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People in the Appalachian Mountains have an increased prevalence in poverty, low educational attainment, and low employment opportunities that are associated with poor health outcomes. Also, the Appalachian Mountain people suffer stigmas that have been propagated since the late 1890s. However, much of the research has been an etic focus and the emic focus is limited. A qualitative study of emic care explored the ways people in the Appalachian Mountains of Western North Carolina assured wellbeing. Leininger's Culture of Care model was used to guide the study and discover emic ways of wellbeing.

The sample included 21 persons between the ages of 25 and 70 years old, persons who had lived in Western North Carolina (WNC) for 15 years of more and who had generational roots to Appalachia. Individual interviews were conducted in homes, at workplaces and in community settings after consent was obtained. Audiotapes were transcribed verbatim and analyzed through multiple levels to ensure trustworthiness, credibility and validity of findings.

Emic themes were identified and included Communal Caring Relationships, Spirituality, Place Matters, Grandmothers Caring, and Etic Care. Specific actions and situations within each theme were reported. For example, the Place Matters theme included participants relating their ingestion of healthy diet of fresh fruits and vegetables from the garden or locally grown (the land). Enjoying the outdoors was related to physical, emotional, and spiritual wellbeing. Spirituality was found to be a major

component in a sense of wellbeing, and was described by participants as going to church, not going to church and the old ways. The use of wild crafted herbs and home remedies occurred by the participants in this study.

Leininger's theory and model were useful in guiding the study, as were Spradley's ethnographic interview guidelines. The well-being discussed by participants provides the emic sense of wellbeing in the Appalachian culture. However, the model was not fully supported in terms of participants' discussion of challenges or barriers to wellbeing. Rather, the researcher was able to classify participant responses within the areas of physical, spiritual, and mental well-being. Perhaps this is another indication of how etic perspectives focus much of the perceived Appalachian and non-emic health. The findings provide an understanding of well-being and health that can guide future.

INVESTIGATING EMIC CARE IN APPALACHIANS

OF WESTERN NORTH CAROLINA

by

Delia England Frederick

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Approved by

_____
Committee Chair

I would like to dedicate this dissertation to the memory of Dr. Carolyn Blue. Dr. Blue was always smiling, encouraging, and excited to teach healthy ways. She taught me the obligation of all nurses to be of service to the community. Dr. Blue guided me to learn about epidemiological effects of health and disease. Her untimely death left an empty place in North Carolina. She was a leader and a servant to the people of The University of North Carolina at Greensboro.

APPROVAL PAGE

This dissertation, written by Delia England Frederick, has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

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Finally, I express my happiness from having met my classmate from the Fall 2011 cohort. I learned so much about ways of thinking and solving nursing and health care problems from all of you. I do miss singing before class with some of you and hope we can sing together again. I miss our weekly time together.

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CHAPTER I

INTRODUCTION

The Appalachian Mountain Region of the Eastern United States has some of the poorest health outcomes in the country. The Appalachian Mountain Region has an increased prevalence of poverty, low educational attainment, and limited employment opportunities (Appalachian Regional Commission [ARC], 2013; The Centers for Disease Control and Prevention [CDC], 2013). These characteristics are associated with poorer health outcomes and an increased incidence of disease. Appalachian populations die on average at younger ages (<75years) from disease than the US population on average, with the US being 49.5 per 100,000 and the Appalachian region being 63.9 per 100,000. There is a high correlation between premature mortality and economic distress index as derived by the ARC.

The Appalachian Mountain Region covers the range of mountains in the Eastern United States that extends from the upper most portion of Maine in the north to the rolling hills of South Carolina, Georgia, Alabama, and Mississippi in the south. The region defined by The Appalachian Mountain Region consists of 420 counties within 13 states. These states have mountain ridges or rolling hills of the Appalachian Mountain chain. The Northern most portion of the region designated by the Appalachian Regional Commission is in southern New York. The southerly most portions are counties in South

Carolina, Georgia, Alabama, and Mississippi. West Virginia is entirely within the Appalachian Mountains. North Carolina, Virginia, Maryland, Pennsylvania, and New York's most western counties are in Appalachia, whereas, Tennessee, Kentucky, and Ohio's most eastern counties are in Appalachia (The Appalachian Regional Commission [ARC], 2013).

The Appalachian Regional Commission was established in 1965 as part of the War on Poverty. The goals of the 2011 to 2016 strategic plan from ARC (2013) are to "increase job opportunities and per capita income to reach parity with the nation, strengthen the capacity of the people of Appalachia to compete in the global economy, develop and improve Appalachia's infrastructure to make the region economically competitive, and to build the highway system to reduce Appalachian isolation" (p. iii). These goals are meant to bring Appalachians into modern times by improving Appalachia's competitiveness in the world market, but industries have left Appalachia and jobs have been lost to overseas markets which adds to the challenges of Appalachians to improve their status in the US and the world.

There are still valuable resources within the Appalachian Mountains. The Appalachian Mountains are rich in natural resources, coal, timber, and environmental spaces for outdoor recreation. Resources for economic gain are available, but the resources for health care access are less readily available for people who live in the Appalachian Mountains. Health care costs, coverage, and access disparities are greater in Appalachian counties when compared to non-Appalachian counties within their states

and the United States (US). Medicare disability is correlated with economic distress, poorer health outcomes and the incidence of disease when healthcare cost, coverage and access index relationships are examined for Appalachian populations as compared to US populations (ARC, 2013).

Appalachia is rural and sparsely populated with only a handful of cities. Many families and communities are isolated from towns or urban centers. This isolation adds to the natural beauty of Appalachia, but isolation may be detriment to health care access. The Appalachian Mountains represent an environmental riskscape of chemical and non-chemical stressors that burden Appalachian people with physical illness, poverty, poor educational opportunities, emotional distress, and unhealthy habits. Riskscape is the allostatic load of lifestyle, environmental toxins, chronic stressors, low socioeconomic status and low educational attainments (Hendryx, 2012).

Articles about Appalachian care and health have been elucidated within the context of professional care-cure practices, and nursing practices, but there is currently no knowledge of a distinct Appalachian health lifestyle (Knight, 2012). Perhaps the lack of an emic understanding of Appalachian caring ways has prevented positive health outcomes for many Appalachian people. Emic caring is the generic folk ways of a people group. Conversely, etic care delivery comes from professionally trained people within a culture. The literature has been limited in emic ways of protecting wellbeing among Appalachian mountain people.

Purpose

This ethnonursing study of Appalachian people in Western North Carolina was conducted to elucidate the caring behaviors that are emic ways of nurturing and protecting wellbeing, especially as related to self, family, kinship groups and community. A second purpose was to focus the emic ways of wellbeing within the context of Leininger's Theory of Cultural Care Diversity and Universality. The research questions were:

What are the caring behaviors to nurture and protect wellbeing?

What were the caring behaviors that benefit the physical, emotional, mental, and spiritual wellbeing of Appalachian people of Western North Carolina?

What were the caring behaviors that neither benefit nor harm the physical, emotional, mental, and spiritual wellbeing of Appalachian people of Western North Carolina?

What were the caring behaviors that may harm the physical, emotional, mental, and spiritual wellbeing of Appalachian people of Western North Carolina?

Stigma

Appalachian people continue to carry the stigma of being backward and uneducated. Jack Weller (1965) defined the deficits within an ethnographic-like text, *Yesterday's People*. These same terms are used to describe Appalachians today. He described their strong family ties and kinship connections as a people-based culture. As a people who remain traditional instead of modern, Appalachian people are defined as

uncivilized (Fraley, 2010). The stigma of Appalachian people's isolationist behaviors existed before Weller's text and remain after.

Weller (1965) applied negative characteristics and these characteristics are commonly used to describe Appalachian people in research. Behringer and Friedell (2006) discussed the use of fatalism as incorrectly applied to describe Appalachian people in *Where Place Matters*. Ludke, Obermiller, Jacobson, and Wells (2003) recount the fear of Appalachians with lower educational levels and poor health literacy and poor health outcomes being viewed as hillbillies. Ludke and Obermiller (2012) further discuss the attitudes of health care workers who are from outside of Appalachian regions that bring the perceptions of backward, poorly educated, and fatalistic people with them. Often, the workers come for their required time for educational program experience or loan service payback into rural health then leave, never learning about who Appalachians really are.

The way health care workers view Appalachian people today is not unlike the way missionaries and land developers saw them in the late 1800s and early 1900s (Fraley, 2010; Weller, 1965). The natural resources of coal, petroleum, natural gas, copper, timber, and even gems were sought. Rights to natural resources were bought from mountaineers for minimal sums of money, far less than the market value (Caudill, 1965). Appalachian Mountain people were used as a cheap and dispensable labor in the dangerous work of mining and lumber works. Most of the men who benefitted from the income produced were not in the Appalachian Mountains or a part of its people. Current

and historic actions towards the Appalachian Mountain people would understandably produce a distrust of outsiders.

Fraley (2010) describes the concept of wilderness and people who live in the wilderness as untamed. Even in the early 1900s, undeveloped lands and peoples who lived there were believed to be without God, more likely tempted by the devil, and uncivilized. Missionaries in the early 1900s cooperated with land developers, who desired Appalachia's natural resources. Missionaries used the notions of wildness to ingress into Appalachia to save the people from fallen degradation, regression, and stagnation despite the fact that many churches were well established in Appalachia.

Weller (1965) continued to voice negative attributes of Appalachians as poorly churched as he described groups within a community belonging to two separate churches and failing to collaborate on important issues of need within the community. Weller described the Appalachian Mountain people as a closed-door culture, failing to advance as the rest of American society advanced. He defined the Mountain people as having the characteristics of individualism, traditionalism, fatalism, seekers of action, fearful, and person oriented.

Individualism is the product of living in isolated hollows within the mountains. There is a pattern of depending on one's own strength to survive. Weller (1965) conversely defined individualism in the mountain people as being self-directed for the purpose of one's own gain or well-being. Though he did recognize some of the actions which the Appalachian people needed to be collaborative, Weller ignored these actions as

he defined Appalachian people's actions as being for private good instead of public good. Weller even disparages the Appalachian people for taking advantage of the New Deal assistance and remaining as an isolated people in the hollows of the mountains.

Traditionalism is the adherence to old ways. Traditionalism has been defined as repressiveness in a display about Appalachians in the 1960s at the Great Smoky Mountains National Park (2015). Weller (1965) wrote Appalachian people do not look forward to the future but encourage an attachment to the past. Life in the Appalachian Mountains has been hard and uncertain. The mountain person carries out agriculture without scientific methods, he values the homestead with fond memories of good times. Even the music of the mountains is mournful, longing and lonesome. Weller even suggested Appalachian speech is backward talk about what was instead of what is or will be.

Fatalism is drawn from the harshness of the land, per Weller (1965). Fatalism is a passive resignation that approves and accepts undesirable conditions as the norm. The Appalachian Mountain person does not complain or question poor conditions or news. A woman who was interviewed during a time of severe unemployment stated to a reporter, "I guess there is nobody to yell to who could do any good anyway, is there?" (p. 37). This fatalism is connected to God's will. Weller described the children as repressed with no laughter.

Weller (1965) described Appalachian Mountain people as seekers of action, people whose lives are episodic. Routines in life are endured as the lull between

weekends of drunkenness, card games, or longer periods of hunting and fishing. The failure to prefer routines of stable work, schooling, participation in church and committees is in direct opposition to the routine-seeking life of American middle-class. In West Virginia, coal mining was a major employer. Weller called this an action-seeking behavior with its dangerousness, walkouts and strikes. Even taking the out-of-work benefits during times without employment was viewed in a negative light by Weller.

Weller (1965) describes Appalachian people as having a psychology of fear. Bravery and fearlessness are admired by Appalachian people. Tales of responses to danger are common. Despite this, Weller states Appalachian Mountain people are filled with fear. The Appalachian family is bound together by the fear as a need for each other's support and dependence. In addition, Weller describes a fear of misunderstandings that would create hard feeling between family members and others. No one is willing to press an opinion that could result in disagreement. Collaborative decision-making for all of life's milestones occurs. Also, decision-making falls under the venue of collaboration and agreement.

Appalachian Mountain people are defined as person-oriented (Weller, 1965). A person-oriented person has the goal of being part of a group. Conversely, an object-oriented person strives for a goal or object outside himself; a lifestyle, a status in life, an educational goal. The Appalachian Mountain person is not willing to separate himself from his relationships with others in his family, kinships, or community. Being person-oriented thwarts achievement and advancement in modern life but maintains the

interrelationships within the culture. Weller says this person-oriented way of being sees others as calculating, without heart, and manipulative for personal gain and a life of striving.

Yet, Appalachian populations are seen in a positive light for their strong family values and kinship connections (Fish, Amerikaner, Lucas, 2007; Gottlieb, 2011; Helton & Keller, 2010; Templeton, Bush, Lash, Robinson, & Gale, 2008). Family and kinship patterns can be the emotional, social, and spiritual support needed for the community and the person to be a success (Keefe & Curtin, 2012). The spiritual perspective of security in God's sovereignty and a sense that Appalachia is home, aids in the valued personal assets Appalachians have of living independently, being self-reliant, neighborliness, familism, sense of beauty and sense of place (Behringer & Obermiller, 2012; Helton & Keller, 2010).

The stigma of being of and from Appalachia is carried on in Western Health Care workers minds. The stigma of being isolated, traditional, fatalistic, action-seeking, drunkenness, and failures to prefer routine work, schooling, and participation in church and community committees continues. What Weller (1965) saw as a negative attribute being people oriented is described by others as having strong family values and kinship connections by other authors (Fish, Amerikaner, Lucas, 2007; Gottlieb, 2011; Helton & Keller, 2010; Templeton, Bush, Lash, Robinson, & Gale, 2008 (Fish, Amerikaner, Lucas, 2007; Gottlieb, 2011; Helton & Keller, 2010; Templeton, Bush, Lash, Robinson, & Gale,

2008; Keefe & Curtin, 2012). The sense of neighborliness, beauty, and place, along with a belief that God is sovereign could be attributes to support improved health outcomes.

Background and Significance

Health outcomes are often described in relation to morbidity and mortality rates (Halverson, Ma, & Harner, 2004). Appalachian health outcomes are significant in relation to hospitalization frequency, morbidity designation, and death rates between ages 35 and 65 (ARC, 2012; CDC, 2013). Cardiovascular diseases, that include heart attacks and strokes, occur at higher rates in Appalachian populations (Danzi, 2013; McCracken & Firesheets, 2012; Sergeev, 2013). Appalachian people have higher rates of cancer of all types as compared to the rest of the US (Fisher, McLaughlin, Katz, Wewers, Dignan & Paskett, 2012). Chronic lower respiratory diseases are attributed to tobacco use and industrial pollutants within Appalachia and occur at higher rates when compared to the US as a whole (Hendryx, 2012; Knight, 2012). The incidence of diabetes mellitus is higher in Appalachian population than the US population (Barker, Crespo, Gerzoff, Denham, Shrewberry, & Cornelius-Averhart, 2010; CDC, 2013; Denham, 2012; Tessaro, Smith, & Rye, 2005). Appalachian populations have higher rates of death at earlier ages for heart disease, cancers, strokes, chronic lower respiratory diseases, and diabetes mellitus (Hendryx, 2012).

In addition, county economic status is significant, since there is an association between economic status and health outcomes (ARC, 2013). The ARC defines the economic status of Appalachian counties by the three-year average unemployment rate,

per capita market income, and poverty rate of the number of people living below the poverty threshold. Depressed counties fall into the worst 10% of economic status in the US. Counties at risk are those that rank economically between 10% and 25% of the worst counties in the US. Transitional counties rank economically between the worst 25% and the best 25% in the US. Transitional counties fall within the median range economically of all counties in the US. Competitive counties rank economically between the best 10% and 25% in the nation. Attainment counties are economically strong being at or above 10% of the best counties economically in the nation.

The people of the Appalachian Mountain Region have been studied by numerous scientists from various disciplines. Qualitative and quantitative studies have asked questions about prevalent diseases, both physical and mental (Barrish, 2008; Brown & May, 2005; Burkhardt, 1994; Caldwell, 2007; Carmack, 2010; Cavender, 2005; Drew & Schoenberg, 2010; Gottlieb, 2001; Helton, 1995; Hendryx, 2008; Hutson, 2007; McGarvey, 2011; Rayman & Edwares, 2010; Schoenberg, 2011; Templeton, 2008; Tessaro, 2005). Research from the etic prospective of Western health care has occurred. However, studies about Appalachians' caring behaviors within the Appalachian cultural context and from the emic perspective are lacking.

The cultural values, beliefs and lifeways of Appalachians are relational and communal. Appalachians value independence, self-reliance, and pride. Neighborliness, familism, personalism, faith in God, humility and modesty are valued personal traits. Love of place, patriotism, sense of beauty and a sense of humor are part of lifeways.

Appalachians work hard. They are crafters of useful and beautiful tools. Song, music, and storytelling, as well as laughter, are part of the way of being. Being secure in God's hand is a strong source of support for Appalachians (Caldwell, 2007; Gottlieb, 2001; Helton, 1995; Helton & Keller, 2010; Templeton, Bush, Lash, Robinson, & Gale, 2008; Wagner, 2005; Welch, 2011).

The trait of familism may cause Appalachians to choose a greater pressing family need over their own immediate health need (Drew and Schoenberg, 2010). This cultural belief and consequential outcome may confound a Western Health care provider's sensibility. Familism is an aspect of relational priority that places concern for another person's welfare over one's own (Wagner, 2005). Well-being is best described as being able to do for oneself and family, instead of being free from disease (Brown & May, 2005). Socialization and childrearing are considered an all community job. The community, as well as parents and kinship members are involved in raising the next generation (Templeton, Bush, Lash, Robinson, & Gale, 2008).

Much of employment in Appalachia involves physical labor and working with one's hands. Jobs in Appalachia are agriculture, mining, logging, construction, and industrial blue-collar work (US Labor Bureau, 2012). These employment opportunities add a riskscape to the Appalachian environment, not only for workers, but for their families as well. Riskscape is the allostatic load of lifestyle, environmental toxins, chronic stressors, low socioeconomic status and low educational attainment (ARC, 2013;

Healthy Carolinians, 2012; Hendryx, 2008). Mortality in Appalachia is a disparity that is due to economic and ecologic factors (Borak, Salipante-Zaidel, Slade, & Fields, 2012).

The top ten causes of death in Appalachia are heart disease, cancers of all types, chronic lower respiratory disease, cerebrovascular disease, unintentional injury, Alzheimer's disease, diabetes mellitus, pneumonia/influenza, motor vehicle accidents, and suicide. Many studies have been carried out on chronic diseases and ten primary causes of death in Appalachian population. (Behringer, Friedell, Dorgan, Hutson, Phillips, Krishnan, & Cantrell, 2007; Blake, Shankar, Madhavan, Ducatman, 2010; Danzi, Hunter, Campbell, Kuperstein, Maddy, & Harrison, 2013; Halperin, & Reiter-Purtill, 2005; Hendryx, 2005; Procter, Bernard, Dearney & Costich, 2012; Tessaro, Smith, & Rye, 2005). Surveys and qualitative studies have tried to ascertain if Appalachians understood what healthy means by its Western Medicine definition of health (Barker, Crespo, Gerzoff, Denham, Shrewberry & Cornelius-Averhart, 2010; Della, 2011; Denham, 2012; Ely, Miller, Dignan, 2011; Zahnd, Scaife, & Francis, 2009). Other interventional studies have attempted to demonstrate how best to care for oneself and one's family to have positive health outcomes (Au, Cornett, Nick, Wallace, Wang, Warren, & Meyers, 2010; Cottrell, Harris, Deskins, Bradlyn, & Coffman, 2010; Griffin, Lovett, Pyle, & Miller, 2011; Howell & Fiene, 2005). It is not known what Appalachians view as best actions, attitudes, and practice for wellbeing within families and for themselves. A need for comprehensive information about Appalachian's health disparity issues exists by studying Appalachian people (Ludke, & Obermiller, 2012).

Cavender (2005) has described the historic folk medicine that was brought with various European groups to the Appalachian Mountains. Little is known whether Appalachians currently adhere to the historic humeral theories or herbal usage of generations in the past; Appalachian history of folk medicine (emic) use is not clear. Barrish (2008) did find the use of home remedies and herbals as a way to maintain wellbeing, but no explanation of how the remedies were used was given.

Pieces of Appalachian care have been elucidated within the context of professional care-cure practices, and nursing practices, but there is currently no knowledge of a distinct Appalachian health lifestyle (Knight, 2012), perhaps the lack of an understanding of emic caring ways has prevented positive health outcomes for many Appalachian people. The results of this study provide nurses and other health care workers aspects of emic caring behaviors that are congruent with a healthy lifestyle for Appalachian people. The stories told by participants provide aspects of emic behaviors that can be accommodated and the aspects of emic behaviors that need to be repatterned.

Conceptual Framework

Leininger (1995) developed the Theory of Culture Care Diversity and Universality (the theory) in order to assess, and then be able to provide culturally-sensitive care. Leininger "postulates human care is what makes people human, gives dignity to humans, and inspires people to get well and to help others" (Leininger & McFarland, 2006, p. 3). Leininger carried out an observer-participant ethnographic study in of the Gadsup Akunans people in the Eastern Highlands of New Guinea (Leininger,

2006) as a mean to support or refute her theoretical assumptions that caring is culturally defined, valued, and practiced. Care needs to be based upon cultural precepts of people groups in order for beneficial health outcomes to occur for those people. Cultures provide actions to help their people maintain health, attain health if ill, and to cope with disability or death. An in-depth understanding of the lifeways of a culture is needed to develop therapeutic responses and interventions of care towards individuals, families, communities and collective groups by nursing. For nursing care to be effective in providing healing, well-being, or to help people face disability or death; nursing care must be culturally based.

The ethnohistory of a culture supplies the background of a collective group of people. The factors of a culture interact and influence care behaviors. The ways care is expressed and practiced is influenced by generic folk ways (emic) and professional ways (etic) of a culture. Care is framed in an emic way, whereas health belongs within an etic context. A number of researchers have used the Culture Care Diversity and Universality Theory to guide their research (Evans, Bell, Sweeney, Morgan, & Kelly, 2010; Farrell, 2006; Frederickson, Acuna, Whetsell & Tallier; 2005; McFarland & Zehnder, 2006).

