be successful, individuals often include their strong family beliefs about health-promoting activities, personal commitments, and the perceived health status of their family, because family values and beliefs may determine the likelihood of initiating and complying with health-promoting behaviors for some people. Those who believe they are in better health are more likely to maintain, perform, and continue health-promoting behaviors (Capik, 1998; Pender et al., 2006).

Although there is a body of literature about health promotion behaviors and the advantages of adherence to these behaviors, little has been published about why some older adults follow healthy lifestyles and other older adults are unsuccessful in adopting

healthy lifestyles. In addition, very little is actually known about why some older adults age more successfully than others. This study explores older adults and their health promotion behaviors.

Key Health Behaviors

There are specific health barriers that may prevent certain health promotion behaviors from occurring. Determinants of health are affected by our behavior, physical environment, and social environment (Healthy People, 2010). Personal behavior is affected by internal and external factors, such as one's personal knowledge, social norms, and perceived risk or barriers. Health behaviors are affected by age, sex, race, poverty, lifestyle and health, stress, medical care, and genes. Indicators such as one's nutritional status, physical activity, coping mechanisms, access to health care, and environmental issues are key factors for an individual's health-promoting behaviors, and lack of these indicators may be perceived as health behavior barriers (Evans, Whitehead, Diderichsen, Bhuiya, & Wirth, 2001).

Nutrition and Physical Activity

Physical activity and nutrition are linked closely together and have been consistently recognized as playing a major role in promoting health and decreasing the incidence of morbidity and mortality from chronic diseases, such as heart disease, diabetes, cancer, and obesity, in the older adult. A lack of exercise and consuming empty calories can lead to obesity (Kennedy et al., 2004); these practices are very common in older adults and are usually considered a positive indicator of malnutrition (USDHHS, 2002). According to Jensen and Friedman (2002), women and men with functional limitations usually have increased weight related to the lack of food quality and intake of

nutritious foods. Nutritional problems in the rural older adult have the potential to lead to less productive lives and decreased physical functioning. The importance of proper nutrition and physical activity will be discussed in the following paragraphs.

Nutrition. Numerous studies have confirmed that good nutrition is instrumental in creating a healthy lifestyle. The American Cancer Society estimates that as many as 35% of cancer-related deaths may be prevented or delayed through modifications of diet (Byers et al., 2002); population studies suggest that diets high in fruits and vegetables and low in total calories, animal fats, and meats are associated with a decreased incidence of several common cancers (Byers et al., 2002). Nutrition is clearly a factor in determining the quality and perhaps the length of life (Smeeding, 2001). Improvement in nutrition in this century has contributed to an increased life expectancy and greater public awareness of the significance that nutrition plays in health (Smeeding, 2001). The expanding older adult population is very susceptible to nutritional risk. About 40% of rural-dwelling older adults have inadequate food and nutrient intake, which affects their health and the ability to function independently (Souter & Keller, 2002); some have evidence of clinical malnutrition (Bailey et al., 2007; Zulkowski & Coon, 2004). Age-related chronic disease has the potential to be prevented or delayed by nutritional interventions (Bailey et al., 2007; Smeeding, 2001; Zulkowski & Coon, 2004).

Findings in the research literature show that obesity is common in rural areas (Ledikwe et al., 2003; Vitolins, Quandt, Bell, Arcury, & Case, 2002; Vitolins et al., 2007). Factors that contribute to this problem include diets high in fat and calories, lack of nutrition education, decreased access to health care providers such as nutritionists, and a further distance to travel for health care access (Ledikwe et al., 2003; Vitolins et al.,

2002; Vitolins et al., 2007). There are several reasons rural older adults do not adhere to dietary recommendations. Social isolation is common in the rural older adult, resulting in losing interest in preparing or eating regular meals (Rosenbloom & Whittington, 1993). Access to grocery stores is limited in some areas (Khan et al., 2009). Many rural older adults living on fixed incomes cannot afford healthy food (Jetter & Cassady, 2006); one in five older adults has an income that is below the poverty level. As expenses increase, some individuals opt to reduce food intake or replace healthy fruits and vegetables with cheaper, less nutritional processed foods, which can increase the risk of obesity. According to Dean and Sharkey (2011), 60% of rural older adults reported fewer grocery stores or supermarkets in their area, 46% reported that food prices were too high, 34% had to travel an average of 13 miles for groceries, 33% reported that there was little food variety in local stores, and 15% reported household food insufficiency (Johnson, Sharkey, & Dean, 2010; Sharkey, Johnson, & Dean, 2010)

Poor nutrition has a pronounced effect on the older adult, resulting in low body mass indices and inadequate energy, which are associated with a decline in function and the ability to thrive (Marshall, Stumbo, Warren, & Xie, 2001; Souter, & Keller, 2002). Understanding the importance of good nutrition and eating healthy foods aids in maintaining an ideal weight; can reduce the incidence of certain diseases associated with aging, such as diabetes, heart disease, and osteoporosis; and can reduce the treatment of and recovery from illness (Bailey et al., 2007).

Physical Activity. As the population of older adults continues to grow, the WHO (2009) has emphasized the importance of maintaining and improving the functional abilities of older adults. According to a study by the Robert Wood Johnson Foundation

(2001), a lack of regular exercise is a problem among rural older adults. Three fourths of the older adult population does not currently exercise at recommended levels (Nied & Franklin, 2002). Yet, many rural older adults have worked hard their entire lives in farming and in outside employment as laborers. According to Crombie et al., (2004), physical activity has been demonstrated to enhance general well-being, improve overall physical and psychological health, help to preserve independent living, reduce the risk of developing certain noncomunicable diseases such as hypertension, help to control such conditions as obesity and diabetes, help to reduce the effect of certain disabilities, and possibly help to change the stereotypes of old age. In addition, regular exercise helps to postpone age-associated declines in balance and coordination highly correlated with falls (Barnes & Schoenborn, 2003; Gordon, 2004; Gregg et al., 2003). Exercise contributes to the preservation of health and helps elderly individuals to maintain activities of daily living and independence (USDHHS, 2008). Older adults need to maintain as much of their functional ability as long as possible to preserve physical independence (Weinart & Long, 1987; Williams, 2001).

Any type of reduced mobility may threaten not only the daily functioning of older adults but also their mental well-being and capacity to establish and maintain social contacts, creating a sense of isolation. However, despite the benefits of physical activity, many older adults are not as active as they could be. It is well documented that physical activity may result in improvements in cardiovascular, metabolic, endocrine, and psychological health and therefore may enhance the quality and quantity of life (Barnes & Schoenborn, 2003; Crombie et al., 2004; Davidhizar, Eshleman, & Moody, 2002;

Gordon, 2004; Gregg et al., 2003; Nied & Franklin, 2002; Resnick, Palmer, Jenkins, & Spellbring, 2000; Wilcox, 2002).

Coping

How one perceives aging may affect longevity. Levy, Slade, Kunkel, and Kasl (2002) conducted a study in which data collected in 1975 from 660 adults older than 50 years of age were analyzed together with data from the National Death Index over the following 25 years. Participants in the 1975 survey who had more positive perceptions of their own aging lived a median of 7.6years longer than those with more negative perceptions of aging. This effect remained significant after controlling for other factors, such as age, gender, income, loneliness, and health status. No one knows for sure why a positive attitude seems to lead to a longer life. Levy et al. (2002) hypothesized that positive thinking about aging can increase a person's will to live, making him or her more resilient to illness and more proactive about health. They found that will to live (as measured in a follow-up wave to the 1975 survey) partially mediated the relationship between positive attitude and survival over the following 23 years.

Being satisfied with one’s past and present life has been shown to be one of the most important factors in healthy aging. Coping styles entail such components as happiness, self-concept, zest, mood, attitude, optimism, positive outlook, self-worth, self-efficacy, and overall well-being (Wong, n. d.). Studies on older adults have shown that their life satisfaction and subjective quality of life were usually fairly high (Sarvimaki & Stenbock-Hult, 2000; Wong, n.d.). Functional capacity, perceived health, good housing conditions, an active lifestyle, and good social relationships were some of the factors that contributed to life satisfaction (Sarvimaki & Stenbock-Hult, 2000). However, older adults

who focus on the burden of old age and the decline and failure of the body bring a negative perspective that inevitably dominates the aging process, which can lead to social isolation, loneliness, and mental health decline (Sarvimaki & Stenbock-Hult, 2000).

Studies have shown that indicators for healthy aging include, but are not limited to, continued physical activity, social involvement, effective coping skills, optimism, and more positive thinking (Sarvimaki & Stenbock-Hult, 2000; Strawbridge, Wallhagen, & Cohen, 2002; Wong, n. d.). The aging process is associated with an individual's life satisfaction and self–esteem, which are driving forces during the life span of each individual (Strawbridge et al., 2002). However, there is evidence indicating that as people age, physical activity declines, isolation occurs, poor coping skills are implemented, and poor nutritional habits continue (Strawbridge et al., 2002).

Why do some older adults have driving forces and strengths that contribute to their ability to meet and handle adversities, and keep or regain health? Nygren et al. (2005) discussed such findings as resilience, sense of coherence, purpose in life, and self-transcendence within older adults in relation to their perception of physical and mental health. Resilience, a personality characteristic that moderates the negative effects of stress and promotes adaptation, has been associated with indicators of successful aging.

A recent study by Depp and Jeste (2006) linked an individual's personality to compliance with maintaining a healthy lifestyle. Whether the rural older adult is an extrovert or introvert will greatly affect his or her adherence to a lifestyle change. Older adults' perceptions of the aging process depend not on disease or physical disability, but rather on their attitude and coping style toward life in general (Montross et al., 2006).

Optimism and effective coping styles were found to be more important components of successful aging than traditional measures of health and wellness (More, 2008). More than 500 older Americans, aged 60 to 98 years, who lived independently within the community were asked to rate their own degree of successful aging (Depp &Jeste, 2006). Despite the prevalence of physical illness and disabilities, the older adults gave themselves high ratings. These results indicate that one does not need to be physically healthy to consider oneself to be aging successfully. Their perceptions were based on the way they coped with their illness or disability.

Socioeconomic Barriers

With the significant increase in the number of rural older adults in the United States, addressing health care needs as well as the aging process itself has become an important concern. More than 5 million older adults were below the poverty level or classified as "near poor" in 2001. The economic situation of rural older adults has a profound influence on their health behaviors. Therefore, health-promoting choices for the older adult must be readily available and financially affordable. According to an article by Butterfield (1990), an individual's economic situation has a profound influence on his or her health behavior. Many socioeconomic barriers, such as transportation issues and a lower socioeconomic status, hinder the rural older adult's ability to embrace aging. Rural older adults with limited financial resources face tremendous challenges to healthful eating and are at greater risk for insufficient household food resources.

Transportation is one of the most important socioeconomic concerns reported by rural older adults when discussing issues concerning their health care needs (Ahmed, Lemkau, Nealeigh, & Mann, 2001; Arbuthnot, Dawson, & Hansen-Ketchum, 2007;

Arcury, Preisser, Gesler, & Powers, 2005; Dibartolo & McCrone, 2003; Green-Hernandez, 2006; Hicks, 1990; Quam, & Lurie, 1994; Strasser, 2003). Nearly 80% of rural counties have no public transportation (Bailey, 2004). Nearly 40% of all rural residents in the United States live in communities with no public transportation (Dewees, 1998; Friedman, 2004). Fifty-seven percent of rural poor older adults do not own a car. More than one in five Americans aged 65 years or older living in rural areas do not drive. More than 50% of non-drivers aged 65 years or older, or at least 3.6 million Americans, stay home on any given day because they lack transportation options (Bailey, 2004). Furthermore, many low-income rural older adults do not know how to drive, particularly female older adults, and lack funds to purchase and maintain an automobile (Arbuthnot et al., 2007).

Because of these transportation problems, many low-income older adults rely on family and friends to meet their transportation needs. These arrangements are usually unreliable over the long term (Bushy, 2000; Friedman, 2004; Li, 2006; Magilvy & Congdon, 2006). Without transportation, even a short distance to health care facilities can become an insurmountable problem (Arbuthnot et al., 2007; Arcury et al., 2005; Strasser, 2003).

Often, reservations for rides need to be made days to weeks in advance; this may work for scheduled routine visits, but not for acute health care needs, such as emergency visits. Because of reduced budgets, public transportation programs are usually cut because of high expense and limited use. Transportation van programs are expensive to run and usually are not implemented in most rural areas (Arcury et al., 2005). In addition, rural older adults have limited funds to pay for transportation (Fitzpatrick, Powe, Cooper,

Ives, & Robbins, 2004). Living on a limited income in a rural environment is an obstacle to the health and well-being of the rural older adult (Hays, 2002; Hearle, Prince, & Rees, 2005; Rue, 2003; Swanson, & Wojnar, 2004). This transportation barrier remains a major obstacle to the health and well-being of those in rural areas who do not drive. These findings suggest that the needs of the rural older adult often exceed the available resources. Accessible health services and social support must be organized and funded in the near future to meet the needs of the rural older adult in this aging society.

Cultural Values

The rural population is increasing in diversity. The lack of health-promoting lifestyles is an issue among rural older adults, as well as the application of culturally appropriate programs to encourage older adults to embrace personal responsibility and to adopt healthy behaviors. Because every cultural group is unique and multidimensional, a one-size-fits-all approach will not be applicable to rural older adults (Belza et al., 2004; Gordon, 2004).

All people have a cultural identity and cultural values, regardless of who they are or where they live. Culture refers to the learned, created, and shared experiences that are passed along to succeeding generations. Culture is a "way of life belonging to a designated group of people" (Leininger, 1990, p. 54). Culture is universal, active, learned within a family, and determines the path of a person's life on an unconscious level (Leininger, 1990).Cultural beliefs and value systems are of utmost importance in determining the health status of the rural older adult population (Belza et al., 2004; Gordon, 2004; McAllister & Farquhar, 1992), as individuals' beliefs about their own health are influenced by culture, experiences, and exposure to health promotion lifestyles.

Beliefs about health promotion are culturally sensitive; therefore, any health promotion education should also be culturally sensitive (Belza et al., 2004; Gordon, 2004; McAllister & Farquhar, 1992).

Ethnic minority older adults in the United States, such as African Americans and Hispanics, have a high prevalence of chronic diseases, including diabetes, hypertension, and heart disease. Studies have shown that these groups are also less likely to engage in health promotion lifestyles (Damron-Rodriquez, Frank, Enriquez-Haass, & Reuben, 2005; Johnson & Nies, 2005). Furthermore, non−English-speaking individuals can feel isolated and misinformed about their health status because of a lack of native-speaking health care providers from their own ethnic background (Belza, et al., 2004: Lister, 2005; Mutchler & Brallier, 1999; Weech-Maldonado et al., 2003). Older women of color and people with low levels of education and financial income are the least physically active. According to Gordon (2004), European Americans exercise the most (38% are sedentary) and African Americans and Latinos exercise the least (52% and 54% are sedentary, respectively). American Indian/Alaska Natives and Asian Pacific Americans fall in the middle (46% and 42%, respectively).

Rural culture has many factors that create barriers for the rural older adult seeking health services. Living in rural areas, often distant from services and other people, the older adult relies on independence and self-reliance as survival values. These values are instilled in rural people early on, making it difficult to modify them. The rural older adult values a more conservative approach to life, especially when one must be self-reliant (Mulder et al., 2000; Siama, 2004). Rural older adults tend to stay to themselves, thus making the idea of opening up and talking with health care providers, who are often seen

as strangers, very difficult (Mulder et al., 2000; Siama, 2004). Seeking health care and promoting healthy lifestyles for the rural older adult continues to be a challenge.

Chapter Summary

Chapter 2 presents a review of the literature relevant to health-promoting behaviors and health promotion barriers among rural older adults. The theoretical framework for the study was Pender's HPM, which addresses factors that enhance health-promoting behavior, leading to improved health and quality of life for the older rural adult. This study provided the information necessary to determine the behaviors of and barriers to health promotion practices in the rural older adult. The main theoretical proposition of HPM is that previously related behaviors influence beliefs, affect, and enactment of health-promoting behaviors. The HPM model represents the interrelationships between cognitive factors and modifying factors influencing the occurrence of health-promoting behaviors. Health is seen as a positive, high-level state.

CHAPTER 3

METHODS

Chapter 3 describes the methods that were used in the proposed study. The chapter consists of five parts: (a) qualitative methodology, (b) ethnography, (c) focused ethnography, (d) methods, and (e) chapter summary.

Qualitative Methodology

Qualitative research is a form of social science research in which the researcher seeks to explore a phenomenon or experience from the point of view of participants (Denzin & Lincoln, 2003a). Qualitative research describes and builds theories about human behavior through the use of observation or interview in a manner that places emphasis on the implicit meanings of the participants' words and actions (Denzin & Lincoln, 2003a). Qualitative research methodologies are designed to give the researcher the perspective of targeted participants through immersion in their culture or situation, usually with in-depth involvement with participants in the study (Denzin & Lincoln, 2003a). Qualitative methods are intended to help researchers understand the meanings participants assign to their everyday lives and to elucidate participants' understanding of social and psychological processes underlying their behaviors (Denzin & Lincoln, 2003a).

Ethnography

Ethnography is the earliest distinct research tradition within the qualitative paradigm and is the art and science of describing a group or culture. The term *ethnography* is derived from the Greek word *ethnos*, meaning "people" (Patton, 2002, p.

81). The approach is used by investigators to help understand and describe why a group of people does what it does, by going into the field and having direct and personal contact with the people under study in their own environments (Patton, 2002; Roper & Shapira, 2000). Ethnographic studies encourage nurses to embrace a better understanding of how patients and clients construe their experiences of health and illness (Morse, Swanson, & Kuzel, 2001) and have been used to describe and provide insight into the diverse aspects of health behavior (Oliffe, 2005).

Ethnography is the methodological and philosophical foundation for cultural and social anthropology and qualitative sociology. At the beginning of the 20th century, ethnography was used in cultural anthropology to study and describe unfamiliar societies (Bailey, 1997). Historically, anthropologists spent many years living with and studying nonindustrial societies. Researchers spent their time observing and interviewing participants, often repeating the process over a period of years. Meaning was created through analysis of the data collected (Agar, 1994; Creswell, 2003; Denzin & Lincoln, 2003b, 2003c; Patton, 2002).

Although ethnography is best known as a science of description, it is also a powerful means to learn about social situations and the way they change and develop (Chambers, 2003). It emphasizes the portrayal of everyday experiences through participant observation, documentary analysis, and interviews with key informants (Ambert, Adler, Adler, & Detzner, 1995; Creswell, 2003; Denzin & Lincoln, 2003b, 2003c; Munhall, 2007; van Manen, 1990). Ethnographers aim to discover how groups define their world, how members behave routinely in everyday life, and how they make sense of their experiences (Brunt, 1999). A strength of ethnographic research is that

skillful researchers are often able to identify emergent context-based meaning and patterns, thus permitting alternate interpretations, which in turn, increase the depth of knowledge of the group being, studied (DeSantis & Ugarriza, 2000).

