

DEEP ROOTS SUPPORT NEW BRANCHES: THE IMPACT OF DYNAMIC, CROSS-GENERATIONAL RURAL CULTURE ON OLDER WOMEN'S RESPONSE TO FORMAL HEALTH CARE

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ABSTRACT

Rural, older adults experience marked disparity in access to quality health care when compared to their urban counterparts. One aspect of promoting health access to these individuals that has received little attention is rural cultural competence. Semi-structured interviews and review of cultural artifacts informed this case study of a rural, community-dwelling, 83 year old woman who is co-managing her chronic disease with the formal healthcare system. The purpose of the study was to situate the life story of one rural, elderly woman within the context of the rural culture that she has experienced, and, through the application of Bonder, Martin, and Miracle's (2002) Culture Emergent Theory, illuminated the theoretical and practical aspects of how dynamic culture influences health care practices and nurse-client encounters. Recommendations discussed include individual and system level strategies for developing cultural awareness, cultural knowledge, cultural skill, methods for participating in cultural encounters, and considerations for growing cultural desire. These strategies are considered imperative for the promotion of culturally competent rural nursing, nursing education, and rural patient advocacy.

INTRODUCTION

The increasing healthcare needs of the growing population of rural, older adults (age 65+) are a primary concern today amidst a rapidly changing rural culture and continued disparity in healthcare quality and service access (Cox, Mahone, & Merwin, 2008). In this case study, the reader will meet "Sarah" (a pseudonym), an 83 year old, rural woman who has been a lifelong resident of the Midwestern Plains. The purposes of this case study were (1) to illustrate evolving rural health beliefs and practices through a case study of an older woman residing on the Midwestern Plains, (2) to situate this case within a larger, dynamic rural culture by applying Bonder, Martin, and Miracle's (2002) Culture Emergent Model, and (3) to utilize the case exemplar to elucidate opportunities for integrating culturally competent approaches into nursing care for rural, older adults, both for patient satisfaction and improved healthcare outcomes (Bushy, 2008; Starr & Wallace, 2009).

METHODS

This case study was drawn from a larger study of rural healthcare needs done in the fall of 2007. The study was approved by the Institutional Review Board and informed consent was obtained from participants. Methods included semi-structured interviews collected through digital recordings and anecdotal notes, all which were transcribed for data analysis. Data was also collected through review of participant observation notes and cultural artifacts such as newspapers, photographs, and diaries. Data was reviewed by the key informant to verify accuracy three times throughout the analysis process. Interviews were conducted with a retired, rural health nurse; a rural clergyman; and the woman in this case study, who had been a long-term resident of a rural, Midwestern community. This elderly woman, who will be called Sarah, shared many aspects of her life with one of the investigators through multiple interviews in her home, albums of family pictures, and newspaper clippings. Excited about being part of this research, Sarah voluntarily wrote a reflective health diary in which she recorded memories of significant health and illness events throughout her life course. Writing the diary allowed Sarah to narrate what she considered to be significant behaviors that contributed to illness and health in her family, her beliefs about the efficacy of chosen treatments, and patterns of health preservation in daily activities. Collectively, these documents provided cultural artifacts that helped Sarah reproduce an in-depth recollection of her life and health history. She expressed her memories through a poignantly rural perspective of self-reliance and community interdependence. Her stories illustrated both the strongholds of rural survival and the changing aspects of rural culture as it is now lived out among her own (now older adult) children and continuing generations. This case study highlights some of the distinct cultural differences across historical cohorts, while enlightening similarities that endure across rural generations.

BACKGROUND

Rural, older adults in the Midwest experience vulnerability from multiple demographic effects that must be considered when assessing their health needs. Historically, the majority of rural, older adults tend to be widowed females, with up to 27% having less than a ninth grade education (Rural Assistance Center, 2009; Smith, 2003). Presently, Midwestern older men are more likely to have higher educational attainment than women. This gender difference contributes to an educational disparity among elderly women with lower lifetime earnings contributing to rising poverty rates (15.5%) and poorer healthcare access (U. S. Department of Agriculture Economic Research Service, 2007).