Evans, Bell, Sweeney, Morgan, and Kelly (2010) used the theory to consider the culture of nursing as compared to the new culture of critical care nursing. The authors described the ways new nurses to critical care had to learn the rules of the critical care environment, and to identify the key informants that would help them become successful members of critical care nursing culture. Curren (2006) and McFarland, Mixer, Lewis,

and Easley (2006) used the theory to reflect on the culture of nursing. Curren described the need for nurses to become versed in and aware of their responsiveness to all clients' cultural needs. The needs she addressed were effective communication within the language that clients speak, as well as the appropriate ways to discuss private, intimate matters. She addressed the needs of clients as having the person at the bedside who makes them feel secure regardless of a nurse's personal bias. Through several vignettes, Curren describes needs of behaviors unique to several cultures; the overall premise of providing appropriate cultural care is to present oneself as warm and accepting, to demonstrate a desire to meet the needs of the client and family.

McFarland, Mixer, Lewis, and Easley (2006) presented the work of a Midwestern university nursing school goal of increasing diversity within the nursing student body by recruiting, engaging, and retaining students from the varied cultures that surround the university setting. This is an Institute of Medicine ([IOM], 2005) goal for nursing. A diverse nursing workforce may increase the respect and acceptance of varied cultural groups within the US.

Understanding a word, phrase, or concept in nursing requires knowledge of the meaning not only in American English, but also in the language of nurses in other parts of the world (Frederickson, Acuna, Whetsell, & Tallier, 2005). These authors found the concept worry differed for native speakers of American English and Mexican Spanish. The concept analysis of worry in each language resulted in two different definitions of worry. Nurses would need to be aware of these nuances in language when caring for

people from diverse cultures. Although not framed in the Cultural Care Diversity and Universality theory, a physical therapist in Appalachia found the meaning of "I don't care to" (Blakeney, 2005, p. 162) differed from her understanding of the phrase.

Leininger (2006) provides six enablers to explore the domain of inquiry within ethnonursing research. The theorist states to provide an answer within the domain of inquiry an in-depth examination of data using both material and non-material evidence is needed. The Sunrise Model is one enabler. The other five are also needed to effectively explore a culture's caring ways. These enablers are the Observation-Participation-Reflection enabler, the Researcher's Domain of Inquiry enabler, the Stranger to Trusted Friend enabler, the Ethnodemographic enabler, and the Acculturation enabler.

The Observation-Participation-Reflection Enabler guides the researcher to obtain focused observations of the informants in their familiar and natural living or working environments. A gradual movement through the phases of this enabler allows the researcher to confirm findings from observations, ensure a sound data collection process and to obtain full and accurate data from informants. It is important for trust to be built between the researcher and the participants being interviewed. Reflection of observations noted within field notes and verification of analysis of data with informants is needed (Leininger, 2006).

The Domain of Inquiry is the research question. The research question must be carefully stated and then rigorously examined with regards to the theory tenets according to the criteria described by Leininger (2006). An in-depth examination of the data

confirms the findings and respond to the research question. Material and non-material evidence such as informant biographies, photos, written and verbal stories, as well as, data collected with the Observation-Participation-Reflection enabler helps to cover the aspects of care and culture related to the research question or Domain of Inquiry.

The Stranger to Trusted Friend Enabler is used as a powerful means for self-disclosure, self-reflection, and assessment of self towards becoming a trusted friend. Progressing to trusted friend allows the researcher to enter the world of informants to learn about care meanings and practices. Trust enables the researcher to obtain authentic emic data for understanding care meanings and lifeways within the culture. This enabler assists the researcher in becoming reflective of and honest about one's own behavior as one moves from stranger to trusted friend. This reflection may be likened to bracketing one's own thoughts and opinions about a culture, so that one can hear the emic cultural data (Leininger, 2006).

Ethnodemographics enabler uses open-ended interview questions to obtain data about informants to include their ethnic orientation, history, family of origin, socioeconomic factors, gender, and geographical location of living, environmental concerns such as water supply, building types, work, food sources, dietary habits and access. A short demographic questionnaire may be used for this or the data may be gleaned from the interview (Leininger, 2006).

The Acculturation enabler identifies the extent in which informants are more traditionally or less traditionally oriented in relation to their culture. The Domain of

Inquiry guides the questions used to assess acculturation and lifestyle patterns of caring behaviors within the culture (Leininger, 2006). Informants as members of the culture help define the culture under study.

The Sunrise Model is an enabler used to discover the cultural and social structural factors that influence care within a culture. The Sunrise Model allows the researcher to explore a culture within the context of the domain of inquiry. Material and non-material data are used as evidence of caring within the culture. The Sunrise Model is a guide to determine technological, religious and philosophical, kinship and social, values, beliefs and lifeways, political and legal, economic as well as educational factors that influence caring behaviors (Leininger, 1995; Leininger, & McFarland, 2006). The worldview of a culture is the overarching umbrella that influences care.

The Sunrise Model is an enabler used within the ethnonursing method. Ethnonursing is an ethnographic qualitative method that focuses on observing and interviewing as an open discovery of a group of people's worldview and its meanings as the worldview applies to care. Nurses can benefit from this knowledge to be able to provide culturally congruent caring to individuals, families, communities and collective groups (Leininger & McFarland, 2002). Ethnonursing focuses on caring, whereas Western health care focuses on health and disease.

Definitions

Leininger (1995) encourages nurses to focus on a culture's worldview of caring. "Caring refers to actions, attitudes and practices to assist or help others towards healing

and wellbeing" (p. 12). An effective use of Leininger's theory require an understanding of the theorist's meaning of factors in the use of the Sunrise Model. Factors are defined to enable researchers to consider what constitutes caring for a given culture. Cultural values, beliefs and lifeways provide the expectations of communal caring relationships of families, kinship relations, communities and collective groups.

Within the context of language, ethnohistory, and the environment, several factors apply to caring (Leininger, 1998; Leininger & McFarland, 2006). Spiritual, philosophical and religious factors are moral guides for daily living. Worship practices and ceremonies are a means of demonstrating spiritual concepts. Kinships and social relationships are the organizational structures of a culture that define family units, extended families, and communities. These relationships are the framework for providing protection, security, and concern for one another. Political and legal factors focus on how a culture effectively and successfully deals with local and communal affairs, address crisis situations, and maintain control within a culture.

Economic factors within a culture are not only the exchange of money for goods, but the reciprocal exchange of helping, sharing, and providing care for those in need (Leininger, 1998; Leininger & McFarland, 2006). Technological factors are the tools and resources needed for work, for artistic expression, and for celebration. Educational factors may be formal school systems for children and young adults, as well as the informal training of children in the necessary skills and knowledge to survive within the

ecological environment. Storytelling of the culture, as well as explaining the rules to live by, are part of education (Spradley, 1979).

Folkways of caring are the emic practices that nurture and protect the health of adults and children within cultures (Leininger & McFarland, 2002). These are the behaviors that are carried out at home and may continue within a health care setting. Folkways of caring provide assistance to help with wellbeing. Professional care is the etic practices that are formally taught within educational institutions. An example of etic care is Western medicine, the etic practice of identifying and treating disease. Etic care practice may fall into what western people would call complementary and alternative medicine. The ways a collective group look upon life and health will influence care and caring decisions.

Frederickson, Acuna, Whetsell, and Tallier (2005) state that a concept must be explained in a multi-cultural way with agreement from a multi-cultural team before it can be understood within nursing worldwide. Leininger (2002) supports that care is the essence of nursing and a distinct, dominant, central, and unifying focus. Just as worry has a subtle difference in meaning within Frederickson, Acuna, Whetsell, and Tallier's conceptual analysis from American English speaking and Mexican Spanish speaking people, care may have subtle meanings that differ from people group to people group and culture to culture. Language is how reality is constructed. It is necessary to understand the native language of a people to interpret their reality (Spradley, 1979).

Leininger (2006) defines care (caring) as “actions, attitudes and practices to assist or help others towards healing and wellbeing” (p. 12). Caring is a powerful dynamic action to help people maintain health, attain health or face disability and death (Leininger & McFarland, 2006). Similar words to care include conscientiousness, heedfulness, attention, focus, observation, and vigilance. Care is often used in the verb forms of caring or cared.

The CDC (2013) defines health as one of the domains used to define overall quality of life (QoL) including jobs, housing, schools, neighborhoods, culture, values and spirituality. The World Health Organization (WHO, 2003) has defined health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.” Within the broad definitions of health as defined by the CDC and WHO, Appalachia lacks complete positive healthy qualifiers. The word health will be avoided by the researcher to prevent influencing the use of a western medicine concept while exploring an emic Appalachian concept for wellbeing and care (Frederick, 2014).

Well-being may be the best qualifier for defining Appalachian health and care. A pilot study by the researcher found responses to questions using health as the overall concept provided eat right, exercise, get enough sleep, and see the doctor (Frederick, 2014). Well-being on the other hand is viewed as a good or satisfactory condition of existence characterized by health, happiness and prosperity. Brown and May (2005) found Appalachians view well-being as being able to do for oneself and family, instead

of being free from disease. The CDC (2015) defines well-being as the presence of positive emotions and mood, satisfaction with life, fulfilment and positive functioning.

Contribution of the Study

The focus on Appalachia and health has been primarily etic in nature. The need for a clearer emic perspective is required. There are few studies that explore the context of care or caring within the Appalachian culture. The failure of Appalachians to be on parity with national health outcomes may reflect a failure of nurses and western health care providers to meet the emic care needs of Appalachian people. This study provided the knowledge of Appalachian Mountain people of Western North Carolina's emic caring ways for themselves, within their families, kinship groups, and communities. The emic caring ways may help explain behaviors that are stigmatized as negative attributes by etic health care providers, but are considered as culturally beneficial behavior by Appalachians. The findings may assist nurses and other health care workers to understand aspects of emic caring behaviors for well-being that are congruent with a healthy lifestyle for Appalachian people.

Context

While the Appalachian region is the general geographic focus of concern, one state in Appalachia was used for the study. North Carolina has 29 Appalachian counties with Graham, Rutherford, and Swain being distressed. Alleghany, Ashe, Burke, Caldwell, Cherokee, Clay, McDowell, Mitchell, Watauga, Wilkes and Yancey are at risk. Alexander, Avery, Buncombe, Davie, Forsyth, Haywood, Henderson, Jackson, Macon,

Madison, Polk, Stokes, Surry, Transylvania and Yadkin are transitional. No counties have reached competitive or attainment levels (ARC, 2013). The economic ranking of the Appalachian counties in North Carolina contribute to the poor health outcomes for the people who live there.

The seven counties that lie in the western most region of North Carolina are Cherokee, Clay, Graham, Macon, Swain, Jackson and Haywood. These seven counties in WNC are mountainous, with the elevations of these most southern Appalachian Mountains being the highest in altitude and steepness of topography (The Appalachian Trail, 2015). These counties are rich in timber and spaces for outdoor recreational activities. Access to health care facilities and health care providers is limited. Health care outcomes are poor, employment and educational attainment is low. Morbidity and mortality are increased in WNC as compared to the US (ARC, 2013).

The number of medical doctors per county range from two to forty-one (County Health Rankings, 2013). All the counties are listed as Health Professional Shortage Areas, and Medically Underserved Areas/Populations (US Department of Health and Human Services, 2017). There is no hospital in Graham County with the closest being in Swain County. Clay does not have a hospital but has driving access to the hospital in Cherokee. The rest of the counties in Western North Carolina (WNC) have a hospital or two within the county, though the hospitals are small and without full service. The hospital beds range from 25 to 100+ within the seven western counties. West Care in Jackson and Haywood Regional in Haywood are the largest hospitals.

Chapter Summary

The purpose of this study was to investigate the caring behaviors for wellbeing among the population, with a context within the Appalachian Mountain Region of Western North Carolina. An ethnonursing study elucidated the caring behaviors that are emic ways of nurturing and protecting wellbeing. Leininger's (1995) Theory of Culture Care Diversity and Universality guided this research. The findings of this study compliment what is known from the traditional etic perspective. The western health care tradition may be able to provide care in a more culturally competent manner using the findings to preserve a lifestyle of wellbeing and health, to accommodate the healthy emic care actions, or to negotiate change of emic care behaviors that are harmful (Leininger, 2006).

CHAPTER II

LITERATURE REVIEW

Qualitative Research Methods Used in Studying Appalachian Health

Qualitative studies have been utilized to ask groups and individual Appalachian people about their thoughts on particular holistic issues. Issues such as tobacco cessation, intimate partner violence, use of folk medicines and herbs, cancer prevalence, patterns of care, education, spirituality, plans for preventative health care, physical activity, complaint of 'nerves', drugs and alcohol use, and the need for cultural competence by Western health care providers. Qualitative research can be defined as a group of research based on theoretical backgrounds that see humans and the human existence as having meaning to individuals, groups and cultures. The researcher used data collection methods and data analysis methods that seek to understand, clarify, and narrate that meaning (Munhall, 2012; Richards & Morse, 2013). A root philosophical stance of qualitative theory is hermeneutics (Ramberg & Giesdal, 2009). Hermeneutics frames linguistics and non-linguistic expressions as a way to understand and interpret communication. Heidegger believed hermeneutics is ontology. Hermeneutics is about man's condition and being in the world. Heidegger did not see hermeneutics as a methodology for human sciences, yet the human sciences supported by language as symbols that aid in understanding culture and reality has its beginnings in the use of hermeneutics.

Ethnographic research obliges the researcher to discover the meaning of reality from the insiders' views. Traditional ethnography involved traveling to some wild and primitive place (Richards & Morse, 2013). Observation, participation, and reflection on the observations by field notes occurred. The entire people group, and culture was observed to gain an understanding of their way of seeing reality. Interviews of individuals who are able to recognize the cultural aspects of their reality of being are needed for individual interviews, but people who are being in the reality of a culture can also provide rich data by interview. Spradley (1979) framed his ethnographic interview techniques by asking people to explain the symbols of words that define a group or culture, after having learned a grouping of words that seem to belong in the same category. This method may be helpful for researchers that speak the same language, but not the same dialect to protect against assumptions of meaning (Hertz, 2006).

Quantitative Methods Used in Studying Appalachian Health

Quantitative research uses measurable data to determine associations and relationships. Quantitative research comes from the positivist view of understanding the world. An understanding of the world requires sense experience (the five senses) for knowledge to be informed. Quantitative research tests cause, association, or relationship using statistical methods to support or refute a hypothesis of the research question. (Munhall, 2012; Richards & Morse, 2013; Spradley, 1979).

Studies of Appalachian populations compared Appalachian populations to non-Appalachian for incidence or prevalence of chronic disease and attributes that contribute

to chronicity such as excess weight, lack of fruit or vegetable consumption and low to no physical activity (Au, et al., 2010; Barker et al., 2010; Blake, Shankar, Madhavan, Ducatman, 2010; Carpender, 2012; Della, 2011; Ely, Miller, & Dignan, 2013; Griffin, Lovette, Pyle, & Miller, 2011). Surveys were used to collect data by either closed- or open-ended data. Barrish (2008) asked about complimentary or alternative medicine usage in an Appalachian population and was able to receive a listing of herbs and household products people used instead of going to the doctor. A reason expressed for using alternative care methods was the lack of access or affordability of Western Health Care services (Weisz, 2011).

Surveys and questionnaires clearly are an effective tool to quickly discover relationships and associations. Many of the studies in the Appalachian region were surveys or questionnaires. Perceptions, beliefs, and habits were discovered using this method. A detriment of surveys or questionnaire for the topic and the way information as told is established by the researcher. Data may exist that is needed to best address Appalachian health that requires allowing Appalachians to tell the story. Surveys and questionnaires were used by intercepting people as they entered a store or primary care provider's office, from people participating in a group, or random telephone dialing.

Research of Appalachian Health Framed by Leininger's Sunrise Enabler

Environmental Context.

Appalachians are a people group who live in mountainous terrain. Appalachians live in rural and isolated, geographically confined places. The people who live in the

Appalachian Mountains are viewed as a distinct group, and ethnically they are generally of European decent (ARC, 2013; CDC, 2013). Appalachians are viewed as a homogeneous group whose health outcomes are the poorest in the US for European American populations. The demographic characteristics of Appalachians in WNC are similar to the rest of the people in the Appalachian Mountains.

Cultural Values, Beliefs, and Lifeways.

Cultural values, beliefs and lifeways provide the expectations of communal caring relationships of families, kinship relations, communities and collective groups (Leininger, 2000). Appalachia can best be described as a collective society (Wagner, 2005). People in collective societies are more concerned with other people's feelings and welfare than their own issues. A person's identity in a collective society is connected with the community of birth and rearing. One's family connections, as well as one's position in the community, are very important. Self within Appalachian is developed within a collectivist orientation. Stepping away from the commonality of one's people would be "like separating from one's own flesh" (p. 59). Typical American fashioning of self is towards independence (Gottlieb, 2001), but for Appalachian's, self-fashioning remains within home and place, the mountains. This collective nature of Appalachian culture provides for a strong sense of family responsibility, not only within the nuclear family, but the extended kinship family and community as well (Helton, 1995).

The typical characteristics of this collective society are self-reliance, independence, and egalitarianism. Self-reliance is defined as reliance on one's own

efforts and abilities (Merriam-Webster, 2014). Reliance is the state of needing someone or something for help or support. Appalachians rely on themselves and their kinship and community for help. Independence is the freedom from outside control or support. Appalachians view the network of family, kinship and community support as being an indicator of self-sufficiency and independence within their culture (Templeton, Bush, Lash, Robinson, & Gale, 2008). Egalitarianism means a respect for human equality with respect to social, political, and economic affairs.

Helton and Keller (2010) interviewed a group of ten women who self-identified as Appalachian. These women were middle-aged to elderly. The women were asked to describe their growing up years, and how the way they were raised affected their ability to cope with adversity and struggles as adult women. The conceptualization of these interviews was constructed around values that Appalachian people espouse. The values were independence, self-reliance, and pride, neighborliness, familism, personalism, religion, humility and modesty, love of place, patriotism, sense of beauty, and sense of humor. Assets identified as affecting their ability to cope well were support, boundaries and expectations within close kinship ties; constructive use of time by hard work, sense of beauty in crafts, music and sewing, sense of humor in jokes and storytelling, place and religious support. Each woman learned to develop social competencies of neighborliness and being in person-centered relationships. Interactions required that no one behave arrogantly nor affront another person. Belief was that all people were equal and should be

treated with respect. Education was valued, since no one could take that away from you. Hard work was a must and helping out neighbors was common (Helton & Keller, 2010).

Discourse analysis uses written documents to determine the reality of a culture or group of people. Gottlieb (2001) read essays from honor high school students and social work graduate students that described their intimate connection to West Virginia (WV), their mountain home place and family ties. The value of place was a recurring theme for the group of mountain people who saw hard work as honorable. A criticism of this WV sense of identity and meaning to life has been that it is a romantic remnant of a past culture and love of place becomes a barrier to progress and integration into the American mainstream.

The rich responses of the high school and graduate students indicated a love for their state, Home County, and their land, kinship group, and community. Even though these students represented individuals who advanced their lives with education and job skills that could or did take them away from WV, many stated they returned to WV because it was home. It was home, where their families, history, and land reside (Gottlieb, 2001).

Appalachians are often described as a people for whom place matters (Behringer & Friedell, 2006). The Appalachian Mountains are loved for their beauty and family history. People who were born and raised in Appalachia will call themselves mountain or mountain people (Gottlieb, 2001). Mountain people are known for their storytelling, which keeps people rooted to their mountain homes (Chase, 2005), and also allows the

community to be aware of the bad outcomes of life-threatening diseases (Hutson, Dorgan, Phillips, Behringer, 2007; Knight, 2012; Tessaro, 2005).

Health Care Providers of Western Medicine have been frustrated in caring for Appalachians due to a social trait called fatalism. Fatalism may have a faith-based aspect which is ascribed as oppositional, prideful, apathy based on ignorance, or as upholding a quality of life (Welch, 2010). There is a logical reason to apply the fatalistic concept to Western Health care (Drew and Schoenberg, 2010). Families must choose from conflicting obligations when making decisions. Fear of bad diagnoses may be one component in decision-making, but competing demands on time, effects on the body, and competing advice and information influence decisions. In addition, a relationship of trust with the provider and the cost of treatment are influential factors. One woman pointed out, "well, if I went to the doctor, I wouldn't be able to afford the medicine. Couldn't afford the treatments, so what's the point of knowing?" (p. 271).

Prioritizing related to competing demands can be explained by the Appalachian culture's strong sense of familism. Familism is a sustaining emotional support within multigenerational families, kinship groups, and communities (Helton, 1995; Lengerich, Bohland, Brown, Kignan, Paskett, Schoenberg, & Wyatt, 2006). Often families in Appalachia suffer from limited economic opportunities and thus limited income (Drew & Schoenberg, 2010) that causes families to choose where money is spent for the overall good of the family, instead of solely considering a single family member. There are habits and behaviors that can contribute to wellbeing within Appalachian culture. Women

view themselves as healthy if they are able to carry out housekeeping chores and keep a garden of flowers and vegetables (Brown & May, 2005). Appalachians are known to be hardworking, though they may be poor. They are honest and friendly. Appalachians value their home and land (Brown, 2001; Gottlieb, 2001). Many can name the mountains around them and where their family had lived for generations (Wagner, 2005).

Appalachian ways of communicating require slowing down to socialize before getting to work on one's agenda. This way of communicating is important to their sense of personability (Gross, Lovett, Pyle, & Miller, 2011). Appalachians are reputed to speak slowly (Keefe & Greene, 2005). Slow speech is not the equivalent of low intelligence. The researcher who is patient will find that Appalachian people value egalitarianism in communication and are less concerned with rank. Appalachians give and expect to receive a personable relationship with those with whom they interact. Appalachians prefer to avoid conflict and see assertiveness as akin to violence. Communication is meant to support relationships and not damage them.

Focus groups were asked about their perceptions of healthy eating and what challenges existed for maintaining healthy diets. Key informants of the area helped to suggest and recruit members of the focus groups. Eight general focus groups (N=99) and 6 key informants focus groups recruited from community centers and churches discussed perceptions of healthy eating and unhealthy eating. The authors found many participants equated healthy eating with dieting and weight loss. Healthy eating means increasing

fruits and vegetables and decreasing soda, white bread, and greasy foods. The more natural the food the better with processed foods being bad (Schoenberg, 2013).

Tessaro (2005) wanted to know the knowledge and perception of diabetes risk in West Virginia Appalachia. The attitude that the development of diabetes was caused by laziness, lack of self-discipline, or eating too much sugar was prevalent. A belief that diabetes struck every other generation was prevalent. Barriers to early detection were common, since people did not go to the doctor because of a lack of transportation or money to pay for medical care. Many people felt diabetes was an additional burden on the family, thus kept quiet about having it. If diabetes was diagnosed, little education about how to care for oneself was offered by health professionals. Incorrect and limited information came from the person's social network. Stigma of the disease and little support for coping with diabetes occurred.

