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Being aware: The meaning of the relationship between social support and health among independent older women.

Susan Elaine Trippet
University of Alabama at Birmingham

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Trippet, Susan Elaine, D.S.N.

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BEING AWARE: THE MEANING OF THE RELATIONSHIP BETWEEN SOCIAL SUPPORT AND HEALTH AMONG INDEPENDENT OLDER WOMEN

by

SUSAN E. TRIPPET

A DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of Doctor of Science in Nursing in the School of Nursing in The Graduate School, The University of Alabama at Birmingham

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ABSTRACT OF DISSERTATION
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Americans are aging and the majority of those aging are women. As a result of the rising numbers in the aging population, researchers are looking at health. The health of older women can have a bearing on women's social support, yet the relationship between health and social support lacks clarity.

The purposes of this study were to clarify the meanings of the concepts, health and social support, and to discover the meaning of the relationship between health and social support among independent older women. Clarification of the concepts and their interrelationship helps to make operational the definitions of the two concepts which aid researchers in adequately measuring the concepts.

Three research questions were answered by utilizing a descriptive grounded theory methodology. Those three questions were: (a) What is the meaning of health, (b) What is the meaning of social support, and (c) What is the relationship between health and social support among independent older women? After receiving study approval by the Institutional Review Board for Human Use, these questions were asked of 15 women.

A substantive theory was generated from the findings. Health meant being in harmony or balance, well-being, and "managing stress." Social support was the outcome of caring, acceptance, and trust. The meaning of the relationship between health and social support was being aware which had three stages.

The implications for nursing practice and nursing education dealt with the three answered research questions. Recommendations for further refinement of the theory and for future research were made.

Abstract Approved by: Committee Chairman Janice Templeton Day

Program Director

Date _____ Dean of Graduate School

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To the women, my subjects, I give a special appreciation. They gave willingly and openly of their time, energy, thoughts, and patience. From them I learned not only about health and social support, but, also, how I might be as an older woman.

I thank my family for being tolerant and supportive when I could not be with them. I appreciate my father's generous support during the doctoral process. To my sister and brother, thank you for understanding and supporting me.

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CHAPTER I

The Problem

Americans are living longer, and researchers are projecting that by the year 2030 approximately 20% of the American population will be age 65 and older (Andreoli & Musser, 1985). With the rising numbers in the aging population, researchers are looking at the concept of health to ascertain how to deal with acute and chronic conditions occurring in the aging population.

Women constitute the majority of the aging population in the United States because they live longer (Woods, 1985). Not only are women living longer, they are living with specific issues that affect the aged. One of those issues is social support, those people with whom older women have relationships and to whom the women turn in times of need. The health of older women can have a bearing on women's social support. The relationship between health and social support among older women appears to be interactional, but, as yet, the interaction lacks clarity and definitiveness.

Health

Health has been conceptualized and studied from several perspectives. Two perspectives have been psychological well-being (Fuller & Larson, 1980; Keith, 1985) and perceived health, which includes psychological and physical well-being (Antonucci & Jackson, 1983; Brown & McCreedy, 1986; Reed, 1983). Antonovsky (1979) advanced the salutogenesis model of health in an attempt to integrate anthropological philosophy and medicine.

Grasser and Craft (1984) discussed the differences among health promotion, disease prevention, health maintenance, and wellness behaviors. Jordan-Marsh, Gilbert, Ford, and Kleeman (1984) presented a conceptual framework for assessing health status which included support structures and the environment. A conceptual framework including factors and responses in the person-environment-health fit was presented by Shaver (1985). Washington (1985) suggested a similar model of the person-environment-health fit in relation to wellness. Gelein (1983) proposed that there was a difference in self-perceived health and perceived well-being in the elderly. She advocated an interactional fit of person, environment, and health from the elders' meaning of health (Gelein, 1983).

Jordan-Marsh et al. (1984) specifically linked health status and social support. Several other authors noted a link between health and social support (Gore, 1978; Hubbard, Muhlenkamp, & Brown, 1984; Langlie, 1977; Lin, Simeone, Ensel, & Kuo, 1979; Moriwaki, 1973; Turner, 1981). These authors confirmed the assumption that there is a relationship between health and social support.

Social Support

Experts with the social support concept have agreed that social support is necessary for individual well-being (Cobb, 1976; Henderson, 1977; Ide, 1983; Israel, 1982; Lashinger, 1984; Mitchell & Trickett, 1980; Mueller, 1980). The statement that social support is necessary for individual well-being implied that human beings need to feel the sense of being supported by others. Some experts advanced that idea to include the negative: The absence of some form of social support may lead to disease (Dean & Lin, 1977; Dimond & Jones, 1983; Kaplan, Cassel, & Gore, 1977; Nuckolls, Cassel, & Kaplan, 1972). Weiss (1974) suggested

that without social support or social bonds, an individual would suffer social isolation. Without social support, however defined, human beings would experience some distress, which would in time affect their physiological or psychological functioning.

In order to discuss the usability of social support, a clarification of the term and the related terms is necessary. Social support is sometimes confused with social networks. Social networks usually involve linkages between members and an exchange between the members with emphasis on the linkages. Social interaction often is used synonymously with social support. Social interaction is a verbal and non-verbal exchange between people. All three terms tend to be measured quantitatively, e.g., frequency of interaction and number of people interacting. Social support is more than those measures, although it is frequently part of research variables. Social support is the nature of the relationship: the relational provisions, the information given, the structure, and the interaction (Dimond & Jones, 1983). Some experts suggested that social networks encompass social support (Cobb, 1976; Conner, Powers, & Bultena, 1979; Israel, 1982; Laschinger, 1984; Mitchell, 1969; Simons, 1983-84; Tolsdorf, 1976). Other experts suggested that social support encompasses social networks (Broom & Selznick, 1973; Hubbard et al., 1984; Killilea, 1976; Lin et al., 1979; Linn, Dean, & Ensel, 1981; Norbeck, 1981; Shumaker & Brownell, 1984; Thoits, 1982). Social support would appear to encompass social networks because social support does not require the linkages nor the intensity (density) within the linkages that social networks appear to require. Social support, also, would include social interaction because that interaction requires some sort of relationship, however tenuous.

Social support appears to play a part in the older person's social interaction with others, older person's perceptions of themselves, and their physical and psychological functioning. Because social support and health are considered multidimensional concepts, many researchers have chosen to study selected aspects of both concepts.

Throughout the literature there was a lack of adequate and consistent conceptualization and measurement of social support and health (Thoits, 1982; Tilden, 1985). Social support and health usually were conceptualized and measured from the researchers' perceptives without consideration of the subject's perspective. No research was found to have explored the meanings of social support and health to older people, specifically older women, from the perspective of the women. Thus, this study focused on "identifying the conceptual links among categories of data" (Knafl & Howard, 1984, p. 22) that underlie the multidimensional facets of health and social support. The explication of the conceptual linkages facilitated the development of operational definitions.

The Purposes

The purposes of this study were to clarify the meanings of the concepts of social support and health and to discover the meaning of the relationship between social support and health among independent older women.

Theoretical Considerations

Both social support and health were considered multidimensional concepts for which no consistent definitions were found in the theoretical and the research literature (Tilden, 1985). The conclusions in the theoretical literature on social support (Depner, Wethington, & Ingersoll-Dayton, 1984; Ell, 1984; Shumaker & Brownell, 1984; Thoits, 1982; Tilden, 1985) and health (Gelein, 1983) were that the meanings of both concepts

should be examined from an inductive and deductive approach to facilitate understanding and measurement of the concepts. Gelein (1983) suggested that a clear understanding of the person-environment fit in the acquisition of health was lacking. At present, the fit is based on health professionals' perceptions of the declining health patterns in the aging population and on the possible age bias in the standards and norms for assessing health (Gelein, 1983).

Several researchers have suggested that research in the women's health arena occur from women's lived experience (MacPherson, 1983; McBride & McBride, 1981; Oakley, 1981; Webb, 1984). To facilitate conceptualization of the meaning of the relationship between social support and health and to project adequate descriptions of social support and health the following concerns must be addressed: (a) clear definitions and understanding of the meaning of the relationship between social support and health (Thoits, 1982; Tilden, 1985), (b) delineation of the conceptual framework (Tilden, 1985), (c) delineation of the assumptions underlying the framework and the concepts (Tilden, 1985), and (d) operational definitions of the concepts (Tilden, 1985).

Conceptual Framework

The conceptual framework for this study included the metaparadigm of nursing as described by Fawcett (1984), the concepts of social support and health, and symbolic interactionism. The decision to utilize the metaparadigm of nursing and symbolic interactionism with social support and health was based on the ideas presented by Gelein (1983), Shaver (1985), and Washington (1985). These authors presented their conceptualizations in the context of the person-environment-health fit which is the basis of Fawcett's (1984) metaparadigm. Gelein (1983) supported

using symbolic interactionism as the linking element in the person-environment-health fit. Symbolic interactionism is a common conceptual framework used with qualitative inquiry.

Before a discussion of metaparadigm can occur, a brief discussion of paradigm is necessary. Kuhn (1962) was most often cited in the literature as having suggested the current usage for the word paradigm. He suggested four uses of paradigm: (a) representing a new conceptualization of the phenomena, (b) suggesting a new methodological procedure, (c) suggesting new problems for solution, and (d) application that explains phenomena in a new way (Kuhn, 1962). In the present study, paradigm is being used to suggest a new methodological procedure and through its application will explain the phenomenon of the meaning of the relationship of social support and health among independent older women in a new way. The link between paradigm and metaparadigm is, according to Hardy (1983), that a metaparadigm is the gestalt or world view held by a majority of the members of a discipline.

Metaparadigm of Nursing

The metaparadigm of nursing, as described by Fawcett (1984), included the concepts central to the discipline of nursing: person, environment, health, and nursing. The person is the individual, family, community, or society receiving nursing actions (Fawcett, 1984), In the present study, the person is the independent older woman.

According to Fawcett (1984), the environment is the "relevant animate and inanimate surroundings within which the person exists" (p. 6). The environment of the present study includes the physical resources and sociocultural resources in society (Gelein, 1983). Physical resources may include the human needs of air, food, water, elimination, shelter,

safety, and security. Sociocultural resources may include norms, standards, and values, also, perhaps the needs of love, belonging, self-esteem, and self-actualization (Gelein, 1983).

Health is the place on the "health-illness continuum within which the person falls at the time of interaction with the nurse" (Fawcett, 1984, pp. 5-6). Health is a fluid or dynamic state and is subject to individual interpretation. Health, for the present study, is the meaning given by older women to health.

Nursing is the "nursing actions themselves" (Fawcett, 1984, p. 6), the actions performed by nurses. Nursing actions during the present study are questioning, listening, and commenting by the investigator in interaction with independent older women.

Social Support and Health

Social support is conceived as a health behavior that potentially influences states of health and illness, i.e., "being loved, cared for, or simply listened to can make people feel better, thus reducing perceived stress and, also, promoting (directly or indeirectly through its effects on stress) physical and mental health" (House, 1981, p. 37). Social support can directly enhance health and well-being because it meets important human needs for security, social contact, approval, belonging, and affection (House, 1981). Health is conceived as the internal resources and external expression given by people to reflect their state of being (Gelein, 1983). Health ". . . depends on personal need satisfaction as well as environmental resources . . . [and it is] a continuous process" (Gelein, 1983, p. 64). "To understand more about the process of health, and what influences maximal health in older women, it may be necessary to leave behind predefined variables and explore inductively the meaning of health in old age" (Gelein, 1983, p. 60).