Many rural landscapes in the Midwest have sparse populations scattered across vast territories. Neighbors, friends, and family are often geographically distant in proximity from each other in comparison to urban communities, and individual households must be fairly self-sufficient for survival. Rural, older adults manage their health care in general isolation, separated geographically from healthcare providers, supportive services, and often emotionally from their community (Goins, Williams, Carter, Spencer, & Solovieva, 2005). Structural factors, such as lack of transportation and long distances to healthcare services staffed with medical specialists, serve as barriers to accessing care. Rural, older adults may have other reasons for not seeking formal care, such as mistrust of health providers, fear of hospitals, misunderstanding of program

qualifying guidelines, and failure on part of the healthcare providers to communicate meaningfully with this population (Harju, Wuensch, Kuhl, & Cross, 2006; Li, 2006).

As a result, rural older adults have developed pride in remaining self-sufficient, demonstrating interdependence only with trusted structures within their rural community. There are social, interactional, and cultural dimensions within these rural communities of geographically distant neighbors that involve an emotional closeness, reciprocal giving, and an informal healthcare network (Sebern, 2005). Related to this informal healthcare network, as well as to families' limited resources, a cultural norm is that rural, older adults put off seeking formal healthcare until their health needs are no longer manageable through self care efforts and the help of family, friends, and neighbors. Formal health care is sought more as a last resort for illness care rather than as an ongoing source of prevention and health promotion (Hayes, 2006). This pattern has been observed in other environments of poverty, scarcity and underdevelopment (Johansson, 1991).

Rural, older adults' historic need for independence has led to self care practices that take advantage of local resources, including the use of and belief in home remedies as fundamental to their healing. Herbal medicine is a central strategy for health protection and disease self-management, used by up to 62% of Midwestern older adults (Shreffler-Grant, Hill, Weinert, Nichols, & Ide, 2007). Midwestern rural elders also use the highest number of the over-the-counter medications in the form of analgesics, laxatives, and nutritional supplements for self care than any other U.S. elder group (Hanlon, Fillenbaum, Ruby, Gray, & Bohannon, 2001). Although effective to an extent, rural dwellers' familiar and accessible health resources remain limited to herbs and over-the-counter drug store medications due to continued geographic isolation, poor economic conditions, and the accepted norm of self-reliant health seeking patterns (Easom & Quinn, 2006).

With the technological advances in online information sharing, however, rural, older adults are expanding their social networks to include both traditional and online health information sources. Up to 41% of American adults, age 65+, report using the Internet as a health information source. However, they are most commonly getting their information from family members who are accessing online reviews posted by other healthcare users (Fox & Jones, 2009). The threads in the patterns of rural life, as discussed above, are clearly illustrated in Sarah's life story, below.

SARAH'S STORY

Sarah was born in 1924 to parents who farmed during the Dust Bowl era with its windy, sweltering summers and frigid winters. Sarah grew up in a small farmhouse without electricity and with a cook stove as the only source of heat. Sarah described each family member having a specific role that was necessary for the survival of the household. Sarah's jobs were picking up corn cobs from the pig pens and chopping wood for the family to burn in the cook stove.

Some routine activities that promoted survival also contributed to health. Saturday was bath day, because that evening the family would go to town to sell eggs and milk. A large copper boiler was filled with hot water in the kitchen and towels were draped over the chairs to provide privacy. "Mother kept us well by always keeping us clean and warm," Sarah said. While bath day contributed to cleanliness, hot clothes-pressing irons contributed to warmth. The irons were

wrapped in wool socks and placed at the foot of the bed to keep cold feet warm at night. Water boiled on the wood cook stove provided humidity to keep everyone breathing well.

Sarah attributed a great deal of her health as a child to the basic demands of her rural environment. "Daily walks to and from country school kept us well; reading by kerosene lamps made my eyes stronger." Sarah also valued the contribution of nutrition to health. "We drank lots of water. We always had fresh eggs and milk and we ate home-raised garden vegetables throughout the year that we preserved by drying or canning."

Sarah's only memories of going to the doctor were in times of emergency, such as her brother's appendicitis and her mother having all her teeth pulled due to gingivitis. Most of the injuries and illnesses that occurred during Sarah's childhood were managed at home or with the help of neighbors. "Mother and I would walk a mile to the neighbor's home to dress her wounds every day. We would also take things along for the neighbors to eat. We work together to get what needs to be done. We never let each other down, we were always willing to help out and work."