Webber and Quintiliani (2012) used a telephone survey to ask about barriers, motivations and self-efficacy towards weight loss to plan a future intervention for weight loss. The respondents had similar Appalachian demographic characteristics. Ninety-four percent were white. Twenty-three percent were high school graduates with 13.1% having college degrees. Twenty-five percent of participants had an income of less than $40,000 per year. Sixty-nine percent were overweight or obese. Two-thirds of the group reported participating in physical activity in the last month with those who had a diagnosed health condition being less likely to be physically active. There was an interest in receiving a physical activity program that helped with weight loss, with no clear mode of program

delivery was determined from survey responses. Time, current eating habits and physical condition were barriers to weight loss with health, appearance, and desire to feel better reported as weight loss benefits.

Rye et al (2009) used a survey to discover how readiness to change may affect physical activity in the face of a lack of place for physical activity. Without stating that the model used was the Trans-Theoretical Model of Change, Rye et al. classified each woman's readiness to change by the current level of physical activity and expressed plan to further advance physical activity. Chi-square (x^2) tests were used to determine statistical significance between readiness to change and barrier to physical activity, as well as, BMI of the individual participant. A Mann-Whitney was used post hoc to test specific stages and prevalence of perceived barriers. Bonferroni's correction was applied due to repeated applications of Mann-Whitney to determine alpha level required. The lack of support caused the greatest percentage of women not to participate in physical activity (52.4%), whereas, lack of willpower (50.8%), money (35.2%), time (30.1%), place (19.2%, and don't need more (6.8%) were also barriers. As BMI value increased the probability of one or more barrier being present increased. Time was the only statistically significant barrier for all groups as defined by readiness to change and BMI.

Kinship and Social Factors.

Kinships and social relationships are the organizational structures of a culture that define family units, extended families, and communities. These relationships are the framework for providing protection, security, and concern for one another. The concepts

of place and relationships are bound together in kinship patterns for Appalachian people. Studies have described ways of upbringing within a family and neighbor networks that result in an interdependence within the network, as well as support for becoming an independent person (Fish, Amerikaner, & Lucas, 2007; Gottlieb, 2001; Helton & Keller, 2010; Templeton, Bush, Lash, Robinson, & Gale, 2008).

A case study is often used to expose an issue that is not well known or to provide an example of an issue. Helton (1995) used a case study approach to explain the need for personalism and taking time to build relationship with Appalachians to have a successful culturally specific care practice.

Templeton (2008) asked about socialization of adolescence by significant adults in their lives. Templeton discovered many people serve in the socialization of adolescents in rural Appalachia. Themes included it takes a village, we do it all together, we are watching out for you, teach them responsibility, and giving them some leeway to make mistakes.

Appalachian kinship groups are involved in strategies of socialization for children and adolescents in the community. Parents, teachers, significant adults, and other community members do [child rearing] all together. The community is involved in affirming and guiding development of children and adolescents. Adolescents stated they were aware that everyone in the community was "watching out for you, monitoring behavior" (Templeton, Bush, Lash, Robinson, & Gale, 2008, p. 60). All persons agreed it

was important to teach responsibility and guide adolescents toward a time of independence “by giving some leeway” (p. 71).

Fish, Amerikaner, and Lucas (2007) explored parenting patterns of rural lower socioeconomic Appalachian mothers of preschoolers. The parenting styles in Appalachian mothers of preschoolers from rural lower socioeconomic status ranged from warmth with a level of expected behavior from the children to minimal responsiveness to the child by some mothers. The variance is not significantly different from findings of maternal parenting of the US as a whole (Fisher et al.). The relationships of parenting styles and child development are bidirectionally correlated. Mothers and preschool children interactions result in responses from one another.

Schoenberg (2011, 2013) carried out two anthropological studies, using socioecological methods consistent with ethnography. In a study using open-ended questions from a semi-structured interview the researcher asked people about the experiences and management of multiple morbidities. Participants were attending a clinic in a distressed county in Kentucky. The sample characteristics were people older than 41 and having had diagnosis of more than one chronic disease. The authors findings aided in an improved understanding of how vulnerable rural residents experience and manage several simultaneously occurring chronic health conditions.

Religious and Philosophical Factors.

Spiritual, philosophical and religious factors are moral guides for daily living. Worship practices and ceremonies are a means of demonstrating spiritual concepts. Many

express a belief that Appalachian people are philosophically fatalistic. Behringer and Friedell (2006) and Welch (2011) express that this belief is unfounded in its hopeless connotation. An understanding of Appalachian philosophy may be better explained in the Appalachian understanding of God's will and free will from the Reformed church as influenced by Calvinistic and Baptist beliefs (Mattei, 2013; Schellenberg, 2013; Vann, 2007). It is typical for Appalachian people to have a belief in God. This is not to say there are no people in Appalachia who do not belief in God; it is to say though, that the people who have lived in the Appalachian Mountains over generations, since the eighteen century, have believing in God and Jesus as their main religiosity.

Calvinists believe that there is human will and God's will. The human will of the Calvinist is bound within God's sovereignty (Mattei, 2013). Therefore, a person who chooses to be obedient to God has freedom of choice within God's plan for him. A person who chooses to live outside of God's grace (forgiveness of sin) has the free will to continue in his behavior, but still lives in a world that is under God's sovereignty. To Calvinists, there is little way to live outside of God's will. People can carry out decisions that are evil whether they are Christians or not.

Libertarians (Baptist) believe that there is human will and God's will. Libertarians have the religious belief that the self can be the center of decisions (Mattei, 2013). Within this thinking, actions carried out by an individual are directly related to his choosing and, thus the person is responsible for the outcome of the act. The belief is that liberty is complete and unrestrained. The thinking about God for libertarians is that God's actions

will be fair and just in all instances. God's will does not possess evil, human will does possess evil.

Reformed belief is in some ways a blending of Calvinism and Libertarianism (Mattei, 2013). It is described in the Westminster Confession of Faith (WCF). There is God's will and free will. One can choose to carry out good or evil. There are consequences for one's actions. With this view, mankind within an innocent state (saved by grace) has the freedom and power to will in a way that is pleasing to God. A natural man conversely is averse to good, and is dead in sin, thus his freewill actions are displeasing to God.

The relationship between fatalism and belief in how one's will is perceived is supported by the Appalachian belief that God has sovereign control, and people are able to choose for themselves. There is a security in God having a plan, even in bad events. Appalachians trust the plan is for their best interest. In fact, Stroessner & Green (2001) found that individuals who have a strong sense of free will and those who have a strong sense of God's sovereignty each have a strong internal locus of control. Fatalism has been incorrectly defined as meaning the person has no control. The Appalachian saying of "it's in God's hand" means God has the person's best interest at heart. Appalachians believe an event such as disease is in God's hands, and Appalachians will utilize health care as an instrument of God (Caldwell, 2007; Welch, 2011).

Burkhardt (1994) used grounded theory method that asks what is going on. It supports that reality changes as people interact and relate using symbols to express their

reality (Munhall, 2012; Richards & Morse, 2013). Burkhardt used grounded theory to interview 12 women who live in Appalachia their entire lives about spirituality as an essential component of the human condition. Burkhardt found that spirituality is a wholeness that permeates life as a process of becoming, being, knowing, doing, strength, meaning, journeying, and connecting to God or a Higher Power.

Educational Factors.

Educational factors may be formal school systems for children and young adults, but also describe the informal training of children in the necessary skills and knowledge to survive within the ecological environment. Storytelling of the culture, as well as explaining the rules to live by are part of education. Educational pursuit and employability skills are valued by Appalachians (Helton & Keller, 2010; Templeton, Bush, Lash, Robinson, & Gale, 2008). Positive social interactions between parents and children improve early educational outcomes (Fish, Amerikaner, and Lucas 2007).

The influence of educational attainment can be found in the educational aspirations and attainment of parents. Adolescents that lived in households that had at least one parent with post high school education were more likely to have college work as a goal (Brown, Copeland, & Worthman, 2009). Adolescents that came from working class families were more resistant to the philosophy of advancing oneself with post high school education ((Hendrickson, 2012). The rationale behind not seeking college education was that jobs in their town or rural area did not require post high school education. Parents did not want the child to go away; family closeness was more

important. Families encouraged adolescents to go into the family business or a vocational trade that did not require college work.

Knowledge in Appalachia, as in many rural regions, has been skills based. The knowledge of how to do things hands-on has been valued by Appalachian families and students alike (Hendrickson, 2012). Traditionally, employment has been in natural resources such as forestry, agriculture, and coal-mining with chemical industries and manufacturing processing the raw products (ARC, 2013; US Labor Bureau, 2013). The world economy has caused changes in work locations and structural changes in business economics has occurred, Appalachians have lost jobs. At its peak in 2008, Appalachia had an unemployment rate of 9.8% overall, with South Central Appalachia (KY, TN, VA, WV) having the highest unemployment rate of 11%.

Informational services are projected to be the most active job growth industry in the US (Fluharty, 2003). The rate of job growth related to manufacturing is much lower. The knowledge required for informational services is challenging for Appalachians living in rural areas to receive. The economy is now demanding employees with a combination of advanced education and creativity. Shaw (2005) found educational attainment in post high school degrees increased in the last decades of the twentieth century, but Appalachians educational attainment continues to lag behind more urban areas of the country. Appalachian students and families need to realize that science and technology abilities are needed to compete in current and future employment markets (Gabe, Stolarick, & Abel, 2012; Henderson & Abraham, 2004). Comprehension of science and

technology requires skills in reading comprehension and critical thought about context and meaning.

Eighty-four-point-five percent of the US population graduate from high school, but only 83.2% of Appalachian Region citizens graduate from high school. In the US 27.5% of the population has a bachelor's degree, but only 25.1% of the Appalachian population does (U.S. Census Bureau, 2009). People who live in Appalachia would benefit from a shift in thinking about educational attainment, to subsequently improve socioeconomic level and health.

Economic Factors.

Economic factors within a culture are not only the exchange of money for goods, but the reciprocal exchange of helping, sharing, and providing care for those in need. Economic opportunities typical of Appalachia are high injury risk jobs. The economic opportunities for much of Appalachia involve physical labor. Common jobs sources are agriculture, mining, logging, construction, and industrial blue-collar work (US Labor Bureau, 2012). Employment opportunities and their effect on Appalachians cause the Appalachian Mountains to be a riskscape. Riskscape can be defined as the allosteric load of lifestyle behaviors, environmental toxicants, and chronic stressors from poverty, poor employment opportunities, and low educational levels in Appalachian counties (Hendryx, 2008). Higher mortality rates from chronic heart, chronic respiratory and chronic kidney disease are correlated with living in coal mining counties of Appalachia. The incidence of

these diseases is greater in coal mining areas than non-coal mining areas of Appalachia (ARC, 2013; Healthy Carolinians, 2012).

The U. S. Census Bureau (2010) and the Appalachian Regional Commission (2014) monitor the poverty rates in states within Appalachia. When Appalachia as a whole is compared with the US, poverty rates are 16.1% and 14.3% respectfully. Some counties within Appalachia have minimal poverty rates when compared to the US, but Appalachia has some of the highest percentages of its population living in poverty. Educational attainment is associated with income generation. Those who do not have a high school diploma have median earnings of $19,000 per year, whereas those who graduate from high school have a median earning of $27,000 per year. Those who achieve a bachelor's degree have a median yearly income of about $47,000; and those with advance degrees may earn even more (US Labor Bureau, 2013).

Some sociological dimensions of Appalachians cannot be changed. Socioeconomic status, education, employment and leisure time activities can be changed. In Appalachia, low socioeconomic status and educational attainment are associated with poor health outcomes. It is important to consider the individual's demographics when thinking about healthiness and unhealthiness. Hendryx (2012) found that health outcomes may be related to the riskscape from environmental factors within Appalachian. Economic opportunities exert a role in disease incidence for Appalachian people.

Technological Factors.

Technological factors are the tools and resources needed for work, for artistic expression, and for celebration. While no research specifically addressed the artifacts of Appalachian technology, articles suggest the implements that are needed in Appalachian culture. An economy that is supported by agriculture would necessitate plows, tractors, trucks, combines, and animal husbandry implements (Employment Security Commission, NC, 2014). Older Appalachian women described the sense of beauty in crafts, music and sewing (Helton & Keller, 2010). These activities would require able hands, guitars, banjos, fiddles, a willing voice, and sewing machine or needle and thread. Implements for construction would be hammers, nails, saws, and logging would require axes and chain saws. Each manufacturing, trade and transport, professional, education or health service has its own implements to carry out daily tasks. Leisure and hospitality require a friendliness and willingness to show visitors the area. The technological implements used in employment increase the vulnerability to injury to people living in Appalachia (Hendryx, 2012). The employees are not the only people vulnerable to the riskscape of Appalachia; the population is exposed to the products of industry as well, placing their health at risk.

Political and Legal Factors.

Political and legal factors focus on how a culture effectively and successfully deals with local and communal affairs, address crisis situations and maintain control within a culture. The political values of Appalachians can best be understood in their

value of independence and egalitarian positions as well as the way children are raised to become successful individuals within Appalachian culture. Appalachians are less likely to participate in the federal political process. Appalachians believe they are able to influence local outcomes, but believe they are not heard at state and federal levels (Cassese, Zimmerman, & Santoro, 2012).

Bickel and Brown (2008) found Appalachians are more likely to vote Republican as it is consistent with their sense of self-reliance and independence. These authors comment voting patterns may be to their detriment in meeting disparate needs in Appalachian counties. The political situation of Appalachians is related to their socioeconomic status, educational attainment status, and their more frequent dependence on governmental health insurance than private insurances for health care access. Attributes of socioeconomic status, educational attainment and need for governmental assistance is associated with the poor health outcomes in Appalachia (ARC, 2013).

Generic (Emic) Folk Ways.

Folkways of caring are the emic practices that nurture and protect the health of adults and children within cultures (Leininger & McFarland, 2002). Behaviors that are carried out at home may continue within a health care setting. Folkways of caring provide assistance with wellbeing. Folk medicine practiced in Appalachia historically was not unique to the Appalachian Mountains but was from the practices that Europeans brought with them to the Americas (Barish & Snyder, 2008; Cavender, 2005; Weisz, 2011). Folk medicine involved the use of botanicals brought over from Europe or using similar plant-

life to treat known condition or illness. In addition to botanicals, metals, minerals, animal parts, and even urine and bowel waste product was used in curative measures. Some treatments were highly effective and some dangerous to health.

It is more typical today for Appalachian people to seek medical interventions from a biomedical physician, but there remain some individuals who treat illness with interventions that more closely resemble folk medicine (Cavender, 2005). Folk medicine was historically passed down from one generation to the next orally, but today those who are herbalists may read botanical and pharmaceutical resources to support their learning. What is more likely to be seen today is a blending of philosophical ideologies of health and illness from many health systems of the world.

The humeral theories that some healthcare providers may recall from their education is the foundation of the folk medicine brought to the Americas and the Appalachian in the 1800s (Cavender, 2005). The humeral theory is the balance of four body fluids: blood (hot), phlegm (cold), black bile (dryness), and yellow bile (moisture). These coincide with temperament people may have of sanguine (blood), phlegmatic (phlegm), melancholic (black bile), and bilious (yellow bile). The way to maintain balance was through medicinal plants and food within a hot/cold classification.

Cavender (2005) explored the folk-medicine practices by carrying out face-to-face interviews of Appalachians who lived in East Tennessee, Western Virginia, and Western North Carolina. Cavender found folk medical beliefs and practices are not confined to Southern Appalachia's poor undereducated class but may also be found

across socioeconomic classes where little research has been done. The knowledge of folk medicine has diminished. Cavender also found associating with a particular religion is not an impediment to effective health care delivery. The medical pluralism in Southern Appalachia encompasses more than biomedical and folk medicine, as complementary and alternative medicines are also used.

Much of the memory of folk medicine and humeral theory has fallen away with the event of germ theory and seeking bio-medical care. Health interventions that an individual participates in may reflect a pluralistic use of health care modalities and not only bio-medical health care (Cavender, 2005). It is easier to obtain over-the-counter medications at the store than find botanicals in the woods. Much of the older folk medicine knowledge is no longer common in most families. Cavender (2005) also provided a story of a local unorthodox healer of skin cancers in southwestern Virginia.

For safety's sake a health care provider should ask about supplements and herbals a person is taking. Cavender (2005) found that younger aged group adults are more likely to use herbals and supplements than people born before 1940. Assessment of all medications prescribed or otherwise should occur for all age and socioeconomic groups. Another important consideration is people may be treating themselves with home remedies in addition to received biomedical care. Health interventions that an individual participate in may reflect a pluralistic use of health care modalities. Whether this is healthy or not may depend on individual additions or omissions of needed care.

Professional Care-Cure Practices.

Professional care is the etic practices that are formally taught within educational institutions. Western medicine is an etic practice of identifying and treating disease. The ways a collective group looks upon life will influence care and caring decisions. Knight (2012) searched for distinctive patterns that may indicate an Appalachian health lifestyle. Data collected in the mid-1990s suggested a difference in tobacco smoking, seatbelt use, and alcohol use. These differences have disappeared in data collected in 2009. There is no indication of a distinct Appalachian health lifestyle from the research Knight reviewed.

McGarvey (2011) used a questionnaire to gather data about personal health status, health perception, and health care utilization using general linear models to show how health perception relates to stated health status. Health status was poorer and health perception was worse in residence of Appalachian counties. Health insurance did not make a difference in perception of health.

An effective way of aiding Appalachian people in identifying personal risk factors for disease is to help individuals and families write a health history. Au, Cornett, Nick, Wallace, Wang, Warren & Myers (2010) found aiding Southwestern Ohio families to write family health histories demonstrated the need to have more frequent cancer screenings. Participants discovered heart disease increased their risk of stroke and diabetes. Primary care providers who take the time to develop comprehensive family health histories and review the meaning related to risk will meet two goals of health care

provider-patient relationships for Appalachian people. Appalachian people expect health care personnel to take the time to talk and listen (Brown & May, 2005; Gross, 2005). A mutual trust must be built. There is a preference to insider caregivers to stranger outsider caregivers, especially if these caregivers provided care in the home. Insiders are people from Appalachia. Outsiders are people who are not from Appalachia. Appalachians have related that healthcare providers ignore what they say; this has resulted in frustration, anger and mistrust towards healthcare providers and resulted in Appalachians not returning for future care (Gross, 2012).

Access to a healthcare provider, as well as the need to listen to patient's concerns and ask for clarification if a word used by the patient is not known by the care provider must also occur. Some words that a provider might not know are high blood for too much blood, not high blood pressure. Another would be thick blood or thin blood reflecting consistency of the blood, not the length of time to coagulate. Having sugar does mean having too much sugar in the blood such as in diabetes, but it is still a good idea to clarify meaning instead of assuming meaning.

Weitz (2011) found Appalachians of Southwestern Virginia utilized chiropractic care for the health needs since accessing Western medicine practitioners was more difficult. People were able to get appointments or walk in to see the chiropractor, but there were long waits for getting an appointment with Western medicine practitioners. People were using chiropractic care not only for musculoskeletal problems, but for hypertension, diabetes, and mental health disorders.

A phenomenological study asked what it like is to have a particular lived experience. Caldwell (2007) interviewed nurse practitioners who were Appalachian and served in Appalachian communities in southwest Virginia. The stories related working within close knit communities as they meet holistic health care needs. Confidentiality and trusting relationships were part of what made working in close knit communities a challenge and a joy. The nurse practitioners were part of the close-knit community and knew their patients outside of their health care jobs as well.

Carmack (2010) observed care delivery in a medical van. Her research question was about confidentiality in the close quarters of a medical van. Staff interviews followed a period of non-participatory observation. The mobile health clinic staff focused on providing medical care in a rural impoverished area of Appalachia, but had challenges related to maintaining the rules of privacy and confidentiality in the mobile clinic with areas divided by non-sound proof partitions. A radio in the common waiting area may have helped, but other patients were party to the discussions of health and illness at times. Carmack (2010) describes using Glasser and Strauss' techniques for analysis of staff interviews in a van used for medical care.

Several studies used focus groups for the purpose of learning what types of community-based interventions would be acceptable to a group. Behringer et al (2007) asked what might reduce cancer prevalence, as did Hutson et al. (2007). Two workgroups were presented with topics that compared national and regional cancer mortality outcomes related to communication, culture, beliefs about cancer, and cancer research.

Finally, the groups were brought together to answer the research question: what makes Appalachia different. Participants provided themes of geographic characteristics, health care system characteristics, cultural characteristics, getting health promotion implications right, and addressing regional social justice issues.

Cancer.

Lack of knowledge related to risk factors for developing cancer, to the needs for prevention behaviors and screenings, as well as understanding health care providers' role in cancer related care. Appalachian cultures tradition of storytelling may contribute to failure of Appalachian populations to carry out preventative behaviors for cancer. Appalachians tell each other about their experiences with cancer care. There is still some indication that Appalachian people may avoid cancer screenings due to fear of finding out cancer exists (Hutson, Dorgan, Phillips, & Behringer, 2007). In addition, belief that a cancer diagnosis is fatal remains (Huang, 2010).

Hutson et al. (2007) found a pattern of cancer story-telling that effects perceptions of cancer care, a cancer diagnosis for one person effects the whole community, the sense that health care systems treat Appalachians as second-class citizens being the last to get anything, good doctors being one of them, the expectations of cancer care receipt is low as the right to standard care is not realized. The authors discussed the perception of fatalism of Appalachian people as being the problem when the disparate availability of health care may be more of the issue for Appalachians receiving cancer care. Some of the participants related getting well from cancer, as proof to others that healthiness can

return. Rayman and Edwares (2010) asked several groups of primary care provider clinic groups about their role in breast cancer care continuum.

Cardiovascular Diseases.

More than one-third of the U.S. population has one or more types of cardiovascular disease (CDC, 2011). Behavioral risk factors associated with cardiovascular disease include tobacco use, physical inactivity, overweight and obesity, and dietary choices (CDC, 2013). Co-morbidities that increase the risk of heart attacks and strokes are presence of diabetes mellitus, elevated cholesterol and triglyceride levels as well as hypertension (Blake, 2010). Hendryx and Zullig (2009) report environment, behaviors, genetics, demographics, and poor access to health services contribute to an increased risk of cardiovascular diseases. Lifestyle habits have been attributed to Appalachians having more cardiovascular disease. Populations with similar demographic characteristic do not have the same incidence of cardiovascular diseases as Appalachians do (Blake, Shankar, Madhavan & Ducatman, 2010), suggesting there might be another contributing factor to cardiovascular disease that has yet to be identified in Appalachian populations.

Diabetes Mellitus.

