# THE DETERMINANTS OF HEALTH AND WELL-BEING AS PERCEIVED BY SENIOR RURAL WOMEN IN SOUTHWESTERN SASKATCHEWAN

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# THE DETERMINANTS OF HEALTH AND WELL-BEING AS PERCEIVED BY SENIOR RURAL WOMEN IN SOUTHWESTERN SASKATCHEWAN

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## ABSTRACT

The purpose of this study was to identify the determinants of health and well-being as perceived by rural senior women. These perceptions are of value to determine what sustains these women in a rural environment. The study area included three rural municipalities (RMs) within the Prairie Ecosystem Study (PECOS) project in southwestern Saskatchewan.

A phenomenological qualitative study was implemented. Twenty-nine rural women between 55 and 75 years of age, the formative retirement years, were interviewed utilizing an interview guide. The Q.S.R. NUD*IST (© 1990) computer program was used to assist in the sorting and collating of the categories and themes emerging from the transcribed data. The data for analysis also included: (a) field notes collected over the course of the research process and (b) participant oberservation with personal reflections by the researcher. The conceptual framework for this study was the Mandala of Health—a Model of the Human Ecosystem developed by the Department of Public Health, City of Toronto.

Three major categories of themes emerged from the data analysis: (1) the aging/maturation process, (2) the community (social) support systems, and (3) the family support system. It is suggested that these thematic categories are of importance for the self-perceived health and well-being of the women in this study and for their sustainability in a rural environment.

At the conclusion of the thesis, the emerging principal themes and their significance are discussed. The implications for nursing and for the PECOS study are also addressed.

## ACKNOWLEDGEMENTS

This thesis bears my name yet there are so many others who have been a part of its development. It was difficult for me to curb my praise for the women of this study while writing this thesis. To the 29 women who opened their doors and shared with me a glimpse of their lives, I give my thanks. Your stories were individual and I appreciate the miracles and hardships you have endured. Collectively, your stories offer knowledge about rural women which needs to be identified and respected.

My graduate experience was most enhanced by my thesis committee members. Gail Remus, my supervisor, offered countless hours of guidance, encouragement, and support. Her enthusiasm for my study was ever present and I cannot begin to thank her for her constancy. Mary MacDonald, Dr. Nikki Gerrard, and Dr. Don Irvine gave much of their time and expertise to help guide me through my first research process. The committee's support added to the richness of this experience for me.

In the epilogue I allude to the gift I received in being a part of the PECOS project. This interdisciplinary research project was a novel experience of which I am grateful to have been a member. I am thankful for the generous financial support as well as for the academic and friendship liaisons which resulted.

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# CHAPTER 1: INTRODUCTION

## Background for the Study

Is rural living able to sustain elderly women in Saskatchewan today? This question and other questions regarding rural sustainability have intermittently plagued the twentieth century as rural life is affected by the economy and employment, politics, natural phenomena (such as the amount of precipitation), and the integrity and justice of humankind. Even as early as 1913 agricultural areas were seeing problems such as population out-migration, farm income not matching farm expenditures, institutions not meeting rural needs, and rural communities lacking support (MacDougall, 1973). Although changes to agriculture and rural life have occurred over time, the challenge of sustainable development still exists.

## Prairie Ecosystem Study (PECOS) Project

Sustainable development is tentatively defined as "development that meets the needs of the present without compromising the ability of future generations to meet their own needs" (World Commission on Environment & Development, 1987). The Prairie Ecosystem Study (PECOS) is a project supported by the Eco-Research Program of Environment Canada's Green Plan and is administered by the Tri-Council Secretariat representing the Medical Research Council (MRC), Natural Sciences and Engineering Research Council (NSERC), and Social Sciences and Humanities Research Council (SSHRC). The PECOS project is an interdisciplinary research project incorporating medical, social, and natural sciences, and the overall

study addresses questions related to the sustainability of the semi-arid prairie ecosystem. PECOS is studying sustainable development in part of the Palliser triangle in southwestern Saskatchewan (Census Agricultural Region 3BN) (Appendix A). The PECOS project, of which this study is a part, is community-based and incorporates investigators at the Universities of Saskatchewan and Regina.

## Statement of the Problem

In the PECOS Research Proposal the problems to be studied were summarized as follows:

> Rural Canada is in crisis. Nowhere is this more clear than on the Prairies. Long-standing concerns about the capacity of the prairie ecosystems to sustain agricultural and other land use practices have acquired a new urgency. Soil erosion, the loss of biodiversity, the degradation and exhaustion of soil, the eutrophication or pollution of waterways, and the reduction of wetlands and other wildlife habitat, for example, have prompted many to conclude that the prairie ecosystem is incapable of sustaining existing land use patterns.
>
> The current crisis expands beyond concerns over the continued capacity of the ecosystems to sustain agricultural and other land use practices. There is also widespread concern about the sustainability of the ways of life that the people have developed in relation to current agricultural practices. The social and personal dimensions of this crisis include increased numbers of forced farm foreclosures, accelerated rural depopulation, increased incidence of interpersonal and family violence, mental health problems, alcohol and drug abuse, and rural crime, to name a few. These indicators of social disorganization are seen by many as threats to traditional rural lifestyles and forms of community. (University of Saskatchewan & University of Regina, 1993, p. 6).

One of the questions of focus for the PECOS study was, "How do land use patterns associated with agriculture affect the health and

well-being of the people?" (University of Saskatchewan & University of Regina, 1993, p. 6.2). With the population aging, one identified topic for research was the health, well-being, and sustainability of the rural elderly. The specific research focus of this study was to identify, describe, and examine the self-perceived determinants of health and well-being of the rural senior woman.

## Purpose of the Study

A preliminary literature search, summarized below, showed that little research has focused on elderly rural women. Of specific interest for the present study was the woman from 55 to 75 years of age [identified in this study as a 'senior'] as this is the age range in which retirement or transitional decisions will be made for the final developmental stage of life. These decisions are affected by the status of health and by the quality of life or well-being of the individual woman and may influence the ability of that senior rural woman to be sustained in a rural setting.

The purpose of this study was to identify the determinants of health and well-being as perceived by rural senior women in the study area. One imperative for the study was an understanding of an individual's, a family's, and a community's concept of health and well-being in order to understand the motivation for health promotion, health maintenance, and illness treatment (Long, 1993). The literature review revealed a gap in the research literature regarding perceived health and well-being of elderly rural women and, furthermore, what they perceived their needs to be. This lack of 'grass-roots' analysis could lead to inappropriate and unnecessary program development or underdevelopment of programs. The

understanding to be gained from the present study, then, would help enable the community nurse to offer relevant care. The relevance of this study to PECOS was to identify facets within the ecosystem which allow for the sustainability of elderly women in their rural homes.

## Definition of Terms

**Senior woman.** A woman between the ages of 55 and 75 years (inclusive) as these are the formative retirement years when decisions are made for the final stage of life.

**Rural.** Statistics Canada (1993c) defines 'rural' as a sparsely populated area lying outside urban areas. An urban area is "a continuously built-up area having a population concentration of 1,000 or more and a population density of 400 or more per square kilometer" (Statistics Canada, 1992c). Women living on a farm or in a rural community of less than 1000 population within the study area were defined as 'rural'. All of the women aged 55 to 75 years within the PECOS study area were considered 'rural' except for those living in the urban setting of Swift Current.

**Health.** The study participants' definitions of 'health' were explored to identify what these women perceive health to be. These definitions are compared to the World Health Organization's (WHO) and other definitions of 'health' in Chapter 4 of this thesis under 'Discussion: A Comparison of Definitions'.

**Well-being.** Various terms are substituted in the literature for 'well-being' such as quality of life, life satisfaction, and wellness. For the purpose of this study, the definition of well-being will be subjectively defined by the study participants themselves.

**Determinants.** To determine is "to be the cause of; be the deciding or regulating factor in" and a determinant is "a thing or factor that determines" (Dorset & Baber, 1983, p. 497); therefore, for the purposes of this study, *determinants* were the regulating or deciding factors of health and well-being as perceived by the study participants.

# CHAPTER 2: REVIEW OF THE LITERATURE

This chapter reviews the literature relevant to the stated purpose of this study. Initially, broad searches on CD-ROM databases were done on Silverplatter using the Cumulative Index of Nursing and Allied Health Literature (CINAHL) (1982—1994) and Pollution and Toxicology (POLTOX) (1990—1993), combining a search of the variables elderly/rural/health or elderly/rural/well-being or wellness. POLTOX was included in the search due to the ecological/environmental focus of this PECOS integrated research study. The bibliographies of the initial studies plus shared information from other college disciplines within PECOS (a multi-interdisciplinary study) led to a broadened literature search in other disciplines such as psychology, agriculture, and sociology. A more specific literature search was done from the emerging themes that arose from the analysis of the collected data and is reported on in Chapter 5.

The themes extracted from the initial search of the literature were: (a) a subjective view of health of the elderly (perceived health); (b) empowerment of the elderly and how this affects their health; (c) health and aging; (d) rural versus urban comparisons of the elderly; (e) health and elderly rural women; and (f) ecological studies which may affect the elderly. Few studies had embodied phenomenological research. There appears to be a paucity of studies focused on elderly rural women and, more specifically, Canadian elderly rural women. With the diversity of the geography

and the population density in both the United States and Canada, most studies were of an esoteric (non-generalizable) nature.

**Rural Elderly: Self-perception of Health**

How an individual perceives his or her health is of concern as this perception will reflect onto other aspects of the individual's life. Too often one is 'told' how healthy one is through diagnostic tests or by comparative analysis, whereas health is a relative concept and a personal experience; therefore, a subjective critique of one's health would be valuable. A defined handicap or a compromised health situation may be perceived entirely differently by different individuals.

Three of the reviewed quantitative studies used the Perceived Health Status (PHS) questionaire, compiled by Engel in 1984, to quantify the perceived health of the rural elderly (Johnson, Waldo, & Johnson, 1993; Lee, 1991a; Lee, 1993b). The PHS tool consists of three subscales: physical, mental, and social health. The three studies are summarized below.

In a study of rural adults (farmers), a relationship between hardiness, a trait where one remains healthy while experiencing many changes in one's life, and perceived health status was demonstrated (Lee, 1991a). Adults with higher levels of hardiness appeared to have a more positive perception of their mental and social health but not of their physical health. Hardier individuals also reported experiencing fewer stressful events. Health, hardiness, and living on a farm appeared to be interrelated. The significance of these findings was enhanced by use of a large random sample (n=162). There was no significant relationship between gender and

perceived health status but there were 83 percent males and only 17 percent females in the sample. Not surprisingly, Johnson, Waldo, and Johnson (1993) found the higher the reported stress, the poorer the perceived health status of the rural elderly (over the age of 65 years). They also found 'older' rural elderly experienced greater stress and poorer health compared to the 'younger' elderly.

Lee (1993b) compared results of her study (n=162) to two previous large studies of more than 1000 participants and found some conflicting results. In the Lee (1993b) study, farmers and ranchers demonstrated less concern about their health and were more apt to reject the 'sick role' than was found in one of the larger comparative studies. The older elderly farmers (70 years or older) were more realistic about perceiving illness being a part of life as they aged, compared to the younger group of 30 to 70 years of age (Lee, 1993b). This could be interpreted as the 'old old' saw some degree of illness as a normal part of their developmental stage.

Two studies looking at perceived health of the rural elderly were qualitative (Butler, 1993; Roberto, Richter, Bottenberg, & MacCormack, 1992). Roberto et al. (1992), in a grounded theory approach using quasi-statistical analysis to analyze the data, ranked the order of the participants' (health-care providers vs. elderly) perceptions of predictors for utilization of services for health care needs. Fear of dependency, of depleted financial means to carry out health care, and of loss of identity were the main predictors of health care utilization by elderly with a health-care need. Although the interviews were independently categorized by two researchers, thereby controlling against subjectivity, the interview questions for

the two groups (health care providers and elderly) were substantively different, possibly not rendering the groups to direct comparison.

In a small pilot study (n=8), women subjects were asked to define health and their perspective of their health needs which affected their well-being (Butler, 1993). Butler (1993) found elderly rural women maintained a sense of well-being and health by giving and caretaking, keeping busy, having a strong family support system, and by being resilient. A significant relationship between hardiness and perceived health status was interpreted to mean hardier rural adults have a better perception of their health status (Lee, 1991a). If hardiness and resilience can be interpreted as synonymous, then the two studies (Butler, 1993; Lee, 1991a) support each other.

A quasi-experimental quantitative study of Linn and Linn (1979), using randomization, a control group, but no manipulation, compared a younger elderly urban population (65 to 75 years) to an older elderly urban sample population (75 years and older). Participants' subjective views about their own health were compared to more objective health indicators. Self-assessed health (the subjective view) was determined by one question with a five-point Likert scale (Polit & Hungler, 1991, p. 647) response with responses varying from very good to very poor. The objective view of health was obtained from analysis of medical records. The data showed the very old reported better health marginally more often than the younger old. From the accumulated data, Linn and Linn (1979) suggested self-perceived health may be a better indicator of overall health than is chronological age.

One study reviewed and compared the nursing literature from 1987 to 1991 on the relationship between quality of life and perceived health in the elderly (Moore, Newsome, Payne, & Tiansawad, 1993). From the 17 studies found, using content analysis, the researchers found: (a) an inconsistency of terminology for 'quality of life' and for 'perceived health', (b) three of the studies reported that how one perceived one's health was a significant predictor of one's life satisfaction, and (c) seven studies found either inverse or positive relationships between the variables quality of life and perceived health.

## Empowerment, Well-being, and the Elderly

Does the control one has over one's life, or being empowered, have an affect on one's perception of well-being? A review of the current literature found three studies which addressed whether an elderly individual's sense of autonomy affected that individual's well-being (Fleury, 1991; McWilliam, Brown, Carmichael, & Lehman, 1994; Slivinske & Fitch, 1987).

In a qualitative study using a sample of elderly residents and their caregivers, there appeared to be a relationship between individual autonomy and one's mindset (McWilliam, Brown, Carmichael, & Lehman, 1994). Elderly with a positive mindset and a sense of purpose and direction in life did not appear to experience a threat to their autonomy in the 'paternalistic' domain of health-care compared to elderly with a more negative frame of mind and who lacked a clarity about goals and a purpose in life. This could be interpreted that elderly with a more positive attitude, within a larger life context, had a more positive perception of their well-being.

Fleury (1991) suggested that individual behavioral changes could affect personal health-promotion practices if the individual was empowered by a good self image. Possible weaknesses of this study were the small sample size (n=29) coupled with a large age range (25 to 79 years).

In an experimental quantitative study, Slivinske and Fitch (1987) found support for the activity theory of aging (Belsky, 1990, p. 176). Elderly participants enrolled in a program of fitness classes, educational classes, and conferences experienced significantly greater improvement in their level of perceived control (empowerment) and wellness; the elderly of the control group who had no such program experienced a small decrease in perceived control and wellness.

## Health and Aging

In reviewing the literature on the elderly, the bulk of the studies related to health and aging. Many retrospective governmental studies, utilizing demographic, morbidity, and mortality statistics, have objectively determined the predictors for health of the elderly (Health and Welfare Canada, 1988; Saskatchewan Health, 1992; United States Department of Health, 1992). The predictors of health included access to health care, availability of social support systems, level of functional mobility, and individual preventative health care practices. These predictors were supported by other independent studies, some of which are related below.

From the data of the First Duke Longitudinal Study of Aging (1955-1976), 18 suggested predictors of 'successful aging' were analyzed using instruments measuring levels of intelligence, physical

function, happiness, activities, emotional security, socioeconomic status, and prestige (Palmore, 1979). 'Successful aging' was defined as survival to age 75; a physical-function rating of less than 20 per cent disability; and being generally or always happy, contented, and unworried. The study suggested that the two strongest predictors of successful aging were an individual's initial high levels of physical function and happiness (determined in 1955).

Two journal articles, reporting results of data from the Framingham Disability longitudinal study (1976-1978, n=2654), evaluated social disability and physical disability among aging adults (Branch & Jette, 1981; Jette & Branch, 1981). Compared to men, women generally reported a higher degree of unmet social needs, were more at risk of developing unmet social needs, and had more difficulty with the more physically intense activities with advancing age. Even though the data revealed a consistent increase in physical disability with advancing age, the data also suggested that the majority of the study participants will still maintain substantial physical ability in the later years of life (Jette & Branch, 1981).

Ashworth, Rueben, and Benton (1994) compared functional activity in elderly adults to younger adults by monitoring the cardiovascular system (pulse and blood pressure). In this study, older women spent significantly more time than younger persons or older men with basic and intermediate levels of activities of daily living. This does not support the findings of Jette and Branch (1981) who found a gender difference with only the more intense physical activities. It should be noted that in these three studies only elderly who were living independently (non-institutionalized) were studied.

A tool for assessing the health needs of elderly rural people was developed and tested to determine their actual health status, opportunities, activities, and attitudes and, thereby, to assess their specific psychological, social, and medical needs (Allen & Miller, 1986). The tool developed was an interdisciplinary team project with the team consisting of college departments of sociology and psychology; faculty from dentistry, family medicine, nursing, nutrition, occupational therapy, and physical therapy; and community groups such as social workers, senior citizens' groups, and counseling centres. The data revealed that the rural elderly were generally satisfied with their lives (54% very satisfied, 34% moderately satisfied) and most felt their health was good (70.8%) (n=94).

Using an ethnographic research design, Craig (1994) found social support systems for the rural elderly went beyond the family and included the community. Health for the rural elderly was found to be dependent on the reciprocal relationships between themselves and the community. Interestingly, close community relationships showed possible negative implications for the health of the elderly. The close supportive relationships often interfered with or threatened individuals' privacy and promoted stress. Casarett (1991) earlier found similar results with a rural 'neighborly' system (support system). This 'support system' was actively involved with the elder's health through active participation. This participation ranged from listening to complaints about the health care system, to being a liaison between the health care provider and the elderly individual.

## Rural versus Urban Elderly

There were conflicting research findings as to stress in the elderly and its relationship to place of residence, that is, urban versus rural residency. Preston and Crawford (1990) suggested the experience of stress in the elderly differs according to the social context and the environment in which they live. Their study looked at the effect of three environmental conditions, or community characteristics, on the levels of perceived stress. The three conditions were: (a) metropolitan (urban) versus non-metropolitan (rural—less than 2500 population) status, (b) community population size, and (c) community population change (declining, stable, or increasing). The urban population experienced significantly more stress with finances and health than did the rural population. Speake, Cowart, and Stephens (1991) found place of residence (rural vs. urban) was not independently predictive of stress management of the elderly.

Among the elderly population of the study, a relationship was not found between (a) health status or level of dependence, and (b) place of residence, whereas a relationship was found between older age and health dependency (Krout, 1989). The urban elderly tended to use community services slightly more than the rural elderly which Krout (1983) suggests could be due to the rural elderly's dependence on availability of transportation.

A limitation in rural versus urban comparison studies was a lesser availability of support systems and services in the rural areas compared to urban centres (Cordes, 1989; Coward, 1979; Henderson, 1992; Lancaster, 1988; Lee, 1993a; Long, 1993; Talbot, 1985). One

area which demanded attention for further research, according to various American studies and assessments, was the lack of mental health care for the rural elderly (Abraham, Buckwalter, Neese, & Fox, 1994; Buckwalter, McLeran, Mitchell, & Andrews, 1988; Bushy, 1994). To compensate for the closure of rural hospitals, home-care and health promotion should be on the 'upswing', according to a rural Oklahoma study (Bender & Hart, 1987). It is apparent from this literature review that there is a great discrepancy in the availability of health care and health maintenance agencies in rural versus urban settings.

## Studies of Elderly Rural Women

A literature search showed a scarcity of studies on elderly women, on rural women, and on elderly rural women. Of the four studies found, two dealt with widowhood, one with perceived health and well-being, and one with stress and illness. Butler's pilot study (1993), as mentioned earlier, looked at the perceived health and well-being of elderly rural women. These women maintained a sense of health and well-being through giving and caretaking, by staying busy, by being adaptable and resilient, and by focusing on the family as the central support system. McCulloch (1991) also found, in a retrospective study, that "surviving older rural women represent a 'survivor elite group' characterized by a hardiness that continues over time" (p. 292), and that older rural women tend to evaluate their health in a positive way. These same 'hardy' or resilient women were found to not necessarily decline in health with advancing age. Hardiness and resilience are often used

interchangably in the literature even though the definition of hardiness refers more to "courage" and "physical endurance" (p. 826), and resilience is defined as "the ability to recover strength, spirits, good humor, etc. quickly" (p. 1540) (Dorset & Baber, 1983).

Contrary to what Johnson, Waldo, and Johnson (1993) found in a gender-inclusive (men and women) study, Bigbee (1988) found with rural women there was no significant relationship between rurality and stress nor between rurality and stressful life experiences. The population sample of the Bigbee study (1988) included a wide range of ages (18 to 65 years) with a mean age of 37 years.

Less psychosocial and physical dysfunction among elderly widows was attributed to religiosity, social support systems, resources (e.g. financial), and good prior mental health (Gass, 1987). For elderly widowed and/or retired rural women, good health and maintenance of a social support system were predictors of retirement satisfaction (Dorfman & Moffet, 1987). Widowhood for elderly women was not necessarily a negative transition as it could also allow for the rediscovery of suppressed personal identities (Adlersberg & Thorne, 1990).

Dietz (1991) saw the stressors of elderly rural women as including: (a) extremes in weather, (b) isolation, (c) rural economy (including a paucity of services), (d) the multiple roles that women must play, (e) the health of these women and their families, and (f) the availability of health care. These stressors may be compounded with widowhood. Therefore, Dietz saw these stressors

as determined by personal characteristics as well as social and environmental factors.

Some authors have studied and written extensively about the issues of 'rural' women with a focus on demographic, economic, sociocultural, and health factors (Bushy, 1990; Bushy, 1993; Kohl, 1976; Miller, 1990). However, '*elderly* rural' women have been only a small part of that focus.

## Rurality and Ecology

No studies were found which related to the rural elderly and their health and well-being specifically from an ecological perspective. Rural studies relating to environmental factors and hazards, such as zoonotic (animal/man) diseases, atmospheric influences (e.g., heat/cold), epidemiological components (e.g., organic dusts, microorganisms), chemical use, and farm accidents, were found to exist but most lacked the 'elderly' as an independent variable (Donham & Mutel, 1982; Geller & Ludtke, 1991; Macey & Schneider, 1993; To, Wacker, & Dosman, 1993; Yawn, 1994; Zejda, McDuffie, & Dosman, 1993). Geller and Ludtke (1991) defined the "rural health paradox", by a demographic look at the rural population, as "a population that is on average older, poorer, more prone to chronic disease, and more likely to be working in an industry with very high accident rates (e.g., farming, mining, forestry)" (p. 345). The paradox is this 'frailer' rural population, (often thought to be younger and healthier due to 'country-living'), is increasingly burdened by a decreasing access to medical services.

Even though an attempt has been made to view the human role in the biosphere (Brody, 1973), there remains a gap in research

regarding human health and ecology related to sustainable development (Labonté, 1991a; Labonté, 1991b). Labonté (1991b) cites 12 principles for the integration of health and sustainable development. These principles are combined and paraphrased as follows: (a) to make the best decisions today with the present scientific knowledge, that is, to "anticipate and prevent" (p. 149); (b) to make decisions which encompass economy, environment, and health; (c) to lessen the wealth gap between nations and within Canada; (d) to promote activities for sustainability which provide equal empowerment and increase individual democracy; (e) to make decisions which enhance the creation, sustainment, or re-creation of communities; (f) to champion decisions or activities which enhance replenishing, replacing, recycling, and reusing; (g) to demand accountable accounting; (h) to promote activities which support sustaining human (cultural) and ecological diversities; (i) to encourage decisions which nurture the 'intangibles' that affect quality of life or well-being such as beauty and culture; and (j) to be accountable to future generations.

Labonté's (1991a; 1991b) insight can be directly applied to concern for the sustainability of rural elderly women as they are a part of the ecological chain. The literature researched to this point studied elderly rural individuals from a biophysiological perspective and viewed their worlds inclusive of the family, culture, and community, but neglected to incorporate the holistic ecological aspect of the biosphere in which they lived. With this dearth of a holistic perspective identified in the literature, an empirical approach to the study of rural women, with an experiential focus, is warranted. The

main research question which arises from the literature review is, "What are the determinants of health and of well-being as perceived by rural senior women?" Also relating to the gaps in the literature, the following questions will be significant parts of this research: (a) Are environmental and ecological changes regarded by senior rural women as having an effect on their lives?; (b) Are there common health related and quality of life (well-being) related factors of senior rural women and, if so, what are they?; and (c) What are rural senior women's feelings regarding their retirement or the next transition in their lives?

As well as the ecological gap in the literature, the literature researched lacked consistency in definitions: (a) of elderly (some were 55 years and older, some were over 65), (b) of rural (some were communities under 1000 population, some were under 2500), (c) of health (some were more holistic than others), and (d) of well-being (quality of life, life satisfaction, or happiness). Most studies lacked generalizability due to the use of convenience samples, non-random samples, or small population samples. Attrition by death was a weakness in many of the studies due to the advanced age of the sample population. Replication of these studies with larger population samples could help support findings and sort out contradictory research results.

The majority of the studies reviewed were quantitative. More qualitative research would add a depth to the knowledge-base on elderly women. Asking these women to talk about their lives captures a viewpoint that cannot be grasped with any other research method and provides valuable knowledge of this population.

# CHAPTER 3: METHODOLOGY

The purposes of this chapter are: (a) to provide rationale for the choice of the design of the study, (b) to provide rationale for the choice of the conceptual framework and a description of that conceptual framework, (c) to describe the development of the interview guide for the semi-structured interviews, (d) to describe the choice of setting (the study area) and the choice of sample population, and (e) to describe the specific data collection and data analysis procedures used in the study.

## Rationale for Naturalistic Inquiry

This research was a qualitative study (naturalistic inquiry). An exploratory phenomenological approach was preferred as the experiential view of the subject was of prime importance in answering the research questions addressed. According to Knafl and Howard (1984), "qualitative findings are important in and of themselves since it is the richness and detail of the data that give the reader an understanding of the the subject's social world" (p. 18). As qualitative research is "concerned with humans and their environment in all of their complexities, [with] an emphasis on the subjects' realities" (Polit & Hungler, 1991, p. 497), it was the research methodology of choice for this study.

Naturalistic inquiry or phenomenological research is applicable to women's studies. If we are to understand how women perceive and react to the everyday world, a subjective, naturalistic, qualitative approach is more appropriate than a view from the traditional 'scientific' mode of quantitative inquiry. This approach to

the sociology of women will then disclose deeper 'truths' (Smith, 1987). Hearing the women's spoken words about their percepts, without the use of leading questions requiring dichotomous 'yes/no' responses, helps to elicit the wealth within the data. It allows the researcher to enter the "everyday worlds [of the women] rather than in an imaginary space constituted by the objectified forms of sociological knowledge" (Smith, 1987, p. 153).

The researcher, upon engaging in this study, endeavored to suspend her preconceived ideas of what health and well-being might mean to the subjects. The researcher watched for themes to appear from the interviews. The data were analyzed and coded and grouped into categories of evolving themes which reflected the participants' perceptions (Knafl & Howard, 1984). Phenomenological research is to "start in silence...[with the researcher being prepared] to see rather than to think about a phenomenon" (Oiler, 1982, p. 180).

## Conceptual Framework

Although there was a preponderance of literature and research on aging and health where the holistic model of medicine (psychosociological/physiological) was used, no study looked at the elderly individual as a part of the ecosystem or biosphere. For humans to be sustained in the ecosystem, and for a healthy population to survive, humans must be interdependent with the biosphere and not have a 'superior species' attitude.