Upon graduation from school in 1941, Sarah married a neighbor boy, Dwight, who drove the school bus for her township. They moved in with his mother one month after marrying when, concurrently, Dwight's father died, a drought caused loss of production and income, and foreclosure on his parent's farm loomed as a threat. Sarah described this time as happy, but with lots of hard work milking cows and tending to the animals during the day. She gave birth to the first of her two children two years later, and her mother-in-law helped care for them. In times of injury or illness, Sarah treated the family maladies, including both minor and chronic ailments, with supplies from their medicine cabinet. These included common locally known treatments such as mustard plasters for respiratory ailments, vanilla for burns, turpentine for open wounds, alcohol for fever, mentholatum salve applied to the bottom of feet for colds, Epsom salts for swelling, mercurochrome for infections, aspirin for pain, bag balm for sore breasts, and a hot water bottle for sore throats and ear aches. Sarah did not believe in smoking or drinking alcoholic beverages. She valued getting lots of exercise with farming and involving their children with the livestock to decrease stress and maintain her family's health.

In 1948, Sarah's family experienced a series of catastrophes. A blizzard arrived on November 18th that kept them homebound for months and without coal to burn for heat. Dwight cut and gathered wood for the furnace, and when wood became impossible to find, the Red Cross airdropped coal in their front yard. To make matters even worse during this time, Sarah's mother-in-law was dying of cancer and required 24 hour care. "We were both so wore out. He did chores and cut wood all day and then would sit with his mother at night so I could get some rest." During the last two weeks of her life, her mother-in-law's pain became so intense that the Army flew in the community doctor to provide her with medicine. When she died, the weather required the Army to use a bulldozer to transport the family to town so funeral arrangements could be made. "It's your faith that carries you through the tough times. I am thankful to God for showing me the way to cope with stress."

Sarah's life progressed happily on their farmstead. Her children graduated from high school, married, and developed professional careers which moved them to more distant regions of the state. Sarah then worked outside the home as a social services advocate in her county, enjoying socialization with new people. Sarah and Dwight remained on the farm throughout their older adult years. "We rented out the land but kept our cattle. After all, you have to have some work to do on the farm to stay happy."

Sarah survived significant health events during her older adulthood that required functional assistance and emotional support. Sarah described losing her functional independence after a stroke in 1993 as her most difficult and stressful life event. She struggled to keep a positive outlook. “It’s strange how sometimes you find out things about your health you didn’t know. You have to be thankful to God for showing you the ways to cope with the stress. You have to have a positive outlook on life. You can’t dwell in the past. You do what you can to change and if you can’t, your faith carries you through the rough times.”

Sarah described how her life changed as a result of her stroke. Her daily routines were disrupted with frequent doctor and physical therapy visits, the need to arrange transportation, traveling long distances, and being away from home for several hours. Sarah felt that getting formal medical care, adapting to the new medicines and treatment regimens, including an eventual pacemaker, progressively lessened her autonomy and quality of life. She feared she might not be able to afford these treatments or manage them at home. Sarah was frustrated by her inability to comprehend the health information she was given during doctor visits. “They don’t explain things in our language; they don’t give reasons why you need to take the medicine.” Sarah said she did not always take her prescribed medication as ordered because she didn’t understand its purpose in treating her ensuing heart failure. Sarah commented tearfully that it was nurses’ support and encouragement that helped her get through these tough times. “I had a 1-800 number I could call and ask the nurses questions. They were so nice and always helpful. I don’t know what I would have done without them.”

Medicare benefits were also difficult for Sarah to comprehend and inhibited her desire to seek medical care, specifically when she received letters of non-coverage for healthcare services that resulted in high out-of-pocket costs for her. Lacking satisfactory explanations from her physicians about her health, she did not understand what symptoms warranted seeking further care. She felt her physicians did not understand her life or her suffering. “I felt like, oh, you don’t know how much it hurts to do this.”

Over the years, as Sarah watched her children grow up, she saw a change in how this new rural generation approached and managed their health and illness. “My kids are more aware of what services are out there to fulfill their needs. In my days, you were your own boss. Now with these government programs, there are a lot of regulations to comply by. These kinds of changes are stressful.”