Diabetes is the seventh leading cause of death in the US. In the self-reported component of Behavioral Risk Factor Surveillance System (BRFSS), 9% of Appalachians reported having diabetes. The range of diabetes self-report was 13% to 6% with economically distressed counties having more diabetes than Appalachian counties

which have attained economic stability (Barker, 2010). Carpenter (2012) found Appalachians in WV expressed having diabetes was more of a challenge than a threat. On the Summary of Diabetes Self-Care Activity, WV Appalachians reported following a healthy meal plan 4.1 out of 7 days. Appalachians reported eating fruits or vegetables and consumption of red meat or full-fat foods 3.8 days out of 7. Physical activity of at least 30 minutes and as a specific exercise session occurred 2.9 days out of 7. WV Appalachians did take prescribed diabetes medicines 6.6 days out of 7. It is clear that WV Appalachians, and possibly Appalachians in general, need to improve their diet and physical activity.

Before indicting Appalachian people as non-compliant, barriers to health care access and improvement in socioeconomic status and knowledge about diabetes needs to improve. Tessaro (2005) asked a group of WV Appalachians their knowledge and perceptions of diabetes. As a culture, Appalachians viewed susceptibility to diabetes as being due to laziness, or eating too much sugar, being obese, and hereditary. Appalachians without those risks could not understand how they would get the disease. Appalachians do have challenges for preventing and control diabetes. A lack of knowledge about early detection screenings, about diabetes, and lack of transportation, money, and failure of physicians spending time with their patients were cited as barriers to diabetes care. There is a stigma of people who get diabetes within the Appalachian Region, that diabetes is from some bad behavior, a self-induced punishment occurs. Some Appalachians did not want to relate they had diabetes to family because of the

burden of the disease in costs and requisite food consumption. One participant in Tessaro's (2005) study stated, "I think it's worse than cancer. . . It's a slow process of dying." (p. 4).

Chronic Respiratory Diseases.

Chronic respiratory diseases are characterized by airflow limitations. Airflow limitations are due to inflammation, narrowing and loss of elasticity of airways, and destruction of alveoli. This process limits the lungs abilities to diffuse oxygen and carbon dioxide (Global Initiative for Chronic Obstructive Lung Disease, 2013). There is a higher occurrence of chronic respiratory diseases in Appalachia than other locations. Residents of Appalachian counties have higher exposure to industrial toxins. Toxins are released into the air, water, and soil from coal mining, chemical industries, metal refineries, and environmental tobacco smoke (Haynes, Beidler, Wittberg, Meloncon, Parin, Kopras, Succop, & Dietrich, 2011; Hendryx, 2012). Respiratory disease insurance claims are higher in coal-mining regions than in other industrial regions. Current industrial protections are not sufficient to protect the respiratory system of the coal-miner (Hendryx & Zullig, 2005; Van Houtven, 2010). Often the behavior of smoking has been correlated with Appalachians' prevalence of chronic respiratory illness. Van Houtven expresses smoking behavior could be a confounding factor in analyzing male workers in a variety of industries, but smoking behaviors between coal-mining and construction workers is similar without the outcome of chronic respiratory diseases being similar.

Psychological Diseases.

Appalachian people traditionally maintain their mental health disorders within the family (Keefe, 2012). The stigma of having mental health issues is shameful in Appalachia. Appalachian people are more likely to have somatic complaints that send them to their primary care physician instead of bio-medically recognized mental health disorder symptoms. Anxiety, depression and self-medicating are not unusual in Appalachia (Dunn, Crout, & Marazita, 2012; Keefe & Curtin, 2012).

Nerves.

Nervous disorders are found in a range of symptoms (Cavender, 2005; Halperin & Reiter-Purtill, 2005). Simple nervousness is the mild transitory condition caused by life stressors. A severe, incapacitating, long-term disorder associated with someone of weak constitution that is unable to cope with a traumatic event or life is often called ‘nerves’ or ‘the nerves’ (p. 267). Teas, tonics, time, and tenderness were the common ways to help a person through these nerves, historically. It is important to realize; a person may even use this term to describe serious psychiatric problems or violence or suicide. Bio-medical intervention are needed to address these latter problems.

Substance Abuse.

Substance abuse has been increasing in Central Appalachia in recent years (Dunn, Behringer, & Bowers, 2012). Alcohol use and abuse has a long history in Appalachia, with the stereotypical distilling of moonshine and the legal access of a variety of distilled

spirit now. Binge drinking occurs more frequently in adolescence with adults being less likely to consume alcohol due to religious edicts to dissuade its use.

Tobacco is grown in the mountainous regions of North Carolina, East Tennessee and Eastern Kentucky. Tobacco use is viewed as more common in Appalachia and had historically been a product consumed by Appalachians. Studies as long ago as 1993 found that tobacco use in Kentucky was similar to smoking rates in other parts of the country (Knight, 2013). Though Ahijevych, Kuun, Christman, Wood, Browning, & Wewers (2003) found rates of tobacco use were higher for Appalachian counties of Ohio than the rest of Ohio. A strong correlation of heart disease to tobacco use suggests an increased tobacco use, though few studies have been carried out in Appalachia to support the elevated heart disease and tobacco use supposition. A focus on tobacco use or cessation in an Appalachian population by Ahijevych (2003) found that people from groups that continue to smoke and those who have ceased smoking relied on self to succeed. The major impetus to quit was the effects of tobacco use on their family members.

Prescription drug use is widely abused in the Appalachian coal fields of Kentucky, East Tennessee, and West Virginia (Dunn, Behringer, & Bowers, 2012). It is thought that the heavy physical labor of coal-mining may induce physicians in the area to prescribe liberally to keep the men who mine working. In addition, prescription drugs are stolen or borrowed from family members who have narcotics and used or sold on the streets for money. The depressed economy and the advent of mountain-top removal

mining have decreased the employment opportunities even further in poverty-stricken coal-mining areas. Depression is thought to be attributed to narcotic abuse, as well as family acceptance of drug abuse across generations.

Methamphetamine use, abuse and production have been seen as a means of self-medication and income production (Dunn, Behringer, & Bowers, 2012). The dangers of productions and ingestion are a serious health threat to children and adults alike. Use of the drug causes extreme weight loss, oral health destruction, and psychological disturbances of anxiety, confusion, mood disturbances, and psychotic breakdown to include violent behavior, paranoia, hallucinations and delusions. The risk of fire, explosions result in burns or death.

Marijuana is highly trafficked in Central Appalachia (Dunn, Behringer, & Bowers, 2012). A third of the US production occurs in Appalachia, since the soil and climate are ideal for marijuana growth. In addition, the many National Forests allow for hidden cultivation and protect growers from personal property seizure if plants are found.

The consequences of substance abuse for Appalachian people are devastating (Dunn, Behringer, & Bowers, 2012). Individuals, families and communities suffer from increased crime, criminal prosecution, mental health issues, family violence, lifetime disability and death. The breakdown of the typical supportive structure of Appalachian families and communities occurs from drug related activities. Social crisis is found in Appalachian communities where substance abuse is present. Access to rehabilitation centers and mental health care is challenging for rural Appalachian people. Communities

that have addressed the issue in the holistic worldview of Appalachian culture have been successful in reducing substance abuse and the behaviors connected with it.

Chapter Summary

The people of the Appalachian Mountains are an independent, self-reliant, collective group. Their kinship and communities support one another as a reliable resource. The mountains are the place that matters to Appalachians. It is their home. Most Appalachians have a strong Protestant faith in God. This reliance on God is a support and resource for them.

Personability is an important trait for building relationships within an Appalachian community. Socializing is a component of keeping close relationships in Appalachia. Family closeness as well as community closeness are strong attributes of Appalachian people. Education has not been as strongly stressed in Appalachia, since most employment opportunities only required a high school diploma. Employment opportunities do not afford sufficient income for many families in the Appalachian Region. Many of the jobs demand hard physical labor.

Emic folk medicine may be used by some in Appalachia. Cavender (2005) found that the people born after 1940 were more likely to use folk medicine than older people. The remedies may not be the same as had been used in past generations. Chronic disease and early death from chronicities are common. Time spent developing relationships and knowledge about a family's health history may improve health care provider – Appalachian person's interactions and trust.

What is Known about Appalachian People

Appalachians are mountain people. They are a collective who see themselves as a part of home and place, the mountains of Appalachia (Gottlieb, 2001; Helton, 1995). Appalachians have a strong sense of family that causes individuals to choose what is best for the family, instead of just oneself (Helton; Drew & Schoenberg, 2010; Lengerich, Bohland, Brown, Kignan, Paskett, Schoenberg & Wyatt, 2006). Appalachian kinship groups are involved in the socialization of children and adolescents within the community (Templeton, Bush, Robinson & Gale, 2008). Appalachians tend to rear children in the ways of Christian religious belief that assures them that God has the person's best interest at heart (Stroessner & Green, 2001).

Family has a great influence on education values. Families that had at least one parent who completed college work were more likely to encourage their children to attend college (Brown, Copeland & Worthman, 2009). At the same time older Appalachian women stated that education is very important since no one can take it away from you (Helton & Keller, 2010). The closeness of family and kinship relationships did have an influence on educational course, because many families do not like children being far away from them. Education may also be the informal training of working side-by-side learning needed manual labor skills and knowledge to survive in the ecology that is the Appalachian Mountains (Hendrickson, 2012).

The economy in Appalachia has changed in recent years. Employment traditionally was in gleaning natural resources of timber, agriculture, coal, and

manufacturing (ARC, 2013; US Labor Bureau, 2013). Job growth industries are found in science and technology. Information service knowledge is needed for Appalachians to advance in the job market (Fluharty, 2003). Education attainment and job opportunities are associated with socioeconomic status. The traditional jobs sources demanded physical skill and a blue-collar workforce (US Labor Bureau, 2013). Current employment demands college and post-graduate education to succeed in the job market (Gabe, Stolarick & Abel, 2012; Henderson & Abraham, 2004). Higher educational attainment would decrease the poverty rate in Appalachia (US Census Bureau, 2010).

Appalachian people may not participate in preventative screening due to fear of receiving bad news and the lack of ability to pay for prescribed treatments (Drew & Schoenberg, 2010). There is a higher prevalence of cancers, cardiovascular disease, chronic lower respiratory disease, diabetes mellitus in Appalachia when compared to the US (ARC, 2013; Barker, Crespo, Gerzoff, Denham, Shrewberry, & Cornelius-Averhart, 2010; Danzi, 2013; Denham, 2012; Fisher, McLaughlin, Katz, Wewers, Dignan & Paskett, 2012; Hendryx, 2012; Knight, 2012; Sergeev. 2013; Tessaro, Smith & Rye, 2005).

What is Not Known about Appalachian People

Emic health ways are a blending of historical folk medicine and biophysical Western medicine. Much of the memory of folk medicine has fallen away with the event of germ theory (Cavender, 2005). There has been no distinct Appalachian health lifestyle found in research (Knight, 2012). Many studies have been completed within the

professional care-cure practice of Western medicine and nursing, but it is not known what Appalachian people do at home within their families, kinship groups, communities and collective groups to care for each other to assure wellbeing for members of the group.

Therefore, the findings of this study add knowledge of Appalachian emic caring behaviors that occur within families, kinship groups, communities, and collective groups. These findings may be used to accommodate and negotiate those emic care actions that are healthy and congruent with known etic caring ways of health, wellbeing, as well as, assist with illness or dying. In addition, these findings may help nursing find emic care that is in need of repatterning and restructuring towards lifeways that are beneficial to health and wellbeing (Leininger, 2006).

Western Health care should be able to provide care in a culturally competent way from these findings to preserve a lifestyle of wellbeing and health, to accommodate the healthy emic care actions, or to negotiate change of emic care behaviors that are harmful (Leininger, 2006).

CHAPTER III

METHODS

The product of this qualitative study was an inductive analysis to organize data participants provided about their ways of wellbeing. Qualitative methods allowed for a rich understanding of a person's, a family's, or a group's perspective of reality. Reality is defined within situations consistent with the person, family or group worldview (Munhall, 2012). A holistic narrative that describes and explains occurs with analysis of data (Spradley, 1979). Qualitative studies provide a way to free the interviewee and researcher to express the problem and area of study by examples, explanations, and discussion. The researcher was the learner, and the interviewee was the knowledgeable teacher (Munhall, 2012; Spradley, 1979; Weiss, 1994).

A qualitative study was used to discover what Appalachian people in Western North Carolina do at home for themselves, within their families, kinship groups, communities and collective groups to care for each other to assure wellbeing. The method selected for researching Appalachian lifeways was based upon the goal of the research questions (Munhall, 2012; Richards & Morse, 2013; Spradley, 1979). Leininger suggests to the nurse researcher that emic caring ways may be healthy thus preserved and maintained, congruent with etic care and thus accommodated, or unhealthy with the need

to negotiate ways to eliminate the behavior. Therefore, ethnography was the method utilized.

Ethnography

Ethnography is a type of qualitative research in which the researcher participates in the social settings of a culture to observe and understand the situations and thus are able to penetrate culture's lifeway (Emerson, 2011; Leininger, 2006; Spradley, 1979). Ethnography is an observing, listening, and participating activity to explore the meanings of human behavior within a culture (Churchill, 2005: Leininger & McFarland, 2006; Spradley, 1979; Weiss, 1994). Ethnographers listen to the stories people use to explain themselves. The story teller collaborates with the researcher to understand and filter cultural meaning from the stories told. An ethnographer who is similar to the people studied may have an easier access to the culture of interest (Hertz, 2006), but will need a strong reflexivity and objectivity about self to realize assumptions that interfere with understanding meanings observed (McCorkel & Meyers, 2003).

Fieldwork is a major portion of many ethnographic studies. Historically ethnographers spent isolated time with a culture unknown to themselves to observe and participate in the life of the people (Emerson, 2011). Note taking about experiences and reflection of those experiences occurred in a private setting for later coding. Note taking included recordings of the relationships, gender roles, work activity, and social interactions observed. Informants were interviewed to give explanations and meaning to the actions observed.

Interviews of select individuals helped to elucidate the researcher's findings. Interviews were used to "discover the insider's views" (Spradley, 1979). Ethnographers need to hold a belief that the people of the culture are who define reality within their world. Ethnographers are ignorant of the worldview of the people being studies and must avoid replacing their etic understanding of concepts and words for similar concepts and words used by the people interviewed. This is especially important if the people being studied share a common language.

Spradley (1979) defines culture as "a system of meaningful symbol" that a people group use to convey meaning in their world. This system of meaning provides the context for people within the culture to learn, maintain, and define the reality of their world. Leininger (2006) used the theories of anthropology to develop an understanding of the construct care within cultures. She posited that factors of culture influence how care is expressed.

The process for ethnographic research requires the ethnographer to complete a literature review to discover what is known and not known about a culture (Spradley, 1979: Weiss, 1994). Since the purpose of all ethnographic studies is to discover the meaning of reality from the insiders' views, observations and participation within the culture are needed to describe and explain reality from that culture's view. Leininger (2006) provides an observation-participation-reflection enabler to guide nurses using her methods as a process to become a familiar, typical feature within the culture, and to build

trust before interviewing informants. This enabler also guides the process of reflection upon the accuracy of data analysis within the cultural and social structure.

Over the time an ethnographer is interacting with a people group, the ethnographer is explaining the reason for the interest in the culture. Leininger (2006) provides an explanation of this within the stranger to trusted friend enabler. Spradley (1979) calls the process of building trust, building rapport. Each author makes it clear that informants need to become comfortable in telling the people's stories.

The literature review may guide the research questions, but Spradley (1979) asserts that the ultimate decision about what the problem is and thus the research question or questions is dictated by the informants within the culture. A successful emic description and explanation obliges the ethnographer to validate analysis with key informants. Leininger (2006) provides the domains of inquiry enabler to focus nurse researchers on purpose and research questions. Leininger states the domain of inquiry is developed by the researcher to focus on care and cultural care constructs. Although Leininger provides a structured research question set, the participants and informants within this study explained the meaning of wellbeing within the Appalachian cultural context.

Leininger (2006) defines care as a powerful and dynamic force that is culturally based, and has beneficial outcomes for health, wellbeing, and survival. Health is a state of wellbeing as defined by the culture. Health enables individuals and groups to carry out their daily roles and activities. The use of the Cultural Care Theory allows nurses to gain

knowledge of a culture's care values, beliefs, and lifeways. This knowledge is "essential to help people from diverse cultures to heal, recover, and face death or disability" (p.4). The social structures that support emic caring in Appalachia were discovered in individual interviews with participants and informants. The Sunrise Enabler provided the factors Leininger found contained aspects of care and caring within cultures. Spradley (1979) provided interview guidelines.

Purpose

The purpose of this study was to explore the emic caring ways of wellbeing among Appalachian people within their family, kinship groups and communities. Caring ways were explored, and descriptions of folk care were explained from the view of the participants and informants. Care was taken to prevent translation into etic "symbols of meaning" (Spradley, 1979, p. 6), by the ethnographer or the participants and informants.

Nurses and health care workers need to preserve positive lifestyle patterns within the emic ways of care of Appalachian people. Some lifeways need repatterning. The ethnographer examines change needs with informants of the study. In providing nursing care, there is a need to support what is good, accept what is neutral, and guide towards better choices what is harmful.

The research questions were:

What are the caring behaviors to nurture and protect wellbeing?

What were the caring behaviors that benefit the physical, emotional, mental, and spiritual wellbeing of Appalachian people of Western North Carolina?

What were the caring behaviors that neither benefit nor harm the physical, emotional, mental, and spiritual wellbeing of Appalachian people of Western North Carolina?

What were the caring behaviors that may harm the physical, emotional, mental, and spiritual wellbeing of Appalachian people of Western North Carolina?

Setting

North Carolina (NC) contains 29 counties within the Appalachian Mountain Region as defined by ARC (2013), for this study only the farthest western counties of NC are observed. This area is defined as Region A of North Carolina, of these Swain and Graham are distressed, Cherokee and Clay are at-risk with a distressed area, and Haywood, Jackson, and Macon are transitional with areas of the counties that are distressed.

Western North Carolina (WNC) Appalachian Mountains are similar to Appalachia in general, since it also has poor health outcomes when compared the US in general (ARC, 2013; CDC. 2013). The morbidity and mortality rates are greater than those of the US in general with death rates occurring between 35 and 65 at a higher rate for the WNC population (Healthy Carolinians, 2012). The leading causes of death for the seven most western counties in WNC are heart disease, cancers, chronic lower respiratory disease, cerebrovascular disease, unintentional injuries, Alzheimer's disease, diabetes mellitus, pneumonia/influenza, unintentional motor vehicle accidents and suicide (NCDHHS, 2012).

Educational attainment for WNC Appalachian Mountains is 25.8% to 34.6% high school attainment as compared to the US high school attainment of 89.9%. Only 13% to 20.6% of WNC individuals graduate college as compared to 33.6% of the general US population (Healthy Carolinians County reports, 2012; National Center for Educational Statistics, 2013). Within the seven most western NC, 19% to 30% of individuals do not graduate from high school. The unemployment rate ranges from 6.3% to 13.8% in WNC as compared to the US unemployment rate of 6.8%. The poverty rate in WNC is 12.3% to 22.4% as compared to the overall US poverty level of 14.3 % (Healthy Carolinians, 2012; US Labor Bureau, 2013). The sociological dimensions low educational attainment and poverty contribute to poor health outcomes in WNC Appalachia.

The economy in these seven counties is supported by agriculture, mining, logging, construction, manufacturing, trade and transportation, professional and business services, education and health services, leisure and hospitality services, and government employment. The unemployment rate ranges from 6.3% to 13.8% as compared to 6.3% in NC, and 6.6% in the US. NC's labor force participation rate is 60.9% with 56.9% of the population being employed (Employment Security Commission, NC, 2014). Poverty rates of living under 100% of the poverty level in the seven most western counties of NC range from 12.3% to 22.4% as compared to NC as a whole of 15.5% (Healthy Carolinians, 2012).

The top leading causes of death in these seven most western counties in NC are heart disease, cancers of all types, chronic lower respiratory disease, cerebrovascular

disease, unintentional injuries, Alzheimer's disease, diabetes mellitus, pneumonia/influenza, unintentional motor vehicle accidents and suicide (State of North Carolina Department of Health and Human Services [NCDHHS], 2012). Each county varies in ranking, though heart disease is the primary cause of death with a range of 181.7 to 259.1 per 100,000 age-adjusted deaths. Cancer of all types ranks second for all most westerly counties in NC with a range of 163 to 202.9 per 100,000 age-adjusted deaths. Chronic lower respiratory disease ranks third for Clay, Haywood, and Jackson with age-adjusted death rates ranging from 37 to 50 per 100,000 for all seven counties.

Unintentional injuries rank third for Cherokee, Graham, Macon, and Swain with age-adjusted death rates ranging from 31 to 56.2 for all seven counties. (NCDHHS, 2012). Cerebrovascular disease ranks fifth as the cause of death for all seven most westerly counties with a range of 31 to 56.2 per 100,000 age-adjusted deaths. Alzheimer's rank sixth for all counties, except Graham with a range of 19 to 44.8 per 100,000 age-adjusted deaths. Diabetes Mellitus ranks seventh for all counties, except for Graham with a range of 13 to 47.3 per 100,000 per age-adjusted death. Graham has a higher incidence of diabetes deaths than Alzheimer's disease deaths. Pneumonia/influenza, unintentional motor vehicle accidents and suicides rank eighth, ninth, and tenth with ranges of 13.2 to 36.3, 10.5 to 28.5, and 12.2 to 22 per 100,000 age-adjusted deaths respectively. In North Carolina the top ten causes of death per 100,000 age-adjustment are heart disease (184.9), cancers all types (183.1), chronic lower respiratory diseases (46.4), cerebrovascular diseases (47.8), unintentional injuries (28.6),

Alzheimer's disease (28.5), diabetes mellitus (22.5), pneumonia/influenza (18.5), unintentional MVA (16.7), and suicide (12.1).

Sample

The inclusion criteria for recruiting and enrolling participants to interview was people who a) lived in Cherokee, Clay, Graham, Macon, Swain, Jackson, and Haywood counties in WNC. b) lived in WNC for fifteen years or more, c) had generational roots to Appalachia, d) considered themselves mountain, e) were aged 25 to 70, and spoke and wrote English. This age grouping allowed for cross generational consideration of generation X to Baby Boomers to be interviewed. Excluded were people of Hispanic heritage because most usually had not lived in WNC for generations and their cultural ways may have been different from the majority of Appalachian people. Also excluded were persons who had been hospitalized for mental illness during the past 3 months, to avoid any exacerbations and to avoid caring ways mainly related to one condition or exacerbation.

It was expected that participants and informants were primarily White, though there were Black and Indian citizens who had been living in WNC for generations. Also, some of the potential participants in the area identified with the Cherokee people of WNC.

