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HEALTH SEEKING BEHAVIORS:  
LIFE HISTORIES OF AFRICAN-AMERICANS, WHO ARE OLDER,  
HAVE A LOW INCOME, AND LIVE IN RURAL SOUTH ALABAMA

A Dissertation

Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for  
the degree of Doctorate of Philosophy

By

Leigh Ann Chandler Poole

May 2008

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2008



PhD PROGRAM

**APPROVAL OF FINAL DEFENSE OF DISSERTATION**

**STUDENT:** Leigh Ann Chandler Poole

**DATE OF ADMISSION:** April 2, 2008

**DISSERTATION TITLE:** Health Seeking Behaviors: Life Histories of African Americans, Who are Older, Have a Low Income, and Live in Rural South Alabama

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## ABSTRACT

### HEALTH-SEEKING BEHAVIORS: LIFE HISTORIES OF AFRICAN-AMERICANS, WHO ARE OLDER, HAVE A LOW INCOME, AND RESIDE IN RURAL SOUTH ALABAMA

By

Leigh Ann Chandler Poole, PhD, FNP-BC, RN

May 2008

Dissertation Supervised by: Dr. Joan Lockhart, PhD, CORLN, AOCN®, CNE, FAAN

The study provides information on health-seeking behaviors across the lifespan of African-Americans who are older, have a low income, and reside in rural south Alabama. A qualitative naturalistic inquiry was conducted utilizing De Chesnay's (2005) life history methodology. The aim of the study was to produce knowledge that could be utilized in developing age, race, and socioeconomically appropriate health promotion intervention strategies for this population.

Participation was voluntary and confidentiality was protected. Participants (N=7) were informed on the purpose of the study, methods of data collection, and their right to withdraw. Inclusion criteria was utilized to purposefully select study participants who were African-American, between the ages of 65 and 85, residents of rural south Alabama, and who met the definition of low income according to the 2006 Federal Poverty Guidelines (Federal Register, 2006). Both male (n=2) and female (n=5) participants were included. Data collection tools included the researcher, a semi-structured interview guide, genogram, and timeline. The study took place in rural south Alabama. Data collection

was recorded under a pseudonym and conducted at a time and place convenient to the study participants. Nine major themes resulted from data analysis: (a) not sick, (b) knowledge and use of home remedies, (c) childhood preference for generic folk-learned remedies, (d) adult preference for professional health care, (e) need for and use of non-professional health care services, (f) need for and use of professional health care services, (g) limited health promotion and disease prevention education, (h) limited health promotion and disease prevention practice, and (i) trust help is available. Findings indicate a need to explore home remedy use and improve health promotion and disease prevention education related to preventive screenings and chronic disease.

## DEDICATION

I would like to dedicate this dissertation to my family, without their support, this would not be possible. My handsome husband, Senator Phil Poole, has always been supportive of my ambitions and has encouraged me to achieve all my dreams. My Mom, Bessie Chandler, is an RN and has spent her life in dedication and service to others. She is an angel sent straight from heaven. My Dad, Bob Chandler, is someone that I know I can always count on whenever and for whatever I need. My grand-dad, who I call “Danie,” has taught me that much can be learned by caring and listening to others. My sister, Dr. Kathy Chandler, is beautiful, brilliant, and is my very best friend. My brother, Fred Chandler, can always cheer me up and make me laugh. My sister-in-law, Summer Richards Chandler, has given our whole family great joy and the best present in the world; and her name is Charlee Ann. Thank you all for helping me to make a dream come true!

## ACKNOWLEDGEMENTS

I would like to acknowledge the hard work and support of my Committee at Duquesne University. Dr. Joan Such Lockhart served as my Chair and helped to guide me through the process and details of writing a dissertation. Dr. Mary De Chesnay mentored my learning of life history research. Dr. LuAnn Richardson provided me with help and insight related to health behaviors. I would also like to acknowledge the encouragement of the administration at Samford University; Sigma Theta Tau International, Epsilon Omega Chapter, who provided me with a grant to help with this dissertation; my family and friends who encouraged me every step of the way; and the many research participants who without their help and sharing, this knowledge would not have been gained.



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# CHAPTER I

## INTRODUCTION

### 1.1. Background of Study

Current approaches are not effectively eliminating the health disparities of the most vulnerable populations in the United States (Healthy Alabama 2010, 2000; Institute of Medicine [IOM], 2002, 2004, 2006). A review of literature indicates the existence of notable health disparities among persons who are: African-American, elderly, residents of a rural or southern geographical location, and who live with socioeconomic status disadvantages (IOM, 2006; Jackson, 2005; Satcher et al., 2005).

Progress towards health disparity elimination is promoted and monitored by multiple state and national organizations such as the U.S. Department of Health and Human Services (DHHS), through Healthy People 2010; the Alabama Department of Health, through Healthy Alabama 2010, and the Institute of Medicine. Healthy People 2010 (DHHS, 2000) has developed two major goals for the U.S. population. These goals are focused on (a) increasing life expectancy and life quality, and (b) eliminating health disparities. Healthy Alabama 2010 (2000), a related initiative of the Alabama Department of Health focused on improving the health of all Alabamians, recently reported that life

expectancy disparities have actually worsened in Alabama over the last 10 years. The IOM has further examined health disparities and their extent in racial and ethnic minorities and in a recent publication concluded persons of racial and ethnic minorities face health disparities related to quality of health care. The IOM reported that persons of racial and ethnic minorities do not receive the same quality of health care or the same medical procedures as non-minorities (2002).

The IOM (2004) further found health illiteracy to be a significant problem facing more than half of all Americans, especially those within racial and ethnic minorities. Health illiteracy has been determined to be a contributor of worsening health inequalities within vulnerable populations. In attempt to decrease the health illiteracy facing ethnic and racial minorities, the IOM recommends using culturally sensitive information and including the population which will use the information in the actual development of the information.

Health disparities are abundant among persons who have a low income, are older, African-American, and reside in rural Alabama (Alabama Rural Health Association [ARHA], 2003). Recent reports (ARHA, 2003; DHHS, 2001) outlined multiple key indicators which serve to emphasize the status of health for persons living in rural versus urban Alabama; the following figure highlights these known disparities and inequalities in the rural population:

Table 1.1

*Known Disparities and Inequalities in the Rural Population*

|   |   |   |
|---|---|---|
| Little or no insurance coverage and high cost                     | Inadequate mental health services   | Shortage of available health professionals  |
| Lack of culturally appropriate health care providers and services | Compounding lack of access to health care issues, including transportation and emergency services | Higher mortality rates from gunshot wounds, motor vehicle accidents, and occupationally injuries. |
| Economic related concerns   | Social isolation and decreased social support   | Lack of anonymity and confidentiality   |
| General health disparities  | Unmet health needs  | Inadequate provision of preventative services   |
| Nutritional concerns  | Higher rates of chronic disease   | Lower educational levels compared to urban residents  |
| Higher rates of smoking and obesity                               | Increasing rates of HIV   |   |

Health disparities are greater in rural versus urban Alabama, especially rural south Alabama (ARHA, 2003). Alabama rural residents have a lower life expectancy (73.1 years) when compared to Alabama’s urban residents (74.5 years; ARHA). The rural Alabama setting selected for initial recruitment of study participants has yet an even

lower at birth life expectancy (70.2 years; Center for Health Statistics, 2004). Rural Alabama residents have greater mortality rates for accidents, Alzheimer's, cancer, diabetes, heart disease, stroke, and suicide than Alabama urban residents (ARHA). Homicide is the only mortality indicator noted to be higher in urban versus rural areas (ARHA).

Health disparities are also notably different when comparing rural south and rural north Alabamians (ARHA, 2003; HSRA, 1998). The racial composition of the residents in these geographical areas also differs significantly. Persons belonging to a minority racial or ethnic group comprise only 13% of the population in north Alabama. However, 41.4% of the population in rural south Alabama belong to a minority racial or ethnic group; and this is, coincidentally or not, where the greatest health disparities exist in the state. When comparing the percentage of racial minorities within the population, it is notable to find that five of the top ten counties in the nation with the highest percentage of black residents are located in rural south Alabama (HSRA, 1998).

Alabama's rural population is growing older. By the year 2025, it is projected that one out of every five rural Alabama residents will be an older adult (ARHA, 2003). Marks and Lutgendorf (1999) described the importance of good health behaviors in the older adult population, but reported a limited availability of data on health behavior predictions for this population. While the proposed study does not seek to predict health behaviors in older adults, it will allow us to learn more about the little known health behaviors in the older adult population.

As a person ages, health care becomes increasingly important; but for many older, rural Alabamians, health care access is a problem compounded by significant poverty.



Those suffering from poverty are at a higher risk for health disparities. Many rural Alabamians suffer from extreme poverty. Approximately one out of every five rural residents lives below the poverty level (ARHA, 2003), which varies according to number of persons in the household. In 2000, the per capita personal income of rural Alabamians was nearly 29% less than their fellow urban Alabamians. Notably, this income was 51% below that of the average person in the United States. In fact, there are 6 rural Alabama counties which rank in the lowest 250 per capita income counties in the United States. The rural south Alabama county chosen for initial recruitment of participants is one of these six counties, with an average per capita income of \$16,476 (ARHA, 2003).

Lack of adequate employment is another problem facing rural Alabamians. Without adequate employment, persons may lack sufficient funds to acquire health insurance. Persons without insurance are at risk for decreased access to care, inability to secure health care, medicines, and other health care related necessities. Rural Alabama counties have an unemployment rate of approximately 7.1%, compared to the urban rate of 4.8% (ARHA, 2003).

Problems related to sufficient insurance coverage and costs of premiums are not limited to the rural Alabama population. The percentage of persons estimated to be uninsured in Alabama (18.3 – 22.6%) exceeds the national average of 17% (Alabama Department of Public Health ([ADPH], 2006). However, rural residents typically pay a greater percentage of their salary for premiums than urban residents. Rural residents are more likely to be self-employed or work for smaller companies, which do not provide the insurance benefits provided by larger organizations (Coburn, Kilbreth, Long & Marquis, 1998). Typically, rural residents are not as economically successful as urban residents

(ARHA, 2003). Therefore, persons residing in a rural area are at a greater disadvantage with respect to percent of income paid for health insurance (Coburn et al.).

Lack of adequate health insurance is especially problematic for rural residents with a chronic medical problem, such as HIV. A study by Beltrami et al. (1999) compared HIV status and insurance in rural Alabama. Subjects were recruited by clinic staff or researchers, either during their clinic visit or per telephone. Convenience sampling was used to invite 454 persons, representing 5% of all known HIV cases in Alabama at the time, to participate. This convenience sample included 417 persons who were known to be HIV positive and who live in a nonurban location in Alabama. The study sample included male (74%), female (26%), Black (43%), and White (55%) participants. The study utilized 1-hour interviews at six clinics providing HIV services to persons in Alabama. Findings revealed rural Alabama residents who were HIV positive were more likely to have inadequate health insurance, with 39% reporting having no insurance, and 16% losing insurance after sero-conversion. Study participants were also likely to participate in high-risk behaviors; with 10% visiting an STD clinic within the year before the interview, 7% reporting crack-cocaine usage within the last month, 36% using alcohol before sex, and 35% reporting inconsistent condom use with sexual activity. Participants were additionally more likely to have acquired HIV in a rural (61%) versus urban area. This increase in HIV transmission was noted to be disproportionately growing in the rural South, and caused further concern related to lack of adequate resources to support the health needs of HIV positive persons in rural south Alabama (Beltrami et al.).

Transportation as a means of accessing health care is also a problem in Alabama. Twenty percent of Alabama counties have no public transportation; and it has been estimated that over 70% of Alabama's population has no access to public transportation (ADPH, 2006). This crisis is notably worse in rural Alabama, with an estimated 9.63% of rural Alabama households reporting no automobile, compared to 7.68% of urban households (ARHA, 2003). Without transportation, persons have increased difficulty accessing any available healthcare resources.

The healthcare resources available to residents of Alabama are also limited. Alabama has both one of the highest hospital closure rates in the nation and a great shortage of health care providers in the rural areas (ADPH, 2006; ARHA, 2003). There are only 5.74 primary care physicians for every 10,000 rural residents in Alabama; compared to an average of 11.01 primary care physicians for every 10,000 urban residents (ARHA). Specialists such as dentists are even more difficult to recruit to the rural areas. There are only 2.5 dentists per 10,000 rural residents, compared to 5.01 dentists per 10,000 urban residents (ARHA). The site chosen for initial recruitment of study participants is without a pediatrician, obstetrical or gynecological specialist, has no assisted living facilities or baby delivery services, and is one of eight rural Alabama counties without a hospital (ADPH, n.d.; Alabama Medical Education Consortium [AMEC], 2006).

Appropriate provision of mental health care is an issue of great concern for rural residents. There is a lack of ethnic and culturally appropriate research, diagnoses, treatments, and pharmaceuticals (DHHS, 1999). Other mental health related concerns include inadequate funding for provision in the rural areas, difficulties accessing

available mental health services due to the stated transportation complexity, and the effect of stigma from mental health diagnoses. Stigma is of particular concern especially with the lack of confidentiality in rural areas (DHHS, 1999, 2001).

Mental health care services are not typically easy to access in rural Alabama. For persons who have a low income, mental health providers are more difficult to find. There are many rural Alabama counties that have limited or no mental health services available at all (ARHA, 2003). The rural south Alabama county chosen for initial recruitment of participants is one of these areas with very limited mental health services.

Emergency care is a problem for rural Alabama residents. Volunteers often provide the available emergency services. These volunteers often operate without adequate financial support. A lack of financial support results in, among other things, limited life support equipment. Transit time for emergency help is greater for rural versus urban residents. It takes an average of 16.4 minutes to respond to requests for emergency help in the rural areas, compared to an average of 12.9 minutes in Alabama's urban areas (ARHA, 2003). The DHHS (2001) reports that trauma mortality is disproportionately high in rural areas, as there are 31.3 motor vehicle accident deaths per 100,000 in the rural areas of Alabama, compared to only 18.5 per 100,000 in urban Alabama (ARHA).

Rural residents are at an increased risk for death after a trauma due to the time it takes for emergency medical services to arrive (ADPH, 2006; Grossman et al., 1997). The rural population has a death rate 63% higher than the urban population for persons involved in a motor vehicle accident (ADPH, 2006). A separate prospective cohort study compared response, scene, and transport times of emergency medical services. The sample (N=459) contained subjects who were involved in a major trauma of like severity

in rural (58%) and urban (42%) areas. Findings revealed a longer transport time for rural (17.2 minutes) versus urban (8.2 minutes) occurring traumas. The response time was notably greater for rural (13.6 minutes) compared to urban (7 minutes) traumas. Overall, the study found that rural residents had a 7 times greater mortality rate compared to urban residents when emergency medical services took more than 30 minutes to respond to the accident scene (Grossman et al.).

Many of Alabama's rural hospitals are in grave financial trouble, and offer limited services to their community members. Sixty percent of rural Alabama hospitals do not deliver babies, requiring women in labor to travel to distant communities for delivery (ARHA, 2003).

Lack of adequate preventative services is another concern for rural residents. Ewing, Selassie, Lopez, and McCutcheon (1999) studied the provision of preventive services by physicians. This cross-sectional study successfully recruited 3,881 participants. The subjects were randomly selected and sampled across varying specialties and across varying geographical locations. The sample contained 51% of rural practicing physicians. Chi-square was utilized and compared at an alpha value of .05. Findings indicated no physician groups provided their patients with adequate prevention services. In addition, rural practicing physicians reported providing cholesterol, cervical cancer, and breast exam screenings at a rate of one-third of metropolitan physicians (p. 65).

## 1.2. Purpose of Study

The purpose of the study is to understand a lifetime of health-seeking behavior experiences as lived by persons who are African-American, older, have a low income, and reside in rural south Alabama. The aim of this study is to produce knowledge that can

be utilized in developing age, race, socioeconomic, and culturally appropriate health promotion intervention strategies for this population.

### 1.3. Research Questions

The study seeks to answer the following research questions:

1. What are the lifetime health-seeking behavioral experiences of African-Americans who have a low income, are older, and reside in rural south Alabama?
2. What are the common universalities and diversities in health-seeking behavioral experiences among study participants?

### 1.4. Definition of Terms

*African-American.* This term is consistent with the words *Black* or *African-American*, and includes persons “having origins in any of the Black racial groups of Africa. This term includes people who indicate their race as ‘Black, African Am., or Negro,’ or provide written entries such as African-American, Afro American, Kenyan, Nigerian, or Haitian” (U.S. Census Bureau, 2000, Race), and will be self-identified by participants.

*Health-seeking behaviors.* An expansive term that will be utilized in its broadest sense. It includes movement towards higher wellness (Mosby, 2002). The term will initially be described to the participant as *those things a person does to get or stay healthy*. Answers to questions concerning what a person does to *get* healthy will be described as health promotion practices. Answers to questions concerning *staying* healthy will be correlated to disease prevention practices. Information related to both folk learned and professional health seeking behavioral practice experiences will be sought.

Ultimately the participants will describe their individual health-seeking behaviors and those descriptions will be reported in the study's findings.

*Rural South Alabama:* Includes those areas designated in Appendix 1 as rural Alabama and all areas positioned below the 180-degree line within the state of Alabama. These counties include: Autauga, Baldwin, Barbour, Bullock, Butler, Choctaw, Clarke, Coffee, Conecuh, Covington, Crenshaw, Dale, Dallas, Escambia, Geneva, Greene, Hale, Henry, Lowndes, Marengo, Monroe, Perry, Pike, Russell, Sumter, Washington, and Wilcox (ARHA, 2003).

*Low income.* Defined according to the ARHA (2003) guidelines, and includes all persons who earn below 200% of the 2006 Federal Poverty Guidelines (Appendix 2) which are based upon number of persons residing in the household, as described in the Federal Register (HHS, 2006). Income will be accepted as self-reported by the participants.

*Older adult.* Defined as a person who is between 65 and 85 years of age (Jarvis, 2004). Age of the participant will be accepted as self-reported by the participant.

## 1.5. Assumptions

The following assumptions have been accepted in the proposed study as being true and are without need for proof:

1. Participants will respond honestly to interview questions.
2. Similarities and differences in health seeking behaviors exist within and between persons of all cultures.

## 1.6. Limitations

The following limitations have been identified in the proposed study. It is expected that study limitations may be expounded upon after study completion.

1. The researcher is of different ethnic background from study participants. A potential limitation is that it may take the researcher longer to develop rapport with the participants. Nevertheless, since the researcher is of different ethnicity, scientific objectivity will potentially increase. To reduce the potential limitation caused by ethnicity, the researcher will inform the study participant of the endorsement of the study by the key community gatekeeper known to the participant.
2. Trust and comfort in talking about life experiences may be initial limitations as well. Participants may have different perceptions concerning the researchers' intent and will not know the researcher personally. However, the researcher has gained the trust of several key African-American community gatekeepers. It is hoped that the established trust and acceptance by a gatekeeper will transition into increased trust and comfort of the participants. The researcher's degree of involvement in the community is documented further under the instrument section of chapter III.

## 1.7. Significance to Nursing

The proposed study will add to the body of scientific nursing literature available on the study's population. While multiple sources (AMEC, 2006; ARHA, 2003; IOM, 2002, 2004, 2006) have documented the existence of health disparities within the proposed study population, the IOM (2006) has recommended conducting research



specifically on health behaviors that may have lead to these health disparities. The proposed research will fill a gap in the knowledge base on health seeking behaviors within this significantly effected vulnerable population.

Study findings will provide nurses and other health care providers with an understanding of this population's actual health seeking behaviors and provide a better understanding of persons within the culture of the study's population. Once actual health seeking behaviors have been identified, these specific behaviors can be addressed more appropriately, and within a cultural context, as nurses provide care for persons within the culture and work to decrease the overwhelming health disparities within the population.

Perhaps Leininger said it best:

If human beings are to survive and live in a healthy, peaceful and meaningful world, then nurses and other health care providers need to understand the cultural care beliefs, values and lifeways of people in order to provide culturally congruent and beneficial health care. (Leininger & McFarland, 2002, p. 3)

## 1.8. Summary

Chapter I provided a description of the proposed study. Definitions were supplied to orient the reader to specific study related terms. The assumptions were focused on the premise of the qualitative paradigm and assumed participants would respond honestly to research questions. Two research questions were outlined and focused on understanding a lifetime of health-seeking behaviors and identifying common universalities and diversities. The background section provided documentation of multiple health disparities and supported a need for the current research. Rationale related to the significance to nursing was provided and further described the study's importance. The purpose of the

study was outlined as seeking to understand a lifetime of health-seeking behavior experiences as lived by persons who are African-American, older, have a low income, and reside in rural south Alabama.

# CHAPTER II

## REVIEW OF LITERATURE

The literature was reviewed to provide information on available research and knowledge gaps associated with the study's population subsets related to the research questions. The review included the use of multiple databases, including: CINAHL, PubMed, ProQuest, Medline, Digital Dissertations, Jake, along with key word searches in various library databases including Duquesne University, Samford University, the University of Alabama at Birmingham, WorldCat, and multiple well-respected federal information sites, including the DHHS. Key words used in the search included a combination of the following terms: African-American, Black, health/health-seeking behaviors, health promotion, disease prevention, Alabama, south Alabama, low-income, poor, generic care, health care practices, folk medicine, professional health practices, and complementary alternative medicines/practices.

The findings from the review were limited due to the lack of literature available on the study's population, especially when paired with the concept under investigation. However, the review of literature did serve to confirm that the dissertation research will be original, significant, and important to fill a knowledge gap. It is expected the

preliminary review of literature will be expounded upon with the emergence of new themes resulting from data analysis and that study findings will be compared and contrasted with available related literature at the completion of data analysis.

Chapter II will provide a description of the theoretical support for the study and a review of the available, current, but limited study related literature. The review of literature will include noted areas of agreement, disagreement, and gaps in the literature. Findings from the review of literature are categorized and presented systematically. Except where noted, all research presented was current and peer-reviewed. However, theoretical support literature exceeds current literature guidelines to include seminal works and to allow for adequate coverage of the content.

## 2.1. Theory Supporting the Study

Leininger's culture care diversity and universality theory (1985, 1988, 2001) will be utilized as theoretical support for the theory. The theory's concepts and assumptions provide a foundation for research questions and support the significance and need for the study; however the theory itself is neither being tested or used as a theoretical framework in the proposed study.

Leininger's theory describes the importance of understanding a concept within a culture (2001). The theory asserts that cultures, and human beings within individual cultures, are alike and different in many ways. The theorist promotes the collection of in-depth cultural knowledge from an emic perspective to discover these similarities and differences. In the process of discovery, multiple items of influence are explored, including cultural and social dimensions. Health patterns, professional, and generic practices are also examined within and among participants. Once data are discovered, the

theorist promotes the use of these findings in the provision of culturally competent care through the use of one or more of her three modes of action, which are described by the theorist as (a) culture care preservation or maintenance, (2) culture care accommodation or negotiation, and (c) culture care repatterning or restructuring (Leininger, 1985).

### *Leininger's Culture Care Diversity and Universality Theory*

Madeline Leininger is known as a nurse, anthropologist, and theorist (Johnson & Webber, 2001). This theorist was the founder of the transcultural nursing practice specialty, from which she formulated the culture care diversity and universality theory (NTPR Project, n.d.). She created a research method named ethnonursing, and has been nominated for the Nobel Peace Prize (NTPR Project). Leininger's theory on culture care diversity and universality (1985, 1988, 2001) developed over several decades, and continues to be refined, but was originally published in its entirety in 1985. The theory contains 14 concepts, 18 orientational definitions, 13 assumptive premises, and lists 175 known care/caring emic constructs, which have been derived from decades of both domestic and international research (Leininger, 2001). Several of the theorists' publications have explained and explored the theory in detail (e.g., Leininger, 1988, 2001). She credits the discipline of anthropology as helpful in the development of her philosophy and transcultural nursing culture care knowledge (Leininger, 2001).

### *Definitions*

The culture care diversity and universality theory contains 18 major orientational definitions of theory-associated concepts (Leininger, 2001). These concepts have been described as *orientational*, to assist the researcher with understanding these concepts as viewed within the culture care diversity and universality theory (Leininger). The

proposed study does not intend to utilize all 18 theoretical concepts, as all theoretical concepts listed in Leininger's theory are not applicable to the proposed study and therefore do not require defining. However, five of Leininger's concepts and their associated definitions will be accepted for use within the proposed study. The five common concepts which are defined as *orientational definitions* and which are thought to be fundamentally essential to understand in the current study are: worldview, cultural care diversity, cultural care universality, generic (folk or lay) care system, and professional care systems (Leininger).