Focused Ethnography

Focused ethnography is a type of ethnography suited to studying a specific identified research problem within a subgroup or subculture (Muecke, 1994). Focused ethnography is a small-scale ethnography that is usually limited in terms of the time, place, and/or scope of the problem. Because the intent is to concentrate on a specific subset of behavior, often in the context of a subculture, the research can be accomplished within a shorter timeframe than traditional ethnographies. Data are collected using both structured and unstructured approaches, with an emphasis on interviews, which are supported by observational data. In focused ethnography, researchers make frequent but episodic visits to the community or group, rather than living among the community. The short duration of these field visits is offset by the intensive use of data collection methods (Knoblauch, 2005, Muecke, 1994; Roper & Shapira, 2000). Focused ethnographic methods are, therefore, well suited for studying the health-promoting behaviors of the rural older adult. Determining why members of this subculture behave in certain ways and what their beliefs are will help promote the development of culturally appropriate interventions to aid in supporting health-promoting lifestyles.

Methods

This research study used ethnographic methods to describe the health-promoting behaviors of rural older adults and explored the barriers that prevent them from adhering to healthy lifestyle behaviors while living in an independent senior center. Understanding

of these issues is central to determining why some rural older adults experienced healthier aging than others.

Human Subjects Protection

Any time one conducts research, there is a risk to those who participate in the study. It is the responsibility of the researcher to protect all research participants. The study was noninvasive and presented minimal risks to the participants. All participants were informed that their participation was voluntary and that they could withdraw at any point without negative consequence. The privacy and dignity of the rural older adult was maintained at all times. To ensure anonymity, each participant was assigned a pseudonym at the beginning of the study. That pseudonym was used throughout the study. All participants preferred to use a pseudonym of the alphabet along with a numerical number. Participants were encouraged to discuss relationships rather than individuals (e.g., sister, brother). Approval from the University of New Mexico Human Research Review Committee (HRRC) was secured, as well as a letter of permission from the senior living center where the study was conducted and a signed HRRC-approved consent form from each participant (see Appendix A).

Setting and Sample

The setting for this study was a local community senior citizen living center located within a rural town in West Tennessee. The town meets the Census Bureau definition of rurality, with a population of approximately 2,000 (U.S. Census Bureau, 2007). The 30 rural older adults who participated in this study were all residents of a senior community living center. This center is a free-standing facility that houses independently living older adults in an apartment/condominium-type environment. In this

particular living center, the older adults must be independent because they are responsible for maintaining their apartments inside and ensuring that all their personal needs are met. The rent for these apartments is based on the yearly income of the resident. All utilities are included in the rent, with the exception of telephone, Internet, and cable services. Participants reported inclusion of utilities in the rent as an attractive feature of living at the center. The facility has a lobby/common area in which planned activities, excursions, and crafts are available. The center was chosen for the study primarily because it is consistent with the study focus on independent older adults, and drawing participants from all aspects of the community would involve diverse levels of independence.

All participants were exposed to the same community events, such as church services, bingo, potlucks, singing, and various other activities held in the community center. Attendance at these functions was purely optional for all residents. All outdoor yard work and maintenance upkeep is provided by the center at no cost to residents. The grounds of the center are very plush, with flowers, shrubbery, and trees and they are well lit from various decorative ground pole lights. The building is structured in a circle, with the center's office, lounge, laundry facility, and post office area located in the middle of the complex. All exterior apartments are red brick, and each has a private covered front porch area and private walk. All apartments have one parking spot designated for each tenant's personal vehicle. The center is located in the heart of the city, just a couple of miles from supermarkets, drug stores, and restaurants. Delivery from restaurants and drug stores are available to the center as well. The center is built for 35 residents, and according to the manager, all apartments are usually occupied. The tenure in years of residence varies from less than 1 year, to more than 20 years. All 30 residents who reside

in the senior community living center agreed to participate in the study, and all 30 residents were interviewed twice.

Recruitment

A sample of rural older adults who met the inclusion criteria was recruited from those living at the senior center. To be included in the study, participants had to reside in the senior living apartment community, be 62 years or age or older, be able to understand and answer questions coherently, and live independently in terms of self-care and day-to-day activities. Participants had to be able to understand English sufficiently well enough to complete the study documents and engage in the interview in English. All participants living in the senior center met the inclusion criteria and consented to participate, so none were excluded. The study was advertised through flyers placed in the lobby area, a central area where activities take place, for all residents to see. The flyers described the study and listed convenient times for potential participants to meet and talk with the researcher in the lobby area (an opportunity for the researcher to set up interview appointments with those who agreed to participate). The flyers also contained the researcher's contact information. The researcher introduced herself to each potential participant and provided the details of the study.

Determination of a sample size in qualitative research is controversial, and there is no consensus regarding how many participants a researcher should recruit (Higginbottom, 2004). Selection of participants continued until the point of data redundancy or theoretical saturation (Miller & Crabtree, 1999). Authorities suggest that to reach saturation in qualitative research, the researcher must conduct approximately 10 to 30 interviews (Russell & Gregory, 2003). Saturation of the data appeared to be

achieved with 20 of the participants, but the interview process continued for 10 remaining participants to ensure diversity of views and because all of the participants were eager to take part in the study.

Data Sources and Collection

The study had four sources of data: interviews with participants, demographic questionnaires, and observational data recorded as field notes, and the researcher's notes on the research process.

Interviews. Ethnographic interviewing is an interviewing approach in which the researcher sets out to uncover the conceptual as well as the cultural meaning of the phenomena being studied. In-depth interviews are conversations that incorporate the art of asking questions and listening. A semi-structured approach for the interviews (see Appendix B) permitted follow-up questions based on the participants' responses. Because each interview was different, there was no set order for asking the questions, and questions were modified in the field as the situation warranted. Interviews elicited the participants' stories and their social view of their lives in their own words through experiences, feelings, and thoughts (Fossey, Harvey, McDermott, & Davidson, 2002). The semi-structured format permitted participants to tell their stories in their own words according to their judgments of relevance to the interview. Although the interview guide proposed a set of questions, the goal was to elicit emerging stories that were detailed and relevant. This approach assured acquisition of complete and contextualized data from which a more holistic understanding emerged (Patton, 2002). The interview guide was modified over the course of the study in response to evolving themes identified from earlier interviews, observational data, and field notes.

The interviews began with broad, "grand tour" questioning, which helped define the area under inquiry. Beginning with broad questions and then moving to specific lines of questioning was helpful in obtaining in-depth information about those elements determined to be significant (Lincoln & Guba, 1985). One example of a grand tour question is: *Please tell me how you feel about the aging process?* Clarifying and probing follow-up questions (e.g., "Tell me more about that," "What was that like for you?" and "When did you first start to notice that or feel that way?") were used to acquire detailed data to accurately describe the participants' way of life and culture.

Interview process. Interviews took place in the apartment of the participant. The interviews were scheduled at times that were convenient for participants and when they were able to meet privately to ensure confidentiality. The participants were asked to engage in two in-depth, audiotaped ethnographic interviews. Multiple interviews allowed rapport to develop between the participant and the researcher. Once this happened, the trust relationship between the participant and the researcher was richer; therefore, more contextual data were gathered (DiCicco-Bloom & Crabtree, 2006). Multiple interviews also allowed additional questions and information that arose out of the data from the first interview to be explored in more depth.

Interview one. During the first interview, the consent form and the purpose of the study were reviewed. The participants were also asked specific information from the demographic questionnaire (see Appendix C). The demographic questionnaire served as a tool to assist the researcher in describing the participants. Ample time was allotted for the interview guide questions, thus allowing the participants to speak freely. The interview lasted between 1 and 2 hours; time was adjusted for each participant on an individual

basis. The second interview was set up at the time of the first interview and was determined by the participant.

Interview two. A follow-up interview was scheduled approximately 2 to 4 weeks after the first interview. The participants were contacted by phone to remind them of the upcoming scheduled second interview. The interview summary and a second interview guide based on the emergent themes from the first interview and on the themes developing across the interviews guided the second interview. During the second interview, the participants reviewed a summary of the first interview for accuracy and verified or clarified the initial analysis of the data (Lincoln & Guba, 1985).This interview also served to provide closure with the participants.

Researcher-designed demographic questionnaire. The researcher-designed demographic questionnaire was administered to all participants at the first interview. The purpose of the questionnaire was to collect basic demographic data: age, educational level, income status, religion, race, gender, and marital status. Data from the demographic questionnaire were collected orally using a tape recorder to ensure accuracy and to collect any discussion associated with the demographics as narrative (see Appendix C).

Participant observation. In this ethnographic study, the engagement with the participants was one way to ensure minimizing distortion of data and elicited a context for the developing themes. Participant observations presented the "here and now experience" (Lincoln & Guba, 1985, p. 273) that allowed the researcher to see the participant's world as the participant saw it and to identify the environmental cultural aspect. Accordingly, researchers must continuously be aware of the influence that their

presence is having in the field and also reflect on and monitor the influence of the research setting on their observations.

Participant observation is useful in gaining an understanding of the physical, social, cultural, and economic context in which study participants live; the relationship among the participants; and participants' behaviors and activities. After permission was obtained from the facility manager and from the participants for the researcher to observe and document the observation data, I attended as a passive participant observer at a weekly planned potluck gathering at the senior living center, in which all participants were invited and ask to bring a dish. I found a place to observe the activities, assumed the role of bystander or spectator, and did not actively participate in the event. Observational data were collected by observing the participants actively taking part in the potluck activity held in the lobby of their living quarters. During this time, I recorded my observations as field notes, which became part of the ethnographic record. During observation, nonverbal behaviors were also noted as field notes. These field notes did not include any identifying data. All observational notes about the participants were kept throughout the research process and were recorded and analyzed in the same manner as the interview transcripts.

Data Analysis

Overview. The process of data collection is not an end in itself; rather, it is a beginning. Equally important are the processes of analysis, interpretation, and presenting the findings (Patton, 2002). The first steps of analyzing, reviewing, and synthesizing are enabled by organizing the data through careful verbatim transcription of audiotaped interviews and review of field notes (Patton, 2002). Interpretation of the data began

during the data collection process by documenting preliminary interpretations. Analysis proceeded with a line-by-line review of the transcribed data, supplemented by the field notes for elements not captured on the audiotapes, such as smiling, laughing, frowning, and other nonverbal behaviors. Data were indexed according to differences, commonalties, and key words or phrases expressed by the participants (Patton, 2002). After indexing, narrative data were interpreted in context to identify themes and subthemes.

Preparing the data. Once the interviews were completed, the audiotapes were transcribed verbatim. To protect the identity of unconsented individuals mentioned in interviews, potentially identifying information on the transcripts was anonymized. The researcher reviewed the transcripts for accuracy and began making observations of key ideas pertinent to the transcript statements. The qualitative software analysis package Atlas.ti was used to assist with data analysis. Data from the transcripts were entered into the software program to aid in the management, discovery, indexing, and retrieval of data.

Familiarization. Familiarization refers to immersion into the raw data. Familiarization involves listening to the tapes, reading the field notes, and revisiting note extensions and transcripts. During the familiarization process, the key ideas that emerged from the data were listed. Once the key ideas were identified, data analysis advanced (Borkan, 1999).

Final analysis of the data. Interpretation of the data for the study (e.g., interview transcripts, field notes, observational data) was guided by the process of immersion and crystallization, an iterative, contemplative, and reflective process whereby ideas and

themes emerge throughout the analysis (Borkan, 1999). In this process, the data were converted from an emic (i.e., implicit) meaning for the participants to etic (i.e., explicit) meaning for the researcher that was validated by participants through member-checking (DeSantis & Ugarriza, 2000).

Themes captured the essences and meanings of the data from which they emerged and, hence, of the experiences and understandings embedded in those data (DeSantis & Ugarriza, 2000). DeSantis and Ugarriza (2000) proposed three criteria for identifying themes: they emerge from the data, they are general themes that are implicit, and they are themes that represent patterns. A line-by-line review of the data followed the immersion and crystallization process to verify that the crystallized findings were contextual and data driven (Mendelson, 2003). Repetitive analysis of reading and reflection of the data allowed unyielding associations to be connected through the participant's responses. Therefore, themes and subthemes were shaped from the interviews and the observational data. Themes and subthemes that evolve from the interviews and observations contain abstract meanings that surround the lived experiences of the rural older adult and illuminate what they do and why they do it.

Field notes were kept during all phases of the research process, which included the recruitment process, interviews, and data analysis. These notes helped the research process by documenting emerging themes and creating an audit trail of analytical thought processes and observations throughout the data collection and analysis stages.

Methodological Rigor

Researcher's assumptions and perspectives. All research with human subjects represents some degree of perspective rather than the absolute truth. It is common for

investigators to bring preconceived ideas, thoughts, visions, or concerns to the research study. Although this usually represents the reason or the desire to study and explore the topic, it can become a distraction or source of bias (Patton, 2002). Through making ones' assumptions and perspectives explicit throughout the research process, the effects of predispositions on interpretations can be understood and moderated through methods of methodological rigor and vigilance by the researcher (Patton, 2002). Vigilance was preserved throughout the entire research process to ensure that I was not imposing personal assumptions and preconceived notions about the data. To ensure that the participants' perspectives were being portrayed truthfully, a rigorous audit trail was maintained, triangulation among data sources was performed, and emergent themes and key concepts were confirmed and verified by participants (Patton, 2002). As the instrument in qualitative research, I remained aware of any personal or professional information that may have influenced the data collection and analysis to ensure the credibility of the study. It is very important that I, as a novice qualitative researcher, had direct mentorship from a seasoned researcher to assist in the development of researching skills to become a successful qualitative researcher (Morse et al., 2001). The dissertation committee chair, Dr. Cindy Mendelson, is an experienced ethnographer; she and other committee members mentored me in my study and in the process of identifying emergent themes, as well as validating the assumptions and information obtained during the course of the study.

Trustworthiness. Lincoln and Guba (1985) identified criteria for rigor in qualitative data analysis. Trustworthiness pertains to the credibility, transferability, dependability, and confirmability of findings.

Credibility. Credibility in qualitative research was secured through the development of prolonged engagement, persistent observation, member checks, and triangulation (Lincoln & Guba, 1985). All of these criteria were employed in this study. Truth value or credibility of the data, and its interpretation were supported through meticulous descriptions of the participants, the setting, and observed events.

Prolonged engagement. Prolonged engagement is the process of allowing ample time to achieve the wisdom of the culture one is studying, build trust with participants, and ensure that saturation is achieved (Lincoln & Guba, 1985). Engagement with older adults began more than 20 years ago for this researcher while employed as a community home health nurse. Since then, I have had the opportunity to work with rural older adults on many occasions and in many contexts. I have had extensive exposure over many years to the health behaviors of rural older adults through employment in assisted living centers, in the community, and in nursing homes. Living the past 30 years as a dependent military wife, I had the opportunity to relocate frequently, and this moving permitted the opportunity to observe both rural and urban older adults in their respective physical and social environments. The design of this study consisted of two in-depth interviews with each participant, which allowed me to have sufficient time to understand the culture of this micro-community and to build a trusting relationship with the participants.

Persistent observation. Persistent observation is used to identify those elements relevant to the issue being investigated. Persistent observation provides focus, depth, and relevance to the data collection and analysis processes (Lincoln & Guba, 1985). The sequential interviews and the participant observation provided a basis for persistent

observation, therefore allowing for opportunities to probe more deeply into prominent thoughts that emerged after the initial encounters (Lincoln & Guba, 1985).

Triangulation. Triangulation is the significant process of ensuring that the findings and interpretations are credible by verifying the information against several sources (Lincoln & Guba, 1985). This research study employed the use of triangulation in data sources, such as the demographic questionnaire, and data collection methods, which were observations, the demographic questionnaire, and multiple interviews. By comparing observations to interviews and then interviews to each other, a better depth of understanding and a larger database for analysis was developed (Lincoln & Guba, 1985; Patton, 2002).

Member checks. Member checks are a crucial technique for establishing credibility in ethnographic research (Lincoln & Guba, 1985).During the interview process, an informal means of member checking involved validation of responses at the end of each interview with the participants. A more formal process of member checking occurred by asking the participants to review and verify the initial data analysis at the second interview and ensured that the findings were generated from the data itself. All interviews were closed with a summary of understandings and a request for participants to authenticate their comments and answers to the questions, as well as their own stories.

Dependability. Dependability has to do with the authenticity of the research process and the findings of the research study. Dependability was preserved through audits of the field notes. I discussed and debriefed about the research procedures and its findings in an ongoing manner to ensure accuracy with my committee chair, Dr.

Mendelson. These debriefings assisted in exploring the contents of the research that might have remained only implicit within the researcher's mind (Lincoln & Guba, 1985).

Transferability. Transferability of precise research to other populations is the responsibility of the person seeking to make the application elsewhere (Lincoln & Guba, 1985). The original investigator must report sufficient data to make such judgments possible (Lincoln & Guba, 1985). The researcher is responsible to present the research study in a narrative design by using detailed, rich descriptions, thus permitting the consumer of such work to determine whether any of the findings are transferable to other groups of populations.

Confirmability. Confirmability is the constancy of the findings and is ensured through data audits, study measures, interpretation, and study findings (Lincoln & Guba, 1985). The researcher maintained all data, codes, and themes/subthemes for assessment by the research committee to ensure confirmability. My dissertation chair, Dr. Mendelson, served as an auditor and reviewer for my data and analysis process.

Chapter Summary

Chapter 3 presents the methodology for this ethnographic research study, which explored the health promotion behaviors of the rural older adult. Ethnography was used as the method to reveal the unheard voices of rural older adults and to access knowledge into the barriers influencing the health behaviors of these older adults. Data included two in-depth interviews with the participants, demographic data, observational data, and field notes. Immersion and crystallization were chosen for the data analysis to allow for an inductive generation of study findings that answered the research questions. The researcher maintained trustworthiness through the processes of credibility, prolonged

engagement, persistent observation, triangulation, and member checks. Using rich, thick descriptive narratives maintained by providing information for audit purposes allowed transferability of the findings, confirmability, and dependability.

CHAPTER 4

DEMOGRAPHICS AND NARRATIVES

Chapter 4 consists of four parts: (a) demographic information for the sample of 30 participants; (b) narrative overviews of a subsample of 9 participants who represent the diversity found among residents of this community center; (c) the context that framed the experiences of the participants; and (d) chapter summary.

Demographics of the Sample

Thirty participants who met the inclusion criteria were interviewed. Table 1 provides demographic information for these participants, and a summary of key characteristics appears below.

Twenty six women and 4 men participated in the study. All the participants were born in rural Tennessee. Ages ranged from 63 to 93 years. Twenty-eight participants (93.3%) were widowed, and 2 (6.6%) were never married or were single. Two participants were African American; 28 were White. Four participants never had children, 9 had one child, 7 had two children, 5 had three children, and 5 had four or more children. All participants were Protestant: 22 were Baptist, and 8 were of other denominations. Most had resided at the center for 1 to 10 years (5 for < 1 year; 8 > 10 years). Participants' highest level of education ranged from 8thgrade to postgraduate college. Half (50%) completed less than high school, 12 (40%) graduated from high school, and 3 (10%) had some formal education beyond high school. Only 1 participant had a bachelor's degree or higher. The 4 male participants reported careers as an engineer, farmer, laborer (ditch digger), and ticket agent for a railroad. The 26 female

participants were mostly housewives (*n* = 15) and factory workers (*n* =7); the remaining women worked as a computer programmer (*n* = 1), cook (*n* = 1) and nurse (*n* = 1), and 1 participant never worked because of a disability at birth (*n* = 1).