Two specific models were identified in the literature relating humans directly to ecology. Lawton and Nahemow (1973) developed an ecological theory of adaptive behavior and aging (Aging and Adaptation Model). The Public Health Department of Toronto, Canada

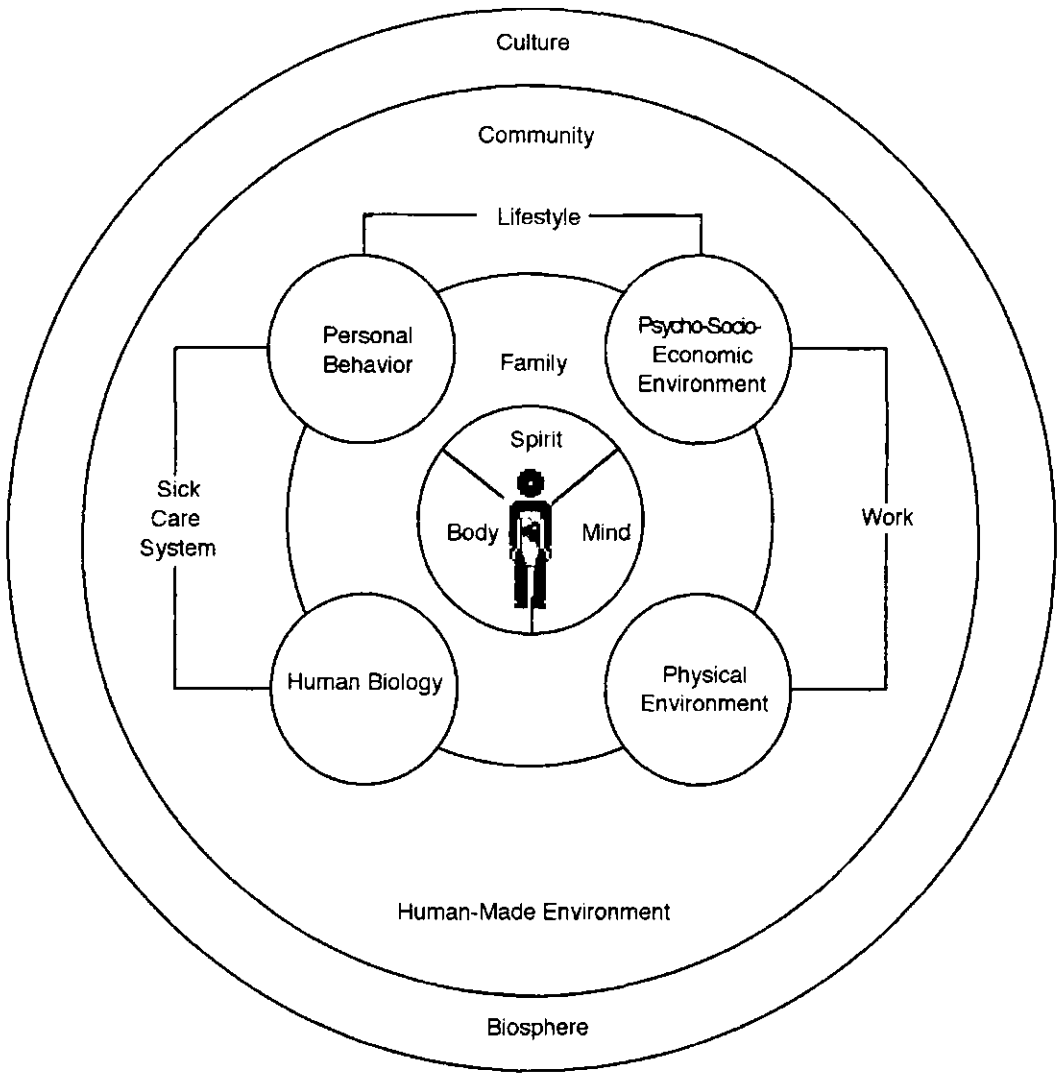
developed an ecological and holistic model of human health (Mandala of Health—a Model of the Human Ecosystem) (Hancock, 1985).

The initial premise of Lawton and Nahemow's (1973) preliminary Aging and Adaptation Model was appealing as the authors identified that "ecology refers to the study of natural systems, emphasizing the interdependence of one element in a system upon every other element" (p. 619). They considered "the ecology of aging in terms of the adaptation of man to his environment and his alteration of the environment as part of the process of human adaptation" (p. 619). The authors relate that "the impending catastrophe due to many years of disregard for the maintenance of existing natural systems" and, less obviously, "the frequently unanticipated behavioral and social consequences of changes, such as destruction of values, in the man-made environment" (p. 620) are warning signs for the ecosystem (Lawton & Nahemow, 1973).

On looking more closely, this theory seemed to veer away from the ecological and focused in on the environmental. The theory appears more sociological dealing with 'behaviors', 'adaptation', 'competence', and 'affective responses'. This complex theory did not gear itself to humans in the biosphere.

The model of the Mandala of Health—a Model of the Human Ecosystem [henceforth referred to as mandala of health] is an ecological and a holistic conceptual framework of human health. It was used as the conceptual framework for this study. The conceptual model of the 'mandala' (Figure 1), a circular symbol of the

universe, depicts the individual as the centre or focus but he or she does not exist in isolation.




A model of the mandala of health. Source: Department of Public Health, City of Toronto



**Figure 1.** Mandala of Health—A Model of the Human Ecosystem (Copyright 1985 by the City of Toronto. Reprinted with permission.)

This conceptual framework implies that even though cultural values, attitudes, and beliefs influence health or how one perceives health, the biosphere is the ultimate determinant of health (Hancock, 1985). This model depicts the health and well-being of the individual to be viewed beyond the body, beyond the family and community, and to be inclusive of the total ecosystem.

The mandala, integrating social and natural sciences, suggests that human health is dependent on a healthy, stable, and safe ecosystem. The ideal state of the ecosystem is that of being healthy. What the mandala lacks as a conceptual model is depiction of how movement of the variables within the ecosystem model, or an imbalance within the ecosystem, initiates a reaction which challenges equilibrium.

Even though it would be "ecologically insane" (Hancock, 1985, p. 4) to support activities that impair the health of the ecosystem, in reality such activities do exist. The mandala of health also represents, again idealistically, social justice as health depends on a just and equitable distribution of wealth. But, injustice exists and always will. For example, universal and equitable health care or universal uncontaminated drinking water are nonexistent. A weakness of the mandala model is the circles do not allow for portrayal of movement of the model variables to depict these injustices. Such a shift or movement of the variables could direct where potential solutions to the injustices may have to be initiated. The answer to an injustice is not always to provide more services but could be to provide a more equal distribution of society's resources

which would lead to global health, the final circle of the mandala (biosphere).

The mandala addresses humans at individual, community, societal, and global levels. Actions within the community and a broader culture could be important determinants of health. Therefore, the determinants of health or sickness of the individual are not just an individual responsibility but the responsibility of the community, society, and environment as well. There is a social and political nature to health.

The mandala of health views the health of the individual as also being determined by the individual's self-worth. This self-worth is reinforced by the institutions of work and school and by social situations. Therefore, "mindless schooling, meaningless work, and disempowered communities are antithetical to good health" (Hancock, 1985, p. 6). An organized and empowered community is better able to cope with rising concerns which affect such ecological and environmental entities as the water quality, educational system, or social support network. A strong united community is better able to improve the health of the community as community action can collectively attack the health-threatening factor. To act against an injustice, the community must be empowered to stand up to challenge the economic, political, educational, and health care systems.

The sustainability of rural communities, and specifically the sustainability of rural senior women who could be considered a risk population, can be visualized in the mandala of health. The circles imply interdependence. Therefore, the sustainability of the rural

community, senior rural women, agriculture, and the land, air, water, flora, and fauna are all interconnected.

The interdependence within the mandala supported the interviewing of elderly senior women to identify what they perceive as aspects of the biosphere which may threaten their health and well-being and, ultimately, their sustainability in a rural environment and lifestyle. From these perceptions, policy makers, institutions, and community development may be guided as to the implementation, modification, or the exclusion of practices affecting the sustainability of rural elderly women.

## Development of Interview Guide

This study utilized the semi-structured interview process, incorporating an interview guide (Appendix B). The questions of the interview guide were interjected into the conversation randomly but all questions were addressed in each interview. The lead or direction of the interviews (or conversations) was taken by the participants' answers to the questions with no prompting from the interviewer. This allowed for the focus to be solely upon the participant's perception of the question. The interviewer used focused interview techniques incorporating the appropriate communication skills such as pausing, paraphrasing, and affirmation (Zeisel, 1985).

The interview guide consisted of a list of open-ended questions, to which the answers were verbalized in addition to demographic questions. The guiding questions were developed specifically for this study with the basis being the mandala of health conceptual framework. Butler's (1993) pilot study was a minor guide for some of the questions but ecologically-focused questions were added. The

questions were a topic guide encouraging the participants to talk freely (Polit & Hungler, 1991) on the topics of health, well-being, environment, and the future.

The demographic section of the interview guide was presented at the beginning of the interview. Questions were asked about: (a) farm location (legal land description), or location of town residence was noted, (b) age of participant, (c) marital status, (d) number of years living in a rural setting, and (e) past and present occupation. This information allowed for geographical location of the participants in the study area and for statistical information which may be of use to PECOS' geographic information systems (GIS). It was determined if the subject lived on a farm or in a village or town. Pinpointing where this residence was also allowed the researcher to determine such factors as how far this individual lived from a health care centre or various amenities. The demographic section gave information about the transitional stage of the participants by 'age' and 'occupation', about farm or nonfarm rural status by 'location', and about their independence or interdependence by 'marital status'.

## Setting of the Study

As this was a rural study and, as was addressed in the background for this study, 'rural Saskatchewan is changing', attention must be given to the setting of the study. The study took place in three of the 14 rural municipalities (RMs) of the PECOS study area in southwestern Saskatchewan and this study area was located within the Palliser Triangle. The PECOS study area is Statistics Canada's Census Agricultural 3BN. To ensure anonymity of the participants,

the specific RMs will not be noted. The three RMs of study were all designated as 'rural' as no town within these areas was over 1000 in population.

The vast majority of the families in the three RMs are Protestant and many are from a British or German background and some have Norwegian roots (Statistics Canada, 1993b). Interestingly, there was no reported unemployment of persons over 25 years of age in the RMs or towns in the study area (Statistics Canada, 1993b).

The Palliser triangle was the last large area to be settled in Saskatchewan as it was looked upon as only useful for pastureland. Since the year 1940, much of the land has been cultivated (Jonesville Homemakers Club, 1954). Compared to all other provinces, Saskatchewan farmers pay the highest on rent, interest, and machinery, the lowest in wages, and the highest overall percentage on expenses (Statistics Canada, 1992e). Gross receipts were down 12.6 percent between the last two census years (1986-1991) for Saskatchewan farmers (Statistics Canada, 1992e).

Changes in farming methods and farm economy have historically proven to often be unstable and unpredictable. Interestingly, a notation written by R. Goodwin (1971), at the end of W.O. Mitchell's Who Has Seen the Wind, predicted that:

> Farming methods, they say, will have to change. The farms will be smaller, more specialty crops will be grown, beef cattle and dairy products will multiply, weed control will become an even more important part of the farmer's task. Within a few decades the face of Saskatchewan will be greatly changed (p. 308).

Yes, the face of Saskatchewan has changed and is changing but contrary to what was written above, Saskatchewan farms have decreased in number but are getting larger (21 percent fewer farms in 1991 than in 1971), much more wheat is being grown, the cattle industry is declining, and there is a marked decrease in use of insecticides and fungicides and a slight decrease in the use of herbicides and commercial fertilizers (Statistics Canada, 1992a; Statistics Canada, 1992b). Farming has changed but not as it was often predicted.

The three RMs were chosen by the researcher because of their geographical and topographical diversity. RM 'A' is south of the South Saskatchewan River, is bisected by the Trans Canada highway, will not fear the closure of its railway line, has experienced little change in its health care services, and has land that is more profitable and has been cultivated for a longer period of time than in the other two RMs of the study. RM 'B' is bordered by a major secondary highway, is destined to lose its railway line in the early 2000's, and has suffered much change in the closure of health care facilities. RM 'C' of the study is quite remote and hilly, is more desolate and has more recently-broken range land, will lose its railway line in the early 2000's, boasts the highest 1991 gross farm receipts of the three RMs at $90,000 (Statistics Canada, 1993a), and has had major health care system losses. Although the overall average family income varies somewhat less among the three RMs, when looking at the population of the major towns, the two major towns from RMs 'A' and 'C' have a substantially lower average family income than the major town in RM 'B' (Statistics Canada, 1993b).

The rural farming population of the three RMs being studied has seen great changes. The 1991 farming population of Canada was 3.2 percent of the total population (Statistics Canada, 1992e). Approximately 40 percent of the population in Saskatchewan is rural (Statistics Canada, 1992e). Saskatchewan was the only province to show a decline in the total population from census year 1986 to census year 1991 (Statistics Canada, 1992d). All the RMs and towns of the study showed a decline in population in this same time period.

Table 1, on the following page, shows characteristics of the main towns around which the women interviewed lived. A '*' highlights the main town of that RM. 'Dying' is a word attached, by the researcher, to those towns in which there was little sign of life and there was only one or two remaining business(es). It is of interest to note that even though all the towns are experiencing a decline in population, all the towns are fighting in some way to survive. Community support is evident in all but one of the towns and the landscape architecture [noted as 'town's appearance' in the table] around and within all but one of the towns is being maintained by the local residents.

**Table 1**

Description of the Towns Within the Study Area

| RM | 'A' | | | 'B' | | 'C' | |
|---|---|---|---|---|---|---|---|
| TOWN | X | Y | Z* | J* | K | M* | N |
| CHARACTERISTICS | | | | | | | |
| Churches | - | - | | - | | | |
| Service clubs | - | - | | - | | | |
| Hospital | | | | - | | - | |
| School(s) | | + | + | | - | | |
| Businesses | -/+ | - | + | -/+ | - | | - |
| Houses | -/+ | | + | - | - | + | - |
| Community centre | | + | + | + | + | + | + |
| Town's appearance maintained | | + | + | + | + | + | + |
| 'Dying town' | y | | | | y | | y |

Key
+ = new or active
- = closure or demise
'blank' = not applicable
* = major town of RM

## Sample Population and Criteria for Participation

The sample population of the study met the criteria for participation by being English-speaking women aged 55 to 75 years and by living in a rural setting (population of less than 1000) within the study area. A nonprobability (convenience) sample of 29 women was acquired from the approximately 385 women in this age group

in the three RMs of the study (Statistics Canada, 1993b). A convenience sample is the most efficient, least costly, and quickest means of acquiring a sample population. A random sample would have required more traveling time and the purchase of names from Statistics Canada.

Names of eligible participants, meeting the sample criteria, were initially drawn from community contacts within the PECOS project. Several senior rural women from RM 'A' showed an interest in the PECOS study following a PECOS workshop in 1995. They were approached to be part of the study sample. Other participants were drawn randomly from 33 names suggested by the Director of Care (DOC) of a local Health Centre in RM 'B' and from 40 names suggested by a DOC of a local Home Care office in RM 'C'. From the women telephoned of these 73 contact names, snowball sampling was still employed. The researcher did not want to skew the results of the study by using only names of women who utilized the health care facilities as this might imply they were undergoing treatment and, as the study was asking about health and well-being, a more representative sample was hoped for.

From the initial sample contacts, snowball sampling commenced. Snowball sampling is a means of acquiring potential participants' names from referrals by earlier participants. To ensure confidentiality, participants were informed that prospective participants would be chosen on a random basis and this was honored. In this way, a woman could identify her neighbor as meeting the criteria for participation but would not know if that neighbor would be actually contacted. Of course, this is very

idealistic as in a small community the researcher's vehicle could be recognized, therefore, it could easily be deduced by a former study participant that an interview was taking place if she saw the researcher's car outside a neighbor's home. An interesting aside and an impediment with snowball sampling is when there is a definite age range requested for a study, not always do neighbors know their friends' actual ages. In five of the telephone contacts the women proved to be under 55 years of age; two of these five women were very offended that they were considered that old by a neighbor. Conversely, one woman telephoned was over 75 and was very flattered to be thought to be under 75 years of age.

Interviews with new participants were to continue until saturation point of the data was obtained. Saturation point is when no new strong themes appear to be emerging from the data. The data should then reflect the views of the overall sample population. After the initial interviews in RM 'A', no new themes emerged in the data in RMs 'B' and 'C'. A continuation of interviews after the saturation point was reached strengthened the data and, thereby, gave added validity to the research results. The researcher also felt it was of interest to see if rural women from various geographic areas had different perceptions.

All of the 29 women interviewed were married or had been married. All had living children and all but one had grandchildren. Seven of the women were widowed. Sixteen of the women lived on a farm. Stratification by age was (a) 55-59 years of age—7 women, (b) 60-64 years of age—8 women, (c) 65-69 years of age—7 women, (d) 70-75 years of age—7 women. One of the women in the 70 to 75

year old range asked to be deleted from the study leaving the data of 28 women for analysis. The age range was from 56 to 74 years of age with the mean age of 65 years. Two of the participants were immigrants to Canada.

It is important to note that the women were very responsive to requests for interviews, as well as very receptive to welcoming the researcher into their homes. In RMs 'A' and 'C' there were no refusals. In RM 'B' there were four refusals and of these four, only two women seemed somewhat skeptical on the telephone when declining an interview. The other two reluctantly declined due to time conflicts with the researcher's limited availability. The plausible explanation for the two hesitant refusals in RM 'B' was that the PECOS project was little known there. In RMs 'A' and 'C' most of the women had some conception of the project as other PECOS researchers had preceded this study. The two skeptical refusals were still done with courtesy and almost apologetically (one had said 'yes' to an interview and then changed her mind when the researcher appeared for the interview).

In this study, the researcher found the women interviewed to be open, personable, warm, and welcoming. The field notes and tapes with the researcher's comments, when referring to the women interviewed, revealed such words and phrases as "honesty", "didn't seem to hold anything back", "articulate", "thoughtful", "focused", and "didn't go off on tangents". Carbert (1995) often attributed the warm reception at rural interiviews to loneliness and appreciation for the company. In the present study, this was perceptible on occasion, more notably with farm visits, but was not overly apparent.

## Ethical Considerations and Confidentiality

Ethical approval of the study methodology was obtained in written form from the College of Nursing (June 30, 1995), the College of Graduate Studies and Research (July 24, 1995), and from the University of Saskatchewan Advisory Committee on Ethics in Human Experimentation—Behavioral Science Research (August 3, 1995). Further written consent was obtained from each participant. Attention was paid, in designing and executing the study, to honor the ethical principles of fairness, respect, and beneficence.

The PECOS project was extensively publicized in the study area and had received excellent community support. Credibility of the study was well founded as it was supported by the federal government and the Universities of Saskatchewan and Regina. Hence, it was hoped many potential participants would have some prior awareness of the study. In two of the three RMs of study [A and C] this was the case, thus making it easier for the researcher to acquire interested participants who had a level of trust in the study. Cooperation of the community was essential for the success of the PECOS project. As it was an interdisciplinary study, there were many researchers in the community collecting data so ethical considerations were paramount for the success of all the individual studies.

Participation in the study was voluntary. Two identical written consent forms were presented to each participant (Appendix C). One was retained by the participant, the other by the researcher. The consent form included assurance of anonymity, confidentiality of data, sensitivity in the use of the data, and feedback of results.

The researcher's and supervisor's names, their affiliation, and a contact telephone number were on the consent form. In signing the form, the participant was aware that she could withdraw from the interview or study at any time, as this was also made explicit in the consent form. This 'form' met all the criteria of the Advisory Committee.

On the cassette tapes of the interviews, the women were referred to only by their first names. Following the interviews, the women were referred to by number (1 to 29). The remunerated transcriber of the tapes would, therefore, only be able to identify the participant by first name or interview number. The supervisor on the thesis committee was the only person other than the sole researcher who had access to the full name and address of the participants, and the participants were aware of this from the consent form.

Each participant received a copy of her individual personal transcript of the interview (with an accompanying cover letter) (Appendix D) to review and to give input as to inclusion or exclusion of the information shared in the interview. As direct quotations were to be used in the writing of the analysis of the data, the participants' consent for use was requested for ethical reasons. The participants were given a date to respond by if they had any reservations about the inclusion of their interviews. None responded to the telephone number provided (even with the provision of reversal of calling charges). Nine of the 29 women interviewed responded in writing. The responses were personally written and a sense of humor was a common thread through most of the letters as

they felt they often sounded inarticulate or vague: but they gave permission for the use of the transcripts anyway. Two of these nine women asked that their interviews not be included. In follow-up telephone calls, one woman changed her mind and was very compliant when she found out all the transcripts included many 'uh's' and incomplete sentences. The other woman declined the use of her interview as she had divulged personal information which she felt was identifiable and private. Apparently, as soon as her neighbor saw the interviewer's vehicle leave the yard, the neighbor was on the phone to 'get the scoop' and the interview participant felt threatened about what she had shared. Her request for deletion was honored and the transcript and cassette tape were destroyed.

Following analysis of the data, a cover letter and summary of the data (Appendix D) were sent to the women to give them a second chance to have input. They were asked to respond to the researcher or to the thesis supervisor if the interpretation of the data did not reflect their perceptions. This second opportunity for response had been proposed to them in the consent form. The researcher received no inquiries nor any negative responses.

Following the final writing of the thesis, all interview tapes will be erased.

## Data Collection

### Role of the Researcher/Observation of Participants

The use of the researcher as the major data collection instrument in this naturalistic inquiry was essential to aid in the extraction of more insightful responses by the participants to the topics of discussion. This method allows for the capturing of

emotional depth to verbalized responses by the participant; as well the researcher was able to observe the participant. Smith (1987) feels the "stretches of talk" elicited in this way reveal perspectives which are indigenous of the people being interviewed (p. 189); therefore, the true perceptions of the women are more apt to be discovered.

The topics of inquiry were health and well-being. It is suggested that the fact that the researcher was a registered nurse presenting these topics aided in the access to the homes and stories of these women in that the researcher was accepted as a professional from a humanitarian focus.

The researcher had been associated with the nursing profession for 25 years. This history has afforded her the experience of the evolving perceptions of health of an individual. These perceptions have changed from viewing an individual using the medical model, with its physiological and psychological dimensions, to viewing an individual through a holistic overview. The holistic model encourages the nurse of today to view an individual in an all-encompassing framework which is well represented in the mandala of health (e.g., psychosociological, physiological, spiritual, cultural, economic, vocational, educational, familial, communal, and ecological dimensions).

## Semi-structured Interviews

The audio-taped interviews for the study were carried out by one interviewer, the principal researcher. The face-to-face interviews were 1 to 1 1/2 hours in length (maximum 2 hours). Face-to-face interviews allowed for observation of the participants

by the researcher. Open-ended questions using an interview guide (Appendix B) guided the interview. A focused (semistructured) interview method was employed using some probes or conversational skills to help carry the interview but without injecting bias by the interviewer (Zeisel, 1985).

Following a time for introduction, the consent form was offered to the participant. It outlined the responsibilities of both the participant and the researcher. The consent form also included a brief description of the study without divulging too much information lest it lead the participant in a biased direction of conversation.

The beginning of the taped interview was always a bit forced due to the discomfort of the conversation being tape-recorded but this discomfort level soon dissipated.

Comments from the first four women interviewed led the researcher to add an additional question to the remaining women interviewed. The question was, "Who do you think is responsible for your *husband's* health?". This question was added because the first four women were very assertive by answering "I am!" to the question "Who do you think is responsible for *your* health?" The additional question added an interesting comparison within the data.

## Field Notes

Field notes were recorded following each interview with: (a) subjective information about each participant and her family, and (b) objective information as to the researcher's observation of the participant. These were noted in a Kardex file. Notes, files, and cassettes were also kept recording experiences of the researcher, the

settings of the research (e.g., town descriptions, farm descriptions), and the researcher's regimen; therefore, both descriptive and reflective field notes were accumulated. The value of these field notes was in capturing more than just the women's 'words' from the interviews. This journalizing also added an experiential component by the researcher that could view the women in greater totality in their individual environments. As the researcher was 'outside' the experience, as she was not from within the rural community nor of the age group of the participants, she could be more objective in her observations.

An example of descriptive and reflective field notes follows to illustrate their value:

Descriptive Field Notes (March 29, 1996)

> Snowing slightly. Air chilled. Excited talk about building a care centre by July for levels 2/3. Financed by the town. Dr. X and nurse practitioner will be opening a special clinic. Dr. X is very well loved, approximately 50 years of age, married to a local girl. Town also bought the motel (shareholders) to keep it open—restaurant poorly run (e.g., closed on Saturday). [*These notes reminded the researcher of the importance of the doctor to these women and of the community spirit*]

Reflective Field Notes (November 29, 1995)

> *Example (a)*: 'X' works very hard on farm with husband including feeding cattle two times a day plus breaking ice in dugout—very young and spry for her age (*over 65*).
> *Example (b)*: Very emotional about isolation and friends leaving—broke down crying 3 times.

## Data Analysis

### Content Analysis

Content analysis was used to analyze the data. This type of analysis technique is "designed to yield objective and systematic information" (Polit & Hungler, 1991, p. 509) if the proper controls are followed. The unit of analysis in content analysis is a complete thought which may vary and take the form of one word, a phrase, or several sentences. Under the direction of the researcher, these 'units of analysis' evolve into themes which are identified and coded by the researcher. A 'theme' describes "the characteristics of the content of the message" (or portion of the interview) (Polit & Hungler, 1991, p. 509) which is being analyzed.

In this study similar themes were found throughout the subsequent interviews in all three of the RMs and this redundancy and repetition gave validation to the data. As more and more themes evolved, they were grouped into categories which also added validity to the study as it showed more objectivity and was more systematic. That is, the more often a topic (theme), such as 'loneliness', is alluded to by participants, the stronger that theme becomes. Also, this repetitiveness proves it wasn't randomly identified by the researcher nor was the researcher interpreting the data too subjectively due to the interpersonal nature of interviews. The redundancy of the 'thought' (unit of analysis) by many participants validates what the researcher has uncovered in the data. This objectivity now allows the researcher to deduce systematically that, for example, 'the farm women of the study were lonely'.

## Constant Comparative Analysis

Transcribing of interviews and coding and categorizing of the data were ongoing and changed as necessary (constant comparative analysis) as more data were collected. One control undertaken in this study to help yield objective and systematic coding was to have another researcher, the thesis supervisor, code and categorize six random interviews and compare her categories to the coding of the interviewer. The comparative analysis identified few discrepancies between the coding of the principal researcher and the independent researcher. This demonstrable strength of interrater reliability reduced threats to internal reliability of the study.

The coding was originally done by hand on the hard copies of the transcribed interviews. The Q.S.R. NUD*IST (© 1990) computer software package was used to compile the coded themes and categories from the transcribed interviews (Appendix E). QSR stands for Qualitative Solutions and Research and NUDIST stands for Non-numerical, Unstructured, Data*Indexing, Searching, and Theorizing. This computer package is designed to work with unstructured, non-numerical data in qualitative analyis. It creates a mode for the researcher to store and explore large amounts of data, allowing for more flexibility of movement of data and less clerical output of time. The manipulation of the program is dependent upon the knowledge, analytical skills, and organizational skills of the researcher.

Within the NUD*IST program, a file now existed of each coded theme with all the data collected from within the 28 interviews in that file. Each 'theme' file also included information such as the

category name, the amount of data in that file, and how many participants referred to that theme. Some units of analysis appeared in more than one file as the narrative material is not linear (Polit & Hungler, 1993). That is, some 'thoughts' (units of analysis) may fall under more than one coding (e.g., a thought shared about 'loneliness' may be attached to the 'loneliness' theme but also may be attached to the theme of 'widowhood').

Each theme file was then analyzed and sub-coded again for the final analysis. At this point the researcher had nine categories. The determination of these categories was influenced by the researcher's nursing background which encourages a holistic view of an individual or group of individuals. These nine categories were later collapsed into the three broad categories of: (1) Aging/Maturation Process, (2) Community Support Systems, and (3) Family Support System. The orginal 29 'theme' files assisted in the writing up of the data. These theme files were also collapsed later into 19 themes, and finally to 8 major themes. Collapsing is done by combining themes (or categories) that are strongly interrelated or similar or overlap (e.g., the original categories 'community' and 'health care' were collapsed into a new category of 'community support systems' as they overlapped as *social support systems*).

## Validity/Credibility of the Research

In qualitative research, credibility refers to "how vivid and faithful the description of the phenomenon is" (Beck, 1993, p. 264). Validity or credibility in qualitative research can be achieved through: (a) the accuracy with which the data is recorded, (b) the level of spontaneity during the collection of the data, (c) the lack of

bias presented by the researcher during data collection and analysis, and (d) cross-checking the analysis of the data with another independent researcher.

The researcher increased credibility of the research by keeping field notes on and observing the participant's reactions while they shared their life stories. A genuine empathy was felt by the researcher without the feeling of a necessity to get involved in the emotional pain many of the participants were living. Because of the researcher's age, being one to three decades younger than the women interviewed, the researcher was not living many of the experiences the participants were living so could remain 'outside' and, therefore, had no difficulty separating her experiences from those of the participants.

The unabridged transcripts of the interviews were coded. Comparative data analysis was used to ensure interrater reliability of emerging themes in the data. In writing about the findings within the data, extensive examples were used to support the researcher's interpretation of the data. Relevant or accurate interpretation was also supported by the redundancy of the themes among so many of the women interviewed. This mass of repetitive data was possible because of the sample size.

None of the study participants questioned the researcher's deduction of the principal themes or determinants. This should confirm an affirmation that their perceptions were identified. If the researcher has accurately interpreted the data, the participants of the study, and any readers of the study who could identify with the participants, that is, other senior rural women of that area, should be

able to 'see' themselves through the researcher's description and interpretation of the data. This step in the data analysis added credibility to the research.

## Limitations of the Study

The intent of this study was to acquire perceptions of rural senior women in three RMs in rural Saskatchewan. Due to the small sample size and the use of a convenience sample versus a random sample, the results of this study are not generalizable. Therefore, the results do not necessarily represent the perceptions of the majority of senior rural women.

One to two hours of contact time with each participant was the only personal face-to-face contact. Although the researcher was touched by the sharing of many intimate family stories of tragedy, no intimate researcher/participant relationship was established; therefore, more in-depth information about what affected the health and well-being of these women may not have been shared. Conversely, because the researcher was a stranger from outside the community, a nurse, and had offered the assurance of confidentiality and anonymity, the women may have shared more personal experiences because they felt 'safe'.

In RM 'A', due to snowballing, the majority of the nine women were from the same church as they gave names of friends. Also, most were involved in the same community non-profit organization. This may have been a limitation as this may have added unforseen and unsolicited independent variables of religion and activity. This may have skewed the results slightly due to the lack of diversity of the women. Also, in RM 'B' the majority of participants happened to

live in one of the major towns and in that town the hospital had recently been closed. The closure may have affected these women more than those who lived on a farm in the same RM as the farmers may have had better access to another hospital in another community. The results may have been skewed as there was an apparent overwhelming concern with health care in RM 'B' in comparison to RMs 'A' and 'C'.