1. *Worldview* refers to how a person perceives the world around them. The proposed study seeks to understand the worldview of the participants from an *emic* perspective, or a perspective that comes directly from the participant him/herself (Leininger, 2001).
2. *Cultural care diversity* refers to each culture having differences, not only from other cultures, but also within individual members of the same culture. Provision of cultural care avoids stereotyping and includes attention to individuality (Leininger, 2001).
3. *Cultural care universality* refers to each culture having similarities within its individual members. Cultural care provision is focused on similarities and commonalities within members of a culture and should be anticipated (Leininger, 2001).
4. *Generic (folk or lay) care systems* are learned cultural practices. These practices are outside of what is considered typical Western

medicine. It includes both traditional and folk health care practices used in the pursuit of wellness (Leininger, 2001).

5. *Professional care system(s)* refer to typical Western medicine. It includes practices formally learned and those that are scientific in nature (Leininger, 2001).

#### *Assumptive Premises*

There are 13 assumptive premises in the culture care diversity and universality theory, all of which are described in detail in Leininger (2001) and are described as a guide for nurses to use towards discovery within the culture care phenomena (p. 44). The proposed research does not intend to use all 13 assumptive premises as a guide, but will utilize five of Leininger's assumptions to support the significance of the study. The following are the researcher's interpretation of these five supportive assumptions:

1. Culturally based care is essential to provide and involves the inclusion of holistic knowledge in deciding how to best provide it (Leininger & McFarland, 2002).
2. All aspects of culture care have certain similarities and differences that vary between and among cultures (Leininger & McFarland, 2002).
3. All human cultures have both generic and professional practices and knowledge, and these practices vary between and among cultures (Leininger & McFarland, 2002).
4. Culture-care practices, beliefs, and values are entrenched within and influenced by the characteristics held by a culture including: world-view, spirituality and religion, overall philosophy, language, relationships,

politics, social interactions, education, finances, history, and the environment (Leininger & McFarland, 2002).

5. Providing culturally based care is beneficial to the population and affects overall well-being within the environment in which it is lived (Leininger & McFarland, 2002).

*Sunrise Enabler/ Model*

Leininger's theory has been depicted in a model illustrating the relationship of the theory's concepts. The depiction was previously known as the *sunrise model*, but is described by Leininger as an *enabler*, to help persons understand the theory. A depiction of *Leininger's sunrise enabler to discover culture care* (Leininger, 2004) follows and has been reprinted with permission.



*Leininger's Sunrise Enabler to Discover Culture Care*

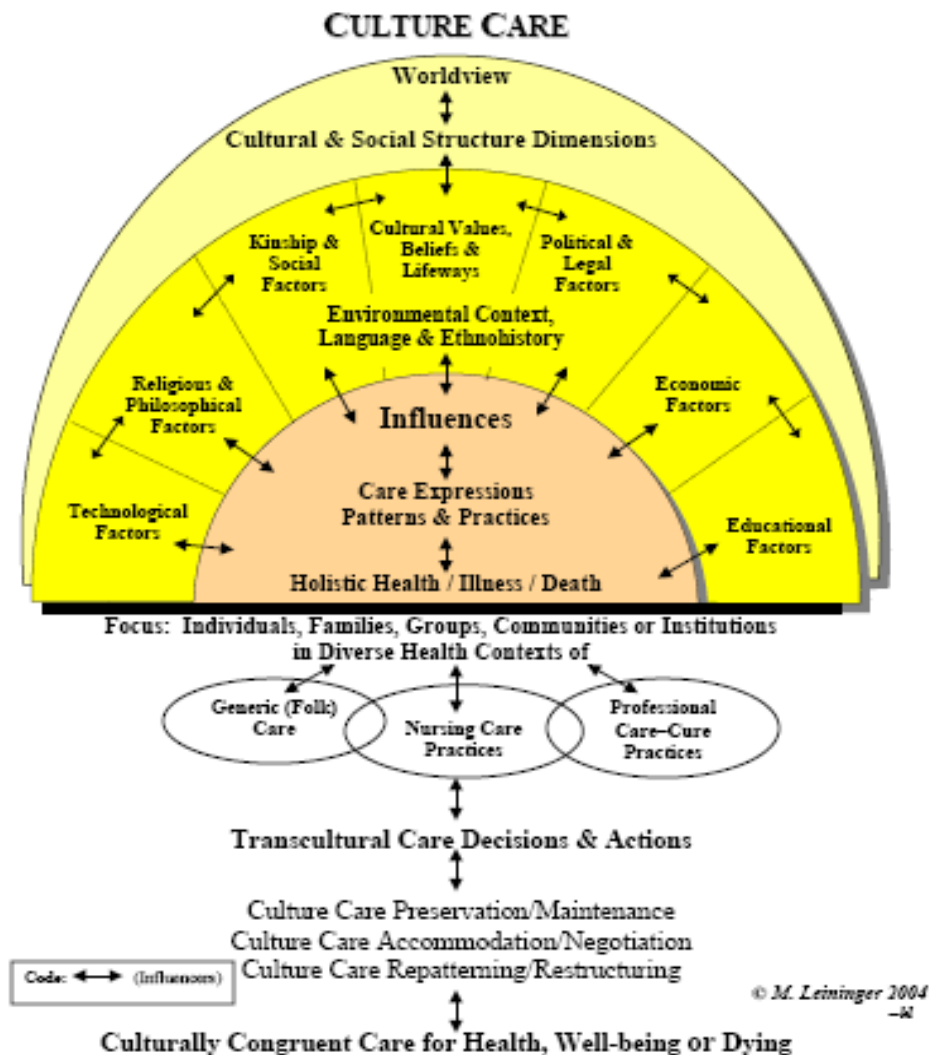


Figure 2.1. Sunrise enabler.<sup>1</sup>

<sup>1</sup> From “Leininger’s Sunrise Enabler to Discover Culture Care”, by M. Leininger, 2004, Retrieved March 17, 2006, from <http://www.madeleine-leininger.com/> : NTPR Project. Copyright 2004 by M. Leininger. Reprinted with permission.

Use of the enabler has been encouraged to facilitate the process of inductively formulating knowledge, which can be used in assisting health care providers to provide culturally competent and congruent health care (Leininger, 2004). Researchers are encouraged to begin with their area of interest and an understanding of the worldview of their participants, thus working from the top of the model downward.

The enabler visually depicts the theory. World-view is positioned at the top, followed by interacting cultural and social structure dimensions. These dimensions interact with each other (depicted with arrows in the model) and various care aspects that include patterns, expressions, and practices. These influencers are positioned above the interacting diverse health systems, which include generic, professional, and nursing care practices. Knowledge gained from exploration of the concepts and dimensions in the enabler can be used to formulate culturally competent nursing decisions through the use of one of Leininger's three modes of action (Leininger, 2001).

#### *Applicability of Theory*

Leininger's culture care diversity and universality theory (2001) will provide foundational support for the study. Leininger's assumptive premises and concepts have been used to formulate the proposed research questions and further lend strength to the overall significance and need for the study. Leininger's theory will be used to advocate for and inform the proposed study. Inductive reasoning will be utilized to develop patterns, theory, concepts, and themes as they emerge from the data, but the theory itself will not be tested in the research.

The theory will be further used as a theoretical lens to bring into view the importance of the concept under investigation and the population important to

understand. It serves to inform the researcher of the importance of gaining an understanding of both the generic and professional health seeking behaviors of this population.

In applying the theory's assumption that populations have universalities and diversities, the researcher will seek to understand these similarities and differences in the study population. As cultures are assumed diverse, certain culturally specific information may emerge from this research that leads the scientific medical community to alter their current approaches to health promotion and disease prevention within this population. As cultures are also similar, findings may reveal certain modes of action or health strategy approaches that are more effective in the study's population.

Leininger (2001) discussed the importance of determining specific cultural information. Other researchers agree with Leininger, that current health promotion and disease prevention strategies generally lack cultural specification, as they are primarily based upon the general leading health indicators of *Healthy People 2000* and *2010* (DHHS, 1990, 2000). This study seeks to gain culturally specific knowledge and will utilize assumptions and concepts from Leininger's (2001) theory in the process of examining the culturally specific health seeking behaviors of the study participants. It is hoped that by identifying patterns of health-seeking behavioral practices, appropriate modes of action can be taken by the medical community to promote the health of the population and decrease health disparities within the study population. Leininger's theory will therefore be applied as theoretical support in the study's foundation. The theory strengthens the study's significance and need, and has been interwoven throughout the proposed research into both design and research questions.

## 2.2. Health-Seeking Behavioral Practices

Every culture has both professional and folk learned practices; and each person within a similar culture may have independent variances, irrespective of their race or other demographics (Leininger & McFarland, 2002). The proposed study seeks to understand the health-seeking behavior experiences of the participants in this study. A review of literature was conducted on known health seeking behaviors in the African-American population in terms of those practices considered as either generic folk learned practices or those practices accepted as professional scientifically founded medical practices. Findings from the review of literature are described below and are categorized into either professional medical practices or generic folk learned medical practices.

### *Professional Medical Practices*

The following research studies have explored known professional medical practices as health-seeking behaviors in populations similar to the study. The subsequent research studies pertain to health-seeking behaviors thought to conform to Western medicine. The importance of exploration of this content was previously described by Leininger (2001).

King et al. (2004) studied the frequency of professional testing related to diabetes. The pilot study sample included 80 African-Americans and 23 Caucasians who were recruited from senior centers and other community events. These participants were residents of a southeastern U.S. state. The initial pilot study was conducted between the years of 1999-2000. African-Americans were compared to Caucasians to determine receipt of a hemoglobin A1C, lipid testing, eye exams, kidney testing, feet exams, and counseling for nutrition and self-management of diabetes. Findings revealed all

professional tests and counseling services surveyed were used with less frequency in the African-American population, even though African-Americans are 1.6 times more likely to have diabetes than Caucasians.

However, after two years of interaction in the African-American population, as part of the Racial and Ethnic Approaches to Community Health (REACH) 2010 Project (Centers of Disease Control [CDC], 1999), the study was repeated. The convenience sample (N=308) included African-Americans (n=159) and Caucasians (n=149) in the same geographical location. The subjects answered or were assisted by a same sex survey administrator to answer an open ended self-report questionnaire. Both groups had a mean age of 59, but Caucasian participants were noted to have a significantly higher median income and educational levels. Findings after this 2-year community interaction revealed comparable self-reports concerning receipt of or counseling on various diabetes related tests, smoking cessation, and diabetes management. However two measured items revealed a significant difference. African-Americans were more likely ( $p < .001$ ) than Caucasians to report (a) having good kidney function test results and knowledge of those tests; and (b) having received education related to nutrition ( $p = .003$ ). Other differences between African-Americans and Caucasians were not found to be significant ( $p = .05$ ).

Resick, De Chesnay, Kubinski, and Zolkoski (2005) conducted an ethnographic action research study on the medication practices of African-American seniors. The study is included here as well as in the following generic folk care practice section, since it explored both professional and generic care practices. The need for the study was initiated by community members. The study purpose was to discover information related to types of medicines used and to further understand what participants knew in regard to

use of their particular medicines. The sample included 25 participants, of these, 22 were described as community and 3 as non-community residents. There were 5 male participants and 20 female. The setting was a large urban city located in western Pennsylvania. Data collection was initialized with participant observation and then followed with pilot interviews. The semi-structured interview guide was refined and administered to participants, in their home. Findings included a basic understanding of proper medication usage, although in many cases participants could not identify the medicine by its proper name, and instead used a description of its purpose to describe their medicine. Participants were also noted to have developed a routine for taking their medicines, to have accountability of use, and most notified their provider for troubling side effects. Participants described rarely missing a dose of medicine, and exercised the practice of not sharing or borrowing medicines. Further findings indicated participants did occasionally run out of a medicine or have to wait for a refill, and were in general, not concerned about forgetting to take medicine. Participants rarely had a negative comment concerning their health care provider. There were no apparent differences in findings related to gender and no comparison group.

Mitchell, Mathews, Hunt, Cobb, and Watson (2001) also examined management of prescription medications, with the purpose of identifying mismanagement of prescriptions and examining how socioeconomic status (SES), medication profile indicators, and overall health status affected the mismanagement. The cross-sectional design utilized random sampling and included 499 older male and female adults in a rural southeast community in the United States. Participants were equal groups of African-Americans and Caucasians and were between the ages of 66 and 95, with a mean age of

76.9. Forty-three percent reported living in a rural area. One third of the sample reported earning less than \$7,000 a year and one third reported earning greater than \$10,000 a year. Subjects completed a structured interview in their home, which was administered by a same sex researcher. Findings from a structured survey revealed a number of groups were more likely to mismanage their medicine regimen compared to others. Those found to be significantly more likely to mismanage medicines were found to be: (a) African-American, (b) in a poorer state of mental health, (c) younger older adults, (d) those with more acute care visit needs, and (e) persons who had difficulty paying for their medicines.

The cost of the medicine appeared to have been problematic for some participants, with 30% reporting some difficulty and 14% reporting great difficulty in paying for medication; but the majority (56%) of all study participants did not see cost as a problem. Many participants reported various strategies in medication management, including purchasing a portion of the prescription instead of paying for it all at one time (17%), others (15%) reported using less than prescribed amounts in effort to extend available medicine, while 19% reported asking for samples to help allay problems related to costs of medicines (Mitchell et al., 2001).

Jha, Fisher, Li, Orav, and Epstein (2005) reported study data from the Harvard School of Public Health. The study's purpose was to examine how often a specific surgical procedure was performed. African-Americans and Caucasians were compared in relation to receipt of the studied procedures. The sample size was reported to be nearly 40 million older adults. Participants were Americans and were all Medicare beneficiaries enrolled between the years 1992 and 2001. Nine common procedures were classified

according to their ICD-9 code. Rates of procedure were calculated by dividing total number of procedures performed by total number of persons eligible to have the procedure. Findings indicated African-American subjects were less likely to receive life-saving surgeries than Caucasian subjects, and that the previously known gap regarding receipt of these surgeries failed to substantially decrease. There was no speculation published as to the rationale of why African-Americans received these potentially life saving surgeries less than Caucasians.

Schneider, Chleary, Zaslavsky, and Epstein (2001) examined racial differences in the use of influenza vaccination and compared participants who had managed care with those who did not. The nonrandom study included persons as participants (N = 13,674) if they were enrolled in Medicare, were older than 65 years of age, and racial identity was known. Persons who were residents of Puerto Rico were excluded from the data analysis. The sample included Caucasian and African-American participants who completed the 1996 U.S. Medicare Current Beneficiary Survey. Participants had either managed care or fee-for service insurance. Findings, at a 95% confidence interval, revealed African-Americans (46.1%) were less likely to take the influenza vaccine than Caucasians (67.7%) Participants who had managed care (71.2%) were more likely to take an influenza vaccine than those persons with a fee-for-service (65.4%) insurance. The five most common reasons for not taking an influenza vaccine were identified and included: (a) not knowing to get one (20.6%), (b) thinking the vaccine would cause the flu (18.4%), (c) concern of adverse side effects (15.0%), (d) no confidence that the flu would be prevented by taking the vaccine (14.5%), and (e) either forgetting or missing the vaccine (12.6%). There were no statistical differences found between African-American and



Caucasian participants related to these five most common reasons for not taking the influenza vaccine.

Winston, Wortley, and Lees (2006) also compared racial differences in the use of influenza vaccination and further explored awareness and provider recommendations for both influenza and pneumococcal vaccination. Stratified sampling was utilized to attempt to locate 400 Hispanic, White, and Black subjects in designated survey settings. The study sample included 4,577 Medicare beneficiaries; however, subjects were excluded from data analysis if race was unknown. White subjects (n=2,072) were used as a comparison group with Black (n=1,680) and Hispanic (n=744) subjects who participated in this computer assisted telephone survey. Attempts were made to contact potential subjects via phone up to ten times, solicitation via telephone occurred at various times and days of the week. Results were based upon the cross-sectional survey from Medicare beneficiaries residing in five states, including Mississippi, New York, Illinois, Texas, and Wisconsin. Findings, at a 95% confidence interval, revealed a greater number of Caucasians (70.3%) received a pneumococcal vaccination than African-Americans (40.8%) or Hispanics (53.2%). Influenza rates were also greater for Caucasians (76.2%) than African-Americans (50.7%) or Hispanics (65.7%). The study found that African-Americans and Hispanic participants were more likely than Caucasians to believe that influenza vaccine had caused them to become sick in the past.

Armstrong, Micco, Carney, Stopfer, and Putt (2005) examined the role of race as it related to use of genetic testing for breast cancer in women with a positive history of either breast or ovarian cancer. The sample (N=408) included (n=217) women who had undergone genetic counseling and compared findings with a control group of (n=191)

women who had not undergone genetic counseling. The study was a case-control design which was conducted in Philadelphia, Pennsylvania. Findings, at a 95% confidence interval, indicated African-American women were less likely than Caucasians to submit to genetic counseling. Education about genetic counseling with their physician, socioeconomic conditions, overall attitudes towards genetic testing, and perception of risk or worry were examined, but failed to yield a probable etiology to explain study findings.

Mitchell, Mathews, and Mayne (2005) examined technique differences in self breast exam in elderly Caucasian and African-American women. Participants were recruited for this longitudinal study from five comparable counties located in eastern North Carolina. The sample included (N=1011) an equal distribution of African-American and Caucasian women who were at least 50 years of age, and who participated in at least three interviews with a researcher over a period of 8 years. While participants of both ethnicities reported performing self breast exams, technique varied according to race. African-Americans were found to be more likely to visually inspect their breasts; while Caucasian women were more likely to perform a breast exam using tactile technique, which is known to be more consistent with western medicines recommendations for performing a correct self breast exam procedure.

Armstrong, Long, and Shea (2004) examined mammography screening adherence to scientific recommendations, in low-income women. The sample (N=399) included low-income women who were between the ages of 50 and 75, who were Caucasian (14%), Hispanic (13%), Asian (8%) or African-American (64%). The setting for the retrospective cohort study was a Medicaid Managed Care Organization in urban

Pennsylvania. Subjects were given the option of completing the self-report mammography questionnaire in either English or Spanish and the self-report was compared to billing claims or records from providers. Study findings included inconsistencies in recommended mammogram screenings when comparing self-report with actual evidence of self-reported claims. African-Americans were noted to have the greatest discrepancy in considerably overestimating adherence to recommendations, in self-reported cases.

Russell, Perkins, Zollinger, and Champion (2006) examined mammography screening use in a socio-cultural context. The sample (N=175) included women between the ages of 40 and 97 (average age 62.2) who were African-American (n=111) or Caucasian (n=64), with no personal breast cancer history. Household incomes of the participants were assessed to be either below \$10,000/year (47%), between \$10,000 and \$30,000/year (25%), and or greater than \$30,000/year (24%). Seventy-one percent of participants reported being unemployed at the time of the study. The retrospective, descriptive, cross-sectional study utilized structured interview questions. Survey questions were read to participants and conducted either in person or over the phone. Findings revealed African-American participants had a more fatalistic view of a diagnosis of breast cancer and perceived less of a benefit from screenings than the Caucasian participants ( $p = .001$ ).

#### *Generic Folk Learned Medical Practices*

Generic folk learned medical practices refer to learned cultural practices which are considered to exist outside typical Western medicine and which are used in the

pursuit of wellness. The following research studies have explored known generic folk learned medical practices in populations similar to the current study.

Resick et al. (2005) studied medication practices in African-American seniors. The qualitative action ethnographic research study sought to discover information related to types of medicines used and to further understand knowledge of medication use, and was previously described under the professional health seeking behaviors section. The sample included 25 participants. Twenty-two participants were described as community residents and 3 as non-community residents. There were 5 male and 20 female participants. The setting was a large urban city located in western Pennsylvania. Findings revealed use of both scientific professional medicines and complementary alternative medicine. The professional medication use findings were discussed in the preceding section. Folk medicine use was found to include the practice of eating healthy, various applications such as hot water or baths for pain, vinegar, mustard, and garlic use for other illnesses such as an upset stomach, throat soreness, and phlegm. Herb use was reported as well, but was not generally reported to be an acceptable replacement for prescription medicines.

Yoon, Home, and Adams (2004) studied patterns of herbal use for health promotion purposes and management of health care needs. The study sample consisted of 57 African-American women who were at least 65 years of age and who were residents of north central Florida. A questionnaire and two scales were used to collect data from the convenience selected sample. The cross-sectional descriptive designed study revealed the use of herbal products in 33% of these participants over the previous year and

discovered that 40% of these herbs were not discussed with the participants' health providers.

Smitherman, Janisse, and Mathur (2005) studied folk medicine remedies specifically used to treat fever, colic, and teething, in African-American children living in Michigan. Structured interviews were conducted with 107 caregivers of African-American children from a largely low income family, and who took care of healthy children who were at least 2 years of age. Participants were a convenience sample of caregivers of patients at a Children's Hospital. Folk remedy knowledge and use was found in all participants, with an overall increase in the use of these folk remedies noted in caregivers who were greater than 40 years of age. Findings were noted to be independent of maternal education level. Remedies were learned from the maternal relatives of the caregiver, specifically mothers and grandmothers. Use appeared to be cultural in nature.

Ness, Cirillo, Weir, Nisly and Wallace (2005) studied the use of complementary or alternative medicine (CAM) in older American adults. The purpose of this study was to yield data that could be further used in consumer education, as well as with health policy, practice, and medical training in general. Participants numbered 1,099 and were part of a randomly selected sample from the 2000 Health and Retirement Study. The 2000 Health and Retirement Study is a longitudinal study surveying 22,000 adults who are 50 years and older every two years on issues related to their health, retirement, and aging. "The HRS (Health and Retirement Study) is sponsored by the National Institute of Aging (grant number NIA U01AG009740) and conducted by the University of Michigan" (hrsques@isr.umich.edu, personal communication, February 5, 2007).

Participants were at least 52 years of age. Findings revealed 88% of participants over the age of 65 used a CAM. Women were more likely than men to use a CAM, except when asked about chiropractic services and other items such as meditation, which were described in the study as personal practices. Older adults were more likely to use nonherbal dietary supplements, but as age increased, they reported less use of alternative practitioners for health care. African-American participants were noted to use less dietary supplements and chiropractic services than Caucasians, but reported greater use of personal practices. Participants with a higher education level used chiropractors less frequently and reported the use of herbal and dietary supplements with greater frequency than those with a lesser education. Study participants using CAM also reported more use of conventional medical services than non-users and reported greater out-of-pocket medical expenditures, especially as many complementary alternative medicines and or providers are not covered by insurance.

Graham et al. (2005) also examined CAM use with the purpose of better understanding racial and ethnic minorities use. Subjects were Hispanic, non-Hispanic Caucasians, and non-Hispanic African-Americans who responded to the 2002 National Health Interview Survey (CDC, 2002). Data were obtained from the Alternative Health Supplement of the 2002 National Health Interview Survey (CDC). Excluding prayer, findings revealed 36% of Caucasians, 27% of Hispanics, and 26% of African-Americans used more than one CAM. While Caucasian's reported using CAM with greater frequency than Hispanics and African-Americans, Hispanics (68.5%) and African-Americans (65.1%) were found to be less likely to share their use of CAM with their health care provider than Caucasians (58.1%).

Smith (2001) published an ethnographic research study that examined home remedy use by African-American children. The purpose was to describe traditional health practices and other home remedies. Participants (N=30) were between the ages of 38 and 98, African-American, and residents of a semi-rural southern area of the United States. Participants were selected by nominated sampling from two initial key informants. An interview guide was used to facilitate data collection. The initial audio-recorded interviews lasted 45 minutes to 2 hours. Data from 800 hours of field work and observation were included for use in data analysis. Findings suggested African-American children of participants received various home remedies and herbs for both health promotion and disease prevention. Additionally, a long history of herbal and home remedy use was noted in this population. The study further described these herbal remedies according to use and folk name.

Dessio et al. (2004) examined health care choices, spirituality, and religion in African-American women. They specifically studied patterns of the use of spirituality for health reasons. The sample included 3,172 women, who were African-American, Mexican American, or Chinese American. However, the research presented in their publication focused on findings of the African-American population (n=812). Participants were selected by the use of either random digit dialing (n=64) or geo-targeting (n=748), based upon known residential areas of African-Americans. Interviews were conducted via telephone and were computer assisted. The setting included multiple locations throughout the United States. Findings revealed 43% of African-American women did report using either spirituality or religion for health purposes. Factors related to increased use of spirituality and religion were noted to be increased as health status worsened in

participants with an income range of \$40,000-60,000 per year, in those with a higher education, who were between the ages of 37 and 65. Findings revealed African-Americans used spirituality and religion for serious diseases and disorders. African-Americans who used spirituality and religion for health purposes were more likely to use a CAM, and to have seen a physician in the last year, than those who did not use religion and spirituality in health care practices.

True et al. (2005) examined preferences of treatment and planning for end-of-life directives. The role of ethnicity and spirituality were evaluated in the process of coping with a diagnosis of either colon or lung cancer. The sample (N=68) included both Caucasians and African-Americans and attempted to determine if any differences existed between these ethnicities. Interviews were conducted and analyzed. Findings revealed that while both African-Americans and Caucasian participants described themselves as being moderately to very religious and spiritual, African-Americans reported greater use of spirituality as a coping mechanism than Caucasians. Patients who reported the use of spirituality for strength, coping, support, and guidance were more apt to believe in divine intervention. Although they were not as likely to have a living will, they were more likely to use all measures available to sustain life; such as cardiopulmonary resuscitation, intubation with mechanical ventilation, and hospitalization, in maximum efforts to sustain life during a near death incident.