Symbolic Interactionism

Symbolic interactionism undergirds the paradigm by providing the linkage of the four concepts in the metaparadigm; it is the theoretical background for the symbols of communication. Symbolic interaction theory espouses that a person develops a sense of self and a sense of environment through social interaction and subjective interpretation of the person's own behavior and the behavior of others (Hardy, 1983). From the interpretations of the person's own behavior and the behavior of others meaning is derived.

Symbolic interactionism, as conceived by Blumer (1969), was based on three premises,

> . . . human beings act toward things on the basis of the meanings that the things have for them. . . . the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows . . . these meanings are handled in, and modified through an interpretative process used by the person in dealing with the things he encounters (Blumer, 1969, p. 2).

These premises will provide the basis for the assumptions of the study found later in the chapter.

Interrelationships of the Concepts

The interrelationships of the four concepts in Fawcett's (1984) metaparadigm within the context of the study are as follows. The person, the independent older woman, is interacting with the environment to maintain health. Health requires the interaction of the person with other people and the environment. Social support arises from the interactions of people within the environment in order to maintain health. Nursing has knowledge of health and environment as well as of people. With the results of the research, nurses can provide formal or organizational social support to independent older women, assisting or augmenting their health behaviors.

Assumptions

The assumptions for the study were that:

1. Social support exists among older women (Adams, 1985-86).

2. Social support has meaning to older women (Adams, 1985-86; Heller & Mansback, 1984; Roberto & Scott, 1984-85).

3. Health has meaning to older women (Laschinger, 1984).

4. A relationship exists between social support and health among older women (Gelein, 1983; Shaver, 1985; Washington, 1985).

5. Independent older women are different from dependent older women.

6. Independent older women participating in social or professional organizations are able to articulate their meanings of social support and health.

The Problem

The problem was--What is the meaning of the relationship between social support and health among independent older women?

Research Questions

The research questions were as follows:

1. What is the meaning of health among independent older women?

2. What is the meaning of social support among independent older women?

3. What is the meaning of the relationship between social support and health among independent older women?

Definition of Terms

The definition of terms were as follows:

Meaning - A person's mental extraction of the social interaction with other people which is modified through a subjective interpretative process (Blumer, 1969). The operational definition of meaning is the

words and phrases used by independent older women to describe social support and health in the context of their experiences.

Relationship - The connection between two or more ideas, concepts, or things.

Social Support - Through interaction with others, a person's social needs are gratified (Kaplan et al., 1977; Thoits, 1982). The operational definition of social support is the meaning older women give their relationships and behaviors.

Health - A person's perceived dynamic state of well-being which encompasses the physical, mental, social, and emotional dimensions. The operational definition is the meaning older women verbalize about their state of well-being.

Independent - A person's physical ability to complete the activities of daily living alone and to choose to live in nonage-segregated environment, her own home or apartment. The operational definition of independence is determined by the Screening for Independence Criteria tool (see Appendix A).

Older Women - Women aged 60 to 74.

Significance of the Study

Through the qualitative exploration of independent older women's meanings of social support and health, the two concepts will be clarified. Discovering the subjects' meanings of the concepts adds a new dimension to the current definitions. The added meanings from the subjects' perception helps to make operational the definitions of social support and health.

Because of the multidimensionality of the concepts, quantitative researchers have been limited to studying selected aspects of social support and health. A qualitative approach is less restrictive with

multidimensional concepts, thus, allowing for a more complete picture of the concepts. Also, the context of social support and health will not be removed from the meaning as it may be with the quantitative approach.

Clarifying the conceptualization, including the subjects' perceptions of the conceptualization, and providing operational definitions of social support and health will advance researchers' abilities to adequately measure the concepts (Depner et al., 1984; Shumaker & Brownell, 1984; Thoits, 1982; Tilden, 1985). The attainment of these two goals will contribute to the body of knowledge for nursing as well as other disciplines. The knowledge can be tested and used to develop measures of social support and health from which standards and norms regarding health among independent older women may be generated (Gelein, 1983).

CHAPTER II

Preliminary Review of Research Literature

Introduction

The review of the research literature focuses on six areas of research: research on health in the elderly and in older women, research on social support in the elderly and in older women, research on social support and health in the elderly, and research on social support and health in older women. The purpose of the review is to highlight some of the previous research as it relates to this study. For a study using a grounded theory methodology, the investigator needs to review the literature to ascertain what has and has not been researched, what the methodological problems have been, and what the findings were. There is a constant possibility of the investigator sensitizing him or herself to the subject area; therefore, the investigator must be selective in the review of literature. For that reason, the review of empirical literature is scant in some of the six areas of focused research.

Health and the Elderly

Two empirical articles on health and the elderly were selected. The first (Larson, 1978) was a classic article cited in many other reports. The second article (Brown & McCreedy, 1986) focused on the health behaviors of the elderly and highlighted the finding that health status and health behvaiors were not necessarily related.

Larson (1978) conducted a secondary analysis of the last 30 years of research on subjective well-being, one of the ways of perceiving and

measuring health. He identified the diversity of measures and variables studied, the loose operational definitions of the concept, methodological problems with sample size or procedures, and the over generalization of the findings. Unfortunately, he did not offer any suggestions on how to reduce or eliminate the problems.

Brown and McCreedy (1986) described the health behaviors of the elderly and explored the determinants and health consequences of those behaviors. Of the 386 subjects, almost half were 65 to 74, while the older half was split between 55 to 64 and 75 and older. Two-thirds of the subjects were women. Health was implied to be in whatever perceived physical state the person was. Brown and McCreedy concluded that the subjects' health status and health behavior were not related and that older people might benefit from health promotion programs tailored to the individual, and that health professionals might encourage the promotion of infrequently practiced health behaviors around the home or automobile safety.

Health and Older Women

During the preliminary search of the empirical literature, only one article was found that reported on health in older women. All other research was on health and social support in older women. The fact that only one research report was found suggested the need to study older women and health. It also gave the opportunity for the investigator to include older women's perceptions of health.

Utilizing several measures of psychological well-being, Carp and Christensen (1986) interviewed 88 women aged 60 to 92 to assess the relationship between the objective environmental resources and well-being. Their measures were researcher-constructed and used language that the ordinary person would not use, such as harm-avoidance and

noxi-avoidance. Carp and Christensen's results validated that well-being had its own meaning for women that may or may not fit with the researchers' meaning, particularly as defined by present scales and questionnaires.

Social Support in the Elderly

The research literature encompassing friendship and the confidant relationship comprised the literature on social support in the elderly. Babchuk (1978-79) queried 800 men and women 45 to 85 years old on the confidant relationship. She found that around age 70, people begin losing their primary friends and at 65 begin losing their confidant friends. She concluded that women more than men have extensive social ties.

On the issue of friendship, Cohen and Rajkowski (1982) discovered that people had different meanings for friendship and that no current measurement would adequately cover those various meanings. They sampled 161 residents of single room occupancy hotels in New York City. All the residents were 60 years old and older.

Ide (1983) explored social networks in 85 people aged 60 to 89 to determine the relationship between perceived accessibility resources and interactional social network elements. She found that range and perceived availability were the important access properties. Closeness, content, durability, and directness were the interactional properties. Directness meant "lack of reciprocity in relationships" (Ide, 1983, p. 237).

The three empirical articles cited issues of the elderly. Those issues were losing their important friends in the sixth and seventh decades; the meaning of friendship being different from the available measures; and the perceived availability, closeness, and content of

social relationships had importance for older people. These conclusions suggested that friendship and the interactional properties of relationships change their meaning and usage with age.

Social Support in Older Women

Social support in older women was studied from the perspectives of coping, loneliness, and marital status. Research was found that studied health and social support among older women.

In Switzerland d'Epinay (1985) studied how coping related to socio-cultural conditions of older women living in urban and rural areas. He was interested in how older women dealt with depression and discovered that rural women had a more difficult time coping than urban women. He attributed the difficulty to the social structure of the rural community and the fragility of the rural marriage. He speculated that the rural woman had a smaller and more fragile support system.

Essex and Nam (1987) examined the relationship of loneliness to marital status in 356 older Wisconsin women. Using several measurements, they concluded that there were differences in the never married, married, and formerly married groups. The differences in loneliness were related to how the experiences of loss were perceived and that the relationships of women were "most important in determining the frequency of loneliness" (Essex & Nam, 1987, p. 104).

These two studies on social support in older women suggested that the individual woman and the meanings of the selected concepts perceived by researchers to be contributing to the presence or absence of social support had to be taken into account and in agreement with the women. The current measurements of social support were inadequate.

Social Support and Health in the Elderly

The following paragraphs highlight the studies dealing with social support and health in older men and women. Each study utilized different definitions and measures for health and social support. Because there was no consistency with definitions or measures, only general conclusions can be made.

Moriwaki (1973) employed the Bradburn Affect Balance Scale and the Supported Self-Disclosure Index with 71 elderly to discover that role loss was the only significant condition that had an impact on the relationship between self-disclosure and psychological well-being. The significant other was directly related to psychological well-being in elderly men and women. Health was described as psychological well-being. Role loss in relationships affected the human needs of security, love, belonging, and perhaps, self-esteem, which was reflected in this study as supported self-disclosure.

Utilizing a social interaction and life satisfaction questionnaire, Connor et al. (1979) studied 218 men and women aged 70 and older. Social interaction was defined in terms of a support system, equity theory, and need theory. The authors reported that identified personal needs were met by interaction and that the meanings attached to various social relationships were important. In addition, they learned that there were circumstances under which substitution of social relationships did occur and that the frequency and scope of interactions were not curcial to understanding psychological adaptation to old age.

Lin et al. (1979) correlated social support, stressful life events, and illness with 170 Chinese-Americans. They reported that social support contributed significantly and negatively to illness symptoms and that stressful life events were positively related to illness.

Duff and Hong (1982) surveyed 278 men and women over age 60 to ascertain "the frequency of socializing with friends and relatives as the amount of satisfaction with friendships and family life" (p. 420). They reported that the frequency of interaction with friends and relatives was not as important as how much satisfaction the elderly people derived from the interactions themselves. The quality of the relationship was the significant factor in understanding life satisfaction for the elderly.

Simons (1983-84) took some of the recommendations of Connor et al. (1979) to study the specificity of human needs and substitution of people within social networks among the elderly. The needs specifically addressed were safety, security, intimacy, and affirmation of worth. The results of 299 questionnaires suggested that some substitution of individuals within the social network was taking place with a person who rarely participated in groups and organizations. Friends were apparently the source of self-esteem for the person who preferred to participate in few organizations or groups.

Thomas and Hooper's (1983) longitudinal study of 40 elderly suggested that the subjects reported that they had adequate, satisfying social bonds and that the subjects exercised some control over their lives and health. This study, as well as the Connor et al. (1979) study, suggested that older people adapted to the physical health limitations and social limitations they encountered.

Using 40 elderly subjects, Laschinger (1984) studied the relationship between quality of social support and the elderly person's level of health and reported that quality could not be measured by defining it as the number of social supporters. There was no indication that the quality of support would or would not have any buffering effect on the

older person's health. Furthermore, the subjects seemed to perceive a higher quality of social support from professionals than from non-professionals.

These studies highlighted the need to examine the meanings people give to their relationships (Connor et al., 1979), the relationship of roles and health (Moriwaki, 1973), the relationship of social support and health (Lin et al., 1979; Simons, 1983-84; Thomas & Hooper, 1983), and the quality of social support (Duff & Hong, 1982; Laschinger, 1984). The studies did not explicate the meanings of health and social support among the elderly nor the relationship between the two concepts.

Social Support and Health in Older Women

Utilizing 50 elderly women and a questionnaire, Heller and Mansback (1984) studied the categories of structure, function, and quality of relationships in social support. The authors reported that the number of supporting people was not as important as the amount and frequency of contact. Heller and Mansback, also, suggested that "the relatives provided companionship . . . and the neighbors provided problem solving" (p. 108).