The data were collected over three time frames. Harvest was underway during the first nine interviews in RM 'A' so there was some level of stress with the farm women as it was a very busy time for them (September 18, 1995 to September 21, 1995). Some of the interviews had to be set at the convenience of the women hauling grain. The second set of interviews in RM 'B' was when harvest was winding down, but there was the present stress of worry about finances by the women involved with farming, and it was still a busy time (September 26, 1995 to September 28, 1995). Some interviews from RM 'B' and all the interviews from RM 'C' were held after the snow arrived and so winter had set in (November 29 and 30, 1995; March 29 and 30, 1996). By this time the farmers knew 1996 had been a good crop year and so there was an apparent lack of stress for these farm women. The economy, the weather, and the time of year were therefore unforeseen variables by the researcher which had an influence on the farm women interviewed or on those who had children who were farming. The presence of any of these variables may have affected the direction of the conversation taken by the women when questions were asked about well-being and the environment.

Another limitation of the study may have been that cultural and educational backgrounds of the women were not included in the demographic data. The researcher found the participants to have many similarities which may have been due to the sample criteria. One example was their rurality which attested to this homogeneity and was further supported by the fact that all of the women but one had lived on a farm and that 24 out of the 29 participants had lived on a farm for more than 30 years. In future research it would be of interest to ask specific questions about culture and education.

# CHAPTER 4: PRESENTATION AND INTERPRETATION OF THE PERCEPTIONS OF THE SENIOR RURAL WOMEN OF THE STUDY

The purposes of this chapter are: (a) to give an overview of the women who participated in the study, (b) to interpret and discuss how these women define health and well-being, (c) to present the emerging themes from the conversations with the women, and (d) to give the researcher's interpretation of these themes (or perceptions) in the form of a discussion.

As this present study was a part of a large interdisciplinary study (PECOS), there may be interest in integrating or relating findings from the other graduate studies to this study. For this reason, this chapter will include greater detail in presenting samples from the data to support the emerging themes than might otherwise have been documented in this thesis chapter.

For each theme, with the series of participants' quotations which follows it, each separate quotation represents a different woman. Therefore, following an introduction to a theme, up to ten different supporting quotations from ten different women of the study may be displayed.

## Introduction of the Women of the Study

The number of interviews per RM were: (a) RM 'A'—9, (b) RM 'B'—10, and (c) RM 'C'—10. All of the 29 women interviewed were married or had been married. Seven of the women were widowed. All had living children with 16 of the women having 3 or more children. All but one had grandchildren. Eight of the women were

known current caregivers to elderly parents living either in the local town or a neighboring town.

Sixteen of the women lived on a farm and/or were presently farming. Fourteen of the women lived in towns. All but five of the 29 women had lived on a farm for 30 or more years; 12 of these 24 women had lived on a farm for 50 or more years. Therefore, many of the women had lived all their lives on a farm whereas some had moved into town for their retirement years. Only one of the women had never lived on a farm.

Six of the women described themselves as presently working as farm managers or farm partners. Another six worked outside the home in the part-time jobs of piano teacher, Avon distributor, receptionist, secretary, library aide, and Home Care worker. Eight of the women had never worked outside of the home/farm. Seven of the women had had professional careers as teachers or health care workers earlier in their lives.

Although they were not asked their religious affilitation, it was gleaned from the conversations that the majority were Protestant which fits with the Statistics Canada (1993b) demographics of these RMs. The age range was from 56 to 74 years of age with a mean age of 65 years. Two of the women were immigrants to Canada.

The statistics do not accurately describe these women as there was much more to them. From the phone calls of those who regretted they were unable to take part in the study and from the face-to-face visits with these rural women, there was an overall air of openness. They exhibited confidence. They were articulate and interested in the current events of the day. In only one interview

was the participant somewhat evasive and hesitant but this could have been due to the presence of her husband during the interview. Overall, it was as if these women wanted the status of 'rural women' to be accurately represented. Perhaps for some they were just glad to be able to share their story as many of these women, especially those over 65, had lived through many hardtimes—the 'dirty thirties' and a world war, not to mention other years of droughts or blights. Carbert (1996) found this same 'keen' attitude in interviewing Ontario agrarian women. The researcher of the current study was uninhibited by the interview process which could partially account for her establishment of good rapport with the women interviewed. Communication was a key factor in acquiring the richness of the data which was collected.

## Participants' Definitions of Health

All respondents were able to define 'health', which was the first question asked in the interview. The responses came hesitantly. Only one respondent related health to the absence of disease. Health was defined using such words as 'healthy', 'well-being', 'how you are feeling', 'psychological/physical/mental', or 'stress', and 'doing what you want'.

Fifteen of those interviewed referred in some way to the physical dimension when defining health such as, "It's the way you physically feel.", "eating healthy", "just taking care of yourself", "looking after yourself and staying well", and "being fit". Some other statements which referred to the physical component in the definition of health are:

> There's a lot of factors that go into [health] to make you feel well...what you eat...your lifestyle and environment...heredity.

> We're a healthy family; none of us have ever had to doctor very much.

> How I feel in the morning when I get up; how much ambition I have, that's maybe because of my age now because some days I really don't feel like moving very much so I think it's just a state of how well your body wants to function.

> The well-being of how strong and healthy your body is, how it's functioning normally and if you do normal things.

Seeing health holistically by including the mental or psychological part of the person along with the physical aspect in their definitions was referred to by 14 of the women. This bears close resemblance to the mandala's sense of the mind/body/spirit being the centre of 'health'. Examples are:

> Physical and mental and social well-being...'cause [sic] I think that your mental attitude and your social life have a lot to do with your health.

> Health is sometimes a state of mind, sometimes a state of body.

> Feeling good and content and able to do whatever I wanted to do.

> It is your physical, your mental, and your spiritual well-being. Your overall, the whole comes together.

> Both mentally and physically happy and well. I think mostly mentally is the biggest to me. I guess it's just too hard these last few years coping with life here on the farm.

'Stress' was part of four definitions of health. This was interpreted by the researcher to refer to the psychological aspect of health.

> Any kind of stress level does create a negative in your life and so it does affect your health.
>
> Depressing, I guess my mental health gets that way when my physical health gets [poor]...mentally you become so into yourself when you become physically ill.

Eight of the respondents described health abstractly using derivatives of the word 'feel' with such phrases as, "If you're not feeling good, you have different views than if you were feeling up"; "It's how you feel"; "to feel good"; "feeling well"; and "to be cheerful".

The words 'well-being' to define health were used by 12 women with such examples as, "total well-being", "well-being...both mentally and physically", and "a sense of well-being".

**Discussion: A Comparison of Definitions of Health**

The ability to understand another individual comes from communicating with that person until you have a feeling of what it is like to 'walk a mile in her shoes'. Many things affect how a person perceives his or her life. Culture, environment, relationships, life's events, and one's own genetic make-up all play a role in molding each person to become a unique individual. The mandala of health (see Figure 1, p. 23) depicts an even more detailed picture of this individual and the many influences which can affect the health of the person. Therefore, to enter a geographic area and presume that a community feels a certain way because another geographic area feels

that way may lead to gross misunderstandings or misinterpretations. As the topic of this study is "The determinants of health and well-being *as perceived by senior rural women* in southwestern Saskatchewan", one must first have an understanding of how these women define health and well-being.

These women valued their health and one of the women stated emphatically:

> Health to me is really important because if you don't have health, you haven't really got anything. It doesn't matter how much money you have or how much of anything you have if you haven't got health; it's the most important thing in your life.

Although almost all of the women saw themselves as slowing down as they aged, the majority of them saw themselves as healthy. Many had different chronic pathological conditions but because they felt a contentment in their lives, they thought of themselves as in good health. As one woman stated, "as you get older,...the meaning of health, I don't think, is any different". According to another of the women, to be able to "enjoy life" was to be healthy.

Generally the answers to the question "How would you define health?" were not very in-depth. In every interview this was the first question asked and the researcher feels that the women were somewhat apprehensive or intimidated initially due to the use of a tape-recorder. The definitions did include, in a broad fashion, reference to the physical, mental/psychological, and, in a few instances, social and spiritual components of life, and often the word 'well-being' was used interchangeably with 'health'.

Only one direct reference was made to the environment as being a part of health. When stress was offered as part of the definition, not enough information was shared initially in the interview to relate what effect a change in the environment might have had on this stress.

The overall body of the women's interviews reflected the perceived interdependency of the environment and the community on their health (even though it is very apparent that this interdependency is lacking in the definitions directly offered by these women). Therefore, this thesis is their statement on health.

**Participants' Definitions of Well-Being**

The third question asked of the women was, "How would you define well-being?" Three of the 28 women could not think of an answer. As stated earlier under the definition of health, 12 of the women used the word 'well-being' in their definitions of health. For this third question, not surprisingly, 13 of the women saw health and well-being as meaning the same thing.

> I don't see how you can be really healthy without a good feeling of well-being.

> I don't think health is a different subject to well-being.

The definitions of well-being were often more abstract than the definitions of health, with inferences to emotions. Seven referred to either mental or physical/mental health when defining well-being. Three referred to 'coping' and another three referred to 'peace of mind'. Therefore, 13 of the women related their mental or emotional health to well-being.

If you're unhappy, depressed, it's going to affect something else, your body, I think.

To be able to cope with one's own problems without always having someone come in to bail you out...I think that's what well-being is.

The total picture, whereas health would just be your physical...I think your mental attitude has a lot to do with your physical health.

Your mental attitude is about life in general.

Being at peace with yourself; accepting your life the way it is.

Not being depressed, always looking optimistic, that bright side of life, having faith and taking care of yourself to achieve these things, your diet, your rest, having someone that cares.

Well-being can be imagined or it can be real or a combination of both...mentally feeling good and being active...a combination of your mental attitude and your physical being.

Any family problems we might have had puts you really into a more depressed state of mind and farming itself hasn't always been wonderful.

If you learn to cope with these disabilities...then you would be able to say you have a sense of well-being.

In control...to have a feeling of well-being you sort of have to have things under [control], that you've got a grip on things; that things in your life aren't just all out of hand; that you can cope with things...a good feeling.

Many of the women went a step further in subjectively describing more precisely what gave them a sense of well-being. Fourteen of the women saw that their well-being depended upon

such factors as their sense of happiness, contentment, feeling 'okay', feeling secure, and/or having a happy marriage. Examples include: "If you're happy, then you're more actively healthy"; "Just being a happy person and content with what you do"; "Happiness and well-being go hand in hand"; "A happy marriage...well adjusted children". Additional examples are as follows:

> Where you're contented or discontented with your life or with your marriage...having a very good marriage...we respected each other's opinions...it's important to have humor, a good sense of humor, and laughter in a marriage.

> Knowing you're always going to be safe and secure where you are and health care is good. Like, we have a good doctor here now and we feel secure.

> Your well-being is okay because [you are] quite contented in [your] own environment; [You] make friends easily....I get enough to live on; I really don't want for anything as far as survival is concerned. I don't have money to do a lot of traveling or buy a different car but my actual well-being is fantastic I think.

> Having, not lots, but enough money...just being healthy and having enough money to live pleasantly, comfortably.

All of the women interviewed are very active in their lives. Six of the women related well-being to being active, busy, and being involved and not alone, for example: "I sort of believe you have to be busy" and "Being busy and active and taking part in social activities". Other examples are:

> You know, when I think back to when we were on the farm, we'd get together with our neighbors and we'd play cards or we'd play games or just have a visit and coffee

> and they don't do that anymore....You know, you almost have to make an appointment or phone somebody to see if they're going to be around....People just don't socialize so I think that might have an affect on our well-being, you know, if you're the type of person that gets lonely or needs company.
>
> If things are all right in your life and you know you're working, you don't mind working hard...as long as you can see some results.
>
> Still able to be busy, you know, a person is physically able to carry on with most of your work and a good mental attitude.

One woman responded very concretely that well-being to her meant "routine, having your meals on time and doing this regularly....Like, if you go away and you eat differently,...you feel differently." Another woman saw well-being as not being confined, "Out in the open [on the farm], you have more freedom, rather than in town, you feel kind of [confined]."

**Discussion: The Meaning of Well-Being**

Well-being and health were seen as interchangeable by 13 of the women. In the literature, well-being is often referred to as quality of life, life satisfaction, or wellness.

The major difference in the responses of the two definitions, health or well-being, was the emotional component. Talking about well-being elicited more detailed and thought-provoking answers and these answers were wrought with feelings. Also, well-being was looked at more globally, that is, beyond themselves. With definitions of health, the women were apt to be more intrinsic. With well-being they were more apt to view their lives looking outwardly. To these

women, their bodies were of less importance than their psyche when monitoring their well-being.

When defining well-being, the psychological and emotional aspects were referred to by 24 of the women using various words such as 'coping', 'peace of mind', 'contentment', 'happiness', and 'feeling okay'. Six of the women related well-being to being active and involved with others.

Overall, the definitions of well-being seemed to relate to feelings and relationships and were somewhat more ethereal and not as concrete as the definitions of health. Although there was a large variability in the narrative descriptions of well-being, the depth of emotion and wisdom of these women came through in these definitions. Wisdom is perhaps only realized with advancing age due to having survived the miracles and hardships of life.

The most emotional times during the interviews, almost universally, were the stories revealed when the women were asked what changes in their lives had affected their well-being. Not one of the women had been spared tragedy in her life.

## Emerging Themes: The Perceived Determinants of Health and Well-Being

The interviews were semi-structured, therefore, the questions asked of the women were of a broad nature allowing for interpretation and direction by the individual who was being interviewed. The questions referred to environmental changes, community changes, the unfolding future, and personal health-promotion practices. The universal themes (categories) relating to health and well-being which emerged, from analysis of

the data, related to (a) the aging/maturation process, (b) the community support systems, and (c) the family support system.

The 29 emerging sub-themes found in the data were categorized under these three universal themes. The sub-themes are the more specific determinants of health and well-being as perceived by the women, such as widowhood, availability of a doctor, or coping skills. These sub-themes were not always as universal, which is understandable as each woman presented her own life story. Some women were widowed, some were farmers, some were retired, while others still worked part-time; therefore, this variety of backgrounds and living arrangements adds to the diversity of these women. Common factors shared by the participants were that: all had children, all but one had grandchildren, all had been married, all lived in rural Saskatchewan, all were experiencing the changes which were taking place in rural Saskatchewan, all were entering or were in the 'retirement' phase of their lives, and all were experiencing their bodies aging.

The first theme of aging will be subdivided into (a) the age-related changes these women are experiencing in their bodies and what they are doing about theses changes (health-promotion practices), and (b) the resilience or hardiness of these women. The second theme reflects on the community. This theme will be subdivided into (a) the spirit and sense of responsibility of the community to each other and, (b) the changes which are being experienced within the community and how these changes are affecting the women of the study. The third theme reflects on

families and their impact on the health and well-being of senior rural women. This theme will be subdivided into (a) family proximity, (b) family participation, and (c) caregiving. Each of the sub-themes has an impact on the lives of most of the women and will affect the ability to sustain them in a rural environment.

## 1. Aging/Maturation Process

### (a) Aging Body/ Health Promotion

How these women perceive their bodies appears to have a bearing on what they feel they are able to physically accomplish and what they must do to maintain this level of 'fitness'. This theme of aging is subdivided into the aging body and health-promotion initiatives.

**Aging body**. The women were aware of the changes going on in their bodies and they took responsibility for the causes of some of these changes. The women attributed their body changes to the natural aging process, to heredity, and to personal neglect.

> I quit smoking 2 1/2 years ago because...I found I had partial blockage in my leg arteries.

> [*after having fallen off a ladder*] [The doctor] called it compressed fracture of the vertebrae....What a dumb thing to do, I said I must have been brain dead that morning because you know you're getting older; you can't do those things!

> Menopause was a big change, I think. Physically I'm not able to do the things that I was able to do 20, 25 years ago. I can't keep up that same pace anymore. Your body just seems to, I don't know, doesn't want to cooperate. The brain does but the body won't!

I had a real bad case of hemorrhoids which is not life threatening but very uncomfortable and a little scary at times when they go, [because with] your bowels, you know, you might have cancer or a blockage or something.

I like to read only my eyes seem to be bothering me so I don't read as much as I should. I go to sleep when I try to read.

I'm a bit deaf....I miss a lot of conversations....I did get a hearing aid but I really don't like them....But you know that adds to your health....Well, I haven't worn [the hearing aid] for quite a while, I must say. I think I miss some conversations. I just smile and pretend that I know what they're saying.

When I was having my aches...[the doctor] just said to me, 'you just want to do too many things'. You know, he said 'you do too much for your age' and I said 'no I don't'.

As you get older your muscles kind of slack off and don't hold you together quite like they used to.

You start to slow down; you hurt more when you wake up in the morning. I think your mind wants to keep busy, in fact, it's overactive most of the time, but the body just can't keep up and I think good health must be learning your limitations like learning you have to slow down...and maybe not try to accomplish as much.

I get tired more easily now, signs of old age creeping up on me. I have a little bit of arthritis. I can't do as long a day as I did one time but other than that...I feel well.

Your body changes, that is, develops creaks and arthritis and things like that, so the biggest fear I have, of course, is that I will cripple and not be able to do some of these things.

I have gained far too much weight. I'm worried about my heart...because I have a little bit of a history in the same area, too, so therefore, I want to lose weight.

As well as physical changes, these women are experiencing changes to their psyche. Comments from 11 of the respondents addressed nine different areas they have identified as new challenges they are facing at this stage of their lives. Work has taken on a different meaning. There has been a role reversal with their parents for some of the women. Menopause has resulted in a change in the psyche which may have led to some of the other challenges which came to the forefront such as a change of priorities, a welcoming of the solitary life without children, a new sense of freedom, or a new dimension of self-esteem. This time of life could bring with it new stressors including death of a spouse, death of parents, breakdown of children's marriages, and the realization that death for themselves was also approaching. This new phase of life held its mysteries for these women, sometimes in the form of surprises and seeming miracles, and sometimes in the form of unbelievable heartache and tragedy.

> I just love my life, the way it is now. I work only in the afternoons for a few hours; I'm free in the morning; I'm free in the evenings; I'm free on the weekend. I can just do whatever I want, what I enjoy.

> We actually got [our parents] settled into the nursing home and I think that's the hardest thing I ever did in my life was walk away and leave my mother in there. You know, you don't think it's going to be that hard until you have to do it and you have to do the role reversal and it's not easy.

> (*This women refers to the death of her young adult child.)* Because of what happened two years ago...I'm not as happy as I was....I get panic attacks now but I never did before....I used to feel I used to like myself and basically that's all I could say about myself....I've always

made friends easily and kept my friends....you wonder where you've gone wrong.

I think there comes a time in life when you...just feel like maybe you want more time to yourself...to do the things...where you're not tied down to a farm or with a young family.

Death in the family, that affects your health; my husband retired, that certainly affected the way I felt.

I used to clean the whole house, houseclean, like really spring housecleaning in three or four days, now it's just not a priority anymore.

When there's a breakup with one of your children, you do suffer a certain amount of grief....I have to handle it and so far as I'm concerned in the best way I know how, and sometimes that's just trying to keep out of it and trying to avoid it and let them work out their own problems.

It's seeing the older generation dying off and then finding myself in that [generation].

Many of the fears mentioned related to the aging process—fear of their bodies aging and failing them, fear of a loss of independence in making their own choices, or fear of retirement. Seven women mentioned aging-related fears or fears of not actualizing their dreams.

You tend to be afraid because time is passing by so quickly and you're wondering if you're ever going to be able to do what you really wanted or whether you're physically going to be able to do it as you age....The biggest fear I have, of course, is that I will cripple and not be able to do some of these things....I feel like I'm aging in fast forward and when I see people (I've lost a very close friend who was only a few years older than me) all of a sudden you're not immortal anymore!

> My younger sister, three years younger than me, just died two months ago, just out in the garden, from a massive heart failure and she never had any problems at all. All my older brothers and sisters have had bypasses, had heart attacks, one had a stroke. It's in the family. Well, the doctor says maybe you're going to be the black sheep and not have this gene in you but then when my sister just died tragically and sudden, that scared me.

**Health promotion.** When the women were asked what they did to promote a personal healthy lifestyle, five topics arose: (1) diet, (2) exercise, (3) preventative measures, (4) education, (5) being active. Almost all of the women (24) referred to their diet, that is, what they eat, how they cooked the food, the home grown and homemade items, and/or vitamin supplements, as a way they promoted their health. Many compared today to 'days gone by' when there was no junk food, no additives, and vegetables were plentiful and fresh from the garden; but they also identified there had been an abundance of cream, butter, fatty marbled meats, fried foods, and home-baked sweets. Therefore, some change was viewed as a plus and some was viewed as a minus. Overall, they were very cognizant of the value of the food they prepared. Some found old habits 'died hard' and still felt making things from scratch, having your own garden, and fried foods was just how they would always approach their diet. Others made a concerted effort to change their diets to the new media-driven and 'avant garde' diets, many after a major health scare for themselves or their husbands. Diet played a major role in their lives as was indicated in their quotations below:

> Cutting down fat and watching sugars...it really has changed the way I cook.

I like to try and make healthy meals....I try to see that [my husband] does the right things although he doesn't, you know, he likes his cream and butter and stuff like that; whereas, we try to cut down on this [kind of food].

I'm a great vitamin person. Whether that's good or bad, I don't know.

We're very conscious of how we eat, cutting back on the fats and eating more legumes and things instead of always meat and brown bread.

I take vitamin C every day; I take garlic twice a day, calcium once in a while.

I watch the diet now closer because of my husband....We don't eat fat and we don't have rich desserts like we used to on the farm but then, of course, we don't have the cream either....I don't fry; I broil more and I trim the fat, of course, off the pork chops.

We still like the frying pan pretty good, which we shouldn't, but another way that our health has maybe improved is...we have so many more foods, more selection, food that we never thought of when I was a kid growing up on the farm; now we can have any food we want...like broccoli, you never saw that.

When you eat a treat...you know, fast food all your life, you're never going to be healthy and that's why I always wonder about children today, so many of them eat just so much garbage and I guess coming up in the hard times there wasn't those choices. [There were] your basic foods so maybe you got trained to eat and Mom was home so the cooking was done and [was] homemade.

I like to cook and, of course, we were able to have sugar then so what did you do? You baked and baked and baked and it was just the wrong thing.

Exercise was the next most talked about item which the women felt they did or didn't partake in order to maintain their health with

22 of the women mentioning it. Interestingly, many felt they fell short in this area. Twelve of the women walked fairly regularly whereas 5 said they should walk but didn't, didn't want to, or couldn't due to health restrictions. Three of the women boasted stationary 'bikes' in their basements which they used in the winter months. All who mentioned exercise for health promotion recognized its merit.

> I try to be active...and if I get tired I just call it a day and go to bed. (*She is diabetic* )

> I consciously get out and walk a bit then because I only have these four walls staring at [me; when] it gets cold, I have a bike downstairs.

> I don't always have a real exercise program but I try to do some [exercise] at least three times a week, like either walking or bicycling...I go on this grid road. I golf a little bit. I'm not a good golfer....And I have a stationary bike that I use in the winter.

> I have a big garden....I just think it's the environment, more or less, that keeps me busy and active.

> [I live] half a mile [from town]. I suppose eventually it'll probably be a problem but I can walk it if I can't drive it so right now I walk. I do walk it. [*Even with your arthritis?* ] Well, it's good for me to do that, I think.

> [I walk] every morning, a couple of hours every morning....It's an added bonus having the dog and making yourself go....I don't ever take a car here, I walk.

> I like to walk alone, [in the winter] that's when I like it the best....There's no phones out there...and I talk to my God.

In the area of preventative care, only 14 of the women stated they have regular physical check-ups and 8 of the women said they attributed their health to following doctors' orders for medication, some treatment, or a lifestyle change. No explanation was given why they didn't go for regular check-ups other than proximity of a doctor.

> I make my yearly trips to the doctor. I do breast self-examinations.

> I do have a touch of high blood pressure so I go every couple months. [*Your feminine check-ups?*] Not as much as I should.

Four women mentioned smoking and how it related to their health. All were aware of the dangers of smoking but not all were willing to change their present habit.

> [*Wow! you quit after how many years of smoking?* ] 40 years; anyway...my husband quit at the same time, too.

> I guess I'm kind of stubborn. I've smoked for so many years, I'll be darned if I'm going to give it up....I might better myself if I quit smoking...and go for walks....I would probably be better off for it but in the meantime, I guess I'm just going to fool around with living dangerously!

There was an inquisitiveness about keeping their bodies healthy. Ten of the women actively read health-promotion literature and some attended seminars and watched educational channels on health.

> I discovered that I was allergic to milk and I shouldn't have been eating anything with milk in it...just by reading and whatever I've come across.

> I've read quite a bit about osteoporosis and heart disease and various other health problems....I request books a lot...through the library. I think there's better

> education now. I think people are more aware of how to live a healthy lifestyle....They have these nutrition seminars.
>
> I've read some good books on grieving and death and dying and it just helped me understand why there's anger, why there's denial, why there's all these things related to loss of a mate or spouse....I thought there was something wrong. I would talk to him and I'd be angry; I'd be crying but I found that this is all quite normal.
>
> Did you ever read Sugar Blues? Well, you should, that finished me on sugar!

Nine of the women mentioned that 'keeping busy', or having a positive attitude to life promoted good health, especially good mental health. Keeping 'busy' or involved was also how some of the women defined 'well-being'.

> I keep myself busy and occupied. When I'm not out and about I'm sitting around here doing something.
>
> Try to keep busy; keep your mind active, I think is the best thing.

The activities that kept these women 'busy' were varied. Involvement in the community and personal activities at home were the two main categories. Traveling was also an activity mentioned by many of the women. At home what kept most involved was handwork, reading, cooking, or baking. Their hands were never idle: ten knitted, crocheted, sewed, or quilted; cooking and reading kept another ten busy at home; gardening was mentioned by seven; and canning was often talked about as well.

> I can't, for the life of me, think what did I do before I took up crocheting....Did I just sit there and watch TV; stare at the TV?...Crocheting is keeping me healthy because I don't worry about a thing...when I'm

> crocheting; it's just like I'm in my own little world and I'm contented.

> I knit and crochet and paint....I won't live long enough to do all I want to do!...As long as I have my hands and my eyes, I could never be bored. And I like to bake. When I get mad at something that's what I do, I make bread because I feel that is the most rewarding thing. I can punch the daylights out of that bread and then I end up with all these nice buns!

The availability of amenities in a community, of course, will help determine in what activities the citizens can participate. With the rural community changing, the activities also change. Many of the rural churches have closed and in other cases, where the churches are surviving, membership is down. This may account for only eight of the women mentioning church activities as part of their involvement. Other community amenities which are either opening or closing, in the three RMs of the study, are rinks, golf courses, and bowling alleys. Eight of the women stated they were actively participating in bowling, 'shuffling' (shuffleboard), and/or golfing. Of these eight, most of them mentioned that they had at one time curled. Therefore, organized sports was not an activity of great prominence for the women of the present study.

With the ages of the women interviewed, all were either in the 'retirement' years or were at an age when retirement was a part of their near-future planning. Interestingly, some activities one might automatically associate with retirement, such as membership at a Seniors' Centre, traveling, or playing cards and bridge, were not stressed by these women. Eleven women talked about doing some traveling (or about having no interest in traveling); five mentioned a

Seniors' Centre with only three of those five being participants; and four mentioned that playing cards or bridge was a major part of their social life. Perhaps these are activities more often identified with their urban counterparts.

Although family participation and family involvement will be discussed later as a major determinant in health and well-being of these women, when asked about their activities, only three specifically responded that the grandchildren were a part of their activities. This involvement was spoken of as babysitting or as watching a sporting event or recital.

These ladies were busy, but six of them felt their "coffee-time" was of utmost importance. For most who identified with 'coffeeing', it was an 'outing' as the ladies met in a local restaurant. As you drive through the small towns, the cars are often lined up in front of the local cafe, especially in the morning. However, 'coffeeing' isn't for everyone.

> I don't enjoy just going for coffee and sitting around gossiping and things like this. I get nothing out of that. I'd rather be 'doing'....I like meeting different people and talking to them and I get very bored if things get too small.

> There's some of us widow ladies that get together in the evening and go out for coffee; that's sort of a ritual.

Many of the activities have not changed for these women with the passing of the years—the gardening, the canning, and the church work. For some there was not time in their earlier years, with the raising of a family and farming, to be part of organized activities. Now these women appear to be the backbone of the community as

they have more time to expend and they have a sense of duty to their communities. There is almost a sense of "if 'we' don't do it, who will?"

Traveling was hoped to be a part of future plans for 11 of the women. For some traveling had already been a part of their lives, whereas for others it was the freedom of time in retirement that would finally avail them to travel.

> We travel in the winter because we're still farming [so] we really can't travel that much in the summer time. We go away for two months in the winter. Go down to [the USA] as a rule and we've done that for the last 11 winters now. [We'll continue] depending on this money business.
>
> [We'll travel] if the money is there, like this year is good, and especially if our son comes home and farms and is here all year....You don't like to leave a farm that's empty for weeks on end.
>
> I would like to [travel]. I thought if I could find a lady that was about the same age as me with like interests, we could go.
>
> We're going to buy a fifth-wheel. We're going to do some traveling.