Table 1. *Demographic Characteristics of the Participants*

Name	Age, years	Martial Status	Gender	Ethnicity	Religion	Children	Prior Career	Education	Yearly Income, $	Length of Residence, years
A1	80-85	W	F	AA	B	3-5	Housewife	Primary	<10,000	>10
A2	80-85	W	F	C	B	1-2	Housewife	Some high school	<10,000	<1
A3	80-85	W	F	C	B	1-2	Housewife	Primary	12-14,000	3-5
A4	85-90	W	F	C	B	1-2	Laborer	Primary	14-16,000	3-5
B2	65-70	W	F	C	B	1-2	Housewife	High school	<10,000	1-2
B3	75-80	W	F	C	B	1-2	Housewife	Primary	<10,000	1-2
B4	75-80	W	F	C	B	3-5	Laborer	Primary	<10,000	6-10
C1	70-75	W	F	C	P	1-2	Housewife	High school	<10,000	1-2
D1	>85	W	F	AA	P	1-2	Housewife	High school	<10,000	>10
D2	70-75	W	F	C	P	1-2	Laborer	Primary	<10,000	>20
D4	>85	W	F	C	B	1-2	Laborer	Primary	10,000	6-10
E1	>85	W	M	C	P	1-2	Laborer	Primary	<10,000	1-2
E2	70-75	W	F	C	B	3-5	Laborer	Primary	<10,000	3-5
E3	85-90	W	F	C	B	0	Housewife	High school	14-16,000	>15
G1	70-75	S	F	C	B	0	Professional	Post high school	12-14,000	>10
G2	75-80	W	F	C	B	3-5	Housewife	High school	<10,000	1-2
G3	>85	W	F	C	P	3-5	Housewife	High school	<10,000	3-5
G4	>85	W	F	C	B	3-5	Housewife	Primary	<10,000	>15
H1	75-80	W	F	C	B	1-2	Laborer	High school	<10,000	3-5
H2	60-65	W	M	C	B	0	Professional	Post high school	14-16,000	<1
H4	70-75	S	F	C	P	0	Never worked	High school	<10,000	>20
J2	70-75	W	F	C	B	>5	Housewife	High school	<10,000	3-5
J3	65-70	W	M	C	P	1-2	Laborer	Primary	10,000	1-2
J4	>85	W	F	C	B	1-2	Professional	Post high school	14-16,000	>10
K1	65-70	W	F	C	B	6-10	Housewife	Primary	<10,000	3-5
K4	75-80	W	M	C	B	1-2	Laborer	Primary	14-16,000	3-5
L1	70-75	W	F	C	P	3-5	Housewife	High school	<10,000	6-10
L2	65-70	W	F	C	B	1-2	Laborer	High school	<10,000	< 1

Note. W = widow; F = female; M = male; C = Caucasian; AA = African American; B = Baptist; P = Protestant.

Participants' Narratives

"Narrative meaning is one of the processes of the mental realm, and functions to organize elements of awareness into meaningful elements" (Polkinghorne, 1988, p. 1). Narratives are used to organize the experiences of the participants in a contextual framework and to depict the social realities of their daily lives (Crabtree & Miller, 1999). Narratives include a recollection of past events, as well as anticipations for the future (Crabtree & Miller, 1999). The narratives from the rural older adults who participated in this study serve as recollections of how they have moved through time and created significance and meaning in their lives. All 30 of the rural older adults who participated in this study completed both interviews. Because the narratives were all obtained from a single dwelling community center, to maintain the anonymity of the participants, narratives of 9 of the participants are provided as exemplars to provide the reader with context for the analysis of the data that follows and to introduce the participants. The narratives are composed from all encounters with the participants, including two scheduled interviews, participant observation, and time spent visiting in their apartments.

Miss H4's Story

Miss H4 is a very short, slender woman about 5 feet tall, with dark almond-shaped eyes and dark brown, thick, straight hair. It is cut short and square all around her face, with bangs. She does not look her 71 years. She has a very young-looking face and a childlike smile, which she kept throughout the entire interview. She was dressed in a white turtleneck and corduroy pants; she used a quad cane and wore an elevated boot. She tended to hold her disabled arm as we stood and talked; she told me that if she did not hold it, it would just dangle.

Miss H4 was raised by her parents on a farm. She had one older sister and never married or had any children. Born with a disability, she was very sheltered and never allowed to participate in normal daily activities, from helping around the house to going out on the weekends with friends. She completed high school, but never worked outside the home. Miss H4 had lived in the center for the past 20 years. She moved there after her father passed away. Her mother had died years before, and she remained in the house with her father until he died. After his death, she sold the family home and moved to the center.

Miss H4 has never driven, and modern conveniences were a plus when deciding to move to the center from her previous home. She is very active in all activities within the center, including attending bingo games, potlucks, outings, church services, and sing-alongs that are held onsite. She travels by taking a transportation van to all medical appointments and the grocery store. Miss H4 is very independent despite a disability that affects her arm, hand, and foot. She stated, "This has never really been a handicap; this is me. I have had this since I was born. I don't see myself as having disability." She is very happy about living in the center, and for the first time in her life, she is independent.

Miss H4's family kept her sheltered until she was about 50 years of age. She told me she had never dated or been kissed. She has an older sister whom she considers to be, at times, overprotective. She cooks and cleans for herself adequately and, simply stated, she is enjoying her life now and is very happy. "Life is about living for yourself and being your own boss, and I believe I am living a good life." She is a very religious woman who says that through God and prayer, she is where she is today. Her apartment was very clean and organized. It was filled with beautiful antiques, pieces that had been

handed down from her grandmother more than 120 years ago. She was very friendly and took pride in showing me glassware that had been passed down through three generations. Miss H4 is a pleasant, positive woman, happy to be out on her own. Her final words to me indicated that the only thing she wishes had been different was that she was allowed to live like a normal child. She said she would tell others

> "To not restrict your children, regardless of their handicap. To allow them to be independent and not be controlling, overprotected, and above all let them explore on their own."

Mrs. D1's Story

Mrs. D1 is a 93-year-old African American woman who was raised in the country by her parents, both of whom lived to be older than 96 years. Mrs. D1 met me at the front door with a huge smile on her face. The apartment was full of very positive energy, and Mrs. D1 was a genuinely happy, delightfully positive woman. She was dressed very nicely in a dress, stockings, shoes, and apron. She wore a pearl necklace and earrings. She was about 5 feet 5 inches tall and very slender. Mrs. D1 was soft-spoken and gentle with her words, and her apartment was very clean. She had a lot of things in a very small area, but all were things she could not bear to part with, so she just lined them all up against the walls. She loves the color red, so the drapes and furniture were all red. Everything was color coordinated.

Mrs. D1 was raised on a farm, where the family meat was cured onsite, and they always had a big garden. She graduated high school and had two daughters, who still live locally. She never worked outside the home while married and wanted to be referred to as a "house technician." Mrs. D1 was very pleasant and laughed through both of the

scheduled interviews. She watches very little television (TV) but reads the Bible daily. She is very religious and attends church services three or more times a week. She loves puzzle books and believes they help to keep her mind active. She has diabetes and adheres to her diet very closely. She stated that while she would love to have some fried chicken and cornbread, she realizes those days are over. She is very active outside the center and has lived there for more than 12 years. She uses the center's transportation van to attend medical appointments or go shopping. She says that through prayer and praises to God, she gets through each day without stress. She believes that her problems with her new diabetic diet and new disease process were resolved through God. "God will bring you through anything," she stated.

Mrs. D1's husband died more than 42 years ago in a motor vehicle accident, and because she is a member of the Church of Christ, she believes that "God gives you one husband, one soul mate, and I never remarried."

Her final words to me were,

> "Be positive, don't look for the bad, be happy each and every day, treat people with respect, and do what is right, what your heart tells you, and leave it all to God for he will take care of you."

Mr. E1's Story

Mr. E1 is an 89-year-old Caucasian man who completed the 8th grade before going to work for the railroad as a ticket agent. He was a very friendly man, who did not look 89 years old. He was very well-groomed and bald, with a white, neatly trimmed, narrow mustache. He was wearing blue jeans with a white t-shirt tucked in and a brown belt. He was about 6 feet tall and of average weight. He laughed a lot throughout both of

the scheduled interviews. He was very positive and smiled often. He was raised on a farm by his parents, but was not interested in the farming life, so he left the area looking for work.

Some time after obtaining his railroad job, he married and soon after had one child, a son. He has lived in the center for about 2 years, following the death of his lifelong wife, whom he described as his sweetheart. His late wife was a housewife, and Mr. E1 stated that "cooking has been the biggest challenge for me; my sweetheart always done all that sort of stuff." He makes a point to eat a big breakfast every day or else he finds himself hungry all day long. Breakfast is usually "eggs and more eggs," with bacon or sausage. He uses the transportation van to get to his medical appointments or shop. His son is now older and has diabetes, so he does not call on Mr. E1 regularly. Mr. E1 was married to his sweetheart for more than 68 years, and he says he misses her each and every day. He says he knows she is in heaven and waiting for him. He is very religious and looks to God for strength in all he does. He attends church regularly and puts his faith in God.

Mr. E1 feels that he is in good health; he is independent enough to tend to all his needs and attributes this freedom to never smoking. He has worked hard over his lifetime, and he feels the long hours he worked have kept him healthy, since he never exercised. His last words to me were:

> "Aging is something you cannot control, it is coming [whether] you like it or not; time moves fast, and before you know it you are old. Be happy, and make the best of everything; be positive. You cannot change the aging process, but take it as it comes, and live each day the best you can. Relax, take time out to rest."

Mrs. J4's Story

Mrs. J4 is a 93-year-old Caucasian woman who has lived at the center for 14 years. She was very pleasant and friendly. She was about 5 feet 6 inches tall, with short gray curly hair. She was wearing very casual clothes and had no trouble getting around the house. Her house was clean, organized, and decorated nicely. She was raised by her parents on a local farm. She finished high school and went on to finish nursing school. She was married shortly after she graduated from nursing school and had a son and daughter. Her husband died at the early age of 55, and she never remarried. Her only son died the following year. She felt her husband's shoes could never be filled, as he was her best friend and soul mate, and she chose not to date after his death. She felt that because she was already 55 years of age, she did not want to become someone else's wife; she wanted to remain her deceased husband's wife. She said she had enough love to last her a lifetime and was fulfilled in every way. She was still wearing her wedding band and stated that she never takes it off. She lived in their home until the age of 80 and then moved to the center.

Mrs. J4 sees herself as very independent; she continues to drive herself daily to appointments and does all her shopping herself. She is very knowledgeable about her health and has made healthy choices. She is also knowledgeable about nutritional issues and discussed the importance of healthy eating and making sure to eat a sound breakfast. Mrs. J4 reads stays current on the latest medicines and treatments. She considers herself very healthy; she only takes digoxin for her heart and feels that eating healthily her entire life has helped her to attain the age of 93 and to still be able to take care of herself. She laughed constantly during the interviews; she was very pleasant and a joker, and

questioned me at times about my breakfast habits and those of my children. She reported no history of smoking or drinking alcohol of any sort and feels this abstinence also played an important role in her healthy state. Mrs. J4 feels that pork, grease, fat, and salt should be avoided at all costs. She watches very little TV and reads the Bible from to beginning to end every year. She stated that she is here for a reason, the love of her life left her early on for a reason, and she has not doubted God; she trusts God and prays to Him every night. Mrs. J4's final words to me were:

> "Take care of yourself, rest, sleep 8 hours a day. You just get one body, take care of it, and it is like a car, keep it filled with water. Healthy eating, positive attitude, and never doubt God. Trust in God with decisions beyond your control, and of course read your Bible. It is God's will, and we are merely his puppets. We must remember this, He is the master and He is in control. . . . I wish for nothing, I want for nothing, and I am happy to be here."

Mrs. J2's Story

Mrs. J2 is a 71-year-old Caucasian female who moved into the center about 3 years earlier. She was about 5 feet 4 inches tall, and her hair was short and neat. She was very pleasant and smiled throughout our entire time together. She was wearing makeup and laughed a lot. She was a very personable person. Mrs. J2 met me at the door, and the table was set for her upcoming lunch with her daughter. The place settings were carefully arranged with napkins, silverware, water glasses, and tea glasses. It was obvious to me that she spent a lot of time and took pride in setting the table.

Mrs. J2 lived at home with her parents until she graduated from high school and then married her late husband. Her parents lived in the country; they raised animals and

lived off the crops they grew. She was the youngest of eight children and worked hard as child. Her husband was a farmer, and her family had wished that she would not marry a farmer due to the difficulty of earning a good living in that profession. But Mrs. J2 felt that her soon-to-be husband was a good man and married him anyway. They had nine children and raised them all on their farm. She was a housewife who kept the freezer full from the garden at all times. She credits her hard work in her youth for her health in old age. Her faith in God has been a real strength behind her success in aging, as well. She has remained positive, despite rough times because, as she said, they do pass and life does go on. She said that maybe life is not as we would like, but life does go on.

Mrs. J2 raised nine children and always worked the in the garden; she would freeze and can everything she could. She likes all vegetables and has never had to watch her weight. She continues to prepare home-cooked foods every day. The day of the first interview, she was preparing cabbage and cornbread; she stated that she has never used "microwave foods." One of her daughters comes by every day at lunchtime so they can eat a meal together. The daughter works about 5 minutes down the road, and they have been meeting for lunch for a year.

Mrs. J2 feels fortunate to live in this area. "Living here in town is a dream. It is a breeze compared to my earlier way of living," she stated. She has always been active outside and continues to take walks when the weather is nice. Her life is based on prayers to God; she believes that all one can do is to give it all to God and then go on with your life. She does not report any health problems except for arthritic fingers; she thanks the Lord for His blessings. She feels that going to bed early is also important; she usually goes to bed around 8 pm, and by early morning, she is up and reading her Bible. She feels

that morning is a time for quietness and stillness, and has followed this routine for a long time. She attributes her healthy state today to hard work, being devoted to living for God, never smoking or drinking alcohol, and staying positive despite life's ups and downs. She is very happy to be independent. Her final words for me were:

> "Be a Christian, trust it with God, and be happy; take care of yourself, stay positive, know that you are blessed and help others all you can. Put God first each and every day. I know I have been blessed and owe my life to the Lord. Without Him I would be nothing."

Mrs. E4's Story

Mrs. E4 is an 83-year-old Caucasian woman who lived in the center for 15 years. She has gray hair and wears glasses. She is of average size and height. She was sitting in her recliner crocheting when I arrived and didn't miss a stitch as I entered and introduced myself. She crocheted and knitted the entire time. She had knitting needles already wrapped in yarn in her lap, and occasionally she would drop the crocheting needle and pick up the knitting needles and continue seamlessly.

Mrs. E4 was raised by her parents and married right after high school, at which point she and her husband moved Chicago for employment. Jobs were scarce in the South at the time, and she and her husband did not want to farm. Reflecting back on the decision, she still believes moving north was the best way to make enough money to live on. After her late husband passed away 15 years ago, she moved back to Tennessee to live. As a young family, she and her husband worked hard and played just as hard. She said she has eaten in the finest restaurants and traveled the world. Mrs. E4 never had children and does not have any close relatives living nearby to provide the assistance she

requires. She has diabetes and gives herself insulin injections daily. She has always eaten well and taken care of herself. Mrs. E4's maid stated that Mrs. E4 only eats organic foods and wants only the best; the maid has driven more than 50 miles to purchase the right brand for her.

Mrs. E4 is a very religious person who thanks God for all her blessings. She is very positive about her life and never has doubted why she was unable to have children. She is grateful to God for taking care of her financially. She keeps busy with knitting and crocheting daily, and she is very active in helping needy families of local churches. When I asked whether she minded if I looked through her house, she said, "You go right ahead," called to the maid, and asked her to give me a tour. The apartment was spotless and very well furnished, from oil canvas paintings to a specially ordered orthopedic mattress. All of the furnishings were very expensive, including a custom-made couch. The bathroom was well decorated and was wallpapered in a light pale blue with white towels because, according to the maid, Mrs. E4 requested a "spa-like" bathroom. She had beautiful Tiffany lamps everywhere, from floor lamps to table lamps, and had replaced all of the hanging fans with Tiffany chandeliers. She stated that the curtains were also custom made to make sure the fittings were right. Overall, the apartment was tastefully decorated, and once inside, you forgot you were in a residential center. Mrs. E4's last words to me were

> "Trust in God, give it all to God, give with your heart, and you will receive twice fold; remember, it is God's plan and not to question God."

Mrs. A4's Story

Mrs. A4 is an 85-year-old Caucasian woman who moved into the center about 4 years earlier. She was very friendly, alert, and energetic, with a positive disposition. As I entered her apartment, she patted my hand and arm in a caring manner. She had manicured fingernails, a matching necklace and earrings, permed and professionally styled hair, and a very youthful appearance.

Mrs. A4 was raised in a country setting. Her late husband passed away 17 years earlier, but she lived in their family home for more than 13 years alone before moving to the center. She is very independent and was very confident in her decision to stay in the country for that length of time. She felt her on-the-go lifestyle was a reflection of her past husband, who worked in real estate. She accompanied him on many business trips, which she believes contributes to her now wanting to "go-go every day somewhere, even if it is just Wal-Mart." She has one daughter and maintains a very close relationship with her; Mrs. A4's daughter comes by almost daily to either check up on her or to go with her on outings.

Mrs. A4 is very active in church activities and drove her own car up until the previous year, when she was 84. She makes a point to get dressed to leave the apartment every day, whether to go to Wal-Mart or to get her hair done. She believes she needs to "go and go some more" to maintain her physical health. She is very active, plays bingo weekly, and attends all functions held at the center, as well. I observed Mrs. A4 at a potluck gathering as she took a leadership role in organizing the dishes and offering to serve all the participants. She is definitely a people person; she told me stories of going to the grocery store and striking up conversations with cashiers or other people just to hear their life stories. She gave me the grand tour of her apartment before I could ask her for

one. It was decorated nicely in green and blue colors. Her space was very homey and warm; she displayed much pride as she showed me old pictures of her family.

Mrs. A4 did not report any ongoing health problems, but stated she had a mild stroke the year before. She maintains a healthy and balanced diet; if she desires dessert, she will cut back on a roll during the meal. She maintains a close relationship with God and attributes her blessed life to God above. Her last words to me were:

> "Life is what we make it, you can curl up and die, or you can make the best of what you have. Money is only money, but your life, your positive attitude, and your faith is everything. We all will get older and our bodies will fail, but remember they don't work the same way they did before because they are heavy and worn out from life's experiences and the wisdom it now carries."

Mr. H2's Story

Mr. H2 is a 63-year-old Caucasian male who has lived in the center for less than 1 year. He is a short and small-framed man who is balding and wears glasses. He was wearing dress pants and a polo shirt. He walked and paced most of the time during the interview. He said he was tired of sitting and, if it was okay with me, he would just walk around the living room as we talked. Mr. H2 graduated with an engineering degree. His wife passed away about 1 year earlier, and he moved back to this area. He said he was born the region, and it just made sense to move back "home." Mr. H2 and his wife never had children. He traveled weekly with his job, and his wife was able to accompany him on his business trips. Mr. H2 said that they enjoyed eating out in fine restaurants and drinking some of the finest wines. They enjoyed having a drink and a smoke, as well. Mr. H2 reported that he is a heavy smoker and drinker to this day. He stated, "It is a way of

life for me, my life; it is my body, and I will do as I please. I am an educated man and understand the effects of both on my health. I am 63 years of age. I will never probably be as old as my neighbors, but I have lived the way I wanted and will continue to do so."