Roberto and Scott (1984-85) focused on the friendship patterns of older women based on equity theory. They interviewed 150 senior women using three measurements: (a) types of helping behavior, (b) equitability of the relationship, and (c) the number of close friends. The authors concluded that those women who perceived normal or low equity of helping behaviors with friends had a higher mean morale score than those women who were perceived as over benefitted. While the methodology lacked clarity, the researchers made cogent points regarding equity theory and the older person. They suggested that not only did the older person subtract the cost in the relationship from the rewards to

determine the satisfaction of the relationship; but, also, the older person attended to the expectations of reciprocity. Because the sample was only with elders, no comparison with other age groups was done to see if others viewed reciprocity similarly.

Adams (1985-86) used a combination of a structured questionnaire and unstructured questions with 70 senior women. She found that: (a) the closer the geographic distance, the more emotional closeness; (b) the longer duration of the relationship, the more emotional closeness; and, (c) the closer the proximity of the relationship, the more frequent the interaction. The quality of the relationships older women had with the perceived supportive individuals was important.

Gibbs (1985) interviewed 20 rural older women and 20 urban older women to determine the perceived and actual importance of family to widows after the initial grief period. She reported that the nature and quality of social relationships and interactions with children were more important. The sample population was specific and the results paralleled those of Duff and Hong (1982).

The studies focusing on older women reiterated the conclusions in studies on olders in general. The quality of the relationships in social support influenced the health of older women. What that relationship is remains to be discovered. How the health behaviors of older women are associated with social support (Tilden, 1985) is still unclear.

Summary

The 18 studies cited in the preliminary review of research literature confirmed that: (a) the concepts of health and social support have not been adequately conceptualized, (b) the meanings of the two concepts are as diverse with the researchers as with the subjects, and (c) the relationship between health and social support has yet to be explicated.

These conclusions are particularly related to the population of older women in the United States. A combination of inductive and deductive methodology would facilitate the discovery of the meanings independent older women have for social support and health and the relationship between social support and health among independent older women.

CHAPTER III

The Methodology

Introduction

An overview of grounded theory is presented, followed by a discussion of instrumentation, subjects, and approval by the Institutional Review Board. Because the chosen method is qualitative, data collection and analysis are presented together with grounded theory language as subheadings. The chapter concludes with a discussion of validity and reliability of qualitative methodologies and the limitations of the study.

Overview of the Research Methodology

The descriptive research approach chosen was grounded theory as described by Glaser (1978). Grounded theory is a combination of inductive and deductive processes. These processes are used to abstract concepts and propositions about the relationships among them from the data provided by the subjects through participant-observation, observation, interview, or a combination of these data collection strategies. Grounded theory was chosen in order to obtain the information about women's lived experiences regarding social support and health and to ascertain the meaning of the relationship women attribute to the concepts.

There are two types of grounded theory, discovery or substantive theory and emergent-fit theory. Substantive theory is the generation of a theory. Emergent-fit theory is the testing of a substantive theory that would refine or extend the theory. The general methodology of

substantive theory, the one selected for this study, involves several processes occurring simultaneously. Substantive theory requires the use of theoretical sampling which

> . . . is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges (Glaser, 1978, p. 36).

Once the research questions have been developed, the population identified, and the strategies identified that would best gather the information, the investigator procedes to collect data. During data collection, the investigator simultaneously is doing data analysis. Data collection requires the use of "constant comparative analysis" (Glaser, 1978, p. 36) of the data through theoretical coding and theoretical memoing. To facilitate an understanding of coding and memoing, a discussion of the instrumentation and the subjects is presented.

Instrumentation

Three instruments were developed to facilitate the research process. The three instruments were the Screening for Independence Criteria, the Personal Data Sheet, and the Interview Guide. The Screening for Independence Criteria (see Appendix A) was based on the definition of independence. The tool screened for the appropriate age group of older women, where the women lived, and six independent functional activities necessary for daily living. The Personal Data Sheet (see Appendix B) was based on the general information needed on every subject to facilitate the investigator's decision that the subjects represented diversity in the population. The Interview Guide (see Appendix C) was constructed from the three research questions (p. 9) and the conceptual framework (pp. 5-8). Additional questions that emerged came from the individual and collective information generated by the independent older women.

The Interview Summary Form (see Appendix D) was adapted from a form that Miles and Huberman (1984) had developed as a worksheet for any investigator. The Summary Form was used by the investigator to summarize the data given by the subjects and to make decisions about selection of subjects for second- and third-round interviews.

The Subjects

Subject Selection

The original subjects were selected from a population of independent older women participating in social or professional organizations in a southeastern urban community in the United States. The reason for choosing women who participated in social or professional organizations was that the investigator assumed that those women would be able to articulate their meanings of social support and health to the investigator. Women aged 60 to 74 were chosen because it was the current age range for people categorized as young-old in the research literature (Ebersole & Hess, 1985). The investigator contacted members of a professional organization and a social organization to assist the investigator in recruiting subjects.

Subsequent subjects were referred to the investigator by the original subjects. The actual number of independent older women interviewed was based on the amount of data collected from intensive interviews with them. The subjects formed a convenience sample. Because the sampling technique was theoretical rather than statistical, no attempt was made to control the sampling for various demographic information, such as race, religiion, or profession. The sampling procedures followed theoretical sampling techniques in accordance with the grounded theory methodology (Glaser, 1978).

Description of the Subjects

The total number of subjects asked to participate in the study was 21. Of the 21, 2 women refused to participate, 1 was ill, and 1 was quite hard of hearing and a bit confused. Three women who were approached did not meet the Screening for Independence Criteria (see Appendix A). Additionally, one woman was rejected because she had her own agenda for the study; i.e., wanting the investigator to help her lose weight and stop smoking. The total number of participating subjects was 15. Subsequent information which described the independent older women came from the Personal Data Sheet (see Appendix B).

The age range for the 15 participating subjects was 63 to 77 with a mean of 68.8 years. Within the age range of 60 to 64 there were 4 subjects; between ages 65 to 69 there were 4 subjects; and within the ages 70 to 74 there were 5 subjects. Two women over the stipulated age range of 60 to 74 were asked to participate as further validation that the emerging theory was representative of other independent older women. These two women were age 76 and 77.

The marital status of the 15 participating subjects included 2 never married, 3 married, 1 divorced, and 9 widowed women. No women said that they were separated from their husbands.

The 15 subjects provided the following information about their living arrangements: living with a spouse or partner, living without a spouse or partner, and living alone. Of the ten subjects who had been divorced or widowed, one had been without a spouse for only 1 year. Two women had been without a spouse 2 to 4 years, one for 5 to 9 years and six women had been without a spouse for over 10 years. Six women, both married and unmarried, had been living with someone for several years. One had been living with a relative for 5 to 9 years, while five had

been living with a husband, relative, or female friends for over 10 years. Nine of 15 subjects had been living alone. Three had been living alone for 2 to 4 years. Three of the 15 had been living alone for 5 to 9 years, and three women had been living alone for over 10 years. These nine subjects represented the married, never married, and divorced marital statuses.

The educational background of the 15 subjects was diverse. Five subjects had completed high school, four subjects had completed 4 years of college, and six subjects had completed 1 to 3 years of graduate study.

All 15 subjects were Caucasian. Two of the 15 women were responsible for the care of an older adult. One woman had been responsible for her mother for less than 1 year. Another woman had been responsible for her husband for 2 to 4 years.

Institutional Review Board

Expedited permission was obtained from the Institutional Review Board of the University of Alabama at Birmingham prior to conducting the research. Expedited format was chosen because of the necessity for repeated taped interviews with the subjects which put the subjects at low risk. Permission by the Institutional Review Board for the study was granted May 6, 1987 (see Appendix E).

Data Collection and Analysis

Theoretical Sampling

Theoretical sampling is the collection of data based on the need to examine categories and their relationships as well as to assure that representativeness in the category exists (Chenitz & Swanson, 1986).

> The general procedure for theoretical sampling . . . is to elicit codes from raw data from the start of data collection through constant comparative analysis as the data pour in. Then to use the codes to direct further data collection, from which the codes are further theoretically developed with respect to their various properties and their connections with other codes until saturated. Theoretical sampling on any code ceases when it is saturated, elaborated and integrated into the emerging theory (Glaser, 1978, p. 36).

Theoretical sampling was accomplished by means of interviewing independent older women, using the Interview Guide (see Appendix C) to ask similar questions on the same topics of every older woman.

Interviewing

Independent older women aged 63 to 77 were asked to be interviewed in their homes or communities at least once and as many as three times over a 6-month period. The women were contacted by telephone, informed of the research project, confidentiality, and asked if they would like to participate in the project. They were interviewed from the fourth week of May 1987 through the second week in November 1987. All 15 women who agreed to participate and who met the criteria (see Appendix A) were interviewed in their homes at their convenience.

The interviews were audiotaped, with the women's permission, and transcribed, deleting any identifying information, such as name. Only one woman refused permission to audiotape the interview; thus, field notes were taken during the interview. Following the transcriptions, the tapes were erased to protect the confidentiality of the subjects. During the interviews the investigator drew a map of the women's social support system to comfirm the investigator's understanding of the women's relationships (Antonucci, 1986). Because women usually participate in a number of social groups, mapping those groups to clarify the interpretation of the relationships was helpful (see Appendix F).

No more than two women per week were interviewed in the location and at the time of their choice. On two occasions, the investigator interviewed two women on the same day.

Each interview averaged about 2 hours. A total of 52 hours was spent with the women, and approximately 38 hours were spent by the investigator in interviewing independent older women. The number of hours was approximate because time was spent in engaging each woman to talk about health, social support, the meaning of the relationship between them, and in terminating the interview. The amount of time needed for engagement and termination varied considerably with each woman. The investigator interviewed 15 women for a total of 23 interviews.

The audiotapes were transcribed by a person who was verbally sworn to confidentiality. The audiotaped interviews were taken to the transcriptionist the same day or as soon as possible after the interview. The investigator transcribed the field notes taken during each interview and completed the Interview Summary Form (see Appendix D). As soon as possible after the interview, the investigator reviewed the transcribed interviews, coded the interviews and the transcribed field notes, and wrote any memos generated on the major codes.

Theoretical Coding

Theoretical coding of the raw data, the content of each interview, was the beginning of the constant comparative analysis (Glaser, 1978). A code is "an abbreviation of a symbol applied to a segment of words . . . in order to classify the words" (Miles & Huberman, 1984, p. 56). "The code conceptualizes the underlying pattern of a set of empirical indicators within the data" (Glaser, 1978, p. 55).

The codes generated by the investigator were a single word or a short phrase which described the content of a specific portion of the interview. The specific portion might have been a phrase, a sentence, or a paragraph within the interview.

The investigator coded each transcribed interview and concurrent set of field notes taken during each interview as the raw data suggested words to the investigator. The investigator analyzed the transcribed interviews and field notes line by line and generated codes on phrases, sentences, or paragraphs as the raw data suggested.

Theoretical Memoing

> Memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding . . . . Memoing is a constant process that begins when first coding data, and continues through reading memos or literature, sorting and writing papers or monograph (sic) to the very end (Glaser, 1978, p. 83).

". . . it (memo) can be a sentence, a paragraph or a few pages . . . . it exhausts the analyst's momentary ideation based on data with perhaps a little conceptual elaboration" (Miles & Huberman, 1984, p. 69).

Each memo written by the investigator began with a notation at the top of the page that this was a memo, to what code it belonged, and the date the memo was written. The second line of the memo identified the subject's number, the number of the interview, and the date of the interview. Next, the actual words of the subject were written which applied to the code. Last, the analysis of the subject's words were written, the memo.