**(b) Resilience (Hardiness)**

The women of the study had an apparent inner strength. This strength was synonymous with resilience or hardiness. Resilience is where one remains healthy while experiencing changes in life or "has the ability to recover strength, spirits, and good humor quickly" (Dorset & Baber, 1983, p. 1540). This resilience was seen through their aptitude to deal with life's events. Resilience was revealed in

many facets of these womens' lives such as: in spirituality, in contentedness, in a sense of independence, and through coping skills.

**Spirituality.** A faith or a spirituality was made reference to as a grounding force to deal with life by seven of the women. Two other women faithfully attended church alone even though their husbands were not interested whereas, for another woman, the fellowship of family attending church together was her strength. Many of the women spoke of being actively involved in church activities and on various church committees, but only the seven spoke of their faith as a source of peace or strength.

> I have a faith that keeps me going, gives me peace and a hope for a future and it's that faith that binds our family together....You have a peace, what we call a living hope, that it doesn't matter what God plans for you in the future, if you're just willing to accept it, you'll know the best is still ahead.
>
> You have to have faith. I do. I don't know what some people that have a lot of real problems, I don't know how they cope if they don't have the faith.
>
> When you look back you see blessings even in the shadows....We all have our crosses to bear in life and it's just how we handle them or how we relate to them and how we overcome, I mean, some have heavier crosses, we think, than others. I thought we were blessed, we had 42 good years. (*widowed*)
>
> I like to walk alone....There's no phones out there. [I] talk to my God....I say the serenity prayer, like grant me the serenity to accept the things I cannot change, the courage to change the things I can and the wisdom to know the difference and lots of times, you don't have that wisdom.

**Contentment.** There appeared to be a genuine sense of acceptance and peace with the way life was unfolding for most of the

women. Four of the women even referred to a derivative of the word 'content' to describe their health or their lives. Nine of the women made strong statements about the acceptance they had found in their lives. This contentment showed itself as a sign of strength or resilience, as:

> I've always been happily married and my children have always been good to me....I'm content....I'm not a person that really expects a lot. Years ago, I guess I thought it would be lovely to have a brand new home and all this, but as you get older, you find those things don't mean as much to you anymore.
>
> As far as my mental health, I'm happy; I'm at peace with myself and I'm content [with] where I am and what I'm doing.
>
> I'm not a worrier; I just go about my life day by day and I'm always fairly optimistic. I don't worry or brew [sic] about things. I'm generally very happy and I think that has a lot to do with your health, what your mental attitude is about life in general....I just love my life the way it is now. I work only in the afternoons for a few hours, I'm free in the morning, I'm free in the evening, I'm free all weekend. I can just do whatever I want, what I enjoy. This a very good time in my life, I just really am happy with it.
>
> I like home and this is where I want to be.
>
> This is the time to live, now, not [dwell on] what happened yesterday....I just let things take their course....I'm very, very contented....I don't worry. My husband and I never worried about retirement....We were so busy enjoying life that we were never going to get old....My crocheting is keeping me very healthy because I don't worry about a thing. When I'm crocheting, it's like I'm in my own little world and I'm contented. I'm safe and, to my knowledge, my family is safe. The people I

> love are all safe so why would I have to sit there and stew about things. What is there to stew about?

**Independence.** When asked the question, "Who do you think is responsible for your health?", all 28 of the women emphatically responded, "I am". The self-esteem and self-worth of these women were exemplified through their decision-making, that is, in making decisions about their health needs and about taking initiatives in the events of their lives. There was no apparent self-pity, nor was there a feeling of self-absorption; what was apparent was a sense of self-confidence and a strong self-identity.

A lack of self-pity for past and present hardships was very evident when interviewing these women as in the following examples:

> A lot of people wouldn't be able to stand [living on a farm] likely because I am here on my own a lot. But I always find something to do. There's lots to do in the house if you want to do it.

> We've always worked for every dollar we've made...I can remember our son going to the old rink and dragging home all the senior hockey sticks after a game and he taped them up and he'd heat them in a pail of boiling water and hold them between the two doors to get the right curve on the blade and we couldn't afford to buy him a new hockey stick every time he broke a stick. So that's what he did. I mean I don't think it hurt them. If anything I think it helped them. He's got a good job now....I'm hoping that maybe sometimes he thinks back to how it used to be.

> I've had surgery and that kind of thing but to me that's par for the course. You can't go along and not have some kind of ailment....They're sort of an inevitable thing, like having your tonsils out or having a hernia repaired.

Having to put [our mothers] in a home, I found that really stressful and that I think affected me because it was at the same time as we were having this other problem with another daughter so it just seemed like my whole world was sort of caving in at one time. But I basically think if I wouldn't have had other things to keep me going, like a lot of interests, it would have been a lot harder. Just basically you keep going, you keep doing things, you have responsibilities and you just keep going. You don't go to pieces.

Being a bit older you learn to accept the knocks that you get without letting them throw you too much because when you were raised in the so-called 'dirty 30's', you didn't expect that much.

When the first two [children] were small, we had no electricity, no running water....For bathrooms we trotted out in the cold...and the old Eaton's catalogue was toilet paper. I felt just great when we got the bathroom, running water, and electricity. Then you get so you take all that for granted.

When my husband was so ill you had to keep yourself upbeat so that you wouldn't become depressed.

Anything that has been something serious enough to have to face, I have either studied about or learned [about] and come to grips with myself because I don't think you can run away from that sort of thing. I can cite [an] example. My son and his wife separated with two small children....I have an excellent relationship with my daughter-in-law....So there's that disappointment from a parent and grandparent point of view that it wasn't the way we thought it would be....These are areas that we have had to deal with.

[My husband] has no indoor hobbies at all other than TV and we only get two channels whereas I knit and crochet and paint. I said I won't live long enough to do all I want to do. I will never ever as long as I have my hands and my eyes, I could never be bored. And I like to bake and so if I run out of something then I come and make buns

> or something....A little dough about this big and I end up with a whole kitchen full of stuff and to me that still amazes me. I still always just love to look at it.

A part of the autonomous nature of these women may be due to their sense of self-worth and a healthy self-identity demonstrated in the following statements:

> I take very good care of myself and I try to be active and watch my diet and don't overdo and if I get tired I just call it a day and go to bed.

> We're very fortunate to have those homes [to look after our parents or] I don't know what we'd do. It's given me a life.

> I'm totally independent. I drive. I can go and do what I like. I don't have any controls on me.

> He just takes me in to church, like I always have gone....At the centre, he'll just go up there and watch TV until church is out because he isn't a church goer.

> I'm a writer....I have friends all over the province and other provinces, too, so I know it would be stressful to move but you can make friends no matter where you go, you can find like-minded people.

> I'm really jealous of my Saturdays, I don't want to go to town. I do everything [during the week] so I've got Saturday for me to stay home.

> This is the feminist in me—the [women] that don't know how to write a cheque and their husband will die and they have no idea of how to pay a water bill....It's frustrating.

Keeping busy and involved was an aspect of their well-being, therefore it was not surprising to see these women showed initiative in the events that affected their lives. Such initiative is seen in the following examples:

> I am here on my own a lot but I can always find something to do....I'll do some more traveling even if I have to go alone.
>
> I thought now when I quit 'subbing' I'm going to start a piano class. It took a bit of nerve because I don't have this degree in music and I started with one student.
>
> I had my first airplane ride this summer (*at the age of 70*).
>
> I'm kept busy. I sell Avon, I work, I have a garden, do my own cooking and canning. I never find that there's a day that I wish somebody would come over or I feel like talking to somebody; [if you want to talk] you can go to coffee row.
>
> If [my husband's] busy and I want to go and see the kids [in the city], well, that's fine, I can just get in the car and go....So I'm free to do that and I quite often just take off and go.
>
> When things get a little too much here, I just get a bus ticket....I just catch the bus and go out and stay there for a few days with each of [my children].
>
> I drive to Winnipeg on my own. I tried the bus once and I hated it with a passion so I'll never go [that way] again, not as long as I have wheels.

At home and in the community, it was modelled again and again how these women looked beyond themselves and revelled in helping others; they were not self-absorbed. Examples are:

> I'm not a person that dwells a lot on my health because I've not had a lot of sickness and if something happens, [it happens] and then it's over.
>
> The only way you can get along in this world is you've got to think about the good things and less about the bad.

> We've lost a granddaughter, that was a stress. She had a brain tumor but then every family goes [through things], you can't skip all those [hard times], you're not immune, you're not any different.

> We had our ups and downs but we grew up in the age where you didn't really expect a lot and we seemed to be able to cope.

**Dealing with death.** Seven of the women spoke of traumatic losses in their lives with the death of a family member (other than a husband). The topic of the death was often broached when they were asked about things in their lives that may have affected their health or well-being. Some had faced many deaths in their lives. The resilience, seen in the examples below, was in their acceptance of things they had no control over or could not change:

> Losing your parents, brothers, sisters, which I have lost, I think that probably affects your well-being temporarily.

> [We lost a grandson, he was] just 16....He went very suddenly....It wasn't expected but yet it wasn't unexpected either....I think a person can learn to accept the things, I mean, you can be upset but you don't need to let it really throw you....I had a lot of sickness in the children, two premature babies....So I think you learn to accept those things, like we did, quite early, and then when different problems come up, you just think, well, you just have to handle them and you carry on. [My husband and I] never let it throw us too much....I guess in some marriages, they drift apart, I think it made us closer.

**Widowhood and coping skills.** Two of the respondents talked about widowed elderly mothers. Seven of the women interviewed had lost their spouses, some as recently as a few months past, others had lived with widowhood for a few years. Most made

comments that would directly or indirectly indicate that widowhood had affected their well-being. But even though many of these women said they were sad and lonely, they were 'fighters'; they were not ready to give up on life. They appeared to have strong coping skills, as indicated below:

> [*Husband died four months ago*] I'm very sad and it's painful and I sometimes wonder how I'm going to continue but I have to, there's no other way—I have grandchildren; I have children....I just think at the moment it's such a very lonely time particularly in the mornings and evenings and there's no one to discuss your problems with or share your joys or sorrows or nobody to complain to....I knew it would be sad but I never realized how painful losing a mate would be....Sometimes it looks so bleak and dark and it's just because I'm—the word 'alone' is so overwhelming. Everything you do is alone....I don't know what's going to happen, just to spend [life] alone, I'll have to entertain a lot of people or have people in in order to help fill the evenings, I guess, and they'll be happy with that, too.
>
> Being a widow has certainly affected my well-being....You have someone in your life for 49 years, it's a long time and it's very lonely. You just try to fill your days with doing things for other people so that you can make them feel better and that makes you feel better, gives you more of a purpose.
>
> Some of [the ladies I play cards with] remarked that now that I'm leaving, we're going to miss you....So that made me feel good in a way, too, because I came out of a bad time [with losing my husband] and yet I'm still able to bring maybe some pleasure to someone else and that helps me, too, because if I can generate happiness in others, it has a habit of falling back on you a little bit!
>
> (*She and her husband [now deceased] used to go south for the winter.*) They've been after me to go [back to the USA] but it's that first time, you know....Mind you, to go back now and

> [have a] rerun, that would probably hurt a little bit here and there but I think it, in the long run, would be a good hurt because the memories become more precious....When you don't have anything to look forward to, then that hole gets darker and darker; you know, you have to apply yourself to receive sometimes; you have to give.

Many of the widows talked about the loneliness and the fight against it appeared to be ongoing for many as some had been married for more than 40 years. All of the widows showed definite signs of grief when talking about their losses and loneliness seemed their biggest enemy. But they were not really alone as there was definitely a support system at work, sometimes it came from family and sometimes it came from the community.

> I spend a lot of time with my kids [and grandchildren]. Each day [since my husband's death] gets a little better so I'm sure that if I can get through this winter without too much boredom and not seeing a lot of people, I think by next spring I'll really be able to take hold and take over.

> [Our local doctor] asked me many times [since my husband died], how I'm feeling, that used to be his first question and 'are you getting out and doing things like communicating with others, don't just close your door and say, well, I've had it'....Well, the ladies invited me to play cards with them so I thought, well, that would get me out of the house once or twice a week and we could have a lunch together and just play cards for the fun of it....You learn from experience, as a lot of [the ladies I play cards with] are widow ladies so, therefore, they've been widowed a lot longer than me. With talking, there's lots of things you can help each other out with because lots of times the women in that age group weren't involved in business.

Only one of the widows lived under a heavy financial burden since becoming a widow in her 50's. Within a couple of years of being widowed she also lost her job due to closure of the business.

This woman was relying on her savings to get her through until she could apply early for her pension. Some of the widows felt trapped in their present housing as their homes were paid for and yet the housing market was so devastated that to sell their home, the monies received would not allow them to find alternate housing and maintain their accustomed lifestyle.

**Loneliness.** Certain aging factors and life changes really tested some of the women's resilience. The women were not bashful about admitting that loneliness could insidiously creep into their lives unbeckoned and unappreciated. Loneliness was a significant factor in widowhood. Five of the seven widows interviewed referred to it. Yet when looking at all of the interviews, 13 responded with stories relating to loneliness. Some examples of phrases about widowhood and loneliness were: "not having anybody to talk to", "everything you do is alone", "being a widow...very lonely and you just try to fill your days". Another example is as follows:

> I think some of the people I see, they're lonely, like widows. A lot of them, they just have no other excuse but to come out to see the doctor and to talk to him and maybe they tell him their troubles...and he really does care.

The loneliness often extended to those women living on farms, especially in the more isolated areas, as is shared in the following statements:

> We were eight [miles from town]. There would be days when you're ready to climb the walls because everything's the same. You're doing the same thing over and over. You would just like to get out and talk to another adult.

> It's very easy, especially in wintertime when the weather's not as nice, to just sit on the couch and watch TV, where years ago you would just get together and make a quilt and then you'd have conversation.
>
> I get, very, almost, depressed because, for one thing, I don't go away very much. My husband doesn't like me to leave and I said 'there's nothing here but men'. You miss that woman conversation....I belong [to a ladies group]. I'm telling you, if it wasn't for that, I would go star [sic] crazy mad. I just go there and I can walk in that door and I'm completely in another world, and there's just the women and we all giggle and gossip and coffee, and I come home feeling much better.
>
> I try not to spend too much time alone because that's not good for you mentally. If I start to feel down in the dumps, I get dressed and I just go [into town]. I go and half an hour will do it, and I can come home and work again.

Some of the women were saddened by friends moving away and were faced with dealing with the resulting loneliness. Often the elderly woman friend that felt forced to move from the rural setting was also experiencing the loneliness.

> We did have a bridge club here...and one person died and two or three moved away and others just got old and lost interest, weren't keen to begin with. I used to play a lot of bridge at night.
>
> Two of my friends that have moved both had nervous breakdowns....[One] said 'I couldn't even hang a picture on the wall, I'd just cry'.
>
> A lot of these people that left and have gone away, some of them are leading a pretty lonely life....a lot from here had gone to live in homes in [the city].

The resilience of the women was sometimes challenged. When looking ahead to retirement, some first had looked back with regrets—for things that had been left undone, poor choices of the past, hauntings from their youth. Three of the women wished they had traveled more when they were young. They have now either lost their health or their spouse, leaving them feeling robbed of their dreams of adventure. Two women felt they made compromises in their lives by marrying young and staying in rural committees leaving them falling short of their potential, one of whom always had wished to finish university and be a writer. Two felt that poor choices made in younger years left them with irreparable regrets, one losing her mother who she was unable to care for when the mother was dying, and the other, after 50 years of farming, seeing no rewards for the hard work on the horizon of old age. Two others brought the haunts of war and death experienced in their youth into their old age and they were just now realizing how these horrors had dominated their lives making them live their lives like victims. The majority (19) looked to the future with some apprehension.

**(c) Discussion: The Aging/Maturation Process Affecting Health and Well-Being**

The latter stage of life can be referred to as the maturation stage or the stage of aging. Both words, 'maturation' and 'aging', are applicable as they refer to two processes which are intertwined. The body is changing and preparing itself for the final closure of life. At the same time there is seen an increased intuit and wisdom. Life is truly viewed through wizened eyes and, to coin a word, through 'wisened' eyes.

The maturity with which senior rural women approached the aging process was seen to reflect on their health and well-being. Two determinants of health and well-being which evolved from the data analysis were: (a) how the women approached the care of their aging bodies, and (b) how resilient the women were to life's trials.

In response to the aging process, one participant inferred that she was going to die 'young', no matter how old she was!

> I don't want to date myself. I don't want to be old before my time. I doubt that I ever will. When I buried my mother I buried her in rose, bright rose, her favorite color....She's not going down a little old lady and that's exactly how I feel, too!

Although one woman interviewed stated, "As long as you can keep your physical health, then your mental health probably will improve, too, if you stay physically well at our age", most of the women would not have worded it quite this way. Even though the women saw their bodies and energy levels changing, they felt a positive mental attitude was probably the predominant determinant of having a 'healthy' life. The two inner mandala circles (see Figure 1, p. 23) highlight the physical and mental aspects of the individual ('mind/body/spirit', 'human biology', 'psycho/socio/economic environment', and 'personal behavior').

Deep down inside, the women intimated they felt as they had always felt, that is, the eternal young woman with the same emotions, only wiser. But their bodies were letting them down and, although the women were seeing those around them age, there was some evidence of surprise that it was now happening to them. Almost all who talked about their bodies changing used the phrases

'slowing down', 'not as spry', or 'aches and pains'. There was often visible evidence of aging. When the women shared information about their health, they often alluded to complex pathology such as diabetes, arthritis, hypertension, varicose veins, hearing loss, osteoporosis, cataracts, and bowel disorders. For some there was a covert fear of a future with functional disabilities attributed to aging.

The question was asked, "What are some things you are doing to maintain or promote your health?" The answers are related back to the mandala of health where most of the responses are seen to revolve around 'lifestyle'. This incorporates one's 'personal behavior' and the 'psycho/socio/economic environment'. The women's personal health was seen as being promoted in the social activities engaged in and in their inherent life skills relating to diet, exercise, and personal growth. Health promotion or indifference to personal health promotion and maintenance can be tied to the womens' perceptions of their aging bodies ('human biology') and to the women's care of their ailing bodies ('sick care system'), that is, how the women perceive their individual worth will determine the care they will take of themselves.

Therefore, the attitude of the women to personal health promotion and health maintenance was a determinant of their health and well-being. The women perceived health promotion as giving attention to: (a) a proper diet, (b) exercise, (c) preventative care such as annual check-ups with a doctor and following prescribed treatment, (d) continuing education to aid health promotion, and (e) involvement in activities and keeping busy. Diet and exercise were the two most prevalent health-promotion practices referred to

by the women of the study. Their involvement in activities was the health-promotion practice in which they really excelled. Preventative health measures and health education as part of their health-promotion regimen were mentioned by fewer than half of the women.

Another determinant of health and well-being was identified as resilience. This was deduced by the researcher after listening to many shared stories of endurance after losses and hardships. Resilience, which is sometimes referred to as hardiness, is reflected in the mandala of health under 'psycho-socio environment' and in the 'spirit' of the individual. Resilience was a quality which, perhaps, existed due to the pioneer roots of these women as it appeared to be universally prevalent among the senior rural women interviewed. Not one of the women interviewed was spared some tragedy in her life. The tragedies ranged from death of a spouse, child, or grandchild, to struggling through drought or bankruptcy. The phrase 'What doesn't kill you makes you strong!' had a significant meaning for these women.

Attributes which may account for this resilience are their spirituality, contentment, independence, and/or coping skills. For some, spirituality and religiosity offered tranquility. Others found peace through a contentedness with their lives. All had their unique ways of coping with what life threw at them. There was a strong sense of autonomy or independence in most of the women interviewed; they may not have been able to control events in their lives but they had a sense of being 'in control'. These women showed a mature acceptance of things they could not change.

Death, widowhood, and loneliness touched many of the lives of these women. Their resilience helped them endure as these women portrayed healthy coping skills. There was no sense of denial of their pain; they were realists. They displayed no shame or reservation in showing or voicing their feelings of hurt and loss. This forthrightness, perhaps, was part of their resilience which enabled them to maintain a sense of well-being.

When asked, all of the women interviewed emphatically responded that they were responsible for their own health. There was never a hesitation in the response. This alone was a strong indicator of the independence and self-actualization of these senior women. They subtly acknowledged that they mattered. There was an apparent lack of self-pity and self-absorption, whereas a sense of self-worth, self-identity, and initiative was demonstrated.

### 2. Community Support Systems

The question asked those interviewed was, "Does your community play a role in your health or will it in the future?" Most found the question difficult to answer and many were tempted to answer dichotomously 'Yes' or 'No'. In delving more deeply into the interviews, definite answers to the question were cited, but more indirectly, from the informal conversation, and not from directly answering the posed question. Two themes emerged from the data: (a) community spirit and community responsibility, and (b) the changing rural community. The essence of both these themes has an impact on the health and well-being of these women and on all rural inhabitants.

## a) Community Responsibility and Spirit

**Social support.** There appeared to be a natural continuous support system at work in the rural community. This showed itself in many guises, from caring for the sick and elderly, to support of local programs (discussed later), to the relationships with friends and neighbors.

> The whole community has got to be responsible because nobody's an island unto themselves. I think people should maybe be taught in schools that we are all responsible for each other's well-being in life.

> Much more in the rural area than it is in the larger centres, we have to look out for each other.

The community looks out for each other, often with special attention to the sick and elderly. This is illustrated in the following statements:

> [My mother's] friend takes her to church every Sunday....She always knows somebody's going to be coming.

> We have a friend....He's a bachelor....We still go and pick him up and take him to Town J which is an outing for him....It's a lot of driving but it's good for him.

> None of [our children] were able to come. All had jobs but the neighbors would come and sit with [my ill husband] for an hour just so I could get downtown, pick up the mail, get groceries and get back here. A lot of the men would come and spend an hour just chit chatting about old times and things like that which he totally enjoyed....There was one guy came and did my snowblowing for me and someone else would come in and check the furnace or whatever....They were all very supportive.

> I spend my time just doing the shut-ins or the elderly. There's a lady across the street that I go and play cards with about two nights or three nights a week.
>
> [When my husband was ill], I didn't drive and these people came forward, a lot of them I didn't really know that well but they knew my husband because he was born and raised in this town, and it just seemed people would come to my door and say do I need to go to the city, do I need something, can they be of help, could they come and stay with him if I wanted to go to the city....Small towns, I guess; that's Saskatchewan!

There appears to be a 'good neighbor policy' at work in the towns and in the countryside as shown below:

> I don't like walking out here on these gravel roads. About the time I get out to walk, somebody will come along and say 'Would you like a ride?'!
>
> [When I was a patient], I was fortunate enough to have four girls from Town J that were [working] on that floor [in the city Hospital] so they'd poke their head around and say 'Hi X, how are you?'
>
> We've got about 15 ladies in town here that play [cards] on a regular basis....A lot of them are widow ladies....You can help each other out because lots of times the women in that age group weren't involved in the business end of life.
>
> The ladies are already talking about coming up and having a card party at my place to see where I'm at [when I move to the city]....Some of them are considerably older than me but there's always one younger person in the group that will drive yet.
>
> I check on several [older women] just to see that they're okay and [I] drive them....You just can't abandon people because they don't have any family or anything close by.

> She wanted to go to the restaurant for coffee and it was icy....Well, she fell. So I just ran into the restaurant, just yelled; I knew whoever was in there would come and help. It didn't matter who was there, they would come and they did. That's just part of the old pioneer thing that has carried on through the years. People just help each other and they don't think twice about it.

The communities were often dedicated to fight for their survival. It was very evident that the women of the study were dedicated to doing their part, and did so willingly. These women were very visible in the supporting of local programs as follows:

> Our club supplies teddy bears for the ambulance if kids have to go.

> There's always church ladies that go to both the nursing homes and they do a lot of volunteer work. We're going to do it through the museum. We're going to start next month putting [antiques] in a suitcase together that we [take up to the nursing home] once a month and it's to stimulate conversation.

> I belong to the Royal Purple and am treasurer of the X church and work at the rink whenever I'm called to. We make pies.

> I do a fair bit of volunteering at the hospital.

> I guess I'm one of the more fortunate women in that I can devote all my time, or a lot of my time to a hobby. I mean that's more or less what the museum has become....We feel we're doing something so worthwhile. It was a vision to save the building in the first place.

> We have our own [golf] club. Last year [the town] put on a $100-a-plate dinner and then they divided up [the money] between the different organizations. Last year they gave some to the senior citizen's organization and they gave some to the golf course.

> [The rink] is the centre of our universe here in the wintertime. It's one of the nicest rinks there is and it's all paid for and it was paid for without getting government help. It was paid for by work.
>
> At the centre, every Friday night you can go down and there's some kind of activity all winter long....[It's run by] a few of the women and I guess there's a few men, too....We all contribute. We donate to a fund to keep it up.
>
> The church is quite active, up to the point where some of the members have to take the service about every month....It's a three point charge. Nobody wants a 1:30 service on Sunday, so to get away from that, [the minister] has two [services] one morning and then the third place has to have their own [lay service] that day to get away from the 1:30 service.
>
> Last week I spent two days at the golf course. We had the provincial finals for high school here and they wanted golfers to be walkers.
>
> We're involved in the rink in the fact that we work there. [My husband] works inside and outside. He looks after the ice surfaces....It's all volunteer.

'Local politics' still prevails in any community. Individuals and various community groups often have their differing agendas. Many of the women shared stories of how the 'sense of community' was threatened from within their communities.

> There's two churches [of the same denomination], one out west of town and one in town. They're both open. Some go to the one and some go to the other. Kind of funny! They don't see eye to eye, I guess, from what I understand [and they have the same pastor].
>
> This community is one of a fundamentalist religion....It's stressful for someone like myself who is a very liberal thinker to keep their mouth shut and you recognize that

> they don't think that way and so you try and live in harmony.
>
> Our son that went through the bankruptcy, that was hard on the whole family because it's kind of a shame. You're ashamed and he ended up having to lose everything and go back to square one....It's pride especially....So many have even heard the remark that he took the easy way out....It just really hurt because those people that said this don't realize it isn't the easy way out. It was the only way out for him.
>
> Because your neighbors don't like you very well if you don't spray....If he had to spray, he did very little but his neighbors complained that he didn't spray enough.
>
> I don't care what anybody says, [our local golf course] is a good course to golf on but, of course, a lot of the people now want grass greens and wider fairways...but we have to have money to do it and so [they're not supporting] the local golf course.
>
> I worry, too, about later, how we can have a community if our store's closed? A lot of people don't shop locally. They drive to [the city]....I think we have to support locally...and eventually when [the non-supporters] get older, these same people are not going to have any store in town and they have their homes here.

**Environmental changes.** The question was asked of the women, "Can you think of any environmental changes or changes in your surroundings that have affected your health and well-being or that of your family or community?" The majority brought up the issue of the use of pesticides. The concern over the use of chemicals was generally that of worry. Nineteen of the women talked about chemical use in farming and another four included concern with pollution and the atmosphere. Concern over chemical use was voiced in the following statements:

> Chemicals in the sprays and food additives and that sort of thing, well, they may have affected some of the grandchildren nowadays. There's a lot more allergies and that sort of thing. A lot of health problems that are probably attributed to sprays which they don't come out and say, but they are, you know.

> When we were on the farm, we never ever really used many sprays or insecticides, pesticides. That's quite a few years ago; they just weren't using it that much, where in town they're spraying for dandelions, they're spraying for mosquitoes....I can't really see where it's affected my life but I know it's out there....You used to always maybe worry a little more about your vegetable gardens and washing things off.

> There's a year or two that we didn't get sprayed at all...so we try not to use too much and one year we had a real outbreak of grasshoppers and that one was a tough one. We had to [spray] it over and over and over.

> I see more alkali coming up out of the land which is a problem and of course all these sprays that we've been putting in the ground for years and years and years, I don't think are very good for your soil; and we've got now so if you don't spray, the weeds are just nuts. You miss a little piece in the corner and it's just solid yellow mustard because you happened to miss the little piece so the weeds got stronger or something.

> There's so many bigger farmers, they're coming in and squashing the little farmer out, and they just...wheat spray, wheat spray, wheat spray.

Almost half of the women interviewed were concerned about the health or pathology of the population of humans, that is, health related to the use of chemicals. From these 13 interviews, more than 28 stories were shared about health conditions they felt might be

tied to the use of farm chemicals. Some examples of these stories are:

> He is now [more cautious with the use of chemicals]. I don't know if he always was, but he's careful now....Well, he does have a bit of,...a little bronchitis when he's working and so that has made him aware that he has to be a little more careful.
>
> I think lots of people aren't careful enough with all these sprays and things, maybe use too much of them because you'll see people with spray cans around....The family over here that has a young boy, asthmatic.
>
> I think of the years that my husband sprayed for cutworm and weeds in the early days of the spraying on the farm in the 50's. They were not aware of the dangers and neither were we and you don't know how those have affected you but they could have....I had two miscarriages...I'm not sure there's any ties, you wonder though.
>
> This area is bad for allergies, very bad. XXX and this area [are] supposed to be one of the highest incidences of allergies.
>
> I remember [my husband] getting a spell in the bin with all the seed treatment and making him sick and that's had to have affected people, I think...A neighbor, a friend of ours, said he had farmer's lung now and they say that was from these chemicals.
>
> I know my dad and my husband, too, both say that now when they go out, like Dad is retired, he doesn't do anything anymore, but he did say that in his later years of farming that [chemicals] bothered him more all of a sudden, like he could smell it faster and it made him feel a little nausea and the same, it bothers my husband.
>
> We spray the yards; we spray the crops; we spray 2-4-D; we use a lot of chemicals here to control bugs and things and I feel it's harming and maybe it doesn't show up today but maybe 5, 10, 15 years down the road

> I'm sure that that's why...in our area there's so many men have had prostate problems....We're polluting the environment.