Lastly, Shellman (2004) reported on a study that sought to understand the life experiences of African-American persons who were older. In this qualitative phenomenological study, life review was utilized in an attempt to understand the life experiences of 7 African-Americans both men (n=3) and women (n=4) who were raised



in the southern United States. Purposeful sampling was utilized with key religious leaders acting as gatekeepers referring persons for participation via an interview. Participants agreed to confirm shared information in a follow-up interview if needed. The following themes emerged from the data: “(a) nobody ever asked me before, (b) stories of discrimination, (c) coping with discrimination, (d) the hurt of discrimination, and (e) self-discoveries” (p. 308).

Shellman (2004) found that the act of reminiscing was beneficial to participants, as they related feeling like someone, particularly someone Caucasian, cared enough to ask about their life. All participants reported this was the first time that a Caucasian ever sat down with them and asked about their life experiences. Asking about life experiences was found to be associated with caring. Stories of discrimination included comments that it was just that way, and that they were not to mix (with White people), and thus did not (Shellman, 2004). The coping with discrimination theme led to the following subthemes: home remedy use, strength in faith, family seeing to family’s care, moving north, and memories of their mother. Several participants recalled relatives, especially grandmothers or mothers, using special natural remedies to make a health promoting tea or other form of medicine. A participant reported medical care being difficult to find or get and that family members often learned how to make home remedies and used these as medicine, to avoid having to go to the doctor (Shellman).

Prayer was additionally noted as common coping method within this study. One African-American elder stated:

I just prayed to God and asked him to help me, to get me through this hard life. That’s all you got to do. Go on your knees and pray, ask the good Lord to take care of ya, that’s all you got to do, and He gonna take care of ya.” (Shellman, 2004, p. 313)

The hurt from a lifetime of discrimination was noted to have further subthemes of “life regrets, abuse... [and] feeling different” (p. 311). Discrimination was noted in instances of sickness and in seeking health care. One participant stated “back then by being Black, the [White] doctors wasn’t too eager to work on Black folk, so you had to make do” (p. 313). This was further emphasized by the following recollection:

Back then if you went to see the doctor, you went to the back-door step and the doctor would come when he wanted to. If you was sick you even had to walk 2 or 3 miles to even get him to look at you...he didn’t use no stethoscope, didn’t ask me or my mama no questions, or nothing like that. (Shellman, 2004, p. 312)

Self-discovery was the last theme. Participants reported having good feelings about talking and getting to express events in their past that no one had ever asked them about (Shellman, 2004). Findings from the Shellman study served to provide qualitative insight into the historical influencers, culture, and life experiences which shaped the health practices of the study population.

## 2.3. Evaluation of the Literature

### *Areas of Agreement*

The majority of literature revealed a consensus among studies related to the existence of health disparities within the proposed study’s population. Health disparities within the African-American population and in rural south Alabama were basically consistent, well documented, and described in the significance section of Chapter I. Although studies were in agreement concerning the existence of these disparities, data lending speculation on etiology of disparities were limited.

The literature review revealed areas of agreement concerning the use of both generic and professional health-seeking behaviors in the African-American population. The majority of studies reported the African-American population’s utilization of

immunizations and screenings to be less frequent compared to Caucasians (Schneider et al., 2001; Winston et al., 2006). Etiology for decreased use of screenings appeared to be consistently linked with a fear of diagnosis of cancer (Russell et al., 2006). Increased use of screenings tended most often to be linked with family encouragement and community interventions that promoted various health screenings (King et al., 2004).

The uses of generic health-seeking behaviors were found to be a common practice within the African-American population (Ness, et al., 2005; Smith, 2001; Smitherman et al., 2005; Yoon et al., 2004) especially related to prayer, spirituality, or dependence upon a higher power for healing and wellness (Dessio et al., 2004; Shellman, 2004; True et al., 2005). Problems with disclosure of complementary alternative medicine use to a health care provider appeared to be problematic for all races and ethnicities in the literature (Graham et al., 2005).

The health-seeking behavior research, while not agreeing on a specific definition, term, or composition, did agree on the importance of knowing more about health care beliefs, behaviors and practices (IOM, 2002, 2006; Leininger, 2001; Shellman, 2004). Agreement was noted on the need for additional behavioral research especially in the older adult and minority populations (IOM, 2006).

#### *Areas of Disagreement*

Areas of disagreement related to study findings were limited in this review. The majority of the literature reported that the African-American population utilized immunizations and screenings with less frequency when compared to Caucasians (Schneider et al., 2001; Winston et al., 2006), but there were some exceptions, especially after personal or group interaction was utilized (King et al., 2004). The literature revealed

the use of generic health-seeking behaviors to be common practice within the African-American population, but the frequency of use and specific practice varied when compared to other ethnicities (Ness et al., 2005; Smith, 2001; Smitherman et al., 2005; Yoon et. al, 2004).

Findings related to medication use/misuse in the African-American population were noted have some inconsistencies (Mitchell et al., 2001; Resick et al., 2005). One study (Resick et al.) found that in general older African-Americans could manage their medication regimen and make independent decisions regarding medication use. While another study (Mitchell, et al., 2001) found that mismanagement of prescribed medicines were common place within both older African-Americans and Caucasians.

Irregularity of terminology was noted as well. Many studies used the terms *health promotion* or *disease prevention* versus *health-seeking behaviors*. Terms used to determine generic practices had multiple descriptors. The most common terms found in the literature were the terms used in this study, including: *lay*, *generic*, and *folk*.

#### *Research Gaps*

Literature is available on all individual subsets of the current research population, although some is more limited than others. However, the literature available on the current study population as a whole is extremely scarce. Not many studies have looked at a population which includes all subsets of the proposed population, specifically a culture which is African-American, has a low income, is older, and who lives in rural south Alabama.

Gaps in the research were noted when searching for specific cultural health seeking behaviors and practices within the current study's population, especially within

rural Alabama residents. There was a noted lack of available data on etiologies, especially related to those practices considered by the medical community to be harmful.

Literature available on health-seeking behaviors was inconsistent with respect to uniformity of definition. Research available on health-seeking behaviors was noted to most often focus on a specific health behavior, examined in isolation, versus exploring more than one behavior.

The current research will fill several gaps in the literature related to this population as an inclusive culture. No studies were noted to have explored health-seeking behaviors across the lifespan of the proposed study's population. Findings will yield broad data on health-seeking behaviors and data will not be limited to a single isolated health behavior. New cultural data may emerge from study findings to assist the medical community in further understanding the health-seeking behaviors practiced by these participants and may offer insight into how to best approach persons within this culture when discussing those behaviors considered by the medical community as potentially harmful.

The review of the literature will be expounded upon to include information related to emerging themes. Gaps will be further expanded after a comparison is made between the emerging themes and the existing literature and recommendations for future research will be described in chapter five.

## 2.4. Summary

The theoretical support for the current study has been identified as Leininger's (2001) culture care diversity and universality theory, with its associated assumptions and concepts providing a foundation for research questions and lending to the significance

and need for the current study. The theory has been widely used across disciplines and cross culturally in both domestic and international settings.

Generic and professional medical practice literature related to health-seeking behavioral practices were discussed to provide the reader with known behavioral practices within the study's population. An analysis of the similarities and differences found in the research literature were discussed, and gaps were identified. Based on the review of the literature findings, the researcher has determined the current research is original, would fill a gap in the literature, and is of importance to the population under investigation.

# Chapter III

## METHODOLOGY

Chapter III describes the overall study design of the proposed research.

Information related to life history methodology is discussed, including guiding principles and rationale for use in the study. A description of the study's setting and sample follows. Instruments for data collection are described, as well as the process for data collection and data analysis. Trustworthiness of qualitative research and how it was assured in the proposed study were discussed. Finally, ethical considerations and protection of human subjects participating in the study are explained.

### 3.1. Design

The current study is qualitative in nature. Life history methodology was utilized to conduct a naturalistic inquiry into the health seeking behaviors across the lifespan of the study's participants. Data collection instruments included: (a) the researcher; (b) a semi-structured, open-ended interview guide; (c) a genogram; and (d) a timeline (De Chesnay, 2005b). Data were analyzed into reoccurring concepts and have resulted in the emergence of themes and concepts reported with thick descriptive data. Ultimately, the data described the participants' experiences according to the research questions posed.

## *Life History*

Over the years, the definition of what constitutes life history research and its degree of acceptance has changed based upon factors such as time, most accepted paradigm, and discipline. Life history methodology first began at the University of Chicago in 1914 (Warren, 1982). Robert Park, a sociologist and former newspaper person originally popularized this particular research tradition. Park encouraged his students to go out into the streets or the field, and to collect data in the form of life histories to convey the story of the city of Chicago. He was especially interested in ethnic minorities, including African-Americans (Maanen, 1988). Since record of its inception, this method has been used across various disciplines, including anthropology, sociology, medicine, psychology, political science, oral history, and education (Warren).

Life history research is not as well known as other qualitative research methods. A review of the literature concerning life history research was limited in findings compared to other qualitative methodologies. Polit and Beck (2004) described life history methodology as a self-reported narrative of the life experiences of a person which are focused on a subject of interest.

In the literature, life history has often been compared to auto-biographies and oral history (Hagemaster, 1992). Some authors freely interchange these terms (Safier, 1977), while others describe life history as having similarities with other research methods using a narrative account and describe perceived differences between auto-biographical and oral history research (De Chesnay, 2005b; Hagemaster). While autobiographical and life history research provides an historical account of a life lived, the two differ according to who is interpreting the data. An autobiography is generally interpreted by the person



being described, but a life history is interpreted by the researcher or someone other than the one having lived the life (De Chesnay, 2005b).

Perhaps the most important concept to consider in life history research is context (Cole & Knowles, 2001). Understanding the context in which an individual's life was lived provides valuable information to frame the concept under exploration. It may serve to add to or minimize the intensity of a situation described. It may shed light on the reasons why a person felt or acted in a certain manner. Context affects an individual's experiences and shapes perceptions and interpretations of reality (Cole & Knowles).

Although many aspects of the current study mirror those assumptions and terms used in ethnographies, life history may or may not be used as a technique in ethnography (De Chesnay, 2005b). Cole and Knowles (2001) described their understanding of the differences between life history research and ethnography and based their explanation on the particular use of the context in research. Ethnographers focus on the emic perspective, as in this study, but the ethnographer's focus is centered on understanding the culture itself, or a context within a culture. Life history research is concerned with context; however, according to Cole and Knowles, life history does not have context as its primary focus. Typically, life history researchers use context to frame the concept under investigation. Context then is used more as a background for understanding the life experiences. Therefore, life history seeks to understand a concept within the context of the life lived (Cole & Knowles).

Race, socioeconomic status, health, and historical influences are among many issues recommended for contextual exploration in life histories at various points of a person's life (Cole & Knowles, 2001). During the life history interview portion of the

proposed research, information was solicited to explore the participants' health seeking behavior experiences within the context of what life was like for the participants at different points in their life.

Cole and Knowles (2001) describe the principles guiding life history research as: (a) *relationality*, (b) *mutuality*, (c) *empathy*, and (d) the practice of *care*, *respect*, and *sensitivity*. These guiding principles include those personal elements known to be ethical and moral, and which are practiced on a daily basis as we interact with others in various social settings (Cole & Knowles).

*Relationality* has to do with forming a relationship based upon mutual interest (Cole & Knowles, 2001). In the research process, the researcher and the participant engage in a relationship. This relationship involves openly sharing an account of one's personal life experiences, and requires an understanding that the vulnerabilities shared will be respected. Sensitivity and care with the information shared are crucial practices to develop trust between the participant and researcher (Cole & Knowles).

Various authors have described *mutuality* in terms of what role the researcher and participant play within the relationship (Cole & Knowles, 2001; Hammersley, 1979). Hammersley spoke of striking a bargain that included a strict set of expectations and rules about boundaries in behavior. Previously, Cole and Knowles (1993) used the term *mutuality* in terms of *negotiation*. However, Cole and Knowles revised their description of the term *mutuality* and now consider it more of a natural process during the formation of a relationship and phrase the term as "conversation-in-relation" (p. 29). This is due to the authors' opinion that if the relationship is in fact a mutual one, it is expected the

people involved in the relationship can come to an agreement as to their respective responsibilities and roles (Cole & Knowles).

*Empathy*, as practiced in life history research, involves being *reflexive* (Cole & Knowles, 2001). The researcher is involved in the conversation taking place, and needs to empathize with the person sharing the information. The sharing of a life history can be a very intimate and personal experience. Certain events in a person's life may be difficult to recall; therefore, the researcher should be prepared with an appropriate response to any highly emotional moments the participant may experience (Cole & Knowles).

*Care, respect, and sensitivity* intensify over the time the researcher and participant spend together. Trust is important to establish, but the researcher must monitor his or her involvement with the participant so that the relationship does not become so casual the meaning of the research becomes unclear (Cole & Knowles, 2001).

Cole and Knowles (2001) also suggest the value of researcher self-awareness in life history research. Before beginning life history research, researchers should try to understand their own biases and views (Cole & Knowles; Hagemaster, 1992). These authors describe the importance of gaining a better understanding of the researcher's perceptions on the content, setting, or subjects, at the onset of the research study. This may be accomplished through the use of a written record of what the researcher reveals after careful contemplation, and serves to increase the self-awareness of the researcher concerning what he or she personally brings into the research study process (Cole & Knowles).

The current study sought to understand the health-seeking behavior experiences of African-Americans who are older, have a low income, and reside in rural south Alabama.

The current study explored these health-seeking behavior experiences across the lifespan of the participants. Life history research has been used successfully with all groups of the proposed study, including African-Americans, persons who are older, persons with a low income, as well as in the rural south (De Chesnay, 2005a; Leininger, 1985; Lewis, 1959, 1961; Moore, 2001; Shellman, 2004; Smith, 1998). Additionally, there was the legendary exploration of low income families in Mexico (Lewis) which resulted in the concept of *culture of poverty* (Polit & Beck, 2004). Leininger (1985; 1988; 2001) has consistently recommended life history research as an effective method for studying older adults.

It is also important to note that life history research is appropriate to utilize in the investigation of a life time of health seeking behaviors (Hagemaster, 1992; Leininger, 1985). Leininger encouraged the use of life history in collecting historical information related to health care practices, including those which are, as she terms, *professional* and *generic* practices (Leininger, 2001). Hagemaster described life history as a research method useful in

Identifying and documenting health patterns of individuals and groups... [which furthermore] challenges the nurse to understand an individual's current attitudes and behaviors and how they may have been influenced by initial decisions made at another time and in another place. (p. 1122)

Life history is being utilized as the most appropriate qualitative approach to the proposed research as its use has been validated as an appropriate method for gaining historical information on a life time of health seeking behaviors. Life history methodology has been used with populations, who are African-American, older adults, have a low income, and live in a rural area. The study sought to understand health seeking behavior experiences and the use of life history provided the researcher with a lifetime of data related to the topic under investigation. Ultimately, life history was used

as it was an effective research method for examining health-seeking behaviors occurring across the lifespan of the participants.

### 3.2. Setting

The study setting was rural south Alabama. Descriptions of the issues rural Alabamians live with on a daily basis were discussed in the significance section of chapter I. The county chosen as the site for initial recruitment was selected based on geographical location, demographics, low life expectancy, lack of health care resources, as well as the researcher's on-going relationship with this community.

Multiple health disparities exist in the rural south Alabama county chosen for initial recruitment of participants, and the status of primary health care in that county is grave (AMEC, 2006). There are minimally operating mental health care services that are open four hours on the second Saturday of each month, or on the first and third Fridays of each month (AMEC). There are five primary care physicians serving residents in the rural south Alabama county chosen for initial recruitment of participants, which results in 3.8 full-time-equivalents and in only 3.3 primary care physicians per 10,000 members of the population. This is in comparison with the state of Alabama's average of 8.7 primary care physicians per 10,000 population (AMEC). There are no practicing pediatricians, no obstetrical or gynecological services, no delivery services, and no hospitals in the rural south Alabama county used for initial recruitment of participants (AMEC).

The rural southern Alabama county chosen for initial participant recruitment has 11,522 residents. The county is composed of 2000 square miles, averaging 16.5 persons per square mile compared to 87.6 persons statewide (U.S. Census Bureau, *Quick Facts*, 2000).

The initial setting for participant recruitment has a rich history. It is the home of the late Coretta Scott King, who married the Civil Rights Leader Martin Luther King, Jr. The Confederate flag was designed by an art teacher in the county, and was later sewn by several lady residents. The historical roots also include slavery, plantations, and racism. Nathan Bedford Forrest drew up battle plans on the wall of a house located in the county, and after “the [Confederate] war” he formed a Klu Klux Klan chapter in this same location (B. Matthews, personal communication, August 26, 2005).

The researcher recently visited a cemetery located in the largest city within the county chosen for initial participant recruitment. A long-time resident of this community shared a well-known story at this cemetery. A summation of the story is provided below and serves to provide insight into the setting and context of life for persons who live in the study setting.

There are two small colleges located in study’s setting; one college is known as a school for girls and the other college, as a school for boys. The Baptists started both of these organizations in the 1800s. One of the past presidents of the school for boys was a slave owner, who had a slave named Harry. Harry did not have a last name, since persons who were slaves were often not given last names during this time. One night a fire broke out and burned down the college. Harry was said to have run up and down the stairs, in and out of the building, shouting frantically, “I’ve got to wake the boys; I’ve got to wake the boys!!!” (B. Matthews, personal communication, August 26, 2005). All the boys in the college were saved, but Harry was last seen running back into the burning building seeking to save more students. As was common practice during that time, the town had segregated cemeteries. The townspeople were very thankful for Harry’s sacrifice and

demanded he be buried in the “White’s only” cemetery. His tombstone is very recognizable. It is tall, pointed, and made of white limestone, and is even today meticulously cared for by local residents, the researcher’s university, and the institution located where the college for boys once stood (B. Matthews, personal communication, August 26, 2005).

The school for boys is now the oldest military junior college in the nation. The bricks that cover the school were made by people who were slaves (B. Matthews, personal communication, August 26, 2005). Although racial and gender de-segregation have long since arrived at this institution, within the study’s setting, there still exists evidence of a divide between the “Whites” and the “Blacks.” Many people talk about “the Black part of town” and “the White part of town” (B. Matthews, personal communication, August 26, 2005).

Currently there are coalitions of both African-Americans and Caucasians working together to try to improve the health and education of this community (K. May, personal communication, August 26, 2005). Although a visitor to this community can still see evidence of segregation, hope exists for a more equal future.

This rural south Alabama county chosen for initial recruitment of participants has a slightly higher than average older adult population (14.9%) when compared to Alabama as a whole (13%). This county also has a much larger population of persons who are African-American (68.4 %) when compared to the overall total African-American population within the State of Alabama (26%; U.S. Census Bureau, 2000).

According to the U.S. Census Bureau (2000), the percent of persons living below the poverty level in Alabama is approximately 16.1%; however, residents of the county

for the study's setting have a 35.4% poverty rate. The median value of homes owned in the county is \$47,600 compared to a median value of \$85,100 statewide (U.S. Census Bureau, 2000a). One third of the homes in the county are mobile homes and 97% of school-aged children are on the free lunch program (K. May, personal communication, August 26, 2005).

This community is of active interest to a private Alabama university, of which the researcher is a faculty member. The rural south Alabama county chosen for initial recruitment of participants is the university's community of origin and suffers from multiple health disparities and economic depravity. Faculty are encouraged to be involved in the university's community of origin in efforts to improve the quality of life for the residents of this community of interest. The researcher is actively involved in ongoing and inter-disciplinary health promotion interventions with residents of the rural south Alabama county chosen for initial recruitment of participants, such as the annual county wide health fair.

### 3.3. Sample

Inclusion criteria for participants were as follows: (a) 65 to 85 years of age, (b) reported African-American heritage, (c) resident of rural south Alabama, and (d) met the definition of low income (Appendix 2). Participants were sought that could verbally express themselves and be willing men and women who could provide the researcher with answers to the research questions. Superficial conversation was utilized in the initial phase of introduction to determine the existence of any obvious severe cognitive disturbances that may have prohibited the participant from conveying his/her life history



accurately to the researcher. Non-English speaking persons were excluded from study participation.

Study participants were asked to provide information related to their age, race, residential history, and yearly income. This information was recorded as self-reported, as questioning the participant's veracity is not the best way to establish trust and comfort in sharing (Leininger, 2001).

When conducting qualitative research, it is important to focus more on gaining in-depth content knowledge rather than a large number of informants (Creswell, 2003; Leininger, 2001). The researcher included both male and female participants in an effort to increase the heterogeneity of the study's population. Participants were initially selected by purposeful sampling facilitated by referrals from key community gatekeepers.

Three community leaders were recruited to assist with identifying potential key informants. The community leaders were provided with detailed knowledge on the study and were asked to identify key potential participants. Two community leaders provided the researcher with contact information and the researcher made first contact to determine their potential interest. The third community leader made the initial contact to determine if the potential participant would be interested in talking to the researcher about participation. This third community leader would often make the actual introduction of the researcher and the potential participant. The researcher would then discuss the study in further detail privately and assess the potential participant for inclusion criteria. This method of first contact by the community leader proved far more successful in recruitment than cold-calling potential participants with a referral from the first two community leaders.

Participants lived in RSA for at least some portion of their childhood, teenage years, young adulthood, and were current residents of RSA now as older adults. Participants were born, reared, and reside within a 60 mile radius of each other. Seven participants were included in the study. This number was well within the recommended number by Leininger (2001) and Sandelowski (1995). Participants were solicited until saturation of data occurred. The researcher concluded that saturation occurred when repetition of data was noted and re-occurring themes resulted from the data (Cole & Knowles, 2001).

### 3.4. Instrumentation

The instruments for data collection included: (a) the researcher; (b) a genogram; (c) a timeline; and (d) a semi-structured, open-ended interview guide. De Chesnay developed the technique and standardized the process of using the combination of a genogram, timeline, and life history interview, in the mid 1990s and published her work in 2005 (M. De Chesnay, personal communication, March 18, 2008). This technique has been used specifically with life history research within the African-American population (De Chesnay, 2005a; Smith, 1998). The proposed study replicated De Chesnay's instrumentation methodology. De Chesnay attributes anthropology as her discipline source for life history (De Chesnay, 2005b). Rationale for the use of each instrument is discussed in the following sections.

### *Researcher*

Qualitative research practices dictate the researcher serves as the primary instrument for data collection (Creswell, 2003; De Chesnay, 2005b; Leininger, 2001; Polit & Beck, 2004). The researcher is a resident of rural south Alabama and has had extensive interaction with the proposed study's population, as a both health care provider and health educator.

The researcher has an extensive volunteer history of approximately 25 years serving and assisting with various socioeconomically disadvantaged persons from various cultures, such as: African-Americans; Native Americans; various cultures experiencing a natural disaster; and persons from Central America, in the countries of Honduras and Nicaragua. She has served in a volunteer capacity to provide medical care or health promotion education to persons across the lifespan.

The researcher is an experienced family nurse practitioner, and has been regularly involved with persons within the study's community of interest for several years. Currently, the researcher is involved with an organization dedicated to improving the health care of the residents who live in rural south Alabama, specifically the elderly African-American population. The researcher has served on a state task force charged with increasing access to care for the rural population through the use of nurse practitioners, and reported these recommendations to a member of the Alabama House of Representatives, various legislators, and to the Joint Committee of the Board of Medical Examiner and the Board of Nursing, for possible implementation.

The researcher is a university faculty member acting as the coordinator of the family nurse practitioner program at an academic institution that originated in the area

selected for the site of initial recruitment of participants. The researcher's academic institution has strong ties to the proposed study's community and highly encourages its students and faculty to develop and participate in programs that will promote the advancement of the socioeconomically disadvantaged through education, in order to "give back" to its community of origin. Therefore the researcher began data collection in the described county to assure residents from that area were included in the study.

The researcher has past and present experience working in an interdisciplinary group with key African-American leaders to provide regular, on-going, community health promotion events within the community of interest. In a recent community health promotion event in the community chosen for participant recruitment, an elderly African-American participant asked the researcher to come back and "help [them] some more" and stated she was "really enjoying this...and learning so much" (Anonymous, personal communication, April, 2007). Another community gatekeeper, who is an African-American pastor and the owner of a radio station in the research setting, has requested the researcher "continue to provide health education" through his radio program and has requested a permanent program be instituted for the researcher to continue broadcasting health education to the 21 counties served by the radio station (G. King, personal communication, June 21, 2006).

Although the researcher had no personal relationship with individual participants of the proposed study, the researcher was familiar with both the study's geographic location and the general population that resides in the community selected for participant recruitment. As a long time resident of rural south Alabama, the researcher is also familiar with terminology commonly used in rural Alabama.