Beginning with the first interview, the investigator wrote memos on all the codes perceived as major codes. Perceived major codes were those codes that came up frequently in the data and for which a relationship with another code was perceived.

After seven different coded interviews were analyzed, the investigator revised the data collection procedure. The investigator decided to consult the literature on the major developing categories, caring, loneliness, coping, and social support. The reason for the consultation was to learn whether the subjects were saying similar or different things about the major categories. Memos were written on the literature read. The literature consultation was a deviation from Glaser (1978).

> In our approach we collect data in the field first. Then start analyzing it and generating theory. When the theory seems sufficiently grounded and developed, then we review the literature in the field and relate the theory to it through integration of ideas (Glaser, 1978, p. 31).

During the analysis process of the theoretical coding and memoing, categories with properties began to emerge. In time the core categories, a higher level of abstracted concepts, emerged. In order to arrive at categories and core categories, the following steps had to be applied to coding and memoing. The induction process begins with comparing "incident to incident with the purpose of establishing the underlying uniformity and its varying conditions" (Glaser, 1978, p. 49). From the comparison of incidents, concepts emerge. Second, the analyst compares "the concept to more incidents . . ." (Glaser, 1978, p. 50) which generates the theoretical properties of the concepts. Last, the analyst "compares . . . concept to concept with the purpose of establishing the best fit of many choices of concepts . . ." (Glaser, 1978, p. 50). To induce a concept the investigator begins with the identification of a concept's properties which leads to the emergence of a category. The categories comprise a core category. Core categories may or may not lead to a Basic Social Process. "Theoretical saturation of a category occurs

when in coding and analyzing both no new properties emerge and the same properties continually emerge as one goes through the full extent of the data" (Glaser, 1978, p. 53).

The investigator used the following procedure. At the conclusion of 10 different interviews, the investigator wrote memos on all codes to be sure that the research was not missing some important category. At this time the investigator wrote between-interview memos to determine the developing patterns. From the between-interview memos a diagram was developed that included the categories, core categories, and the patterns of perceived relationships among the categories and core categories. Diagrams were helpful to construct because they:

> . . . are visual representations of one's analytical scheme in whole or in part . . . . Diagrams are a visual representation of the categories and how they link together. Examination of a diagram can point out where the theory needs further development; they are especially useful when the analyst is overwhelmed with memos and needs an overview of the analysis (Chenitz & Swanson, 1986, p. 117).

More literature was collected on the categories of coping, caring, health, loneliness, older single women, social support, trust, and well-being. The literature provided additional knowledge base about the categories for the investigator and assisted in verifying the developing patterns.

The investigator went back to the subjects, both first-time interviewees and second-time interviewees, to clarify the patterns that seemed to be developing and the discrepancies between the subjects' information and the literature. By this time 13 women had been interviewed.

Of the 13 women, 5 were selected for a second interview. The selection was based on additional questions generated from the first interview, as evidenced on the Interview Summary From (see Appendix D), and on the woman's ability to articulate her thoughts and feelings on the emerging

concepts. To clarify and to provide some continuity for the second interview, the investigator developed a diagram of the emerging categories and core categories on health, social support, and the meaning of the relationship between them (see Appendix G). During the second-round interviews this diagram was shown to the five women who clarified and verified the concepts and their interrelationships. As the women looked at the diagram, the investigator described each concept, and the woman and the investigator discussed the interrelationships among the concepts from the woman's perception.

Memos were written on the codes generated from the second-round interviews. Based on the subjects' discussions and reactions the categories were rearranged. Further analysis of the transcribed second-round interviews provided evidence to the investigator that she had not used the same language in describing the concepts with each subject. To correct the lack of consistency, the investigator wrote a narrative sketch which included the categories, core categories, their descriptions, and the interrelationships. Some of the categories and their descriptions were induced from specific indicators to generalizations.

The third-round interviews utilized a narrative sketch of the developing theory. The narrative sketch was written to provide all the selected subjects with the same descriptions of the concepts and the explanations of the relationships. The sketch was given to five women selected for the second-round interviews and two women who had never been interviewed. The rationale for selecting two women who had never been interviewed was based on the idea that if two women unfamiliar with the concepts could read the sketch and verify the meaningfulness and interrelationships of the emerging concepts, then the sketch could be representative of other independent older women.

Seven women reviewed the sketch. Of the seven, two women familiar with the study said that "the sketch was fine" and that "caring was most important;" thus, the two women were not interviewed further. The other five women, who were interviewed, clarified and validated the meanings in the sketch.

The investigtor reread all the transcribed coded interviews a third time to look for mention or illustration of the properties of categories that were possibly missed during the first two codings. Memos were written on all the properties that were found.

The investigator took the notes written or given orally by the women on the sketch and modified or incorporated those notes into the sketch or into memos. Rearranging the categories and modifying the category and core category descriptions were based on the third set of interviews.

A core category had to meet certain criteria. Those criteria included the following: (a) "It must be central, that is related to as many other categories and their properties as possible . . .; (b) It must reoccur frequently in the data; . . . and (c) It relates meaningfully and easily with other categories" (Glaser, 1978, p. 95).

The highest level of abstraction of concepts is the Basic Social Process (BSP). ". . . BSP's are processural or as we say, they 'process out.' They have two or more clear emergent stages" (Glaser, 1978, p. 97). "A process is something which occurs over time and involves change over time" (Glaser, 1978, p. 97).

Six concepts derived from the data met the criteria for a core category. The BSP that processed out from the data was being aware. The six core categories and the BSP are presented in Chapter IV.

Theoretical Sorting

To generate a theory, the analyst must go through the process of theoretical sorting. "Since the sorting is of ideas not data, it is conceptual sorting, not data sorting . . ." (Glaser, 1978, p. 116). "It (sorting) generates more memos, often on higher conceptual levels which further condense the theory. It integrates relevant literature into the theory, which is being sorted with the memos" (Glaser, 1978, p. 117). "He (the analyst) should simply start sorting the categories and properties in his memos by similarities, connections, and conceptual orderings" (Glaser, 1978, p. 117). "As the analyst makes these connections, he should theoretically code the conditions under which the relationship will vary" (Glaser, 1978, p. 121).

Through the theoretical sorting and generation of more memos, the definitions and the propositions of the core categories and BSP began to emerge. The definitions and propositions were refined by the investigator and are presented in Chapter IV.

Theoretical Pacing

The pacing of the data collection, coding, memoing, and analyzing is critical to the development of a theory. If the analyst spends several hours in a day in data collection, then the next day will be spent in writing codes and memos (Glaser, 1978). If the analyst spends too much time during any day with the data collection and analysis, then the analyst is at risk for becoming sensitized to the data which might cause a premature closure (Glaser, 1978).

For the two reasons given above, the investigator did not spend more than 5 to 6 hours a day with the data. Glaser (1978) recommended that coding and analyzing should be done "regularly two to four hours a day" (p. 23).

There were two further notations made by Glaser (1978):

(1) His (the analyst's) job is to contribute to this literature, not completely to master it. His contribution is integrative and recognitive, not reverant (Glaser, 1978, p. 126).

(2) It is not incumbent upon the analyst to provide the reader with description or information as to how each hypothesis was reached (Glaser, 1978, p. 134).

Theory Evaluation

According to Glaser (1978), ". . . a theory must have fit and relevance, and it must work . . .. By fit we meant that the categories of the theory must fit the data" (p. 4). "By work, we meant that a theory should be able to explain what happened, predict what will happen and interpret what is happening in an area of substantive or formal theory" (Glaser, 1978, p. 4). "A theory must be readily modifiable, based on ever-emerging notions from more data" (Glaser, 1978, p. 4).

These three criteria of Glaser's (1978) were used to evaluate the theory of being aware. Theory evaluation is found in Chapter V.

Validity and Reliability

Validity

In quantitative inquiry validity referred to the relevance and meaningfulness of the results of the study or the data, while in qualitative inquiry validity was termed evidence. Validity was categorized as internal and external with subcategories under each. Internal validity was concerned with "the construct or theoretical label used to describe the variables and propositions . . ." (Chenitz & Swanson, 1986, p. 10). The most important threats to internal validity in this study were subject maturation and investigator bias.

The investigator was concerned how the investigator influenced the subjects as a result of her relationship with them (subject maturation). Subject maturation was dealt with through the maintenance of detailed

field notes about the investigator-subject relationships. The field notes were scrutinized to examine the effects of maturation and changes over the course of the study. Evaluation of the field notes suggested that perhaps the women familiar with the study were biased while reading the narrative sketch. As a result of the examination of the field notes, two women unfamiliar with the study were asked to read the narrative sketch.

A parallel concern to subject maturation was the possibility of investigator bias. The investigator was always at risk for assuming the attitudes and the behavior of the subjects. While it was expected that the investigator would change during the course of the study, i.e., become more proficient with interviewing and more sensitive to the subjects, the investigator had to control the effects of change. Control was effected by keeping personal notes on actions, interactions, and subjective states during the interviews. Analysis of these personal notes helped to control attitudes and behavior by becoming more sensitive to the possibility of leading a subject.

A second strategy was employed to reduce investigator bias, that of combining some first-time interviews and some second-time interviews during the same time period. If the investigator was cognizant of the possibility of leading the subjects to certain conclusions, then she could control this bias by choosing subjects to interview the first time and waiting for the women to come up with the concepts that the investigator did during her analysis.

External validity in qualitative inquiry was concerned with generalizability of the results to other populations. How generalizable the results were depended on the diversity and representativeness of the data extracted from the theoretical sampling (Chenitz & Swanson, 1986).

If the internal validity was maintained, then the external validity would be met. This threat was addressed in grounded theory by the investigator searching for negative or conflicting cases that do not fit an existing category or proposition (Glaser, 1978). The results had to "fit" the subjects' lived experiences; they had to be meaningful and applicable to the subjects. Both for reasons of validity and reliability second- and third-round interviews were conducted. New subjects were interviewed during the same time period as the second- and third-round interviews.

Reliability

Reliability in quantitative inquiry referred to the consistency of unambiguous information over repeated measures. In qualitative inquiry reliability referred to "the use of the theory and its applicability to similar settings and to other types of problems over time" (Chenitz & Swanson, 1986, p. 14). Reliability for this study was accomplished through the verification of concepts and ideas about the relationships by the subjects (Sandelowski, 1986).

Limitations

The limitations of the study were as follows:

1. There was only one researcher, a novice in grounded theory.

2. The time and financial constraints involved with interviewing, transcribing the tape recordings, and processing the data limited the extensiveness of the generated theory.

Summary

The methodology presented in this chapter included an overview of how the method of grounded theory was produced. Explanations were given of the instruments used, the subjects, how the data were collected and

analyzed, and how the theory would be evaluated. The investigator described how validity and reliability were maintained and what the limitations of the study were.

CHAPTER IV

The Theory

Introduction

The findings describe the discovery process, the theory. Three research questions were answered: What health means to independent older women; What the meaning of social support is among independent older women; and, What the meaning of the relationship between health and social support means to independent older women. Relevant literature is presented with the findings as supplement and support for the findings (Glaser, 1978). The chapter concludes with the definitions of the seven core categories and the propositions of the theory. A summary follows the propositions.

The Meaning of Health Among Imdependent Older Women

Being in Harmony or Balance

The first research question asked of older women was: What is the meaning of health to you? Among independent older women health meant being in harmony or balance. The core category combined with the core categories of well-being and "managing stress."

Harmony or balance was both internal and external to the women. The internal balance was of the body, mind, emotions, and spirit in that one had to be aware of one's body, mind, emotions, and spirit, and the interactive elements of each. As one woman said, "without health there's no way of achieving much in life because our inward self seems to control us so much to the point that we must have good health." The external

harmony or balance was a combination of the internal balance of the person with the social and cultural environment and a balance with nature, "the oneness of all things."