For this convenience, but purposive sample, participants and informants were selected by the researcher from acquaintances without etic health care training within the seven most western counties in Western North Carolina. Participants and informants were

selected by the researcher from acquaintances from nursing, western health care workers, and complementary and alternative medicine practices. Participants and informants were interviewed in face-to-face one-hour sessions. It was assumed that participants and informants were able to identify the universality and diversity of WNC caring ways (Leininger, 2006). Three people were selected to be informants since they had the ability to see the culture of WNC Appalachia critically. Selection occurred after all interviews were completed.

Recruitment.

Informants were recruited by face to face or telephone solicitation to participate in the study. A flyer was available to hand those who were met face to face. Face to face interviews occurred as a single meeting. Flyers were taken and posted or handed out at local libraries, health departments, and cooperative extensions within the counties, but those recruitment measures did not yield any participants. Participants were asked to recommend further participants by social nomination to extend and enrich the knowledge of WNC Appalachian Mountains emic caring ways. Flyers were provided with study contact information so that participants could share with neighbors and others. Three of the participants were asked to act as informants to clarify and validate the researcher's analysis of data.

Informed Consent.

The participants were provided informed consent in writing and verbally. The consent described the study, explained risks and strategies to decrease risk, what they

were expected to be asked, study activities, time commitment, and incentives. The Internal Review Board of The University of North Carolina at Greensboro approved the study.

Data Collection

Interview Questions and Demographic/Health Forms.

Interviews question began as, *I want you to tell me about what it is you do to assure wellbeing, take care of yourself.* Prompts were used throughout the interviews to allow participants to tell their story. Samples of prompts included, but were not limited to: *Let me ask you this, can you tell me a story about how your mama or daddy would make sure that you or your family, growing up, was well and was cared for? When you were little, if you think about a time you were sick at home, what did your mama do about that, like the things that she did at home.*

What were the ways you have used care or caring to assure well-being for your children, family or kin? Do you remember any stories that your grandma or your grandpa told about care or caring to assure well-being for you and your family?

Tell me about the differences in ways you see nurses and doctors care for people in the Appalachian Mountains and the ways your family cares for people.

Are there any other stories you can tell about care or caring practices used for physical, emotional, mental, or spiritual well-being for yourself, your family or kin?

Demographic and health data were collected from the informants in using a demographic form questionnaire. The questionnaire followed the interview to maintain

the spirit of open responses during the interview. Completing a questionnaire first may result in brief perfunctory responses during the interviews as well (Spradley, 1979; Weiss, 1994). The questionnaire is consistent with the Ethnodemographic enabler by Leininger (2006). Leininger suggests open-ended questions to obtain this data, as do Spradley and Weiss. The formatting of the demographic questionnaire was based on Behavioral Risk Factor Surveillance System (BRFSS) questionnaire, which included sociodemographic, economic, and health information. The demographic questionnaire can be found in appendix A (p. 179).

Fieldnotes.

The ethnographer retained several types of field notes (Spradley, 1979)**.** A condensed account of a sighting or an interview was written while observing a landscape, physical area or interviewee's home or another interview place. Notes and phrases were jotted down during the interviews, and after the interview in the car or at home. The notes were used to complete the account d using the transcribed interview to provide a complete description of the observations and a verbatim report of an interview.

The tape-recorded interview allowed verbatim transcription for a full report. A fieldwork journal was kept as a diary of reflections, process, ideas, realizations, and problems that occurred during observations and interviews. Finally, field notes of analysis and interpretation were made. This journal had notations of semantic relationships, domains concepts and a taxonomy of the local dialect. Physical spaces were observed during interview and described within field notes. Insights, further problems to

study as well as brainstorming on paper were recorded in the interview field notes book (Spradley, 197).

Place, Time, and Interaction.

Interviews were conducted in homes, on front porches, in coffee shops, while eating a meal together, and in the back yard while watching children play. One interview was carried out while waiting in the car. Her son was playing basketball with a group of boys to earn money for the American Heart Association. We talked and watch the boys play.

Interviews lasted from 30 minutes to an hour and were audiotaped. No participant refused audiotaping. To get to the places where interviews occurred, the researcher drove curvy mountain road and steep inclines with poor signage to the final destination. Some type of precipitation is typical in the mountains. Rain and thunderstorms occurred in the summer months and snow and ice made roads treacherous in winter months. Several interviews had to be rescheduled across the year.

Coffee was typically offered in the participants homes, though during the heat of summer water was provided. When the participant wanted to meet someplace public, coffee shops were often selected. Some participants offered to meet in a local restaurant for a meal. The interview lasted approximately an hour when meals were taken, and small talk while eating.

Analysis of Data

Analysis of Qualitative Data.

The interviews were tape recorded and transcribed verbatim, then checked for accuracy by the primary author and one experienced scholar. Data analysis began after the first interview. Qualitative data analysis looks to discover cultural meaning within the culture's own descriptions. The stories conveyed by informants provided the meaning for the concepts of caring and well-being. These stories were analyzed through several steps. Analysis of data occurred in a three-tiered review of interviews. An initial reading of the data was used to hear the stories and ways one participant's stories connected to other participant stories in terms of context, categories, and themes. A second reading stepped away from the first's impressions as from a fresh set of eyes approach to see what was being related. Finally, the third reading used Leininger's Sunrise Enabler to Discover Culture Care from the Appalachian perspective.

The data was organized into categories across the interview as it related to the culture. Within ethnography, analysis explores parts of a culture and tries to understand the relationship of the parts to one another conceptually. Within this study, the concepts explored were caring ways towards assuring well-being for one's self, family, kinship group and community. In addition, the wellbeing was examined as it related to other health issues. Examination of the data continued until the criteria of examination and discovery was achieved (Leininger, 2006; Spradley, 1979).

Verification and rigor for this study was conducted through several methods. The researcher had two experienced scholars confirm the findings by reading select transcripts, reviewing the coding schema at differing points in the analysis process, and reviewed and discussed the final findings. Analysis of qualitative data continued with each new interview and review of interview expressions. Often, data ideas were reclassified or added after ideas were revealed in subsequent interviews. The researcher explored the data for recurring patterns of expressions that were consistent with one another, and new patterns that emerged. Experienced scholars supported the researcher in the discovery and understanding. This included both written and graphical depiction of data. Second, one of the experienced scholars reviewed field notes with the primary researcher to assess reflection of accuracy and consistency with context. Third, one experienced scholar discussed primary author bias in early interviews and analysis to avoid this in subsequent activities. Subsequent activities were discussed throughout to identify bias with interpretation of data and conclusions.

Trustworthiness of any study requires evidence of diligence in the study process. A pilot study was conducted prior to the main study. The interview questions, process and recruitment processes were assessed and revised. Within the main study conduct and analysis, experienced nurse scholars and the three select informants confirmed that the findings were credible. The informants were asked to confirm the data by direct expression and acceptance of previously documented data, the themes generation by the interpretation of data. The three informants were asked to meet for further clarification,

description, and explanation of WNC Appalachian care behaviors from the analyzed transcribed interviews. The three informants were asked to further spend time with the researcher to assure categories and themes identified in analysis of data reflected emic care and wellbeing. The contexts of the findings were understandable to informants as part of their natural and familiar environments, which is a recommended by Munhall (2012), Spradley (1979) and Weiss (1994). The theme examples reflected interview data and cultural ways. The researcher used this collaboration to ensure credibility and trustworthiness, as well as prolonged engagement over a 9-month period and debriefings with an experienced scholar. Interviews continued until the research data reached saturation and no new themes were identified. Saturation of the data occurred when the researcher, experienced scholars and select informants discovered no new findings within the data (Leininger, 2006; Spradley, 1979). Care was taken that redundancies did not occur because of a narrow group of informants. Saturation may be suspect if only one family or kin group was interviewed. Purposeful selection of participants from a variety of groups in WNC were contacted. Further recommended participants were diverse as well. Experienced scholars guided the recognition of adequate diversity of people within the culture and a broad saturation of qualitative data findings across the interview months. Additional participants were recruited and included until saturation was reached. The senior scholars assisted in evaluating when saturation was reached.

Analysis of Demographic and Contextual Data.

Descriptive quantitative analysis of the demographic survey questions provided context for the sample's characteristics. Frequencies, proportions, and averages were computed for the appropriate level of measurement for the selected variables (Table 1). Quantitative data analysis provided a description of the sample group in terms of ethnicity, age, gender, education, employment and income, family relationships, and participation in the Western health care systems. This analysis provided support for the similarities and differences of the sample group to the cultural group. The potential for transferability occurs for similar cultures within the context. The large geographic area that WNC represented provided varied pockets of the same culture (Munhall, 2013; Polit & Beck, 2012; Richards & Morse, 2013). Yet qualitative findings of a small sample size may not be fully representative or generalizable to the larger Appalachian population.

Reflection

The primary researcher has lived in WNC Appalachian Mountains since 1993. The researcher has vacationed and visited family within the Southern Appalachian Regions of WNC and East Tennessee for decades. The researcher's mother is an Appalachian from East Tennessee with relatives in East Tennessee and WNC, and the author experienced the influence of Appalachian ways of caring throughout her life. These life experiences allowed the researcher to enter into the lives of WNC Appalachians with the ease as an insider. The researcher considered her story of Appalachian influence as she listened to the stories told by informants (Hertz, 2006).

Also, 20 years of nursing care and educating student nurses in the WNC Appalachian Region induced the researcher to be interested in Appalachian people's health and wellbeing. The researcher considered her own responses to the research questions as explored through interviews. One component of data analysis was the author's self-reflective field notes. Another strategy was senior scholars reviewed audiotapes, interviews and data coding and interpretation and conducted debriefings with the primary author.

Limitations

The initial limitation was acknowledgement of researcher bias. The researcher considered her positive bias towards Appalachian people in WNC and East Tennessee. The researcher's life experiences in Appalachia induced her passion for Appalachian people, and her view of Appalachian people's emic caring ways is a positive one. A second limitation is that the study one conducted in one area of one Appalachian state. Though the counties are similar in many social determinants of health to other Appalachian areas, these counties may not provide exactly the same specific wellbeing findings as other states and areas. A final limitation is that the participants in this study may have been more educated than other parts of Appalachia, which may or may not have provided different experiences and descriptions of wellbeing.

Chapter Summary

This qualitative study allowed for the inductive analysis of the Appalachian people from WNC to provide their perspective of well-being. Interviews were an

important component of the ethnography to clarify and understand from persons who live within the culture. The purposeful selection of participants was expanded by asking initial participants to recommend further participants. Field notes of observations, interviews, and reflections as well as multiple levels of analysis were used to answer the research question. Methods for ensuring reliability and validity of the findings were enacted.

CHAPTER IV

FINDINGS

The insider's voice of Appalachians within Western North Carolina helped explain the meaning of the cultural context of wellbeing. Meaning was derived from social interactions within families, kinship and community groups. The participants of the study described the insiders' view of ways they assured wellbeing for themselves, their family, and their communities as interrelated context from spiritual, physical, emotional, and the natural world were present.

Analysis of Demographic and Contextual Data

Twenty-one persons were interviewed. Eighty-five percent of the participants identified with the geographic region of the North Carolinian Mountains as home by stating they were Appalachian (38.1%), North Carolinian (14.29%), Southern (4.9%), or Mountain (28.57%). Those who stated they were Mountain, most often stated they fit the other identity descriptors as well. The identifiers are not necessarily mutually exclusive but provide an understanding of what Appalachians in WNC want to be called. The participants ranged from ages 25 to 70 years. All had an education level of high school or higher and worked for wages. The median income for the group was $35,000 to $50,000 with the lowest income reported was $10,000 to $15,000. Ninety-nine percent identified

as European American, with one stating a mix of Cherokee and European American. The majority were married (Table 1).

Nearly seventy-two percent lived in Macon or Jackson Counties with the rest residing in the remaining five counties. Most participants identified their health as very good or excellent, though two expressed having health issues. All had some type of health insurance. All had at least one medical doctor with the majority having seen a doctor in the last year.

Responses from the demographic questions demonstrated the persons interviewed had similar demographics of Appalachian groups in general. Height ranged from 5" 2" to 5"11" and weight ranged from 110 lbs. to 205 lbs., with resulting BMIs ranging from 18.8 to 37.5. One person reported being overweight, yet his BMI was 29.5. Colonoscopy testing occurred for those in the appropriate age group (100%). Only half the women had Papanicolaou smears with many reporting they no longer needed to get one. Mammography occurred within the excepted age group with about half receiving a mammogram in the last year. Two of the three men had a prostate exam.

Three participants provided clarity of Appalachian culture as key informants. Each of these three informants had family heritages within Western North Carolina or the Southern Appalachians for many generations. One woman's family had purchased land from the Cherokee for twenty-five cents an acre. Her great-great grandfather established a plantation on the land that subsequently became Franklin, NC. She was a graduate of Chapel Hill and served as a librarian in her home county. The second key informants had

a paternal great-grandmother who was a witch within the context of Celtic Oldways. All the people of the community sought care from her when they or their children were sick. The tradition of herbal remedies was passed down to her father. Her mother was also well versed in herbal care. This second key informant used herbal remedies to care for her children. This informant was a licensed practical nurse. She had asked her father to let the researcher interview him. He declined. The researcher wondered if as a registered nurse, she was considered as opposing the emic health care ways of herbal use. The third key informant identified as having a maternal Cherokee grandmother. The grandmother had 'the memory' of the herbal and spiritual ways of healing from the Cherokee. This key informant also had a paternal aunt of Irish decent, who knew how to cure with herbs and spells. This informant was a local journalist in her county.

Leininger's (2006) Sunrise Model was used during data analysis, but subsequently other ways to describe the themes arose with analysis. A table comparing the two thematic labels can be found in the Appendix (Table 2).

Communal Caring Relationships

A collective society provides communal caring relationships of families, kinship, communities and collective groups. Establishing and maintaining good relationships between one's people is important for overall wellbeing. Appalachians are family oriented. Appalachians in WNC describe communal caring relationships as a strong sense of family responsibility for the nuclear family, kinship family and community. Collective

communal caring relationships demonstrate a concern with other people's feelings and welfare more so than one's own issues or problems.

One woman's description of wellbeing provides a good example of establishing and maintaining relationships.

> I was always told that I was the peacekeeper. I also have the tendency to have an intense desire for justice, and I will almost demand it, which not everyone accepts so readily, as far as trying to – I will try to even out relationships by force. Anytime that there is turmoil, and it's usually around situations like that, I am willing to come to an agreement, to compromise, to say I'm sorry. I am quick to accept responsibility. I am quick to apologize whenever it's necessary – not necessarily an unnecessary apology, but I am not one of those proud folks that won't admit when I'm wrong and say I'm sorry. I will talk. I am very candid and very honest. I don't get my feelings hurt real easy, so I can handle people being candid with me, because I would much rather know exactly where I stand, than to sugarcoat things just to even things out. Let's nip it in the bud, and make it really okay, so that there is no animosity, there is no anything like that. When I see you, I'm genuinely glad to see you, and you are genuinely glad to see me, and we are in this peaceful back and forth together.
> Another woman relates the importance of nurturing relationships instead of holding onto anger and unforgiveness.

Another woman relates,

> I think relationship, not just with God but with other people, He's given us tools to nurture relationships with Him and with other people. That knowing how to nurture a relationship and God gives us all kind – in Scripture and just in general. You are given the tools to nurture relationships with one another and how to be kind and how to be good to one another and being able to let go of things and forgiveness. I think being able to be in good relationships is vital to your health, absolutely vital because it will erode you away. If you choose to nurture that gray squiggling mass inside of you that has those things where you're still pissed off at somebody 15 years later, what's wrong with you, if you are still nurturing that, you're putting your energy into feeding that grayness,

> you will be sick. It will drain you and God gives us the words and that ability – He gives you the tools to not feed that anymore. You don't even – your goal is to not have that, that grayness, to be able to forgive. I mean ultimate forgiveness is learned there and when you can do that, when you can forgive, wow, I mean it makes you a different person.

Kinship Relations

Kinship and social relationships are the organizational structures of a culture that define family units, extended families, and communities. These relationships are the framework for providing protection, security, and concern for one another. Kinship relations are the mechanisms of the way the Appalachian culture effectively and successfully deals with local and communal affairs and address crisis situations within the culture. Children, family members and kinship groups provide support for each other in local and communal affairs.

Protection and Security.

> [My parents] took care of us very well in their way, but back then we didn't have – my daddy believed in just working. I was raised on a farm and we had cows, pigs, chickens. There was always, something to do and he believed in working so we worked the biggest part of the time on the – we had some type of kittens and little puppies and stuff we played with. We never did have a lot of – never did have a bicycle, never did a lot of toys, but we grew up with plenty to eat and good, happy safe environment.

> Well, they fed us. We always had a clean house. We weren't rich by no means but there was always food on the table. Back then, you didn't expect all these nice stuff. It was always tough money-wise, but I look back and we always had food and love and happy so what else could you ask for really?

> Well, we always had heat, we always had food. We never really had money. We never keep abundant amount of toys or anything. We always played outside but we never went without food. We were never cold. They took us to the doctor regularly. They still continue to meet my needs, help with bills when they can, help watch my children, change my oil, check my tires. Still to this day, they provide for me more than anyone.

> Well, we ate right. The diet was definitely – I mean we ate. We had the cholesterol and all that. We had always had little desserts and this and that but yes, we – I mean we had vegetables. We had meats that some of the family may have killed, beef, whatever and we would put it in the freezer. Of course, the fish, we always had – because daddy loved to fish. As far as dietary, we had good diets. We had good diets. [My grandmother] can go in a kitchen with nothing and have this fabulous meal. I never did quite figure that one out. Of course, I wasn't allowed in the kitchen a whole lot either.

Family Caring and Closeness.

The closeness of families was described. Participants described time spent and relationship built as assuring wellbeing. "I think family is important in Appalachian Americans. Spending time, helping each other like we're doing today, helping each other, helping our kids, helping our family or neighbors."

A young woman describes,

> My dad was there and played with us a lot, and I think that really was great. One-on-one playtime, spending time with us. We were always kind of afraid of him. As far as Mom, I guess she wasn't really the playful type, but she took care of us in other ways. She made sure the house was cleaned and made sure that there was food on the table. I guess between the two of them.

She further describes the difference between her mother's family and her father's family.

> Mom has a good relationship with [her parents], obviously. My dad never did have a relationship with his parents, so I got to see the contrast between. I guess that's good, but it's a total opposite, my dad's parents. My grandparents on my dad's side were mean. My biological grandfather is an alcoholic and my step grandfather was abusive towards my dad and uncle. He had a really poor relationship. I can see how it's affected how my dad taught me. It helps me understand how we moved around. Definitely a contrast between what Mom has and he has. I can see that difference for sure. Just being there, being around, being aware. They don't call him on his birthday and they are just not interested. They live next door. They couldn't be more opposite.

Two women explained the conscientious ways of caring that their mothers and fathers provided in their childhood. Conscientious means keeping a clean home, caring for health needs, providing healthy foods, and making sacrifices for the children.

> We lived in a very small home, but there was four sisters. My mother was a very, very, very conscientious mother. She kept a very clean house and when we needed to go to the doctor, we went to the doctor. She took us for our dental care. We kept up with all of that. Anytime we needed shots for school or anything, she was just really very conscientious. I've worn glasses all my life and so that was kept up with. Yes, our health care was – you know, we've never – I don't think that we were left without any healthcare.

> It was my sister and me, and they were very conscientious. My dad was into isometrics, so we did our isometrics every day. My mother was somewhat of a nutritionist. She didn't believe in processed sugars, so we never had desserts much. If we had dessert, it was a really special occasion. We went hiking a lot. And biking – my dad got me a bicycle and we did biking.

A man explains developing trust and security from his mother. He was raised by a single mother related,

She had to make a lot of sacrifices. And so, for some things, she didn't really have much of a choice, you know, where she was like, you know, I – I have to be at this job. I just have to trust that my children aren't going to burn the house down. And that she never – she never made us feel as though we were second to her jobs, to the things. She always made sure that she didn't weigh us down with the adult problems that she had. She let me experience life the way that I wanted to experience it, and with the only rule, don't break my trust. She told me one day – she said, son, I would trust you from here to the moon, don't ever make me cry. And so that's made our mom. But – but I kept that, you know, I kept that every single day.

He continued,

A lot of people sit there and say that kids that grow up in a single parent family are at a disadvantage of not having a mother or father figure. And I kind of have to call BS on that. I have to think it depends on how that parent decides to let their children deal with that situation. She didn't want to say anything negative about [my father] to make me feel – because she wanted me to experience and understand who my father was and his ways based on my own experiences with him.

You know, growing up, you know, in this county, and growing up especially – the valley, I had a childhood that was like the kids growing up in the 1950's [had] been, able to ride their bikes, you know. You know, around – around the communities, you know. And I knew that growing up I could walk up to any of my friends' mother or, you know, parents' houses, or grandparents' houses and be like, hey, can I get a jelly sandwich and they would make me a peanut butter and jelly sandwich. Because of – how can you make your kids understand to trust people if you don't trust people?

Communal Caring.

Participants attributed taking care of others within relationships as a part of wellbeing. Caring for others in a central attribute of Appalachian people. Several

participants described how helping others aided them with their own wellbeing in addition to aiding wellbeing for the one helped.

One woman said,

> I assure my well-being by pretty much getting self-satisfaction and helping other people. I try to take time out for myself, but that has been impossible. That's been a little bit hard to do, but as far as going out for a walk, trying to get back into the mental karma there, just kind of relax a little bit, but I try to take care of myself, eat well, try to exercise, take care of my family. I have my sister and my husband I've got to take care of.

Another explained how helping others helped her,

> I've always found if I'm getting down and getting out and get depressed, if I help somebody else, then that gets my mind off me. I try to do that, if I can be a help to somebody else. When I pray, I try to pray daily. When I pray, I ask God to let me be a help to body that day.

One of the men stated while helping others,

> I think there's a lot of well-being from that. Like my neighbor, I don't know if you know him or not. Anyway, he's had a lot of problems and he's been in Asheville from a nursing home, to care partners, to the hospital. He had football injury and he's only probably 50, early 50s. He got that Guillain-Barre infection and he's just really had problems with it. He's coming home Tuesday, I think. He's been gone for over two months, he hurt his foot, kind of like a broken ankle or something. They go in there and put a pin in there. Well, he gets an infection from the pin, so they have to take his leg off. He's just a tough guy. He wouldn't sit still. He worked with the amputee and all that. I think it kind of got aggravated and got infected. I don't know if that's where the infection come from, I don't know. Anyway, he's had a hard road. I've tried to help him out when they need it or whatever. I don't know. As far as well-being, I try to be there for any -body that needs me and that helps me too.

Participants describe the relationships in community and church. Sometimes a participant related seeing differences between families, kinship, or community groups.