Not everything is negative for Sarah in spite of the advancement of her chronic illnesses. She reports receiving a sense of love and belonging from her connections with her husband, family, friends, neighbors, their farmland, her dog, and her guinea bird. She continues to reach out and help her children and grandchildren through daily phone calls with them. She also sends cards to and calls homebound friends, as well as sends food and back issues of newspapers and magazines to neighbors. Sarah now embraces the improved socialization and independence she is able to maintain as a result of technology. “I do my shopping from home. My daughter is in the city, 70 miles away. She calls me from the store and I tell her what I want. Thank God for cell phones.” Thus, Sarah’s local social interactions, in combination with her embracing of communication technology, form a web of connectedness that bridges Sarah with friends and family at a distance while maintaining her sense of rural identity.

APPLICATION OF CULTURE EMERGENT THEORY

Bonder, Martin, and Miracle's Culture Emergent theory (2002) posits that individuals undergo changes in their cultural patterns over time through interactions with the environment and society around them. Cultural structures learned early in childhood are reinforced and negotiated as individuals experience new encounters over their life course. These cultural configurations influence beliefs and practices regarding health and illness care by creating dynamic decision-making boundaries. Five constructs guide the culture emergent process: culture is learned, culture is localized, culture is patterned, culture is evaluative, and culture has continuity with change.

Culture is Learned

Rural health lore is passed down through generations transmitted through observation and conversation. As new beliefs, values, and behaviors emerge from understanding different interactions, the learned culture is evaluated and subsequent group identity transformations occur (Bonder, Martin, & Miracle, 2002). Sarah's choice to delay seeking formal care is best understood through her cultural history of relying on lay remedies for self-care practices. These patterns over time became her rules for illness behavior, even as other options were becoming available. Thus, Sarah continued to act on learned culturally-designated decision markers, influenced by geographic isolation, her underinsured status, her historic need to learn and use self-care practices and lay remedies, and her pride in her autonomy and ability to work despite illness.

Only when Sarah's disease symptoms became debilitating, hindering her ability to accomplish daily household tasks, was the learned decision point on the rural continuum of where "healthy ends" and "ill-begins" triggered (Johansson, 1991). Accordingly, formal healthcare was sought when Sarah had her stroke, but she perceived the ongoing health maintenance care needed after the stroke as a threat to her quality of life through loss of autonomy. She feared she would not be able to afford new treatments or manage at home independently. Sarah's case reflects how poor accessibility and affordability of healthcare for rural dwellers impose a restricted definition of what it means to be "ill". In other words, rural, older adults are forced culturally and financially to manage their maladies independently without disrupting their task-performing role. It is not until an acute disease crisis forces their seeking of formal help that they consider themselves "ill".

Culture is Local

Health information is understood based upon local ideals, traditions, and norms. Localizing information is what makes it meaningful to both the nurse and the patient. With each clinical encounter, only part of the older person's rural norms are revealed based upon the social context and topic of discussion. Misunderstanding the rural cultural context can result in missed opportunities for nurses to clarify poorly understood information (Bonder, Martin, & Miracle, 2004). Sarah's frustration with medical encounters, for example, was largely due to receiving communication that was not presented in a localized language or context. The lack of culturally embedded meaning in the medical language coupled with the authoritative social status of the

physicians hindered Sarah's discourse with them. Sarah's poor understanding of the medical language lead to her lack of adherence with illness care instructions, because she did not understand the purpose of the medication or what symptom severity would warrant seeking further assistance. Sarah understood lay remedies much better and trusted them more because their purpose and use had been shared over generations in a language common to her community.

Culture is Patterned

Rural culture is patterned from both individual and social behaviors that become ritualized to the degree they translate into expressions of group affiliation (Bonder et al., 2004). Sarah's self care practices are influenced by historic, economic, educational, and environmental factors that have reinforced patterns of use and her belief in home remedies as fundamental to healing (Shreffler-Grant et al., 2007). Sarah reports her basic daily needs for maintaining health as a stable environmental temperature, a balanced diet of home grown foods, daily exercise through work, prayer, "cleanliness" through regular bathing, and stress management through caring for her farm animals. Sarah maintains and promotes her health in the same ways as her parents and neighbors had. Sarah's extensive use of home remedies for treatment of illness prior to seeking formal care is reinforced by several factors: (1) the easy accessibility via traveling salesmen, radio, and mail order catalogs; (2) local knowledge about and affordability of the remedies; (3) the marketing of many home remedies as appropriate for use in both animals and humans which promoted understanding of their indications and usefulness; (4) repeated successes in treating illnesses with home remedies and; (5) reinforced confidence in the efficacy of their use. Formal healthcare is used sparingly and is perceived to be less effective for the treatment of health problems due to the numerous barriers surrounding its use. While Sarah reports using formal care more than her parents had, the use of home remedies for health maintenance is not diminished, for many logical reasons.

