1993

Flexible time management: Women handling responsibilities of multiple roles to implement health-promoting activities.

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FLEXIBLE TIME MANAGEMENT: WOMEN HANDLING RESPONSIBILITIES OF MULTIPLE ROLES TO IMPLEMENT HEALTH-PROMOTING ACTIVITIES

by

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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

BIRMINGHAM, ALABAMA

1993

ABSTRACT OF DISSERTATION
GRADUATE SCHOOL, UNIVERSITY OF ALABAMA AT BIRMINGHAM

Degree D.S.N. Major Subject Nursing

Name of Candidate Nancy Merrill Magnuson

Title Flexible Time Management: Women Handling Responsibilities of Multiple Roles to Implement Health-Promoting Activities

Research has shown that health-promoting activities significantly improve health and increase the quality of life. Studies have been done with large corporations implementing worksite health promotion. The health care system in the U.S. is in the midst of an economic crisis. Increased health of individuals would reduce health care expenditures. Although small businesses are interested in health promotion, current literature revealed no information from the perspective of employees in small businesses. The number of women in the work force and in small businesses continues to increase. The responsibilities of multiple roles of working women influence mental and physical health.

The purpose of this study was to explore what women working in small businesses were doing with regard to health-promoting activities. Grounded theory was the research approach for this study. The exploration revealed a process that was occurring in order for the women subjects to implement health-promoting activities. The focus of the study became the exploration of how women employed in small

businesses were handling responsibilities of multiple roles in order to implement health-promoting activities.

Subjects were females 30-54 years of age employed full time in businesses in a southeastern urban community with 50 or fewer employees. The employers of the subjects provided no formal program of health promotion.

The conclusion of the study was that women working in small businesses who used flexible time management to handle responsibilities of multiple roles were implementing health-promoting activities. The proposed theory describes health-promoting activities that women subjects were implementing, explains how the women subjects facing the responsibilities of multiple roles coped in order to implement health-promoting activities, and predicts probable success of implementation of health-promoting activities by the women subjects.

Implications included incorporating health promotion theory into nursing education and the utilization of nurse consultants for the purpose of designing and implementing health promotion programs for women employed in small businesses. Recommendations for future research were suggested.

Abstract Approved by: Committee Chairman Carol H. Miller

Program Director Elizabeth Stellenberg

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ACKNOWLEDGEMENTS

For their interest and time, I would like to thank my committee: Dr. Carl Miller, chairperson; Dr. Ann Clark; Dr. Alberta McCaleb; Dr. Michael Bowers; Dr. Brenda Roberts; and Dr. Byron Chew. Each committee member has provided me with support and expertise in their own unique way. This contributed to enrichment of the research process for me.

I feel a special appreciation for the women that I interviewed. They were all open and willing to share of themselves and their lifestyles.

For providing much more than typing, I would like to thank Irene Whiddon. Also, for his devotion and timeliness in the transcription of the interviews, I would like to thank Martin Hamilton.

I am grateful to God for the blessings of wisdom, ability, and a supportive family. Appreciation goes to my father who instilled in me the value of higher education, and to my mother for always being on my side.

To my husband, Norman, goes my heartfelt gratitude for his abiding support and encouragement. Last, but never least, a special "thank you" to my son, Jonathan, for never letting me forget that life is a continual process of discovery and that things go much better when you take the time to have some fun along the way!

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CHAPTER I

Introduction

The health care system in the United States (U.S.) is in the midst of a crisis. The current health care system costs the U.S. in excess of $660 billion (Rovner, 1991). Health insurance costs continue to increase. Therefore, health care reform is currently a major issue in the U.S. Problems which policy makers are seeking to address include: (a) reducing the number of deaths resulting from unhealthy lifestyles, (b) cost containment, and (c) access to health care for all Americans.

Over 50% of all deaths in the U.S. today are related to causes that can be prevented. These deaths result from the practice of unhealthy lifestyles. National health objectives include reducing the number of these preventable deaths by the year 2000 (Healthy People 2000, 1990). According to Laughlin (1982), businesses lose over $50 billion a year because of disease, disability, and death of employees. Green (1989b) noted that in 1988 U.S. companies spent $400 billion on health care expenses and disabilities resulting from controllable problems such as obesity, alcoholism, drug addiction, smoking, high cholesterol, stress-related illnesses, and hypertension.

In an effort to curb rising health care expenses, many large corporations have instituted health promotion programs and are receiving the benefits of cost savings. Results from a five year study of employees participating in Johnson & Johnson's Live for Life Program revealed hospital costs that were half that of non-participants. Based on results of a current wellness program, American Telephone and Telegraph (AT&T) will save $10 million in 10 years from reducing the risk of cancer and heart disease among their employees (Green, 1989b).

General Motors Corporation (GMC) reported a three to one return on dollars invested in their comprehensive wellness program. This return is attributed to a 50% reduction in on-the-job accidents and a 60% reduction in sickness and accident payments (Whitmer, 1984). Other investigators addressing health promotion in the business industry have reported similar findings (Alexy, 1991; Edington, 1986; Fielding, 1982; Verespej, 1993).