Mr. H2's apartment is very sparsely decorated; he tells me that he sold everything after his wife died. He has tried to pick up odd pieces and make them work. He stated that he is not into the house at all, and all he cares about is the microwave. If it were not for the microwave, he would not cook or eat. He showed me around the kitchen and is very proud of his wine rack hanging from the ceiling. He told me that he drinks more than a bottle of wine a day. He said that he is awake about 18 hours a day, and either a wine glass or a cigarette, or both, are in his hands at all times. Mr. H2 stated, "I have always enjoyed my wine and cigarettes, and my wife did, too. His final words to me:

> "I would say have fun, enjoy life, make yourself happy in what you do, do what makes you happy regardless of what people say. It is your life, and you must live it. Work hard, and play even harder. Spend money like crazy and enjoy it, because you can't take it with you when you die."

Mrs. L3's Story

Mrs. L3 is an 83-year-old Caucasian woman who has lived in the center for more than 15 years. She is a very thin woman, with short grey hair and glasses. She was dressed in khaki pants and a turtleneck and was wearing New Balance walking shoes. She sat with her legs crossed during the entire interview and swung her foot slowly back and forth as she talked. Most of the time, she kept her hands loosely grasped together and cupped over her knee. She was smiling and maintained eye contact at all times. She was very friendly and relaxed, and had an air of confidence about her. When she laughed, she

leaned all the way back against the couch and laughed loudly. She is an outgoing woman at ease with herself and displays much self-assurance. She was not in any hurry to finish either of the scheduled interviews. When I observed Mrs. L3 during a potluck gathering, she exhibited leadership qualities and social skills while talking with the other participants.

Mrs. L3 graduated from high school and married her high school sweetheart. She has two children who live locally. She moved into the center after her late husband died 15 years earlier. She was a housewife and raised her two daughters. She has always eaten a well-balanced diet. Mrs. L3 drinks plenty of water daily and says she never goes to bed full. She eats a light supper and feels this helps her to sleep well. This routine has been her lifelong habit, and she raised her daughters the same way. She is still responsible for all holiday meals for her family; the apartment is so small that she resorts to placing a tablecloth on the floor so that everyone will be able to eat at the same time.

Mrs. L3 has always been very active and continues to walks 3 miles daily, rain or shine. She also lifts 1-pound weights daily. She does not watch TV and reads about five books per week, making weekly trips to the library to pick up new books. She attributes her good health to being blessed and being happy with who she is.

Mrs. L3's apartment was decorated in blue, with a couch, recliner, and footstool, which held her weights. Her kitchen was spotless, with blue valance curtains. Her bedroom had a bedroom set with a blue bedspread, pillows, and curtains. Her apartment was very organized, with numerous family photos all over. She said she likes blue because it is soothing. Her final words for me were:

> "Life is good and has been good to me. I am a happy person, lucky to be healthy, and my husband treated me like a queen. Look at life as a gift, and you will treasure it, and always look on the bright side of things. I am a positive person, a very active person, outgoing person, and always thankful for my blessings. I appreciate my life. I am living better than most, and I remind myself daily of this. I do not have much money, but don't need it. I am blessed."

The Context

The commonalities of childhood experiences, deceased spouses, God, and children form the context of this study for all of the participants. The context provides a framework for understanding the participants, their experiences, and their behavior (Patton, 2002). The context of this study was derived by analyzing data from the interviews, demographic data, and the participant observational data.

Childhood

The participants were asked to recall their childhoods and to talk about growing up. Most of the participants recalled childhood memories of positive and pleasant times of country-style living on a farm. Mrs. G3 commented:

> I was raised on a farm, very simple. Daddy and Mama lived on a farm. We had gardens to eat off of, and Daddy worked the fields. He grew a lot of corn and soybeans for our income. Very simple country life, lived off of vegetables from our gardens, and Daddy killed our meat from deer, hogs, and cows. Oh, and chickens too. We lived a country life.

Most of the participants felt that their parents were hard workers and had provided the best life possible for them. They felt their parents had wanted a better education for

them so that they could pursue a more lucrative career than farming. One participant, Mrs. L3, reported:

> My father was a farmer, a hard-working man, a honest Christian man, and treated all people with respect. We had enough; we were not rich, but not poor as some. He saw that we got a education. We [her sister and brother] all went through 12th grade. My father could of worked us all on the farm; he worked very hard to get things done by his self and let us go to school. Most of the children helped in the fields; I knew we were lucky to go and get educated.

A few participants commented that there was a connection between living on a farm and suffering from limited food and conveniences, but most centered their discussion on what they characterized as the good Christian child-rearing they had received from their parents.

Spouses

Two participants never married. The other 28 participants had long-term successful marriages and were currently either a widow or widower. There were no divorces in this sample. Many of the women had lost their spouses at a very young age for reasons ranging from a car accident to a sudden heart attack, and they remained widows for the rest of their lives. They simply did not want to replace the wonderful men they loved and chose to not remarry or date. Mrs.D1 stated:

> My husband died at the age of 50 years old; I have lived 42 years alone. Church of Christ believes God gives you one husband, and you don't go around with other men. A lot of people say he is dead, but a marriage is done in the eyes of God, and today in the eyes of God he is still my husband and always will be. We

> were married under the vows of God. So I have been alone for a long time now. Even if I had divorced, he is still my husband in the eyes of God. You cannot remarry. You are given one husband, one husband only by God.

Another participant commented on not remarrying and waiting to be rejoined with her husband in heaven. Mrs. J4 stated:

> My husband was a wonderful man; he died when he was only 55 years of age. We never argued, and he was the best-natured man you would ever meet. My best friend left me. We were best friends, I loved him so. I thought I would die, too. But he is waiting on me. I know him, he will wait for me. It has been over 35 years now. I never remarried or even wanted to. You know he had tall shoes to fill, and I know no one could ever fill them. I did not want to marry; I was his wife and wanted it that way. It would take away his memory. I meant for him, I want to be with him, no other man, here or in heaven.

One participant reported an unhappy marriage in the latter part of her 50-year-long marriage; her husband came home one day and asked for a divorce. According to the participant, this was a surprise because she had thought that their marriage was fine. This was the only participant in the study who felt her marriage had failed. However, her husband died before the divorce was final. There were no reports of mental or physical abuse from any of the participants. All participants spoke of their late spouses with kindness and love, and the majority referred to their spouses as waiting for them in heaven; one gentleman made reference to his late wife during the entire interview as his "sweetheart."

God

The study was conducted in the "Bible Belt," region of the United States, where the Protestant religion is a significant part of the Southern culture, and Christian church attendance across all denominations is extremely high. All participants had a religious background and recalled attending church services multiple times per week growing up; they have continued to attend church services faithfully. All of the participants voiced their faith in God, their close spiritual relationship, their need to read and hear the word of God on a daily basis, and their belief that with prayer, anything was possible. The participants prayed on a daily basis, and some even prayed each hour of the day. Several participants reported reading the Bible from front to back each year. All participants reported living for God, feeling blessed, and having a strong, close relationship with God.

Children

Twenty-six participants had at least one child; 4 participants did not have children. The participants who were parents felt that their children had their own lives to live; they did not want to be a burden to their children and wished the best for them.

The involvement of the participants' children varied. Although some children were able to stop by daily for a visit or to go shopping, others lived out of state and were unable to visit as often. One participant reported that she cooks lunch every day for her daughter who comes by from work. All comments about children were positive, and the participants spoke with pride as they discussed their children's careers and their much-anticipated visits. All participants who were parents were happy they had children and felt blessed by them.

Chapter Summary

Chapter 4 summarizes the demographic characteristics of the participants, provides narratives from a subsample of participants, reports participant observational data, and describes the context in which participants lived their lives. The narratives provide the reader with an introduction to the lives and experiences of these rural older adults who live in a senior living center.

CHAPTER 5

FINDINGS AND INTERPRETATIONS

In Chapter 5, the themes, subthemes, and interpretations derived from the qualitative data analysis of the ethnographic data are presented. This research was guided by three research questions: (a) Research question one: What are the barriers to health-promoting behaviors in the rural older adult?; (b) Research question two: What are the health promoting behaviors in the rural older adult?;(c) Research question three: What qualities facilitate healthy aging in rural older adults? and (d) chapter summary. The findings are presented according to these three key research questions.

Research Question One

Research question one was: What are the barriers to health-promoting behaviors in the rural older adult? The literature reports multiple unhealthy behaviors among older adults, including poor nutrition, lack of physical exercise, and perceived difficulties in aging (Dean & Sharkey, 2011; Kennedy et al., 2004; Souter & Keller, 2002; USDHHS, 2002; Vitolins et al., 2007). I developed the interview questions to acquire information about the barriers to health-promoting behaviors in rural older adults and their life experiences in a rural environment. Two themes emerged from the analysis of their responses to this question: (a) bad habits and (b) difficulties in aging. The themes and subthemes appear in Table 2 and are described in detail in the following section.

Table 2. *Themes, Subthemes, and Participant Quotes for Research Question One*

Research Question One	**Theme**	**Subtheme**	**Participant Quote**
What are the barriers to health-promoting behaviors in the rural older adult?	Bad habits	Alcohol, and tobacco	I have smoked my entire life.
		I eat whatever I want.	You are not going to want to hear what I eat.
	Difficulties of aging	Health issues	My health is shot.
		Stress	So I guess my health is my stress right now.

Theme One: Bad Habits

The theme *bad habits* describe the indulgences that the rural older adults participated in on a daily basis. This theme was divided into two subthemes: (a) alcohol and tobacco, and (b) I eat whatever I want.

Subtheme: Alcohol and tobacco. Four participants reported smoking; of these, 2 reported also drinking alcohol throughout the day, and 1 reported dipping snuff. These participants tended to have unhealthier behaviors overall and more negative attitudes about health and aging. Smoking, particularly, was cited by 4 participants as a behavior that they believe contributed to their (usually poor) health, and although these smokers generally acknowledged the detrimental effects of smoking and expressed regret about having compromised their health, all of them were unwilling or unable to quit because of the importance of smoking as a ritual, as an addiction, and for comfort. For example, Mrs. A3 noted that her lungs were damaged and that she feared her condition would result in eventually having to move to a nursing home. Her husband had passed away with much suffering from smoking, yet she continued to smoke. Reflecting on her life as a smoker, she stated:

> My lungs are gone, completely gone. I smoked my entire life, and I guess you can say I am paying the price now with bad health. Last year, I was in and out of [the] hospital so much, they said I should just move from here to a nursing home. But I got better and was able to come back. I have been back here and out of the hospital 1 month now. . . . Not sure how much longer my lungs can breathe for me. My daughter knows I do not want any tubes or breathing machines when the time comes; just let me go on to be with my husband. Boy oh boy did he ever suffer, too. The smoking does a number on you that is for sure. I am really tired right now, and if God takes me, I am fine with it. I have lived a full life. Right now it is hard for me to even breathe (A3, lines 31-52).

She went on to say

> My dear husband suffered so with his lung cancer and all while he was laying there suffering, I continued to smoke and he begged to smoke. It takes your life. It will kill you. If you don't smoke, don't ever start. Take care of your lungs because when you get my age of 84, you will not need the problems that I have with breathing. If you cannot breathe just to do simple stuff, then it makes the day really long and bad (A3, lines 74-79).

Mrs. A3 thus conceded that smoking has jeopardized her health and independence and regrets her decision to begin and continue smoking. Yet, despite this, Mrs. A3 was not willing or able to quit smoking. Another woman also noted the longtime presence of tobacco in her life as a contributing factor to her current poor health. Mrs. G1 said, "I smoke a lot. I smoked myself to death just about, too. I eat at work, I eat at home, smoked and smoked, I watched TV, and got up and done it again" (G1, lines 26 - 40).

One female participant, Mrs. D2, had dipped snuff since the age of 2, reporting that her parents had allowed her to have some to prevent her from crying and so that she wouldn't reach for theirs. She had dipped for more than 70 years, despite her receding gums and loss of teeth. Mrs. D2 noted, "I have done this for a long time. . . . I will die with snuff in my mouth. Bottom line is just that" (D2, lines 15-19). All 3 women seemed resigned to the presence and consequences of tobacco in their lives; despite their acknowledgement of its detriments, they admitted they were powerlessness to change.

Drinking alcohol was another bad habit cited by 2 participants, along with tobacco, as a behavior that may be unhealthy but was a part of their lives and not subject to change. Mr. H2 spoke of his drinking and smoking as relieving his stress; although he worries about his health in the future, he has continued to indulge in smoking and alcohol. He explained:

> There is not anything out there that a good glass of wine won't make it go away [laughs]. I have some stress with living here. Not my ideal place really. Thought this would be a good move for me, but [it is] really dead. I stress about my meals, microwaving stuff and wishing I was in a five-star restaurant eating a good big lobster with a big glass of wine. Really do miss my life. I worry about my health. I know I should not probably smoke as much as I do, but I am bored and walk around about 18-19 hours a day with one in my hand. I drink too much too I know (H2, lines 49-50).

Mr. H2 reported enjoying a "nice glass of wine" with a meal in the past with his wife. He said he drinks a bottle of wine a day, mostly "from boredom." Although he acknowledged that smoking and drinking alcohol were not good for his health, at 63, he

is one of the younger residents. He doubts he will achieve the longevity of most of his neighbors, but he was quick to comment that he had lived the life he wanted, regardless of the health status he now suffered:

> I have used every body part I have to the fullest. I done what I wanted and did not care of the consequences and done it anyway. So now my body is gone at the age of 63 years. I drink and I smoke way too much, but so what? It is my body, not the doctors', not anyone else's. Most people might not agree with me. I done what I wanted and I have not one regret, not one regret. One should do what they want with their life and their body (H2, lines 54-60).

Despite awareness of the negative effects of his actions, he sees himself as an empowered agent of his own health status. He continues his patterns of drinking and smoking due to addiction and his boredom.

Although most of the participants who smoked or drank explicitly cited these behaviors as impacting their health status, Mrs. G4 did not refer to her past and current heavy smoking or alcohol usage as a contributing factor to her poor health today. She reported:

> I have always been tired and weak. I had four children and had to take care of them. There was always work to be done, I worked really hard as a mother and wife then. I have never had a good life. I was overworked. I had four children back to back and then I cared for each one of them, 24 hours a day. . . . I have never had a good life, or a good time really. I feel my health suffered because of all of this. I don't remember a time when I felt really good (G4, lines 70-75).

Although this participant was a smoker and a drinker, she felt that being a mother

of four children had caused her poor health and lack of satisfaction with life, rather than attributing these circumstances to her alcohol or tobacco use. Mrs. G4 seemed depressed during both scheduled interviews and reported her smoking and alcohol usage as excessive. She spoke in a monotone voice and never smiled throughout the entire interview. She smoked the entire time and reported that she was drinking before I arrived for both interviews.

Despite knowledge of the ill effects of drinking alcohol in excess and smoking cigarettes, the participants continue to take part in this behavior. Some participants agreed that these behaviors were adversely affecting their current health, as well as their past and future health outcomes, yet they were adamant about continuing to use tobacco and alcohol due to boredom, past habits, and addictions.

Another addictive substance cited by respondents as a "bad habit" was caffeine. One participant drank coffee as a replacement for meals. Some used coffee as a way to start the day or to relax. In the same way that others described smoking or drinking as a daily ritual, for Mrs. E3, coffee is an essential part of her day to the point that it replaces a meal.

> Well I usually get up about 8 am and drink coffee. I drink a lot of coffee. I love coffee. Do you? I have always drinked a pot all day long. I like it black. I don't like breakfast; I usually don't eat breakfast. Like about, well, I guess 10 or 11, I might eat me a piece of bread or maybe toast it, or I have been known to eat a few crackers. That is so my medicine doesn't burn my stomach. My stomach has acid in it and it burns just about every day (E3, lines 30-32).

Subtheme: I eat whatever I want. Participants who cooked for themselves followed healthier diets, but they also felt better about their food choices than those who ate out or ate packaged food. By contrast, those who snacked or chose to eat frozen, quick meals seemed to overeat or eat more non-nutritional, high-calorie foods. Some participants with diabetes struggled with following the diet prescribed to them, and some resented either following the diet or being made to feel guilty about not following it. Some diabetic participants were aware of the importance of adhering to a diet, but did not follow it because they did not like the diet or found it to be overly bland. Others tried to follow the prescribed diet but had difficulty doing so:

> I know I could at times eat better and do better, but it is hard when you love the food so much. I was raised eating these foods, and I cooked these foods for my kids, and I still want these foods. I have tried to cut back on salt; my blood pressure is really high (A2, lines 42-45).
>
> I love fried chicken. I was raised on fried chicken. Everybody here eats fried chicken down here in the South, and of course, cornbread. That is what bothers me the most, is trying so hard to eat healthy foods now (D1, lines 65-67).

For these two women, their past eating habits made it difficult to follow a diabetic diet, although they are aware that they should eat differently, and they attempt to restrain themselves. Mrs. B2 values her dietary autonomy over any prescribed lifestyle:

> I eat usually something quick. I eat frozen dinners a lot. I tried to drink milk with them, but I am not a big milk drinker. I really don't care for fruit, either. I like pie a lot. My daughter keeps me with pies. I have always liked sweets better than anything else. I have been a light eater my entire life. I might eat a piece of cake

> or pie with a cup of coffee all day long. This is how I have eat[en] my entire life. I love sweets the best (B2, lines 39-44).

Mrs. E3 described her diet this way:

> Well, you are not going to want to hear what I eat. For I don't eat much at all. I do more drinking coffee all day than anything. I don't like breakfast, never did. I take my medicine in the morning with bread, and I might eat some crackers and peanut butter late in the afternoon. I just don't get hungry. I like to drink my coffee mostly and usually like my cigarettes, too. Guess you saw my cigarette cases on the kitchen counter top, and I know you are probably thinking she shouldn't smoke. The whole world is mad at us smokers; sometimes, I wish they would get a life and leave us alone (E3, lines 39-45).

Mrs. E3 reported drinking coffee and having a cigarette as a habit of her past, and she has always been a light breakfast eater.

Mrs. G1, who was obese, described her lifelong coping mechanism: "Well I ate. I ate myself silly" (G1, line 40). She described her current diet:

> I eat corn chips; boy, do I love corn chips. The salt taste so good on them. They have got to be my favorite. I am a chip eater, always has been my entire life. As I said earlier, my body weight has always been heavy (G1, lines 37-40).

These five women represent a continuum. Mrs. A2 and Mrs. D1 struggle with following a diabetic diet because of their historic preference for unhealthy foods. Mrs. B2 and Mrs. E3 are not ready or able to change due to historic eating habits, and Mrs. G1 falls in the middle, acknowledging the adverse health effects of her preferred foods but lacking the willpower to change her eating habits due to her food addictions and using

chips as her lifelong coping mechanism.

Theme Two: Difficulties of Aging

Difficulties of aging emerged as a theme from participants' reported medical issues of diabetes, heart disease, and high blood pressure. The findings within this theme are presented as two subthemes: (a) health issues and (b) stress.

Subtheme: Health issues. The participants saw their illnesses as a hindrance to their lives and felt burdened by having to take certain medications and adhere to specific diets, such as low-salt, low-cholesterol, low-fat, and diabetic diets. Some participants felt that their health conditions had negatively affected their aging process. Illustrating this attitude is Mrs. G4, who reported:

> Well I would not know, for I do not have good health. I have worked hard [all] my life and took care of four kids. My health is shot. I am overweight, my joints hurt, my kidneys are bad, I have diabetes, and I have to eat particular foods, which are impossible. Good health is something everyone wants to have. I have bad health, so I don't know what it would be like to be this old and have good health (G4, lines 70-75).