One woman said Appalachians are unique in that,

> When people are sick, if you're sick, you got people that come to you and stay with you, and care if you needed it, and feed you and there's not a time limit. It's not a burden. It's almost an obligation. I don't care if it's from your sister to your fifth cousin twice removed or whatever. It doesn't matter. Family is family no matter what bridges were burned, no matter who married who or whatever the situation might be at the current status. If you are family, you are always family. Those bonds never break; they never change.

A second woman tells about her grandma's parents,

> they talked about – of course, when family members were ill, they put them – I mean they would be in the – sometimes in the living room or the bedroom right off the living room. They would keep them there even if they were – if they were dying or anything like that. I mean they would all keep them there and everyone comes. I remember when my great-grandma was sick, everybody would be there at the house still. I mean I guess that was kind of – that doesn't happen now, we don't stay at home and really everybody be there. I remember they always talked about people always coming and everybody just kind of sit and waited.

Another woman described her experience with kinship and community.

> I've had a long stand here with my life where I've not been involved in my communities. I'm not – because out in Hanging Dog where I lived, you know, the community club meetings, and the 4H meetings and stuff that I went with my kids and they were much more informal and kind of like community. Do you know what I mean? I think it might be unique to Appalachian is for – when somebody is sick, or somebody dies, the neighborhood kind of comes in and brings food, and does things. They do things for each other like that when they're in trouble, it seems to me. Especially church groups, and maybe I've got a biased view but – you know, there's so many churches in this area.

> And I think that's because they fight, and they decide that they will split up, and somebody goes and makes the church. But, you know, I went to church a lot when I was younger so that's what I've observed too. But they are there for each other. You know, the church family is very close. And I think the communities can be very close-knit. Not so much with other communities. Everybody has their own pockets that communities – and they kind of take care of their own that way.

Spirituality

Spiritual, philosophical, and religious factors are moral guides for daily living. Worship practice and ceremonies are a means of demonstrating spiritual concepts. Spirituality in the Appalachian perspective is the blending of the physical world, use of herbal cures from the Old Ways, Cherokee ways, and Christian faith. Appalachian people have varied philosophies, spiritualities and religiosities. Appalachians are often identified as Christians, but a few participants described themselves as having a spirituality of the Oldways where healing and the natural world are a spiritual blend.

One participant describes well-being saying,

> I think that well-being encompasses way more than just physical health. It also encompasses spiritual health and comfort in your surroundings and knowing that your people are okay. I have to have all of those elements before I feel well, and that my life is at peace."

Another responded,

> Well-being, What I see as Well-being? I think it's the whole package; I don't think you can have well-being without having all of your, the petals of your flower, I guess. I'm big on the spiritual aspect of the sense that I'm a Christian and try to spend time every day reading the Word and praying to make sure I have that relationship with God. I think relationships with

> others . . . I think spiritual is the most important, and then your physical well-being comes in second, because you can't have any other relationships functioning well if you are not physically well. And then emotionally, wellbeing. I think when I am spiritually well, I tend to be more emotionally well.

She continues to explain where her spiritual belief comes from.

> [My grandparents] are very spiritual people, as well. They have also influenced me in that way. I have seen that they have stayed friends with the same people for their whole lives and they have good relationships with their families and I think that's all crucial.

The Christian Church.

It is typical for Appalachians to express a belief in the Christian faith. Most participants expressed a belief in God. Some of these told about attending a church. While others did not attend or belong to a formal church.

I Go to Church.

> I go to church on a regular basis. I'm involved in a church; a little church and I try to stay busy. When I pray, I try to pray daily. When I pray, I ask God to let me be a help to somebody that day.

> Yes, spiritually, I was going to say yes, I love going to church. In fact, we drove all the way to Mountain City to go to a church because of the preacher that's gone up there. Yes, I look to spiritual things or needs very seriously. I try to pray every day, read the Bible when I can. I'm very well-rounded in spiritual stuff.

> Spiritually, I go to church every Sunday. I try to read the Bible every day and pray. Sometimes that doesn't happen; I'm human, but mostly it does.

We are members of a church together. We go every Sunday to church; we are part of a small group. Our church doesn't meet on Wednesday night. They have what they call "small groups", which are smaller groups of 8 to 10 people, and we get together, and they actually encourage us to have a meal together; that relationship building that helps us kind of cement the spiritual side of our relationship. We pray together. We pray for each other. We tend to be very physically close, whenever we pray. We hold hands; we hold our bodies together.

I Don't Go to Church.

Some participants do not belong to a formal church but expressed a belief in God.

I try to have a relationship with God like a spiritual relationship and that seems to help because I don't have a whole lot of friends and not a lot of people that I talk to. I don't like to burden people with what I feel as my problems.

So right now has been a very stressful time, but usually I try to take time out and relax and enjoy the beauty of the country and I don't go to church, but I do believe, and I sit and pray alone and get that spiritual part that everybody needs, everybody needs, because we are not alone; there is somebody there for us. Whatever you believe, but anyways.

I don't go to church. I do believe in God. I also believe you don't have to go to church to believe in God, or to talk to God. Some people do; they think if you don't go to church, then you don't, qualify, or get in. I don't know what they mean by that, but we don't do that. I went to church a lot when I was a kid. Talk to God when I think I need to, and so it's just like I believe when you are born, you have a time when you're going to die, and pretty much no matter what you do, that's what's going to happen, because you have a time that started designated, so that's as long as your lifespan is going to be. I just believe if you are good people then life turns out pretty good for you.

The Old Ways.

One woman described the spiritual healing of the Cherokee**.**

> My grandmother was Cherokee; not full-blood, but she was, but she could pass for not being Cherokee. She still had that knowledge, and at one point, she looked at me and she said, you were born with the memories. So maybe you are talking about Appalachia and what we hold as the same as everybody, maybe it's some part of DNA we inherited that way, in the memory channels. I don't know.

The woman continued,

> I think it's the coming together. It's everybody is family, so when one person has an illness, whatever it is, everybody rallies around them. Everybody has their own suggestions on how to best handle it. But there is power in the people, too, because I can remember once when – I can't remember her name, but anyway – one family member was having a breech birth. What the women did, was, you laid the hands on and in motion you move it, and you chant, and the baby turned. All of the women came and laid hands on. Everybody had to be in sync. Your hands had to touch the next person, and your hands had to move all in sync. One continuous motion.

Another woman described healing and believing in the context of Celtic herbal knowledge. Her father had taught her that a main component of healing is the belief that the healer can heal you.

> My great-grandmother, she was one of the old Appalachian women in the area that they lived in; they called her a witch. Well, she knew different herbs and they would bring all their kids to her when they got sick. She would make up different things for them. She was like a doctor for that community. She made cough syrup from things, so I try to follow that. My mom and dad are really into the natural herbs and healing.

This woman also expressed being out in nature as spiritual,

> You get to go out and spend time and be in the quiet in the woods and enjoy that. Just like going out, spending time with kids and walking trails, I love to do that, always liked nature. That's your calming influence in life. I've always been a gardener. To me, it's like therapy to grow things or make things pretty.

Philosophic Spirituality.

There are even some Appalachians who have blended philosophical, spiritual, and religious beliefs. One participant described a different approach to spirituality.

"We try to meditate and maybe sit in little prayer circles and send healing for emotional and caring towards others, things like that."

Another woman expressed her spiritual life.

> Well, I have a fairly strong spiritual life which means both time alone, time to process thoughts; I read a lot. I don't do a whole lot of self-reflection or self-help kinds of stuff but I think I just am sort of generally optimistic and self-confident. I have a strong church family and that's a lot of where I get interaction with people who may not think like I do, but we have good exchange of ideas and beliefs and we're still friends. I love to sing and I always have music stuck in my head even if I'm not singing. Because of church, it's mostly church music. I practice yoga which teaches you not only about your body but also about your mind and your spirit and how all those interact with each other and relate to each other. I like helping people, so I think that gives me a sense that I'm doing something good to help myself as well as others. I try to get regular exercise and eat right and do all the basic things that you're supposed to do to take care of your body which hopefully helps take care of your mind too.

Finally, one participant stated,

> I am very active mentally. I am an engineer by degree. I'm an engineer by the mentality in everything I do. I'm an electrical engineer. I stay mentally active even if I'm sitting on the couch. As far as spirituality, I don't profess to be such a spiritual person. Definitely not religious in the traditional sense of that word. The way it's practiced in our culture, anyway. I don't know what else to tell you about that.

Place Matters

Environmental context is an over reaching idea of geographic location, ways of living within culture, lifeways, relationships, religion, emic, and etic caring ways. For Appalachians in WNC place matters. Place matters describes the importance of the fabric of the landscape in relation to Appalachian wellbeing. People like to be outdoors in the natural world. The environment of the Appalachian Mountains provides aspects of spiritual, physical, and emotional wellbeing.

The Southern Appalachian Mountains have the highest altitudes of all the Appalachian Mountains (Appalachian Trail, 2015). The geography consists of steep sloping mountains and hollow and chapel communities. Hollows are the division of two mountains by a stream or river. Chapel is another expression used to describe hollows. The rural lands are pastoral or wooded. One winter trip the researcher took describes traveling in WNC during winter. The rains of Saturday turned to snow on Sunday. When I arrived at the steakhouse, it was flurries, but very cold. I had gotten there early, since I had two mountain ridges to cross to get here. With snow, a ridge can be slick or covered

up with snow even though the hollows and valleys are just flurries. Cowee and Balsam were better than expected.

The fabric of the landscape is an important aspect of Appalachian ways of being. The researcher was told by a waitress in the area that people around here like to be outside, even if it is just to piddle. The participants supported the idea of the importance of the natural world and being outside to their wellbeing.

Being Outdoors.

One young woman stated,

> I think the outdoors are important. A lot of people, at least my age, well, I think everybody, all generations, we like to do things out. We don't have a lot of things to do as far as go out in town, so a lot of it is hiking and I think there's a lot to be said about being out in nature. They are experiencing it and exercising." Outside is "kind of a component of both physical and spiritual, emotional wellbeing.

Another woman explained,

> We're usually just outside, we'll go to my sister's and we play outside with the kids with our children. Sometimes we'll hike. They like to – we have four-wheelers, so we ride four-wheelers. In the summertime, we kayak, just nothing big just around the lakes. We tube a lot. We go over to Rainbow Springs and we tube down the river. We have friends over there.

A Place to Dig, Plant, and Garden.

Participants described the need to have a place to dig, plant, and garden.

> That's a big deal. That is a big deal to me, is having that place that – that's the reason I love where I am now. Where I was before, it was asphalt.

> It was basically an apartment. It wasn't my home. I have animals. I have goats. I have dirt. I have grass. I have lots of sunshine." This participant even asked me, "do you have dirt around your house? [yes] That's good; you need some dirt to dig in.
>
> I like a yard. I like being able to – Because when I lived in apartments in Chapel Hill, I still wanted to grow stuff and I'd go out and clean the weeds out of the little four by four yard I had and plant stuff because I just couldn't stand it. I had to have something.

Wellbeing from the Natural World.

A woman described how her mother took care of her wellbeing with the natural world.

> She was a firm believer that if you set in the sun for a little while and let the warmth get into your bones that you would feel better, that you would feel better. If I can just sit in the sun and breathe, I'm going to feel better and I do.
>
> I think water will heal so many things that you have no idea that it will. Consuming it, bathing in it, the things that water can provide. The sun, just sitting in the sun, letting it get all the way into you, not just a casual walk, it has to be an awareness, that awareness of sitting in the sun and shutting off other things and making it about you and that warmth, that exchange of letting it be a part of you and letting it come back out.
> God gave us bees with honey. Honey does so many things.
> My son has horrible, horrible [seasonal] allergies. [Our pastor] raised bee and had honey. He brought us a jar of honey. My son [took] a spoonful every day, and it worked. It alleviated so much of [his allergies]. It didn't completely work, but it alleviated so much of it. I also kept the window open all the time at that house on the mountain. I left the windows and the doors open. Everything to get good fresh air. It didn't help my son, but my daughter and me, we were good to go.

Another woman describes the practical uses of ginseng. Ginseng is used to help with wellbeing and can be a source of extra income.

> My husband actually digs ginseng every year. He's like this country boy, does all the old things. He'll dig the ginseng every year to help us get extra money for Christmas because it's right around that time that they start harvesting it. Because he worries about the kids getting – and that's a little hard time of year. He'll go out and dig the ginseng. I'd been with him a couple of times and it's really fun except it likes to grow under roots of trees so you're digging in roots of trees to try to get it out. He likes to throw the seeds back out so it'll re-grow because you don't want to take the seeds away, because it'll kill off the plant. Some people try to take them and grow them at home. It really does not work out because it needs to grow on the north side of a mountain and usually in rock cliff. It likes rocks and trees. It likes to grow in shady areas. It's rough. Then snakes are crawling, so you have to wear snake straps and all that, but it's a lot of fun. You get to go out and spend time and be in the quiet in the woods and enjoy that.

Gardens and Livestock.

More participants describe healthy eating and gardening as part of the Appalachian culture.

> That is a big deal to me, is having that place that – that's the reason I love where I am now. Where I was before, it was asphalt. It was basically an apartment. It wasn't my home. This isn't mine either, but I have different rights to this. I can do whatever I want to. I have animals. I have goats. I have dirt. I have grass. I have lots of sunshine. I have a deck, soak up some sun. I can open up the windows. I'm sorry that I'm not the subject that – I don't have the same – I can't tell you all kinds of – because we're just not sick people. Our health, I guess we're just generally healthy people. Our well-being is good.

An older woman related life with farming.

> We didn't have all them processed foods. We sure didn't have all that sugar and sweetening and stuff. We lived too far away from the stores. I wish my grandkids could say that now. Some of it. We were talking about that this past week, talking about how they used to kill all them chickens and stick then in that hot water to get the feathers out. I was telling him how bad I hated that scent. Lord, it stunk, wet feathers, it stunk.

A man told of his childhood with gardening.

> Yeah, we did a lot of gardening. In my younger days when we lived with my grandfather over in Borough, we had milk cows, had a couple of milk cows, chickens, hogs; it was a real farmer's life. Then when we built our own home only a half-mile away, basically just down the road, we no longer had animals, but we still had a garden, and we had strawberries to work. Oh my gosh, strawberries for miles. I used to accuse my dad of only having me to help in the garden.

An older man relates getting the garden spot ready.

> I used to plow on mules a lot. My neighbor had a mule, so I'd plow the garden up. Pop was always away at work. Of course, when he's home, he would do what he had to do. He'd leave me instructions on what to do. See, I was the oldest boy. I had two older sisters, so I had to do all the garden work. David, my younger brother didn't want to work.

A participant relates that many of their friends and neighbors are going back to gardening and having livestock.

> I think that the food availability to a lot of people is not what we had. I think that it's cheaper to buy three boxes of blue box macaroni than it is to buy the stuff to make a salad or a decent serving of fresh fruits or

> vegetables, or good lean protein. I think that there are so many things, because as we discussed before, there's nothing west of Asheville, so a lot of people grow their own foods – that's part of our culture. It's on an upswing right now; people are going back to that – they are raising their own hogs, [they are] raising their own beef, they are growing their own gardens – and I think that's a kickback to our culture because most of us remember our grandparents doing those type of things to supply for themselves.

Environmental Wellbeing

A woman describes the importance of the outdoors and nature to her, and an obligation to the environment.

> I have always felt that nature sort of held the key to a lot of things. I guess what really did it for me was trying some of the things, being open-minded enough to step back from what I was doing and try [herbals and essential oils]. When I saw positive results. This stuff really works, and it seems to be way healthier and better for you than all the stuff that's sold in the stores that most seem to have added chemicals and toxins and things in them.

> I just think that we all need to have a bigger part and bigger responsibility in the environment. Little things like my family choosing to make our own medicines, if you will, or cleaning supplies or things like that, it means that we're doing a lot of reusing and recycling and we're not purchasing as much plastic that's ending up in the landfills and we're not supporting these companies some of which that I feel are raping the environment. We're trying to buy more locally, in small scale and from people that we know so hopefully, even just little bits that everybody does to help for our children down the road so that we have a better, cleaner place to live.

Sadly, some industries adversely effected the natural world and with it, people's health. A woman relates the adverse effect industry had on her cousin's health.

> I had this cousin that lived in Haywood County, and she couldn't get insurance because in Haywood County, they had done a study and found it was a high breast cancer rate, and I think that was because of Champion, the Canton paper mill. So, she could not get – well, she could get insurance, but it was exorbitant, and other people who lived in Buncombe County and I can't think of the other County, but they didn't have to pay that. It was just Haywood. And she did get breast cancer. She was one of the statistics, and Haywood County had an enormous – I don't know if they still do, but at that time, this was the 70s – an enormous amount of breast cancer.

> [A lot of our health outcomes could be due to pollutants and not lifestyle behaviors, unless you call being employed a lifestyle behavior. I suppose it is, in some ways. It's very discouraging.] "Because for Haywood County, not only did those pollutants go in the air due to emissions, it went right in the Pigeon River, too, and I'm sure the soil. I think pollution is a very contributing factor on adverse health. So many different kinds of pollution. One of my dearest friends, died of breast cancer [last year].

Grandmother's Caring

Emic folkways of caring are the practices that nurture and protect the health of adults and children within cultures. Behaviors that are carried out at home may continue within a health care setting. Folkways of caring provide assistance with wellbeing. Grandmother's caring for wellbeing include eating a nutritious diet, exercising outdoors, and using the remedies passed down through generations for maintaining and attaining wellbeing. The participants describe how they take care of their wellbeing.

Self-care by Diet and Exercise.

A woman describes the importance of healthy eating and exercise.

> We eat a lot of organic foods; that's one way that we nourish our bodies. We do mostly all organic that we can find locally and purchase and afford.

As far as physical, we do a lot of supplements and vitamins and essential oils. I try to get exercise on a regular basis to try to keep healthy.

Another woman talks about the ways she assures wellbeing for her family.

Diet obviously. We try real hard at home to eat a well-balanced diet or healthy foods. I don't take medicines, low stress. I try to do just take breaks. We try to get out, go to places. Do things. I do not exercise like I should. I have in the past, but I have not been exercising lately. But we are active as far as the weekends and what not. We go do a lot of things. We are usually pretty busy on the weekends.

A grandma considers how she takes care of wellbeing.

My wellbeing? Well, physically, I try to exercise, like I said, and I go hiking, swimming, do a lot of stuff with my grandchildren. I have seven grandchildren. And I just work, clean the house. That's physical. Spiritually, I go to church every Sunday. I tried to read the Bible every day and pray. Sometimes that doesn't happen, but mostly it does.

A man explains what he does for wellbeing.

I guess the main thing I do is ride a bicycle very strenuously. I typically average about 80 to 100 miles a week. Like I told you yesterday, my wife and I eat fairly well; she loves to cook. She is a certified health coach, so nutrition is very important to her. We buy, basically the best food that money can buy and conscious of our health in all ways. We don't abuse ourselves too much, I don't think. I do go out to fast food restaurants occasionally, but only about 20% of my intake is from a place like that.

A woman considers how she assured wellbeing for her family.

Hum, Well, I don't know. We tried to eat pretty good. Cook most of our meals. We tried to eat as a family. I breastfed my children. Get out in

nature. (I) don't do it as often as I should. I like to go outside, walk the dogs.

An older woman describes how she assures wellbeing for herself.

I try to eat healthy. I try to eat – I don't do sugar, not regular sugar. I don't do like much caffeine, like one – a cup of coffee a day. I don't do much bread or much red meat, just mostly chicken, and turkey and fish. I try to get exercise every day. I like to walk a mile, at least one mile. I try to get a mile in. I just come from the doctor's office last week and I turned up pretty healthy, no medications. Thyroid pills, that's all I do."

Wellbeing with Health Problems.

One woman relates the challenge of health problems.

I'm pretty guilty of not taking care of myself very much at all. I don't exercise, eat quickly and conveniently. I always have this. I have chronic bronchitis, asthma, allergies that are, I'd say, seasonally but it's every season, I'm allergic to something. I have had allergy testing and shots that did help, but I do not have health insurance, so I currently don't have an allergist. I just pretty much live with this day in and day out. Zyrtec makes me sneeze about the third of the amount of the times I would normally.

Another woman describes how she assures wellbeing with her chronic health issues.

Well, I have some health problems, so I do have to do some self-care. I take several medications. I try to do some upper body weightlifting because I have some paralysis in my lower body. It was a bleed at the base of my spine. I do some weight training and my program was set up by a physical therapist, so that he could tell me the things that would make my condition worse or help my condition, to strengthen the parts of my body I need to strengthen. I continue to sleep upstairs. Against my husband's wishes, because I figure that's part of my physical therapy, is climbing those steps

> and sleeping upstairs. I watch my diet really carefully and not just to maintain weight, but because of the fact of having problems with the heart and everything else. I do watch what I eat, and I try to eat healthy and I try not to eat a lot of sugar or a lot of carbs but try to keep it balanced.

A third woman with diabetes told that,

> Well, I try to go to the beauty shop frequently. (laughs). Well, I do take my medications and I try to watch what I eat as far as my diabetes. I think I exercise a little bit. I will say I don't have a particular routine but like I say, I exercise. I play with the kids. We play. I think that's important to be mentally healthy, happy, find something that makes you happy and that makes me happy. I take vitamins, vitamin D and just the Multi-Vite, acidophilus pretty regular, just social activities like this, having lunch.

Parents and Grandparents Home Remedy Care.

Many of the participants describe the herbs, rubs, soups, and teas that helped with welling when they were children. Honey was prominent in home remedies as well. A woman talks about ways her mother and grandmother cared for her siblings and her.

> My mother and grandmother, both, whenever anyone was not feeling well, we did a lot of hot tea and we did chicken soup. We did a humidifier in the room where we were if somebody was stopped up and congested. Years ago, I guess, my mom – it seems like I remember something almost like a Vicks type rub or something that would go into the diffuser that would go into the air. I don't remember what it was, honestly. Yes, the smell. It did have, I'm sure, some kind of a menthol, camphor type smell to it. My grandmother always sort of pushed warm, hot fluids instead of cold. She thought warm and hot was better than cold. Herbal teas. Peppermint tea, if we had a stomach ache or if we weren't feeling well with our gut. Anything for our gut, we got peppermint tea.

A woman describes her experiences with being sick as a child.

Years ago, I would get strep throat. It was such a long remote, long drive from where we lived. We lived in a very remote area in the mountains. It probably took us an hour-and-a-half drive at least, minimum to the nearest clinic, the nearest hospital. [So, before we went to a doctor.] They would put vapor rub on your chest and neck, keep you bundled up. Back in that time, they would give you like for cough and croup and it was good for a lot of things. They'd give you a drug called Creomulsion.