> I have a sister who has MS [multiple sclerosis]....She has been doctoring in Saskatoon and is working with people who are really into finding out where this comes from and they have found DDT in her system and that's what they attribute the MS to. Then they tested her husband and he doesn't retain them and they said that some people retain the chemicals and other people don't, so, they haven't linked it yet but in her case they are very, very sure.

Safety with the use of chemicals was another issue of concern of the women. Of the women interviewed, 8 stated concern for themselves and their families with the handling of farm chemicals; all 8 were farm wives or retired farm wives. Most assumed or thought their husbands and sons handled the pesticides carefully but many did not realize the danger of bringing the chemicals into the home on the work clothes. Examples of the concern for safety are:

> I am concerned about the spray. I know we didn't take enough precautions. You didn't think of washing all those clothes separate. They were sometimes thrown in with the other clothes...at the same time our children were born....They must have been exposed to some of that, too.

> I think there really was a danger when we used to use a lot of air spraying but even like the air spray companies now are much more aware and there's more stringent regulations and I think it's a lot better than it was.

> If he's ever sprayed anywhere around the house...they want us to close the windows and he uses masks and gloves.

Aside from the chemical issue, there was a variety of other issues related to changes in the environment mentioned sporadically

by the women. A number mentioned the increase in automation and technology such as more traffic on the highways, and electricity, telephones, and running water to the farms. Farm machinery was now bigger, better and safer, and ranching was easier. These issues would fall under the 'human-made environment' in the mandala of health framework.

Again we see the mandala of health reflected when many women show grave concern for ecological health. There appeared to be a covert wish for farming to return to its organic roots. One questioned the tillage of range land for crops. Another had joined forces with Sask Power to mount hawks' nests on lone telephone poles, to try to help avoid another endangered species, as the hawks' natural habitat was destroyed due to the cutting down of trees. An opposite point of view was seen by another, as she saw the 'bald prairie' becoming more treed. Yet another was concerned about the change in the weather patterns with the hotter sun and more violent storms.

**Future/ retirement.** The question was asked, "How do you see your future unfolding?" Half (15) of the women stated they wanted to 'stay put' and not move, hopefully, until their dying day. Many found it hard to envision life away from the farm and were especially concerned that their husbands would never accept a move.

> I'd rather live here than in town, that would be stressful for me, four walls, I would get sick of [it].

> It's more like out in the open and you have more freedom, rather than in town you feel kind of [confined]....I always tell my husband I don't want to move to town.

> When you look ahead and you're thinking when we don't farm anymore...it's the fear of leaving everything that's comfortable....The unknown plus there's so many advantages to what you live with. We have a nice home; we have a nice lifestyle. We are free to come and go, someplace else you might lose the comforts and the security, especially if you get into a city where you have a higher cost. There's always that panic attack when you start thinking about what you will do but realistically you know that you can't live in one house forever, I mean as a 90 year old, I don't think you're going to be able to cope! So these are very real fears that go through your mind.
>
> We'll just continue to live here and take care of our health the best we can and accept whatever is our portion.
>
> It's home. I lived here, like I was born down the other side of [Town K], so I've been here all my life....I couldn't live in a city and [my husband] couldn't either.
>
> We could have sold our house when we sold the store but I didn't want to because I just didn't want to move that fast and now that we kept it, I don't know what we'd have done.
>
> [If our children moved to the city] I would miss them terribly, yes, but we'd go to the city and see them. It wouldn't encourage me to move to the city, no. We're not city people....This is home and it's quiet and nice here and we like it....I think we're looking at maybe 10 to 12 years of retirement in this house and then we're going to have to move to town....You can't follow your kids around; Lord knows where they might be.

Twelve of the women could see themselves moving even if it was just from the farm to town. To some, the decision to move to the nearest city was determined by possible future health care needs.

> I couldn't live in a motor home or something like that for the rest of my life, I'm too much of a home person....An apartment later if it gets so we can't look after our yard. Never the city, never.

> I worry....The younger people are leaving and our school will go and our town will be gone....Maybe ten years ago we would have been happy to live in [Town J], well, there's no way now....I think we'll go to the city. My husband likes to golf....I think we just would like to be where there's more people our age where you could do some things together.

> I can't see us retiring here, where we'll go, I don't know. No hospital. We have a doctor but [for] how long....I just don't think we're going to have the services and if we sell our farm I can't see us just sitting here. I can't see us moving into town because that's really no advantage, it's no better to be in town than it is to be here. I wouldn't stay here just because I have friends here....You can make friends wherever you go.

> [I'm moving to the city] mainly because I found the yardwork too much for me to care for. My back has been bothering me. I don't drive, that's probably at the top of my list...and then I worry about how long [the doctor] will be here and I think, well, if I get sick, I have to go by ambulance to [the city] anyway so I may as well be there....I'm not afraid to move; I'm young....Some things have kind of crossed my mind is how safe it is. You can walk here for miles and nobody would bother you.

From the 15 women who addressed the future possibility of entering a care home, there were mixed responses. Nine women were positive to indifferent, whereas 6 were strongly negative about living in a care home.

> My dad had Alzheimer's and so you figure, well, this is what is ahead....I would want to know that I could go [to a care home] if I had to.

> I don't think that our generation will have the same feeling about going into a home as the older generation. I think [we are] much more positive.
>
> *[Nursing home as a part of your future?]* Oh, God, no! No, no, no. Suicide would probably come first.
>
> [Move] into one of those homes there?....I don't even want to think about it!
>
> I never want to end up in an institution. I could never survive an institution....If I ever have a stroke and [had to] go in a nursing home, I'd probably refuse to eat.
>
> [Like being] drunk...how you can sometimes make a fool of yourself and people kind of laugh at you...that's the way I characterize a nursing home, not drunk but you're not in your right mind and you're doing stupid things and people are laughing at you....Why can't a person just die when they're still enjoying life rather than go into a nursing home and just fade away and not be in your right mind, not know what you're doing.

Having friends move out of the community was hard on some of the women, both for those who left and those who were left behind.

> [*very emotional, weeping*] We lost a lot of people....Well, we shouldn't say we lost them but they moved.
>
> Two of my friends that have moved both had nervous breakdowns;...they didn't want to go....[My friend said she] couldn't even hang a picture on the wall, she said 'I'd just cry'....She just wasn't ready to go I guess.

In looking ahead to their future, six of the women volunteered that they did not want to be a burden on their children so would take whatever measures, be it a care home or moving, to avoid this.

> My kids are too busy with their kids to take on the responsibility of an aging relative.

> I would go into a home if I had to...because I don't think it's fair [to burden] young people when they're trying to raise their own children.
>
> You don't want to park on your children's doorstep. They have their own families and, mind you they want me to come up there, but that's not always the best.

**Hidden stressors.** It should be mentioned briefly that other stressors were mentioned albeit rarely. Three of these 'hidden' stressors that affected a few of the families were homosexuality, alcoholism, and physical abuse. There was anger and sadness exuding from these women when their tales were told. The anger was often directed at the community's apathetic or judgmental reaction to the situation. These women seemed to feel a sense of unfairness and a sense of helplessness in the face of this community reaction, yet there was a stoicism apparent in their own reaction.

Three interviewees shared stories of homosexuality having an effect on their personal lives as well as resulting in a reaction from the community. Two situations involved children who came forward openly about their sexual preference and a third situation involved a pastor within a church who also went public. The result varied from community and parental shunning of the individual to open acceptance of the individual while not necessarily acceptance of the chosen lifestyle.

In only one situation was alcoholism mentioned. The effect the alcoholism had on the family was a shift from a shared workload on the farm to an unfair burden on some of the members. This strain on the other family members led the woman who was telling the story to worry about the health of her family.

Two women talked about having to cope with physical abuse inflicted on ones whom they loved. The situations surrounding these abuses had not been immediately apparent to these women so the emotional aftermath of finding out about the abuse was absolutely devastating to them. Both women were very much aware of the toll the emotional strain was taking on their health.

**(b) Community Changing**

Rural Saskatchewan has seen many changes over the last century with the development of this virgin land. The economic swing of the 1970's started a domino effect which was to change the face of rural Saskatchewan. Senior rural women have seen more drastic changes to their rural home in the last two decades than at any other time in their lives (while living in the countryside). These changes often appear frightening as they may affect these women's ability to live out their lives in their 'home'.

**A changing face of the community.** It was a grave concern for many of the older women to see the changes taking place in their respective local towns. None of the eighteen women who specifically addressed this issue seemed as concerned about their own future as they did about the future survival of rural life. Depending on the specific local town, some women were very optimistic about the town's future.

> Town J hasn't been affected that badly like a lot of small towns where they've had businesses close and leave and you're left without a service that you've always had. We've been very, very fortunate; I think we're situated in a good place, on [a main highway] which makes a difference. Our town seems to be growing.

> [In Town M] our stores are going good. We've got good grocery stores and we have a bank. We've got a couple of gas stations so things are not going downhill. I think everything is looking pretty positively....We have a doctor here and he's keeping his business up so we're going to be pretty well fixed health-wise.
>
> [In Town Z] I feel that we're very fortunate to have two good grocery stores plus a drug store plus a doctor plus a hospital plus a school. I think we've got everything here that any young couple coming into town could really appreciate. I think it's a wonderful, wonderful town to raise a young family.

But not all the women were able to look so brightly into the future of their town. The three towns spoken about above are thriving towns. Several towns in the same vicinity have not been so fortunate; there, buildings were being boarded up and businesses were locking their doors for the last time. Churches were closing, as shared in the examples below:

> The town used to be a thriving town but everybody that I associated with has either moved away or passed away because for years I was in [the ladies church group]. Well, it got down to just myself and one other lady left so I go to the next town...in other words, you either drive further or you move.
>
> With the church it's just a battle to get people to church to get enough money-wise....With our church, what we're going through right now is, is there going to be another year or not?
>
> We go to the X church and it stays about the same but there isn't many younger people there.
>
> It's not a very big congregation. About ten people come.

In many of the towns, school enrollment was declining and schools were closing. There was an ever-present fear of a school closing as so much of the viability of a town was dependent upon the young families staying.

> It's the way the rural is going. That's the way the towns are going....If the school ever closes, then you know [the town] will likely go down really quickly.
>
> Our daughter is a teacher down here. She said she would have to go if they closed the school and that could be if the enrollment goes down any more.
>
> She's had to leave the community to get a job because of the numbers in school being lower.

In some towns, every aspect was suffering—businesses, service groups, and recreational facilities.

> Our town is literally dead. There's nothing open there except the elevator....The other day, a little coffee shop in town in a house, this lady re-opened it.
>
> [The Kinsmen] they're going down the drain, too. All these organizations are going down the drain....This town is overorganized....[The Legion] they're down to about five Legionnaires now that are active.
>
> We used to have a bank. We had two stores. We had two hotels, a hairdresser, a laundry, a hardware store. We have the RM [office] yet. We still have a post office....We don't have any school anymore....The curling rink has been dismantled....The figure skaters use the rink....We used to have hockey teams but because the kids are going to different schools, they got on the hockey teams in the bigger centres.
>
> All that's left there now is the bar, everything else is closed up....They are a really good community. They still have got a hall....They put on fowl suppers and have the

> Town M drama club over there in the spring and put on a dinner theatre.

> Town Y was such a lively town. Like on a Saturday, I mean the stores were busy and people were coming to town. Now we don't see that anymore....Year by year these changes come in but you don't really notice it. You get used to it....I guess, people do so much traveling now that they just go to the city to do their shopping which makes me sad because we have to [support] our local merchants.

Health care was changing and with the changes came closure of facilities as well (this will be addressed in more detail later). New employment opportunities were scarce in many of the rural communities of the study. Farming was becoming more difficult to economically maintain (this will be addressed in more detail later). The rural economy was suffering; often people were forced to move to survive, as the following examples depict:

> There's no jobs here.

> There's no employment and they've had to go elsewhere.

> There's nothing around here except farming....There's a lot of young people who would like to be out there farming but they can't afford to with the price of things now.

> Housing here is just going for practically nothing. You can get good houses here for $10,000, practically new. Just terrible....Two of them on this next block, fairly new houses and their husbands died, they figure the places are too big....I'd say they would probably have been looking at something around $70 to $80,000 when they bought. Well, they'll be doing good if they get $20,000. The trailers here are just going for $2000 to $3000.

> Well, with all the people moving or leaving because there is no jobs, there's nothing to keep them here, it's going to be scary.

All of these changes in the community often left the women with fears for the future of rural life and for their grandchildren.

> We still had this one quarter of land...and I said, 'I wonder if we shouldn't just hang onto that. Maybe not in our time but maybe our grandchildren—I can almost see the economy, the way everything's going, maybe they're going to have to end up living on a little chunk of land somewhere and just raising their own food....I'm not sure there's going to be jobs there for everybody and enough money to live the way you want to live.

> Young people now, they don't want to be without anything. They want everything right now. They've all got a TV and a computer and they're not waiting to buy anything. And then I think, all those bills, you can't make all those payments if you don't get your crop in.

> My husband is 56 and should he retire or shouldn't he? You're too young to retire and yet should you be spending all this money on new equipment and what is going to happen to farming?

> Our hospital employed quite a few people and I feel with those cutbacks some younger people will go....I worry...the younger people are leaving and our school will go and our town will be gone....With these railways going, I could see rural Saskatchewan just going. I just see some big baron coming in here to do the farming and it's going to happen because you just see the little farmer is gone.

**Economics/farm stress.** Of the 18 women who spoke out strongly about economic concerns, 12 were related to economic concerns of the farmer (It should be recalled that of the 28 women interviewed, 16 were farmers). The word 'stress' was used in abundance. Much of the stress was due to debts and mortgages, high

production costs, and the commodity market. Rural economic stress, especially related to farming, affected individuals, families, and the community collectively. Therefore, the rural economic milieu definitely affected the health of these women directly and indirectly.

> The whole family [is affected by it]....They see it at school. Well, they're still seeing it. There still are financial problems with a lot of farms because wheat prices have been down but the interest is up, fertilizers are up, and chemicals are up. Like it's just unreal. So it's all stress.

> Just trying to get your crop off in a given period of time; my husband was holding down another job besides farming, trying to balance two things. He was truck driving, too, that was sort of a third job and he sort of did that on the days that were wet, and there was always livestock to look after.

> [Our son] farms along with us and he manages [another business] to kind of keep his bills paid so he can pay for land....[Of the four sons] there's one that remained on the farm, I think more of them might have except that you can't acquire enough land....They all have really good jobs and [son X] has the hardest time but he's the one that chose to farm.

> Farming was more a way of life where now farming is a business. You have to be in touch with world needs and marketing...whereas years ago you could just grow enough wheat to pay your bills and have enough feed for the cattle....There isn't the assurance of the future like we had. The cost of things is so high....They laugh when they talk about cash flow, sure they make money but it all goes for pasture fees, breeding fees,..vitamins for supplements for cattle. It's all cost, there's very little profit left....Same with growing grain [and the cost of] fertilizers and sprays.

> We have better equipment but the stress is still there. It's the weather stress, that's number one....Our other

> combine was ten years old, [it was] debatable if he could even get parts if he needed them....if you can't get parts that's pretty stressful.
>
> Our son...helped his dad through a very hard time of just about going bankrupt...[then our son ended up] declaring bankruptcy on [his own] farm. This is hard on us, you just don't like it to happen but it was the only way out [for him], but we couldn't, for some reason declare bankruptcy, we had to try and get through, work things out. It was awful hard on us, hard on the marriage....We were worried about [our son] for a long time until it kind of worked it's way out. Time is the best healer. Like we kept telling him 'you're not the only one, there were thousands more like you' but then it's not the same when it happens to you. It's like an accident, you hear it on the radio somebody's killed but until it involves you and your family, it doesn't affect you. And then it affects the children up there in their teens.
>
> When the land prices were high, that's when we were having to buy...and when the interest got so high, we just couldn't see the light at the end of the tunnel.

Sometimes indirectly, eight of the women stated concern for their retirement because of financial worries. Some of the worries related to the farming issues already discussed and some were widows trapped in the economic squeeze in rural Saskatchewan. These widows had either lost their source of income due to loss of a job, or the housing market had decreased the value of their main asset, or educating their children had drained much of their assets. Some of these various concerns are shared below:

> My job will probably come to an end when [my boss] retires so I've been hoping that he'll hang in there for at least two more years. [By then] my husband will be 65. I will be able to take out early Canada Pension. We don't have a big income....We really have no nest egg to rely on.

> We raised four children and educated them, well, 19 years of post-education....Those are our assets. (*widowed*)

> Do I want to go to [the city] where I can't afford to live in some of these places, like it's more expensive. My house is paid for....The only problem is it's hard to sell a house in a small town now. (*widowed*)

> It's just that things are getting more expensive. When you get bills they seem to be much more and it seems that is a thing that kind of worries a person because it just keeps on and on and on and where is it going to end?

> I think probably money is about the biggest thing that has made any big difference, because of the lack of it has made hardships for a lot of people....When the hospital closed, I lost my job....I just have to let each day come and go and whatever happens, happens....If I can make it for another year [and can get the pension] I'll be better off. (*widowed*)

Two aspects of farming that added a sense of pressure or stress to some of the farming women were the long working hours and isolation. Long working hours were a worry because of the fear of accidents when the husbands or sons had put in so many hours in a day and would then take 'shortcuts' without safety in mind. The emotional stress on these men to 'beat the weather' when seeding or harvesting or in calving season added to the worries of financial stress if things weren't done in the window of time of the good weather. This in turn caused worry for their wives and mothers. Nine of the women talked about this farm stress; of these nine, five were actively farming.

> This year [my husband and sons] picked up a nephew's land....They're doing about 3000 acres....When

> they're working that much more land, you're seeing more stress on them and time is a factor....[Accidents] worries me a little because a few nights they've worked until three in the morning and you feel they're cautious but when people get overtired... .
>
> It was the farm life, maybe....You've got to be equipped to go and do anything, anytime. I think it's stressful and I think maybe that the product was the hypertension....The heavy work...plus the pressures and crop failures year after year after year, it's enough to sort of get you down....The sprays, the dust, the machinery that you're involved with, if you're overtired and you're not really paying attention or are really that safety conscientious....I think farming in itself is very stressful.

Five of the women, four of whom are actively farming, mentioned the stress of being alone on the farm, the feeling of isolation.

> I think that because you're so far from everybody out in the country and if something goes wrong you're sort of on your own to get out of it the best way you know.
>
> The isolation, so many people moving away, we don't have the same contacts with people....We lost a lot of people.
>
> You've got to be [on the farm] all the time to be a chore boy....[I] get very, almost, depressed because for one thing I don't go away very much. My husband doesn't like me to leave, nothing here but men, you miss that women conversation.

**Health care system.** The convenient availability of a health care system was perceived by the senior rural women as a determining factor for their health and well-being. There was a mixed reaction by these women to the changes now taking place in

the health care system in Saskatchewan. Three areas of concern were identified by these women: (1) doctor availability, (2) hospitals closures, and (3) health care services accessibility.

(1) There was a very apparent worry or fear expressed by these senior women if their *local doctor should leave or retire*; would he be replaced? The overall response, by the twelve women who talked about the local doctor, was that the older rural people were dependent on their doctor. Having a local doctor gave them a sense of security.

> It's always still a little scary and I'm sure the older you get the more fearsome you become of not having that security of having a doctor there....I know for a fact because already [I know] older people that are actually thinking of moving maybe to where their children live or somewhere closer to some family or definitely a bigger centre where there is a doctor and that's really sad, really sad. We're almost being penalized for living in the country or in the rural area.

> If our doctor ever left,...there would be an awful lot of people that would have to move, because there's an awful lot of elderly people in [town].

> In a community like this I just feel very strongly that going to the doctor's office is almost a social situation.

> We have a good doctor here now. We feel very, very secure in our health system here....It's just that he's going to burn himself out...It's a big area he covers....He's too conscientious, I think....I always think some of the people I see, they're lonely, like widows, a lot of them are lonely. They just have no other excuse but to come out to see the doctor and to talk to him and maybe tell him their troubles....He understands all your problems, not only medical....He just gets so involved with the people.

> We have a fantastic doctor up there; you will hear that everywhere....I'm afraid if he happens to leave here that they'll never get a replacement.
>
> We have this doctor but I don't think we'll get another one. I don't see another doctor coming to a little town like ours. I don't like that but there isn't anything you can do about that.

Some of the rural doctors have moved possibly due to hospital closures and the long hours of being 'on call' because there are few relief doctors. But some doctors have become very much a part of the community and have chosen to stay on, much to the delight of the local citizens. The women interviewed in the vicinities of Town Z and Town M, where the younger doctors chose to stay on, unanimously spoke with great affection and trust of their local doctors.

> They have a younger doctor that's married to a local girl so he's interested to stay in that community and do a bit more or they'd be in bad troubles [there with the hospital closing].
>
> We have a good doctor and as far as we know he plans on staying, retiring here....He married a local girl which helps. He's one of the top doctors, you know.
>
> I feel comfortable talking with [our local doctor] because he never talks above you.
>
> [Our local doctor] just gets so involved with the local people. [He's engaged to a local girl]....He likes to go fishing here at the lake and his life's his own here.

(2) *Many of the hospitals in the vicinity of this study had been closed*; therefore options for acute care were drastically reduced. Yet only 12 of the 28 women spoke out strongly about hospital closure affecting their health and possible decisions in their future as

to where they would choose to live. Five of these 12 women, although concerned, stated they sensed an extravagance and misuse of the rural hospitals and understood something had to be done, and, therefore, accepted the closures. No one blatantly stated they were glad a hospital closed but some stated that they understood the reasons behind the decision to close.

> They closed a lot [of hospitals], of which there were probably too many open. I can't say because it hasn't affected us...but if you've got something wrong, you wouldn't stop at [the hospital in town Z] because they wouldn't have the equipment.

> We've abused [the health care system] and the doctors have abused it....There's no point in running to a doctor for a cold....They'll give you antibiotics, well, colds just take their course....We've had a doctor here that has put people in hospital too much.

> I know it was a big luxury, all these small towns had hospitals and we had 33 employees, now you can't tell me we needed 33 people.

But by some of the women, there was expressed anger and worry about the closure of the hospitals. Some didn't see the effects of the closure affecting themselves as yet, but saw it affecting elderly parents, such as:

> We had such a beautiful hospital and now I don't like it at all. If any of us gets sick, you can't go up there and be [put] in hospital...because they don't have any beds, like you can only be there, I don't think it's even 24 hours....I know my husband had a bad flu this spring and a congestion on his chest and he went up and he got pills the first day and then the second day he went up and they just put him in as a day [patient] and gave him a bag of intravenous with antibiotics, and then he had to go back up again the next day and have another bag

whereas if the hospital was the same as it was, they probably would have kept him in.

[We moved here] 12 years ago because we were getting older and our concern was to be closer to a doctor. About eight years ago my husband had a stroke. He woke up in the middle of the night and his side was all paralyzed....I got him into the car and the hospital was the the other end of the [block], so I don't think it was 15 minutes from the time that he felt sick until I had him in the hospital and the doctor was there treating him....[Now the closest hospital] is [miles away].

It was very much [a concern of ours that our hospital closed], not so much for ourselves but my dad was in the hospital but we had to move him to [the hospital in town P] because they were closing so there was no room for him to stay here....[It's harder now] because it takes a little more time to go...so we really don't get there too much [to visit him].

(*The local hospital has closed*) If they get sick in the night, you phone this number...of the health centre in [Town P] and there's no one there so they route that to [Town Q]. Someone in [Town Q] gets on the phone, depending on how busy they are, then they assess you....The three doctors in [Towns M, P, and Q] work together so one of them is supposed to be on call. Well then, they talk to the doctor and they decide what you need, if you need to go to [Town P] or they decide if they should send the ambulance or if the local doctor, will he come and see you?; it's confusing and it's two o'clock in the morning and you're sick.

There's a lot of old people in [Town J] and a lot of them are really upset that the hospital closed.

Both young and old are choosing to move from the rural setting due to hospital closure. Often the young have been forced to leave due to loss of a job directly related to the hospital closure. Many elderly appear to be at a loss as to what decision they should make

with their lives, whereas just a few years ago the decision was so clear, based on the support system of the rural hospital.

> In the last two years, people that would have retired in [Town J] that have quit farming, they've gone to [one of the cities] from this area. If we had a hospital that wasn't just a 'one day' and then you have to be shipped somewhere, I think people would have stayed because to older people, a hospital meant a lot to them.

> The closing of our hospital is a big concern. I was very upset because I have elderly parents who have health problems and if they get sick now in the middle of the night, it's a problem, and they're both 82 years old and between them they've had three heart attacks...They've lived here all their lives and it's hard to move somewhere else now, and where do you move to and the family is here and their friends are still living here.

(3) Twenty-one of the women talked about the health care system from a variety of perspectives other than from a focus on hospital closure or availability of a doctor. Some mentioned the *Home Care system* which they had had the opportunity to see working; some spoke about the *ambulance response system* which they or a family member had utilized. There was both 'blaming' and 'acceptance' among the women regarding changes in the health care system. The distance one must now travel to access care was a topic of concern.

Six of those interviewed had used Home Care for a spouse or for a parent, or worked for Home Care. Those who had actually used the service, found it a positive experience. One concern which surfaced was some of the elderly parents did not want to accept the help of Home Care.

We have a really good Home Care group here in town.

> [The Home Care women knew it] was difficult for [my husband] to be cared for by someone else's wife in such a personal way but he grew with them and they with him and they became good friends so on his death it was hard on them, too.

> [My mom] really didn't accept Home Care very well. She's a very independent lady and didn't like those Meals on Wheels and the same with [my husband's] mom and dad, they aren't very acceptive of Home Care.

> Old people get to be very good actors....Someone [from Home Care] came down to do an assessment [on my in-laws]....[My in-laws said] 'No, we're fine, we don't need any help. We can look after ourselves'....[The Home Care assessor] phoned here and she says 'your in-laws are perfectly able to stay in their own house and look after themselves with a bit more care. They just need someone in to bath them'. I said, 'if you can get anyone to put them into a bathtub in their own home', I said, 'you're welcome to it!'....I knew they couldn't but you can't blame them for trying.

The ambulance system seems to have some inefficiencies. While only two of the women interviewed had stated they had used the service, both were bad experiences. In one case, the closest local hospital was ten minutes away but the ambulance called came from 50 miles away. In the other case, in a different town, the ambulance had to be called three times, twice by the wife and once by a neighbor, before it was dispatched. Both of these incidents involved victims of heart attacks.

Five of the women feel they have clearly witnessed the health care system letting them down because of their rural location and the lack of access to proper care. An example of one of the shared grievances is:

> [Coming home from the city hospital to Town J hospital by ambulance], they weren't prepared for him. He came on a Saturday because he was released from [the city hospital] and they weren't ready for him [in Town J] until Monday so we didn't have a receiving doctor to get him admitted so it took all the ingenuity on the nurse's part so they could at least admit him as soon as he got here....[The only alternative] would be go back to [the city hospital] or try another hospital and nowadays you can't just do that.

Seven of the women spoke out against the changes in health care and blamed the government. Ten other women reacted more positively, accepting the health care changes and showing an understanding for the decisions to make the changes.

> The government is definitely responsible for the situation we are in now. If they'd gone at it a little slower and maybe cut back on only half as much, people could have got adjusted to using the hospital for emergency things and not for your everyday little illnesses.

> If [the government] take [rural health care] all away, it may not affect us so much but it'll certainly affect people who have no way to get health care....They keep throwing out a little more every year but the people who are the sickest oftenest [sic] will feel it the most.

> We may as well [move to the city] where we can have better services available. I guess I'm really hurt because I was [working] in that Health Care and I don't like what's happened to rural Saskatchewan because I think they forgot all about us and they don't care. I guess it's the government or the health board, I mean, the government made the choices and the health board sends it down.

> For your own personal health, you're responsible yourself. The system is by the government of the day or the next one but you still have that option of telling your

> elected people what you want....It's the written word that has more clout....[The government] has to provide the facilities...but then you still have a responsibility not to demand so much.
>
> I don't even mind going to [the city] for a doctor's appointment or whatever as long as you can still count on up here [in the Health Centre] for emergencies.
>
> We have an ambulance, we're having first-on-the-scene people trained, and stuff like that, so the town is definitely working as much as they can to help [adapt to the health system changes] as far as I can see.
>
> We can't have an ambulance on every corner, I realize that but I'm very happy that there is a 911 we can call.
>
> In 20 minutes we could be near a doctor, we've always lived here; we've always had to go to [the city] or Town M or Town P; our health care here, so far has been good.

Fourteen women showed concern over the distance needed to travel to access appropriate health care. Three others were concerned about the distance away from 'home' for many elderly who were being placed in care homes.