Mrs. K1, who stated that she would rather die than give herself insulin injections, expressed grief in her voice, while frowning throughout the entire interview:

> I am a sick person. I have diabetes. I smoked the majority of my life, and I am paying for it now. I take metformin for my diabetes now. Health should be good, something one looks forward to having. Unfortunately, my health is not the best. Health and getting older is not what it is cracked up to be. I am sick with diabetes, and there is nothing I can do about this. Hard to believe I am going to have them

> until I die. Bad health is something that no one wants to get, and I hope you don't get it. It keeps you down and out all the time. I am trying to adhere to the diet for diabetes, which is horrible. No sweets, and all this information about carbs, white foods, white potatoes, you might as well go ahead and die. I am sick to dead [death] of buying food with all labels marked Carb Balance or Carb Smart. I am sick of this, really I am. I am sick, I am a sick person. I have an incurable disease (K1, lines 40-58).

Both of these participants exhibit a sense of misery and powerlessness or fatalism about their diabetes, which they feel has doomed them to a difficult aging process and a monotonous diet. Mrs. K1 stated numerous times throughout the interviews her desire to just die if her diabetes progressed to the point of her needing insulin injections instead of her current oral tablet. She spoke mostly in a monotone voice, with evident sadness. She stressed that, for her, taking the injection would be a sign that her condition was worsening. It was not fear of the needle or the injection itself that bothered her, but the reason she would need it is what upset Mrs. K1 when asked about insulin.

Subtheme: Stress. I asked all participants about their sources of stress and how they cope with it. Characteristic responses included that poor health was a source of stress, and "bad habits" were often used to deal with stress. One participant, who reported having grave difficulty daily with the act of simply breathing, but continued to smoke (including throughout the interview), said that "her smoking habit was key to alleviating her stress." She attributed her stress to being in poor health, but smoked to lessen the stress:

> The only stress I have right now is my health. I am sick. I fight to breathe every

> day; some days are worst than others. I hate it, but what do I do? I ask the doctor last week, when am I going to die? We would smoke and eat our sweets, and thought we were all right and watch the news. You know, you don't think about the damage you are doing when you smoke. I am living proof, hon, don't you ever smoke, you hear? (A3, lines 43-46).

Despite realizing that smoking was the source of her health problems, and even warning me not to smoke, she was unable to quit.

Summary

Analysis of research question one (What are the barriers to health-promoting behaviors in the rural older adult?) revealed the themes of bad habits and difficulty in aging. Some participants found it difficult to maintain positive health promotion behaviors or lacked the desire or the ability to adhere to a healthier lifestyle. The data suggested that participants were knowledgeable about healthy behaviors. Those who engaged in unhealthy behaviors either made a personal decision to continue them, or they had been unable to quit or change due to past habits or addictions. Dietary preferences were also seen as a barrier to adhering to a healthier lifestyle. The majority of participants reported that food choices were a personal matter, and some continued to eat foods that would compromise their health because these foods were part of their desired diet. Some participants reported that eating patterns were a way of life or a component of culture and background; some said their eating habits were based on conveniences, whereas others stated that eating in general was difficult for them due to their lack of hunger. Numerous respondents cited health as a source of stress, especially those who had been unable to make changes to follow a healthier lifestyle.

Research Question Two

Research question two was: What are the health-promoting behaviors in the rural older adult? I framed the interview questions to draw out the data related specifically to life experiences and events related to health-promoting behaviors. I asked the participants to share their life stories related to their behaviors in the past, as well as their present behaviors. The participants who felt that they were healthy took pride in their personal image and appearance, and this phenomenon extended to the appearance of their homes.

Among the participants, a positive attitude about health and aging seemed to be almost as important as actually being in good health. Many participants felt that being satisfied with one's life and choices represented a healthy mental status, despite being in poor physical health. In some cases, having made the decision to engage in healthy behaviors, such as cooking their own meals instead of eating out or eating packaged food, was an important source of satisfaction (independent of the outcome of such decisions).

Rich data unfolded on the importance of rural older adults having and keeping their independence as the primary motivation for living. Attitudes toward health and medications were also an important factor. Most participants accepted medication as part of their daily routine, with few emotional issues attached to it, but this was not always the case. The majority of the participants exhibited self-control in their diets, their health management, and their general outlook on life. Most participants expressed a strong faith in God and reported that through prayer, they were exactly where they wanted to be. The findings shaped a single theme: Being in control. The theme and subthemes are noted in Table 3 and are described in detail in the following section.

Table 3. *Themes, Subthemes, and Participant Quotes for Research Question Two*

Research Question Two	**Theme**	**Subtheme**	**Participant Quotes**
What are the health-promoting behaviors in the rural older adult?	Being in control	Appearance and self-image	I dress nice, and I want to look nice.
		Attitude and outlook	Aging is what you make it. We can embrace it or fight it.
		Eating for health	I try my best to eat good.
		Independence	I try and go somewhere every day, if it is only to the grocery store.
		Medication and treatment	Of course I take my medicine.
		Self-care	I took care of myself, and it pays off.

Theme One: Being in Control

Most participants felt that being in control was of utmost importance in the aging process. Most expressed gratitude for having the ability to continue to do as they desired, and they felt blessed. Participants reported a general set of self-care behaviors that promoted healthy aging, framed around six subthemes: (a) appearance and self-image, (b) attitude and outlook, (c) eating for health, (d) independence, (e) medication and treatment, and (f) self-care.

Subtheme: Appearance and self image. One participant reported that dressing nicely, putting on make-up, and fixing her hair contributed to her having a healthier outlook on life. Taking pride in her personal appearance seemed to enhance her feelings of well-being and boosted her attitude for the day. Mrs. J4 reported:

I like dressing nice. I have always dressed nice where I go. I want to look nice. I

> stay in shape. It makes me feel good, if I look good. I will fix my hair and put on my make-up (J4, lines 38-39).

Another participant, Mrs. B3, felt that getting dressed for the day in more stylish clothes, such as jeans rather than a muumuu, made her feel better about herself and motivated her to be active:

> I am happy for the way I look. I have worked hard to look this way, and I just did not stay this way from eating those cookies and watching soap operas. Most dishes at the apartment potluck were mashed potatoes with a pound of butter, butter-and-fat-seasoned vegetables; whew, those will do a number on your cholesterol, not to mention your muffin roll above your jeans (B3, lines 95-99).

These women maintain healthy self-esteem by dressing for the attitude and lifestyle they wish to have, rather than "letting themselves go" because they are getting older.

Subtheme: Attitude and outlook. Aging was viewed by many as something we all must undergo. It was seen as a process that one cannot change or be rescued from. Most of the participants viewed aging as a stage in life that all humans will pass through, but *how* they pass through it is affected by their outlook on life. Most saw their lives as positive, and they were happy to be alive. The majority of the participants (n = 25), felt blessed to be in their current state of health, because they knew it could be worse when compared with neighbors or friends diagnosed with a terminal illness.

The participants spoke of a lot about hard times in their past, ranging from losing their spouses to losing a child, yet still reflected on their lives with a positive outlook during the interview process. One participant lost her soul mate of more than 50 years and her only son only 1 year apart, yet was able to have a positive outlook. Mrs. J4

courageously stated:

> We should be positive about living our lives and being alive. I have always looked toward the bright side of everything, regardless how bad my heart was hurting. There is a reason for everything, my dear. One must remain positive. If I wanted to, I could do a pity party; my husband, my best friend, the love of my life died abruptly and left me. I could of went off the deep end then, took up drinking and smoking, but I remained positive and put my faith in God (J4, lines 90-91).

Like Mrs. J4, many participants discussed staying positive despite difficult times and what maintaining a close relationship with God meant to them. They reported looking for the good in everything, knowing that you are blessed, and appreciation for what one has in life. For example, Mrs. G1 said, "Be right in your heart with God. [I advise you] to be positive and always have a good outlook on life, not to give up when things don't fall like you think they should" (G1, lines 63-64). Mrs. J2 said, "I know I am blessed and owe my life to the Lord. Without Him I would be nothing. I have always put God first and will do so until I am dead" (J2, lines 27-28).

Mrs. L3 responded with a powerfully wise comment when asked about why she believed her beliefs and good habits had contributed to her positive outlook. During a potluck gathering, I noticed her positive attitude; she laughed throughout the evening and made a point of talking to every person there, holding eye contact, touching and holding on to the arms of others, and taking an active part in the set-up and clearing of the dishes. She also laughed throughout the interview and exhibited a positive attitude in her body language and how she spoke. She stated optimistically:

Please always be thankful for what you have, be thankful you are here and healthy. Be thankful for your family. Be thankful you are able to walk and work, and always take good care of your body. It will get to old age; if you don't take care of it, then you will suffer with the body not holding up the way you would like. Think good, be good, and do all good things, if you can. I feel I do good things, then it comes back to me, and I have always tried to do the best I could with everything, and I believe I am receiving awards now in my late life. I am not perfect, but I never did any one wrong, never did anything wrong to someone, never was unfaithful to my husband, never treated a soul ugly, and tried to look the other way when someone was ugly to me. I am not perfect, but I have really tried my entire life to be a good person. I know I am fortunate and blessed. I have taken care of my body, dear. I never hurt it, never put anything bad into it, not even once, and I hope that I live a lot longer for this. I live to walk and be out there in the fresh air. I walked in the rain, you know; you can feel the rain hit your face and know that all is good. All is good. Look at life as a gift, and enjoy it while you have it. I am a firm believer that you need to look at the bright side of things, be positive or life will just eat at you until you are a hard-crusted person. Those people never are happy and find something wrong with a perfect situation. That just eats at them until they are nothing. Don't let yourself be caught up in stuff you cannot change. It is not worth getting a gray hair over it [laughs]. Life is good. There is something every day to be happy about, focus on it, and your life will be blessed (L3, lines 83-98).

Subtheme: Eating for health. One of the most successful health promotion behaviors cited by participants was adhering to a healthy diet. Most responded with comments about eating from the garden, making sure to eat plenty of vegetables and fruits, watching fat and calories, cooking and preparing their own foods to avoid or reduce salt intake, drinking plenty of water, and eating modest portions. Mrs. J4 reported,

> "I cook healthy foods and try and only eat what I cook. Eating snacks and eating quick grabs will get you in the gut in more ways than one (J4, line 39).

Participants were aware of the importance of the nutritional value of the foods they consumed and reported watching caloric intake to maintain a healthy status. Mrs. L3, stated:

> I cook and eat as healthy as I can. I eat a salad everyday usually. I really enjoy vegetables, too. I would not say I am a vegetarian, but I do prefer vegetables and fruits. My lunch meal is usually my main meal; I eat very light for supper. I don't like going to bed full, and I don't sleep good at all. I tend to sleep better if I have not eaten a lot before bedtime (L3, lines 36-39).

Likewise, Mrs. E4 reported:

> I eat tuna salad or just a salad for lunch. I eat a good hot meal every night. I am not a snacker. I eat vegetables steamed, no grease and no oils, if I can help it. I really eat exactly what I need for my diabetes. When you are a diabetic, you need to watch what you eat (E4, lines 37-39).

Like Mrs. E4, many participants with the diagnosis of diabetes were quick to elaborate on the importance of adhering to a recommended diet so they could manage the disease with oral medication rather than insulin injections. Mrs. A1 said:

> I try and eat a good breakfast. I know that meal is supposed to be important. It is especially important since I am a diabetic. I try and not snack. It makes me gain weight and I try and watch my weight for my diabetes" (A1, lines 31-37).

Similarly, Mrs. D1 explained:

> I have been a diabetic for at least the past 10 years now. I cook my meat in the oven, and steam all my vegetables. I try and eat right. I cannot eat fried anything. At first, it was hard. Now I bake my chicken with Shake and Bake, and you cannot tell the difference now. It was hard at first at the age of 82, but I told myself I will not become on dialysis, and I have tried to do my best. I want to live longer. I am only 92 almost 93 (D1, lines 27-31).

Diabetes, for these participants served as a primary motivation for following a healthy diet. However, as noted earlier, some participants resented the diet or medications associated with diabetes. Thus, some participants viewed diabetes as a call to action; others viewed it as a life sentence.

Acknowledging this difference in attitudes, participants who were committed to diabetes management through diet were confused as to why their diabetic neighbors would eat such unhealthy foods, knowing such behavior would exacerbate the disease. They were eager to discuss the poor choices of their neighbors and their desire for their neighbors to do better. These participants stated that they would never partake in such unhealthy habits themselves, even without diabetes. One woman elaborated:

> They abuse themselves with drugs, alcohol, and eating unhealthy and then wonder why they are in the shape they are. I have neighbors that are diabetics, and they eat chips and all sorts of food that I would not even eat without having diabetes.

> Doesn't make any sense to me. They are always down and out because of this disease (J4, lines 81-89).

For participants who deliberately followed health-promoting behaviors to manage their diabetes, this participant found it incomprehensible to compromise one's health in the way she felt that some of the other residents with diabetes did.

Another common health problem among participants was high blood pressure. Similar to the diabetic participants who modified their diets, Mrs. C1 proudly detailed the changes she made to her eating habits to control her blood pressure:

> I try and use turkey burger meat if I want a burger. If I eat bread, I try to eat whole grain bread. I really try and eat like I am supposed to. I do have really high blood pressure and avoid salt like it was the plague. I fix all my meals myself. Well, I watch my salt; salt will kill you or so I have heard and read (C1, lines 21-23).

Diet thus served as a critical effort for participants who were committed to actively managing their health conditions. These participants realized that maintaining a diabetic and antihypertensive diet takes willpower; they reported daily efforts to control their diabetes and high blood pressure through carefully thought-out meals each day. The participants felt their motivation to adhere to their healthy diets came from support and encouragement from neighbors with similar health problems. However, several participants felt their diet was simply beyond their capacity to control.

Subtheme: Independence. Overwhelmingly, the participants had strong feelings about being able to care for themselves and to remain independent. Independence manifested itself in being able to get out of the apartment (e.g., for shopping), keeping one's own house clean, and preparing meals. Participants were proud, even to the point of

boasting, when reporting that they still had their private vehicles to use for their errands: When questioned about using her own vehicle and continuing to drive daily, Mrs. J4, age 93, stated proudly:

> Yes, it is right out there, outside in my own parking spot. I still drive myself to Wal-Mart and to church. I run all my errands too, pay my bills and whatever else I need. I drive to the beauty shop. I just go when I want; I know I am lucky to have a car still at my age [laughing] (J4, lines 57-59).

Another participant, Mrs. G3, not only bragged that she was still driving at the age of 87, she compared herself with Methuselah in the Bible, in that he was 969 years of age when he died, and she felt she would be just like him and still driving. She laughed on and off when she said:

> I use that car just about every day. It is that little red Dodge car out there in front. I still do okay with my driving. I just ask my oldest son the other Sunday, do you think I am getting too old to drive, and he said "Mama, you will know when you are no longer safe You will start to worry about driving and maybe hitting someone. Until then, you will be fine." So I still drive every day wherever I want to go. I am very safe and take my time. I go to Wal-Mart every day. I drive myself and enjoy doing so (G3, lines 33-37).

Mrs. E3, age 74, was among several of the participants who continued to drive and own their own vehicles. The ownership of their vehicles and the ability to drive was very important to these participants, in maintaining their independence. Mrs. E3 said:

> Oh yes, I drive myself everywhere. My daughter works, and like I said, if I need her, she would help, but right now I don't need her for anything. I am just fine

> going to appointments; I am just fine buying my own groceries. I want to. It gives me something to do during the day, and she has her own life and family, too (E3, lines 26-28).

For these particular older women (aged 74-93 years), vehicle ownership and the ability to drive daily represented a key piece of their sense of independence.

Other participants did not seem to focus on owning a vehicle as an important aspect of their independence; rather, their focus was directed toward the act of getting out for various activities. Mrs. A4 was very eager to report her daily social excursions, and the mere act of being able to get out of the house on a daily basis was worth more to her than owning a vehicle. Leaving the center regularly provided Mrs. A4 with a critical lifeline to the outside world, enabling her to continue outside contact, even while living in a senior apartment center. She emphasized the importance of dressing up and actually leaving the apartment every day for a few hours as a manifestation of her independence:

> I love shopping. I like to go and get out. I try my best to go somewhere every day. I will go to the grocery store or just Wal-Mart, but I like to look at all the stuff [laughs]. I talk and enjoy their company. I enjoy others and being with others. I guess you could call me a busy body. I have always loved to go-go. I like to be with people. I like dressing up and going out. I am very independent and had my own car. I am a very active person. I would get my hair done one day, the next day I would get a manicure. I know most of the cashiers at the grocery store and of course my hairdresser. So I just talk to them and enjoy listening to their stories about their family or their kids or just the weather. I have always wanted to be out with people instead of home (A4, lines 50-56).

Other participants highlighted the importance of maintaining independence within the home, such as by continuing to keep the apartment clean, tending to their plants, or even just living alone independently. For example, one participant said, "I do my own laundry. I do pretty good with folding too. I go to all the functions here at the center. I cook my own meals every day, and try and keep the house clean" (H4, lines 24-26). Another said:

> I stay active in my apartment, I cook, and clean. I get out on Sundays. I attend church services every Sunday. I get out with my children and buy groceries from Wal-Mart. I try and stay active that way, but I don't walk (A1, lines 42-45).

The activities provided by the apartment complex also offered participants an opportunity to leave their homes, even if they were not venturing out into the community. One participant identified some of the opportunities that were available: "We have bingo; we have pot luck, and boy do the neighbors look forward to potluck. I try and go as much as I can" (J2, lines 12-14).

These examples highlight how those who did not have their own transportation or who might have more difficulty getting out due to their physical condition had opportunities to exercise independence and take pride in self-sufficiency. A potluck is held at the center every week, and each person is asked to bring a dish. During this time of fellowship, the participants eat and mingle with all the residents from the center. This event is a regularly scheduled activity on the same day and at the same time each week. Participants reported looking forward to this event, and they had a sense of independence by preparing a dish for all the neighbors to share and by walking down to the center

clubhouse. Many reported enjoying the fellowship more than the food, and it is a time to socially interact and catch up on the weekly "gossip."

Some of the participants who viewed themselves as healthy older adults were eager to tell stories about how they had been healthy and had had wonderful lives, stressing the importance of independence, a positive attitude, and self-care. Participants described a valuable setting in which they were able to care for themselves due to their good health, which in turn led to more independence:

> I am able to care for myself, I have my mind, I have my health, I have my family, and I have the most wonderful gift of all, I have God on my side. When you write me up in your paper, I want you to emphasize that no one helps me, that I still have my mind at almost 87 years old, that I'm thankful for God and my church, and I have taken the best care of me that I could (G3, lines 48-50).

Subtheme: Medication and treatment. Most participants reported that they viewed taking their medications as part of their daily routine, without any emotional issues attached to it. Taking medication is a routine, but an important, health-promoting behavior for participants with long-term conditions and an easy way to feel in control of their situation. The participants were adamant about the importance of adhering to their medication regimen for successful health management. According to one participant:

> Of course I take my medicine. I take digoxin for my heart. Now I take stool softeners if I need it or maybe a Tylenol if I have a pain or headache, which is rare. But if you are asking me about a prescription, my heart medicine is the only thing I take regularly (J4, lines 35-39).