The person being in harmony or balance with the internal and the external environments led to the "oneness of all things." This "oneness" was connected to the idea that "health is full of joy and the love of life." One of the subjects talked philosophically about the meaning of "good health." "Good health" included the physical (the way one lived), the mental (the way one thought), and the spiritual, emotional, and social (the way one was).

Several authors described health in similar terms to the study subjects. Bilitski (1981) stated that health was a state of the person existing in concert and interaction with the environment. She implied that the person must be whole; that is, all the dimensions or aspects of health must be functioning.

Buber (1958) believed that people lived their lives in mutuality with the universe. This statement implied the oneness of all things, the inextricable bonds between and among man and nature, man and man, and man and spiritual beings. Man in Buber's (1958) context referred to the species.

Kim (1983) supported the idea that human beings were influenced and affected by the social and cultural environment. She said that "an individual's health is affected by the quality of social forces; opportunities in, and quality of, social interaction and affiliation; affection quality in dominant social situations, such as family, work, or neighborhood settings; and stresses generated in social life" (Kim, 1983, p. 89).

Reflecting some of Buber's influence, Watson (1985) suggested that health was the being in harmony of a human being's body, mind, and soul. She said that balance or congruence must be present between I, "the self as perceived" (Watson, 1985, p. 48), and me, "the self as experienced" (p. 48). The I/me balance included the person's being in harmony with the world or the environment so that there was an internal personal balance and an internal environment and external environment balance. Ebersole and Hess (1985) supported Watson's (1985) perception of health but called it wellness.

The philosophy that good had a special meaning when connected to health was reflected by Maslow (1968) and Leichtman and Jepikse (1979). Maslow focused his discussion on what was good for healthy persons. Leichtman and Jepikse discussed what was good for the person (if one's soul was good) was the outcome of right living. The philosophy of these three authors was similar to the subjects' philosophies that good health was the way one lived, thought, and was.

Two empirical studies offered support to the subjects' descriptions of health. One of Fontes' (1983) results, in her study of the relationship among cognitive style, interpersonal needs, and an eudaimonistic model of health with 163 volunteers at a suburban community school, supported the study subjects' descriptions of health. Her results suggested that "the notion of moderation and balance . . . involved . . . such diffuse ideas as harmony with the universe, integrated personality, and wholeness" (Fontes, 1983, p. 95).

Laffrey (1986) presented a report on psychometric testing of the Laffrey Health Conception Scale. One of her conclusions was that "one's conception of health may be a more significant factor than health status

in assessing health behavior" (Laffrey, 1986, p. 112). The study subjects confirmed that one's conception of health was simliar to but different from most research studies.

Both the theoretical and empirical literature supported the study subjects' descriptions of health. The idea of balance was supported by Bilitski (1981), Buber (1958), Fontes (1982), and Watson (1985). Kim (1983) supported the necessity of social forces and how the forces affected humans. Leichtman and Jepikse (1979) and Maslow (1968) focused on the meaning of good.

Well-Being

The core category, well-being, meant "being able to do" and "being well"; it was an expansion of balancing the internal environment. It included for all the subjects the physiological (physical), emotional, mental, spiritual, and social aspects of the person. Presenting a pleasant physical appearance was equally important to well-being. As one subject said, "the function of the physical part of a person affects so much their appearance and a healthy person shows that physical fitness . . . . But your appearance affects other people too . . ." The physical appearance of a person was an indication of the amount of awareness the person had for his or her surroundings, according to this woman. Another woman discussed how she felt when she looked less than her best. "I feel inferior when I'm not at my best." When a woman's physical appearance was less than the usual or "a mess" then one may conclude that the woman may feel inferior when in another's presence, thus influencing well-being.

The categories of "awareness of self," "being in tune," and "awareness of others" formed the support for the core category well-being.

The exact interrelationship of these categories as perceived by the subjects was unclear, thus, will not be discussed in further detail.

The literature on well-being, both theoretical and research, was mixed as to what well-being meant. In most of the studies well-being was described or implied through the measures selected for the specific study. For some authors and researchers, well-being was subjective (George, 1981; Larson, 1978) or psychological (Lawton, 1983) and was made operational through various measures on morale, happiness, life satisfaction, psychological adjustment to specific domains of a person's life, and contentment. Even though the measures varied, they had in common the implication that well-being was an internal personal perception.

Leichtman and Jepikse (1979) came the closest to matching the subjects' descriptions of well-being in this study. They said that "well-being exists when the physical body is healthy, the emotions are sound, the mind is strong, the lifestyle is sane, and the spiritual expression is whole" (Leichtman & Jepikse, 1979, p. 4).

The relevant literature supporting the findings in well-being was mixed as to what well-being meant. Some of the literature reflected the thinking that well-being could be measured with various measurements on morale, happiness, life satisfaction, psychological adjustment to specific domains of a person's life, and contentment. Leichtman and Jepikse (1979) came the closest to describing well-being the way the present study's subjects did.

Managing Stress

The third core category of health was "managing stress" which had positive and negative poles. The positive pole of "managing stress" was "encouraging fortitude and courage," meaning that both the type and amount

of stress encouraged the women to cope or to adapt, a motivator "to accomplish." The negative pole of "managing stress" meant that the type or amount of stress immobilized the women "like a terrible fear." The perceived result of "managing stress" for women in this study was "being physically and emotionally tired."

There seemed to be greater and lesser degrees of perceived stress along the positive and negative poles. Some older women had suggested that they did not let stress reach the point of immobilizing, rather let it go to the point of "anxiety" and then they acted to relieve the stress. The women implied that there were several kinds of stress occurring at one time and over time. What was stressful today might or might not be stressful tomorrow. The induced description of "managing stress" was dealing with a conflict between the person's internal expectations or standards and the external expectations or standards. The external expectations might belong to society, a community, or a small group. The conflict might be in the mental, emotional, spiritual, or sociocultural realm. Stress was perceived as being handled more effectively if a sense of well-being existed.

The categories of coping and adapting formed the support for the core category "managing stress." The exact interrelationship of these categories as perceived by the subjects was unclear, thus, will not be discussed.

Closest to the study subjects' descriptions of stress was Mechanic's (1974) description. He said that stress was "a complex set of changing conditions that have a history and a future. Man must respond to these conditions through time and must adapt his behavior to the changing character of the stimuli" (Mechanic, 1974, p. 35). The study subjects implied that stress came in many forms and changed over and with time.

Using epidemiological terms, Cassel (1976) discussed the relationship between stressors and the psychosocial factors in the human organism. He saw the psychosocial factors acting like stressors and protectors to the human being. The women in this study would have agreed that stress could include a positive action or a negative action in themselves, the positive and negative poles of "managing stress." For the women what kind of action would be induced depended partly on how long the women waited before acting. If they waited too long, the action might have a negative consequence, the immobilizing aspect of "managing stress."

Using social network theory, Tolsdorf (1976) developed his study of stress, support, and coping with "ten recently hospitalized, first admission psychiatric subjects and ten recently hospitalized medical (non-psychiatric) subjects" (p. 410). His study design was a combination of quantitative and qualitative methods and all his subjects were male. The definition of stress that emerged from his study was: ". . . an interaction between an individual and his environment such that demands are made on the individual that tax his individual and network resources to the extent that strong consequencies ensue from his failure to meet the demands" (Tolsdorf, 1976, p. 414). While the subjects' gender, the psychiatric/nonpsychiatric criterion, and the conceptual framework did not apply to the present study, the definition of stress was to be considered. Tolsdorf had framed his definition into a supply and demand framework; the older women had put "managing stress" into a conflict of expectations or standards framework. Tolsdorf said and the older women implied that consequences resulted from "managing stress." The largest difference that independent older women emphasized was that "managing stress" had a positive aspect that was rarely emphasized.

Mechanic (1974) came the closest to supporting the women's descriptions of "managing stress." Cassel (1976) and Tolsdorf (1976) provided limited support for the study subjects' description.

Summary

Health had three core categories: being in harmony or balance, well-being, and "managing stress." Being in harmony or balance included the internal balance of the person with the external balance of the sociocultural environment and a balance with nature. Well-being meant "being able to do" and "being well." "Managing stress" meant dealing with a conflict between the person's internal expectations or standards and the external expectations or standards.

The Meaning of Social Support Among Independent Older Women

Caring

The second research question asked of the women in this study was: What does social support mean to you? Independent older women did not use the phrase social support, nor did they talk about networks, roles, linkages, or groups. They discussed relationships and the meanings or transactions within relationships. The relationships were based on caring, a feeling or attitude and an action. They used the terms "care" and "caring." "Care" was related to a feeling and "caring" was related to an action. The descriptions of care and caring were "an attitude of helping that took place over time" and "making a connection with another." These descriptions reflected both a feeling and an action. Caring, then, was a core category of social support from the older women's perspective.

The older women tried to separate and delineate the feeling and the action of care and caring. Their examples and descriptions

invariably had the feeling and the action together. Thus, for independent older women, the feelings and the actions were inextricably bound together. They may be discussed separately as a means of clarifying only.

As mentioned previously, independent older women discussed social support in terms of relationships based on caring. This fact was further confirmed when the women discussed their relationships in terms of concentric circles with the inner circles having the most intimate relationships. The relationships usually were labeled in dyads of mother-son, mother-daughter, friend-friend, and neighbor-neighbor. These dyads identified the roles but the women focused their attentions on the relationships. All but one of the study subjects saw themselves in the center of concentric circles of relationships. One subject insisted that for her life was "one big circle of love."

Older women's relationships had the element of reciprocity within them, but the reciprocity did not have to be in like amounts or kind, between the same two persons, or at the same time. The women expected at some time to receive caring from someone. Unless the relationship was defined as a marriage or mother-child relationship, the older women did not expect to be the recipient of caring within the parameters of sameness: the amount, the kind, the persons, or the actions.

There was literature to support the finding that social support was linked to caring. Shumaker and Brownell (1984) said that in the "broadest sense social support is the essence of being 'social': it is mutual nurturing and caring" (p. 15).

Cobb (1979) linked social support to caring by calling it "communicated caring" (p. 93), but he limited the link when he said that social support was purely informational and, while explaining the three

components of communicated caring, used the pronoun "she" exclusively. In 1976 he had written a similar paper on the subject using the pronoun "he." Whether Cobb was trying to be fair to both genders, one can only postulate. In any case, he did acknowledge that social support in the context of communicated caring was the most important kind of support.

Known for presenting the metaphor of "convoy of social support," Kahn (1979) defined social support as "interpersonal transactions that include one or more of the following: . . . affect, affirmation, and aid" (p. 85). The definition was focused on one dimension, that of a person giving expression of positive affect, acceptance or endorsement, and aid to another. He said nothing about receiving anything. The only indication of reciprocity was with the word transaction. The words affect and acceptance could mean or include caring.

Shumaker and Brownell (1984), Cobb (1979), and Kahn (1979) loosely linked social support and caring. Other literature was found to support specific parts of the caring core category. The specific parts of caring that were supported in literature were caring as an attitude, the relationship between feelings and actions, the concentric circles, and the reciprocity of caring.

Both Mayeroff (1972) and Noddings (1984) discussed the relationship between feelings and actions. Mayeroff saw the actions in which one involved oneself with another were to help the other care for the self and to become responsible for one's own life. Noddings said that people have expectations of some expression of feelings and of actions from someone claiming to care for one.

On the issue of reciprocity of caring, Mayeroff (1972) suggested that not only did one need to care for the other in order to grow, but,

also, that the other needed to care for the self in order to grow. There was a reciprocity of need, to give and to receive care. This idea was consistent with that of the study subjects.