> If there happened to be two calls for the same ambulance at the same time, then they bring in another one, but that could be from 30 miles away.
>
> Our doctor is getting older....We will never get another live-in doctor so...if something really serious happens you have to be transported 50 miles or more, and yes, that's affected our health.
>
> The government will not allow this medicine to be on hand here, says it's too expensive and so they have to ship [my mother] off, it was the middle of the night, to [the city]. It doesn't make any sense.

> It's not fair to uproot elderly people and send them from a community where they know everyone, to [move] up north because there's a bed up there.
>
> I think they could take better care of some of the older people than when they're shifted from one town to another where they have no friends.
>
> My mental health is affected...and help is so far to get in a place like this. If I drive to [the city] every Monday [for the group session], I could get help but with the weather...I can't just go.
>
> Travel nowadays is nothing so getting to hospitals [is not difficult] unless they have no means, like older people, of getting around.

**(c) Discussion: The Community Affecting Health and Well-Being**

Perhaps rural life exemplifies community in a true sense, that goes understated. In the present study, it appeared that health and well-being of rural residents were dependent upon community. It was apparent that if community spirit died and there was no sense of responsibility to the community, the community wouldn't survive.

It was recognized by the women of the study that it was a struggle to keep the vitality of a community alive. These women seemed willing to do their part, even if it just meant baking pies for donation, as for some, energy levels waned with the aging process. Seventeen of the women stated more directly that they had a commitment to the community. Their involvement in community life included such activities as working at the rink, visiting 'shut-ins', volunteering at the museum, or sitting on various committees.

The sense of community went beyond the borders of the towns and encompassed the whole of the rural municipalities. There were

no boundaries to 'community' by physical setting (town vs. farm) or by age, religion, or career.

But there were problems. A community is made up of individuals and individual agendas often arise. Specific concerns were raised by many of the women interviewed relating to a sense of community. The elderly were often fearful that the young were not supporting the local commerce. It was not always easy for an 'outsider' to move into a rural society and be accepted. Neighborliness often only extended to 'as long as you do things my way'. Much of the community life revolves around socializing at 'coffee row' which could lead to idle gossip. As the women shared their concerns about their communities, there appeared to be many faces to a 'threatening of community'.

When the question was asked of the women, "Can you think of any environmental changes or changes in your surroundings that have affected your health and well-being or that of your family or community?", the majority brought up the issue of the use of pesticides. It was very apparent that the women were aware of their fit and responsibility in the health of the biosphere. The mandala of health shows the human dependence on the biosphere which also includes the air, land, and water.

The concern over the use of chemicals was generally that of worry. Nineteen of those interviewed talked about chemical use in farming. Of the 16 women farmers interviewed, only one was an organic farmer.

Some of the concern expressed in the interviews dealt with the ecological status of the earth but half of the women interviewed

were concerned about the health or pathology of the population of humans, that is, health related to the use of chemicals. More than 28 stories were shared about health conditions they felt might be tied to the use of farm chemicals. Sixteen of the stories related to such lung disorders as bronchitis, 'weak lung', asthma, and hayfever. In 12 stories, conditions they suspected were linked to the effects of pesticide use were heart problems, high blood pressure, miscarriages, nervous disorders, deformities, multiple sclerosis, colitis, and prostate problems. Eight of the farm women were concerned about safety with the use of chemicals.

A question was asked, "How do you see your future unfolding?". The women interviewed ranged from the ages of 55 to 75 years. At this 'stage' of life, it might be assumed that most would be either thinking about their retirement or would have already made some decisions for their futures. Surprisingly, this was not the case. Some lived with the placid attitude of taking each day as it came with no forward planning; some seemed almost afraid to look into the future, a sort of 'ignorance is bliss' attitude; while others, often due to widowhood, were forced to make decisions they would sooner have delayed, decisions forced on them by financial concerns, health concerns, or concerns about security and living alone.

The thought of moving from farm to town, from town to city, or from house to institution held fear for many of those interviewed. There was also a fear of a loss of many friends who would be moving away. For some, the unsolicited decision to move had to do with the aging process—the need for more available health care, the inability to physically maintain a residence, or the inability to independently

exist in the present housing. There were mixed feelings about a future in a care home; some could accept it but there were more who were actually fearful at the thought.

When referring to the mandala of health (see Figure 1, p. 23). one can place the individual's retirement lifestyle and retirement home in the inner circle of 'community' and 'human-made environment'. Retirement housing could be determined by finances ('lifestyle'), the availability of a care home ('sick care system'), and the individual's personal health ('human biology'). The 'community' decides where and if a home care facility or hospital is to become a part of the 'human-made environment'. Also, the ability to travel ('lifestyle') and to leave or sell the farm ('work') will affect the quality of retirement life of some. Therefore, as suggested by the mandala framework, a healthy retirement is interdependent within the biosphere.

Rural Saskatchewan was showing signs of change. The women had seen local churches, schools, businesses, service clubs, and recreational facilities suffering or closing. This changing of the face of the community was met with concern by most of the study participants. Some of the neighboring towns had already met their demise but with the good roads, it often just meant traveling a little farther for services. These women, possibly due to their age and having lived through many changes in the last 55 to 75 years, were adaptable, so they adapted to this change.

The rural economic environment was changing. Many of the women had personally experienced friends and family members moving away due to loss of job opportunities or farms failing or loss

of available health care. There was a farm crisis in Saskatchewan leading to a 'domino effect'. If the farmers were struggling economically, there were repercussions in the towns. Churches and businesses may not have been getting the financial support they needed; this threatened the survival of the town. This in turn threatened the independence and interdependence of the elderly living in that town. Again we see the harmony of the mandala of health challenged.

Economic stress, especially related to farming, had its affect on these senior rural women. The stress the women were feeling personally was just as intense whether they were speaking about their own farm or about the farm of one of their children. Therefore, the grandparents were affected as well as the children and grandchildren. The financial burden on the family, and sometimes the embarrassment of declared bankruptcy, reflected on all the family members, even the young children. Most considered themselves small farmers so the extra burden of finding outside work to support the family was always prevalent. Almost all young wives and young husbands worked off the farm in addition to their workload on the farm. The grandparents often took up some of the parenting roles by babysitting. In some instances, the grandparents lived in separate houses in the same farmyard while in other instances the children went to the grandparents' home in town after school.

As well as the word 'stress', the word 'worry' was also often spoken by these women. These women shared stories about their concerns over their finances for retirement (especially the widows),

worry of an ever-present fear of a farm accident, and stress from isolation on the farm.

The 'sick care system' is a part of the mandala of health. Accessability and availability of health care were identified as determinants of health and well-being by the women interviewed. There were mixed reactions to the changes taking place in the health care system.

Most of the women interviewed had lived in a rural setting all their lives so had become used to having to travel some distance to receive health care. As sixteen of those interviewed were farmers and some of the other women had moved from the farm to town once retired, travel to receive care had become second nature to them. Many local hospitals in the areas around these women had closed. 'Home Care' had become a household word. First responder emergency response systems had been put in place and this involved much community support and volunteerism. Wellness clinics had opened up in some of the smaller towns and short-term stay Health Care Centres had replaced some hospitals. Some doctors had left but many have chosen to stay. These senior rural women had seen many changes to health care but there was a sense that they had not been forgotten or abandoned. That is not to say that some of the changes did not cause hardships or worries. Three areas of concern emerged in the interviews regarding the care system—availability of a doctor, hospitals closing, and accessible health care services.

The concerns about the doctors were: whether they would be replaced if they leave; many of the rural doctors were elderly themselves; and whether the doctors would want to remain if more

hospitals are closed. With hospitals closing, many of the women were now feeling forced to assess their future. Some were already making choices for their elderly parents, choices they could perceive for themselves in the near future. Health care availability was a perceived determinant of health and well-being by these women.

Going back to the core of the mandala, there is the 'spirit' of the individual. With this spirit, the rural community and these senior rural women were fighting back for community survival. Perceptions of these senior rural women strongly suggested they were dependent on that survival for their future in rural Saskatchewan.

### 3. Family Support System

The women of the study wore many 'hats'. The family roles they live may have included wife, mother, grandmother, daughter, sister, and aunt; all these roles may be 'played' within her home community. Each role took its toll and offered its rewards. It was very evident from the interviews that family played a major part in the health and well-being of these women. The category of family is subdivided into three themes: (a) family proximity, (b) family participation, and (c) caregiving.

#### (a) Family Proximity

Twenty-two of the women had at least one child living in town or on a nearby farm. Many had young grandchildren nearby and a few mentioned they had siblings and/or parents in the community. The close proximity of a child was often the reason many of the women stayed in the rural community.

> I'm quite content because our grandchildren are three miles away and our sons and their wives, but I do say, if they weren't there, I would be gone.
>
> All our friends, our family, first of all our family, are here....We're glad our family is close by. [Our daughter] often drops in after her morning run and the kids drop in often, the little ones especially...so it gives us a lot of pleasure and so we'll just hang in [here].
>
> I suppose with the kids living here in the same [farm] yard, we don't feel like we're alone.
>
> We have a daughter here and grandchildren so, therefore, that kept us [here]. If she hadn't have [sic] come back, we'd have probably left, too....So it's quite good that we have somebody here.

Those with young grandchildren found they were a source of 'spice' in their lives. These grandchildren were often a big part of the grandparents' social scenes: watching them play ringette, hockey, and baseball; and attending recitals.

> My granddaughter, she's in ringette and she's looking forward to that this winter and so am I.
>
> [Our grandchildren are] five and seven. They're starting in hockey and you go up and watch the practice and our granddaughter, she's in music so her recital's next week and then there'll be the Christmas concert.
>
> [Our daughter on the farm] has two children and our daughter [in town] has one. We followed every sport there was and even got the 'fan of the year' award one year!
>
> You like to see your little grandchildren grow up and watch them do their things, that's another drawing card [in staying here].

Reliance for help extended beyond the immediate family, at times, to include neighbors and siblings. Six women specifically stated that being able to rely on friends and siblings for help was important to them in choosing to stay in the rural setting.

> I have two brothers in town. They're younger than I am. One is just 66. We could always call on him.

> I have friends here that I'm sure would help me if I needed it.

> I have friends who are like family who would come in an instant if they were needed but if some of those friends weren't here then that might be a little different situation.

Six of the women stated that caregiving duties kept them living in close proximity to elderly parents. Caregiving will be addressed later in this chapter.

**(b) Family Participation**

Seven of the women spoke of the attributes in farming cooperatively with sons or sons-in-law. This allowed for shared decision-making and allowed for greater freedom to take time off away from the farm. This arrangement also kept the family close in proximity and in their daily lives.

> We had cattle; it tied us down all winter long....With the two [boys], they have things set up that one could handle it but they work together. One can handle it for a few days if the other one wants to take off.

> [My husband farms alone] and our son comes out and helps when he's able to....We raise cattle; if we needed to go away for a while then the kids would just go out and do the chores.

> [My husband and I and our two sons] were farming in a partnership before [my husband got sick] so it was just a continuation of that partnership with the boys doing the work and [my husband] being the head if they needed some answers. They'd always talk things over together.

Five of them spoke of the partnership with their husband either in a business or on the farm. Most of these women stated there was a sharing and support in the chores as well as in the decision-making. This sense of cooperation carried into their retirement years as indicated below:

> He helps me [in my gardening] where I can't [do some things]; a lot of jobs he does for me and there's a lot of jobs I do for him.

> We have always worked together. We've always had a business and we've worked together so our problems were together, if you had one problem, it was both our problems not just one.

Being a part of the grandchildren's lives served a dual covert purpose in that it helped out the family, especially with babysitting, but it also brought much pleasure and a reason for living to the lives of these women. Twelve of the women specifically mentioned the babysitting. One of the women, in good humor, said, "I used to have a sign on the fridge that said 'You think your work is done and then you become a grandmother!' " The older grandchildren often give of their time by helping the grandparents by doing chores or by sharing caregiving duties.

> [Our step-grandson] is 13 going on 14 and he comes out and spends a month with grandma and grandpa every summer and we just love him.

> The two [granddaughters], it's only once in a while that they want to stay overnight, but the little fellow, he comes and stays. He likes staying with grandma and grandpa so it gives us a lot of pleasure.
>
> In the summertime the grandchildren are able to go down and cut the grass and look after things [for their great grandmother].
>
> Between my mother and myself we look after [my granddaughter] so that [my daughter] can work.
>
> They have two children, 16 and 12. When mom's gone all day at work,...grandma's here if there's anything they need.
>
> I cook for them a lot because my daughter's so busy. I just have them over and it's nice for me to eat with somebody else for the company.

The adult grandchildren and children were often a big support to these women. This was especially true for the widows who were interviewed.

> [When my husband was in the hospital], always one of my children was with me.
>
> [My son] said 'I'm sorry I can't come home more, mom, but here's some money, hire yourself a boy to cut your grass and shovel your snow', which was really nice. (*widowed*)
>
> Our son has been very good. It's very hard on him because he has a full time job and he farms and this year's going to be particularly hard because we're carrying on as if [my deceased husband] was here and he's not here and it's extra, so much extra work. (*widowed*)
>
> [My daughter and I], we talk on the phone seven, eight times a day. She's always keeping track of me [now that I'm alone]....We're great friends. (*widowed*)

**(c) Caregiving**

Fifteen women shared stories of past or present caregiving experiences. Many were still in a caregiver role to aging parents or in-laws, while others spoke of caring for either an ill spouse or parent who had since died. Five of the 15 respondents were widows; eight had living parents or in-laws. The stories varied widely from having little help (leading to the feeling of confinement and exhaustion), to feeling grateful for being helped by the community and family. The stress created by caregiving often revealed itself as worry or guilt. These stories are shared below.

1. Comments from women who felt tied down with little help included:

> It's very hard on the caregiver. There's days when you'd just like to walk away from the whole thing and forget it ever existed but that can't be done.
>
> Coping with the elderly relatives has been very hard because both my husband and myself are the only ones here to be the caregiver for my mother and his mother.
>
> I look after [my mother-in-law]....I go down every day, sometimes twice a day and do any of her housework and I do cleaning.
>
> Now we never go away for Christmas because mom and dad are not able to go for Christmas and we always have Christmas here at the farm and the kids come to us and mom and dad come....[In the future] if they were in a home, if they're well taken care of, that wouldn't stop me from going for a month or six weeks.

2. Comments from women who appreciated the help they received are as follows:

We're very fortunate to have those [care] homes. I don't know what we'd do [without them]; it's given me a life, if it wasn't for that, I would have to do [all the care] as my sister lives at the coast.

I have a sister and I have a brother in town [and granddaughters] and [my mother] has a caregiver from Home Care that comes in and does the vacuuming once a week and mom really looks forward to her coming as she's a visiting type of person and so it just brightens her whole week up.

We looked after [our mother] at home between my brother [and I]; he lives across on this corner. We looked after her at home for about four months...12 hour shifts for a while and then it got too much and then she managed to get into [a care home].

My arms and shoulder muscles gave out and I couldn't lift anymore so that's why they brought these [Home Care] women in to lift him....Even having them come in for that little time each day, it gave me someone to talk to and it was good to have company.

3. Feelings of guilt and worry often added to the stress of caregiving.

We had to put them both into a home and mom didn't mind but dad hated it. He wanted us to look after him and it wasn't possible; we couldn't lift him, he was a big man.

Two years in January [mom] had to go to the nursing home; she couldn't remember to eat, she wasn't looking after herself....Mom isn't happy in there.

After the second stroke there was no way I possibly could have brought [my mom] home here with me....I'm not a nurse and she needed a lot of care but you always have that little bit of guilt...but then there were two more [parents] that needed looking after...plus you have grandchildren and you have other things on the go.

> The closing of our hospital is a big concern. I was very upset because I have elderly parents who have health problems and if they get sick now in the middle of the night, it's a big problem; they're both 82 years old and between them they've had three heart attacks.

The adult grandchildren were often a help with the caregiving of an ailing parent or grandparent, thereby sharing the burden of care with these senior women. Siblings in the same town or vicinity could also often be counted upon to share the caregiving duties.

> We have one daughter who lives right here in town and that's a blessing because when we do take two months in the winter and go away, she sort of takes over for me. She visits [the grandparents in the care home].

> We do a lot for [my mother], between [my adult daughter] and I.

> My sister takes [our mother] down and gets her groceries and then I take her down to get her hair done once a week...and then we all stop in through the week.

> We have one daughter who lives right here in town and that's a blessing because when we do take two months in the winter and go away, she sort of takes over for me. She visits [the grandparents in the care home].

**(d) Discussion: The Family Affecting Health and Well-Being**

In the mandala of health (see Figure 1, p. 23), the 'family' is next to the core circle of the individual. 'Family' comes before 'community' and influences of the 'biosphere'. Therefore, as if in a 'rippling' effect of the circles, the mandala could suggest that the family has a very close and significant influence on the health of the individual. The researcher of this study suggests that the intent of the mandala, while showing the closeness of family to the individual,

is not to be interpreted as 'culture' being far removed from the individual or family or community. Culture, being intrinsic, cannot be separated from an individual or group of communal individuals.

The family has the potential to interact with all aspects of the individual—one's work, play, psyche, living environment, and wellness/illness. It became very evident, when listening to the women's stories, that family was forever present in their daily lives; therefore, it is not surprising that family influence was perceived as a major determinant in the health and well-being of these women.

Family living in close proximity was important to the participants of the study for more than just a sense of security. The help these women might receive from nearby family members was assistance with their activities of daily living and, emotional and social support. But there was a reciprocity in play here; there was the giving as well as the receiving. Being mothers, and grandmothers, and daughters these senior women were also giving of *their* time, energy, and support.

Family participation and cooperation were seen in many facets of their lives: in work, in recreation, in emotional support, and in their spiritual life. The family participation was exemplified through seeing sons helping fathers on the farm and vice versa; husbands and wives working in cooperation in a joint business or on a farm; siblings and children sharing the caregiver duties of elderly relatives; and grandparents babysitting and attending the grandchildren's extracurricular activities. Widowhood was a special time of reciprocity. Children and grandchildren living in close proximity were great social diversions as well as 'handy helpers'. In times of

stress such as the death of a spouse, a marriage breakdown, or the loss of job, this reciprocal caring vacillated from the young to the old and from the old to the young. The 'need to be needed' and the need for security, when obliged, added to the well-being of these women.

The duties of caregiving to a spouse or elderly parents were perceived as a major determinant of health and well-being for 15 of the women. Although most gave the impression of a willingness to help, their stories were wrought with various negative emotions including guilt, worry, regret, helplessness, or of being overwhelmed. The availability of some form of support, be it hospital, care home, doctor, Home Care, or some form of family support, strengthened the ability of these women to cope in the caregiving situation. Conversely, a lack of support in caregiving produced stories of physical exhaustion, feelings of confinement, and of being torn between the many family roles (mother, daughter, and wife) yet trying to keep a balance in one's life.

# CHAPTER 5: RELATIONSHIP OF FINDINGS TO EXISTING LITERATURE

Much has changed in rural research in the past two years. The rural elderly have been identified as a population at risk and, therefore, much more time and funding have been spent studying this population. There has also been an increase in studies of rural women and of elderly rural women.

In order to explore more fully the themes emerging from the data, another in-depth search for supportive or related documented research was undertaken. From the library search the following CD-ROM files were accessed: CINAHL (1982—1996), PsycLit (1990—1996), Social Work Abstracts (1977—1996), and Agricola (1992—1996). The independent variables for the present study were rural, women, and elderly (as age, gender, and place of residence were the generic variables). These variables were used consistently in all of the searches. The dependent variables which evolved from the study were: well-being/life satisfaction, aging, health promotion, resilience/hardiness, community/social support, farm stress, health care, retirement, environment, religiosity, activities/recreation, widowhood/loneliness, family support/proximity, and caregiver. These topic (dependent) variables were searched for in conjunction with the independent variables. A further search was done from the reference lists of the journal articles gleaned from the above listed search. Books and articles were also suggested by fellow PECOS researchers. The topic variables found in the literature will be

introduced in this chapter by being set in bold lettering making them identifiable.

There were many limitations in determining if the research literature found in the search was actually comparable to this study. There was a wide variation in the definition of rural (a population of less than 1000, 2500, 5000, or 25,000 persons), especially with the American (USA) studies (Lee, 1991b). A further limitation was that almost all the related research was American. Therefore, the settings and local environments of the studies are diverse in ethnicity, geography, economy, health care amenities, health insurance, and farming practices and commodities. Many of these variables are unrelated to rural Saskatchewan. The question was then asked, "Is a comparison of these studies plausible?" Most of the researchers acknowledged that their findings were non-generalizable due to use of convenience samples, small sample size, or to the geographical location and farm type. What was of interest was the increase in the opportunity of rural elderly women to being studied, therefore showing there is concern for this population and that they have neither been forgotten nor abandoned.

The **definitions of 'health'** by the current study participants included such words as 'contentment', 'enjoying life', 'well-being', and a balance of the physical, social, and psychological dimensions of the individual. Similarities exist between the womens' *stated* definitions of health revealed in this study and in definitions of health quoted below; however, the 'environment' and 'community' factors were missing in the *stated* definitions of the present study. This should not be interpreted that the participants did not view these factors as

a part of their health as the text of this thesis reveals that these and other factors were perceived by the women as important entities relating to their health. A more holistic view of health by the current study participants than portrayed in their stated definitions, will be supported in the following paragraphs.

One definition of health from the literature is as follows:

> Health means having fresh air to breathe, clean water to drink, a comfortable place to call home, a safe clean community to reside in, opportunities to develop ourselves, having a sense of purpose, being respected, productive and valued (Saskatchewan Provincial Health Council, 1996b, p. 2).

Randomly throughout the interviews, the women offered statements reflecting their perceptions of the influence of nature on their health. Their statements show a correlation to the above definition of health. Pollution of the air; chemicals used in farming secondarily affecting wild-life, water, or soil; and adverse weather affecting farming practices were seen as examples of direct or indirect effects of nature on the health of the people. The resulting effects may be stress or poor physical health. A rural 'home' was cherished by most of the women and the ability to remain in this setting was often referred to as a benefit to their psychological health. A 'safe, clean community' was respected by these women who were often the stalwart supporters and workers in maintaining the appearance and heritage of the rural communities. It was very apparent that the women of the study were active and involved in family and community life. They confidently showed initiative and pursued opportunities. These pursuits helped confirm that these women valued themselves and viewed their health in a holistic manner.

The women of the study readily identified with the following definition as was seen with their use of such words as 'physical, mental, emotional, social, spiritual, and well-being' in their stated definitions:

> Health is a dynamic process involving the harmony of physical, mental, emotional, social, and spiritual well-being. Health enables individuals, families and communities to function to the best of their ability within their environment (Saskatchewan Provincial Health Council, 1994, p. 3; Saskatchewan Provincial Health Council, 1996, p. 14).

The body of the interviews repeatedly referred to examples of these dimensions of health through such examples as: age-related disabilities, stress, activities, family involvement, and religiosity. 'Community' and 'family' were identified as principal determinants of health as perceived by the participants. These two components were so prevalent that they became categories for many of the emerging themes of determinants of health.

The following definition, although referenced here as 1988, has been affiliated with the WHO for approximately 50 years:

> [Health is] a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization [WHO], 1988, p. 7).

The first half of the definition supports what many of the senior women of the study stated as their definition of health. But 'absence of disease or infirmity' was only directly referred to by one participant. Many of the women included physical dimensions in their definitions but in reality, almost collectively, they did not rate physical wellness or illness as a major component of health. This was

gleaned from their interviews where most of the women saw themselves as healthy regardless of living with chronic ailments.

The following definition of health is unique in its absence of an explicit physiological dimension:

> [WHO (1984) defined health as] a resource for living, a positive concept; the extent to which an individual or group is able to realize aspirations, to satisfy needs, and to change or cope with the environment (cited in Labonté, 1993, p. 89).

The final referenced definition, quoted above, is also from the WHO but it is a more recent definition. The women of the study could be seen as a group who generally pursued healthy lifestyles. They admittedly fell short in some areas of health promotion but these shortcomings were often due to inherent life-skills or habits which had been a part of their lives for a long time. These habits or life-skills were often not identified as life-threatening years ago. Such examples as: smoking, diets high in cholesterol and sugar, and lack of exercise have been proven only in the past few decades as threats to health. The last part of this WHO definition strikes close to the heart of many of the women. Unrealized 'aspirations' surfaced in the interviews. Unfulfilled dreams were sometimes shared with the researcher by these women. Fears of not being able to adapt or cope with the changing environment were also a concern. This 'changing environment' could refer to the demise of rural towns, the closure of hospitals, a local doctor leaving, the inability to look after a large house or yard, or even the ability to climb stairs may have become a burden. All of these factors could be seen as a part of a threat to a definition of health of these women. This definition of health then

can be seen as affecting the sustainability of these rural senior women.

The literature search discovered current literature challenging the methodology of researching **life satisfaction (well-being)**. To more effectively represent the population's views, it was suggested a finer stratification by location than just 'rural' be employed to include defining the size of town or degree of isolation on a farm (Scheidt & Windley, 1982; Scheidt, 1984). This microcosmic breakdown of rurality would appear necessary as life satisfaction appears related to proximity of family and social support systems. In the current study, three RM's were studied guarding for confounds in the research due to geographical location. There was some questionable support for location of residence as an independent variable. An example is, loneliness was found in the towns, especially with the widows, as well as in the more isolated farm. A key strength of these women was their adaptability; therefore, distance from amenities did not appear to be of major concern. Transportation in general did not seem an issue with these women. Where location could affect rural women is accessibility to alternate forms of medical care or a more holistic medical care (e.g., mental health care, ophthalmologist, chiropractor, or dentist).

Qualitative research is possibly preferred to quantitative research when the dependent variable is life satisfaction. A comparative study of methodologies was done with rural Ontario elderly revealing discrepancies between the results with the use of the two methods, quantitative research and qualitative research (Wood & Johnson, 1989). In this Ontario study, quantitative

measures (compared to qualitative measures) provided a more superficial representation of life satisfaction, yet the study results were rendered useful for establishing patterns and categories. A follow-up qualitative methodology added a dimension of understanding and explanation to these categories. The current study was asking for perceptions on well-being (or quality of life). In order to capture the quality of human experience, and therefore an understanding of what affects the quality of life of senior rural women, qualitative methodology was the primary method of choice, as was discussed in Chapter 3. Wood and Johnson's (1989) study results, therefore, strongly supported the choice of methodology of the present study.

A quantitative study relating chronic pathological conditions (of a life-threatening or nonlife-threatening nature) to quality of life (well-being) suggested that the retired rural women in the study felt arthritis and pulmonary disease were the two strongest health predictors of dissatisfaction with their quality of life (Dorfman, 1995b). As this study was cross-sectional versus longitudinal, it addressed the questions of interest at only one point in time during the retirement stage. A longitudinal study may have offered a more varied health record and, therefore, a more broad experiential plane of illnesses. The present qualitative study lends itself as an example: the women's first response to a question on their health was that they were healthy, but, as the conversation progressed, it was discovered that most of them were suffering from some degree of pain or discomfort due to a pathological condition. These 'conditions' often affected their lives by slowing them down or not allowing them

to partake in certain sports or even to walk for exercise. The women were 'tough' and resilient but their quality of life did appear to be affected and was changing due to the changes in their health.

A qualitative study on ecological well-being of an elderly population supported the present thesis study in its findings that both being resilient and being involved and active could be predictors of well-being (Ruffing-Rahal, 1989). Also, women of the Ruffing-Rahal study, who rated themselves as having a positive outlook on life and the aging process, also rated themselves at a higher level of well-being. A difference from the present study was that all of the women of the Ruffing-Rahal study were active in health-promotion programs. The women of the current study acknowledged the importance of health-promotion practices but were not necessarily ardent participants. This difference could be attributed to one study being comprised of rural-dwelling seniors while the other was community-dwelling elderly.

In a study of women, Bigbee (1990) found no difference between residence (rural vs. urban as the independent variable) and level of stress (dependent variable) and suggested this dispelled the stereotypical picture of rural life being stress-free; whereas, the urban elderly women of Gale's (1993) study reported higher levels of stress than rural elderly women. Conflicting findings on the topic of stress, in relation to place of residence, for elderly rural women emerged in other studies as well (Preston & Crawford, 1990; Speake, Cowart & Stephens, 1991). In the current study, when stress or worry were referred to, it most often related to farm practices and farm/rural economics; therefore, it did relate to place of residence.

In a large quantitative study (n= 600, longitudinal test/retest) comparing rural, urban, and institutionalized elderly, the scoring showed that rural participants were the happiest of the three groups (Kozma and Stones,1983). The most important predictors of happiness for rural individuals were marital status (being married) and health (a perception of wellness). Good health was the primary predictor of happiness and the researchers suggested it may reflect a concern about access to medical services. Although almost one third of the participants in the present study were widowed, marital status was not presented as playing a major role in the perceived well-being of the women. Widowhood was broached as affecting well-being, especially at the time of the death of the spouse, but with strong coping skills, the women moved on in their lives.

In an Ontario women's study of 'agrarian feminism', Carbert (1995) found that farming was not positively associated with the women's well-being (quality of life) and farm labor was implied to be "deleterious" (p. 155). The older women of Carbert's study were less apt to have labour-intensive involvement on the farm and were more involved with farm administrative duties; therefore a part of the findings may not be representative of the elderly women. The farm women of the present study would probably defend the claim of farm-work being difficult and physically laborious, but many hoped for the ability to live out their retirement on the farm. This attitude speaks of a positive association with farming and well-being.