Culture is Evaluative

Rural values are culturally engrained and influence one's sense of identity and social belonging. However, these values are constantly re-evaluated in terms of their relevance to the specific context (Bonder et al., 2002). Rural, older adults value a stoic, self-reliant attitude which places emphasis on self-responsibility for health (Bushy, 2008). This rural value includes maintaining a positive attitude despite increasing functional limitations. When Sarah's environment changes due to illness demands that challenged and blurred the boundaries of her usual health behaviors, it forced her value system to change. She chose to positively adapt to the changes around her (Bonder et al., 2002). Sarah's new values are built upon existing values and knowledge that rural culture had reinforced through social interactions and personal experiences over time (Bonder et al., 2004). Sarah's acceptance of her difficult transitions are as always, supported through her strong faith in God and the encouragement of her family and friends. These pillars help Sarah maintain a positive attitude, accept her functional limitations, and redefine a satisfactory quality of life, which allowed her to realize new opportunities in life and improve her overall satisfaction with her well being.

Culture has Continuity with Change

A culture has aspects that remain stable across time, as well as many aspects that constantly evolve as new generations bring innovative, contemporary ideas to assimilate into their environment (Bonder et al., 2004). Sarah's value for self reliance, home remedies, and family care-giving persisted across her life course into her children's generation. While Sarah provided in-home care for her mother-in-law, Sarah's children care for her with the aid of technology that provides immediate accessibility but still supports the rural cultural preference for independence. Remaining rooted in her basic rural values has given Sarah the stability to reach out and try new things. She has integrated formal healthcare and prescription medications into her illness management and has found that information accessed through the TV and Internet (via her children) provide her a large venue by which formal and complementary therapies can be accessed and researched.

The new generation of formally educated, technologically savvy older adults serves as a resource to yet older generations ("their parents") and demand rural healthcare services that both support their preference for independence and provide immediate accessibility. Each new generation and each new development in society will influence cultural knowledge and patterns as new experiences and environmental changes are encountered. Nurses can play a key role in addressing the needs of both the oldest-old and young-old generations of rural adults by understanding that cultural transitions are continual and normal (Hartley, 2004). The dynamic nature of rural culture requires that nurses seek ongoing cultural encounters and continual refinement of cultural awareness, desire, skill, and knowledge toward cultural competence.

IMPLICATIONS FOR NURSING

Culture constantly changes as it is created through the burdens of history and then is socially transmitted across generations (Pierpont, 2004). The lens through which culture is viewed has shifted from a static image of unchanging rules, beliefs, and behaviors to a dynamic image of continual change and adaption. Thus, becoming culturally competent as a health caregiver is not an end point but rather a life-long process. Campinha-Bacote (2003) theory of cultural competence provides a simple, yet comprehensive framework guiding this ongoing process, which involves five aspects of growth and learning: cultural awareness, cultural knowledge, cultural skill, participating in cultural encounters, and possessing and growing cultural desire.

Cultural Awareness and Desire

Cultural awareness, per Campinha-Bacote (2003), involves knowing one's OWN cultural values, beliefs, lifeways, and practices as well as increasing one's knowledge and sensitivity to those of others. Promoting cultural awareness in nurses who care for rural, older adults requires that nurses take time to reflect on their own place in relation to rural culture, and to become aware of their assumptions about rural elder's cultural norms and how they think these beliefs and behaviors affect elders' healthcare. Cultural awareness can be greatly expanded by seeking cultural knowledge.

Being more culturally aware, gaining more cultural knowledge through literature and cultural assessment of clients, hearing life stories, participating in cultural encounters, all tend to further increase cultural desire- the desire to know and apply even more culturally relevant approaches to nurse care (Campinha-Bacote, 2003). On an individual level, these five aspects of learning and practice can promote rural nurses': (1) knowledge and respect for historic methods of survival, including healing ways, passed down through generations, (2) willingness to and skill in being the learner and listener to stories, and (3) ability to create nursing interventions and education that balance and integrate long term cultural norms with ideas that are newly emerging.