They used to have to give you sugar and honey, spoonful of sugar to keep the airways opening because it kept you from coughing because eventually, your tonsils and stuff would touch, you know, you would have to go to a hospital, when you could get there, and get two or three shots. They didn't even bother with the pills; they just stuck shots in you. Penicillin, I'm sure and that's just how they done it, got to drink and eat as much as you could if you could drink or whatever, wrap a rag around your neck with some Vicks Vapor Rub or tie a bandana around your neck and keep you – like a towel in here [her chest] and keep you wrapped up with a sweater or blankets around you and they keep you tucked in to see if it would break any of it loose or just whatever – that was it.

A woman describes the caring ways her grandmother provided to the community.

My grandmother was a midwife, on my mother's side, in a little town in Kentucky called Hardy Hill. She would go to different people's houses and help them with any illnesses that they had. That's who they would call when they needed help. She was like a nurse. She was a midwife.

A woman who lives quite rurally told of her childhood,

We used to get honey. That was always a cough medicine. Whiskey and honey. Now we didn't go to the doctor much. We had to be congested, they did whiskey and honey. Or they done – I mean you take it like cough syrup, like a teaspoon, you know. They'd use like vapor rub. We didn't go to the doctor much. But then we were healthy. We stayed outside. We

played and the food we ate didn’t have all the things in it that it does now. It was more what they call organic.

Another woman relates she would stay with her grandmother when sick.

If I had a sore throat, she always made peach brandy, honey and heated up just a little bit, not much, and would give me peach brandy and honey. For a toothache, or if you had one of those sores in your mouth, she would put tobacco in a little pouch and then put some kind of oil on it. It tasted menthol-y. Peppermint, maybe.

Another woman talks about her life as a child, and her parents caring ways.

I had a high fever, apparently, and they would rub me down with alcohol. I remember getting that treatment, and I suggested it to my daughter, if she needed it for her daughter, but they had never heard of that. The heating pads. I used to have terrible earaches; I remember waking up crying with earaches, and they put some kind of oil in my ear. I don’t really know what it . . . Sweet oil. (It’s olive oil) I think she put it in an eye dropper or ear dropper and ran it under hot water. It felt good.

One woman grew up a distance from town.

I grew up on John's Creek. Do you know where that is? So, people didn't really do a whole lot. They kind of just stayed home and took care of it, whether it was herbs and things that they mixed, there was a lot of white liquor, because a shot of that would cure, with honey and lemon, and they just try to do all of those things, but they really didn't, some of the family, whether it be breast cancer or whatever, they just really did not go to the doctor. They just kind of stayed home, put their liniments on it, which I don't know if they made them or if they bought them, like you can go to the pharmacy down here and buy some of those old home remedies and things like that, or, not necessarily home remedies, but things that they had back then, that black tar kind of stuff, and they used those types of things. I remember them using, if you had a sore, they would put that black tar looking stuff on it – I don't know what it's called.

A woman describes how her grandma took care of her mother in one instance.

> You know, what they always say is, they were busy taking care of each other. Mama was the oldest, and so whenever . . . Mama learned how to take care of babies early. Mama did talk about Grandma putting her in the tub and putting ice on her when she had scarlet fever. To bring her fever down. Grandma [did] that and Mawmaw came and helped her to get Mama's fever down.

One of the men recommends returning to what our grandmothers did.

> I feel like there's more people in the Appalachian area reverted back to, you know, to what their – their relatives used for home therapy. I think they find that it would – that it would work with them a lot better because – Eating honey. Eating honey from the area. You know, going back and going, well, colloidal silver and apple vinegar, or cider vinegar, and stuff like that. Where is that, you know, why – why is that in everybody's in grandmother's house? Yeah. There's a reason for it, you know. You know, when, oh, you've got a – you've got a sore throat, well, moonshine and whiskey or moonshine and honey, you know.

Participants' Home Remedies for Their Family.

Home remedies of herbs, honey, and whiskey or moonshine are more common for adults who were born after 1940 (Cavender, 2003). Many of the participants describe the home remedies they use for their families.

A woman lived in a family who uses natural herbal remedies.

> I usually do some chamomile tea if they're having trouble sleeping or having leg cramps with some honey. The enzymes in honey are very good for your digestion and things like that so I use honey quite a bit in different aspects. I also, as a woman, you have cramps and things like that, my dad, whenever I was a teenager – this is kind of odd, but it was only a shot of whiskey. He would make me a shot of whiskey with honey for my abdominal cramps. It seemed to work. I don't know but it did. I

guess it just relaxes you a little bit. I don't know that I'll do that with my kids, but my dad thought it worked.

We use [peppermint] a lot especially whenever you're having problems with urination because peppermint is a natural diuretic. It'll make you pee like crazy. Make it as a tea. You just put it in regular tea and steep the peppermint in there. When you drink that, you will pee all day long, but it helps a lot if you're having dysuria or like you had a kidney infection or things like that. It'll clear the tract, clear the urinary tract.
We use various different things. We do like a menthol steam and you can get in the shower and do that too. A lot of times, they use the moon-shine and the garlic and honey or ginger because ginger will warm you up and that's the idea of it, is to break a fever. You drink that like a whole thing of it, like a cupful. Then you cover up with several blankets and it's going to make you sweat so you break a fever. Licorice is used a lot for colds and things like that. For migraines [rub peppermint] on your temples. Garlic oil, we use that a lot especially with sinuses. You know how they dry out and they crack sometimes? Rubbing garlic oil in there – and you know, your sinuses run to your ears and they get raw. If you use garlic oil in your ears, it helps too. Yes, garlic is very healing, blood-purifying, that kind of thing.

Another woman describes how care happens in her home.

Depending on if it's a simple cut or a big abrasion or whatever, obviously clean the area well with soap and water. I would tend to put something like tea tree oil or lavender oil onto the area to act as an antibiotic, antiseptic to the area. We've also had some good luck – we use colloidal silver quite a bit for wounds, and cuts and scrapes. I tend to cleanse the area and I'll spray it with a silver type spray solution. Then I'll coat it with a homemade antibiotic type cream that I have made myself with essential oils and may be some bees' wax and coconut oil to make a cream out of it. A balm, yes, salve. We have found that things heal faster since we've been using those remedies than the traditional over-the-counter Neosporin or whatever that we have – I have pretty much, most everything we've switched.

Stories of Inexplicable Cures.

A few of the participants had stories of experiences they had with healing that were directed by a family member or a friend. There was no way to explain how the healing occurred, but each assured the researcher that healing did occur.

Warts.

> My Grandmamma White had all kinds of things, like one time I had warts on my arms. I had warts right here on the sides of my arms right here, and she told me to put these sack bags over my hands, and I did. And then somebody took them off and I went and took those bags that I had to put them underneath a rock up somewhere and the next day, they were gone. I don't know how that worked, and it had something to do, I don't know. But it worked. I still do not have any warts on my – they were right there. And I had them around my fingers, too. They were gone.

An older woman described her aunt.

> I had an aunt who could heal and take away warts. I just come from a family that has a lot of old Appalachian ways. First of all, you had to believe, because when you would go to her, she would say, do you believe I can do this? And then if somebody said, well, I don't know, but I'm going to see if you can do it, she would refuse to do it. I would see people come, and she would take them, and there was always this tree that she took them to, and out behind the tree, and what she would do, I don't know, I never watched because you could not watch. She would take the person to this certain tree, but then they came back in three days, and then it would become, and then after it was gone, she did something else, so it would never come back.

An older man described healing from warts.

> A guy I worked with, he said – I heard he could do that. I said, Bobby, I said, I need to get rid of this wart. He said, what do you take for it? I said,

what do you mean? He said, how much money you want for that wart, which I thought was kind of crazy. I said, a quarter. He reached in his pocket and gave me a quarter. I didn't think much more about it, you know, and that thing left just left. I'd heard he'd done that. That's the reason I asked him. They said he could do it. I'm serious. It was gone. I ain't had no problems since, but I just felt it and it feels kind of rough there but there's nothing there.

A woman with a family history of the old ways told the story.

My grandpa was a logger and he was splitting firewood for our family. My grandpa said – you know how people call them worry-warts? There was this little boy, whenever my grandfather – when my dad was growing up, he was about his age. They were the same age and they were in the same little community and they played together. Well, the boy had warts all over his body and was very self-conscious about it and things. Well, my grandpa said, what you need to do is for every wart you have, pick up woodchip and you rub it on you. You throw it out behind your back and you forget about it. The boy did it. Well, about a week later, his skin was clear. My dad says it was like that's the idea of them being gone. He believed they would, that is what helped him.

The story the researcher was told about getting rid of wart by her mother.

My mother also told me about curing warts. She said that you took a pin and made an 'X' on the warts. Then you go to a certain tree in the yard and stick the pin into the tree. She had her warts go away doing that. The researcher had warts excised and still have the scars; her cousin used the old ways and has no scars.

Stop Bleeding.

Cavender (2003) related bleeding was stopped by saying the Bible verse Ezekiel 16:6 aloud. "And I passed by you and saw you weltering in your blood, I said to you in

your blood, ‘Live, and grow like a plant in the field.’ (p. 126).” Other stories of stopping bleeding were given to the researcher by a participant and the researcher’s mother.

> The story is my grandfather could stop bleeding. If somebody got hurt bad, they’d call him. I don’t know how he did that.” The researcher was told by her mother that the way to stop a nosebleed was to flatten a bullet and hang it on a string around your neck.

Taking out Fire.

A treatment to relieve the pain from a burn was related.

> There just people that could talk fire out of you. Say if you get burnt – in fact, I had a friend I used to work with that got burnt. I called him up for him and he talked to him and the pain just went away. I know two people – [the scar is still there], but just getting rid of the pain. I know two guys that used to do that and one girl used to do that. You talk to them and the pain would leave you.

Cavender (2003) found folk materials for burns were to use potato, soda, vinegar, butter and balm of Gilead to draw out the fire.

Cornbread and Pot Liquor.

A woman who is multigenerational Appalachian says,

> I can tell you the story that I always heard about my father’s mother who died at age 90. When she was young, she apparently had some sort of disease which kept her bedridden and I guess she couldn't walk well or couldn't get around well. I don’t even know what it was. They lived in Virginia and it was sort of a wealthy plantation-style family except they weren’t that far back but early 1900s, I guess, late 1800s. In those days, they didn’t feed people who were sick much, if anything. The story is that the doctor came and told her father, my great-grandfather, to go to Richmond and order the coffin because Nancy was going to die. At some

> point after that, they caught the maid feeding my grandmother pot liquor from collard greens or turnip greens or whatever and cornbread like mushed up. They swear that's what made her well.

Etic Health Care

Leininger (2006) defined etic care as that of the outsider or stranger. The etic care giver is often a health care professional who has institutional knowledge of health, wellness, and illness phenomenon. Emic caring is the caring provided by families, kinships, and communities using the knowledge passed down from generation to generation. Participants described using home remedies for many thing, but also sought at least yearly preventative and promotive care from Western Health Care providers.

Going to the Doctor.

> Well, I can't really say I kind of took care of it myself but I mean I had to go toward the steps of seeing that I was taking care just like this ear infection, you know, go to the doctor and kind of tell him what you need, what's going on, making sure that I contacted the ENT to say, you need to look at this; I need to see you. I kept following through for about a week before I got in, and it was going to be a long-term visit before they could see me, and I said, no, you're going to have to see me right away because I have hearing loss. I said, if you're not going to see me, then you need to send me to somebody else. They called me right back and said, okay, the doctor is in surgery now, but we'll let him know in the morning. The next morning, they called me and set up an appointment for that day. Two days after that, I had surgery to – half the time, I felt like I was proactive in the fact that you're not just going to blow me off. I'm seeing somebody, and this is getting better if I have to be my own referral. You just kind of have to be an advocate in your own care to what you know is going to be beneficial to you because the unsteady gait confusion, I kept hearing ringing in my ears was really affecting me at work. Although this was, they thought, acute issue, at the time, this has been going on about five or six months. See, this is not – no one was just listening to what I was saying.

[The doctors would say], “Okay, the ears are red or maybe there’s a little fluid back, but this is allergies. I don’t ever think that it was. I just think it built to the point where I couldn't take it anymore and it just ruptured, so much of the liquid. Since the tubes have went in, they run like you wouldn't believe. It comes out to where I can touch it It’ll be crusty. Since they’ve put them in – this one just ran. I won’t even know it until I just recently touched my ear and there’ll be drainage there.” I went, really?

A woman from Graham County tells,

Well, I’m proud – you know, I believe it depends on the person and what they want. If they care enough about their, themselves to want to live. Because there’s ways, I mean most of the people in this county are poor, but there’s ways, there’s women’s health plans that gives discounts and all this, there’s a place in getting – having good- if you take care of yourself, there’s ways. I thought, it depends on the individual. I mean I know this is a low income and lots of poor people, but there’s ways.

A woman who is struggling with her wellbeing describes her etic health care.

I do take medications for depression, anxiety, prenatal medications now, nausea medications. I have a referral to start seeing a psychologist, but I have not done that, not followed through with that. I plan to. I think having problems with healthcare right now, I know – you know, Obamacare has come in and it’s actually – it’s the year where it’s going to make a difference at tax time and people are offering doubt over that. People like me where I make enough money to live but not enough money to live as comfortably as I’d like, it’s really hard because I can’t – where I was at, I didn’t have insurance. I wasn’t offered insurance. When I was at the hospital, I was paying so much money a month for insurance, like $600 a month, plus my deductible is $4000. How do you reach that?

If it were easier to obtain healthcare as far as financially and like the cost of medications which has always been a problem, you know, pharmacist coming out with medications that will cost you $700 a month. You can’t

> afford to live very long like that when in all reality, it probably cost them $1 to make it. It's bogus to me.

Local Nurses' Stories.

Three of the participants were nurses of Appalachian origin. While most of their interview's discussed similar things as the other participants, several comments were different. The local nurses relate the problems with Appalachian health and wellbeing that they are seeing now.

One nurse relates,

> I think a big problem is prevention. The world right now, we're having all these shootings and all this, well, such and such found out they have a mental disorder. Well, guess what? They've had a mental disorder all their life but there's such a lack of help when it comes to mental healthcare. There's such a lack of resources and lack of understanding in people that actually – I've heard a lot around – in the mountains especially, it's all in your head; it's something that you could take care of. It's not. It's a disease and it's something that you can't necessarily control. I feel like a lot of things could be prevented if mental healthcare were addressed.

A second nurse describes her experiences,

> After working in medicine in Appalachia for now 15 years all told, as a nurse for 10, almost 11 years – I don't know exactly how many – I don't think that I had the normal Appalachian experience. I think that a lot of Appalachia deals with not having the support that I had, financially and emotionally. I think that there are a lot of children who don't receive the healthcare that they need. I think there are even more adults that don't receive the healthcare that they need. We do live in this culture where mental health is not encouraged nor supported, and really looked down upon and for that, the resources available are scant and of questionable quality at times

A third provides information about the opioid crisis in WNC,

For well-being? I don't know, because I'm seeing a lot of the negative stuff. I'm seeing a lot of the well-being, because of the hospital situation. The negative stuff is the drug use here. It's becoming a terrible, terrible epidemic. The meth, the heroine, the opiate pain meds and stuff like that. You see more and more and more of it and people aren't taking advantage of the services that are out there – what IS out there. It's very limited. It's just the healthcare system, as you know. The current primary physicians I see what they are doing now, they are trying to get all the people. They would try to get these people back off the opiates, because they saw that this opiate epidemic was happening, and now they were able to get people into pain clinics, because we do now have another pain clinic here. So, I see that as a good thing.

Primarily what [the doctors did was taking drugs away and not addressing pain], because they were sharing. Because of the income. They were sharing them with mama, or whoever in their family. A lot of them were selling it, because they could make good money off it. So that was a good thing that Macon County has done, and a lot of people have worked very, very hard, but then you see a lot of the negative. There is still a lot of drug use. And now with the [regional health care] system doing [refusal of] the Medicare or Blue Cross Blue Shield, it's scary. People are going to stop taking care of themselves because they can't afford it, so where are they going to do that? That's my worry.

[We are going to go backwards in health and well-being]. You hate to even think about all the drug use throughout the country. I think I see it more now because I do work in the jail system. It's funny, because I get that one person in and I will accidentally say, "So, what kind of drugs do you use?" instead of saying, "Do you use any illegal substances?" And t they're like, "No, I don't use anything." And you're like, wow. Really? It's that one person.

It's just weird, how many people are in trouble over people using. Which means, we are not solving whatever that problem is. No, because there's no outreach programs. There are waitlists at Meridian and stuff like that, so then they get released and they will go right back out. It's

> disheartening. [There is not enough employment.] "Fruit (of the Loom) is gone, Caterpillar is gone.

The nurses' comments focused on wellbeing concerns related to their communities, child health, opioid use (abuse), and mental health.

Chapter Summary

Emic themes were identified and included Communal Caring Relationships, Spirituality, Place Matters, Grandmothers Caring, and Etic Care. Specific actions and situations within each theme were discussed. The participants expressed spiritual wellbeing as the most important aspect of maintaining or attaining wellbeing.

Participants stated that physical activity in terms of being outdoors was a component of wellbeing. Many told of eating fresh foods that were killed or taken out of the family garden as part of a healthy diet. The use of home remedies was commonly described as current practice and of a generational practice within their families. Two participants expressed this best, [it] "goes back to the Appalachian home therapy. There are more people in the Appalachian area reverting back to what their relatives used for home therapy. I think they find that it would work with them a lot better. There's a reason for that. You've got a sore throat, well, moonshine or whiskey and honey. Eating honey, eating honey from the area, colloidal silver, and apple vinegar, stuff like that. Why is that in everybody's grandmother's house? Your family lived for a reason." A woman relates "I prefer to not let go of the growing of our own food, the salt of the earth, the medicine man, those were my people."

The participants expressed value in the traditional ways of care and caring that occurred in Appalachia. Wellbeing is having a spiritual foundation. Wellbeing is eating healthy foods and having an exchange with the elements outdoors. Wellbeing is eating local honey, and wild crafting local herbs. Wellbeing was maintaining relationships and helping one another with chores, sickness, and loss. Wellbeing is feeling emotionally well because one has maintained the spiritual and the physical.

CHAPTER V

SUMMARY

The data provided a description of what Appalachians in Western North Carolina view as caring ways to assure wellbeing. Leininger (2006) expresses a need to observe a culture to develop for behaviors that aid in understanding lifestyle of wellbeing and health. Culturally competent care relies of preserving lifestyle that assures wellbeing and health, to accommodate the health emic care actions, and to negotiate change in emic care behaviors that are harmful. The factors of the Sunrise Model guided analysis while the final review of data found themes that are similar, but not the same as Leininger's factors (Table 2).

Discussion and Conclusions

Five emic themes emerged from the data. The themes were similar to previous qualitative research with Appalachian groups. Themes identified answered research question one, but persons did not specifically answer questions 2-4 in terms of challenges, facilitators and barriers. Therefore, the researcher provides a summary review to reflect Leininger's model concepts of benefit and harm in terms of well-being discussed by participants.

What Are the Caring Behaviors That Benefit the Physical, Emotional, Mental, and Spiritual Wellbeing of Appalachian People of Western North Carolina?

The outdoors, the natural world, is connected to experiencing the spiritual, physical, and emotional world. Place as a prominent feature of Appalachian culture is supported by Behringer and Friedell (2006). The elements of the natural world are felt to be healing. Sunshine, water, digging in the dirt to garden are all seen as necessary to the participants in this study for wellbeing. Physical activity outdoors was described by participants as an important part of wellbeing. Rye et al. (2009) found that a place to safely engage in physical activity was a deterrent to exercise. Participants expressed no concern with a lack of a safe places to walk, hike, bike, swim, kayak, or run.

Caring is demonstrated by taking care of one another within the family and within communities. Community is connected with church membership or people that live in close proximity within a geographic location. Neighborhood is not suburbia with houses next to one another; neighborhood is within the same valley or hollow. Since much of Western North Carolina is rural, people within the same valley or hollow are a community. One participant supports this finding that churches or community organizations are "very close, very close-knit, they take care of their own."

Protection, security, and concern for each other occurred with families. Participants described the assurance of wellbeing from their parents as being the availability of food from the garden, game or livestock for meat, and heat within the home. Families were physically close within the home. No one had too many material

things or money, but feel that helping one another, our kids, our families and neighbors assured the wellbeing of relationships long-term.

Mothers and fathers tended to healthiness by maintaining clean houses and clean bodies. Exercise was a component of healthy behaviors in families. Caring required sacrifices by parents to assure children were healthy, well fed, and safe. Weller's (1966) comments about Appalachian's lack of interest in material or objectives outside the group demonstrate that the typical American culture and Appalachian culture do differ.

Wellbeing has been measured with a scale that includes health perceptions, social functioning, psychological functioning, physical functioning and impairment (Kaplan, Ganiates, Sieber, & Anderson, 1998). Wellbeing is more than measurements of the Wellbeing Scale to the participants. A focus on spirituality was most important aspect of wellbeing. Physical and emotional wellbeing seemed to hinge upon the presents of spiritual wellbeing. Spiritual wellbeing was related to having the herbal knowledge of the earth, the memories of the Cherokee or as a belief in God. There was a blending of Christianity and herbal home remedies expressed by many. The majority of participants expressed a Christian faith whether they attended church or not, and a few had faiths connected to the natural world. One stated he did not see himself as a spiritual person in any traditional sense of the word. Burkhardt (1994) also found that spirituality was a wholeness that permeated life for the women she interviewed.

Participants described the emic practices that nurture and protect the health of adults and children as behaviors related to diet and exercise. Gardens with organic food sources were cited, as well as, purchasing organic foods that are locally grown. Playing, walking, hiking, swimming, kayaking, tubing down rivers, and biking were components of physical activity. Some related a great deal of physical activity and some reported a need to increase their physical activity. Participants described the care they received as children and that they provide as parents. Home remedies were used by all of the participants, though some had mothers who took them to the doctor when they were sick without the use of home remedies. Many now use home remedies or wait it out for themselves and their children. The most common home remedies were a camphor and eucalyptus blend, whiskey or white liquor and honey and teas from locally available herbs. Barrish (2008) found people in Appalachia used herbs or household products instead of going to the doctor.

A few participants suggested that Appalachians in the area were reverting to using what grandma had in her kitchen for wellbeing care and what grandpa grew as healthy foods in the garden. Attaining wellbeing depends on being well fed with fresh organic foods; attaining a shelter of warmth and safety; and taking care of one another.

Participants did have at least one personal physician that was seen for a yearly check-up with blood work. Participants did complete appropriate screenings for health promotion and prevention. Participants followed medical regimes prescribed by their

primary care giver. Participants did consider diet and physical activity as components of a healthy lifestyle.