The researcher has earned a certificate after completing formal training from the National Institutes of Health on Institutional Review Board (IRB) practices. The researcher is further immersed in ethical practices and human subject protection as an active member of a university IRB committee.

The researcher has previous experience working on life history research as a research assistant in a life history study that focused on successful adult African-Americans (De Chesnay, 2005a). In this previous study, the researcher functioned to: (a) recruit participants; (b) assure proper consent was obtained; (c) protect participant confidentiality; (d) collect data through audio taped interviews, genograms, and a timeline; as well as (e) check transcription records for content accuracy; (f) perform data analysis; (g) and generate study findings in the form of reoccurring themes.

The researcher completed a live training course in Athens, Georgia on the practical application of N6 and NVivo qualitative data management programs developed by QRS International. Additionally, on-line update training was completed on NVivo 7 (© QSR International, 2006) which is the newest version of NVivo and is the qualitative data management program proposed for use during the data analysis phase of the proposed research.

The study sought to utilize qualitative research and the culture care diversity and universality theory (Leininger, 2001) as the theoretical support. The researcher completed an intensive week-long study on qualitative ethnographic research, the sunrise enabler model, and the culture care diversity and universality theory at Kean University under the personal direction of the transcultural nursing theorist, Madeline Leininger. The researcher was required to collect data from international field experiences, develop field

notes, and analyze data. The researcher developed data analysis findings related to health practices within a vulnerable population group; these findings were discussed with the theorist.

### *Genogram*

A genogram is a diagram of the participant's family tree. The genogram serves to provide a summation of family data and is helpful in shortcutting analysis of these data (De Chesnay, 2005a). Information on number, gender, and health of the members of the participant's family and other close relationships were collected and diagramed according to key symbols recommended by De Chesnay (2005a).

Based on prior work by De Chesnay (2005a), the genogram was utilized during the beginning of the interview process. The genogram (Appendix 3) was used first to facilitate data collection and stimulate the participant's recall of persons that may have had an effect on the participant's life and health-seeking behaviors. The time line and interview followed.

The genogram was used to record the participant's response concerning family, relatives, and close friends that influenced personal health-seeking behaviors. The researcher recorded responses in a diagramed picture format. Information obtained regarding the respondent's father's side of the family was recorded on the left, and the mother's side of the family was recorded on the right. Participants were granted access to the genogram during data collection and were asked to verify the accuracy of the genogram prior to the conclusion of the interview.

Watts-Jones (1997) documented the need to include non-biological members of African-American persons when using a genogram. These authors emphasized the need

to include persons who are functionally tied to biological family members as part of the family, as this culture typically includes non-biological but close persons as part of its family. Participants in the current study were asked to share information related to close non-biological persons who impacted their life.

In effort to utilize a culturally appropriate method of data collection, close friends and others who were reported by participants to be functionally tied to the family were included in the genogram. This close, but non-biological relationship was represented by two parallel lines on the genogram. Information was solicited from participants regarding the role each person on the genogram played in their health-seeking behaviors.

Each genogram spanned at least four generations; two of these were preceding generations. Genograms differed in content according to each participant's memory and response.

Watts and Shrader (1998) conducted a qualitative exploratory study in Zimbabwe and Latin America. The study found that utilization of a genogram as part of an interview facilitated conversation in the interviews and provided the researcher with a means to concisely summarize research data. The genogram was found to function as a tool to jog the memory of the participants and provide study participants with a means to accurately verify the answers they provided to the researcher. This tool was additionally noted to be useful when interviewing participants who had a limited degree of literacy. Watts and Shrader concluded that future use of a genogram in research could be helpful in attempting to understand various dynamics within families, in revealing information on decision making and on patterns of behavior. These authors further affirmed that widespread use of a genogram in research would be beneficial in understanding power

relations and how those relationships impact the welfare and behavior of various household members. Finally, Watts and Shrader recommended a genogram be used with another complementary method, a timeline that would document event timing. Therefore, this study also utilized a timeline to provide this event timing to complement to the genogram. The use of the timeline will be discussed in the next section that follows.

### *Timeline*

The study utilized a timeline as one instrument of data collection. The timeline assisted participants to recall critical events according to their occurrence in time (De Chesnay, 2005a). During the interview process, the researcher asked each participant questions related to various times in the participant's life and what health-seeking behaviors were used or practiced during that particular period in time. The timeline was completed after the genogram and was used as a reference throughout the audio-recorded interview.

The timeline followed a standard format (Appendix 4) beginning with birth and extending until the current date of the interview. The timeline was used to record events participants believed were especially important or memorable. This tool provided information related to the context of the time that the participant shared about during their audio-recorded interview. A typical leading question that was used to begin the timeline was: "Tell me about some important times in your life, beginning with when you were a child." Responses were hand recorded by the researcher at the time the information was shared.

Participants were granted access to their individual timeline during the interview and were asked to verify the content prior to the completion of the interview. Information



recorded on the timeline differed in content according to each participant's memory and response. Data provided from the timeline allowed for triangulation of data as suggested by multiple authors and served to improve credibility and trustworthiness of the research findings (Creswell, 2003; Denzin, 1989; Polit & Beck, 2004).

### *Life History Interview*

A semi-structured interview guide (Appendix 5) was developed to be used in face to face interviews. The life history interview allowed the participants to convey their life experiences in their own words (Smith, 1998). The interviews were audio recorded to increase accuracy of data (De Chesnay, 2005a).

The semi-structured interview guide (Appendix 5) facilitated data collection. Questions were developed in consultation with a resident of the study's setting who is a key resource experienced with research and data collection. It was confirmed by several community resource leaders as a tool that used non-offensive, understandable language, and was deemed an effective tool with appropriate questions to answer the proposed research questions.

Interview questions were grouped into seven sets of open-ended questions that assisted the researcher to answer the study questions (Cole & Knowles, 2001). However, the interview guide was not intended to be strictly adhered as a survey. Additional questions related to the research questions were asked during the interview in response to the information shared by the participants. The order of the interview questions varied according to the flow and content of the conversation taking place between each individual participant and the researcher. Therefore, questions listed on the semi-structured interview guide were used as a guide to facilitate data collection.

Interview questions began with each participant's childhood experiences and progressed sequentially throughout his/her lifespan. Questions focused on participants' life experiences related to important events of the time and what they remembered doing to get or stay healthy at each stage of their life.

### 3.5. Procedures for Data Collection

IRB approval was gained from both Duquesne and Samford University prior to implementation of the research (Appendix 6). Participation was voluntary and confidentiality was maintained. Transcription of data took place outside the state of Alabama, after the transcriptionist had been oriented to the sensitive nature of the material and had signed a confidentiality agreement (Appendix 7).

Participants were recruited through referrals from several key community leaders. Once potential participants expressed a desire to participate in the study, the researcher determined if potential participants met inclusion criteria. The researcher informed potential participants on the details of the study, including the purpose of the study, data collection methods, \$20 compensation for participation, and their right to withdraw from the study at any time prior to publication or presentation of study findings. Participants who expressed a desire to continue with research participation, and who met inclusion criteria, scheduled an appointment with the researcher for data collection.

Efforts were taken to assure participants' comfort within the interview setting, including location of data collection and time of day. Participants were asked where they would like the interview to be conducted. In order to increase the comfort level of the participants the researcher offered choices for the location of the interviews, such as their home, community center, or other preferred location. A private room was sought to

conduct the interview to decrease the chance of interruptions and allow the patient greater comfort and privacy in sharing their life history. Most interviews took place in the home of the participants, at their request. Interviews were conducted one-on-one with the researcher and the participant to assure confidentiality of the information shared.

The researcher, who is an experienced nurse practitioner, engaged the participants in superficial conversation at the first meeting between the researcher and the participant in order to determine gross cognitive ability to provide information in the way of a life history. The researcher at no point assumed the participant could read. The researcher read the consent form aloud (Appendix 6) to the potential participant and offered to answer any study related questions the participant had. Participants were fully informed of the study and their rights as research participants and were then asked to provide the information requested on the demographic form (Appendix 8). This was filled out by the researcher and served to document and further assess qualifications as valid study participants. Questions on the demographic form directly pertained to the study's inclusionary criteria and gender. The researcher read aloud the questionnaire to the participants and recorded their responses on the demographic form. Only one willing individual did not meet study criteria. This participant was thanked for his willingness to participate and informed on the reasons why he could not be included in the study.

Persons who met the inclusionary criteria were asked to sign a consent form. The consent form was read aloud again to the potential participant and any questions were answered prior to obtaining signatures. The participant was given a personal copy of the consent form. Once the consent form was signed, the participant was asked to choose a pseudonym and complete an audio recorded interview.

The audio-recorded interview included information from the genogram, followed by the timeline, and finally the semi-structured interview guide. All data were coded to the participants' pseudonym.

A genogram (Appendix 3) was utilized to collect data about the participant's family and interaction history. The genogram was used at the start of the interview (De Chesnay, 2005a), and data provided by the participant were audio-recorded and hand written by the researcher.

The timeline was filled out following the genogram. This timeline (Appendix 4) was utilized to help focus participants on critical events that have occurred throughout their lifespan (De Chesnay, 2005a), and additionally provided information related to the context of events affecting the participants during that period of their life. The timeline was further utilized to establish timing of events and to focus the interview on the proposed research questions.

The audio recorded interview was facilitated by the use of the life history interview guide (Appendix 5). These questions were used as a guide during the interview process. Additional questions were asked during the interview as data led to other significant related questions that assisted the researcher in better understanding the shared experience.

Field notes were recorded by the researcher during the interview (Spradley, 1979). Field notes included data on the non verbal reaction, affect, and response of participants, as well as any environmental or contextual information the researcher considered important during the interview (Spradley). Prior to the interview, the participants were informed that the researcher would be taking these field notes during

the interview to assist in correctly remembering important events and comments made by the participant during the interview. Field notes were included in data analysis as appropriate (Cole & Knowles, 2001; Spradley).

In addition to field notes, the researcher documented supplemental field notes within an hour following the interview. Supplemental notes included the researcher's thoughts about the interview, process, data which needed clarification at a second interview, as well as emerging questions or themes.

The initial interview was approximately 2 hours in length, as recommended by experts (Cole & Knowles, 2001). The collection of the entire life history for each participant typically took place over a period of several days.

At the completion of the life history interview, the researcher provided the participant with an envelope containing the nominal monetary compensation for study participation. An amount of \$20.00 was selected as fair compensation for study participation after consultation with a key community gatekeeper; \$20.00 was also noted to be the compensation amount used in a recent life review interview with older African-Americans in attempting to understand their life experiences (Shellman, 2004).

It was the researcher's intent to yield valid study data. Therefore, several willing informants (n=2) were purposefully selected by the researcher to participate in separate follow-up interviews to verify the researcher's understanding of the data provided during the interview. Persons participating in separate follow-up interviews received an additional one-time amount of \$10 dollars in compensation. A need for follow-up sessions was discussed during the initial conference with the participant (Spradley, 1979). Permission to re-contact participants was obtained again at the end of the first interview.

Once audio recorded data was complete it was transcribed, verified for content accuracy by the researcher, and entered into a qualitative computer program for data management. A sequential listing of the data collection process is available in the appendices (Appendix 9) as a checklist.

### 3.6. Procedures for Data Analysis

Data analysis was conducted concurrently with data collection. This parallel process allowed emerging data to lead the interview questions and facilitated the researcher's understanding of the occurrence of data saturation (Creswell, 2003; Polit & Beck, 2004). Qualitative content analysis was used employing Seidel's (1998) noticing, collecting, and thinking analytic method in the study.

A transcriptionist, who signed a confidentiality agreement (Appendix 7), transcribed the data from all research interviews into a Microsoft Word © document. The transcriptionist was provided with the participants' pseudonyms and did not live in the participants' residential county, but was familiar with common slang terminology used in the south as recommended by Shellman (2004). The researcher verified content accuracy of the transcripts by listening to each audio recorded interview and comparing the words recorded with the words typed in each transcription, as recommended by Polit and Beck (2004). The researcher corrected inaccurate information prior to continuing with data analysis.

Field note data obtained during the interviews were entered into a Microsoft Word (Microsoft Corporation ©) document labeled with the participants pseudonym. Data from both the transcribed interviews, genogram, time line, and field notes were then imported

into the NVivo 7 software program (QSR International, 2006) for data management and to search for reoccurring themes and concepts which were identified by the researcher.

The researcher analyzed the data from each individual interview first. After interviews were individually analyzed for concepts (N=132) related to the research questions, the data from all existing interviews were analyzed as a whole for re-occurring larger themes and smaller codes. The resulting study findings were reported in thick descriptive data. The researcher maintained the original research data under lock until the completion of the study, at which time study related material were destroyed. A sequential listing of the data analysis process is available in the appendices (Appendix 10) as a checklist.

### 3.7. Trustworthiness of the Research

Although qualitative and quantitative research are of different paradigms, both should be held to quality standards and assure trustworthiness of the data (Lincoln & Guba, 1985; Polit & Beck, 2004). Trustworthiness of research is a qualitative term. Lincoln and Guba initially discussed the establishment of trustworthiness in their seminal work, "Naturalistic Inquiry." These authors described the inappropriateness of using the conventional criteria of trustworthiness to assess the trustworthiness of a naturalistic inquiry. The current criteria used in the evaluation of research trustworthiness are: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability (p. 300).

Most qualitative research authors accept the four criteria established by Lincoln and Guba (1985). The following sections will describe these four criteria in further detail and provide the reader with an understanding of how each criterion was addressed in the research to increase the trustworthiness of the study findings.

### *Credibility*

Credibility is similar to the term validity in quantitative studies (Polit & Hunger, 1999). Several measures were taken to improve the credibility of the proposed research. As the researcher is the primary instrument of data collection for qualitative studies, the credibility of the researcher is essential to establish (Polit & Beck, 2004). A section of the researcher's qualifications, experiences, and connections to the community have been disclosed. Credibility in the study was enhanced through the use of method triangulation; this included using interviews, observations, timelines, and genograms (Polit & Beck).

### *Transferability*

Transferability refers to how likely findings from one study can be assumed in another population (Lincoln & Guba, 1985; Polit & Beck, 2004). Although transferability is not an aim of qualitative research and naturalistic inquiry, several measures were taken to improve the possible transferability of the proposed research. Multiple authors (Creswell, 2004; Leininger, 2001; Polit & Beck) have suggested using *thick description* as a means of increasing transferability. Lincoln and Guba describe the importance of providing information on context, and put the responsibility of the possibility of transferability squarely in the hands of the original researcher. Thus, the researcher provided detailed data on the unique characteristics of the study population and the context of the setting as observed and revealed by the study participants. Findings were reported in thick descriptive data.



### *Dependability*

Dependability refers to how stable the data are; this includes both over periods of time and in varying conditions (Polit & Beck, 2004). The researcher performed an analysis of all interviews to assure the transcripts accurately reflected the exact words of the participants. This took place prior to data analysis. An inquiry audit was utilized to improve both the dependability and confirmability of the research, in which an experienced qualitative researcher examined the research process and findings (Lincoln & Guba, 1985; Polit & Beck).

### *Confirmability*

Confirmability refers to the objectivity of the data (Polit & Beck, 2004). Thus, meaning, relevance, and correctness of study findings should be agreed upon by more than one single person (Polit & Beck). The research utilized multiple researchers to confirm study findings. The researcher provided an audit trail and systematically assembled all important research related documents. Polit and Beck recommended a variety of documents be used in an audit trail. The following documents were compiled for audit: raw data, analysis products, and a final draft of findings. Three experienced qualitative researchers were provided with the above audit documents and subsequently evaluated and confirmed study findings.

### 3.8. Ethical Considerations and Protection of Human Subjects

IRB approval was gained from Duquesne and Samford University. The researcher complied with the current “Belmont Report” (1979) guidelines as published by the National Institutes of Health [NIH] and created by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

Confidentiality was strictly maintained. Data was recorded under a pseudonym selected by each participant at time of data collection. The study's transcriptionist was oriented to the critical nature of protecting the confidentiality of the participant prior to receiving any research materials for transcription. All participation in the study was voluntary. Participants were informed on the purpose of the study, the methods of data collection, compensation, risks, benefits, and their right to withdraw from the study at any time prior to the publication of the study findings.

Participants were requested to give their interviews in a private location, in effort to maintain their confidentiality. A plan to address emotional distress was in place, but was not required during data collection. Had the participant become emotionally distraught during the interview, the researcher would have consoled the participant. The researcher has received formal education in interpersonal relationship skills and has personal experience as a health care provider; helping persons who are upset from various events of the past or present. The researcher would have remained with the participant until that person stopped crying and appeared not to be upset. The audio-recorder would have been turned off during that time. The researcher would have further offered to contact someone with whom the participant may have wished to consult or converse with. The researcher would have offered to: (a) discontinue the interview indefinitely, (b) come back at a later time, or (c) give the participant the opportunity to continue.

Compensation for participation was assessed through both collaboration with key community gatekeepers familiar with research practices within this population and a review of the research literature involving similar research studies in like populations

(Shellman, 2004). Comments from an informal survey of community members indicated the amount of compensation was fair, not excessive, appropriate, and was non-coercive for participation (F. Ford, personal communication, June 21, 2006).

The Principles of Professional Responsibility has been outlined by Spradley (1979). These ethical principles were adopted by the Council of the American Anthropological Association (Hagemaster, 1992) and were adhered to within the proposed research. These ethical principles include: (a) putting the participants first; (b) safeguarding the rights, interests, and sensitivities of the participants; (c) appropriately communicating objectives of the research, so the participants know the aims of the study; (d) protecting the participants privacy; (e) avoiding any exploitation of the participants for personal gain, providing the participant with a “fair return” (p.38) benefit; and finally, (f) making all reports available to the participants (Spradley).

### 3.9. Summary

Chapter III has provided a discussion on the methodology behind the proposed naturalistic inquiry and a description of the site selected for primary recruitment of participants. Participation was voluntary. Participants were fully informed on the purpose, methods of data collection, and their right to withdraw from the study at any time prior to the publication of the study findings. Confidentiality of participants was maintained and data recorded under a pseudonym selected by the participant. The researcher adhered to the ethical guidelines as described by the “Belmont Report” (NIH, 1979) and Principles of Professional Responsibility (Spradley, 1979).

Efforts were taken to insure the rigor of the study. Trustworthiness of the data was enhanced through the use of audit-trails; member-checks; triangulation of data, including

interview, timeline, genogram, process notes, methodological log, and member check notes. Prior to publication of findings, an experienced qualitative researcher performed an inquiry audit to validate study findings.

# CHAPTER IV

## RESULTS

### 4.1. Introduction

The purpose of this study was to understand a lifetime of health-seeking behavior experiences as lived by persons who are African-American, older, have a low income, and reside in rural south Alabama. A naturalistic inquiry was conducted to reveal the health seeking behaviors across the lifespan of the study participants and to further delineate whether these behaviors were universal or diverse among study participants.

### 4.2. Description of Participants

Study participants (N=7) were selected by purposeful sampling, recruitment was facilitated by key community leaders. The study included both male (n=2) and female (n=5) participants who met established inclusionary criteria. All participants reported African-American heritage, met the definition of low income (Appendix 2), and were residents of rural south Alabama (RSA). Participant ages ranged between 65 and 75, with a mean age of 68.8 years. Education was viewed as highly important and desirable to all participants; however, need to contribute to household, or other important life events caused many participants not to be able to complete their education. The educational

background of the study participants varied between 8th grade and college, with an average of 11 years of formal education completed. Number of children varied between 2 and 16, with an average of 7.2 per participant. Many participants were assisting their children financially, or were raising grandchildren or great-grandchildren. Annual household income averaged \$9,113. A summary of the participants chosen pseudonym, age, gender, number of children, and income with number of household members has been provided in Table 4.1 to aid in the possible transferability of study findings.

Table 4.1

*Description of Participants*

| Name      | Age | Gender | Income      | Household |          |                      |
|-----------|-----|--------|-------------|-----------|----------|----------------------|
|           |     |        |             | Member's  | Children | Education            |
| Shelia    | 67  | Female | \$2,996/yr  | 5         | 7        | 9th Grade            |
| Susie     | 67  | Female | \$8,000/yr  | 4         | 3        | College, 3 Years     |
| Mary Anne | 65  | Female | \$8,220/yr  | 1         | 5        | 10th Grade           |
| Elizabeth | 66  | Female | \$8,400/yr  | 1         | 2        | High School Graduate |
| Doris     | 76  | Female | \$6,780/yr  | 2         | 15       | 9th Grade            |
| Jay       | 65  | Female | \$14,400/yr | 3         | 16       | 8th                  |
| Cole      | 68  | Male   | \$15,000/yr | 2         | 3        | College Graduate     |

### 4.3. Findings

Data collection and data analysis were conducted concurrently. De Chesnay's (2005b) data collection method was used for data collection; and Seidel's (1998) noticing, collecting, and thinking analytic method was utilized for qualitative content

analysis throughout the data analysis process. The researcher, genograms, timelines, and an audio-recorded life history interview were used as the instruments to facilitate data collection. Several participants were asked to complete a follow-up interview to help clarify data or provide additional information related to emerging themes. The qualitative software program NVIVO v7 © (QSR International, 2006) was used for data management.

Data from each participant were verified for content accuracy and then analyzed individually for concepts. A total of 132 concepts (free nodes) resulted from initial data coding. Concepts were individually examined for frequency of occurrence, patterns, and number of participant sources providing data on each concept. Nine major themes with subthemes resulted after this portion of data analysis. Data were again re-coded to the resulting nine themes and subthemes, for confirmation purposes, before these themes were assigned as findings for the first research question. Data coded within individual themes and subthemes were further analyzed for prevalence and occurrence within each source, and resulted in their assignment as a universality or diversity to answer the second research question. Thick-descriptive narrative verbatim excerpts were provided to emphasize and support study findings. Three qualitative researchers were consulted to validate study findings.

### *Research Question One*

The first research question sought to discover the lifetime health-seeking behavioral experiences of African-Americans who have a low income, are older, and reside in rural south Alabama. Nine major themes resulted from data analysis. These themes are presented as study findings to answer the first research question and are

presented below in Table 4.2. Verbatim excerpts that support study findings will follow later in this chapter, after Table 4.4.

Table 4.2

*Major Study Themes*

| Number | Theme   |
|--------|---|
| One    | Not Sick  |
| Two    | Knowledge and Use of Home Remedies                        |
| Three  | Childhood Preference for Generic Folk-Learned Remedies    |
| Four   | Adult Preferences for Professional Health Care            |
| Five   | Need for and Use of Non-Professional Health Care Services |
| Six    | Need for and Use of Professional Health Care Services     |
| Seven  | Limited Health Promotion and Disease Prevention Education |
| Eight  | Limited Health Promotion and Disease Prevention Practice  |
| Nine   | Trust Help is Available                                   |

*Research Question Two*

The second research question sought to discover the common universalities and diversities in health-seeking behavioral experiences among study participants. The same nine major themes from the first research question were utilized to answer the second research question. However, subthemes were added and were identified as a universality or diversity in health-seeking behavior experiences among study participants. Themes and subthemes found to be prevalent or consistent among all participants are listed under the universalities section; while those themes and subthemes found to differ significantly



among participants are included under the diversities section. Two tables have been utilized to separate the themes into either universalities (Table 4.3) or diversities (Table 4.4). A description of each universality and diversity, with verbatim excerpts from the participants is located after Table 4.4.