One female participant used oxygen as prescribed on daily basis, despite her comments about wishing she did not have to use it. She stated that she had delayed starting this treatment for as long as she could, but ultimately had to accept it and stated:

> I find it confining. I just hate using the oxygen, but it has come to this I guess. The smoking destroyed my lungs. I now need oxygen, and I will be limited in what I do. The tubing in my nose drives me crazy. But it has come to the point I must wear it all the time now. I have put it off as long as I can (A3, lines 76-79).

She delivered the last sentence with a smile, as if to acknowledge that she had done her best to manage her condition without this intervention. She had had some resentment around the need of oxygen, but seemed to have accepted it as a necessity. Like the other participants who must take medications described earlier, it is now part of her daily life, and she continues to use it.

Subtheme. Self-care. Some participants reported attempting to take good care of themselves through diet, exercise, and a positive attitude. They proudly detailed their efforts and outlook. Mrs. J said:

> I took care of myself, and it pays off. I always ate good, slept my 8 hours, used the best of creams on my face, and really honestly, do not feel old. I believe it has paid off here in the end (J4, lines 65-71).

Mrs. E1 provided the following advice when discussing her health and independence:

> Stay healthy and do as the doctors tell you. Second, take time to rest. I can still take care of myself, and that is so important to me. I want to stay independent and take care of myself (E1, lines 76-78).

With much optimism in her voice, Mrs. L1 stated that good health was possible in the presence of a chronic illness, such as her diabetes,

> Just because you a diabetic, you can still be in good health, you know? You can still be in good health even though you have this; just take care of yourself, eat good, take your medicine, keep active, and above all talk to God about it. I do this every day. I feel I am in good health (L1, lines 43-45).

Attitude and intention were crucial to these participants' self-image. It was not just important that they were healthy, but specifically that they had done what they could to ensure their own health and view themselves as healthy individuals.

Participants were very positive when they spoke about the aging process, acknowledging that we all must age, but emphasizing their belief that one must progress through the aging process gracefully, with acceptance. Several participants used symbolic language to describe their attitudes about aging:

> One gets older, but one does not have to look like a slob, act like an old woman, or think she is. I am taking care of my temple, just like God tells us to do. I pamper it like a temple. I pray about everything, give it all to God, to be positive, to take care of your body, eat right, exercise, and be happy with your decisions (B3, lines 65-67).

Another participant said: "I have always done what people tell me. I exercise and eat right. You need to put yourself on your to-do list, and follow through. Always eat right, exercise, and be happy" (L3, line 82).

One participant compared the body to a machine:

> You cannot abuse something and expect it to hold up forever. Take care of your body; treat [your body] as if you treat a machine. It has to last you for many years. Only feed it healthy food, drink your water, and take care of it. I have tried to do the right thing all my life, and I do believe it has paid off. I am a very healthy old woman these days, with very little complains (J4, lines 65-71).

By treating the body as a "temple" or "machine" and deciding to "put yourself on your to-do list," these older adults take a primary role in ensuring their health and longevity.

Summary

Analysis of research question two (What are the health-promoting behaviors in the rural older adult?) revealed the single theme of being in control. Participants shared their life stories and experiences of health-promoting behaviors. Many participants demonstrated knowledge related to healthy lifestyles and took pride in expressing the ways they had treated their bodies well throughout their lives.

The interview questions were framed around the life stories of the rural older adults to reveal a deeper understanding of *why* some rural older adults adhere to health-promoting behaviors and *what* behaviors are seen in this particular group of rural older adults. Analysis of the data indicated the importance of being in control, a theme that surfaced in discussions about personal appearance and self-image, attitudes and outlook, diet, independence, medication and treatment regimens, and self-care habits. The rich data on this theme showed enthusiastic sentiment from the participants. Most participants were content with themselves and carried themselves with dignity and pride, and saw getting older as a process of which they were in control. They expressed pride in the

ways they had taken care of their bodies and advised the researcher to treat the human body as a machine and keep it running adequately with healthy food and exercise, and emphasized the importance of remaining happy and positive. The majority of participants enjoyed their independence and was content with the way in which they were aging. However, a few participants had a more fatalistic attitude about their capacity to be in control of their health. Even for them, being in control (i.e., their *inability* to be in control) mattered very much.

Research Question Three

Research question three was: What qualities facilitate healthy aging in rural older adults? The interview questions were directed at identifying the respondents' current health-promoting activities, their past health promotion behaviors, and their approach to everyday health decisions. The findings pointed to two themes: (a) keeping busy, and (b) peace and acceptance. The themes and subthemes are noted in Table 4 and are described in detail in the following section.

Table 4. *Themes, Subthemes, and Participant Quotes for Research Question Three*

Research Question Three	**Themes**	**Subthemes**	**Participant Quotes**
What qualities facilitate healthy aging in rural older adults?	Keeping busy	Friendship and community	I enjoy others and being with others. I talk and enjoy their company.
		Hobbies/TV	I read some, I knit and crochet some, and I watch TV some.
		Physical activity	I am an active person; I am not one to sit all day.
	Peace and acceptance	Attitude and outlook	I wish for nothing, I want for nothing, and I am happy to be here.
		Family and love	I have enjoyed my life, especially with my husband.
		Content with my choices	I would not do a darn thing differently.
		Religion	I leave it with Him, and He will carry me through this.
		Sleep	I sleep good at night.
		Stress	You can't change it anyway, so why stress?

Theme One: Keeping Busy

Most participants reflected on their lives with stories that incorporated past relationships with friends and family, certain hobbies that they participate in on a daily basis, and the importance of taking part in a form of physical activity (however minimal it may be for these rural older adults). The participants felt that keeping busy was the key

to growing old gracefully; they embraced activities that filled the day; they thrived on meeting, gathering, and having fellowship with one another; and they valued living in an environment with conveniences that enhanced the ability to get out and around more easily. This theme contains three subthemes: (a) friendship and community, (b) hobbies/TV, and (c) physical activity.

Subtheme: Friendship and community. The more social older adults overall had more positive attitudes (and in many cases, better subjective assessments of their health) than those who did not enjoy regular connections with either friends or family. Mrs. G2 exemplified this attitude: "I just get out and visit or walk through stores, anything to keep me moving and going and most of all living. I like to be out with others. It keeps you alive to talk to others" (G2, lines 27-30). Similarly, Mrs. A4 said, "I enjoy others and being with others. I talk and enjoy their company" (A4, lines 49-50).

For some, social connection was incorporated into other activities, such as church, medical appointments, and shopping. Mrs. A1 was happy to report, "I get out on Sundays. I attend church services every Sunday. I get out with my children and buy groceries from Wal-Mart" (A1, lines 43-45). Church meals, along with gospel revivals, were also another way to socially interact with others. Mrs. A4 stated:

> I like having church suppers and meeting new people at our revivals. I like to entertain and be with people. . . . I have dear friends. They will take me to appointments or wherever I want to go. I talk and enjoy their company (A2, lines 48-50, 79-80).

Finding ways to be in the company of friends and family enabled these participants to maintain a positive attitude and reduce isolation. The center provided

social activities scheduled at the same time each week, so that participants would be able to attend numerous gatherings, including potlucks, bingo, shopping trips, sightseeing trips, and religious meetings. Participants reported looking forward to socializing within the community of fellow neighbors. Having a fixed activity schedule enabled them to attend the activities regularly by permitting all outside appointments to be scheduled at other times.

Most of the participants were happy about living in this community center for older adults. The majority felt that living in the center was a blessing, full of modern conveniences compared with country-style living. Safety was another concern of some of the participants; they felt that living in an apartment was the best thing they could have done after the death of a spouse. Mrs. J2, for example, explained:

> I love living here; the neighbors are wonderful and kind. I have never regretted moving into town. Things are easier here. Getting to town, going to church, and even shopping, and I have made wonderful friends who watch out for me. In the country, this would not of happened. We have group gatherings, and I really enjoy this closeness of all of them. We have bingo, we have pot luck, and, boy, do the neighbors look forward to potluck. I try and go as much as I can (J2, lines 12-14).

Living in this community enables Mrs. J2 and her neighbors to have easy access to socialization, providing an important support for them as they attempt to continue independent living.

Subtheme: Hobbies/TV. Simply having something to do, whether it was knitting, reading, Bible study, or shopping seem to help the older adults' moods and attitudes. Some participants preferred TV to social interaction.

Participants described diverse motivations for their TV practices. Mrs. A2 said, “I do watch a lot of TV now, though. I got me a big flat-screen so I can see it just fine. I watch TV all day long now” (A2, line 41). Mrs. E4 keeps the TV on for background noise. She explained, “The TV stays on nonstop usually. I have the TV on for noise mostly. I may glance up once in a while to see what is on, but I do a lot of listening to it too” (E4, line 62). Mrs. D2 continues the TV-watching pattern from when her husband was alive:

> My husband and I were big TV watchers, so I just keep on watching TV by myself. I usually eat in front of the TV; I am a big TV watcher. So I may sit here for hours until noon and watch all sorts of shows before I even eat. Then I make myself lunch and head back to the recliner and watch more TV (D2, lines 31-32).

Whether it offers a voice to keep them company, a lifeline to the outside world, or a way to remember good times with a departed spouse, TV played an important role in keeping these participants happy. Only one participant used a computer to fill her time during the day, instead of a hobby or watching TV:

> So I sit at the computer and play games mostly. I would say that about 99% of my time is sitting in front of the computer. I watch very little TV, but I like the computer a lot. That is my day; sounds boring, I am sure to some, but it is what I want to do, and I do what I want. I like card games, mostly solitaire. My late husband and I played a lot of cards in our lifetime. Those were really good times, playing cards and having a smoke [expressed with much grief in a low monotone voice] (K1, lines 73-76).

The computer was Mrs. K1’s entertainment. She did not participate in the activities

available at the center, stated she preferred to be alone, and frowned throughout the interviews. When asked about her social isolation, she stated that she had always been a loner and preferred her computer to the neighbor's gossip.

Some participants had numerous hobbies, either in addition to or instead of TV, such as reading, knitting, and crocheting. Mrs. L3 was an avid reader:

> I go to the library every week and check out five books. I read these five books in 1 week, and then I go back the next week and get some more. These are not your little paperbacks. I mean, like 300-page books. I usually get them at the library the same day of the week. I pretty much have a schedule, I guess. I like action or mystery; I get involved in them and cannot put them down. I do not watch TV at all; I have one, but do not like watching it at all (L3, lines 40-44).

Mrs. E4 used her quilting and crocheting talents to make items for her church:

> I make afghans, I make quilts, and I make dish cloths and baby blankets. I give them all to the church. For the needy, I give them all away. I sure don't need them. I alternate all day long. For a while, I will crochet, and then I will knit. I do this every day all day long (E4, lines 63-66).

Engaging in hobbies, whether it is watching TV, using the computer, reading, or doing crafts, provided ways for these participants to stay busy, kept their days full, and offered an organizing structure for the day or week.

Subtheme: Physical activity. Being physically active is seen as an especially important health-promoting behavior for these rural older adults. The most common form of physical activity was walking, although some participants also included housework, dancing, or lifting weights in their activity routines. Participants who did not exercise

tended to report never having been the type to exercise, even prior to aging. The following 2 participants laughed as they described their daily walking routines:

> I walk a lot. I have always been a walker. I walk the university track across the street when the weather is warm; sometimes, I walk back and forth right here in my apartment if I cannot get out. I go daily to Wal-Mart, and what would we do without Wal-Mart? I walk the store; I walk and walk the store. So I walk for my physical activity. I am a active person. I am not one to sit all day (G3, lines 35-38).
>
> I walk every day about 3 miles. I do not miss; I even walk in the rain. I like walking in the rain, especially if it is not a cold rain. I lift weights daily, too [hand weights, about 1 pound each, were on her footstool during the interview]. I have walked my entire life. It has warded off the stress, you know. Most of the time, I am the only old woman on the track; I meet kids running or walking with their music on. I like seeing them. I like watching them run past me and think some days ago I could do that. They cannot believe I am 83 years old. It makes me happy to get up and get out and see the people on the track. I walk rain or shine. I do not miss walking; if it is slick or there is a snow, I walk in place inside my house. I look forward each day to getting my shoes on and getting out on the track to walk. I walk 1 mile at a time, come home, and then I will go back later for another mile. I usually end up walking 3 to 4 miles (L3, lines 38-48).

Walking provided these women with both physical activity and a daily routine. Another woman preferred dance as her physical activity for a variety of reasons:

> When my husband was alive, we danced. We danced every single day of the week. We danced and danced. That was our exercise then. Now I don't have a partner, but boy do I try and move to the music. . . . We went out and danced; we went to ballrooms and danced. He was such a good dancer and always worn a dress suit. He looked so handsome in his dress suit and dancing. There is not one dance we could not do, too. We danced until he died; we loved to dance. You know, dancing exercises the whole body. . . . I have never walked much. It bores me. I like the faster life. I had rather watch the dance shows and stand up and try and keep up (J4, lines 44-47).

Mrs. J4 preferred dancing to walking because it is more active, but it also provides her with an opportunity to continue a ritual she associates with her husband, enabling her to keep his memory alive. She also used shopping errands and staying involved in the center's activities to stay active, similar to another participant who found ways to stay active outside of traditional exercise routines:

> Well, I don't exercise like you see in the gym. But I do walk a lot in the grocery store and shopping. I walk a lot, too. I walk daily to the center's lounge for bingo, church, or even potluck. So I may not lift those weights you see on TV, and I don't run outside for exercise, but I do really try and keep moving all day long (A4, lines 42-44).

In addition to those who explicitly articulated nontraditional exercise as a form of physical activity, others reported that although they did not have a history of exercise, they nonetheless engaged in inherently active behavior, such as housework, physical labor, and caring for children:

> No, I never exercised really. I mean, I stayed busy taking care of my kids, washing and hanging clothes out to dry, cooking and cleaning, keeping grass out of the garden, canning, and I even helped my husband cut up our meat for the smoke house. I stayed busy with four kids, but I did not exercise (G4, 35-38).
>
> I try to move as much as I can. I do try to move about each day. I never exercised in my younger days; I didn't have the time to exercise. With four kids and a husband, I was lucky to sleep at night (G2, lines 27-30).

Mr. J3 stated, "I worked all my life digging ditches, really hard labor, too, especially on your hands and back. I dug ditches for a living, ditches for big pipes and drains" (J3, lines 31-32).

Whether participants engaged in conventional exercise such as walking or incorporated exercise into other tasks such as gardening and whether they considered their activity exercise or not, engaging in some form of physical activity represented an important health-promoting behavior for most participants. Even though reported activities from some of the participants were not aerobic, the participants felt that their daily movements benefited their health status.

Theme Two: Peace and Acceptance

This theme includes six subthemes: (a) attitude and outlook, (b) family and love, (c) content with my choices, (d) religion, (e) sleep, and (f) stress. These subthemes are often interrelated; for example, whereas life satisfaction and reflections on successful aging are tied up in family life, such as having had a loving marriage (or not) and having close relationships with children, a positive attitude helped participants to make the best of difficult family situations. Those who exhibited positive attitudes (and, generally,

engaged in health-promoting behaviors) were content with their choices, and participants used the opportunity to reflect on how they would not change their decisions at all if given the opportunity. Also, getting adequate sleep seemed to be a point of pride for those who felt they were successful in self-care, and fatigue was cited by some of the participants who followed an unhealthier path as a major difficulty of aging. Participants with positive attitudes, even if they might have been in difficult situations, generally stated that they did not have stress and had to be probed numerous times to admit any difficulties. Finally, although participants did cite a variety of coping mechanisms, the main approach to handling personal stress was through prayer. All of the participants were religious to some extent.

Subtheme: Attitude and outlook. The participants who reported high levels of happiness seem to adapt to change and to accept the aging process. Despite illness, limited income, and losing dear loved ones, the majority of the participants found something positive to be thankful for on a daily basis. Many of them focused on what they had and were quick to note that their situation could be far worse. One participant, who was devastated after losing her husband after 50 years of marriage, reported, "We should be positive about living our lives and being alive. I have always looked toward the bright side of everything, regardless how bad my heart was hurting. There is a reason for everything, my dear" (J4, lines 90-91).

One participant realized that life could be worse for her compared with others' struggles. That knowledge kept her going and allowed her to accept the life she had with more gratitude. She reported, "I want to remain positive, but at times, it is hard for me. I

know, though, it could be worse, that is the only, and I mean the only, reason I am able to stay positive" (G1, line 73).

Many participants were very friendly and laughed through the interview process. They were at ease with themselves and had a calm gentleness about them. They smiled and reflected a positive attitude toward life in general. When probed about stressful events or something they would change in their lives, they stood by their positive comments; they felt as if their lives were blessed, and they did not want to change anything about past, current, or future life events. This attitude was exemplified by the participant who stated, "I wish for nothing, I want for nothing, and I am happy to be here" (J4, line 93). Other participants explained their inspiration for staying positive: "[A positive attitude] is a gift from God, a truly gift from God. People say all the time they are lucky. Well '*lucky*' is not found in the Bible; it is a blessing, and we must not forget this" (G3, line 40).

Other participants stated:

> I can do the best I possibly can, or I can go to bed. I choose to eat healthy all day long and to take care of myself the best I can every day. No one wants to be sick or have a disease, of course not, but unfortunately, there is something wrong with us all; we all have something wrong with us that we really wished we didn't, but if we take it and make the best of it each day, that it is all God expects from us. To be the best, and do the best, and always do the right thing. I could say I wish I did not have diabetes, but I would not say that, for it could be far worse than diabetes; it could be cancer. Just remember the grass is not greener on the other side, only different. Do not wish for someone's life, for they have problems and issues too,

> just different. And most likely are worse. We often wish for a different life, but you must be very careful when you wish for something, you might just get it and be very sorry. So I do not ever wish for one thing differently, not one thing (E4, lines 80-85).
>
> Well, young lady, life is what you make it. Let's face it. Life is going to be lemons sometimes. You can crawl up and die or you can make the best of what you have. I don't have a lot of money, but if you want good to come from your life, then you have to look for the good in your life. My body parts no longer work the way they did before. They don't work the way they did before because they are heavy and wore out from all the experiences and wisdom they are now carrying. This is how I look at getting older now. You must embrace this process (A4, lines 57-60).

Attitude and outlook were important features of successful aging among participants. Regardless of financial situation or health status, what mattered to many of them was their positive outlook on life. No matter what struggles they encountered, they looked for the good in every situation. Most realized that life could be far worse and remained positive in the face of life's events. They indicated that they were happy with their station in life and wanted for nothing. They knew life was not always going to be perfect, yet still remained positive.

Subtheme: Family and love. Family life was mentioned numerous times when reflecting on life satisfaction. For some, family life included having a loving marriage, for others, a close relationship with their children. All participants spoke of *love*, whether it was for their immediate and extended family, for God, for their church families, for

their neighbors and friends, or for themselves. The word *love* was a common thread among all participants and was mentioned in some manner in virtually all of the interviews.