Health related to the aging process and rural elderly women has increasingly been studied, especially in the United States. DePoy and Butler (1996), using a non-random sample (n=218) from rural

Maine, reported over half (58%) the women defined health as an absence of disease yet the majority also saw health as living without excessive stress (81%) and having a good feeling about oneself (74%). They also felt that giving, that is, "achieving a sense of purpose through helping others" (p. 4), and being productive led to good health (DePoy & Butler, 1996). Most of these women felt they could still be healthy even if they were not satisfied with their lives. In a small pilot (n=8) (Butler, 1993) of this study (DePoy & Butler, 1996), the researcher found that resilience and a family support system also helped these women maintain a sense of health and well-being. All of these findings support the findings of the present study.

A large study of rural elderly in Iowa determined women who had farm-work-history experience (of at least 25 years) had a greater level of physical function and fewer symptoms associated with mental illness than did their rural counterparts of a lesser work history (Yesalis, Lemke, Wallace, Kohout, & Morris, 1985). A limitation to this study was that changes in farming technology have led to a decrease in the physical outlay of energy so it is difficult to relate the findings retrospectively and projectively. The large majority of women of the present study had lived on a farm for more than 30 years, yet it would be difficult to draw a comparison among these women as to the physical outlay of energy. Some worked side-by-side with a husband in a ranching operation, while others maintained the home only and never took part in the farming responsibilities, yet both groups of women perceived themselves as healthy.

In a study related to **aging** and health, Mainous and Kohrs (1995) found that the rural elderly in a Kentucky study had significantly worse health status and poorer functioning (physical, mental, and social) as compared to their urban counterparts. If a direct comparison is plausible, this contradicts the previously mentioned Iowa study where the harder one works appears to predict better health. Gale and Templeton (1995), in an urban/rural, multi-ethnic study on health status of elderly women, were concerned about, and caution against, the use of a measurement tool that is perhaps culturally-biased. With a quantitative tool of a forced-choice measurement with numerous questions (236 in the questionnaire in the above study), level of education and a first language other than English may prove to be barriers.

More studies, related to chronic health disorders of the aged, are involving elderly rural women, therefore rural women appear to be identified as a population at risk. Interestingly, the women in the current thesis study identified themselves as healthy even though many suffered from chronic conditions such as arthritis and hypertension. The researcher of the current study suggests this may be due to the adaptability and resilience, almost to the point of stoicism at times, of these women. They were used to hardships and crises in their lives but they had learned to cope and carry on in order to survive.

Adding the independent variable 'osteoarthritis' to the variables 'elderly', 'rural', and 'women', Lee (1993c) found that those most remotely located rurally perceived their health as better and themselves as more functionally independent than the urban

participants of the study. This supports what was alluded to in the previous paragraph about the resilience and adaptability of the women of the current study ('when the going gets tough, the tough get going'). In Lee's (1993c) study the sample size was small (n=45), for a three group comparison by place of residence, and the definition of rural for this study had unique values which would not easily lend this study to comparison.

Another chronic health disorder study of elderly rural women found hearing loss, which could affect quality of life, related negatively to bone mass (Clark, Sowers, Wallace, Jannausch, Lemke, & Anderson, 1995). Rationale for doing this study in a rural setting was the lack of noise pollution and the lack of certain chemicals (Ca and F) in the water supply in the designated area controlling against confounds within the study. The rural sample was 'purer' due to the absence of these confounds. The study results were intended to relate to all aging women.

More mental health studies are being done with the rural elderly (Gale, 1993; Ganguli, Gilby, Seaberg, & Belle, 1995) but many researchers encourage still more, especially of women (Abraham, Buckwalter, Neese, & Fox, 1994; Bushy, 1994; & Olson, 1988). Interestingly, many of the mental health studies encourage health professionals to break down the barriers that inhibit rural residents' utilization of mental health services. How this is to be done in a rural setting when everyone is often privy to everyone else's business is an enigma, especially when society still attaches a stigma to mental disorders resulting in people preferring anonymity and privacy when undergoing treatment.

The rural elderly women in the current study showed an awareness of **health-promotion** practices and an attempt to promote and maintain their health and optimum functional ability. The practice of health promotion was not as diligently incorporated in the lives of the rural American (USA) elderly which could partially be due to a lack of health-promotion programs in parts of rural USA (Bender & Hart, 1987; Davis et al, 1991; Dorfman, 1995a) and/or could be due to the difficulty in providing programs for the diverse ethnic needs (Duelberg, 1992). One study, which was positive for health promotion, showed an increased frequency of breast self-examination with increasing age (Gray, 1990). A study in Missouri found that there was no relationship between self-care for diagnosed hypertension and women's health conception values, therefore a positive perception of their health did not induce them to increase their self-care (Whetstone & Reid, 1991). Even though methods of guiding older adults in promoting their health have been established and implemented by nursing practice (Frenn, 1996), the elderly are not always receptive and compliant to implementing changes in their life style, as the following study demonstrates:

> Older persons in rural settings, most of whom are unmarried females in good health with less than a high school education, are concerned about issues related to nutritional health promotion and have taken action to have their cholesterol screened. Concern over an elevated reading, however, led fewer than half of the people in this study sample to change their diet. (Dellasega, Brown, & White, 1995, p. 10)

The women of the present study showed a concern about health promotion and an interest in health education. Many of the women had had careers at one time (actual level of education was not

determined) so the average level of education of the women could be predicted at a high school matriculation. Even though many of the women admitted they fell short in their practice of personal health maintenance endeavours, there was a sense of willingness to learn and make modifications to their personal health habits.

'Resilient' and 'hardy' are words the literature often attaches to elderly rural women. The current thesis about Saskatchewan senior rural women found their **resilience** to be quite apparent as did Ross' (1990) study which also took place in rural Saskatchewan. She describes the farm women of her qualitative study as follows:

> These women, each, in their own way, have taken to the road, climbed steep slopes, slid down others, reached plateaus, and continued on. These are farm women who have focused on what they can control, rather than what they cannot. It is about how they have gained enough self-confidence to challenge the script and how, in so doing, they are rewriting it (p. viii)....With very little guidance or support they are facing realities, making decisions, and acting upon them. There is no map, no single, correct path or method to follow. There are only steps which edge farm women toward involvement, self-fulfillment and equality (p. 6).

Butler's (1993) small pilot study (n=8) of senior rural women also attributed resilience as having a strong effect on the women's perceptions of their health and well-being. One study in Idaho of farm couples, most of whom were older, found that the hardier the family, the fewer the problems and the greater the satisfaction with their quality of life (Carson, Araquistain, Ide, Quoss, & Weigel, 1994). Hardiness was self-perceived by the study participants using the following self-report scales: Farm/Ranch Stress Scale, Family

Invulnerability Test, Family Hardiness Index, and an abridged Quality of Life Scale.

A Canadian study in Newfoundland (mean age of 63 years where 70% of the participants were women) found that hardiness was analogous with control (McNeil, Kozma, Stones, & Hannah, 1986). Control was defined as "a belief in personal power to influence the course of life events" (p. 43). Reliability of the study could be challenged due to the use of the adapted Short Hardiness Scale in the study with internal consistency measures of: Test=0.64, retest=0.67.

The present thesis study referred to the women's coping skills and resilience as being interconnected or synthesized. In a rural Pennsylvanian study where half the participants were elderly women, it was found that with such stressors in life as:

> widowhood, and isolation, and in the absence of a well-developed repertoire of coping mechanisms, illness was a way of fulfilling dependency needs. The large size of the helping networks [for these individuals] supports such a notion (Preston & Mansfield, 1984, p. 494).

The "large size of the helping networks" (p. 494) was a compliment to rural life. At a time of need, the elderly were not ignored; they were not viewed with disdain due to their dependency; they were helped. The participants of the current study proclaimed that they hoped the strong sense of community would allow them to be sustained in a rural setting no matter what befalls them. Neighborliness and the promotion of formal social support services are two support factors they felt they could count on. Many of these women shared a complacency and acceptance to growing older and more dependent and saw it as a natural progression. There was no

shame attached to dependency other than some did not want to become a 'burden' on their offspring. Some even accepted a possible future in a care home. The older and more frail the elderly get, the more they rely on the social support networks, such as friends in the community, to buffer them against harmful effects of life events (Mor-Barak, Miller, & Syme, 1991).

Spirituality was also tied to resilience in the current thesis study. The literature often refers to this spiritual nature as **religiosity**, although religiosity tends to be more representative of a tie to organized religion. Most of the studies mentioned here included the variable 'elderly' but not 'rural'. Studies have found religion plays an important role as a coping mechanism for the elderly, thereby positively influencing well-being (life satisfaction) (Koenig, George, & Siegler, 1988; Koenig, Kvale, & Ferrel, 1988; Markides, 1983). The elderly women of Idler's (1987) study who portrayed a higher level of functional disability and depressive symptomatology also were noted to have a higher level of religious involvement. Two studies of the rural elderly found that faith in God (Miller, 1990) and religious commitment (Tellis-Nayak, 1982) were associated with a strong sense of self-worth and self-actualization. These elderly felt their health was not dependent upon life events in that they understood life had its sufferings but through their faith they found meaning (purpose) in the sufferings of life. Spirituality as a source of strength was alluded to by some of the women in the present study but did not stand alone and emerge as a principal perceived determinant of health and well-being.

There was a paucity of literature to support **environmental factors** as a perceived determinant of health. Dewar (1996), in a rural New York study (n=295), surveyed both men and women (but with no 'elderly' variable) to determine their perceptions on farm health and safety. Some of the findings were: (a) more than 3/4 of the men and women felt farming was more dangerous compared to other professions, (b) a third of the women felt farm health and safety (FH&S) was a lower priority than farm prices, (c) 30% of the women felt FH&S was a higher priority than environment, and (d) more than half of the women felt FH&S was a higher priority than soil erosion. The women of the present thesis study were concerned about farm safety, especially with the use of pesticides, and about rising costs.

In the current study, the women perceived community determinants affected their health and well-being. The **social support system** within the community appears to be a major determinant of well-being of elderly women. Research studies are not consistent in definitions of 'social support system' in that some studies refer to 'people' as social support while other studies refer to institutions and/or recreation diversions as social support.

If a move was required within or into a town, one of the main influences of adjustment for rural women, especially widows, was social interaction and support (Armer, 1996). Siblings do not always supply that informal social support. Women rated a sister/sister relationship as more intimate than other sibling relationships but sibling contact was not highly correlated to morale; therefore, siblings living near siblings cannot necessarily be counted on to

provide needed support (Wilson, Calsyn, & Orlofsky, 1994). In the current study the availability of offspring for support was mentioned often, whereas, siblings were most often mentioned only as a support in shared caregiving duties to elderly parents.

Informal support (friends, neighbors, and family members) of the rural elderly was determined to increase their use of formal social support services (most of which were health-related) (Goodfellow, 1983). Goodfellow's study (1983) in Pennsylvania was weakened by the absence of an assessment of the elderly's awareness of the availability and accessibility of social support services. This increase in use of services may be due to the knowledge base about services by the informal support system which was lacking in the elderly individual.

In a mid-Atlantic American (USA) study, in-migrant retirees were compared to long-term resident retirees where it was found that even though the in-migrants were younger, economically better off, and of the same perceived health status, they used more health-related social services than the resident retirees (Glasgow, 1995). This shows the difficulty that could arise for program developers trying to predict future social support needs. A possible explanation of this use of support services may be the novelty value by the in-migrant due to its inaccessibility in the past. A more probable explanation may be the increased anonymity when using a health care service in a larger centre proved attractive to the in-migrant.

The importance of social support networks is shown in a

20-year longitudinal study of rural elderly where participation in formal social networks, such as community service groups and membership clubs, predicted a longer survival time (Hessler, Jia, Madsen, & Pazaki, 1995). Informal support networks of family and friends were also assessed but not with the same positive results as the formal support networks. The current study recognized both family proximity and an intact community as necessary determinants for health and well-being.

In Glasgow's study (1995), mentioned above, both groups of retirees, in-migrant and resident, showed low-level usage of age-related services (e.g., seniors' centres). Another study found the rural elderly were not necessarily active attendees of seniors' centres and it was suggested this was due to the elderly's time being devoted to volunteerism in the community instead (Miner, Logan, & Spitze, 1993). This supports the present thesis research where seniors' centres in the towns were not well attended by the women of the study, nor did many feel they would use the facilities in the future. Most of the women were very active in the community as volunteers. Therefore, there is evidence that age-restricted social networks are not well supported. Carbert (1995) found the rural women valued their community involvement and volunteerism. Senior womens' volunteerism in rural communities appears to have a positive correlation with their life satisfaction, retirement satisfaction, and self-perceived health (Dorfman & Rubenstein,1993). The present study would strongly support these findings.

**Retirement** was little talked about or planned for by most of the women of the current thesis study. This was also supported by

Dorfman (1989) who found that although rural women talked about retirement more than men, the majority had done no planning. Dorfman (1989) also suggested that careful planning for retirement led to greater retirement satisfaction.

There was an abundance of research on **health care** and the rural elderly but it was all American. Most articles could not be compared to Canadian rurality, and in particular Saskatchewan rurality. Important differences existed such as: a different health care insurance system, a different structure of health care system with more private enterprises, different economic threats, or different ethnic situations. This often led to assessing dependent variables which were non-applicable to Saskatchewan.

Two American (USA) studies, that may be compared to a rural Saskatchewan population which relate to health care and the rural elderly, address the issues of (a) entrance to a care home, and (b) noncompliance with medication. In the present thesis study, many of the participants spoke out strongly about fear of entering a care home. A rural mid-west study found that men adjusted better than women to placement in a care home (Joiner & Freudiger, 1993). This difficult adjustment was suggested to be due to the fact that often women are given less choice in placement and, therefore, feel a loss of autonomy (women were more often living alone prior to placement and, therefore, felt a loss of independence). This apparent 'fear' was voiced by some in the present study, whereas others showed no apprehension at the thought of entering a care home. It appears to be a very personal issue which was perhaps dependent

upon a past experiential component relating to parents or grandparents.

In another American rural study of the elderly relating to health care, where half of the participants were women, the study dealt with non-compliance with medications (Johnson & Moore, 1988). Most elderly combined medications without consulting a professional and many ignored side effects and exceeded recommended dosages. Johnson and Moore (1988) suggest that often a nurse was the only accessible health care professional to act as a consultant. The lack of accessibility to a pharmacist or doctor could account for this sense of indifference, nonchalance, or naivety. It also heightens the role of the rural nurse.

**Family proximity** and family interaction with the rural elderly has been a topic for research. Relocation or moving of rural elderly also has a family dimension. Colsher and Wallace (1990) reported that it was women (a) in relatively poor physical health, (b) who were dependent on others for assistance with activities of daily living, (c) who were functioning at a lower level psychologically and socially, and (d) who previously had no intent to move, who were more apt to move to a noninstitutional setting. This unanticipated move was often precipitated either by the death of a spouse, or by a child marrying and moving away. This unsolicited 'isolation' due to severed relationships surfaced in another study of rural women in Colorado, but the resilience of those women often allowed them to move on and reconnect (Geissinger, Lazzari, Porter, & Tungate, 1993). The differences in the two studies were the age range of participants and size of the studies. The Colsher and

Wallace (1990) study included 1,942 elderly women with a mean age of 74.8 years, but in the one year duration of the study, very few had actually moved. The second study sample was much younger, with only four of the women aged over 50 years, and smaller (n=21); perhaps the younger age group had time to reconnect after a loss or change.

Research reveals contradictory results when relating the influence of family support to the rural elderly. Loneliness is often identified with farm isolation or widowhood. Loneliness appeared to be dependent on losses of functional ability due to aging or socialization losses (Rane-Szostak & Herth, 1995). One of the main precipitating factors of loneliness was identified as infrequent visits from siblings (Dugan & Kivett, 1994). An Indiana study found that the importance of a sister's availability was second only to functional ability as a predictor of well-being (life satisfaction) in older rural women; nevertheless, frequency of interaction was not necessarily a determinant of life satisfaction (McGhee, 1985).

Powers and Kivett (1992) found the older rural adults of their study did not feel there was a linear relationship between proximity and kin support. For relying on familial support, closer consanguinal ties (child being the closest) were stronger than proximity of a relative. This supports the present study where offspring appear to be a life-line to the parent(s). Dorfman and Mertens (1990), in a rural study of elderly men and women, supported other research findings that kinship was of great importance; also, they reported that there was no evidence that the rural elderly were abandoned or neglected by family. The women of this study were more overtly

emotionally attached and in contact with siblings and their children than were the men. Somewhat conversely, the women of the current study often spoke of the involvement of the husbands, together with themselves, with the children and grandchildren.

The importance of kinship versus friendship was compared in some studies. Thompson and Heller (1990) found elderly women with low perceived family support had poorer psychological well-being even though they recognized they had a strong support network of friends. The influence of family and friends on rural elderly can extend to a sense of isolation and dependency due to a curtailed permission to drive (Johnson, 1995). The network of friends, especially for the widows and those living on farms, was of great importance to the women of the present study. The married women in the towns were more involved with events which included their husbands. Reliance on their children for assistance and socializing still appeared to take precedence over friends.

Krout (1988) found little difference between rural and urban elderly in terms of the frequency of contact with their children. This study was quantitative and did not measure feelings attached to filial responsibilities nor satisfaction of the visits. In a southwestern Saskatchewan study (n=400), Kohl (1976) studied family or kinship related to rural women because she felt "it is impossible to look at one without considering the other. Nor can the situation of women be understood without relating it to the larger social system in which they are embedded" (p. 1).

Refreshing findings from a study of two-generation Montana farm families showed very little interactional stress between father,

mother, son, and daughter-in-law. The low stress may have been due to coping strategies or due to such family units seeing themselves as emotional and social support 'sub'-systems (Wilson, Marotz-Baden, & Holloway, 1991). This same lack of stress seemed prevalent in the present thesis study where more than seven of the women were involved in two-generation families farming cooperatively.

The **caregiving** duties of rural women can become a negative determinant of well-being with the responsibilities attached to caregiving. It can take a toll on the physical health of the women as well as on their psyche, but their loyalty to family does not permit them to stray from their obligation. An increased burden on the informal caregiver resulted from the elderly's hesitancy to accept help outside of the family, due to their desire to maintain a sense of independence (Russell,1996). The USA is recognizing the plight of the rural caregiver and are implementing various programs to support her/him such as: low cost case management services, the Volunteer Information Provider Program, and the Caregiver Empowerment Project (Botsford, 1993; Halpert & Sharp, 1989; Roberto, Van Amburg, & Orleans, 1994).

A Manitoba, Canada study identified a relationship between religiosity and caregiving the rural elderly (Bond, Harvey, & Hildebrand, 1987). No difference was apparent, between caregivers of the two religious denominations of the study, in the amount of burden felt by the caregiver. The greater the reported overall religiosity, the lesser the perceived burden of caregiving. A qualitative study in the rural midwest USA looked at the spiritual

implications of being a caregiver (Langner, 1995). The participants reflected that they experienced a personal growth through a rediscovery and redefining of a sense of self. They, as caregivers, had to confront a new reality when faced with the change in the relationship with the dependent older relative. As with many participants of the current study, caregiving challenged their coping mechanisms, forced them to face the reality of their own aging and impending death, and forced upon some a new pivotal role of parenting parents.

A large study of caregivers in rural Iowa suggested that the history of the relationship between the adult child and the elderly parent affected the ability of the adult child to have a relationship with the parent and to give support at a time of need (Whitbeck, Hoyt, & Huck, 1994). Two limitations of this study were: (a) retrospective data were used making it suspect to interpretation, and (b) only the caregiver was interviewed, not the aging relative, possibly rendering the findings biased. The senior rural women of the thesis study suggested that the burden fell on their shoulders for the care of both their aging parents and in-laws. Some had brothers in the near vicinity but it was the 'woman' who was apparently expected to give up her time, social life, family life, and sometimes financial resources to care for the aging parents. Caregiving duties ranged from providing transportation, meals, cleaning, hands-on personal and health care, to emotional support. The women of the study were seniors so they often experienced fatigue from the additional responsibilities. These duties also delayed them from

experiencing the freedom and joys and plans of their own retirement.

There is an acknowledged limit to the interpretation of the findings of the above studies in relation to the present thesis study. However, the current literature review reveals there are many gaps that still remain in identifying and addressing issues related to the health and well-being of senior rural women.

# CHAPTER 6: REFLECTIONS

## Overview of the Study

The purpose of this study was to identify the determinants of health and well-being as perceived by rural senior women in the study area. The study was a part of a large ecosystem study (PECOS) on sustainability of rural Saskatchewan. This thesis study was qualitative and had an exploratory phenomenological approach because the experiential view and the perceptions of the participants were of prime importance.

The original objectives set for the present study were:

1. To determine what rural senior women would regard as environmental changes which have an effect on their lives.
2. To identify common health-related and quality-of-life-related factors and issues.
3. To determine how rural women perceive the extent to which environmental changes affect well-being of individuals, of families, and of the community.
4. To gain an understanding of senior rural women's feelings regarding retirement in their rural community.
5. To determine how rural women perceive the general effects of the rural to urban shift on senior women.
6. To determine what will help improve functional independence and quality of life of rural senior women in the study area.

The conceptual framework guiding this study was the Mandala of Health—a Model of the Human Ecosystem (see Figure 1, p.23). It's applicability to this study and within PECOS was founded in the

holistic and ecological view of human health. The individual, in mind, body, and spirit, serves as the core of the consecutive circles which form a rippling effect. These consecutive circles represent family and community and continue on to encompass all aspects of the biosphere. The mandala of health was a natural fit for this ecosystem study. It was found that, although the mandala was very inclusive in constructs, the model lacked the ability of the constructs to move or shift when they became 'unbalanced', therefore, the mandala model could not be operationalized to show problem areas or offer solutions to problems.

The interview guide, which was used in the semi-structured interviews, was developed based on: (a) the conceptual framework, (b) the objectives of PECOS, (c) the literature review, (c) the clinical experience of the researcher, and (d) the guidance of the research committee.

The 28 study participants met the criteria of the study: women, English speaking, between the ages of 55 and 75 (the formative retirement years), and living in the PECOS study area in a rural setting (on a farm or in a community of less than 1000 population). The sample population, which was stratified by age, had a mean age of 65 years. All were married or had been married; all but one had grandchildren; 7 were widowed; 8 were known caregivers of elderly parents living in the vicinity; 16 were farmers or lived on a farm; and at least 7 farmed in some form of a cooperative fashion with an offspring, usually a son. The convenience sample population was obtained by networking for initial contacts and was followed by snowball sampling thereafter.

The analysis process was enriched by the use of 'information 'triangulation'. This triangulation included observation of the participants, in-depth interviews, field notes, and Statistics Canada reference material. Information was also gained from the PECOS project through seminars, workshops, the PECOS graduate university class, focus group meetings, and resource persons from many academic disciplines. Therefore, this enrichment was accomplished by the researcher's use of many sources to acquire knowledge and "to gain a deeper and clearer understanding of the setting and people being studied" (Taylor & Bogdan, 1984, p. 68). The interview data were analyzed using content analysis and constant comparative analysis. The NUD*IST software program was used to help index and collate data. Typology analysis helped divide the data themes into categories.

Twenty-nine themes emerged from the data which were originally divided into nine categories. Prior to analysis of the data, these 29 themes were then collapsed to 18, due to their interrelationships, and the 9 categories were collapsed to 3: (a) aging/maturation process, (b) community support systems, and (c) family support system.

The eight 'principal' themes, highlighted in the summary of this chapter, are the ones that were most generic or repeated across all the interviews and empirically expressed the primary perceived determinants of health and well-being of the women. These eight themes remain under the same 3 categories of aging, community, and family. A strength in doing 28 interviews proved to be the ability to extract these principal perceived determinants (themes). Even

though no new themes emerged after the first 9 interviews, the remaining 19 interviews provided the volume of support for the discovery of principal themes. Therefore, the final results were demonstratably more representative of the senior rural women of this geographic area.

A direct geographical comparison between the RMs of this study was not deemed of value as emerging themes ran consistently throughout all of the interviews. Health care was one topic that participants in one RM seemed more concerned about than the other two RMs'. This could have been due to closure of one of its newest acute care hospitals and to the fear that two of its elderly doctors would not be replaced as they were near retirement.

The objectives of this study were met as knowledge of the participants' perceptions of environment and community, health and well-being, retirement, and the aging process was gained.

## Summary of the Findings

### Definition of Health

Health was defined equally as having physical and psychological (mental) properties. Properties of each of these concepts, physical and psychological, were descriptively defined using the such words or phrases as 'feeling good' and 'stress'. 'Well-being' was seen as interchangeable with 'health' by 12 of the women. The majority of the women deemed themselves healthy even though they admitted to having slowed down. In reality, most of the women had some chronic disorder which underlines how difficult it is to define 'health'; a definition of health is relative to the individual's perception of her own health. References to the

environment or to the community were lacking in the proffered definitions.

It was evident throughout the interviews that such factors as hospitals closing, farm chemical use, proximity of offspring, and loneliness were recognized by the women to have an affect on their health and well-being. Though lacking in the stated definitions, this thesis itself reflects the women's understanding of the interdependency of environment, community, family, and the individual's mind/body/spirit and the effects this interdependence has on her health.

## Definition of Well-being

Well-being was also defined interchangeably with health by almost half the women. Mental or emotional health was related to defining well-being using such words and phrases as 'coping' and 'peace of mind'. Many felt a sense of happiness or contentedness were factors necessary for well-being. Some saw their level of functional physical ability as a predictor of well-being. The question asked of the women to 'think of any changes in their lives that affected their well-being' often elicited thought-provoking answers which were wrought with emotion. The health of their psyche was of most importance when these women measured their well-being.

## Principal Determinants of Health and Well-being as Perceived by the Study Participants

Three overall categories emerged from the data: (a) the aging/maturation process, (b) the community (social) support system, and (c) the family support system, each with its corresponding themes. The eight principal determinants (themes) of

health and well-being perceived by the study participants are summarized below:

1. Acceptance of the body aging. The women had an understanding, and for some an acceptance, that their bodies were aging and recognized it was due to the natural aging process, heredity, and to personal neglect. They especially noted that they were slowing down. Almost half of the women volunteered that they were experiencing changes in their psyche due to new challenges they were facing at this stage of their lives. Some of the challenges mentioned were: menopause, role reversal with aging parents, children marrying and moving away, divorce in children's marriages, death of a spouse, retirement from work, or awareness that death for them was approaching. With these challenges often came fears, such as a fear of functional disability, a fear of a loss of independence, or a fear of not actualizing their dreams. For many their coping mechanisms were being challenged.

2. Health-promotion practices employed (especially attention to diet and keeping busy). There was a definite awareness, by the study participants, of what they should be doing to promote their health. Five topics they identified as crucial to health maintenance were: diet, exercise, preventative measures, education, and being active. Although diet and exercise were the two topics most often raised in regard to health promotion, the two areas they were most apt to honor were diet and keeping busy or active. Half of the women did affirm that they had regular check-ups with their doctor, although this did not always include a 'feminine examination'. However, visits to the doctor for blood pressure and medication monitoring were

often looked upon as 'regular check-ups'. A third of the women read educational material or watched television programming directed at health education. All the women were active and involved with 'living life'. Most were engaged in a variety of activities including: volunteer work in the community, babysitting grandchildren, attending grandchildrens' special events, 'coffeeing', church work, and committee work. At home, most still baked, canned, and gardened.

3. Resilience was their strength. Resilience as a determinant of health and well-being was objectively identified by the researcher from what was gleaned from the interviews. Resilience can be defined as a trait where one remains healthy while experiencing life changes. It could further be defined as having adequate coping mechanisms.

There were many concepts related to resilience that were revealed such as: the ability to cope with death, widowhood, or loneliness; a sense of spirituality or religiosity; and, a sense of contentment and autonomy. Participation in an organized religion was a part of most of their lives, although admittedly, not on a regular basis for some. Seven women made reference to a spirituality in their lives which gave them strength. Derivatives of the word 'content' were used by seven of the women when relating to their lives.

A strong sense of autonomy with all of the women was revealed when they were asked, "Who is responsible for your health?"; all emphatically responded, "I am!" Self-worth and

self-esteem were in abundance with no sign of arrogance. The women were independent in making most of the choices in their lives, or at least did not appear wary about speaking out on what they believed in.

All of the women had been touched by a loss through death. Strong coping skills allowed acceptance of things they had no control over or could not change. This did not mean they did not suffer pain or loneliness; many of them did. They did not deny this suffering; they accepted it. For the women interviewed, resilience was part of their nature. It is a trait that some research suggested was related to their rurality.

4. A sense of responsibility to/of the community. A sense of community was two-fold in the lives of these women. They (a) receive from and rely on the community for support; and (b) they give of their time and energy back to the community. There is generally a sense of neighborliness that is experienced in rural life where there is a feeling of being able to count on those around you. This does not mean things are perfect. There are still injustices to contend with often due to local politics or idle gossip.

The women of this study did their part to fight for the survival of the rural community in ways ranging from baking and donating pies to sitting in committees. They were willing to be good neighbors and help out with the elderly. Because of the age of the participants, being seniors yet not elderly, few of the women were using support services; the services weren't needed. Nevertheless, they had a confidence that the community would support them when it was needed.