Table 4.3

*Universalities in Health Seeking Behaviors*

| Themes  | Subthemes  |
|---|--|
| Not Sick  | (1) In Childhood<br><br>(2) Because of Diet  |
| Knowledge and Use of Home Remedies                        | (1) Teas<br>Types: Many Weed, Pine Top, Rabbit Tobacco, Shuck<br><br>(2) OTC Products<br>Types: Castor-Oil, Black-Draught<br><br>(3) Common Reported Health Problems and Uses<br>Types: Cold |
| Childhood Preference for Generic Folk-Learned Remedies    |  |
| Need for and Use of Non-Professional Health Care Services | (1) Midwife Use in Childbirth<br>For own Birth   |
| Need for and Use of Professional Health Care Services     | (1) Acute Injury or Illness  |
| Limited Health Promotion and Disease Prevention Education | (1) From Family  |
| Trust Help Available                                      | (1) From Family<br><br>(2) From Home Remedies<br><br>(3) From Professional Health Care Provider  |

Table 4.4

*Diversities in Health Seeking Behaviors*

| Themes  | Subthemes   |
|---|---|
| Knowledge and Use of Home Remedies                        | (1) Teas  |
|   | (a) Age of Use  |
|   | (b) Preparation   |
|   | (c) Types: Catnip, Hog Hooves, Lighter, Mullein Pasture   |
|   | (2) OTC Products  |
|   | (a) Types: Alcohol, Aspirin, Bath and Body, Cod Liver Tablets, Garlic, Natural Vinegar, Protein, Three Six's, Turpentine, Tylenol, Vicks-Salve, Vitamins                                  |
|   | (3) Other   |
|   | (a) Types: Jimson Weed, Tallow  |
| Adult Preference for Professional Health Care             | (4) Common Reported Health Problems and Uses  |
|   | (a) Types: Arthritis, Cancer, Chicken-Pox, Colic, Constipation, Fever, Flu, High-Blood Pressure, Measles, Mumps, Poor Circulation, Sore, Sore-Throat, Stomach Ache, Whooping Cough, Worms |
| Need for and Use of Non-Professional Health Care Services | (1) Midwife Use in Childbirth   |
| Need for and Use of Professional Health Care Services     | (a) For Birth of Their Children   |
|   | (1) Hospital Use in Childbirth  |
|   | (2) Chronic Disease   |
|   | (3) Mandatory Requirement   |

Table 4.4 (continued)

*Diversities in Health Seeking Behaviors*

| Themes  | Subthemes  |
|---|--|
| Limited Health Promotion and Disease Prevention Education | (1) From Health Care Providers   |
| Limited Health Promotion and Disease Prevention Practice  | (1) Vaccines <ul style="list-style-type: none"> <li>(a) Flu Shot</li> <li>(b) Pneumonia Shot</li> </ul>  |
|   | (2) Procedures <ul style="list-style-type: none"> <li>(a) Colonoscopy</li> <li>(b) Mammogram</li> <li>(c) Pap</li> <li>(d) Prostate</li> </ul>                           |
|   | (3) Exercise   |
|   | (4) Healthy Diet   |
| Trust Help Available                                      | (1) From Community   |
|   | (3) From God <ul style="list-style-type: none"> <li>(a) With Professional Health Care Intervention</li> <li>(b) Without Professional Health Care Intervention</li> </ul> |
|   | (5) From Medication  |
|   | (7) From Self  |

#### 4.4. Description of Themes and Subthemes

The themes and subthemes of the current study are listed above. A detailed description of the verbatim excerpts that support the study findings in tables 4.3 and 4.4 have been provided below.

##### *Theme One: Not Sick*

###### *As a Child*

All participants reported a perception that they were not sick as a child. This perception was confirmed throughout all life history interviews.

The following excerpts were shared by participants discussing their belief that they were not sick as a child. Mary Anne reported, “We didn’t have no sickness back like everybody’s sick now. I don’t know much about nobody being sick, no more than having a baby, I have really never been sick until after I got grown.” Elizabeth stated, “I was never down sick...I wasn’t sick.... so I just never went to the doctor.” While Shelia echoed the others by saying “I really wasn’t ever sick,” along with Susie who said “We were none of us never sickly. Nobody else that I know of was sick.”

All participants considered themselves healthy as a child. Interestingly though, all reported various illnesses during their childhood years. Cole was asked if he remembered anything about being sick as a child and responded “Mm, mm, not that much sick but, ah, I always had a lot of nose bleeds.” Elizabeth recalled “I was never down sick. You know, you had your – your chicken pox and things like that”; and Jay reported “I never was sick, no more than a bad cold.” Shelia shared “I wasn’t sick. I think I had the whopping cough, chicken pox, and the measles.”

## *Diet*

Diet was consistently correlated with the health of the participants across their lifespan. Cole reported “none of us ever had a cold because...I would...give them, fruits and vegetables every day...never were sick”; and when asked if he had diabetes, as all but one of his nine siblings did, he responded: “No...I try to, try to eat real good and delay that as long as I possibly can.” This participant also spoke in great detail of his long term healthy lifestyle habits. These healthy habits included baking, not frying foods, getting his water from a spring, fasting, daily exercise, not eating fast-food and not allowing his children to eat fast food, avoiding hormones in meat, and raising his own vegetables and animals to eat. He reported that his immediate family practices a healthy lifestyle, but that his health seeking practices are not understood by his family and friends. He recalled his conversation with a friend concerning his limited meat intake, “I told him that I wasn’t a meat eater, so he said... ‘I thought you was crazy not eating meat’....anyway [Cole said]...I don’t have any health problems.”

Only one participant did not directly link diet with health. However, she did report being healthy and believing her children were healthy because of their weight and the food she fed them. However, the diet reported would not necessarily be considered healthy. Doris stated:

The way I brought my children up on syrup and butter and eggs, you know, stuff like that and fried meat for breakfast...Dinnertime every day, one day some peas and I made up what they call a slop pie. Cooked a chicken. That was it. Then next day, some neck bones, butterbeans. You know, I made some teacakes or something like that. That’s the way it was...that’s what my children was raised on. In the morning time, jelly and, you know, peanut butter and stuff. Now they ate so much when they was little like that....But that’s what I raised mine on and they was just as fat as they could be.

Elizabeth reported “I remember food, you know, at that time didn’t have, uh, the chemicals that it have now.” Mary Anne said “I eats a lot....and I don’t eat a whole lot of greasy foods. I just stay – I just stay healthy.” Shelia is a diabetic and informed me that she ate “small portions of food...food that ain’t gonna trigger the diabetes off.” She said “I eat food, healthy food...I’m not gonna eat anything to run my sugar up.”

Finally, Jay shared,

Always tried to stay healthy. I watched what I ate and stuff, and never did eat too much greasy stuff, you know, like that. Just watched what I ate and drank a lot of juice, and stuff like that that helped keep you healthy.

### *Theme Two: Knowledge and Use of Home Remedies*

All participants reported a knowledge and use of home remedies in their childhood. Home remedies were primarily home-made teas; however participants also discussed other non-tea remedies, and various over the counter (OTC) products they considered to be a home remedy useful in the treatment of various common illnesses. While some remedies were used for the same illness, not all illnesses were treated with the same tea type or remedy. Table 4.5 is located at the end of this section and outlines all reported home remedies used to treat common illnesses.

Four subthemes emerged from the data related to knowledge and use of home remedies; these were: (a) teas, (b) OTC products, (c) other, and (d) common reported health problems and uses. Findings related to each subtheme were presented below.

#### *Teas*

*Age of use.* Home remedy tea use in childhood was noted to be commonplace, but has either stopped or decreased over the lifespan of the participants. Cole reported that he stopped using the home remedy teas after he “left home”; but still uses various natural teas that he buys at the health food store. Doris and Mary Anne, along with the majority

of the other participants, continued to use the teas until their teenage years. Mary Anne shared “for a cold, that’s the best remedy, but I wouldn’t use none of it now.” When asked when she stopped using the tea remedies, Mary Anne stated “I reckon after I got grown.” Jay reportedly he still uses one tea “every now and then.” He shared “I would like to get the...shuck tea. I use that sometime.”

*Preparation.* Preparation of home remedy teas was diverse among study participants. Some reported combining various tea products into one tea, while others used teas separately. Cole shared that his mother “never did combine it, always mixed it separate.” However, later he reported that there were certain teas his mother would combine and stated that she “used to mix the mullein tea with the pine top tea,” and that she would “take it and put it in the water and boil it maybe for an hour or two”.

Combining teas was noted to be a similar finding with many participants; as Jay reported,

Daddy would put it all in one pot. All together and boil it...take the pine top, or rabbit tobacco, and put it in there and put the cow patty on top of that, and just let it boil until it come to a real good boil, and put sugar in it and drink it.

However, many participants prepared tea products separately. Shelia described “I ain’t never know’d them to put many weed tea with no other tea...rabbit tobacco, it was by itself.”

Sugar was a common additive noted in tea preparation. The preparation of hog hooves tea with a sugar was described by Jay, as he informed me: When making this tea, “you peel [the nail off the hog] and put it in the tea kettle and let it come to a boil, and add a little sugar to it.” Shelia reported that most teas “taste good ‘cause it got sugar in it.” However one participant did not use sugar in home remedy teas, because, as he described, his mother “might not have had sugar, because sugar was scarce then.” Cole,



whose mother did not use sugar in tea preparation, voiced the most dislike for the taste of the home remedy teas as a whole.

*Types.* Knowledge and use of reported teas varied; but four out of the seven reported teas were noted to be universal. These were: shuck, many weed, rabbit tobacco, and pine top tea.

*Shuck* tea (made from the shuck covering corn ears) was used for a variety of illnesses. It was the tea most often used and for most participants it was the most well-liked. Elizabeth reported the use of shuck tea for chicken pox; she said it worked because “it made the – the little bumps pop out.” Shelia described several uses for shuck tea including “for whoopin’ cough and all o’ that stuff,” and for measles as “it would make the measles come on out on you.” However, the primary use of shuck tea appeared to be for colds; as Jay described “Shuck tea, it was for colds...I drunk many a shuck tea.”

*Many weed* tea was the most controversial, as knowledge of this tea was commonplace, but not the use of it. It was named many weed tea as it came from a cow who eats many weeds. Doris had this to say about many weed tea “they wanted us to take, uh...it was cow manure but they...didn’t call it cow manure...but my mother never did give me none of it.” Elizabeth had a similar response “There was one tea I would not drink...because I knew how they made it I would not drink it...cow dung.” However, others did discuss their use and acceptance of many weed tea. Jay informed me that they would “stand out in the pasture...go get *rabbit tobacco* tea...and *pine top*, and get a cow patty, and boil it, and drink it...what they call the many weed tea.” He said “that’d knock the cold out.”

Rabbit tobacco tea was commonly used for various illnesses. Shelia described rabbit tobacco tea use as follows: its “grown wild out there....its a plant...it don’t get ripe until...the fall of the year. Lot of times [my Mom] would mix a lot of that stuff together...to make it work....that’s for [the] cold.”

Pine top tea was also frequently used by participants. Susie described this tea and stated: Pine top tea “came from the pine tree....you just go out there and breaks...those little sprigs off, and put it in something and boils em.” Mary Anne described her use of pine top tea as follows: “them pine trees...she would [make] tea and we use to drink it....it wasn’t good, but it did us good, it’d kill a cold.”

Other teas were reported to have been used by certain participants but were not reported by all participants. The teas reportedly used with less frequency were: cat-nip, hog hooves, lighter, and mullein pasture tea.

Cat-nip tea was reported by only one participant. Cole stated: “cat-nip is [an] herb....you can buy that at the health food store.....My mother use to have it in the garden. Cole additionally described this as the best tasting tea.

*Hog hooves* tea was used most often from this last group of teas. Shelia described hog hooves tea when she said,

They’d take the nail and listen people would kill a hog and then they’d take... the hoof off the, off the hog feet and then put ’em up somewhere. Back then people would put them in the crib or above the door, or whatever, and then when somebody’d get sick, they’d get up ’em and boil ’em. They’d make tea out of ’em. They put sugar in it after they make the tea.

Lighter tea use was described by two participants. This tea was reportedly obtained from a pine tree, and was used to either start a fire with or boil into a tea. Doris described lighter tea, when she said “You ever heard talk of lighter? Use to get it off a

tree. It'd be real fat. They use to boil it down and it'd be kinda like, um, it had a flavor kinda like turpentine." Shelia also equated the taste of this tea with turpentine.

Mullein pasture tea use was only described by Cole. He stated, "Mullein, it's a big thing grown in the pasture. It's got a leaf."

Teas were used for various problems ranging from colds to whooping cough. A summary of all reported teas and other remedies used to treat common illnesses is provided in Table 4.5, located at the conclusion of the description of the second theme.

### *OTC Products*

OTC product use was a subtheme that included both diversities and universalities. Castor-oil and black-draught (senna) use was prevalent, but reported uses of these products varied.

*Types.* The following OTC products were the reported as home remedies in the treatment of various types of common illnesses and for health: (a) alcohol; (b) aspirin; (c) back and body, an aspirin product marketed by Bayer; (d) black-draught, a laxative made from senna; (e) castor-oil; (f) cod liver tablets; (g) garlic; (h) natural vinegar; (i) protein; (j) three six's, a liquid cold medicine; (k) turpentine; (l) Tylenol; (m) Vicks-salve; and (n) vitamins. Castor-oil and black-draught were the two universally reported OTC products, and although these were not necessarily liked because of taste or side-effects, they were thought of as very effective.

*Castor-oil* was reportedly used for colds, constipation, the flu, and worms. One participant recalled the product's use after-childbirth. Doris spoke of the use of castor-oil for colds when she said, "When you have a bad cold, they'd give you castor oil." This appeared to be a very common use for castor-oil and several participants still report

castor oil use for a cold. Elizabeth talked about her continued use of castor-oil when she said “if I have a cold and I’m coughing and it lingers, then I’ll take some castor oil...I have to take it through a straw, but I take it...it’s the best remedy I know.” One participant voiced that her midwife gave her castor-oil several days after delivery. Shelia recalled her multiple uses of castor-oil, when she reported:

Had to drink castor oil...for a cold and for constipation, run them worms out of you. When you had a baby, the midwife would give you a dose of castor oil or give you two or three doses....after you had the baby. The baby be ’bout three or four days old. See, here....see, you know – let me tell you somethin’. You done had the baby. And you already still have after-birth pain, they call it. And your titties gonna swell up ’cause you got the milk comin’ down and then what they – they call it, your womb gotta go back in place after you have it they call it. Your womb gotta go back in place....and then they’d take, uh, uh, that castor oil and they been – they say you better open up....and then you don’t be takin’ no fluid or nothin’ and when you come out the house you gonna be clean as everything. You won’t have nothin’ in you. Cause...castor oil will put you out. So you clean. You ready for another baby.

*Black-Draught* use was reportedly used for the cold, flu, constipation or as a general colon cleanser. Jay reported “I had black draught syrup, and it was mostly for cold and constipation.” While, Shelia remembered “Black Draught...is a laxative....lotta people use it for to, to make ’em go to the bathroom for their bowels to move and then they’d use it for, uh, cleanin’ out....when you take that Black Draught...everything comes out of you.” Susie shared that she remembered using black draught and that it “...was some kind of medication that could...keep your bowels open, you know if we got sick.”

OTC products reported, but not prevalent were: alcohol, aspirin, back and body, cod liver tablets, garlic, natural vinegar, protein, three six’s, turpentine, Tylenol, Vicks-salve, and vitamins.

Doris and Shelia reported using *alcohol* as a home remedy. Shelia stated “I rub alcohol, for my feet, they stiffen out.”

Shelia reported using aspirin to treat a *fever*. She said “if you had fever, they would... take an aspirin, St. Joseph’s aspirin. They always would...have you take St. Joseph’s aspirin for fever...and put a wet towel or rag on your forehead.”

Elizabeth spoke of using *back and body*. She said “and for my arthritis I take back and body put out by Bayer Aspirin...I was taking 25 milligrams [of an arthritis prescription medicine], and it just stopped working. So now I just take back and body. It helps.”

Susie was the only participant that spoke of using *cod liver tablets*. She reported “I take, uh, cod liver tablets, that’s, uh, for – I take that for cold just occasionally.”

Susie is also the only participant that reported using *garlic*. Susie stated “I just take some garlic pills now...I have high blood pressure now.”

Cole reported using *natural vinegar* for overall health and to avoid cancer. He said “I was reading this book about vinegar and how it keeps you running, and from cancer.”

Cole also reported using *shaklee protein* for overall health and buying this product at a health food store. He states this protein is in “a powder form” and that it comes “from South Africa.” When asked the reason he takes this protein he stated that “it’s supposed to be ah, it has ah, nine amino acids in it...to keep healthy,” and that he has “been taking this since about 1969.”

The use of *three sixes* was reported by Elizabeth. She stated “that is what we used for colds...and it taste terrible.”

Shelia spoke of several uses for *turpentine*. She stated they would use turpentine for tape-worms and said they would put “nine drops of turpentine on sugar and...put it in your mouth and drink the water and then... [the] worms would come out.” She also spoke of someone telling her to add turpentine to an unknown tea, to “bring the period on.” She was four months pregnant at the time and was not seeking an abortion; she just didn’t realize she was pregnant. Shelia said this tea that a neighbor gave her “ain’t brought no period of mine on,” and that she “liked to died with that.”

Only one participant, Doris, spoke of her current use of *Tylenol* for arthritis. One other participant, Elizabeth, discussed her past use of the product. Elizabeth said “My aunt, that I was telling you that’s a nurse....said don’t take Tylenol every day. She said because it messes with your liver; and now when she said that, that was the end of Tylenol for me.”

Doris, along with Elizabeth, spoke of using *Vicks-salve* for chest congestion. Elizabeth recalled that they “used to rub your chest with it.”

Several participants reported past or present *vitamin* use, but this was not a prevalent discussion nor was it reported by the majority of participants in the study. Susie recalled “I take a vitamin....only thing that I remember,” when asked if she had ever taken anything else to improve her health.

#### *Other Products*

Other home remedies which were not an OTC product or a tea, included the jimson weed and tallow. Elizabeth spoke of the use of the *jimson weed* in the treatment of a sore,

Sometimes you’d get a sore on your leg or something. You still didn’t go to the doctor. There was a weed that grew, and they called it a jimson weed....it was

green, and it grew tall. And my mother used to break off that leaf and put it on the stove and let it get warm. And then she would put it on the sore spot on your leg, and that would draw the puss out....it worked.

Then Doris described the use of *tallow* and said its use was similar to the reason why they would use Vicks-salve. She elaborated by saying,

They had, um, uh, something they called tallow.....Just like, you know, um, off a hog or something. They'd...cook the grease down. They call it tallow and they would rub your chest with it. Uh-huh and that would break that cold in your chest.

Commonly reported health problems included: arthritis, cancer, chicken-pox, colic, constipation, fever, flu, high-blood pressure, measles, mumps, poor circulation, sores, sore-throat, stomach ache, whooping cough, and worms. These are included under the theme of home remedy knowledge and use, because these are the illnesses or problems reportedly treated by a home-remedy. All participants voiced having a home remedy use for the cold. Home remedies were noted to have been used in the treatment of all other listed illnesses, but not all participants discussed having a treatment for each illness. Table 4.5 below provides a breakdown of all reported health problems with their associated treatments.

Table 4.5

*Common Health Problems with Reported Remedies*

| Common Health Problems | Reported Remedies   |
|------------------------|---|
| Arthritis              | Rub with Alcohol<br>Tylenol<br>Back and Body by Beyer   |
| Cancer                 | Natural Vinegar   |
| Chest Congestion       | Vicks-Salve<br>Tallow   |
| Chicken Pox            | Let a Chicken Fly over Your Head<br>Shuck Tea   |
| Circulation Problems   | Vitamin B 12  |
| Cold                   | Castor Oil<br>Cod Liver Tablets<br>Shuck Tea<br>Rabbit Tobacco<br>Pine Top<br>Mullein Pasture<br>Many Weed<br>Lighter<br>Black-Draught<br>"Three Sixes" |
| Colic                  | Hog Hooves<br>Castor Oil  |



Table 4.5 (continued)

*Common Health Problems with Reported Remedies*

| Common Health Problems | Reported Remedies  |
|------------------------|--|
| Constipation           | Castor Oil<br>Black-Draught                                      |
| Fever                  | St. Joe Aspirin<br>Back and Body by Beyer                        |
| Flu                    | Castor Oil<br>Many Weed<br>Black-Draught<br>Catnip<br>Castor Oil |
| Hypertension           | Garlic   |
| Measles                | Shuck Tea<br>Many Weed   |
| Mumps                  | Sardines Tied Around Jaw and Don't Get Wet<br>Many Weed          |
| Sores                  | Jimson Weed Compress   |
| Sore-Throat            | Shuck Tea<br>Hog Hooves  |
| Tape-Worms             | Turpentine on Sugar<br>Castor-Oil                                |
| Whooping Cough         | Rabbit Tobacco<br>Hog Hooves                                     |

### *Theme Three: Childhood Preference for Generic Folk-Learned Remedies*

All participants reported a preference for generic folk-learned home remedies; therefore this theme is described as universality. Participants conveyed the knowledge that home remedies were always used first during their childhood and that, for the most part, there was no need to see the doctor because of the home remedy use.

Jay summed up the statements of all participants when he said “we always tried home remedies first...we got all them home remedies, and those home remedies worked.” Jay described the effectiveness of home remedies and said “I never did go to the doctor until I got just about grown.” When asked if he remembered anyone else going to the doctor when he was a child, he replied “uh, not right off hand”. He said, “When I got sick, daddy would get them home remedies and lay them on me, and I’d get well right quick, like, you know”?

Shelia stated “the home remedy is what we would use.” She said “my parent’s didn’t take you to the doctor...no we didn’t go. We all used home remedies.”

Elizabeth further confirmed this theme when she said “You use home remedy, and we didn’t go to the doctor often...sometimes you’d get a sore on your leg or something. You still didn’t go to the doctor. There was a weed that grew...”

### *Theme Four: Adult Preference for Professional Health Care*

Theme four is described as a diversity in health-seeking behaviors among study participants. All but one participant reported a preference for seeking health care from a traditional professional health care provider in their adult life. However, one participant (Cole) was so adverse to seeking traditional health care that the theme has been described

as a diversity. Additionally, there was one participant (Shelia) who does seek traditional professional health care, but prefers divine intervention over professional health care.

Doris was asked what she does now when she is sick and responded “go to the doctor.” When asked if she used home remedies for treating her own children when they were sick, she replied “Mostly I carried ’em to the doctor. Well, they, just, you know, people started carrying the babies to the doctor, and I just said that’s what I would do too.” Shelia also spoke of her childhood use of remedies verses what she did when her own children were sick, when she said, “You know, back when...I was a kid, that’s what was going on, but for my children, they would go to the doctor.” She further stated “But the home remedy is what we would use...my mama used on me, but I never had to use it on my children”. Finally Jay reported “I prefer to go to the doctor now because...as I said, what it is, it’s more, more convenient.”

*Theme Five: Need for and Use of Non-Professional Health Care Services*

Theme five addresses midwifery use in childbirth. Subthemes are midwifery use (a) for the birth of their children, and (b) for their own birth. Midwife use for the birth of the participants’ children was a diversity, as views on this varied among participants. However, all participants reported having been delivered by a midwife, thus midwifery use for their own birth was noted to be a universality.

*For the Birth of Their Children*

Three participants (Doris, Mary Anne, and Shelia) reported using a midwife for all of their children’s birth; and one participant (Jay) reported using a midwife for some of his children’s deliveries and the hospital for the other deliveries. This was a very interesting finding in that any participant that was noted to have worked or lived outside

of a rural south Alabama (RSA) during childbearing years preferred their children to be born in a hospital setting verses delivered by a midwife. Also, any participant living in a RSA area during childbirth preferred to have their children delivered by a midwife.

Mary Anne reported, "I had every child I had at home.... you'd just stay at home and have your own baby in your own bed." She further added;

Didn't nobody go to the hospital to have no baby. I don't believe they was no hospital, not around here. Well there was a hospital but we never did. We had something like a midwife. She knew what to do to deliver the baby. Didn't nobody go to no hospital for no baby....we didn't take no kinda medications....nothing, I mean nothing. No kinda medications.

Doris also discussed the delivery of her children, and had this to say, "I had all my children at home with a midwife." Doris further discussed the role of the midwife as someone who would "catch the baby and cut the navel string."

Shelia also reported "I had my baby at home." When asked if there was someone there to help her deliver she replied "Yeah, my mama and my midwife. Didn't go to no hospital or nothing....I ain't never had a baby in the hospital. Had all of 'em at home."

Jay was the participant that worked outside of a RSA area and had some of his children delivered by a midwife and others by a professional health care provider, in a hospital setting. Jay was asked to share why he chose the midwife for some deliveries and the hospital for others; he had this to say,

Well the, uh, way back then they used to charge you \$50.00. I had two born and I payed the midwife \$50.00 to deliver it. I went to the hospital and, you know, it's a little bit more at the hospital. How much more I don't know. I think it was \$300.00 or \$400.00.

Jay further described his experiences, as a father involved in a childbirth that took place at home, with the use of a midwife:

That's the way they used to do....if it was gonna be born at home, the husband had to make a fire in the stove and heat the water, and carry it to the room. Had to go get the midwife....

One other interesting statement concerning midwifery use in childbirth came from Elizabeth, who was living in an urban area at the time of her hospital delivery. When asked if she used a midwife or a hospital for delivery, she replied "Uh, I think there [in the city] you had to. Yeah, they didn't do the midwives." Elizabeth further reported "the south was at that time was very different from the northern cities... You know, as far as hospitals and things were."

#### *For Their Own Birth*

All study participants reported being delivered by a midwife themselves and thus this particular subtheme is listed as a universality in health-seeking behaviors. Several participants shared interesting childhood stories related to their knowledge and remembrance of midwifery use.

Elizabeth reported having been delivered by a midwife, and shared that:

A midwife who delivered me, messed me up. I ...did not have birth certificate. But see, I don't know...the lady may have gotten the name wrong. She may have put me under a different name....Because you know, at that time, black people didn't have a lot of education. So she may have just put me under a different name.

Cole discussed his childhood memories of a midwife delivery. He stated:

Midwife...she delivered all of us....she probably delivered that man right there [pointing to someone in the near vicinity]. The midwife would come to the house. They would send all the kids away....They send you over to your cousin's house and have all the women be here, yeah, taking care of taking care of the baby.