Participants spoke of the enduring joy they receive from contact with their children and the continual role of being a mom made them feel alive when around their children and preparing a meal for them. They expressed the love they have of cooking for their families, their pride in being able to prepare the food, and the importance of the family gathering together, whether on a regular basis or on special occasions:

> I cook a big lunch every day, so I get started fairly early because my son will be here today, just about 12:10. It is the same time every day. He eats and is back to work by 1 o'clock. Then I clean the kitchen and dishes after he leaves. I never do the dishes while he is here. We talk and talk more, you know. I look forward to this so. I cook home, cooking for him too (L1, lines 24-29).
>
> I still cook every single Sunday meal; not sure what my boys will do when the good Lord takes me home and I am 87 years of age. They just think they want to come to mamas and eat Sunday dinner. This is a tradition that has gone on for since they were born. Every Sunday dinner was always special to them (G3, lines 22-24).
>
> I am 83 years of age, and my daughters tell everyone no one can cook like my mama. I look forward to family days. I spread a tablecloth on the floor and who can get down and eat does, and who cannot get to sit on the couch. My apartment is small, but I look forward to preparing the holiday meal each year. I have done this since I moved in here, for space is an issue here. I prepare the entire holiday

> meal; I do it all and would not have it any other way. They want mama's cooking, even though they are grown, in their 60s and more. I am a fortunate person, for I am able to sit down there too, if I like (L3, lines 60-67).

Being able to continue caring for their families by preparing food gives these women a sense of dignity, purpose, and connection, even when they no longer live with their children. They take pride in the popularity of their cooking, and their identity as mothers remains strong, even in their older age.

By contrast, one participant spoke of the strength of her family life, despite and in the face of *not* being able to be a mother. With tears in her eyes, Mrs. E4 recalled:

> We tried to have children. I was pregnant twice; actually, both were tubal pregnancies. The first pregnancy was not as bad as the last one. I will never forget the pain, I remember like it was yesterday. The second time, I almost died that time; the left tube busted inside of me before they could do surgery to remove my tube, not like the first time when they removed the right tube. But I made it and lost all my female organs that time. Nowadays, I could of been fertilized and probably been okay to bypass my tubes. Doctors were not sure why the baby stopped in my tubes each time; some thought maybe they were too small for the baby to pass on to the uterus. So we knew we would never have children, and I guess that is when we knew it would be just us. I did not think about it for some reason. It was God's will. It was God's will for us not to have children. I have enjoyed my life, especially with my husband. I have heard from thousands of people, you don't have children, oh how awful. God planned for me not to have children, I would not change that, it was God's plan. I think to myself some of

> those people who had children, and they didn't know where they were or what they are doing, or have not seen or talked to their children in years. Just having children is not what matters; it is having love for others. So many people are focused on the fact of just having children; it is far more than that. I don't have children, but neither do they. They don't see them, they are in trouble, or worse yet, locked up in prison. Some people focus more on the act of having a child, not actually the blessing with really having a child. I never really understood that. I trust in God, I believe in God that miracles do happen, give it all to God, and always give with your heart. Remember, God has a plan for all of us; remember to accept the plan and not question God. Love you husband with all your heart. He is your best friend in the world (E4, lines 49-59).

The themes of family and love were experienced by all participants, whether this *love* was focused on their spouse, children, friends, or God; each one had a life story to express about relationships. Family and love were shared by all, with different perspectives; however, they all had a common feeling of loving and wanting to be with family. The need to be a part of a family, whether family meant immediate members, extended members, or close friends, was expressed by all participants.

Subtheme: Content with my choices. For those who exhibited positive attitudes (and, generally, engaged in health-promoting behaviors), there were very few regrets, and participants used the opportunity to reflect on how they would not change their decisions at all if given the opportunity. The majority of the participants were content with the life choices they had made, felt as if life could always be worse, and were grateful for their situations, preferring not to think about wanting for something

different. One participant said, “I would not do one darn thing different” (A2, line 90). The following quotes demonstrate that some were afraid to wish for something different for fear of making their lives worse than their current status; even those with diabetes or high blood pressure were grateful that they did not have cancer, for example:

> I would not do one thing differently. Really don’t see how I could improve my life. I have been blessed by the almighty God in so many ways. I have my health, really good health to be as old as I am. I still drive, I am still sane, and I still get out each and every day. Not sure what else I would ask for, you know. I am a positive person, an outgoing person, and a happy person. I would not start to tamper with a thing, you know (G3, lines 62-63).
>
> Well, sweetheart, not sure I would change one thing right now. I would be afraid if I did, my life would be worse off. You know, the grass is not greener on the other side; we all seem to think it is. We all wish for that other side, but once we get there we would realize it is not any better, just different. I don’t want to change a thing, not one thing. My life has been good compared to most, I always had a job. I worked hard all my life. I did right by wife and family. I was never in trouble with the law. I never cheated on her. I was a good man; I tried every day to be a good man. I am a country man who lived a country life. So there isn’t anything to really change (E1, lines 69-72).
>
> I am not sure I would do anything differently really. Sounds crazy to you, I am sure, for me to say this, but I am blessed, and I would be afraid if I done it all over or wanted to do it differently, I would be worse off than I am right now (J2, lines 54-55).

Subtheme: Religion. Everyone interviewed was religious to some extent. The majority of the participants still were very active in the church and spoke of the importance of attending religious services for worshipping, revivals, and gospel singing. Mrs. G3 said, "I am religious. I attend church regularly; I don't miss a service, or a singing, or a revival" (G3, line 14).

Participants spoke highly of their church families and valued the time they spent with them. Although some of them no longer attended the church they raised their families in, they did attend the senior center's services regularly. All participants spoke of God in some manner and had strong faith, as illustrated by the following responses:

> I read my Bible. I have read the Bible all the way through every year (G2, line 14).
>
> I leave it with Him, and He will carry me through this. I am very religious and love the Lord. I am there for all services. I would not miss it for the world. Without God, none of us would be here (A4, lines 48-50).
>
> I have been blessed. Cannot forget the big man in the sky; he is responsible for it all (J2, line 42).

Their statements revealed that with prayer, they were in touch with God and confidently believed their prayers were answered.

Subtheme: Sleep. The participants who reported getting adequate sleep spoke with a sense of pride about their rest and a sense of personal responsibility around this health-promoting behavior. Most of the participants reported taking naps or resting during the day as well to promote a healthier lifestyle and recognized adequate sleep as an important factor in maintaining health. According to one participant, "I usually go to

bed by 8 o'clock, but I do get up early. I want to get up and read the Bible before the rest of the world is awake. This is my quiet time" (J2, line 38). Getting adequate sleep was important to the participants and was viewed as a positive health-promoting behavior by all of the participants. Most of them realized the importance of sleep and tried to ensure they received enough sleep on a nightly basis. Mrs. J4 said:

> I sleep in usually. I get about 8-9 hours of sleep. You know they tell you if you don't sleep you actually gain weight now. I never slept less than 8 hours in my entire life. Sleep is good for you, your heart needs this time to rest. I have read studies where adequate sleep also helps with your stress and helps your immune system. I make sure to get my 8-9 hours of sleep (J4, lines 29-31).

Participants who did not get 8 to 9 hours of sleep per night spoke of the importance of resting or napping during the day to help fight fatigue from lack of sleep. Mrs. G3 described her process:

> I rest. I take time out each and every day to rest without any distraction at all, deep breathe, and just rest. Something like meditation. I guess I am not sitting in that yoga position or humming or anything, but I am just sitting quietly (G3, lines 43-44).

Subtheme: Stress. Participants generally reported that they did not have stress. I had to ask probing questions to encourage participants to disclose any difficulties. After numerous prompts, some participants cited some specific stressors but quickly noted that this stress was handled through prayer:

> I am not stressed at all. If I am stressed, I usually don't worry about it. You can't change it anyway, so why stress. I just hope that God takes care of it, and He will.

> So I don't deal with stress, I let God deal with it, and He will take care of it. A human cannot change things, only God can (E3, lines 53-56).
>
> I really don't have a lot of stress at this age. Really I don't. I live each and every day to the fullest. You know God does not promise us tomorrow, so I take one day at a time (G2, lines 37-41).
>
> I pray a lot and leave it all to God. God does not put on us more than we can stand. Sometimes you think you are going to crumble, but you continue to walk. Then you realize your strength and what you can do (G2, lines 37-41).

Stress was noted among very few participants and, as demonstrated by the above quotes, the resolution to their stress was prayer. The participants felt that with prayer and God, stress would be resolved. The participants felt that it was not necessary to worry about things that a human cannot change, and found consolation in letting their worries go to God, for they felt that with prayer their stress would be alleviated.

Summary

Analysis of research question three (What qualities facilitate healthy aging in rural older adults?) revealed two themes: (a) keeping busy and (b) peace and acceptance. Participants shared personal life stories about the importance of family, their community, church, and keeping in touch with everyday living experiences. Many of the participants focused on keeping busy with their hobbies or with a daily physical activity regimen. Maintaining an active lifestyle was important, regardless of the mode of movement or the amount of exercise possible for the rural older adult. Physical activity was defined by many participants as being able to move about, being able to stand and walk in place, cleaning house, using the vacuum cleaner, or gardening. Physical activity meant being as

active as possible, given an individual's capacity. Participants felt that some movement was better than none; many seemed to rely on daily housework chores and gardening as their means of remaining active. However, several made a substantial commitment to regular fitness walking. Many participants understood the importance of being physically active and engaging in aerobic activity for its health benefits.

Another frequently noted theme was the subject of peace and acceptance. The majority of participants was content in their choices in life, and despite numerous attempts to probe participants about their stress, most denied having any or did not dwell on the stresses they did have. Most exhibited contentment with their station in life, and all of them demonstrated a strong overwhelming sense of spirituality or religious belief; they found refuge in prayer and released their worries to God.

Chapter Summary

Chapter 5 presents findings from ethnographic data analysis, guided by three research questions: (a) What are the barriers to health-promoting behaviors in the rural older adult? (b) What are the health-promoting behaviors in the rural older adult? and (c) What qualities facilitate healthy aging in rural older adults? All research questions were answered, and the results were presented by themes and subthemes in response to each research question, using participants' own words and life stories as supporting evidence for the analytic findings.

CHAPTER 6

SUMMARY, CONCLUSIONS, AND EPILOGUE

Chapter 6 consists of six parts: (a) a summary of the findings; (b) comparison of the findings with the relevant literature; (c) strengths and limitations of the study, (d) the findings in relation to Pender's HPM, (e) the significance to nursing and recommendations; and (f) the epilogue.

Summary of the Findings

The goal of this study was to explore and describe the health-promoting behaviors of rural older adults living in a retirement community in West Tennessee. Analysis of interviews and observational data provided answers to the three research questions posed in Chapter 1.

Research question one focused on the barriers to health-promoting behaviors in the rural older adult. Only five of the participants in the sample indicated that they experienced substantial barriers to health-promoting behaviors due to smoking, excessive alcohol use, and dipping snuff. Some participants also felt there were barriers to maintaining a well-balanced diet for reasons ranging from a lack of desire for food to personal food choices or, in a few cases, possible food addictions.

Research question two focused on the health-promoting behaviors themselves. For these rural older adults, the theme of being in control revealed distinct subthemes, such as attitude and outlook, eating for health, independence, following through with a medication regimen, self-care, and even one's appearance and self-image. Being in control was viewed as a critical aspect of health promotion. Most participants expressed a

desire to remain independent and yearned for a productive, self-sufficient life. Many participants viewed a productive independent life as simply being able to care for oneself.

Research question three focused on the qualities that facilitated healthy aging in the rural older adult. Healthy aging was viewed as participating on a regular basis in hobbies or physical activity and maintaining core values, including family and love, religion, friendship, and community. Nearly all participants were able to draw strength from these activities and values. Participants found great strength in prayer, giving their troubles to God, and in their church and church families. Most participants had interpersonal bonds with immediate family members, extended family members, friends, and church families. They all expressed love for these chosen and biological family members, and most felt that they were blessed with their current health. Most participants remained positive regardless of their health status, and most tried to focus on the good things in their lives at all times.

Comparison of the Findings to Relevant Literature

The findings of this study highlight three areas of importance related to health-promoting behaviors in rural older adults: (a) unhealthy barriers, (b) being in control, and (c) healthy qualities.

Unhealthy Barriers

A strong theme revealed in this study was unhealthy barriers to health-promoting behaviors among a few participants. Some participants reported chemical dependencies, such as tobacco and alcohol use, well as poor diet choices. Some participants felt that due to these unhealthy barriers, their health had suffered greatly. Yet, they continued these

unhealthy behaviors, whether from addictions, personal choice, or difficulty in changing longstanding habits.

It is well documented that good nutrition is influential in creating and maintaining a healthy lifestyle. Nutrition is clearly a factor in determining the quality and perhaps the length of life (Smeeding, 2001). Bailey et al. (2007) explored the concept of good nutrition and eating healthy foods as an aid in maintaining an ideal weight. Good nutrition can reduce the incidence of certain diseases associated with aging, such as diabetes, heart disease, and osteoporosis, and can reduce the duration of treatment and recovery from illness.

The expanding older adult population is very susceptible to nutritional risk. Age-related chronic disease can potentially be prevented, delayed, or ameliorated by nutritional interventions (Bailey et al., 2007; Smeeding, 2001; Zulkowski & Coon, 2004). Inadequate nutrition has a pronounced effect on the older adult and can result in excessively high or low body mass index and inadequate energy, which are associated with a decline in function and the ability to thrive (Marshall et al., 2001; Souter, & Keller, 2002).

Research literature suggests that older adults' poor nutrition may be caused by various factors, such as lack of transportation and financial issues (Arbuthnot et al., 2007; Bailey, 2004; Bushy, 2000). However, participants in this study all had access to grocery shopping and did not have financial issues to account for inadequate nutrition. The analysis demonstrated that their food choices were knowledgeable and based on personal preferences. For example, some did not like to cook; they felt they had cooked their entire lives for their families and now preferred frozen dinners to save time. Others had

eaten unhealthily their entire lives. A few were picky eaters and had just a few choices of foods to choose from on a daily basis. These are all personal choices rather than situational barriers, such as transportation or financial issues.

Tobacco use is well documented as one of the leading preventable causes of death and disability in the United States and worldwide, and contributes to the health disparities experienced by some racial and ethnic minority groups. Tobacco use is a substantial contributor to morbidity and mortality in the United States and worldwide (CDC, 2003; WHO, 2008). Smoking is responsible for more than one in five U.S. deaths. About half of all regular cigarette smokers will eventually be killed by the addiction (CDC, 2003; WHO, 2008). Smoking is directly responsible for more than 90% of chronic obstructive pulmonary disease (COPD; i.e., emphysema or chronic bronchitis) deaths and approximately 80% to 90% of lung cancer deaths in women and men, respectively. COPD is the fourth leading cause of death and is predicted to become third by 2020 worldwide (CDC, 2003; WHO, 2008). Smoking reduces an individual's normal life expectancy by an average of 13 to 15 years (WHO, 2008).

Four participants in this study continued to smoke, and one participant dipped snuff, despite in the harmful effects of tobacco on their health status. All of the tobacco users were knowledgeable about the dangers of tobacco, but they believed that they had control over their bodies and that it was their choice to continue. They also reported no desire to quit or cut back and believed that nonsmokers should not interfere with their right to continue to smoke or use smokeless tobacco. They realized their addiction was a cause of ill health, but they either had no desire to quit or had tried and been unsuccessful.

Another barrier to health-promoting behaviors in older adults is excessive alcohol use. Two participants in this study drank alcohol in excess on a daily basis. Literature on the subject indicates that alcohol use is on the rise among older adults. About one-third of alcohol abuse in older adults occurs as a result of the stresses and losses associated with aging, such as loss of a spouse, retirement, isolation, and chronic illness (USDHHS, 2010). In the other two-thirds, it is a continuation of a lifelong pattern that may have been marked by periods of greater or lesser drinking. Alcohol or prescription drug abuse affects as many as 17% of older Americans (USDHHS, 2010). It is estimated that as many as 2.5 million older adults in America have problems related to alcohol, and this age group experiences more than half of all reported adverse drug reactions leading to hospitalization (USDHHS, 2010).

Two participants acknowledged drinking excessively. Since moving into the senior center, the social life they were accustomed too had ceased. Both reported drinking their entire lives, usually just socially or with family. However, because of boredom and time on their hands, these participants reported that they began drinking excessively all day long. Nostalgia for their past life with family and co-workers was mentioned by both of these participants during their interviews.

The participants in this study made knowledgeable decisions about living their lives the way they wanted with regard to personal nutritional choices or the use of tobacco or alcohol. Having autonomy is considered not only a state to strive for, but it is a human fundamental right. Making and having personal choices in all health behaviors were important for these participants, because it indicated they were in control of how they lived their lives. Matsui and Capezuti (2008) conducted a study on perceived

autonomy and defined autonomy as the ability to freely make self-directed choices in life. They found that personal autonomy was critical to older adults' quality of life. Fry (2000) found that older adults had clear demands for autonomy of personal choices, being in control, and maintaining independence in their life decisions. Their expectations for future quality of life were also important factors in keeping their autonomy.

Independence and Being in Control

One of the strongest themes to emerge from this research was the importance of being in control. Some of the participants exerted control and maintained their independence by remaining physically active. A few participants walked daily, even in the rain. One went out three to four times a day, walking 1 mile at a time to get in her desired 3 to 4 miles a day. Others walked in place inside the house when the weather was inclement. The majority of the participants asserted the importance of remaining independent and engaging in some form of physical activity as one of the most important factors in the aging process. Some participants were proud of their independence and felt in control because they were able to drive themselves to their appointments and errands.

Others viewed themselves as healthy, independent, older adults who lived their lives with much optimism and by their own rules. Participants felt they were part of the circle of life by taking care of themselves, having good health, and having increased independence. For them, the practice of independence, at whatever level they could manage, was their daily focus for the day, and this allowed them to continue to remain upbeat and follow through on their own personal understanding of independence. Each participant felt that being on one's own was important in the aging process. Independence meant different things for different participants. For some, it meant being able to live

alone and care for themselves. Others viewed it as driving their personal vehicles. Others felt it was just being in control of one's life and making their own decisions, regardless of whether those choices were good or bad, and living with the results. Living life as they wanted and taking ownership of their choices was what mattered.

Being in control had diverse meanings for many of the participants. Regardless of the meaning, all participants desired their own independence, and with their independence came a sense of autonomy.

Healthy Qualities

Another theme that surfaced in this study was the abundance of optimistic viewpoints among older adults. It is well documented in the published literature that a positive outlook is associated with something beyond health and longevity: it is what the older adult values as significant in the quality of his or her life and is rooted in a broader definition of "the good life" in the older adult (Rowe & Kahn, 1997). The idea of a good old age comes from within, when older adults set out to ascertain what makes life meaningful for themselves. Being satisfied with one's past and present life has been shown to be one of the most important factors in healthy aging (Wong, n.d.).The common thread of successful aging for participants, regardless of their age, was that they had a zest for life and a clear sense of life purpose and meaning. The possession of a positive attitude toward life and personal growth in wisdom and spirituality were important aspects of successful aging for participants, as reflected in many of their stories.

Most of the participants in this study believed that staying involved in an active social life was an important element in keeping a positive attitude toward the aging process. Many participants had friendships, had meaningful and positive interactions with

family and friends, exercised as much independence as possible, and actively participated in a variety of social activities. The participants felt that a positive attitude led to a happier and longer life. Those with positive experiences with the aging process tended to be more resilient when diagnosed with an illness and more proactive in managing their health. Many participants emphasized the importance of maintaining a sense of humor, and they voiced optimism about learning to live with changes as part of making a positive choice to stay healthy and active. When individuals feel good about themselves, they want to take care of themselves (Bailey et al., 2007; Crombie et al., 2004;Gorden, 2004;Gregg et al., 2003; Lang et al., 2002; Souter & Keller, 2002; Wilcox, 2002).Older adults who focus on the burden of old age and the decline and failure of their bodies bring a negative perspective that can dominate their view of the aging process, leading to social isolation, loneliness, and mental health decline (Sarvimaki & Stenbock-Hult, 2000).