What Are the Caring Behaviors That Neither Benefit Nor Harm the Physical, Emotional, Mental, and Spiritual Wellbeing of Appalachian People of Western North Carolina?

Participants educational levels varied from high school graduate to graduate school, but none associated their education with health or wellbeing. The majority of participants worked for wages with one participant described wild crafting as way Appalachians earn extra money for Christmas gifts. Handicrafts and gardening were described as aspects of caring and wellbeing. Some participants discussed current political events in North Carolina and the United States, but not in terms of wellbeing.

One participant described the traditional ways of emic caring, stating,

> Eating honey, colloidal silver, and apple vinegar, whiskey and honey. Why is that in everybody's grandmother's house? Your family lived for a reason.

A woman related,

> I prefer to not let go of the growing of our own food, the salt of the earth, the medicine man, those were my people." Cavender (2005) found the use of folk medicine across socioeconomic classes within Appalachia also. No studies of the healthiness of home remedies has occurred, so it may be that the Old Ways of Appalachians are be beneficial.

What Are the Caring Behaviors That May Harm the Physical, Emotional, Mental, and Spiritual Wellbeing of Appalachian People of Western North Carolina?

A single participant described herself as not taking very good care of her wellbeing.

> I'm pretty guilty of not taking care of myself very much at all. I don't exercise, eat quickly and conveniently. I always have this. (Points to her nose). I have chronic bronchitis, asthma, allergies that are, I'd say, seasonally but it's every season, I'm allergic to something. I have had allergy testing and shots that did help, but I do not have health insurance, so I currently don't have an allergist. I just pretty much live with this day in and day out. Zyrtec makes me sneeze about the third of the amount of the times I would normally.

She had only recently gotten insurance again, Medicaid for pregnant women. She reported the most physical and mental health problems. She expressed a lack of friends to go to about her issues. Perhaps the lack of community is related to her poorer health outcomes.

The three nurses describe the problems with poor access to mental health care and the abuse of opioids and street drugs within their counties. One nurse related,

> I'm seeing a lot of the negative stuff. I'm seeing a lot of the well-being, because of the hospital situation. The negative stuff is the drug use here. It's becoming a terrible, terrible epidemic. The meth, the heroine, the opiate pain meds and stuff like that. You see more and more and more of it and people aren't taking advantage of the services that are out there – what IS out there. It's very limited. It's just the healthcare system.

> There is still a lot of drug use. And now with the [regional health care] system doing refusal of some insurances, it's scary. People are going to stop taking care of themselves because they can't afford it, so where are they going to do that? That's my worry.

Dunn, Behringer, and Bowers (2012) identified substance abuse in north central Appalachia. Substance abuse is a problem in southern central Appalachia as well.

A public health nurse describes the concern that children do not get the preventative health care they need due to finances. Adults are not accessing preventive health care even more so. Mental health is not supported.

> I think that there are a lot of children who don't receive the healthcare that they need. I think there are even more adults that don't receive the healthcare that they need. We do live in this culture where mental health is not encouraged nor supported, and really looked down upon and for that, the resources available are scant and of questionable quality at times.

Halverson, Friedell, Cantrell, and Behringer (2012) related that "the underlying cause of poor health outcomes is the absence of community linked and community responsive systems of health care across the region" (p. 89).

The next sections place findings in the context of current knowledge, perception and practice. Appalachian people are stigmatized as backward and uneducated. Appalachian's have been labelled as holding traditional lifestyles that prevent the people group from advancing into modern times. The negative perception of Appalachian people's way of being ignores the positive attributes of Appalachian

culture's lifeways. Appalachians have strong family ties and kinship connections that support the overall wellbeing of the group. The sense of beauty and place as being important to wellbeing is described by the participants of this study.

People living in the Appalachian Mountains are stigmatized by health care workers who are from outside of Appalachian regions. The idea that Appalachians are backward, poorly educated and fatalistic in their fate are readily applied. Stroessner and Green (2001) found that Appalachians have a strong sense of freewill and a strong sense of God's sovereignty yielding a strong internal locus of control. This finding is the opposite of fatalism as having no control.

The expectations of Appalachians are that others are relational and treat each other as equal members of the relationship developing trust (Caldwell, 2007). Health care providers such as physicians, nurses, and therapists are advised to see the people of Appalachia in a positive light and to develop the necessary relationship of trust by being personable. Appalachians have strong family values. Kinship groups and communities give emotional, social, physical, and spiritual support to one another. Appalachians tend to place others before themselves as priorities (Drew and Schoenberg, 2010).

The importance of meeting the care needs of Appalachian people that fit the cultural precepts of the people living there cannot be overstressed. Care actions provide help in maintaining health, attaining health if ill, and coping with disability and death. The lifeways of the Appalachian people should be applied for nursing care

to be effective in promoting wellbeing for people of Appalachia. Nursing care must be culturally based. Western Health care need to provide care in a culturally competent way from these findings to preserve a lifestyle of wellbeing and health, to accommodate the healthy emic care actions, or to negotiate change of emic care behaviors that are harmful (Leininger, 2006).

This ethnonursing study clarified the emic caring behaviors that nurtured and protected for people in the Appalachian Mountains of Western North Carolina. A purposeful use of the word wellbeing instead of health provided responses that were richer than asking about physical health. Appalachians have responded to health questions and survey as found in the literature review. Wellbeing was defined by the participants as a holistic, broader way of how Appalachians see their lives and the positive quality of life their emic way of caring creates.

Participants provided the stories of culturally beneficial care behaviors that assured their wellbeing. An understanding of the emic caring ways for Appalachian practices for holistic wellbeing may promote positive health outcomes for Appalachian people as nurses and other health care professionals provide culturally congruent care. Leininger's (2006) Cultural Care and Diversity theory was used to guide the iterative steps of data analysis, but the responses from participants were not fully consistent with the theory, though there were physical, spiritual, mental and emotional actions and connotations to descriptions of well-being. However, participants did not describe life as challenges and opportunities nor having specific

barriers. The focus for participants was the holistic attributes of the mountains and their culture for meeting their wellbeing.

Summary of Data

Appalachian participants described what life is like living in the seven most westerly counties of North Carolina. Appalachians value living in the mountains independently. Appalachians are self-reliant within their communities. Neighborliness is expected from all interactions. The beauty of the mountains and the connection to the natural world contributes to the sense of place; Appalachia is home.

The first research questions were used to elicit responses of well-being from participants. The other three research questions were answered from the data findings, but were not specifically asked of participants. In fact, the participants did not frame their responses in the more positivist yes or no responses, but solely told what life is like. Life and ways of caring for wellbeing were not described in terms of facilitation or barrier, challenges or opportunities, or good or bad. Ways of caring for wellbeing within the culture were the focus of the participants. Stories in ethnography, as shown in this study, reveal many ideas and understanding important to health that may not be obtained through traditional health assessments and research questionnaires. Providing better avenues for health assessment and care provision, including visit timing and place, is needed.

Clearly there is a need to promote positive health outcomes by improving access to health care, facilitating high school and college graduations at a higher level,

and soliciting industries to come to the seven most western counties of WNC to improve employment and income levels. Education levels, employment opportunity, and access to quality health care are known to improve the overall health of a person, family, and community. Cultural competence is necessary in caring for every person within a nurse's care. Appalachian people are no exception. This research is based on twenty-one participants from Western North Carolina. It is specific to the participant's responses and cannot be generalized to other populations. It does offer an initial explanation of Appalachian culture's emic caring ways. More research on emic caring ways within Appalachia is needed to further demonstrate ways nurses and other health care providers can provide the positive relationships needed to promote healthy outcomes for the people of Appalachia.

The ethnographic method of inquiry allowed this people group to tell their story. This study began to clarify the emic caring ways of Appalachian people, specifically within the seven most western counties of Western North Carolina. Appalachians currently do not meet the national outcomes related to health and disease. The participants in this study describe a lifeway that is consistent with the CDC (2015) definition of wellbeing. The participants described positive emotions and mood, satisfaction with life, fulfilment and positive functioning with one participant being the exception. Further research gleaning the stories of the Appalachian culture's emic caring ways for wellbeing are needed to better serve this people group's health care needs.

Implications from the Findings

Appalachian people need to be provided cultural care in a holistic manner assuring that spiritual, physical and emotional care are all met. Participants see spiritual, physical, and emotional (mind) as closely interconnected parts that cannot be separated from one another. Nurses and other health care providers need to provide holistic care to Appalachian people to effectively promote positive outcomes. The spiritual nature of Appalachians needs to be part of a plan of care while meeting physical health care needs. Nurses need to be attuned to the emotional state of the person being cared for as well as the family's emotional state.

Appalachian people in WNC know that fresh fruits, and vegetables are important dietary components for wellbeing. Nurses should influence cafeteria and patient tray menus towards a healthy diet of fruits, vegetable, whole grains, nuts and lean meats. Provide opportunities for people to go outdoors and into the elements of sunshine, fresh air, dirt, and fresh water. Hospitals could remodel rooms as sunshine rooms with lots of windows.

Emic care should be supported within the health care setting. Honey and lemon are healthful food sources and have been shown to provide positive immunological effect (Bilikova, Krakova, Yamaguchi, & Yamaguchi, 2015). Encouragement of teas for comfort and the biological effect can be supported. Participants like herbal teas and lemon and honey for sore throats. Nurses do not need an order for refreshments. Nurses can give black tea or most herbal teas with no concern for reactions to

medications. Nurses need to have an herbal reference for any concerns of interactions of pharmaceutical medications and herbal remedies to assure safe biological interactions.

A few participants described home remedies for wounds. “Clean it with soap and water of course, “I would tend to put tea tree oil or lavender oil onto the area to act as an antibiotic, antiseptic to the area. We have also had good luck with colloidal silver.” Another relates because they lived so far away from town, “They mixed up herbs and things to make a poultice, liniments or black tar to the wounds. And it would get better.” Physicians and nurses use antimicrobial ointments and colloidal silver in wound care. Perhaps health care providers can accept herbals and essential oils that also heal wounds.

Holistic care and providing the aspects of wellbeing specific to Appalachians may seem time consuming. Nurses also need to be aware that communication requires understanding the importance of personability when meeting with a person from Appalachia. Nurses need to recognize a cordial interaction with an unhurried approach will better achieve a supportive and trusting relationship (Griffin, Lovett, Pyle, & Miller, 2011; Keefe & Greene, 2005). Frederickson, Acuna, Whetsell, & Tallier (2005) remind nurses that effective communication requires an understanding of a word, phrase, or concept meaning understood not only in American English, but in the language the person speaks. Appalachian dialect may present with a different meaning than the nurse’s definition (Blakeney, 2005).

Nurses and other health care providers need to recognize Appalachian people make health care decisions based on overall family needs. To promote healthy outcomes for a person from Appalachian culture, social service supports may be needed to avert undue financial stress on the family as a whole. Teaching for the person, his/her family, and the community has positive effect on health care decisions (Au, Cornett, Nick, Wallace, Wang, Warren, & Myers, 2010).

Access to health care for the participants and others described by the local nurses is dependent on having health insurance and the financial stability to pay for health care services. The data related to health, morbidity, and mortality has not been updated during the interview process of this study. Unemployment rates have declined from ranges of 6.3% - 13.8% to 3.9% - 7.5%, yet the financial and economic distress measurements showed no improvement for any of these counties, and one, Jackson, has declined to be at risk (ARC, 2017). Nurses and other health care providers need to consider these attributes of people within Appalachian communities, since poverty and limited employment are associated with poorer health outcomes. Participants in this study were similar to the Appalachian population in their educational, employment, and financial status, but qualitative research is not generalizable to the entire people group of Appalachians.

One participant described health insurance cost for herself and her children as being $600 per month and a $4000 deductible at a previous employer. Her current employer does not offer insurance. Her required medications would cost her $200 per

month. Her annual income is $43,056. North Carolina (NC) did not expand Medicaid with the advent of the Affordable Care Act of 2010 (ACA). In states where Medicaid was not expanded an annual income of $8,870 or less qualifies a family of three for Medicaid (Garfield & Damico, 2016). She begins a new job that will offer insurance, but the cost to her is unknown.

This participant is not unique in NC. The Kaiser Foundation (June 2017) reports that 35% of NC's population are low income, but only 18% are covered by Medicaid. The participant has only recently qualified because of a pregnancy. This participant is employed like 74% of NC's population on Medicaid. Her income would not typically qualify her for Medicaid in NC, since she nears the 175% ($43,925) of poverty level. Positive health outcomes have been demonstrated with access to health care insurance. The purpose of the ACA was to provide insurance coverage across socioeconomic lines. Failure on NC's part places citizens' health at risk.

Nurses need to become politically involved in expecting all the people they care for have their health care needs met. The researcher would request nurses to read reports and articles that address the disparities of health outcomes within their region. The reference list of this paper is a good place to start.

Several participants mentioned the unemployment or underemployment of people in WNC. One retired teacher said there were previous students of hers, outstanding students, who were working at poorly paying fast food restaurants instead

of better jobs. These previous students, she said were more than capable of skilled employment.

Implications for Further Study

Additional studies of emic caring ways within the various regions of Appalachian may provide data for effective health care interventions and outcomes. An increased knowledge of Appalachian people would allow for a better understanding of how to meet the holistic needs of Appalachians. Nurses need to become readily involved in the research process to assure they provide competent holistic cultural care.

Community-based participation studies with people who have mental health disorders and their families within Appalachia may improve the health outcomes of people who suffer from mental illness. There is a stigma in Appalachia about admitting to having a mental health disorder. Perhaps, educational programs in churches and community centers would provide a way to de-stigmatized mental health disorders.

The opioid epidemic is rampant in Appalachia. One of the solutions a nurse participant described was to stop giving prescription opioids. This solution does not address the underlying cause of opioid and street drug abuse. Research is needed, and an effective intervention designed to address the need for pain medications as an abuse activity. Opioid abusers do need something. Instead of sending people who abuse

drugs on their way without a prescription, discovering what the issue is for them may be a first step in intervention.

Another nurse participant expressed concern that children were not getting all the preventative and promotive care they need as they grow up. A tally of school children's health care access could easily be done. Public Health departments and clinics could provide more care interventions to assure the care a child needs occurs. Comparative research of children who have access to care and those who do not would demonstrate the disparity of health outcomes as children and subsequently adults.

Chapter Summary

The purpose of this study was to explore the emic caring ways of people who lived in WNC Appalachian Region. An emic understanding of Appalachian Region's caring resulted in a cultural context of wellbeing and implications for competent care actions by Western health care providers. Appalachian people need holistic cultural care that includes spiritual, physical, and emotional care. The findings from participants may be used to preserve and maintain healthy lifestyle patterns within the emic ways of care.

These findings may be used to accommodate and negotiate those emic care actions that are healthy and congruent with known etic caring ways of health, wellbeing, as well as, assist with illness or dying. Findings may help nursing and other professionals incorporate emic care that is in need of repatterning and restructuring towards lifeways that are beneficial to health and wellbeing (Leininger, 2006), and etic changes to traditional health care.

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APPENDIX A

QUALITATIVE AND DEMOGRAPHIC FINDINGS

Table 1

Demographics and Behavioral Risk Factor Surveillance System Questionnaire (*N*=21)

Characteristics	*N* = 21	*N* (%)
Identity		
Appalachian		38.1%
North Carolinian		14.29%
Southern		4.76%
Mountain/all the above		28.57%
Not sure	*N* =21	14.29%
Age range	*N* = 21	25 – 70 years
Gender – female	*N* = 21	80.95%
Years of school completion		
Grade 12 or GED		9.5%
College 1 – 3 years		38.1%
College 4 or more years		28.57%
Graduate school (master's)	*N* = 21	23.81%
Employment status		
Employment for wages		71.43%
Self-employed		4.76%
Retired	*N* = 21	19.04%
Annual income		
$10K - $15K		4.76%
$15K - $20K		9.53%
$25K - $35K		19.04%
$35K - $50K		33.33%
$50K - $75K		14.29%
Greater than $75K		4.76%
Refused	*N* = 21	9.53%

Table 1

Cont.

Characteristics	*N* = 21	*N* (%)
Racial group -		
White or European American		99%
Cherokee	*N* = 21	1%
Marital status		
Married		66.66%
Separated		23.81%
Divorced		4.76%
Never married	*N* = 21	4.76%
General health		
Excellent		19.0%
Very good		47.6%
Good		23.81%
Fair	*N* = 21	9.5%
Health insurance	*N* = 21	100%
Health care provider –		
One		80.95%
More than one	*N* = 21	19.04%
Colonoscopy	*N* = 11	72.7%
Prostate exam	*N* = 3	66.6%
Mammography	*N* = 10	100%
Papanicolaou (*N*=18)	*N* = 11	61%
Zip Codes - 28713		4.76%
28716		4.76%
28734		28.57%
28738		4.76%
28741		14.29%
28751		4.76%
28771		4.76%
28779		14.29%
28786		4.76%
28788		4.76%
28789		4.76%
28904	*N* = 21	4.76%

Table 2

Comparison of Leininger's Sunrise Enable to Appalachian Cultural and Social Structure

Cultural values, beliefs, and lifeways provide the expectations of communal caring relationships of families, kinship relations, communities, and collective groups.	**Communal caring relationships** provide a strong sense of family responsibility for nuclear family, kinship family and community. Collective communal caring relationships demonstrate a concern with other people's feelings and welfare more so than their own issues or problems.
Kinship and social relationships are the organizational structures of a culture that define family units, extended families, and communities.	**Kinship relations** are the mechanisms of the way Appalachian culture effectively and successfully deal with family protection and support, as well as, local and communal affairs.
Religious and philosophical factors are the moral guides for daily living. Worship practices and ceremonies are a means of demonstrating spiritual concepts	**Spirituality** is the blending of the physical world, use of herbal cures from the Old Ways, Cherokee ways, and Christian faith
Environmental Context is an over reaching idea of geographic location, ways of living with culture, lifeways, relationships, religion, emic and etic caring ways.	**Place matters** describes the importance of the fabric of the landscape in relation to Appalachian wellbeing. People like to be outdoors in the natural world.
Emic Folk Ways are the practices by a people that nurture and protect the health of adults and children within a culture.	**Grandmother's caring** for wellbeing include eating a nutritious diet, exercising outdoors, and using the remedies passed down through generations for maintaining and attaining wellbeing.
Etic health care is a health care professional who has institutional knowledge of health, wellness, and illness phenomenon	**Emic caring** is the caring provided by families, kinships, and communities using the knowledge passed down from generation to generation.

APPENDIX B

QUALITATIVE AND DEMOGRAPHIC ASSESSMENT TOOLS

Interview Guide

I want you to tell me about what it is you do to assure wellbeing, take care of yourself.

Let me ask you this, can you tell me a story about how your mama or daddy would make sure that you or your family, growing up, was well and was cared for?

When you were little, if you think about a time you were sick at home, what did your mama do about that, like the things that she did at home.

What were the ways you have used care or caring to assure well-being for your children, family or kin?

Do you remember any stories that your grandma or your grandpa told about care or caring to assure well-being for you and your family?

Tell me about the differences in ways you see nurses and doctors care for people in the Appalachian Mountains and the ways your family cares for people.

Are there any other stories you can tell about care or caring practices used for physical, emotional, mental, or spiritual well-being for yourself, your family or kin?

Demographic Survey Questions of Appalachian Health

1. How would you most likely identify yourself from the groups below? (select any that apply)

(0) Appalachian

(1) North Carolinian

(2) Southern

(3) Mountain

(77) Don't know/not sure

(99) Refuse

2. What is your age? (_____) age in years

(77) Don't know/not sure, (99) Refuse

3. What is your gender?

(1) Female (2) Male (99) Refuse

4. In what county, state, and ZIP code do you live? _____

5. What is the highest grade or year of school you completed?

(1) Never attended school or only attended kindergarten

(2) Grades 1 through 8 (elementary)

(3) Grades 9 through 11 (some high school)

(4) Grade 12 or GED (high school graduate)

(5) College 1 year to 3 years (some college or technical school)

(6) College 4 years or more (college graduate)

(7) Graduate school (master's degree)

(99) Refuse

6. What is your employment status?

(1) Employment for wages

(2) Self-employed

(3) Out of work for 1 year or less

(4) Out of work for less than 1 year

(5) A homemaker

(6) A student

(77) Retired

(88) Unable to work, (99) Refuse

7. What is your annual household income from all sources?

(1) Less than $10,000

(2) $10,000 to $15,000

(3) $15,000 to $20,000

(4) $20,000 to $25,000

(5) $25,000 to $35,000

(6) $35,000 to $50,000

(7) $50,000 to $75,000

(8) Greater than $75,000

(77) Don’t know/not sure, (99) Refuse

8. Which one of these groups would you say best represents your race?

(10) White or European American

(20) Black or African American

(30) American Indian or Alaskan Native

(40) Asian American

(50) Pacific Islander

(60) Other

(77) Don't know/not sure, (99) Refuse

9. What is your marital status?

(1) Married

(2) Divorced

(3) Widowed

(4) Separated

(5) Never Married

(6) Member of an unmarried couple

10. How many children less than 18 years of age live in your household?

_____ Number of children

(88) None, (99) Refuse

11. What would you say that in general your health is?

(1) Excellent

(2) Very good

(3) Good

(4) Fair

(5) Poor

(77) Don't know/not sure, (99) Refuse

12. Do you have any kind of health care insurance coverage?

(1) Yes

(2) No

(77) Don't know/not sure, (99) Refuse

13. Do you have one person you think of as your personal doctor or health care provider?

(1) Yes, only one

(2) Yes, more than one

(3) No, I have no person who I think of as my personal doctor or health care provider

(77) Don't know/not sure, (99) Refuse

14. Have you seen a doctor, or health care provider in the past 12 months?

(1) Yes

(2) No

(77) Don't know/not sure, (99) Refuse

15. About how much do you weight without shoes? _____ Weight in pounds

(77) Don't know/not sure, (99) Refuse

16. About tall are you without shoes? _____ Height in feet and inches

(77) Don't know/not sure, (99) Refuse

17. Have you had a sigmoidoscopy or colonoscopy in the past year? Within the past ten years?

(0) not applicable

(1) Yes

(2) No

(77) Don't know/not sure, (99) Refuse

(0) not applicable

(1) Yes

(2) No

(77) Don't know/not sure, (99) Refuse

19. Have you had a pap smear in the last year? Within the past three years?

(0) not applicable

(1) Yes

(2) No

(77) Don't know/not sure, (99) Refuse

(1) Yes

(2) No

(77) Don't know/not sure, (99) Refuse

20. Have you had a mammogram in the last year?

(0) not applicable

(1) Yes

(2) No

(77) Don't know/not sure, (99) Refuse

21. Have you had a prostate exam in the last year?

(0) not applicable

(1) Yes

(2) No

(77) Don't know/not sure; (99) Refuse