Cole further said that the midwife would come "I reckon maybe a day or two ahead of time....[and] move in the house." Cole said his mother said "they would stay about a week."

### *Theme Six: Need for and Use of Professional Health Care Services*

Theme six emerged from multiple comments related to use of traditional western medicine. All participants sought professional health care services, but the reasons for health care seeking varied. Theme six has been divided into four subthemes, based upon the rationale for seeking care. The subthemes include: (a) hospital use in childbirth, (b) chronic disease, (c) acute injury or illness, and (d) mandatory requirement. Participant experiences related to each subtheme were individually described below.

#### *Hospital Use in Childbirth*

Hospital use in childbirth was listed as a diversity, as three participants used professional health care services for childbirth (Elizabeth, Susie, and Cole's wife), and as previously mentioned Jay's wife used the hospital for some deliveries and the midwife for others. All participants utilizing the hospital exclusively for deliveries were persons living outside of a RSA area at the time of delivery. This point was emphasized by Cole who stated, "All my kids, born in the North and ... they born in a hospital".

Elizabeth spoke of her experience with hospital delivery, and when asked what the childbirth experience was like for her, she replied, "I don't know because they put me to sleep....they put me to sleep both times." Jay provided information on why he preferred to have his children in the hospital when he said, "Well, you got better care at the hospital....They had medicine and stuff there, you know."

#### *Chronic Disease*

The need for professional health care in the management of chronic disease was noted as a diversity in health seeking behaviors. A majority of participants reported having a chronic disease, and seeking professional health care to manage their individual

problems; however, not all participants reported having a chronic disease. Diabetes was the most common chronic disease reported followed by high-blood pressure, arthritis, and heart disease.

Elizabeth reported having three of the four most prevalent chronic diseases found within study participants. She stated “I have diabetes, and I take pills. I didn’t become a diabetic until after age 40. After age 40, I have high-blood pressure. I have arthritis all over my body”. Susie reported seeking care from a professional health care provider whenever she needed a prescription for insulin. Jay discussed needing professional health care in the treatment of his “blood clots and stuff” and reported taking “Coumadin to keep my blood thin and stuff”. Shelia reported the most medical problems, including stroke, heart disease, high-blood pressure, various mobility problems, and diabetes. She discussed seeking treatment for her diabetes as follows: “Well, . . . with the health, with the problems I have now like that diabetes, I just . . . do what I have to do.

#### *Acute Injury or Illness*

Use of professional health care services for acute illness or injury was reported by all participants; even Cole, who while he does not like to use professional health care services routinely, reported the use of these services for the occurrence of two fractures. Therefore, this subtheme was reported as a universality in health seeking behavior experiences.

Cole reported “If I break a bone or something like that, then I would go to a doctor.” He reported having had two fractures sustained in a bicycle accident in childhood and one as an adult.

Doris reported seeking professional health care for an acute problem when she stated that she "...had to have a D & C" at the hospital. Elizabeth reported that she would seek medical care "...when I'm ill." Jay reported being in the hospital "When I had this blood clot..." Mary Anne reported that she does not go to the doctor, "not unless they get hurt or something like that."

Shelia was noted to be the primary user of the professional health care system for both chronic and acute illnesses. She reported using professional health care providers for an acute illness resulting from an infection caused by leaving a birth control device in-utero too long. She stated the IUD "set up infection, and [the doctor], he told me that you got so much infection. He took that thing out in his office." She also described a tragic life event when her 5 year old son was accidentally shot and her experiences with seeking professional medical care at that time for the acute injury.

Shelia said, a man:

got me and my baby and took us to the hospital. On the way to the hospital ... I told him; I said, 'Y'all gonna let my baby die.' I said, 'Y'all drivin' too slow.' He said, 'Baby,' he said, 'I'm drivin' fast as I can'; and [my sons] bowels moved in my lap. I didn't know it at the time but that was it and...his bowel moved in my lap and, uh, when I got to the hospital, they already knew; and they was a lady there. It was a white lady....she worked at the hospital and she come out there and she got me and....she cleaned me up, and I had somebody. She'd say, 'It gonna be alright right.' But she knew.

#### *Mandatory Requirement*

Professional health care services were used for a variety of reasons, if mandatory. Only two participants reported seeking professional health care because it was mandated. Therefore this subtheme is listed as a diversity in health seeking behaviors.



Cole reported “I had to go there for a check-up” to get a job. He further stated, “Only time I went to the doctor was more like ah, ah, when, when I got a new job, would have to take physicals.”

The other participant who reported a mandatory requirement for seeking professional health care reported this doctor visit was due to a college admission requirement. Susie stated, “The first time I ever known it was a doctor when I got ready to go to [college]. We went to the doctor to, to get a physical.”

#### *Theme Seven: Limited Health Promotion and Disease Prevention Education*

The seventh theme emerged from the data as a result of information shared on the receipt of health promotion and disease prevention education from two different sources. It was noted that participants received some health promotion and disease prevention education, but the information was limited at best. Thus, theme seven was divided into the two subthemes which emerged as potential sources for health promotion and disease prevention education: (a) from family, and (b) from health care providers.

#### *From Family*

Study participants consistently reported receiving either limited or no health promotion or disease prevention education from family members. Therefore, this subtheme was noted to be a universality, common among all participants. The following examples reveal that any health related information received was limited at best.

Doris provided an example of limited health education, when asked if she was ever given advice about staying healthy or information about how to get well when she was sick. Doris answered “Yes, ma’am ’cause she’d tell me to taking castor oil ever time I had a bad cold.” Shelia shared that she was constantly told to:

Keep your shoes on them feet. You put that coat on. Put that jacket on. Put that sweater on.’ ...can’t play out in the – in the rain and stuff. You...go out there to get wood and gotta cover your head and stuff up where you wouldn’t get the whooping cough.

Elizabeth reported that she was not given health information “...because people wasn’t health wise at that time.” She went on to say, that “parents always told you not to drink and smoke and those things...but...other than that, there was not too much that they could tell us not to do because living here...there was nothing here.” Jay shared that he was not given this type of information, and thought it was “because...I never was sick too much.” Finally, when Mary Anne was asked if anyone ever gave her advice about how to stay well or keep from getting sick, she stated “They never did discuss nothing like that.”

*From Health Care Providers*

The following examples provide evidence of the provision of limited health promotion information from health care providers. Cole was asked if a doctor had ever recommend he take the flu or pneumonia shot or have a colonoscopy, and he responded “no”. When Cole was asked if he would have a colonoscopy if the doctor recommended he have one, he replied “Sure would, um-hmm.” He also discussed having been told that a doctor saw a black spot on his lungs at a mandatory check-up. He informed me the doctor did not recommend he come back for follow-up, or give him medication for the problem. Cole said he had not tried to follow-up about the problem because, he said “...I’m not feeling any kind of sickness at all, but [the doctor] just said he saw a spot on my lungs.”

Doris was asked if she had ever had a pneumonia shot, and responded “I never had no pneumonia shot.” When asked if this shot had ever been recommended to her she

stated “No, ma’am.” When asked if she thought she would get a pneumonia shot if it was recommended to her, she replied “Yes, ma’am, I would”. Doris was further asked if anyone had ever recommended that she get a colonoscopy, and she responded “no, ma’am”, and again when asked if she would have one if her health care provider thought she needed one, she replied “Yes, ma’am.” When Doris was asked about education received from a health care provider concerning exercise, she stated “Well, told me to walk. I need to walk, you know.” When asked whether the doctor or the nurse talked to her the most about things she could do to stay healthy, she responded “the doctor.” The dietary instruction she recalled receiving was simply “they don’t want me to eat no salt.”

Elizabeth reported receiving dietary education related to her gout from a nurse; but received very limited diabetes education from anyone. When Elizabeth was first diagnosed with diabetes she said, “They didn’t give me a machine at that time, but uh, they started me on some pills”. She reported receiving a glucometer “maybe about two years after” she had been diagnosed. Elizabeth reported that the doctor told her that she could “eat a little better.” She said, “[the doctor] told me he wanted my blood sugar to range from 130 to from 90 to 130; and I said to him... ‘Okay, I can’t make the 130,’ so he says ‘so 140’ .....Now, I tend to 140.” When asked if a health care provider had talked to her about things she could do to stay healthy, she replied “No, other than telling me what not to eat, and what I can eat but don’t overeat.” She reported that “the nurse do most of the talking” and that she was told to “...exercise, drink plenty of liquids and things of that nature.” When asked about education related to getting a mammogram, Elizabeth replied, “I went to the doctor and they was talking about a mammogram. I said I’d never had one, and the nurse said “What?” I was supposed to have one after 40. By that time, I was 60.”

Jay reported receiving the most education related to his diet and medication. He described this dietary education as “They don't like meat and stuff, with...me taking this medicine...this Coumadin. I can't have no green beans and no greens...If they cook me green beans, I can't have over a handful, or something like that, you know”?

Mary Anne reported that a health care provider “never has told me to exercise...But I, I do it on my own, but he never told me.” When asked if she believed her health care provider gave her enough information and explained things well to her, she replied “I think so.”

Shelia was given a limited amount of information related to her diet, but when asked if she received a glucometer when she was first diagnosed with diabetes, she reported “uh, unh-unh.” When asked how long after her diagnosis she received a machine she replied “Uh, I really don't know....well, the next year or two, somthin' like that.” She stated “they put me on my pills.” When asked if she believed the doctor and nurse did a good job talking to her about things she can do to be healthy she replied “Oh, yeah... 'cause I went to the doctor...he said, ...you look so good....he said, I'm just overwhelmed 'bout your blood pressure, and your blood sugar and your, uh, uh, uh, uh, oxygen level...and he said, everything is good.”

Susie reported great dissatisfaction with the content and amount of health related education she had been given by her doctor and nurse. She talked about a recent hospitalization and was very displeased because her admitting doctor “hadn't yet to tell [her] anything.” She spoke of a nurse trying to give her education related to her new medicine, but said the nurse just informed her that she should take it, but that the nurse also told her “Well, I have never used it. I have never given, uh, used this [diabetes

medicine] before.” Susie said the nurse “be constantly telling me what to do” but that she thought the nurse wasn’t sure herself. Susie discussed her opinion that health care providers “should do a better job” explaining information to their patients. She said her recent hospital experiences “are the kinds of things that make you kind of draw up from going to the doctor, paying a fee.” Susie did report someone talking to her about her blood sugar and what she was suppose to eat and not eat when she was diagnosed with diabetes; but overall was very unhappy with the amount of health education she had received in her lifetime. She added, “I’ve got arthritis and I’m stiff...I figured that I kept telling them that I found I’m stiff and I figured that they should say, well if the exercise is good, uh, certain things that, you know.” When asked what health care providers had talked with her about that would help keep her healthy, she replied “...they don’t tell you nothing...I have to figure that out on my own”

*Theme Eight: Limited Health Promotion and Disease Prevention Practice*

Theme eight emerged as data revealed that participants did practice some health promotion and disease prevention strategies, but that this practice and utilization of preventive options was limited at best. This theme resulted in four subthemes, which were the most commonly discussed health promoting and preventive behaviors. These themes were: (a) Vaccines: flu shot and pneumonia shot; (b) Procedures: colonoscopy, mammogram, pap and prostate; (c) Exercise; and (d) Healthy Diet. All themes and subthemes are listed as diversities in health seeking behavior.

*Vaccines*

Participants were asked about their use of and perception of two preventative vaccines, the flu and pneumonia shot. The pneumonia shot was seen as more acceptable

than the flu shot. Rationale for deciding not to take these preventative shots varied and ranged from being afraid they would get the flu, not remembering, not wanting anything that was not natural in their body, to not being advised to get one by their health care provider.

*Flu shot.* All but one participant said they would not or had not taken the flu shot. When Cole was asked if he had even taken a flu shot, he reported “No, never take a flu shot”, when asked why not, he stated “...I try to let my food be my medicine.”

Doris said “They prescribe me to take ’em but I don’t ever take that. I just don’t wanna take one.”

Elizabeth stated “I have not had the flu shot.” When asked if she thought the flu shot would cause her to get the flu she shared,

Well, I don’t really know, but I just never thought to go and get one. They had that one lady went, and she didn’t have the flu; and when she took the shot she had it. So I thought, ooh, I don’t need that.

Mary Anne reported

I don’t take no kind of shots”; and Shelia added “I don’t fool with that one.... ‘Cause I don’t...want all that mess put in me....I don’t know what it is no way.” Susie stated, “I don’t get that flu shot because....I will have the flu then.

Jay is the one participant that believed in taking flu shots. He reported “I don’t ever have a cold because I go take flu shots.... It knocks it out. I’ve got to go get me one. I ain’t had it none this year”.

*Pneumonia shot.* The pneumonia vaccine was noted to be somewhat more acceptable than the flu vaccine; but was still underused and unacceptable to some participants. Susie reported “I think I got a pneumonia shot one year.” Cole reported he had not taken the pneumonia shot and that he had no intentions to take this vaccine, as it was not a natural product. Elizabeth answered “nope” when asked if she had taken the

pneumonia shot. Mary Anne stated “I don’t take no kind of shots.” When Shelia was asked if she had taken the pneumonia vaccine she answered “Yeah...I had pneumonia,” but stated “no” she had not taken the shot and that a doctor or nurse had never advised her to take it. Shelia further added that she would not take it even if it was recommended to her. Conversely, Doris also reported “I never had no pneumonia shot”; but stated that if a doctor did recommend that she take one, she would.

### *Procedures*

Procedures discussed with participants included colonoscopies, mammograms, pap screenings, and prostate exams. While some participants reported having had these procedures, none were implemented according to the current United States Preventative Services Task Force (USPSTF, 2007) recommendations. Rationale for not having these procedures varied, but included a trust that God would take care of anything that was in their body, so there was no need to have a procedure performed.

*Colonoscopies.* Shelia and Mary Anne were the only participants that reported having had a colonoscopy. Mary Anne recalled, “They say they don’t see nothing...I don’t know...but they said everything’s fine.” Cole, Doris, and Elizabeth reported never having had a colonoscopy; but stated they would get one if it were recommended to them and if they had a problem. Elizabeth said, “If he recommended it I would take it...since he is my doctor, and if he would think that I needed it...I would take it”. Jay also reported that “if it helps to prevent that, whatever it is, I’d be glad to take it.”

*Mammograms.* Doris reported, “I had one [mammogram],” and have one “once a year”; but that “it ain’t been too many years ago” that she started getting mammograms. Elizabeth reported having had about three mammograms, but reported not beginning

mammograms until age 60. Shelia said she previously had mammograms, but stated "... I don't keep it up going.... it been a while." Her rationale for ceasing to have mammograms was rooted in her faith in God, as she stated "It don't bother me because whatever problems are gonna be, you know, the Lord take care of my body."

*Pap screenings.* Shelia was one of the few participants to discuss gyn exams and pap screening. She reported "I did all that...pap smear and all that stuff"; but, as described above she didn't believe she needed to continue with screenings. Shelia offered two reasons for ceasing this screening. She stated that "you don't put man over God...He got all the healin'," implying that God would take care of any problem she may have in her body. She also replied, "...I tell you I ain't gonna open, open myself up in front of no doctor."

*Prostate exams.* Only one participant discussed prostate exams; however there were only two male participants in the study. Jay reported having his prostate checked every three months. He stated "I have to find out the date I go back to the doctor for them to check me again....I'm doing pretty good."

### *Exercise*

Exercise was found to be a limited activity currently practiced by only a few participants. One participant (Cole) reported exercising at a level that exceeds current recommendations (USPSTF, 2007). Cole stated, "Well, I get up in the morning. I, I do about a hundred sit-up, and follow it with 50 pushups, then I touch my toe about two hundred times." He added, "I don't run every day, about maybe once, twice a week. ...I walk about a mile a day."



Other participants voiced a general knowledge that they need to exercise, but did not. Susie reported “I want to start back to walking”; and Shelia, who is disabled, informed the researcher “I can’t walk like I used to but I move around in this house....I don’t sit that still all the time.”

### *Healthy Diet*

Healthy diet was found to be a limited practice as well. This subtheme was listed as a diversity because of the variances in dietary practices among participants.

One participant reported practicing a nearly lifelong healthy lifestyle. Cole practiced a healthy diet more superior to the diet of other study participants. It was interesting to note this participant had nine siblings, eight of whom had diabetes, and he did not. Cole also did not report any health problems or medication use other than natural products. He described his water intake as follows,

I have a friend that has a well....It’s about ah, 250 feet deep, so....I get my water down there....I try to drink at least about, about like six to ah, six to eight glasses of water a day....But when I’m fasting I drink more than that. I drink about a gallon at least.” He spoke further of his healthy diet when he said “I used to go to...the grocery store and...I would buy...a box of oranges, a box of apples, a box of carrots, I make carrot juice in the morning for them to drink....Mostly I eat, I eat a lot of ah, lot of ah, fruits and vegetables.

When asked about his food preparation he described that “...most of the time when I cook...my food, I use ah, olive oil.” As far as meat intake, Cole said “...I use meat every once in a while....most meat I eat now is that deer meat.” He also reported eating chicken, but stated “...I raise my own chickens,” his rationale for raising his own chickens was that the meat was fresh and that the chickens were not fed hormones.

Doris spoke on her dietary practices and said she was told “don’t eat no salt,” but she reported “I eats a little bit. They tell me to eat that...diet salt....but I eat regular salt, but I don’t eat that much of it.”

Elizabeth reported she tried to practice a healthy diet and said “I mainly eat chicken and turkey and vegetables and fruit.” She further reported information concerning her efforts to eat the right type of bread, when she said, “...the bread Nature’s Own, now the nurse told me that that’s a good bread for me. I can either take the wheat or the white, but [the nurse] said two slices of that bread equals one slice of regular bread, so I buy Nature’s Own.”

Shelia also reported trying to eat the right type of food for her diabetes, but did not follow a schedule for eating, she stated “I can eat anytime....I don’t eat on time. I don’t do that....Not trainin’ my body like that....I know that I gotta eat....but I don’t and then sometimes, sometimes I fast’ed.” When she was asked if she took her diabetes medication when she was fasting, she replied “sometimes I don’t....Now I do it in the name of Jesus.”

#### *Theme Nine: Trust Help Available*

The final theme was a trust that help was available from multiple sources. The term *trust* was utilized because of the degree of confidence expressed in these various sources. Three of these sources were viewed as a universality: trust help available from (a) family (b) home remedies, and (c) professional health care providers. Four sources were viewed as diversities: trust help available from (a) community, (b) God, (c) medications, and (d) self.

#### *Family*

All participants reported receiving help from a family member when they were either sick or in need of health care advice. Family members varied from mothers to fathers, to aunts, and to other close relatives or in-laws.

Elizabeth reported trusting her aunt that was a nurse to give her advice. She stated "...even now, I call her sometime and ask her questions about my health...I'll ask her opinion." Susie and Cole reported trusting in their mothers to help them when they were sick. They both talked about how busy their father's were; and as Cole put it, when he was sick, his mother helped him, "cause [his dad] was always working every day."

Doris reported help from several sources, but felt especially trusting in her mother-in-law. She stated that her mother-in-law "was just like a mother to me"; and that "she know'd about the midwives better than my mother did." Doris also reported her mother-in-law giving her advice to stay healthy, which involved "taking castor oil ever time I had a bad cold."

Jay talked about trusting his father to help him when he was sick. Jay shared that it "wasn't nothing but me and him...if I get sick, he'd see to me, and get me well."

### *Home Remedies*

All participants reported trusting in the effectiveness of home remedies. Every participant reported that every home remedy they used worked; and thus there was basically no need to go to the doctor.

Cole discussed his use of remedies as a child. When asked what he used when he was sick, he stated "Home, home remedy, home remedy"; and when he was asked if he thought the home remedies worked well, he stated "it sure did."

Doris recalled, "...we never went to no doctor for no cold"; and when asked if the remedies worked she laughed and said "yes, ma'am." Even superstitions thought of as home remedies were thought to be effective. Doris discussed treating the chicken pox, as

“the ole sayin said, carry you in the henhouse and let the...chicken fly over your head.”

When Doris was asked if this worked, she said “I reckon so.”

Elizabeth discussed the use of shuck tea for the chicken pox, and reported “Well, that’s what I took. My grandmother made it...it made the little bumps pop out.” She further discussed the jimson weed as a warm compress as well stating “It worked.”

Jay spoke about his experience of using sardines over his jaws for mumps, and he also spoke very confidently about the effectiveness of this home remedy. He shared “daddy would get them old sardines and get a rag, and tie it around up on my, round up under my jaw....it worked.” Finally, Jay added, “daddy worked them home remedies back then. We all got them home remedies, and those home remedies worked.”

#### *Professional Health Care Providers*

All participants reported trusting that help was available from a professional health care provider. Rationale for seeking help varied; and frequency of visits were noted to have increased as the participant aged. All participants expressed awareness that, even if they did not use the health care system often, they trusted a professional health care provider who was available for help if they chose to seek help.

Elizabeth reported if she “had an emergency or something [that she] could go up to medical center.” Shelia remembered “we could always go to the doctor if we...had to go.”

Jay spoke of his trust in his professional health care provider. He declared, “The doctors, they’re keeping it flowing. They give me medicine to keep it, you know, from picking it up and clogging up. So I’ve been thanking them. They’ve been doing a good job.”

Susie spoke of her trust in a professional health care provider, when she shared the following story,

When I got to be about nine or ten, there was a doctor we used.... You [could] go and tell him what was wrong with your children or whatever. And he just. I remember my mother was picking cotton for somebody on his place or whatever, and...I think something was going round then, like...malaria fever I think. Yeah, I think that's what it was, and he was there and he came. And he was out there, and they didn't worry about things like we do now about being, you know, cautious of having things clean....He put his hand in his bag and got a handful of pills, and gave them to my mother and he [said]... to give them one of those pills and everything was okay....I don't know [what those pills were]. All I know, he just put his hand in the thing.

Cole was the participant most reluctant to seek traditional health care; however, he reported seeking health care from a professional health care provider for two fractures, a head injury, and for various mandatory job requirements. Cole stated "I didn't go to a doctor till I broke my arm in 1950." He also spoke about his preference for using the hospital for the delivery of his children verses a midwife. Cole additionally talked at length about trusted advice he had received from several physicians who extolled the value of using natural products and natural health remedies. Cole also sought help from a specialist after the birth of his daughter, who was born with a genetic defect. He shared, "When I saw [my daughter], I knew... something was wrong with her. See I never had experienced that before, and I didn't know what she was going through. But anyway ... I sent her to....see the doctor." He reported that he had heard there was "a specialist" overseas that could help them and so he sought help from this trusted doctor for his daughter.

### *Community*

Several participants talked about trusting the community for help in times of health crisis or needs. Cole shared his recollection of when someone was ill in their

community growing up. He said, But, but get sick, everybody would come to see you.... the women in the neighborhood, they used to walk about a mile or two to help, help you out.”

Shelia was the participant most vocal about her trust in her community members, and God, for help. She said, “they used to help feed us....and we’d knock on the door....We’d go there...saying we want...some newspaper and she’d give us the newspaper; and then I’d [tell my sister to] go back and ask for some bread.” Shelia recalled “she would give us, uh, toast and what they had for breakfast and she would save it for us....it was many people that helped – see, helps raise me.” Shelia also spoke of her strong confidence and trust in the local pharmacist; because he would help her get the medication that she needed. Additionally, she talked about the funeral director that lived in her community, and how he stood by her and helped when her son was shot. She said, “The funeral director at that time...he came in his car...and he got me and my baby and took us to the hospital.” After the death of her son she reported great support from the community, and recalled “people was comin’ and they was black and white....They doin’ supportin’.”

### *God*

All but one participant spoke about God, and their trust in him to help them when they needed help. The degree of trust varied according to whether the participant trusted God to help them with their health, along with a professional health care provider; or whether they trusted God alone to help them, without the use of a professional health care provider.

*With professional health care intervention.* Participants reported trusting God for health related help, but also discussed their use of a professional health care provider as well. Doris discussed a medical condition in which she sought professional health care, but also thanked God for his intervention as well. She stated “I went to the hospital the first time my baby was two years old....the Lord really been good to me. I still limp but thanks to the Lord it didn’t draw it up and I can still walk.”

Mary Anne shared her advice that prayer is helpful in trying to stay healthy or get well. She stated, “I tell anybody to [pray]...prayer will see you though, if you have a problem, pray about it. God will pull you through.”

Shelia, who also trusted God’s power without health care intervention, did report a trust in her doctor. She reported telling her doctor, “Well, I trust in the Lord, and...I trusted in you ’cause see God, He made you. He made me. But I’ll trust God ’cause he get to tell you what to do.”

Jay, who was pleased with his professional health care experiences, also thanked God for intervening in his health status. Jay said, “I have to thank the good Lord for my health, and my family and everything. Thank the Lord for the good health.” Jay further added, “I guess I ask the Lord to give me health and strength to let me see another day. That’s mostly what I depend on....prayer heals anything. Prayer heals anything and prayer works wonders. Shore do.”