Many participants who took part in this research had lost their spouse or children, yet maintained a positive outlook and made the decision to not give up. Many felt they had been left here for a reason, believing that it was God's will, and with this certainty, they were able to stay positive. Most participants viewed their health as good, even if they had a chronic disease, and they expressed thankfulness for what they currently had. The majority of the participants felt they were blessed and maintained a strong belief in God and the value of prayer. Many reported that faith, prayer, and looking forward to something "good" was the secret to aging. Trying to always do the right thing, loving everyone, and always giving God all the credit for one's blessings were mentioned by most participants.

Numerous healthy qualities were noted among the participants of this study, such as a positive attitude and outlook, a zest for life, and a sense of life purpose. Having a positive attitude toward life and being satisfied with one's past and present are two of the most important factors in healthy aging, as demonstrated both in extant literature and among the rural older adults who participated in this study.

Strengths and Limitations of the Study

The main limitation of this study was the lack of diversity within the sample. Participants were drawn from a single location in rural West Tennessee. Of the 30 participants, all but 2 were white, and all but 4 were women. All participants were living independently in a community maintained center located in the center of town, with access to all personal necessities. It is possible that having more gender, racial/ethnic, or geographic diversity might have resulted in different findings. For example, rural older adults who continue to reside in truly rural areas with issues of limited transportation or access to services were absent from this sample. Issues of social isolation and poverty also were not addressed in this sample.

Despite these limitations, the study's main strength was the abundance of rich data provided by participants about their life experiences. I was able to conduct two interviews with all 30 participants who resided in the community center. There were no dropouts from the study, and all participants were very happy and willing to share their life stories. The facility was very cooperative in granting me access to the participants and gave permission to attend scheduled center activities. Full access to the community center grounds was granted, and the ability to observe each participant in his or her own personal setting allowed me to observe independent rural older adults in a community

center housing complex. All participants welcomed me into their private space without reservations. Scheduling the interviews was not difficult because all participants were willing to meet at any time of the week.

Pender's HPM

The health-promoting behaviors identified in this study were consistent with the theoretical framework of Pender's HPM in that the participants' attitudes and behaviors were related to their health status. Pender's (1996) definition of health includes the whole person: the individual's lifestyle, strength, resiliency, potential, and capability. The major strength of Pender's definition of health is that it increases opportunities to improve the client's health because it addresses the whole person. Health-promoting behaviors are desired outcomes defined as actions directed toward attaining positive health outcomes, such as optimal well-being, personal fulfillment, and productive living. This framework offered a guide for exploring the motivating factors that directed each of the individuals in this study to engage in health-promoting behaviors. The participants who engaged in positive health-promoting behaviors also possessed motivating factors, such as healthy eating habits, independence, involvement in physical activity, and a positive attitude and outlook about the aging process. Perceived barriers to action are the real and imagined barriers to health behavior change. These barriers consist of perceptions concerning the unavailability, expense, difficulty, desirability, or time-consuming nature of a particular action. Barriers are often seen as mental blocks to undertaking a given behavior. When readiness to act is low and barriers are high, action is unlikely to occur. The perceived barriers identified in the current study with the rural older adult participants included

factors such as personal eating habits, alcohol and tobacco indulgence, and lack of physical activity (Pender, 2011).

Lannon (1997) explored the desire to develop and maintain health-promoting behaviors. Health-promoting behaviors are deeply rooted in cognitive processes and are influenced by the values placed on these behaviors by the individual. Pender (2011) refers to the cognitive-perceptual factors as primary motivating mechanisms. The current state of wellness or illness, the ability to understand the need for change in these behaviors, and the desire to change them are all influenced by the individual's likelihood of making choices about whether or not to adopt a healthy lifestyle. An understanding of how the individual values health and health-promoting behaviors does, however, help to predict who will be more successful at making any necessary lifestyle changes. Individuals who "feel good" are more motivated and likely to engage in health-promoting activities.

Timmerman (2007) explored Pender's HPM with regard to barriers as modifying factors that interfere directly with performing the health-promoting behavior. For example, with the need to decrease fried foods in the diet, if the barrier of lack of desire to eat foods that are not fried is present, then difficulty in making the healthy change will override the healthy behavior due to preferences. Barriers are important predictors of behavior change. More than three quarters of the studies testing Pender's HPM supported the idea that barriers are extremely influential determinants of engaging in the health-promoting behaviors. There are internal and external barriers; external barriers are obstacles present in the environment that make it difficult to change the behavior, such as a lack of access to fresh fruits and vegetables at an affordable price. If individuals have a

low income, attaining these fresh fruits and vegetables would create environmental barriers to seeking a healthy lifestyle change. An internal barrier relates to the individual and relates to an internal struggle to adopt the new behavioral change. Such barriers could be lack of time, lack of motivation, lack of desire, and disbelief that the behavior is a healthy change. Miller (2002) stated that the need to resolve the conflict between one's intellectual self, which will attempt to adopt a healthier behavior (such as eating fewer fried foods) and one's emotional self, which will struggle to maintain the current behavior because of the misleading thoughts and feelings about healthier behaviors (such as feeling deprived of foods one enjoys) is the key to overcoming one's internal barriers to behavior change.

Barriers to health-promoting behaviors are different for each individual. Such differences such as personal experiences and cultural background contribute to what is perceived as a barrier to the individual. However, some characteristics such as hardiness, optimism, and perseverance can also influence the ability to overcome the barriers. Without evaluating the individual and the barriers fully, a health-promoting lifestyle change will more than likely be unsuccessful.

Most participants in this study engaged in healthy behaviors, although a few did not. Those who adhered to a healthy diet as well a healthy lifestyle were proud of how and what they ate. Many engaged in an active lifestyle to the best of their ability. A positive outlook on life and recognizing their blessings, despite any difficulties they may have encountered, were noted among the majority of the participants from this study.

Significance of the Research to Nursing

This study focused on rural older adults in a single, residential retirement community. The study documents their life stories, beliefs, attitudes, and health-promoting behaviors and the barriers to those behaviors. A few participants were at risk for damaging their already poor health because of tobacco and alcohol use or poor nutrition. However, most participants adhered to positive health promotion behaviors. The findings from this research contribute to the knowledge base related to rural older adults and their health behaviors, and can be useful in community nursing practice and nursing research.

Community Nursing

This research study is important for community health nurses working in a rural setting. By focusing on everyday living among rural older adults, the community health nurse can help the rural older adult to engage in more health-promoting behaviors by identifying and evaluating the healthy or unhealthy behaviors seen in the home setting. Community health nurses are able to explore barriers and assist in creating healthy environments. Encouragement from community health nurses in identifying and improving unhealthy lifestyles will reduce unwanted health problems and improve health status among rural older adults, thus improving their quality of life and longevity. However, the ultimate responsibility for one’s health is up to the individual. Medical professionals play an important part but serve a minor role when convincing an individual to make healthy living choices. Individuals must seek to reform their own lives and must develop their own perception of what is healthy. The main focus of Pender's

model is that it puts the responsibility of healthy living modification on the individual, not on the health care professional.

The nature of the community center lends itself to supporting self-help experiences for the community members. With the guidance of a health professional, healthier living behaviors for this community center could include implementing a group smoking cessation class or healthy nutritional classes held in the center's activity lounge for all interested participants. However, when addressing changes to health-promoting behaviors, many factors must be considered, including cultural influences, daily and past habits, and personal choices.

Nursing Research

Future recommendations for nursing research entail further study of the rural older adult at the community, family, and individual levels. Based on the findings of this study, further qualitative research is needed to explore, listen to, and understand the rural older adults' stories, so that the characteristics of their lives will provide the backbone for health-promoting programs to improve their health and quality of life. By uncovering health promotion barriers, the research findings will help aid in not only identifying the barriers but will also lead to the development of specific interventions to eliminate such barriers. As discovered in this study (and supported by published literature), the health promotion behaviors of rural older adults vary widely, depending on personality (Stibich, 2009; Wong, n. d.), attitude, and motivation (More, 2008). Transportation issues may be a common disadvantage factor for the rural older adult in seeking medical care, maintaining contact with family and friends, and shopping for groceries (Bailey, 2004; Dewees, 1998; Friedman, 2004). Continued rural health research is needed, focusing on

eliminating the disadvantages of living in rural areas for older adults; there is also a need to work with policymakers to change limited health resources, such as transportation.

Epilogue

I hear the participants' voices every day, some days more than others. When I pass their apartments on the way to work, I purposefully slow my car down and look at their now-decorated porches. I cannot help but smile, remembering how, during the interview process, they told me that they couldn't wait for summer so that they could decorate their front porches with ferns and birdfeeders and plant flowers in every spot available. I find this moment of seeing the apartments so sentimental: I am happy that the interview process is complete, but I long to visit and feel that warm welcome that I received. They were so receptive and so trusting when I came into their homes. Certain days I visited certain participants, I tried to stay on a schedule, but surrounding neighbors would come and wave their arm high in the sky for my attention, and called out for me to come and see them again. I truly felt welcomed at all times, and knew they trusted my presence. Some days as I drive by the university track, I see women walking the track and wonder if they are doing okay. I remember the pride in the participant's voice as she told me of her daily walks, and even walked in the rain. These participants made a lasting connection with me, I will never forget them. I will never forget their smiles as I entered their homes each time. I will never forget the lasting wave as I walked down the walkway to leave them (they would wave until I was out of sight), their laughter and their trusting souls, how they trusted me and allowed me into every part of their lives. They shared sad heartfelt stories, showed me family photos, and told stories of their children. This dissertation process has given me far more than I ever imagined; I am honored to be a

part of their lives, and I will never forget them. Not ever. I had one participant tell me "We all will get older and our bodies will fail, but remember they don't work the same way they did before because they are heavy and worn out from life's experiences and the wisdom it now carries". I personally will never forget this as long as I live.

While interviewing two participants, I was blessed to have a wonderful prayer prayed for me while collecting my data. They may have seen the weary tired expression on my face, and felt I needed it (which I did). I feel compelled to include both of their prayers in this dissertation. I was truly blessed the day I received these prayers, as well as through this entire process knowing they had prayed for me. This process has changed my life. I admire the inner strength of these rural older adults, and I tell myself that someday I hope to be at least ninety-three years of age, and exhibit their same positive resilience qualities I saw in these participants.

Prayers for Me

One participant crochets dish cloths for newcomers to her church and blesses the individual who receives them. She insisted that I take one the day I conducted her interview. Following is the prayer she prayed for me:

> Dear Lord, please put your hands on this young woman and bless her in all she does. Dear Lord, she is trying to finish up her education with a PhD, and she needs your blessings. Bless her, dear Lord, and give her the strength and know-how to complete this next assignment of interviews. Bless her and her family, who understands to allow her to do this too. Dear Lord, keep her safe in her driving and allow her to get what she needs from all of us. In your precious name,

> Amen. Please use your dish cloth and remember when you get it wet, a prayer is being sent to you.

Another participant prayed:

> Dear Lord, please bless this young woman in all she does, help her with this paper she has to write, and guide her hands as she types up the conversations of me and my dear neighbors. Dear Lord, please bless her teacher and that she may give this young woman an "A plus" on her paper. This poor girl is walking around and talking to all us old folks and trying to figure us out. She has been out on the property for hours and hours, Lord, in the cold weather. Bless her and her family, and all who reads her paper, Lord. She is a nurse, Lord, and sure needs blessings putting up with us, and she is trying to finish her [PhD] nursing degree, and needs your blessings. Amen.

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Appendix A

Human Research Review Committee Consent to Participate

The University of New Mexico Health Sciences Center
Consent to Participate in Research

Health Promotion and the Rural Older Adult

Purpose and General Information
You are being asked to participate in a research study that is being done by Gloria Ann Browning, a doctoral candidate, who is the Principal Investigator, and Cindy Mendelson, PhD, RN who is her advisor. This research is being done to evaluate the health promotion behaviors of the rural older adult living independently in a senior citizen center.. You are being asked to participate because you currently reside in a rural town in West Tennessee in a senior citizen center, are 62 years or older, and you are independent in all manners of living. Approximately 10-30 rural older adult people will take part in this study at the senior center.

This form will explain the study to you, including the possible risks as well as the possible benefits of participating. This is so you can make an informed choice about whether or not to participate in this study. Please read this Consent Form carefully. Ask the investigators or study staff to explain any words or information that you do not clearly understand.

What will happen if I participate?
If you agree to be in this study, you will be asked to read and sign this Consent Form. After you sign the Consent Form, the following things will happen: You will be ask to participate in two interviews each lasting 1-2 hours. Although unlikely, a third interview may be requested if additional information is needed. The interviews will be recorded. The interviews will occur in your apartment in the senior center at a date and time that is convenient for you. During the interviews you will be asked a series of opened ended questions about your thoughts on health and aging. Example of the opened ended questions that may be used in the interview are: Tell me how you feel about the aging process? Tell me what a daily routine for you is like? How do you handle these stressful situations? During the first interview you will also be asked to complete a questionnaire that includes questions that describe who you are and your living situation. The information from this questionnaire will be combined with the information from the other participants and not be used to individually indentify you.

After the first interview is completed the second interview will be scheduled in 2-4 weeks at a time that is convenient for you. This interview will also occur in your apartment. The investigator (Gloria Browning) will contact you by phone to remind you of the upcoming interview a few days prior to scheduled appointment. The second interview will include questions similar to the first interview, but they will be based on the analysis of your first interview and on the analysis of other participants' interviews. During the second interview, the investigator will also review a summary of the first interview to check her interpretation of that interview with you. If additional information is needed the investigator may contact you prior to the close of the study and request and third interview either in person or over the phone.

Participation in this study will take a total of 2-4 hours over a period of 2-4 weeks..

What are the possible risks or discomforts of being in this study?
Every effort will be made to protect the information you give us. However, there is a small risk of loss of confidentiality that may result in private information being known by others.This could cause embarrassement to you if private information became known to others..Every effort will be taken to guard

against this Potential risks are minimum with possible fatigue from interviews, emotional sadness or discomfort during the reflection of past events.

How will my information be kept confidential?
Your name and other identifying information will be maintained in locked files, available only to authorized members of the research team, for the duration of the study. You will be asked to use a false name that you choose during the interviews and any information that could personally identify you will be changed or deleted. Any personal identifying information and any record linking that information to study ID numbers will be destroyed when the study is completed. Information resulting from this study will be used for research purposes and may be published; however, you will not be identified by name in any publications.

Information from your participation in this study may be reviewed by federal and state regulatory agencies, and by the UNM Human Research Review Committee (HRRC) which provides regulatory and ethical oversight of human research.

What are the benefits to being in this study?
There may or may not be direct benefit to you from being in this study. However, your participation may help find out the health promotion behaviors of older adults living in a rural senior citizen center.

What other choices do I have if I don't participate?
Taking part in this study is voluntary so you can choose not to participate.

Will I be paid for taking part in this study?
There is no compensation amount.

Can I stop being in the study once I begin?
Yes. You can withdraw from this study at any time without affecting your services or living arrangement at the senior center.

HIPAA SECTION (FOR INCLUSION IN STUDIES THAT REQUIRE COLLECTION OF PHI)
Authorization for Use and Disclosure of Your Protected Health Information (HIPAA)
As part of this study, we will be collecting health information about you and sharing it with others. This information is "protected" because it is identifiable or "linked" to you.

Protected Health Information (PHI)
By signing this Consent Document, you are allowing the investigators and other authorized personnel to use your protected health information for the purposes of this study. This information may include: your age, and ethnicity and self reported health conditions.

In addition to researchers and staff at UNMHSC and other groups listed in this form, there is a chance that your health information may be shared (re-disclosed) outside of the research study and no longer be protected by federal privacy laws. Examples of this include disclosures for law enforcement, judicial proceeding, health oversight activities and public health measures.

Right to Withdraw Your Authorization
Your authorization for the use and disclosure of your health information for this study shall not expire unless you cancel this authorization. Your health information will be used or disclosed as long as it is

needed for this study. However, you may withdraw your authorization at any time provided you notify the UNM investigators in writing. To do this, please send a HIPAA Research Withdrawal Form or letter notifying them of your withdrawal to:
Gloria Ann Browning of Cindy Mendelson

MSC 0953501
1 University of New Mexico
Albuquerque New Mexico 87131

Please be aware that the research team will not be required to destroy or retrieve any of your health information that has already been used or shared before your withdrawal is received.

Refusal to Sign
If you choose not to sign this consent form and authorization for the use and disclosure of your PHI, you will not be allowed to take part in the research study.

What if I have questions or complaints about this study?
If you have any questions, concerns or complaints at any time about the research study, Gloria Ann Browning MSN, RN, or his/her associates will be glad to answer them at 731-364-2418 or 731-514-0564 anytime. If you would like to speak with someone other than the research team, you may call the Human Research Review Committee (HRRC) at (505) 272-1129. The HRRC is a group of people from UNM and the community who provide independent oversight of safety and ethical issues related to research involving human subjects.

What are my rights as a research subject?
If you have questions regarding your rights as a research subject, you may call the HRRC at (505) 272-1129 or visit the HRRC website at http://hsc.unm.edu/som/research/hrrc/.

Consent and Authorization
You are making a decision whether to participate in this study. Your signature below indicates that you read the information provided (or the information was read to you). By signing this Consent Form, you are not waiving any of your legal rights as a research subject.

I have had an opportunity to ask questions and all questions have been answered to my satisfaction. By signing this Consent Form, I agree to participate in this study and give permission for my health information to be used or disclosed as described in this Consent Form. A copy of this Consent Form will be provided to me.

_____ _____/_____
Name of Adult Participant (print) Signature of Adult Participant Date

I have explained the research to the subject and answered all of his/her questions. I believe that he/she understands the information in this consent form and freely consents to participate.

_____ _____/_____
Name of Research Team Member Signature of Research Team Member/Date

Appendix B

Interview Questions

1. Tell me how you feel about the aging process.
2. What does health mean to you?
3. Tell me what a daily routine for you is like.
4. What do you usually eat in a typical day?
5. Tell me about the physical activity (not necessarily traditional exercise) in which you participate in an average week.
6. Tell me what you consider to be stressful.
7. How do you handle these stressful situations?
8. Share with me your ideas about successful aging.

I would like to ask couple of questions about your living here in this center.

1. Tell me about what your life has been like since you moved here.
2. Can you compare it to what it was before you moved here, such as activities or transportation?
3. How was it decided to move here?

Please allow me to summarize our interview findings so that I may ensure that I have everything correctly. Tell me if I have incorrect information so that I may fix it before we end this interview. I have asked you many questions about many things; is there anything else you would like to share with me?

Appendix C

Demographic Questionnaire

1). How old are you?

2). Where were you born?

3). Male or Female?

4). What is your marital status? Are you presently living with a significant other?

5). What ethnicity would you say you are?

6). What is your religious affiliation?

7). Do you consider yourself a religious person? Do you attend church?

8). What is your household income?

9). How many years of school did you complete?

10). How long have you lived here?