Noddings (1984) discussed the reciprocity of caring. She suggested that everyone in a relation, the one caring and the one cared for, was in a reciprocal relationship. She, also, said that "if the demands of the cared-for become too great or if they are delivered ungraciously, the one-caring may become resentful and, pushed hard enough, may withdraw her caring" (Noddings, 1984, p. 48).

Cobb (1979), Kahn (1979), Shumaker and Brownell (1984), and Thoits (1982) linked social support and caring. Mayeroff (1972) and Noddings (1984) supported the study subjects' conceptions of the relationship between feelings and actions and of the existence of reciprocity with caring.

Acceptance

The second core category was acceptance, discussed in terms of accepting the other, usually a known other, on a reciprocal basis. Not only did the women have to accept the other, they had to feel that they were accepted by the other. Acceptance meant to receive the known other as the other was, the abilities, the values, and the biases, and was usually reciprocated. As one woman said, "To me, everybody's got some good in them. And I think, if you look hard enough, you can find--instead of just downing somebody."

There were two exceptions to reciprocity. There were times when the older woman would accept a known other without expecting the known other to accept the woman. If the known other was what the woman called an

acquaintance and the woman chose to do something for the acquaintance, then the woman did not expect the acquaintance to reciprocate with some expression of acceptance.

The second exception to the reciprocity with acceptance was with unknown others. A woman might listen to an unknown other and accept what the unknown other said or implied. How women came to the decision to accept was based on the perceived sincerity and genuineness of the other.

Noddings (1984) supported caring as needing the attitude of acceptance of a person as its base. Miller (1986) thought that belonging or affirmation was a higher category than acdeptance. The study subjects rejected that idea and firmly asserted that one needed to feel accepted before one could feel that one belonged.

Trust

The third core category was trust which had reciprocity within its meaning. Trust meant that, first, a woman trusted herself to accurately assess the trustworthiness of others. It required a "belief or faith in oneself that one could accurately assess people's ability to be trustworthy." Second, if the other(s) was tested and found to be trustworthy, then the woman trusted selected others. Occasionally, the older women had to consider trusting an unknown other, like a health care professional, a car mechanic, or a person on the telephone wanting donations. If the other was unknown, then the woman had to decide whether what the unknown other was saying was sincere or genuine for the woman to trust as being the truth. One woman said, "You have to hope that you can understand properly and clearly because if you don't and you trust them, go ahead and trust them, then it's just as much your fault as it would be theirs."

Within the theoretical literature both Boettcher (1985) and Mayeroff (1972) addressed the idea that trust of the self was just as important as trust of the other. Mayeroff put trust in the context of caring, which supported the position of the study subjects. He put faith in the context of a trust and confidence in life which allowed one to be open to caring for the self and caring for others. Boettcher, on the other hand, placed trust in the context of a basic human need within relationships. Both descriptions of trust were in agreement with the study subjects.

A conceptual analysis of trust was performed by Meize-Grochowski (1984). She suggested that trust was "an attitude bound to time and space in which one relies with confidence on someone or something. Trust is further characterized by its fragility" (Meize-Grochowski, 1984, p. 567). The study subjects did not denote or connote trust as being an attitude.

Boettcher (1985) was the only author who supported the subjects' contention that one had to trust the self as well as trust the other. Mayeroff (1972) supported trust being in a caring context.

Summary

To summarize the core categories of social support, caring was the basis of independent older women's relationships and included both feeling or attitude and action. The other two core categories that linked together with caring were acceptance and trust. With acceptance the older woman received the other and was received by the other as they each were. Trust was based on trusting oneself and on trusting the other. Looking at the evidence from the core categories of caring, acceptance, and trust, social support was actually the outcome of a caring relationship for independent older women. If there were shared

caring feelings or attitudes and actions within a relationship along with acceptance and trust, then the person would feel supported in a social context.

The categories of confiding and independence formed the support for the core category trust. The eight categories of empathy, concern for welfare, love, affection, belonging, giving and receiving assistance, sharing for enjoyment, and duty or obligation formed the support for the core categories caring, acceptance, and trust. The exact interrelationships of these categories as perceived by the subjects were unclear, thus, will not be discussed.

The Meaning of the Relationship Between Health and Social Support Among Independent Older Women

Being Aware

Independent older women were asked "What is the connection between health and social support for you?" The women were able to describe the conditions of the connection between health and social support, but only two women clearly identified the connection. It was "being aware" which meant being conscious of everything in and around a person. The actual meaning and stages of "being aware" were induced by the investigator and validated by the women.

"Being aware" was a Basic Social Process in grounded theory terminology, which meant that "being aware" "processed out" (Glaser, 1978, p. 97). To process out, a Basic Social Process had to have two or more clear emergent stages which occurred over time and involved change over time (Glaser, 1978). "Being aware" had two distinct stages, which all independent older women achieved, and a third stage that a few women achieved.

In the first stage, a person had to "be aware of the self," the needs, the capabilities, and the limitations. One had to "make a

connection" with the self, to accept, and to trust the self. The person had to have the knowledge of the self, an honesty with the self. The person had to balance the physical, mental, emotional, spiritual, and social aspects of the self with the external environment to "be in tune" with the self. One woman described "being aware" for herself as:

> . . . awareness itself brings you so much if you're a person--if you have tried and you have been aware, as time goes on your awareness, it becomes more, someway. It brings you more understanding than you would have thinking about it with your intellect . . . then that helps you with everything else. It helps you with your understanding of yourself and with other people, and your situation and challenges, all the things that happen in our lifetime.

The process of "being aware" occurred over time and it took time and reflection or introspection to become aware of the self: one's abilities, limitations, and needs. "Being aware," also, involved change over time. As one increased one's awareness of the self and of others, one changed with the knowledge and insight one had gained.

The second stage of "being aware" was opening oneself to listening and being receptive to another. There were preconditions to being open and receptive. The person had to care about the other and had to have either acceptance or trust, if not both, of the other. Then, the person could be open to listening and being receptive to the other, the conditions of stage two. As the person listened to another, the person would gain a greater awareness of the needs, capabilities, and limitations of the other.

There were two types of listening reported by independent older women, active and passive. One woman said, "Now when I say listen, that means listen with your ears, but also, listen with an intent to know the intents of the person, as you said, knowing what makes a person distraught." Another woman described what might be called passive listening when she said:

> And sometimes the person listening doesn't even enter into it at all. It gives the person who's talking the opportunity to hear themselves if it's bottled up inside too long they don't really know what's in there. They need to air it out to get a proper perspective of it themselves, to understand themselves what the situation is . . . .

Passive listening was just listening to a person without commenting, letting the person talk. Active listening was listening to the words and the feelings behind the words and responding to those feelings.

Listening and receptiveness were critical to "being aware." As one woman said, "awareness helps you develop a better understanding of other people and their problems and how that particular situation might make them react in a different way to something that involves you." The awareness has made "it possible to interpret actions in a manner of getting at the real truth in a situation." The greater awareness one gained from being receptive to the other could open the possibility of being more responsive to the other. The person, then, had a choice to act towards or for the other, to limit the action, or not to act. The choice that was selected was based on the person's being in harmony or balance, on caring, and on the attitude and of the known responses of the other. The attitudes, feelings, and responses of the known other had to be taken into account before the person chose the action.

The third stage of "being aware" was the awareness of the interaction between the awareness of self and the awareness of others. It was through this self-other interaction that the older women discovered the truth and understanding of the self and of others and grew within themselves, as well as assisted others to grow. The third stage required time for reflection or introspection to learn the truth and understanding. Truth was often learned vicariously through the experience of others. There were requirements for learning the truth and for growing.

The self-other interaction was grounded in the person being in harmony or balance internally and externally with the environment and in "making a connection with another," acceptance and trust of the self and the other. The person had to make the connection of learning about the self through others. Without this grounding the older women would not reach the third stage of "being aware." Very few of the study subjects seemed to have reached the third stage of being aware of the self-other interaction.

Some authors provided support for various aspects of the Basic Social Process of "being aware." One author described awareness as "a focusing of the attention on the other, a recognition of the need of care" (Alvino, 1986, p. 74). Being aware of others was the second stage of being aware.

Several authors discussed the importance of being aware and knowing the self (Gaut, 1983; Griffin, 1983; Mayeroff, 1972; Noddings, 1984; Strasser, 1970). Strasser (1970) used a psychoanalytic framework to talk about awareness. For him awareness was "a mode of existance of an ego" (Strasser, 1970, p. 294) and variable in degree and quality. "Awareness of self," according to the older women, would have been a part of the ego. "Awareness of self" had various degrees and quality, depending on the inclination of each woman.

Both Mayeroff (1972) and Noddings (1984) discussed awareness in the context of caring for the self and the other. Both authors implied that one had to know oneself on several levels and to keep those levels in balance or congruence. The authors, also, said that growth of the individual took place in the context of caring. For independent older women, it was more than caring that promoted growth, it was being aware of the self-other interaction.

Gaut (1983) and Griffin (1983) saw awareness as having conditions. Gaut (1983) suggested that to be aware one had to focus one's attention on the other as well as the self, implying the interrelationship between the self and the other. Griffin (1983) said that, as a precondition to maintaining a good relationship with others, one had to have a good relationship with oneself. "Awareness of self," as a prior stage to "awareness of others," was affirmed by older women. "Awareness of self," both the awareness and the knowledge, was a requirement of "being in tune."

Noddings (1984) was the only author to acknowledge the importance of listening in relation to caring, and, in this case, awareness of others. She said that, "listening, that supremely important form of receiving, is essential" (Noddings, 1984, p. 121).

Other than Glaser and Strauss' (1965) book, Awareness of Dying, in which they described their qualitative study of the dying process, no empirical literature was found on "being aware." Unfortunately, Glaser and Strauss' (1965) stages of awareness did not apply to this study. The only part that did apply was their definition of the "awareness context," which was "who knows what" (p. ix). Their definition spoke to one facet of awareness, the knowledge. The other and prior facet was being conscious of everything in and around a person according to independent older women.

Summary

The Basic Social Process of being aware had three stages. The first stage was being aware of self; the second stage was being aware of others; and the third stage was being aware of the self-other interaction. None of the authors cited discussed being aware in the context of stages. These authors discussed selected aspects of the three stages of being

aware with the majority of the authors focusing on the first stage, being aware of the self. Only Noddings (1984) offered support for the condition of listening and being receptive.

Definitions and Propositions

Definitions

An article by Hinds (1984) was used as a guide to write the definitions. Hinds (1984) outlined her procedure for constructing a definition of hope from grounded theory methodology. She suggested that the definition contained "the essence of that which is to be defined" (Hinds, 1984, p. 360), be stated in positive language and include the context (Hinds, 1984). The definitions for the seven theory concepts were as follows:

Being Aware - The stage at which older women are conscious of everything in and around them and have the knowledge of self and others, which were gained through being receptive and listening. Being aware changes over time and is enhanced through reflection.

There were three stages of being aware:

1. Aware of Self - The degree to which a woman is conscious of her needs, capabilities, and limitations and balances these aspects with the external environment.

2. Aware of Others - The degree to which a woman is conscious of caring, acceptance, or trust of another and of listening and being receptive to another.

3. Awareness of Self-Other Interaction - The degree to which a woman is conscious of truth, understanding, and ultimately, growth within herself through interaction with others.

Being in Harmony or Balance - The degree to which older women are able to bring into congruence the internal environment of the body, mind, emotions, and spirit with the external environment of the social and cultural dimensions and nature.

Well-Being - The extent to which older women are aware of the self physically, mentally, emotionally, spiritually, and socially and bring those aspects into balance to extend their awareness to others.