Rural Knowledge

Cultural knowledge is the process of seeking and obtaining a sound educational base regarding various viewpoints of different cultures, and knowledge regarding specific social, biological, and physiological variations among ethnic or other cultural groups (Campinha-Bacote, 2003). Knowledge of rural culture, which can be gained from research literature as well as from rural residents themselves, provides nurses a basis for informed critical thinking about the logic of rural elders' behaviors. It forms a foundation for comparison between often stereotypical "group" cultural norms and the "individual" culture of each client, whose behaviors and beliefs are affected by both group influences and individual experience. This knowledge is important to gain accurate insights into reasons for each person's health behaviors. Seeking such knowledge from individuals requires development of one's cultural assessment skill.

Cultural Assessment

Cultural assessment skills greatly improve the ability of nurses to gain individual cultural information. A variety of cultural assessment tools exist (Giger & Davidhizar, 2004; Purnell & Paulanka, 2008; Spector, 2004) and can be adapted to the situation and time available. These tools provide guidelines for creating questions that, ideally, encourage clients to "tell their story." Liehr and Smith's (2008) Story Theory, recently described by Gobble (2009), offers much guidance regarding dialoguing with rural women and illustrates the power of this approach. This theory is based upon the view that "humans are born into an ongoing story or history (Reed, 1995 in Gobble, 2009, p.101). Stories unfold, as did Sarah's, as individuals interact with each other and their environment.

Stories, like culture, are dynamic and emerge over time. Story theory also "acknowledges that one's story continues even as it is being told" (Gobble, 2009, p.103). Maintaining an ongoing dialogue will help understand how the rural, older adult perceives both the communication and assimilation of the nursing intervention into their ever changing cultural context. Nurses, as a result, will develop improved listening and observation skills with rural, older adults when attempting to critically assess how their lived experience has shaped their ideals for care support amidst their changing health status (Bonder et al., 2004). Stories reveal an individual's deep rooted values and beliefs and how those interact with health and illness decisions. Deep roots can be built upon and can support the growth of new ideas as well.

Cultural Encounters

Nurses should also create cultural encounters for themselves outside the health care setting to better understand the social aspects that surround rural living. Shopping at the local market or dime store, attending a parish soup supper, or having coffee in the small town bakery presents opportunities for learning the local language and understanding the discourse surrounding community living and health. A trip to the local pharmacy will also be valuable to learn about common herbal supplements requested by older adults and the types of home remedies frequently used. Gaining understanding of the local cultural context through these experiences will help the nurse incorporate meaningful approaches into client teaching.

On a systems level, integrating of rural nursing theory, rural bioethics, and rural clinical practicum into nursing program curricula will not only promote development of rural cultural competence but also promote nursing students' desire to serve rural communities. Finally, cultural understanding of how health and illness behavior is locally defined and morally influenced by rural values and beliefs will assist nurses in surmounting contextual challenges when developing patient advocacy resources (Cook & Hoas, 2008).

CONCLUSION

Culture is complex, multifaceted, and constantly changing and growing. Rural culture is no different. The case study of Sarah illustrates the power of story to provide a personalized, contextualized understanding of the influences and logic of both group and individual cultural norms on health and illness. Within Sarah's world are others like her, a population of lifelong, rural dwellers who hold and are supported by deep roots: traditional rural beliefs and pride in their independence, self reliance, and community interdependence. Younger generations, tomorrow's older adults, include the more educated, technologically savvy baby boomers who have branched out to value the immediate accessibility of information and services spawned by the Internet, but who continue to be rooted in the values of independence and self-reliance learned from their rural upbringing. This pattern continues, with the youngest generations taking for granted that cyberspace can immediately span the distance between households and services within a rural landscape. The simultaneous existing of cross generational cultural worldviews calls for rural healthcare services that nurture the deep rural roots of independence and interconnectedness with community, yet, branch out into the provision of immediately accessible communication, information, and services that technology can now offer. Both the roots and the branches must be balanced. Growth of new branches will soon topple a tree with weakened, un-nurtured roots.

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