Women farming and those who had children farming showed a concern with the use of pesticides. Many shared stories of chronic pathological conditions they were experiencing or had seen in the community that they felt could have been attributed to the use of these chemicals. Those with husbands and sons farming were concerned about their safety when using the pesticides and, beyond this, they were concerned about what the chemicals were doing to the environment. Future use of chemicals in farming and in town was determined, by these women, to be a community responsibility, not just an individual one.

5. The community must be kept intact. Peck (1987) feels that community develops naturally in response to a crisis. Another way to look at it is 'community develops naturally for survival'. These senior rural women are counting on the survival of their rural communities for their well-being. Those living in or near thriving towns were very optimistic about the future. Others who were living in or near dying towns found that they adapted. This meant driving farther for needed services and amenities but most accepted this; however, this adaptation was not to be translated that they were necessarily happy about what was happening. They had had years of experience of adapting, especially the women farmers.

Due to the security that the 'sense of community' offered these women and due to their attachment to the rural lifestyle, most did not look forward to the possibility of a move in their retirement years. These women identified that the loss of the security of a nearby acute health care support system was a primary predictor of an unsolicited move in their future. Many of the older participants

in the study had already experienced the loss of friends moving to the city. A fear of having to end up in a care home was made apparent by many of the women.

The women shared a definite concern for the future of their children and grandchildren in the rural community where schools, hospitals, and businesses were closing their doors. (Most often the rinks survived!) In their lifetime, they had seen many changes which had led to the demise of once viable towns. They were also worried about the viability of the small farms as they had seen so many fail and because many of their family members were involved in farming. The loss of their family support system, through family members moving away, often meant a loss of security and a loss of a large part of their social life. Economically, many of the women could not foresee a move no matter what happened in their community because they would lose so much in the sale of their homes. But they also seemed to have a sense that, due to their ages, especially the older participants, they would be able to live out their lives in the rural setting.

6. The availability of a doctor in terms of 'will a doctor who retires or leaves be replaced?' The changing health care system was a worry to many but not always for themselves; often the concern was for their elderly parents. In two of the RMs the women adored their local doctors and felt a security as long as these doctors remained in the community. In the other RM, two doctors were much older and a new acute care hospital had been closed. The women of this RM were much more disgruntled with the health care system. By the time this study was undertaken, the rural people of Saskatchewan,

and therefore these women, had, to a large extent, accepted the fate of hospital closure; they had adapted. They had accepted home care and wellness clinics. The stability of the immediate availability of a doctor was seen to be a prime determinant of their well-being.

7. The close proximity of family, especially offspring. Twenty-two of the women had children living in town or on a farm in the vicinity. This was a major reason many of the women stayed in the community. The family was relied upon for help and security by many, especially the widowed participants, but family also gave these women a sense of purpose in life. This does not mean their lives totally revolved around their children because most had their own social circles and outlets, but it was a need to be needed that helped provide this sense of purpose in life.

8. Caregiving duties and filial responsibilty to elderly parents. Although only 8 of the participants were, at present, known caregivers to elderly parents or in-laws living in the vicinity, 15 of the women shared stories of caregiving. Some of the widows had been caregivers to their terminally ill husbands. Caregiving duties took a toll on these women both physically and psychologically (guilt and worry) yet there was a sense of loyalty that kept them bound to their perceived filial responsibilities. There was often additional support from within the community and from other family members that lightened the load but in most cases the brunt of the care fell on the shoulders of these women.

## Discussion

The eight principal determinants of this study are supported in part by the research literature and by reports of policy-makers.

Butler (1993) stated that the rural senior women in her study maintained a sense of well-being and health due to their resilience, a strong family support system, keeping busy, and giving and caretaking. In a rural Saskatchewan study of older women, a strong sense of self-worth was attributed to a faith in God, independence, and a sense of community among the women (Miller, 1990).

The Saskatchewan Provincial Health Council (1996b) suggests the three broad areas which determine health are the individual, including personal capacity and resources; the social environment; and the natural and man-made physical environments. Canadian governmental advisory groups have determined that the key interrelated factors influencing population health are income and social status, social support networks, education, employment and working conditions, safe and clean physical environments, biology and genetic make-up, personal health practices and coping skills, childhood development, and health services (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1994). An action statement for health promotion in Canada promotes the need for a reformation of health systems and the strengthening of communities to sustain the health of the populations (Canadian Public Health Association, 1996). In relation to health, governmental studies appear to broadly identify several of the same determinants as identified in the perceptions of the rural women of the present study.

# Implications

## Implications for Nursing

The overarching implication of this study for nursing is that the nurse will be better able to offer more relevant care when she/he has an increased understanding and awareness of the senior rural womens' perceptions of their health and well-being. From the eight principal determinants which emerged from the data, rural nursing could benefit this population of women in the following ways:

1. Offering health promotion through positive and preventative education to senior women. The nurse can offer and coordinate educational opportunities from a positive perspective (that is preventative vs. curative or adaptive) on such topics as: the understanding of drug actions, benefits of breast-self-examination, retirement planning, cholesterol reduction, benefits of exercise and increasing the level of activity, and increasing coping skills through stress management (Davis et al, 1991; Dorfman, 1989; Gray, 1990; Johnson, 1996). Senior elderly women appear keen to learn.
2. Being aware of the significance of the diversity of geographical location and social/family support systems. The nurse can adapt care by being cognizant of the geographical diversity of these women, especially being attentive to the most rurally isolated (Scheidt & Windley, 1982). Care should be adapted after assessing for the individuality of each woman's social/family networks. These social networks can be easily monitored with the Lubben Social Network Scale which assesses family networks, friends networks,

confidant relationships, 'helping others', and living arrangements (Luggen & Rini, 1995).

3. Recognizing the interest of senior rural women to be a part of the social network. The nurse can offer challenging roles in volunteerism to these women who are capable, articulate, and educated, as well as willing (Chambré, 1993).

4. Discovering how the women perceive relevant issues. Prior to initiating care, programs, or research, the nurse must acquire or be cognizant of the perceptions of the senior rural women regarding that entity and issues related to it. In this way, programs, care, and research will fit with the needs and interests of these women.

5. Expanding the role of the rural nurse. The rural nurse's role could be expanded to encompass more responsibility of the health care needs of the rural population. This would allow for the placement of more nurse practitioners in the rural setting alleviating the fear of the threat of rural doctors leaving.

## Implications for PECOS

The relevance of this study to PECOS was to identify facets within the ecosystem which allow for the sustainability of elderly women in a rural setting. The women in the study identified the importance of the social support system but not necessarily through development of age-related progams; in fact, the study suggested these women would not support such programming. What they did support and feel supported by, in the rural community, were viable public recreational services, the churches, local businesses supplying basic necessities (grocer, bank), and a local doctor. They weren't looking for special attention; they wanted a thriving community of

which they were willing to be an active and integral part. It was often identified that it was mainly the women of the community who so strongly supported the community on a volunteer basis. Their endeavors and accomplishments included: fighting to preserve the past through historical preservation of the community landmarks; maintaining the appearance of the communities with the use of paint and flowers and imagination; fund-raising 'extrordinaire'; and supporting the youth. They didn't ask for recognition for the role they played in the sustaining of their communities. They appeared to be an attentive 'audience' which was willing to change, adapt, and participate in maintaining their rurality. They were keen to be further educated. Although they often feel they have no control over the changing rural environment, they will not be active participants in its demise. Their enthusiasm is possibly an undertapped resource.

More collaboration between rural communities and university graduate and undergraduate programs is beneficial to both; the community is benefited by baseline data, while the student is benefited by the application or practice of learned research methodology and theory (Kulig & Wilde, 1996). The PECOS project is an outstanding example of this collaboration in action.

## Implications for Policy

The final difficulty arises in taking what the women have described as "problematic of the everyday" and putting it to work (Smith, 1987). That is, what can be done by policy and program developers and decision-makers to react to what has been learned about this population? What is apparent is that the policy-makers must include the community in the decision-making, implemention,

and assessment/reassessment of any proposed changes (Foster, Susman, Mueller, Bowman, & Lunt, 1994). Due to the small sample size, the findings of this study are not generalizable to the rest of Saskatchewan; therefore, policy aimed at senior Saskatchewan rural women cannot be determined solely as a result of this study. In future studies, if similar results are found in other areas of Saskatchewan, this will suggest that the perceived determinants of health and well-being of the present study are more generalizable. Hence, this well-grounded knowledge would be a support to help mold pertinent province-wide policy formulation.

Identification of elderly rural women, by governmental agencies and health professionals, as a vulnerable population or a population at risk is beginning to appear as a contemporary issue. In future studies, it would be interesting and informative to discover if elderly rural women see themselves as vulnerable or at risk.

## Epilogue

*Saskatchewan is my birthplace. Most of my youth was spent in the small southern Saskatchewan town of Yellow Grass. My teen years were lived in Saskatoon. For eighteen years I ventured beyond the prairies to live in Ontario, Alberta, and Arizona. Upon returning to my native province in 1993, I was confronted with a new image. Many family farms comprised of many generations had been swallowed up; 52 rural hospitals had just been closed; provincial and property taxes were shockingly high (I had never seen 'PST' and was living in the United States when 'GST' was implemented; I was forever reopening my wallet to get more money!); my rural hometown brick school had been torn down. There seemed to be a feeling of complacency in this formerly gregarious and warm atmosphere of Saskatchewan. I must admit, I was fearful for the survival of rural life.*

*Then the opportunity to be a part of a study of the sustainability of rural Saskatchewan was afforded me. I was to be granted a front row seat of a 'preview' of the future of our prairie ecosystem while having a 'review' of past factors and issues which have precipitated our present situation. Health of people has been my primary agenda in the geriatric nursing field and in the communities I have lived in, therefore a study on the health of rural elderly piqued my interest. I was about to embark on an adventure where my formerly holistic approach to health was to broaden to encompass the whole ecosystem. The adventure would prove to be enlightening, mind expanding, and encouraging. Especially thanks to*

*PECOS, I now perceive health more globally. I view my partnership with PECOS to have been a gift; I am grateful to have had this opportunity.*

*The women of this study whom I met 'along the way', and who shared their stories, strengthened my resolve. They had concerns for themselves and for the rural lifestyle and community but they remained optimistic and involved and cheerful; their attitude was infectious.*

*I have been reconnected with my roots and the future no longer looks so 'doom and gloom' on the prairies. I see now that much is being done to maintain the sense of community for which Saskatchewan is known and envied. Equality, peace, freedom, neighborliness, and health is sustainable in this multi-cultural province.*

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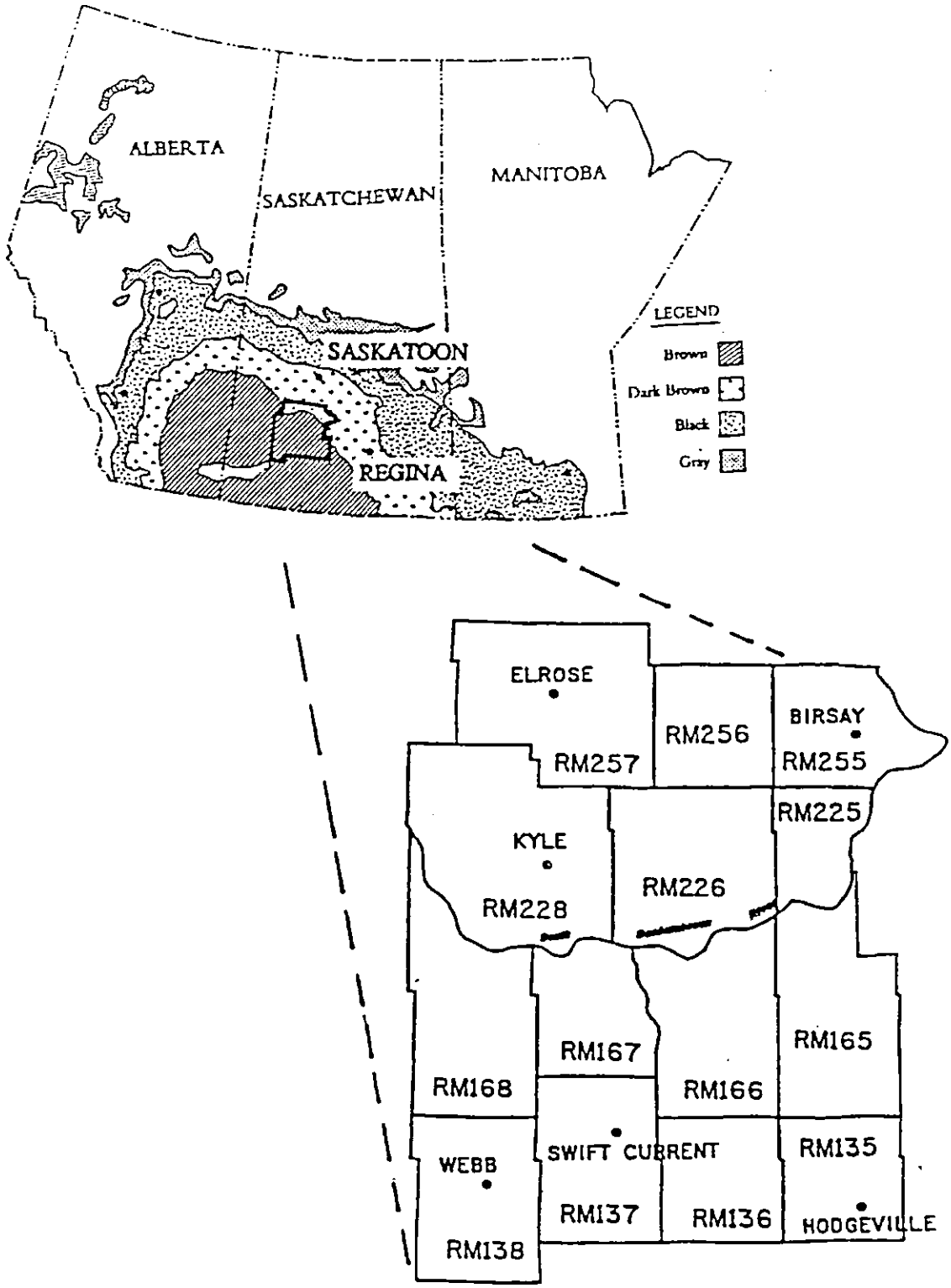
# APPENDIX A

## Map of the Study Area




The Prairie Provinces of Western Canada, showing the major soil zones within the agricultural region. The Palliser Triangle is considered to be the area of Brown soils, with the U.S. border as the base. The Study Area, census agricultural region 3BN is highlighted, and shown at larger scale.

# APPENDIX B

## Interview Guide

## INTERVIEW GUIDE FOR SENIOR RURAL WOMEN

1. How would you define health? How has your health changed over your lifetime?
2. Can you think of any specific changes that have affected your health?
3. How would you define well-being?
4. Can you think of any specific changes that have affected your well-being?
5. Can you think of any environmental changes and changes in your surroundings that have affected your health and well-being or that of your family or community?
6. Who is responsible for your health? for your husband's health?
7. Does your community play a role in your health or will it in the future?
8. What are some things you are doing to maintain or promote your health?
9. How do you see your future unfolding?

## DEMOGRAPHICS

1. Location of residence:
2. Age of participant:
3. Marital status:
4. Number of years living in a rural setting:
5. Occupation (present/past):

# APPENDIX C

## Consent Form

## CONSENT FORM

In signing this document, I am giving my consent to be interviewed by Heather Thompson, a Master of Nursing student with the College of Nursing, University of Saskatchewan. I understand that I will be a part of a research study that will focus on the health and well-being of rural senior women living within the Palliser Triangle in Saskatchewan. This study is funded by the Canada Tri Council Eco-Research Program. The purpose of the study is to gain a better understanding of rural women which may guide some future policies and program development.

I understand that I will be interviewed in my home, or at an agreed upon location, at a time convenient to me. I will be asked some questions about my health and well-being. The interview will take approximately one to two hours and will be tape-recorded. For confidentiality, the tapes will be kept in a secure place and will be erased after being analyzed.

I understand that my age (55 to 75 years), gender (woman), place of residence (rural Saskatchewan), and language (English speaking) qualify me to be a part of this study.

This interview was granted freely. I have been informed that the interview is entirely voluntary, and that even after the interview begins, I can refuse to answer any specific questions or decide to terminate the interview at any point. I have been told that my name and my answers to questions will be kept confidential within the study and that no reports of this study will ever identify me in any way. I understand that members of the student's research committee and her typist may read the typewritten version (transcript) of my interview but my name will be kept confidential from them. I will have two opportunities to review the transcripts of my interview at which time I may ask for a part to be excluded from the study.

I acknowledge that the results of this research will be given to me and that Professor Gail Remus, College of Nursing, University of Saskatchewan, is the person to contact if I have any questions about the study or about my rights as a participant. Professor Remus can be reached at (306) 966-6230.

Date_____Participant's Signature_____

Interviewer's Signature_____

# APPENDIX D

## Correspondence with Participants

May 8, 1996

Dear

Thank you for consenting to take part in my research project for my thesis. Your openness in the interview has offered me a wealth of insight into the senior rural woman. Your comments and your answers to my questions are very valuable to my research.

Would you please review the transcript of our interview, which I have enclosed. At times the conversation may appear disjointed. The reason for this is the secretary types every "um" and "uh" and "you know" that is spoken! Also, as we shared in an introductory visit prior to the tape recorder being turned on, some of the conversation on the tape may have referred to comments made prior to the tape being turned on. The 'blanks' are when the secretary could not understand what was being said and she will sometimes spell things only by the sounds, hence, some misspellings.

Please understand that your name and your location (e.g. town) will never appear in my writings. As was stated on the consent form, anonymity and confidentiality will always be honored. If you are in agreement with me using this transcript or if you have concerns, please contact me collect at (306) 373-3649 or send me back your comments in the enclosed, stamped envelope. If I have not heard from you by May 31st, 1996, I will assume that I have your permission to use your statements in my research.

I feel privileged to have been welcomed into your home and for you to have shared a part of your life with me. I will communicate with you once again this summer with a more concise summary of what I learned from my 29 interviews from the three RM's. Until then, enjoy the wonders of spring after our long winter!

Yours truly,

March 9, 1997

Dear

Well, the study is winding down! The title of my Master of Nursing research study, which you took part in, is "**The determinants of health and well-being as perceived by senior rural women in southwestern Saskatchewan**". The purpose behind the research was to determine what most of you felt were factors which influenced your health and well-being that have allowed you and will allow you to continue to live in a rural environment. Research and studies on what sustains senior women in the country and towns will help to develop programs and policies to meet your needs. This study alone is not enough to determine those needs but it is one of others to represent senior women of Saskatchewan.

As the purpose of this study was to better understand the views of senior rural women, the purpose of this letter is to share with you a summary of the 28 interviews and give you an opportunity to respond if you feel it does not reflect your views. I would ask you to review these findings and if you have any questions or concerns, I would appreciate your comments on or before March 19th, 1997. If I have not heard from you by that date I will assume you are in agreement with the findings. Please call me collect at (306) 373-3649 or call my supervisor, Professor Gail Remus at (306) 966-6230. If my answering machine picks up your call, please leave your name and phone number and I will return your call.

I enjoyed hearing from many of you after the transcripts went out to you and thank you for your positive responses. When my report is completed and the manuscript bound, I will let you know how to avail yourself to a complete copy of the research. You are an integral part of this study and I thank you for your involvement.

I will be in touch again soon.

Yours truly,

# SUMMARY

## Overview of the study

The purpose of the study was to identify the determinants of health and well-being as perceived by rural senior women in the study area. The study was a part of a large ecosystem study (PECOS) on sustainability of rural Saskatchewan.

The participants of the study included 28 women in the PECOS study area who lived in a rural setting (on a farm or in a community of less than 1000 population), were English speaking, and were between the ages of 55 and 75 (the formative retirement years). All were married or had been married; all but one had grandchildren; 7 were widowed; 8 were known caregivers of elderly parents living in the vicinity; and 16 were farmers or lived on a farm.

## Summary of the Findings: Perceived Determinants of Health and Well-Being

Three overall themes emerged from the interviews which the women perceived as the major determinants of their health and well-being: (1) the aging/maturation process, (2) the community (social) support system, and (3) the family support system. The major themes have been broken down to the main determinants. These most important determinants are numbered 1-8.

### Theme of Aging/Maturation Process

**1. Reaction to the body aging.** The women had an understanding, and for some an acceptance, that their bodies were aging and recognized it was due to the natural aging process, heredity, and, at times to personal neglect. They especially noted that they were slowing down. Almost half of the women addressed

that they were experiencing changes in their psyche due to new challenges they were facing at this stage of their lives. Some of the challenges mentioned were menopause, role reversal with aging parents, children marrying and moving away or divorce in children's marriages, death of a spouse, retirement from work, or that death for them was approaching. With these challenges often came fears, such as a fear of disability, a fear of a loss of independence, or a fear of not seeing their dreams come true.

**2. Health promotion—attention to diet and keeping busy.** There was a definite awareness of what they should be doing to promote their health. Five subject areas they identified as crucial to health maintenance were: (1) diet, (2) exercise, (3) preventative measures, (4) education, and (5) being active. Although diet and exercise were the two topics most often raised in regards to health promotion, the two areas they were most apt to honor were diet and keeping busy or active. Half of the women did affirm that they had regular check-ups with their doctor, although this did not always include a 'feminine examination'. Visits to the doctor for blood pressure and medication monitoring were often considered 'regular check-ups'. A third of the women read educational material or watched television programming directed at health education. All the women were active and involved with 'living life'. The activities most were engaged in were varied to include volunteer work in the community, babysitting grandchildren or attending their events, 'coffeeing', and/or church and committee work. At home most still baked, canned, and gardened.

**3. Resilience or hardiness was their strength.** Hardiness can be defined as a trait where you remain healthy while you experience changes in your life. There were many concepts related to hardiness that were revealed such as the ability to cope with death, widowhood, or loneliness; a sense of spirituality; and a sense of contentment and independence. A strong sense of independence with all of the women was revealed when they were asked "Who is responsible for your health?". All emphatically responded "I am!". Self-worth and self-esteem were in abundance with no sign of arrogance. The women were independent in making most of the choices in their lives or at least were not wary about speaking up about what they believed in. All of the women had been touched by a loss through death. A strong coping skill was their air of acceptance of things they had no control over or could not change. This did not mean they did not suffer pain or loneliness; many of them did, and they did not deny this suffering, but they accepted the suffering. For the women interviewed, resilience or hardiness was a part of their nature.

**Theme of the Community Support System**

**4. A sense of responsibility to/from the community.** A sense of community is two-fold in the lives of these women. They receive and rely on the community for support and they give of their time and energy back to the community. There is generally a sense of neighborliness that is experienced in rural life where there is a feeling of being able to count on those around you. This does not mean things are perfect. There are still injustices to contend with often due to local politics or idle gossip. The women of this study did

their part to fight for the survival of the rural community from baking pies to sitting on committees. They were willing to be a good neighbor and help out with the elderly. Because of the age of the participants, being seniors and not elderly, few of the women were using support services because they weren't needed but they had a confidence the community would be there for them.

There was an honorable concern for what the community's responsibility was to the land. Women farmers who were interviewed or those who had children farming showed a concern with the use of pesticides both for human health reasons and for the health of the land.

Due to the security the sense of community offered these women and the rural lifestyle, most did not look forward to the possibility of a move in their retirement years. The loss of the security of a hospital and/or doctor was a primary predictor that these women identified as a possible need to move in their future. Many of the older participants in the study had already experienced the loss of friends moving to the city. A fear of having to end up in a care home was negatively received by many of the women.

**5. The community must be kept intact.** These senior rural women are counting on the survival of their rural communities for their well-being. Those living in or near thriving towns were very optimistic about the future. Others who were living in or near dying towns found that they adapted. This meant driving farther for needed services and amenities but most accepted this, that doesn't mean they were happy about what was happening. They had had years of experience of adapting, especially the women farmers. The

women shared a definite concern for the future of their children and grandchildren in the rural community where schools, hospitals, and businesses were closing their doors (most often the rinks survived!). They were also worried about the viability of the small farms as they had seen so many fail and, as many of their family members were involved in farming. Fear of their family moving away often meant a loss of security and of a large part of their social life. Financially, many of the women could not foresee a move no matter what happened in their community because they would loose so much in the sale of their home. But they also seemed to have a sense that, due to their ages, especially the older participants, that they would be able to live out their lives in the rural setting.

**6. The availability of a younger doctor.** The changing health care system was a worry to many but not always for themselves, often it was for their elderly parents. By the time this study was undertaken, the rural people, and therefore, these women had accepted the fate of hospital closure; they had adapted. They had accepted home care and wellness clinics. The immediate availability of a younger doctor was a prime determinant of their well-being.

**Theme of the Family Support System**

**7. The close proximity of family, especially offspring.** Twenty-two of the women had a child living in town or on a farm in the vicinity. This was a major reason many of the women stayed in the community. The family was relied on for help and security by many, especially the widowed participants, but family also gave these women a sense of purpose in life. This does not mean their

lives totally revolved around their children because most had their own social circles and outlets, but it was a need to be needed.

8. **Caregiving duties and feelings of loyalty to elderly parents**. Although only 8 of the participants were known caregivers of elderly parents or in-laws living in the vicinity, 15 of the women shared stories of caregiving. Some of the widowed had been caregivers to their terminally ill husbands. Caregiving duties took a toll on these women both physically and psychologically (guilt and worry) yet there was a sense of loyalty that kept them tied to caring for family members. There was often additional support from within the community and from other family members that lightened the load but in most cases the brunt of the care fell on the shoulders of these women.

# APPENDIX E

## NUD*IST Categorizing and Coding

Q.S.R. NUD.IST Power version, revision 3.0.5.
PROJECT: Rural Sr Women Health 1, User Heather, .

| | |
|---|---|
| (1) | /Demographics |
| (1 1) | /Demographics/Mar.stat. |
| (1 1 1) | /Demographics/Mar.stat./Married |
| (1 1 2) | /Demographics/Mar.stat./Widowed |
| (1 2) | /Demographics/Age |
| (1 2 1) | /Demographics/Age/55-59 |
| (1 2 2) | /Demographics/Age/60-64 |
| (1 2 3) | /Demographics/Age/65-69 |
| (1 2 4) | /Demographics/Age/70-75 |
| (2) | /Location |
| (2 1) | /Location/Farm |
| (2 1 1) | /Location/Farm/Farm type |
| (2 1 1 1) | /Location/Farm/Farm type/Grain |
| (2 1 1 2) | /Location/Farm/Farm type/Mixed |
| (2 2) | /Location/Town |
| (3) | /definitions |
| (3 1) | /definitions/health |
| (3 2) | /definitions/well-being |
| (4) | /economics |
| (5) | /fam stress |
| (5 1) | /fam stress/caregiver |
| (5 2) | /fam stress/hidden stress |
| (5 2 1) | /fam stress/hidden stress/loneliness |
| (5 2 2) | /fam stress/hidden stress/death |
| (5 2 3) | /fam stress/hidden stress/alcohol |
| (5 2 4) | /fam stress/hidden stress/abuse |
| (5 2 5) | /fam stress/hidden stress/widowhood |
| (5 2 6) | /fam stress/hidden stress/homosex |
| (5 4) | /fam stress/fam prox |
| (5 5) | /fam stress/fam part |
| (6) | /farm stress |
| (6 1) | /farm stress/hours |
| (6 2) | /farm stress/aban isol |
| (7) | /comm |
| (7 1) | /comm/spirit |
| (7 2) | /comm/dying |
| (7 3) | /comm/respon |
| (8) | /health care |
| (8 1) | /health care/hosp clos |
| (8 2) | /health care/dr |
| (8 3) | /health care/system |
| (9) | /envir |
| (9 1) | /envir/allergies |
| (10) | /aging |
| (10 1) | /aging/health prom |
| (10 2) | /aging/activities |
| (10 3) | /aging/body |
| (10 4) | /aging/psych.soc. |
| (11) | /resilience |
| (11 1) | /resilience/independence |
| (11 2) | /resilience/spirituality |
| (11 3) | /resilience/content |
| (12) | /future |
| (12 1) | /future/fears |
| (12 2) | /future/retirement |
| (12 3) | /future/regrets |

# APPENDIX F

## Time Frame of Study

| | |
|---|---|
| January 1995-June 1995 | Drafting of thesis proposal |
| June 21, 1995 | Copyright approval for Mandala of Health |
| June 30, 1995 | Approval of thesis proposal-College of Nursing |
| July 24, 1995 | Approval of thesis proposal-College of Graduate Studies & Research |
| August 3, 1995 | Approval of thesis proposal- U. of S. Advisory Committee on Ethics in Behavioral Science Research |
| September 18-21, 1995 | Interviews RM 'A' |
| September 26-28, 1995 | Interviews RM 'B' |
| September-November, 1995 | Transcribing & coding |
| November 29-30, 1995 | Interviews RMs 'B' & 'C' |
| December, 1995-March, 1996 | Transcribing & coding |
| March 29-30, 1996 | Interviews RM 'C' |
| April, 1996 | Final transcribing |
| May 8, 1996 | Cover letter & transcribed interviews sent to participants |
| May-December, 1996 | Completed hand-coding;<br>Learned NUD*IST software;<br>Set up program in NUD*IST;<br>Inserted hand-coded data into NUD*IST |
| January-March 1997 | Analysis of data;<br>Writing of thesis |
| March 9, 1997 | Cover letter & summary of main themes sent to participants |
| March 11, 1997 | First draft of thesis to committee |