*Without professional health care intervention.* Two participants reported an exceptional degree of trust in God for help with their health conditions. Interestingly, these participants were the most and least educated and reported both the highest and lowest income.

Cole spoke of his trust in God, and reported that he believed if God wanted us to take shots, he would have made the vaccine from nature. He added,

I was reading in, in the Bible. It was saying that...when God sent us this kingdom on this earth, there gonna be a tree....for each month of the year, and they gonna be for medicine....for the whole body....the only thing we have to do is keep God's commandments, and they would never be no sickness.

Shelia spoke at great length about her faith in God and discussed her thoughts on choosing not to take medications, participate in screenings, or have surgery because she believed that God would take care of her problems. She shared "I'm gonna put my trust in God. I'm trustin' in God."

Shelia reported taking medication for high blood pressure; however, she said, "I told the Lord. I told Him, 'I don't wanna take, I'm, I'm tired of these medicines'....I said, 'I want you to complete your healin' on me. I want you to get the glory out of it, not man.'" She said she was not going to have the eye surgery recommended by her doctor, because "One day, God gonna move the...cataracts. God's gonna move it." Shelia further discussed her thoughts that,

When you change and...if you are a, uh, strong believer in the Lord, you don't put man over God. He got all the healin'. My body belongs to Him....and I pick the blood of Jesus against cancer....anything in my body...whatever it is, I pick the blood of Jesus and I know his blood heals all. He said so. He said my blood. He didn't say your blood...He said my blood heals all sickness and disease. He healed my body when the doctor told me it was a big risk. When they said I...was hypnotized at the liver. [The doctor] said, 'You got a swollen heart....You got fluid around your heart...and you got it on your left lung'. He said, 'It's a big risk'....he said, 'If you take this operation, it's a big risk and if you don't take it, it's a big risk'. Now what they tellin' me....I took it to the Lord and I heard Him. I heard the Lord spoke to me. Just as plain as I'm talkin' to you. I heard Him, and He told me. He said, 'Not yet'. In a small quite voice. He said, 'Not yet'. He don't take care if you, if you doubtin' it.... You gotta believe.



### *Medications*

Trust in medications for help was common, but not universal. Two participants discussed not trusting medications. These participants were the two most educated in the group.

Cole reported that he did not take any medication and that he essentially did not trust anything that was not natural. Susie reported taking various medications for her high-blood pressure and diabetes, but not trusting certain diabetes medications, which did not work as she thought they should.

Other participants appeared to trust the medications they were prescribed. Elizabeth discussed going to the doctor to “take shots” in the spring and shared “back then penicillin must have killed everything.” Elizabeth also reported taking “Glucophage and Micronase...and “something called Lotrell” for her blood pressure. Jay reported great trust in the medication he uses; especially his Coumadin which helps his blood “from picking it up and clogging up.” Shelia also takes a number of medications for her chronic illnesses, and every once in a while needs a “sweet water sugar shot,” when her blood sugar get’s low.

### *Self*

Trust in self for help was most obvious in two participants. The two participants most trusting in their self to find out answers to their health related problems and/or seek alternative care were interestingly the most educated participants. Trust in self appeared to have been shaped from a disagreement with traditional professional health care system beliefs, or stemmed from un-happiness with the way they were treated within the health care system.

Cole reported reading many books to educate him-self on natural, alternative health care practices, as well as healthy lifestyle practices in general. He shared “I did a lot of research... I did a lot reading...searching.” He was well aware that his alternative, healthy lifestyle was not mainstream thought, but was not swayed by popular opinion. He read, decided for himself what was best, and then embraced his decision fully. Cole stated that his decision to practice healthy lifestyle behaviors resulted from his desire as a young adult, “to be strong like when I become an old man.” His advice to others who become sick is “don’t go to a medical doctor, go to a health food store and read about it...go to the health food store to try to find out something that [is] healthy that would get rid of that sickness.” When asked what could be done to help people not be sick all the time, he replied “I think they should read more.”

Many participants reported having to “figure that out on my own” when they were asked about what information they had received concerning their chronic disease, diet, exercise, screening or procedure recommendations. Most participants believed that they, as Cole put it “did whatever [they] could do.”

#### 4.5. Summary

Chapter IV provided a detailed description of the study findings related to the research questions posed. Themes and subthemes were described in detail. Verbatim excerpts were utilized to support the study findings. A discussion of these nine themes and their existence in the scientific literature will follow in Chapter V.

# CHAPTER V

## DISCUSSION, SUMMARY, LIMITATIONS, RECOMMENDATIONS, AND IMPLICATIONS

### 5.1. Discussion

The discussion section compares study findings with information in current research literature. Several themes had no or very limited related findings in the literature; while other themes had an abundance of information on the topic to support study findings.

#### *Theme 1: Not Sick*

The literature was searched for findings related to the term *not sick*. Similar synonyms were also searched. No studies were forthcoming on this particular theme; as no study revealed an older adult's recollection of wellness as a child. However, the concept of being well, wellbeing as an adult, or wellness, was proliferate in the literature (Dunn & Riley-Doucet, 2007; Reisig, 2006). No current studies were found to have investigated the older adult's perception that a healthy diet had impacted their state of wellness as a child. However, there was a study published in 1999 that found, among other things, that mother's did link a child's diet with health. Participants (N=40) were single African-American mothers with a low income. Children's diet was viewed as a

remedy and way to get necessary vitamins, which would in turn make a child healthy (Rainey, Poling, Rheaume, & Kirby, 1999).

### *Theme 2: Knowledge and Use of Home Remedies*

A review of the literature revealed the use of home remedies in populations similar to the study participants. However, only a limited amount of studies on the subject of home remedy use in similar populations was available in the current literature.

Previous studies supported the findings of this study, as described below.

Easom and Quinn (2006) surveyed 80 older adults, who were between the ages of 65 and 84, and who were living in a rural area. Findings revealed a high rate of home remedy use.

Another study (Smitherman et al., 2005) found that folk home-remedy use was prevalent in the African-American community. That study was conducted in Michigan, an urban setting, with caregivers (N=107) of black children. Although the study did not determine residential lineage of their participants, the study did discuss a common knowledge that most African-Americans living in Detroit had migrated there from the rural South. This was an interesting finding, as a number of the current study's participants recalled a brief or extended stay in Michigan or another area close to Michigan, during their early adulthood.

The study conducted by Smitherman et al. (2005) found that the use of home remedies was common to the African-American culture and that remedies were thought to be very effective, which was also a finding in the current study. Interestingly, many of the same remedies were reported in both studies, including: castor-oil, senna (reported as

*black-draught* in my study), catnip tea, and Tylenol. The need to cleanse the colon with various agents was also a similar finding in my study and this study.

Smith (2001) also examined remedy use in African-American children. This ethnographic study was conducted in Texas with 30 African-Americans and revealed the use of multiple remedies towards the pursuit of wellness. Several of the findings from Smith's study were similar to the findings within this study. Remedies noted to have been commonly reported in both Smith's study and this study included: the use of pine needles to make pine top tea, ragweed (used in my study to make rabbit tobacco tea), mullein (identified as mullein pasture tea in the current study), hog hooves tea, hog grease (reported as tallow in my study), garlic, catnip tea, cow-chip tea (identified primarily as many weed tea in my study), and of course castor oil. Sugar was a common additive in home remedy teas in both studies, as well as was the combining of multiple products to make teas.

Neither the Smith (2001) or Smitherman et al. (2005) study found the use of the jimson weed or shuck tea, which was the most commonly used and accepted tea in my study.

### *Theme 3: Child-hood Preference for Generic Folk-Learned Remedies*

Findings related to this theme were directly related to comments from participants in my study who used remedies as first-line treatment for common illnesses, and believed these remedies so effective that they rarely, if ever, went to see a doctor in their childhood years. Findings from my study were supported by Smith (2001) who also found that the African-American participants in her study sought professional health care only after using other community resources and folk-learned remedies.

Smitherman et al. (2005) studied folk remedy use in children and specifically looked at remedies for teething, colic, and fever. African-American caregivers (N=107) participated in the study. Findings revealed the use of a number of common remedies, but the study did not examine changes in preference for remedy use from childhood to adult years. There is minimal information in the literature on folk-remedy use and none was found on childhood preference for these remedies as a comparison with adult preference for professional medical care that developed over time.

#### *Theme 4: Adult Preference for Professional Health Care*

A review of the literature did not yield studies on adult preference for a professional health care provider. My study findings revealed a pattern of change in preference from home remedy use in childhood towards the use of professional health care in adulthood. Smitherman et al. (2005) found that, as adults, participants used both home remedies and the professional health care system. The current study revealed a combination of folk and professional health care use as well, but not to the extent found in the Smitherman et al. study. The literature contains information on the use of the professional health care system by adults who are African-American, have a low-income, and live in rural areas; but these studies do not address the change in preference from folk to professional care, over time.

#### *Theme 5: Need for and Use of Non-Professional Health Care Services*

Use of midwifery services in African-Americans and rural residents is well documented in the literature, and was also a finding in my study. Smith (2001) discussed findings from an ethnographic study that described the common use of midwives and reported that these midwives were “more available than doctors and were trusted by the

community” (p. 88). Smith also found that professional health care services were sought more as a “last resort” (p. 92) than a first response to an illness.

*Theme 6: Need for and Use of Professional Health Care Services*

A need for and use of professional health care services is well documented within the research literature; not particularly as the concept under investigation, but is evidenced through reports of persons similar to this population seeking health care from a professional provider. Smitherman et al. (2005) found the reason participants seek professional health care, even when their remedies were thought of as effective, are that “some families are reluctant to relinquish traditional beliefs but want to gain the benefits of modern technology” (p. 301).

Kessler and Alverson (2003) conducted a descriptive study which utilized convenience sampling in order to survey participants (N=82) who had a low-income, and were viewed as underserved and uninsured. Kessler and Alverson found several reasons why participants chose to seek health care from a professional provider. These reasons included acute problems of the respiratory system (17%), regular check-ups (17%), needing a refill of their medications (12%), and back pain (11%) (p. 81). Comparatively, my study found similar reasons for seeking professional health care, including the management of both acute and chronic illnesses.

*Theme 7: Limited Health Promotion and Disease Prevention Education*

The subtheme of receiving limited health promotion and disease prevention education from health care providers was probably the most disturbing information and possibly the most significant data resulting from the study. This was listed as a diversity as some participants reported receiving basic information, especially related to diet.

However, health promotion and disease prevention education related to the most prevalent chronic disease among study participants was limited at its best. Education concerning common screenings, vaccines, and procedures were woefully lacking. What is probably equally concerning is that most participants perceived they were receiving good health promotion and disease prevention education from their health care providers when they were not.

A multitude of preventive related publications are present in the literature. On review, it was noted that few studies examined the adequacy of preventive education in African-Americans who are older, have a low-income, and live in a rural area.

Higgins and Barkley (2004) examined barriers of professional health care providers in providing nutrition education to older adults. Barriers identified by health care providers included various misconceptions and mistaken beliefs related to the nutritional needs and issues of older adults, as well as other funding and learner recruitment issues.

Szilagyi et al, (2005) examined physician attitudes and practice of recommending adult immunizations. Physicians (N=316) provided numerous barriers related to providing or recommending immunizations to their adult patients. Influenza vaccine barriers included: issues related to the safety of the vaccine (58%), a dominance of the visit by an urgent concern (43%), and issues related to reimbursement (26%). Pneumococcal vaccine barriers included the above influenza barriers, plus no patient immunization history (36%). Physicians were also surveyed on various ideas aimed at increasing immunization rates; of the ideas surveyed, the top three most acceptable



possibilities included maintaining a list of patients who are not immunized (74%), instituting a tracking system (72%), and sending patient reminders (70%).

Finally, one study (Nicoleau et al., 2001) surveyed older African-Americans visiting their primary care physician and asked if they intended to get the influenza vaccine and if not, why. After completion of the survey, the participants were provided education related to the influenza vaccine by their primary care physician. A total of 44% of the participants had planned to take the influenza vaccine at the time of the survey; however, after discussing the vaccine with their physician, the number taking the vaccine rose to 63%. This 63% is incidentally greater than the targeted amount (60%) sought by national health objectives (Nicoleau et al., p. 59). This study emphasizes the impact that health care professionals can have on their client's state of health and wellness by incorporating health education into client visits.

*Theme 8: Limited Health Promotion and Disease Prevention Practice and Utilization*

My study revealed that participants did not adequately practice health promotion and disease prevention recommendations available in the scientific literature. This finding was supported in the literature. Multiple studies have found that African-Americans typically do not accept influenza or pneumococcal vaccines as readily as Caucasians. Several studies examined African-American barriers to and perception of taking these vaccines.

Bardenheier et al. (2006) examined vaccine related attitudes and knowledge in older adults (N=4822) living in a low-income area. Several ethnic groups participated in the study. A total of 28.9% of study participants (n=1494) reported not having received an influenza vaccine. African-American participants were found to have the lowest level

of immunization rates (50.2%), compared to Hispanic (31.7%) and Caucasian (20.7%) participants. Rationale for not receiving an immunizations were consistent with findings in my study, and included similarities, such as: a fear that they may contract the flu if they take the immunization, not knowing to get the immunization, and not having confidence or knowledge of content in the vaccine, and not remembering to get the shot.

Santibanez et al., (2002) examined beliefs about both pneumococcal and influenza vaccines in older adults (N=1007) residing in rural, suburban and urban areas. The study found that participants who were knowledgeable on symptoms and/or who believed that immunization against these pathogens was the best way to keep from contracting these illnesses were more likely to be vaccinated. Participants who did not believe they were at risk for contracting the illness and who were not aware that they needed to have the pneumococcal vaccine were less likely to be vaccinated. Similarities between the Santibanez et al. study and my study were that many participants reported they would take the pneumococcal vaccine if their health care provider advised them to; and one participant informed me that taking the flu vaccine would help him not to contract the flu.

A review of the literature also found a lower use of all preventive services, including screenings. Bazargan, Bazargan, Garooq, and Baker (2004) found that African-Americans with a lower socioeconomic status were not likely to seek cervical cancer screening if a provider had not recommended they have the procedure. Further, Johnson and Johnson and Nies (2005) identified possible barriers for participation in health promotion practices in African-Americans; they listed these reasons as primarily either financial in nature, time deficit related, or having to do with motivation.

Another study sought to determine potential barriers to physical activity as a health promotion practice. Walcott-McQuigg and Prohaska (2001) investigated exercise as a health-seeking behavior in older African-Americans (N=103) and utilized focus group participation. Exercise was found to be impacted by such factors as the participant's overall health, as well as their social support, inspiration to, and belief in the effectiveness of exercise. The primary barrier for women centered on their belief that they were too busy due to other family responsibilities.

Healthy diet practices have been studied as well. Higgins and Barkley (2004) examined barriers older adults faced to practice good nutritional habits that had been provided to them. Findings were generalized into categories, and included motivation, attitude, issues related to environment, lower economic status and a low level of literacy within the study population.

Kessler and Alverson (2003) found that persons who have a low-income are more likely to seek care for immediate concerns, rather than for health promotion or disease prevention purposes. This study supported the findings from my study. The Kessler and Alverson study offered some insight into a possible causation for this limited practice and utilization of preventive recommendations. If persons are not seeking specific prevention knowledge during their health care visits and health care providers are not providing preventive education (Ewing et al., 1999), due to a number of their self-identified barriers (Szilagyi et. al, 2005), then a lack of knowledge on the recommendations may be the ultimate cause for limited practice of preventive health behaviors.

### *Theme 9: Trust Help is Available*

The use of the term *trust* was based upon the degree of faith study participants expressed in their various chosen sources for help, when they had a health care need. Participants did not rely on any one source of help in isolation. Multiple sources of help were sought to facilitate the help that each participant needed. Sources of help changed over the years and moved from a source of family, community, and home remedies in the participants younger years; towards trusting professional health care providers, medications, God, and themselves as sources for help.

There is an abundance of literature on trust and importance of family, community, and God in the African-American population. There is less research available on trust in home remedies, medications, professional health care providers, and themselves. Probably the least amount of research is on trusting in one's self for help with health; although it probably exists, but has not been studied well as the specific concept under investigation.

A majority of the literature indicates that African-Americans have a distrust in the professional health care provider and system; however, there are studies that contrast with that information (Armstrong, Ravenell, McMurphy, & Putt, 2007). Neither trust nor distrust of the health care system was a consistent finding in my study. However, my study did find participants trust that help is available if needed from many sources, including from professional health care providers.

Boulware, Cooper, Ratner, LaVeist, and Powe (2003) compared trust in various health care system providers, including physicians, hospitals, and insurance companies. The concept of trust was further compared between African-American (n=49) and

Caucasian (n=69) participants. Study participants were both younger and older adults. The study found that the majority of all respondents did trust their physician (71%), and to a slightly lesser amount trusted the hospital as well (70%), with the least amount of trust being afforded to their insurance plan (28%) (p. 358). However, African-American participants were also noted to trust their physicians less than Caucasians, and to be more suspicious of potential experimentation in hospitals.

Dunn and Riley-Doucet (2007) conducted interviews in a qualitative study with participants (N=28) who were primarily African-American and female, to explore the concept of health and spirituality. The study resulted in five themes which centered around the concept of well-being. The themes that were similar to the findings in my study included the use of faith, and systems of support towards wellness and well-being.

Smith (2001) conducted an ethnographic research study that revealed an association between spirituality and health practices and beliefs for 30 African-Americans between the ages of 38 and 98. Polzer (2007) also discovered the importance of a spiritual connection between African-American participants (N=29) who had diabetes and their provider. This “spiritual relationship” (Polzer, p. 164) was found to assist participants to manage their chronic disease more effectively.

Trust in family for help is a common finding in African-American participants. One such study discussed the role of family support as source of help in persons experiencing a chronic illness (Rennegarbe, 2002). In that study, Rennegarbe sought to understand the lived experience of rural women (N=20) diagnosed with lupus. Participants reported receiving both emotional and physical support from their family members.

Rainey et al. (1999) interviewed participants (N=40) with a low-income, who were African-Americans and mothers. Participants were queried on the health and health practices of their children. A central finding in that descriptive study was a belief that community assistance in childrearing was best and that a modeling of health behaviors by community members was ideal.

## 5.2. Limitations

The study sought to understand the life experiences of the participants' health-seeking behaviors, within a described culture. This study included a small sample (N=7) of the culture, which was purposefully selected; however saturation of data was noted. In keeping with qualitative research premises the study population should not be considered representative of all members of the described culture. Thick description was included to allow the reader to determine if the study findings may be similarity applicable and transferable (Lincoln & Guba, 1985) to persons in a similar culture.

Another potential limitation of the study was that the findings were based upon the memories of participants who are older adults. For some participants, remembering was a difficult process, especially as it related to their family history and events that occurred early in their lifetime. However, multiple research instruments were used to allow for triangulation of the data. The genogram and time-line were noted to be helpful in initiating recall of past life events (Polit & Beck, 2004).

Previous potential limitations of the study were discussed in Chapter I. The first of these limitations involved a concern that it may take the researcher longer to develop rapport with the participants, due to the ethnic background differences between the researcher and the participants. Key community gatekeepers were used to make contact

with each participant, which resulted in greater acceptance, and no noticeable limitations concerning sharing. However, it is the researcher's belief that, had key community gatekeepers not facilitated the introduction and had there been no common trusted friend involved in making the connection and vouching for the sincerity of the researcher's intent, many participants would not have taken part in the study.

Trust and comfort in talking about life experiences was also listed as a potential limitation in Chapter I. The Tuskegee Syphilis Experiment (Kampmeier, 1974) was conducted in a location near the area of participant recruitment. Green, Maisiak, Wang, Britt, and Ebeling (1997) found that African-American participants (N=412) in Alabama, especially male African-Americans, were aware of the Tuskegee syphilis study (CDC, 2008) and this knowledge of the study negatively impacted their desire to participate in health related research. Recruitment of male participants in this current study was a difficult process. This difficulty in recruitment may have been due to a memory of the Tuskegee Syphilis Experiment. Participants may have had different perceptions concerning the researcher's intent and did not know the researcher personally. However, trust and acceptance of the key community gatekeeper appeared to translate into trust and acceptance of the researcher, in all those persons who did choose to participate in my study. All participants appeared to be relaxed and comfortable sharing during their interviews.

### 5.3. Recommendations

#### *Future Research*

Recommendations for future research are to focus on themes seven and eight of the findings in this study; as these themes have the most potential to impact the future

health of the population. Theme seven and eight found that there was a limited amount of health promotion and disease prevention education provided to study participants, and subsequently there was a limited amount of utilization of health promotion and disease prevention strategies. Future recommendations are to:

1. Conduct research on the knowledge of recommended preventive screenings, proper diet, and exercise, in populations experiencing health disparities; and to include a large group of participants.
2. Conduct research to gain an emic perspective on how preventive recommendations can best be disseminated within the population being studied.
3. Conduct local level research to gain information on barriers to practicing health promotion and disease prevention recommendations.
4. Conduct research on best practices in overcoming barriers to recommending and practicing healthy behaviors.
5. Conduct research on the nurse's perception of impact, related to not providing health education and preventive recommendations to their clients.
6. Conduct a retrospective review of health records from the health care system perspective on documented preventive recommendations and clients use of these recommendations.

#### *Implications for Nursing Practice*

Research findings indicate home remedy use is common in the older African-American population. Nurses should include questions on home remedy use when taking



health histories, and should address any remedies known to be contraindicated with their client's current medications or which are otherwise harmful to health.

According to participants, health care providers do not adequately provide preventive education to their clients. Therefore, nurses need to implement health related education associated to: age, gender, health status, and individual medical problems into every client visit. Furthermore, nurses need to be aware that their patients may not be current with screenings, vaccines, and procedures. Nurses should err on the side of providing too much, rather than too little education; especially as it relates to chronic disease and preventive recommendations. Nurses should assume that patients have not had adequate information on chronic medical conditions such as diabetes, and that clients may not be up-to-date on preventive screenings. If nurses and nurse practitioners adequately address health promotion and disease prevention recommendations with every client, the client and health care system as a whole could benefit from competent nursing practice.

#### *Implications for Nursing Education*

Findings revealed that patients generally perceived they were receiving adequate health related education. The reality, based upon participant report, is that these study participants were not receiving adequate health promotion and disease prevention education. Health promotion and disease prevention should be part of all nursing curricula, and is considered to be essential to the educational preparation of graduate nurses (AACN, 1996). However, nursing education of both advanced practice nurses and undergraduate nursing students must include in-depth practice in providing this preventive education (Satcher & Pamies, 2006). Nursing programs need to incorporate

health promotion and disease prevention education into the discussion of the management and treatment of acute and chronic diseases. This education should also include socioeconomic, age and cultural variances. Further, nursing students need to study the importance of providing health promotion education, examine the potential impact of not providing adequate health promotion and disease prevention education to their clients, and learn to incorporate questions related to home remedy use into their routine of taking their client's health histories.

### *Implications for Policy*

Study participants are not receiving adequate health promotion and disease prevention education from their health care providers. Nurse practitioners are primary care providers with an expertise in health promotion (Swenson, 2006). They are safe, well-accepted, cost effective, and especially important in rural settings (Lindeke, Jukkala, & Tanner, 2005; Swenson). Nurse practitioners can fill a gap in providing prevention recommendations in Alabama. However, the Nurse Practice Act (Alabama Board of Nursing, 1993) greatly limits the access this population has to the providers who are most likely to provide their clients with adequate prevention education. Further, the state's primary insurer continues to limit direct reimbursement to nurse practitioners. There is currently a bill in the Alabama State Legislature which would decrease the barriers to practice and increase the provision of prevention to its state's residents. The Alabama State Nurse Practice Act must be amended to allow nurse practitioners who are experts in health promotion to practice to the full scope of their education and receive adequate reimbursement from third party insurers.

Dissemination of study results to policy makers will increase the awareness of a need for funding for preventative services and education. Much attention has been directed towards the need for a national health care system. Policy makers should be made aware of the need to include funding for prevention services and education related to healthy behaviors in any new health care system legislation. Until there is a said national health care system, insurance companies should be mandated to provide adequate reimbursement for vaccines and procedures that will potentially impact the health of individual persons, society, and the health care system at large.

#### 5.4. Findings Related to Theoretical Support

Leininger's culture care universality and diversity theory (1985, 1988, 2001) was used as the theoretical support for the study. The theory was used as foundational support in shaping the importance of the study and the research questions. The theory itself was not tested. It was hoped that by identifying patterns of culturally significant health seeking behavior practices recommendations concerning appropriate mode(s) of action for this population could be made.

Leininger (1985, 1988, 2001) identified three modes of action. These were (a) culture care preservation/maintenance, (b) culture care accommodation/negotiation, and (c) culture care repatterning/restructuring (2001).

Theme four presented the findings related to adult preference for professional health care. This is an example of a finding that should be preserved and maintained. However, we as professional health care providers need to assure that we are doing all we can to earn the trust of our clients in order to maintain this relationship.