Managing Stress - The degree to which older women deal with those situations, conditions, and people that precipitate conflict between the women's internal expectations or standards and the external expectations or standards.

Caring - The extent to which older women possess over time the shared feeling or attitude and the action of making a connection and of helping themselves and others in a social context.

Acceptance - The extent to which older women receive the other as the other is and the women are received by the other as the older women are.

Trust - The extent to which older women have confidence in themselves to accurately assess others' ability to be genuine and sincere and to rely with confidence on the assessed selected others.

Propositions

Propositions are statements that describe: (a) the existence of phenomena, (b) a relationship between concepts, (c) an association of what concepts occur together, or (d) a correlation between two concepts (Reynolds, 1971). Six propositions were generated from the theory of being aware. Each proposition is stated first, followed by support from the literature.

1. For harmony or balance to exist, older women must:
   (a) be aware of the self in all its aspects and bring those aspects into balance in order to extend the women's awareness to others and the external environment and
   (b) deal with those situations, conditions, and people that precipitate conflict between the women's internal expectations or standards and the external expectations or standards.

Watson (1985) supported the well-being portion when she suggested that balance or congruence had to be present between the perceived I and the experienced me to effect an internal personal balance, and an internal environment and external enviornment balance. Mechanic (1974) offered support for the managing stress component. He suggested that man had to respond and to adapt to a complex set of changing conditions.

2. If older women possess well-being and are managing stress, then they are being in harmony or balance.

Bilitski (1981) provided support for the proposition when she stated that health was a state of the person existing in concert and interaction with the enviornment. She was implying that a person had to have well-being to manage the stress to exist in concert and interaction with the environment.

3. For social support to exist, older women must perceive that:
   (a) there is a shared feeling or attitude and action of making a connection and of helping themselves and others;
   (b) older women mutually receive the other as the other is and the women are received by the other as the older women are; and

(c) older women have confidence in themselves to accurately assess others' ability to be genuine and sincere and to rely with confidence on the assessed selected others.

Gaut (1983) and Noddings (1984) supported caring as an attitude. Noddings (1984) supported the definition of acceptance. Mayeroff (1972) and Boettcher (1985) supported the definition of trust being reciprocal, the self and the other.

4. If older women possess the shared feeling or attitude of acceptance, trust, and caring with others, then the women will have support in a social context.

Noddings (1984) was the only source to link caring, acceptance, and trust in the same way the older women did. Other sources would link two of the three concepts, not all three.

5. For older women to be aware, they have to:

(a) be in harmony or balance, have well-being, and "managing stress," and

(b) have caring, acceptance, and trust.

This was the first time for these six concepts to be linked together in this way. No literature support was found for this proposition.

6. If older women are to progress through the stages of being aware, they have to have:

(a) a consciousness of self gained through reflection,

(b) a consciousness of others through being receptive and listening to gain the knowledge, and

(c) a consciousness of the interaction of the self and others gained through reflection.

Support for stage one, consciousness of self, was provided by Strasser (1970) and Griffin (1983). Strasser suggested that a person

had to know oneself, while Griffin said that one had to have a good relationship with oneself. Stage two, consciousness of others, was supported by Alvino (1986), when she said that awareness was focusing on another, and by Noddings (1984), when she discussed the importance of listening in relation to awareness of others. No support was found for the third stage of being aware of the self-other interaction.

Summary

Three research questions were answered. Health meant being in harmony or balance, well-being, and "managing stress." Social support meant "caring, a feeling or attitude of helping over time and making a connection." Along with caring were the core categories of acceptance and trust. Social support was the outcome of caring, acceptance, and trust. The meaning of the relationship between health and social support was "being aware," a Basic Social Process. "Being aware" had three stages: the awareness of self, the awareness of other, and the awareness of self-other interaction.

The chapter concluded with the definitions of seven theory concepts. Six propositions were stated; four were existence statements and two were relational statements.

The findings of the meaning of the relationship between health and social support among independent older women might best be described by T. S. Eliot (1952) when he said:

> And what you thought you came for
> Is only a shell, a husk of meaning
> From which the purpose breaks only when it is fulfilled
> If at all. Either you had no purpose
> Or the purpose is beyond the end you figured
> And is altered in fulfillment (Four Quartets, "Little Gidding," p. 139).

CHAPTER V

The Outcomes

Integration of the Theory with the Conceptual Framework

The metaparadigm of nursing, the concepts of health and social support, and symbolic interactionism were used as the conceptual framework. Within the metaparadigm there were four concepts; person, environment, health, and nursing.

The person or subject of study was the independent older woman, who interacted with the investigator. The person did not change during the course of the study.

Initially, the environment was the physical resources and sociocultural resources in society (Gelein, 1983). The environment, as a result of the study, has two components, an internal dimension and an external dimension. As perceived by older women, the internal dimension included the physical, mental, emotional, and spiritual aspects of themselves. The external dimension was perceived by women as interaction of the internal dimension with other people and nature.

Health was the fluid, dynamic process of being and was initially a state. Nursing was the investigator interacting with the women through questioning, listening, discussing, and observing.

The concept of health changed from the person's perceived dynamic state of well-being, which encompassed the physical, mental, social, and emotional dimensions to being in harmony or balance, well-being, and "managing stress." Health, as a result of the study, is the balancing

of the internal or inner self with the external environment including people and nature. Harmony or balance is accomplished through the sense of well-being and managing stress.

Initially, social support was conceived as a health behavior that potentially influenced the states of health and illness through the gratification of human needs. For independent older women, social support is the outcome of caring, of "an attitude of helping that takes place over time" and of "making a connection with another." Caring, the attitude or feeling and action, combines with acceptance and trust both of the self and of the other. If there is a perceived, shared caring, acceptance, and/or trust within a relationship with another, then the person feels supported in a social context.

The description of the symbolic interactionism process did not change during the study. The meanings, derived by independent older women, were through their interpretations of the women themselves, their behavior, and the interactions of themselves with the behavior of others in concert with the environment. The women's interpretations facilitated their going through the three stages of being aware, the connection between health and social support. Older women expressed that the knowledge gained from these interpretations, the stages of being aware, acted as encouragement for the women to stretch themselves and to grow. Growth was primarily through the third stage of being aware and few older women seem to have reached that stage.

Integration of the Propositions and the Assumptions

Assumptions

There were six assumptions for the study and six propositions were derived from the theory of being aware. In the first assumption (p. 9), social support existed among older women as an outcome of caring,

acceptance, and trust. Second, social support was the meaning of shared caring, acceptance, and/or trust within a relationship with another in a social context. Third, health meant being in harmony or balance, well-being, and "managing stress" for older women. Fourth, the relationship between health and social support for older women was being aware. Fifth, as no dependent older women were interviewed, no conclusions could be reached about the possible difference between independent older women and dependent older women. Sixth, independent older women, participating in social or professional organizations were able to articulate their meanings of social support and heatlh as evidenced by the generated theory of being aware.

Propositions to the Assumptions

All the propositions related to the first through the fourth assumptions. The first proposition (p. 58) described the existence of health being in harmony or balance as occurring through the women bringing into congruence the awareness of self, of others, and of the environment and dealing with internal and external conflict. The second proposition stated the relationship of well-being and managing stress to being in harmony or balance (p. 58).

The third proposition (p. 58) described the existence of the outcome of social support: caring, acceptance, and trust. In order for the three concepts to function in a social context, the women must have had a shared feeling or attitude of acceptance, trust, and caring with others, the fourth proposition (p. 59).

The fifth and sixth propositions (p. 59) described the existence of being aware and the three stages of being aware. Being aware was the meaning of the relationship between health and social support for older women.

Theory Evaluation

An accepted definition of theory in the nursing discipline was by Chinn and Jacobs (1983) when they said: "A set of concepts, definitions, and propositions that projects a systematic view of phenomena by designing specific interrelations among concepts (and propositions) for the purposes of describing, explaining, predicting, and/or controlling phenomena" (p. 70).

The theory of being aware is evaluated with Glaser's (1978) criteria which include that a theory must fit, work, and be modifiable. Fit means "that the categories of the theory must fit the data" (Glaser, 1978, p. 4). Fit was affirmed by the study subjects through the verification of the narrative sketch by subjects familiar and unfamiliar with the study. The theory of being aware was generated with the subjects rather than on the subjects.

The criterion of the theory must work means "that a theory should be able to explain what happened, predict what will happen and interpret what is happening in an area of substantive or formal theory" (Glaser, 1978, p. 4). The stages of being aware explain of what a woman must be conscious to be aware of self, of others, and of self-other interaction. The stages of being aware predict where a woman could be at any given time by applying an evaluation of the stages. The theory of being aware interprets what is happening to a woman through the three stages and the core categories of being in harmony or balance, well-being, "managing stress," caring, acceptance, and trust. Additionally, the theory of being aware has seven major concepts: being aware, being in harmony or balance, well-being, "managing stress," caring, acceptance, and trust.

Definitions of the seven concepts were presented in Chapter IV. Six propositions were constructed which described the existence and the relationship of the concepts, also found in Chapter IV.

The last criterion is that the theory be "modifiable based on ever-emerging notions from the data" (Glaser, 1978, p. 4). The theory of being aware is modifiable in that there is one Basic Social Process, being aware, and six core categories; those are for health: being in harmony or balance, well-being, and "managing stress." The core categories for social support are caring, acceptance, and trust. Through the collection of more data and the constant comparative analysis process, the theory should demonstrate the ability to be modifiable.

Conclusions

The meaning of health among independent older women was being in harmony or balance, well-being, and "managing stress." Health is a balance or harmony within the person and between the person and the environment. Focusing on one dimension, such as the physical, does not explain the interrelationships of the various facets. While several authors recognized that health required some sort of balance or harmony of the person with the environment, no researchers have studied what the balance or harmony is and how it is achieved.

Well-being meant "being able to do" and "being well" which included physical, emotional, mental, spiritual, and social aspects of the person. Presenting a pleasant physical appearance was equally important to well-being. Several authors and researchers explored well-being as a descriptor of health, then subcategorized well-being into morale, happiness, life satisfaction, psychological adjustment, and contentment. These researcher-constructed subcategories do not fit older women's conceptions of well-being.

"Managing stress" meant dealing with conflicts between a person's internal expectations and standards and the external expectations and standards. If older women deal with the conflicts, either by resolving or minimizing them, then they are "managing stress." They are able to manage stress through having a sense of well-being, which leads to health, the balance or harmony.

Social support was the outcome of caring, acceptance, and trust. Caring, acceptance, and trust were perceived by the women to be reciprocal: one has to care, accept, and trust the self before one can care, accept, and trust the other. Few authors acknowledged that the self was important. Caring, acceptance, anc trust were based in the context of relationships. Social support as an outcome was a different way of looking at the concept, particularly in the context of women's lived experiences.

Being aware was the meaning of the relationship between health and social support among independent older women. Being aware was being conscious of everything in and around the person. It required listening and being receptive. To be aware one must have or gain the knowledge and then be introspective or reflective to learn the meaning behind the knowledge. Introspection is needed particularly in the last stage of being aware, being aware of the self-other interaction. The other requirements pertain more to the first two stages: being aware of the self and being aware of the other.

Implications of the Theory

The implications for nursing practice are first, the definition of health. With the focus of health being harmony or balance, well-being, and "managing stress" nurses can assist patients and clients, specifically older women, to get in touch with themselves to use their own

powers of "being in tune" to achieve the harmony of the self with the environment. Some of this getting in touch with the self is being done in the private sector without nurses. Christian Scientists have been practicing their personal powers for years. Other people interested in meditation have been using it to bring themselves into being in harmony or balance. Therapeutic touch is based on the powers of meditation and focusing on the invisible energies within and surrounding the body (Krieger, Peper, & Ancoli, 1979). Therapeutic touch is the only nursing-devised intervention of the three.