Theme two was related to the knowledge and use of home remedies. Although this finding was noted to be a significant practice within the study population, it was also noted to have decreased over the lifespan of the participants. Many of the home remedy products can be found at local health food stores (i.e., Catnip tea) and the practice of the use of these remedies may well be able to be accommodated with negotiation. For example, health care providers need to be aware of the use of home remedy products in each of our clients. The use of remedies could continue to be supported unless there is clear evidence of harm or disruption in the client's pharmacotherapeutic benefit or overall health status. One such harmful example would be the use of "bath and body", which is an aspirin product, with the use of Coumadin.

Another significant study finding was that participants in general do not take an influenza immunization. This is an example of a need for repatterning or restructuring thought. Patients need to be educated about the benefits of taking this immunization. Further, false beliefs concerning risks need to be dispelled through education. However, the education must be non-judgmental in nature and would best be performed by persons known and respected within the community.

## 5.5. Summary

This study sought to answer two research questions: (a) What are the lifetime health-seeking behavioral experiences of African-Americans who have a low income, are older, and reside in rural south Alabama; and (b) What are the common universalities and diversities in health-seeking behavioral experiences among study participants? The purpose of the study was to understand a lifetime of health-seeking behavior experiences as lived by persons who are African-American, older, have a low income, and reside in

rural south Alabama. Experiences were described as either a universality or diversity and were outlined in Chapter IV.

Data collection involved the use of De Chesnay's (2005a) life history methodology. Data analysis revealed nine major themes related to lifetime health-seeking behaviors: (a) not sick, (b) knowledge and use of home remedies, (c) child-hood preference for generic folk-learned remedies, (d) adult preference for professional health care, (e) need for and use of non-professional health care services, (f) need for and use of professional health care services, (g) limited health promotion and disease prevention education, (h) limited health promotion and disease prevention practice, and (i) trust help is available.

Participants reported a perception that they were *not sick* as a child, and often attributed this perception to their diet. Knowledge and use of home remedies was a prevalent discussion with all study participants, with tea use being the primary remedy reported. A child-hood preference for generic folk-learned remedies emerged as participants voiced using home remedies as a child and many recalled never visiting a doctor in their childhood and teenage years, because home remedies were very effective. An adult preference for professional health care followed a child-hood preference for generic folk-learned remedies. Most participants ceased the use of tea remedies and began using a professional provider for their health needs. Need for and use of non-professional health care services existed earlier in participants life, while a need for and use of professional health care services emerged as the participants age increased. Participants as a whole reported receiving a limited amount of health promotion and disease prevention education from their family and from professional health care

providers. This was probably the most significant finding of the study because if addressed appropriately, it has the greatest potential for impact on the health of the study participants. Data revealed that participants had a limited amount health promotion and disease prevention practice. This was to be expected after discovering that participants were not adequately educated on these preventive practices. The final theme was trust that help is available. Study participants trusted that help was available when they had a health related need. Sources of trust varied, but included: the participants family, their community, God, a home remedy, professional health care provider, medication, and their self.

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Appendix 1  
Rural Counties of Alabama



## Rural Counties of Alabama 2000

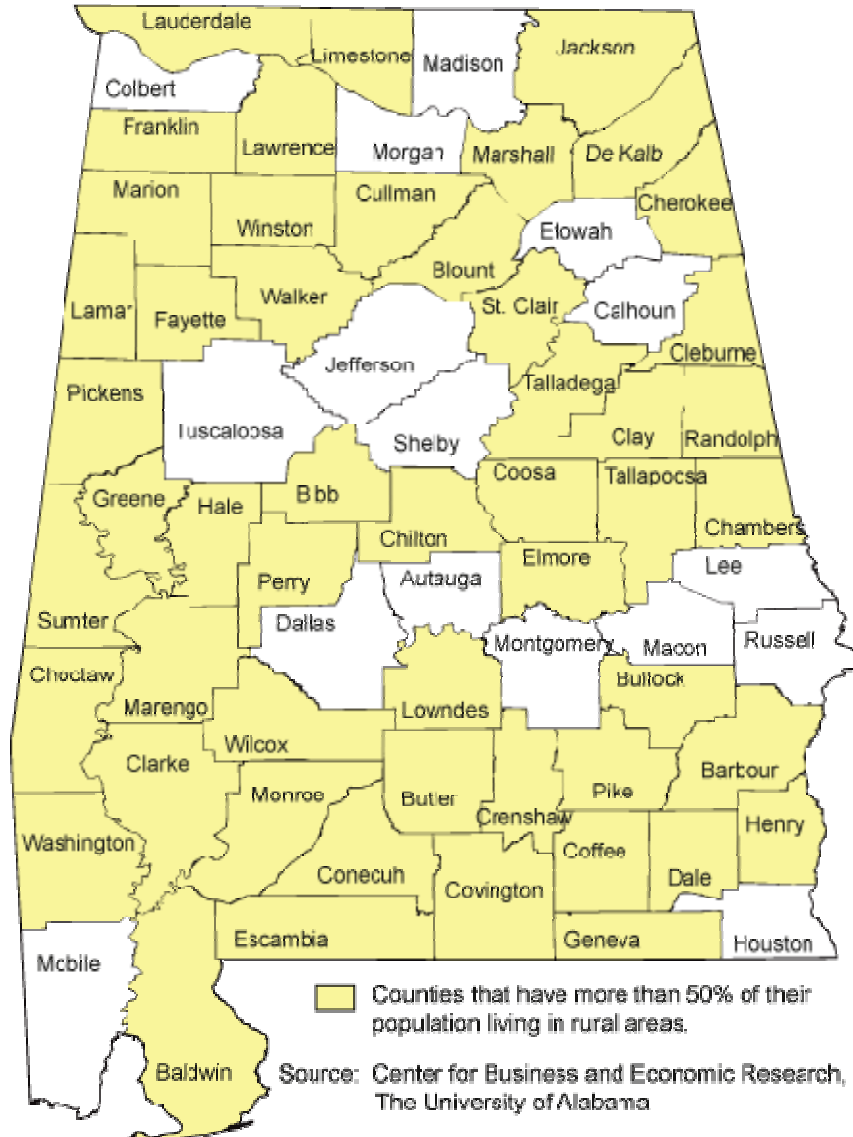


Figure A1. Rural counties of Alabama.<sup>2</sup>

<sup>2</sup> From “Rural counties of Alabama 2000”, by Center for Business and Economic Research, The University of Alabama, Retrieved April 3, 2008, from <http://cber.cba.ua.edu/edata/maps/images/PDFs/ALrural-2000.pdf> : The University of Alabama. Reprinted with permission.

## Appendix 2

### 2006 Health and Human Services Poverty Guidelines








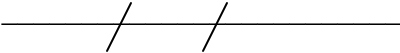
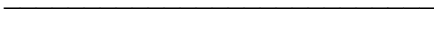
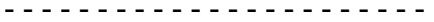
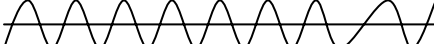
Table B1.

*2006 Health and Human Services Poverty Guidelines*

| Persons in<br>Family or Household  | 48 Contiguous<br>States and D.C. | Alaska   | Hawaii   |
|------------------------------------|----------------------------------|----------|----------|
| 1                                  | \$ 9,800                         | \$12,250 | \$11,270 |
| 2                                  | 13,200                           | 16,500   | 15,180   |
| 3                                  | 16,600                           | 20,750   | 19,090   |
| 4                                  | 20,000                           | 25,000   | 23,000   |
| 5                                  | 23,400                           | 29,250   | 26,910   |
| 6                                  | 26,800                           | 33,500   | 30,820   |
| 7                                  | 30,200                           | 37,750   | 34,730   |
| 8                                  | 33,600                           | 42,000   | 38,640   |
| For each additional person,<br>add | 3,400                            | 4,250    | 3,910    |

Note. Source: 2006 HHS Poverty Guidelines. From “*Federal Register*” Vol. 71, No. 15, January 24, 2006, pp. 3848-3849, by Department of Health and Human Services, 2006. Reprinted with permission.

Appendix 3  
Genogram Instrument Key

|                             |  |
|-----------------------------|--|
| Male Alive                  |     |
| Male Deceased               |     |
| Female Alive                |     |
| Female Deceased             |     |
| Research Participant Male   |     |
| Research Participant Female |     |
| Married                     |    |
| Divorced                    |  |
| Close Relationship          |  |
| Distant Relationship        |  |
| Conflict                    |  |

## Appendix 4

### Standard Time Line Instrument

Current Date



Birth

Appendix 5  
Interview Schedule



1. Tell me about yourself, what was it like for you growing up here? What was your life like when you were a child? What do you remember about being sick as a child? When you were sick, what did you or others do to help you get well? Tell me about anyone who helped you get well when you were a child, and your experiences with that. What do you remember about using special health remedies as a child? When you were well, what did you or others do to help you stay well? What else can you remember about being sick or trying to stay healthy as a child?
2. What was your life like when you were a teenager? What do you remember about being sick as a teenager? When you were sick, what did you or others do to help you get well? Tell me about anyone who helped you get well when you were a teenager, and your experiences with that. What do you remember about using special health remedies as a teenager? When you were well, what did you or others do to help you stay well? What else do you remember about being sick or trying to stay healthy as a teenager?
3. What was your life like when you were a younger adult? When you were sick, what did you or others do to help you get well? Tell me about anyone who helped you get well when you were a younger adult, and your experiences with that. What do you remember about using special health remedies as a younger adult? When you were well, what did you or others do to help you stay well? What else do you remember about being sick or trying to stay healthy as a young adult?
4. What is life like for you now? When you are sick, what do you or others do to help you get well? Tell me about anyone who helps you get well when you are sick now, and your experiences with that. Tell me about any special remedies you use now for health purposes. When you are well, what do you or others do to help you stay well? What else would you like to share with me about being sick or trying to stay healthy at this time in your life?
5. What do you think about going to the doctor? What do you think about going to the doctor when you are well, to get something like a shot to make sure you don't get sick later? What do you think about going to the doctor to have a procedure to make sure you don't have a medical problem? Tell me a little about why you would or would not decide to go to the doctor.
6. What do you think about using special remedies that are not prescribed by a doctor, for health purposes (like herbs, food products, or other items)? Tell me a little about why you would or would not decide to use a health remedy.
7. Can you think of anything else I should have asked you or anything else you would like to share with me about getting well or staying healthy?

Appendix 6  
Institutional Approvals



# DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

## CONSENT TO PARTICIPATE IN A RESEARCH STUDY

**TITLE:** Health-Seeking Behaviors: Life histories of African Americans, who are older, have a low-income, and live in rural south Alabama.

**INVESTIGATOR:** Leigh Ann Chandler Poole  
Samford University, Ida V. Moffett  
800 Lakeshore Drive, Birmingham, AL 35229  
205-726-2726

**Before agreeing to participate in this research study, it is important that you read or have someone read to you the following explanation of this study. This statement describes the purpose, procedures, benefits, risks, discomforts, and precautions of the study. It also describes your right to withdraw from the study at any time. No guarantees or assurances can be made as to the results of the study.**

---

**ADVISOR:** Dr. Joan Lockhart  
School of Nursing  
1-412-396-6540

**SOURCE OF SUPPORT:** This study is being performed as partial fulfillment of the requirements for the doctoral degree in Nursing at Duquesne University and is being supported by a grant from Sigma Theta Tau International, Epsilon Omega Chapter.

**PURPOSE:** You are being asked to participate in a research study that seeks to understand your life experiences and describe what you have done to get and stay healthy all of your life.

**IRB APPROVED  
VALID UNTIL**

**JUN - 5 2008**

**SAMFORD UNIVERSITY  
BIRMINGHAM, ALABAMA**

**Page 1 of 6**

**Participants Initials \_\_\_\_\_**

**DUQUESNE UNIVERSITY  
INSTITUTIONAL REVIEW BOARD**

**APPROVAL DATE: 5-25-07  
EXPIRATION DATE: 5-25-08**

**Informed Consent**

**TITLE:** Health-Seeking Behaviors: Life histories of African Americans, who are older, have a low income, and live in rural south Alabama.

**INVESTIGATOR:** Leigh Ann Chandler Poole, CRNP, RN

---

**EXPLANATION OF PROCEDURES:**

You will be asked to provide basic information about your age, income, race, and where you live. You will also be asked to spend no more than about 2 hours at a time with a researcher, sharing your life history as it relates to those things you have done to get and stay healthy all of your life. It may be that you will need to be interviewed several times, so the researcher is able to fully understand your experiences. During the study, you will be asked to talk and share information about important events in your life, your family history, and participate in an audio-recorded interview. The interview will be taped and transcribed. You may be asked to participate in another interview at a later time to confirm the information you shared.

These are the only requests that will be made of you.

**RISKS AND BENEFITS:**

There are no expected risks greater than those encountered in everyday life. Some people may find it painful to recall difficult experiences, but most people find it relieves their mind to tell their story to someone who is interested. The anticipated benefit of participation is the opportunity to discuss feelings, perceptions, and concerns related to your life experiences.

**IRB APPROVED  
VALID UNTIL**

**JUN - 5 2008**

**Page 2 of 6**  
**Participants Initials** \_\_\_\_\_

**SAMFORD UNIVERSITY  
BIRMINGHAM, ALABAMA**

**Informed Consent**

**TITLE:** Health-Seeking Behaviors: Life histories of African Americans, who are older, have a low income, and live in rural south Alabama.

**INVESTIGATOR:** Leigh Ann Chandler Poole, CRNP, RN

---

**COMPENSATION:** It will not cost you any money to participate in the study and **you will be paid a one-time amount of 20 dollars for participating in the entire study.** Please be aware that the interview may take place over several days so the researcher can fully understand your life experiences. Once your life history interview is complete you may be asked to participate in a different type of interview, to help the researcher confirm that she correctly understood what you have shared. If you participate in this separate type of interview you will receive an additional one-time amount of 10 dollars for your time and any inconvenience.

**PAYMENT FOR RESEARCH RELATED INJURIES:**

Neither Duquesne University or Samford University have made allowance for monetary compensation in the event of injury resulting from the research. In the event of such injury, Samford University will provide assistance to access health care services. The cost of health care services is the responsibility of the participant.

Page 3 of 6  
Participants Initials \_\_\_\_\_

**IRB APPROVED  
VALID UNTIL**

**JUN - 5 2008**

**SAMFORD UNIVERSITY  
BIRMINGHAM, ALABAMA**



**Informed Consent**

**TITLE:** Health-Seeking Behaviors: Life histories of African Americans, who are older, have a low income, and live in rural south Alabama.

**INVESTIGATOR:** Leigh Ann Chandler Poole, CRNP, RN

---

**CONFIDENTIALITY:** If you indicate willingness to participate in the study, your name will be kept confidential. Only the researcher will see the signed consent form. Only the researcher and participants will participate in the interviews. Your real name and any other identifiers will be deleted or disguised in the transcript. Audio-recordings made during interviews will be destroyed after they are transcribed into a written document and the researcher has verified the transcription is correct. Transcription of audio tapes will be conducted by a researcher or researcher-trained transcriptionist who has signed a confidentiality statement. In respect for your privacy, transcriptions will not identify you by your real name and will not identify any people you may discuss with the researcher by their real name. De-identified quotes will be used both in publications and presentation, so the response(s) you share will appear in study finding summaries, under the alternate name you will choose to use in this study. All raw data will be kept in a locked box at the researchers home when it is not in use by the researcher, and will be destroyed at the completion of the study.

**RIGHT TO WITHDRAW:** You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time, without penalty.

Page 4 of 6  
Participants Initials \_\_\_\_\_

IRB APPROVED  
VALID UNTIL

JUN - 5 2008

SAMFORD UNIVERSITY  
BIRMINGHAM, ALABAMA

**Informed Consent**

**TITLE:** Health-Seeking Behaviors: Life histories of African Americans, who are older, have a low income, and live in rural south Alabama.

**INVESTIGATOR:** Leigh Ann Chandler Poole, CRNP, RN

---

**SUMMARY OF RESULTS:** A summary of the results of this research will be supplied to you, at no cost, upon request at completion of the study.

**VOLUNTARY CONSENT:** I have read, or have had read to me all pages of the consent form and I understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. **On these terms, I certify that I am agreeing to and am willing to participate in this research project.**

I understand that should I have any further questions about my participation in this study, I may call Leigh Poole at 1-205-726-2726 for the principal researcher; the Advisor, Dr. Joan Lockhart at 1-412-396-6540; Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board at 1-412-396-6326; as well as Dr. Angela Owusu-Ansah, Chair of Samford University Institutional Review Board, at 1-205-726-2439.

Page 5 of 6  
Participants Initials \_\_\_\_\_

IRB APPROVED  
VALID UNTIL

JUN - 5 2008

SAMFORD UNIVERSITY  
BIRMINGHAM, ALABAMA

**Informed Consent**

**TITLE:** Health-Seeking Behaviors: Life histories of African Americans, who are older, have a low income, and live in rural south Alabama.  
**INVESTIGATOR:** Leigh Ann Chandler Poole, CRNP, RN

---

**This agreement states that you have received a copy of this informed consent. Your signature below indicates that you agree to participate in this research study.**

\_\_\_\_\_  
**Participant's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Participant's name (printed)**

\_\_\_\_\_  
**Researcher's Signature**

\_\_\_\_\_  
**Date**

**Page 6 of 6**  
**Participants Initials** \_\_\_\_\_

**IRB APPROVED  
VALID UNTIL**

**JUN - 5 2008**

**SAMFORD UNIVERSITY  
BIRMINGHAM, ALABAMA**



Appendix 7

Transcription Confidentiality Consent Form

I have been made aware of the sensitive nature of the research process and study related content and agree to keep confidential all information I am given access to, related to the study entitled *Health-Seeking Behaviors: Life histories of African-Americans, who are older, have a low income, and live in rural south Alabama*. I agree not to discuss or divulge information heard in the study's audio tapes, and understand the importance of a verbatim transcription of both the researcher and participants comments. I understand that this is a legal and binding contract.

\_\_\_\_\_  
Printed Name of Transcriptionist

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness / Researcher

\_\_\_\_\_  
Date

Appendix 8  
Demographic Form

**Important Information: It is important that all information you provide be truthful in order to obtain accurate results in this research study. The information you provide on this form will be kept confidential and will not be shared with any other person without your consent. Information provided will be kept in a safe location by the researcher and destroyed at study completion.**

1. Participant's pseudonym: \_\_\_\_\_

2. Age: \_\_\_\_\_

3. Race: \_\_\_\_\_

4. Have you always lived in a rural south Alabama area?                      Yes    No\*

\*If no, where else have you lived, and for how long?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Yearly household income: \_\_\_\_\_

6. How many people live in your home? \_\_\_\_\_

## Appendix 9

### Data Collection Process Checklist

1. Obtain IRB from DU and SU.
2. Ask for referrals from known key community gatekeepers using purposeful sampling.
  - a. Assure community gatekeepers are aware of inclusion and exclusion criteria and the need for referrals only to people who are known to be able to articulate their ideas and share information accurately.
  - b. Contingency plan will include snowball sampling, radio, flyers
3. Contact referrals and request their participation and inform participant of endorsement from the community gatekeeper who recommended them for study participation.
  - a. When determining interest in participation provide full disclosure to participant, inform them of the purpose of study, data collection methods, compensation for participation, and right to withdraw from study at any time.
  - b. Confirm gross ability to provide accurate information in the way of a life history interview through superficial conversation.
4. If potential participant wishes to participate, confirm participant meets inclusion criteria and speaks English language.
5. Determine comfortable, private location and convenient time for the interview.
6. Read consent form to participant and answer any study related questions.
7. Obtain informed consent by having patient sign consent form or make their mark.
8. Ask participant to select pseudonym to be used on all study related material.
9. Read demographic form content and questions to participant and record participants responses to questions.
  - a. If demographic data confirms eligibility to participant continue with data collection.
  - b. If demographic data confirms ineligibility thank person for willingness to participate and inform on reasons why they can not be included in study. Do not collect further data.
10. If demographics confirm eligibility begin data collection.
11. Remind participant about audio recording for which they have previously given permission in the consent form and ask if it is ok to turn on the recorder now.
12. If permission given, turn on audio-recorder.
  - a. If permission not given, explain why audio is needed – to assure accuracy of information obtained. If permission still not given, thank them for their willingness to consider participation and do not collect further data.
13. Begin Genogram data collection if permission to use audio-recorder has been obtained.
  - a. Record fathers side information on left
  - b. Record mothers side information on right
  - c. Collect information on 2 generations above and 1 below if possible.
  - d. Ask about close but not related friends and indicate by two parallel lines.
  - e. Indicate married with a solid line connecting two married persons.
  - f. Indicate divorced with a solid line connecting with two lines intersecting.
  - g. Indicate conflict in any relationship by solid line with curly intersecting line.
  - h. Indicate distant relationships by dotted line.
  - i. Male indicated by a square.

- i. Unfilled square if alive
    - ii. Filled square if deceased
    - iii. Participant square filled in with red color
  - j. Female indicated by a circle
    - i. Unfilled circle if alive
    - ii. Filled in circle if deceased
    - iii. Participant circle filled in with red color
  - k. Ask questions related to gender, health, relationship status, others very close who are not biologically related.
14. Complete Time line.
    - a. Ask questions related to critical (memorable) events beginning with childhood.
    - b. First question “Tell me about some important times in your life, beginning with when you were a child”.
    - c. Progress from childhood, to teenage life, to young adult, and after 65<sup>th</sup> birthday.
  15. Conduct Life History Interview.
    - a. Ask questions to answer the research questions, which are not limited to, but will include most if not all of the seven blocked semistructured open ended questions listed on the interview schedule.
    - b. At two hour time frame, if interview not complete, thank participant and reschedule another date and time convenient to participant to continue the interview.
  16. At completion of complete interview, provide compensation in the amount of \$20 in envelope.
  17. Ask permission to re-contact if need clarification or verification of data.
  18. Offer to provide copy of results, and/or genogram, timeline, interview copy at completion of study.
  19. Write supplemental field notes within an hour following interview
    - a. Includes thoughts about interview (non-verbal reaction, affect, response of participants and any environmental or contextual information I consider important), process, data which may need clarifying at second interview, and emerging themes or questions.
  20. Transcribe interview myself; or have interview data transcribed by a transcriptionist who has never lived in the county of data collection, after the transcriptionist signs a confidentiality agreement.
  21. Select a sub-sample of the participants for a member check/second follow-up interview. These participants will be purposefully selected based upon information shared during the initial interview.
    - a. Primarily the decision for choosing a participant for member check will be based upon whether the participant provided important data that needs either needs further clarification if the researcher needs to validate his/her interpretation of important statement(s).
  22. Conduct shorter follow-up interview for clarification or verification of interpretation of data on the sub-sample.

23. Thank follow-up participant and provide compensation in the amount of \$10 in an envelope.
24. Transcribe data into Word © doc as described in #20.



## Appendix 10

### Data Analysis Checklist

1. Verify transcripts for content accuracy by reading transcribed Word © doc while listening to audio transcripts and making corrections as necessary.
2. Import transcripts from interviews in a Word doc. format into the NVIVO 7 program under the “Cases” folder and label with participant’s pseudonym.
3. Import genogram information NVIVO 7 under the “relationships” folder and label with the participant’s pseudonym.
4. Import time-lines into NVIVO 7 under the “time-lines” folder and label with the participant’s pseudonym.
5. Enter demographic data for each participant case into NVIVO 7 under the “attributes” folder.
6. Enter field note data and general thoughts into NVIVO 7. Import these into the “memo’s” folder and label with each participant’s pseudonym.
7. Conduct data analysis and data collection simultaneously.
8. Code raw data from each individual interview as it is imported into NVIVO 7.
  - a. Code for professional and folk health seeking behavior practice data and other evolving concepts or ideas related to the research questions asked.
  - b. Code by highlighting key concepts, recurring words, and emerging themes, and then assign coded information into a category and save as a “free node” for further data analysis.
  - c. Link data to concepts for further analysis.
9. As new cases are added to NVIVO 7 and have been individually coded as described in #8, search all data cases as a group by running “queries” for reoccurring themes, thoughts, and ideas about the data as a whole.
  - a. Analyze data for both professional and folk health seeking behavior practices looking for similarities and differences, emerging and reoccurring concepts and patterns in the data.
  - b. Save important findings from queries and link data to concepts saved as “free” or “tree nodes”.
10. Promote free nodes (important concepts) to tree nodes (themes) and change category name as appropriate as data analysis progresses.
  - a. Organize both free and tree nodes by number of times the concept occurs in the data.
  - b. Link data to “free” and “tree nodes”.
11. Develop models related to research questions asked and link important thick descriptive data to each theme (tree node) or concept (free node) to allow further visual exploration of emerging findings.
12. Develop findings in thick descriptive narrative data which is linked to each theme and subtheme related to the research questions posed.
13. Provide detail related to context of setting and detailed data related to the unique characteristics of the study population to enhance the possibility of transferability.
14. Confirm findings with an experienced qualitative researcher by providing an audit trail including any needed information related to: raw data, analysis products, notes from member check sessions, and a final draft of findings.