If nurses were to use caring, acceptance, and trust in a genuine sincere way to augment a patient/client's perception of social support, then nursing could effect a change in a person's perception of social support. Laschinger (1984) suggested that social support was perceived at a higher level with professionals than with nonprofessionals by older men and women. Perhaps, her subjects were talking about caring, acceptance, and trust.

The third implication for nursing practice is if nurses knew about the three stages of being aware, then they could assess their patients/clients' stage and assist them in advancing to the third stage. The nurses could encourage their patients/clients to begin to see the interaction between the self and the other and how that interaction impacts on them.

There are three implications for nursing education. The first implication is the new definition of health. If nursing educators were to present health as encompassing being in harmony or balance, well-being, and "managing stress" for older women, nursing students would begin to see the dynamic nature of health and the implications of using

the self to achieve being in harmony or balance. There could be less emphasis on the physical and psychological dimensions and more emphasis on bringing the self to being in harmony or balance.

The second implication for nursing education is with social support. Students would learn that social support is an academic or research term, not words used by older women. Caring, acceptance, and trust are necessary for a woman to perceive that she is supported in a social context.

The third implication for nursing education is with being aware. Nursing educators could use the stages of being aware with their students to help the students get in touch with themselves. The students, in turn, could use the stages to assist their patients/clients in progressing through the stages.

Recommendations

The recommendations focus on nursing research. Because of time and financial restraints, clarification of the interrelationships among the supporting categories of health and social support was not completed. Before any other research is conducted, the investigator should return to the data, the women's interviews, to clarify the interrelationships of the supporting categories. If the investigator is unable to clarify the interrelationships with the existing data, then the investigator should recruit other subjects using the identified criteria. During further data collection and constant comparative analysis, the investigator could clarify the interrelationships among the supporting categories and modify the theory of being aware. After this process has been completed, the following research questions could be explored:

1. Does the theory of being aware fit for dependent older women as it does for independent older women;

2. Does the theory of being aware fit for older men;

3. How does the theory of being aware fit for older men;

   (a) Are any of the core categories and categories different;

   (b) How are the core categories and categories different; and

4. To what other substantive theories does the theory of being aware relate?

Answering the last question would be the first step in the preparation of extending the substantive theory of being aware to emergent-fit theory (Glaser, 1978).

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APPENDIX A

Screening for Independence Criteria

Screening for Independence Criteria

Subject's Number: _____ Date: _____

DOB/Age: _____ Marital Status: _____

SCREENING CRITERIA	NO	YES
Is 60 to 74 years old (born between 1913 & 1937)	_____	_____
Resides in nonage-segregated housing (own house or apartment)	_____	_____
Is living without physical assistance of another	_____	_____

FUNCTIONAL ACTIVITIES OF DAILY LIVING	NO	YES
Able to arise from bed without assistance	_____	_____
Able to dress without assistance	_____	_____
Able to prepare food without assistance	_____	_____
Able to move in living quarters without assistance	_____	_____
Able to telephone without assistance	_____	_____
Able to manage own medications without assistance	_____	_____

Name: _____

Address: _____

_____

Telephone: _____

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APPENDIX B

Personal Data Sheet

Personal Data Sheet

Number: _____

To enable me to compare the results of this study, I would like some additional information about your background. Please complete the following items.

1. Date of Birth _____

2. Marital Status
   _____A. Never Married
   _____B. Married
   _____C. Divorced
   _____D. Separated
   _____E. Widowed

3. If divorced, separated, or widowed, how long have you been without a spouse/partner?
   _____A. Less than one year
   _____B. One year
   _____C. Two to four years
   _____D. Five to nine years
   _____E. Over ten years

4. If you have been living with someone, how long have you been living with someone?
   _____A. Less than one year
   _____B. One year
   _____C. Two to four years
   _____D. Five to nine years
   _____E. Over ten years

5. If you have been living alone, how long have you lived alone?
   _____A. One year
   _____B. Two to four years
   _____C. Five to nine years
   _____D. Over ten years
   _____E. All of your adult life

6. Educational Background

   What is the highest grade of regular school that you completed? (Circle one)

Grade School								High School				College				Graduate School					
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22

7. Ethnic Background
   _____A. Asian
   _____B. Black
   _____C. Caucasian
   _____D. Hispanic
   _____E. Native American (Indian)
   _____F. Other (Specify) _____

8. If you are responsible for the care of an older adult, how long have you been caring for that person?
   _____A. Less than one year
   _____B. One Year
   _____C. Two to four years
   _____D. Five to nine years
   _____E. Over ten years

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APPENDIX C

Interview Guide

INTERVIEW GUIDE

Directions: Facilitate discussion of the following topics with older women. Focus on the perceptions that are willingly shared about social support and health. The questions offered under each topic are sample questions.

HEALTH

What is the meaning of health to you?

Cues will be suggested by the independent older women and will be followed by questions generated by the investigator.

SOCIAL SUPPORT

What does social support mean to you?

Cues will be suggested by the independent older women and will be followed by questions generated by the investigator.

RELATIONSHIP BETWEEN SOCIAL SUPPORT AND HEALTH

What is the connection between health and social support for you?

Cues will be suggested by the independent older women and will be followed by questions generated by the investigator.

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APPENDIX D

Interview Summary Form

Interview Summary Form

Interview Type:
Visit _____
Phone _____

Contact Date _____
Today's Date _____
Interview No. _____

1. What were the main issues or themes that struck you in this interview?

2. Summarize the information you failed to get on each of the target questions you had for this interview.

3. Anything else that struck you as salient, interesting, illuminating or important in this interview?

4. What new (or remaining) target questions do you have in considering the next interview with this person?

Adapted from Miles & Huberman, 1984, p. 52

APPENDIX E

Institutional Review Board Approval

The University of Alabama in Birmingham
Institutional Review Board for Human Use
205/934-3789

FORM 4: IDENTIFICATION AND CERTIFICATION OF RESEARCH PROJECTS INVOLVING HUMAN SUBJECTS

The Institutional Review Board (IRB) must complete this form for all applications for research and training grants, program project and center grants, demonstration grants, fellowships, traineeships, awards, and other proposals which might involve the use of human research subjects independent of source of funding.

This form does not apply to applications for grants limited to the support of construction, alterations and renovations, or research resources.

PRINCIPAL INVESTIGATOR SUSAN TRIPPET, RN., MSN

PROJECT TITLE THE MEANING OF THE RELATIONSHIP OF SOCIAL SUPPORT AND HEALTH AMONG INDEPENDENT OLDER WOMEN

_____ 1. This is a training grant. Each research project involving human subjects proposed by trainees must be reviewed separately by the Institutional Review Board (IRB).

__X__ 2. This application includes research involving human subjects. The IRB has reviewed and approved this application on 5-6-87, in accordance with UAB's assurance approved by the United States Public Health Service. The project will be subject to annual continuing review as provided in that assurance.

__X__ This project received expedited review.

_____ This project received full board review.

_____ 3. This application may include research involving human subjects. Review is pending by the IRB as provided by UAB's assurance. Completion of review will be certified by issuance of another FORM 4 as soon as possible.

_____ 4. Exemption is approved based on number(s) _____.

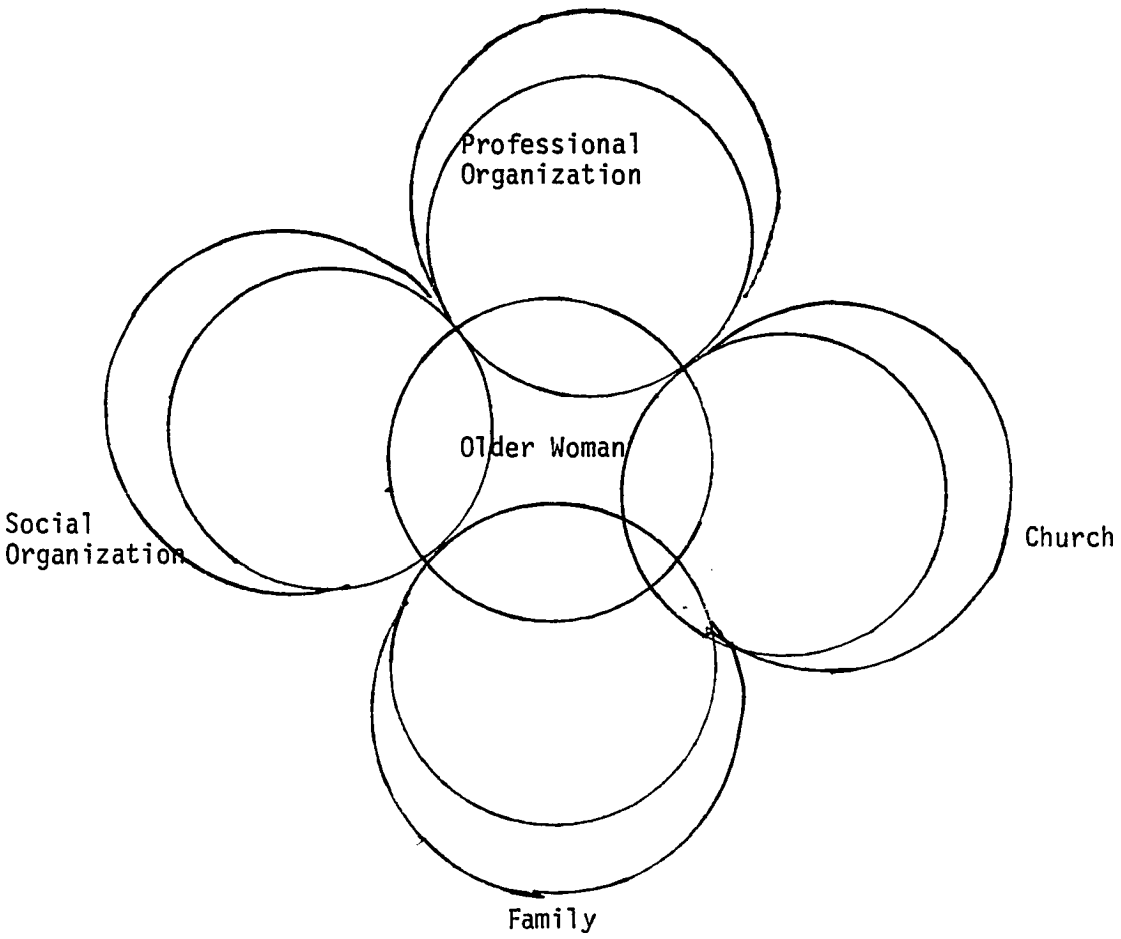
5-6-87
Date

Russell Cunningham, M.D.
Interim Chairman of the
Institutional Review Board

APPENDIX F

Mapping Example of Older Women's Relationships

Mapping Example of Older Women's Relationships



Those people falling into the inner circles were perceived by the older women as having the closest relationships with the older women.

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APPENDIX G

Diagram Example of Core Categories

Diagram Example of Core Categories

Being Aware

Health

Social Support

Being in Harmony or Balance,
Well-being, "Managing Stress"

Caring, Acceptance, Trust

GRADUATE SCHOOL
UNIVERSITY OF ALABAMA AT BIRMINGHAM
DISSERTATION APPROVAL FORM

Name of Candidate Susan E. Trippet

Major Subject Maternal Child Health Nursing

Title of Dissertation Being Aware: The Meaning of the Relationship Between Social Support and Health Among Independent Older Women

Dissertation Committee:

[signature], Chairman

[signature]

[signature]

[signature]

[signature]

[signature]

[signature]

Director of Graduate Program [signature]

Dean, UAB Graduate School [signature]

Date

PS 1478