The major legislative proposals addressing cost containment and access to health care contain a mandate that employers provide insurance coverage for employees and their dependents (Rovner, 1991). Currently there are approximately 34 million Americans who do not have health insurance. More than half of those Americans without health insurance are employed. Estimates are that 74% of employed Americans without health insurance are employed by businesses with fewer than 500 employees (Geisel, 1990).

Small businesses make up 99% of all businesses in the U.S. (Small Business, 1987). The National Federation of Independent Businesses reported that 80% of all businesses in the U.S. have fewer than 20 employees, and that 60% have fewer than four employees (Macrina & Smogor, 1986).

Small businesses generally do not have the same resources as large businesses (Covin & Covin, 1990). Small business owners are faced with the possibility of being required to offer insurance coverage to employees in spite of limited economic resources. Limited resources are a barrier to small businesses who desire to implement health promotion programs of the magnitude of larger businesses (Green, 1989a). The Office of Disease Prevention and Health Promotion, Public Health Service, U.S. Department of Health and Human Services (USDHHS) reported that small businesses are interested in health promotion, but believe that their interests go unnoticed by providers who gear programs toward large businesses (American Health Consultants Inc., 1984).

A few studies (Erfurt & Holtyn, 1991; Ostwald, 1989) have been conducted to examine the results of pre-designed wellness programs on employees in small business settings. These programs were modeled after those implemented with larger corporations. Information gained by the Office of Disease Prevention and Health Promotion of the USDHHS indicated that owners and managers of small businesses reported interest in health promotion. However, few had implemented health promotion programs (Yenney, 1984).

The number of women employed in small businesses continues to increase ("U.S. Small Business," 1990). Employment data revealed that in 1990 women comprised 54% of the United States work force, and the majority were 25-54 years of age (U.S. Bureau of the Census, 1991).

Yenney (1984) stated that "many believe that the potential for health promotion in small business could be great if the key to serving these companies is found" (p. i). A review of the literature revealed no information from the perspective of employees working in small businesses with regard to health promotion needs. More specifically, no information was found from the perspective of women employees. Descriptive data related to health promotion activities of women in small businesses are nonexistent.

Significance of the Study

Information obtained from this study will result in the generation of a substantive theory that will (a) describe the health-promoting activities of the women subjects employed in small businesses, (b) explain how the women subjects coped with responsibilities of multiple roles, and (c) predict the probable success of implementation of health-promoting activities by the women subjects. This information is a beginning step in developing knowledge to guide the practice of nurses and others involved in health promotion and improvement of women's health. Specifically, the information obtained may assist nurse researchers in designing a model for health promotion programs for women employed

in small businesses. The model may be tested and refined so that ultimately it can be used nationwide. Such an effort can contribute to the overall improvement of women's health in the nation.

Pender's Model of Health Promotion

Pender's (1987) model of health promotion is useful for consideration of determinants of health-promoting behavior. The model is derived from social learning theory and organized similarly to the Health Belief Model. Determinants of health-promoting behavior are categorized into: (a) cognitive-perceptual factors - the primary motivational mechanisms for acquisition and maintenance of health-promoting behaviors, (b) modifying factors - factors that may affect or modify health-promoting behaviors through their impact on cognitive-perceptual factors, and (c) cues to action - variables that affect the likelihood of taking health-promoting action (Pender, 1987). The cognitive-perceptual factors include: (a) importance of health, (b) perceived control of health, (c) perceived self-efficacy, (d) definition of health, (e) perceived health status, (f) perceived benefits of health-promoting behaviors, and (g) perceived barriers to health-promoting behaviors. The modifying factors include: (a) demographic characteristics, (b) biologic characteristics, (c) interpersonal influences, (d) situational factors, and (e) behavioral factors.

Pender (1987) stated that health-promoting behaviors are an expression of actualizing tendency of human beings.

Further described is the contrast between health promotion and prevention or health-protecting behavior, which is an expression of stabilizing tendency. Health-promoting behaviors as seen by Pender represent persons acting on their environment as they move toward higher levels of health as opposed to reacting to external threats within the environment.

According to Pender (1987), the modifying factors in the model indirectly influence health behaviors by exerting influence on the cognitive-perceptual factors, which directly influence health behavior and the likelihood of engaging in health-promoting behaviors. The likelihood of engaging in health-promoting behavior is also influenced by internal and external cues to action. According to Pender (1987), "health promotion consists of activities directed toward increasing the level of well-being and actualizing the health potential of individuals, families, communities, and society" (p. 4). Pender (1987) stated that health-promoting behaviors were continuing activities that are an integral part of a person's life.

Research Question

The research question for this study was: "What are the health-promoting activities of women employed in small businesses?"

Definition of Terms

The following terms were operationally defined for this study:

Health-Promoting Activities - any action directed toward increasing the level of well-being or improving the health of an individual including exercising, dietary modifications, and stress management techniques.

Employed Women - females within the age range of 30-54 years working full-time (minimum of 35 hours per week) out of the home.

Small Business - a business employing no more than 50 persons in a southeastern urban community.

CHAPTER II

Review of Literature

The review of literature is divided into the following categories: (a) health promotion, (b) health promotion related to small businesses, and (c) the health of working women.

Health Promotion

Healthy People 2000 (1990) is a document that contains specific goals, objectives, and strategies related to the promotion of health in the United States. The document presented statistics related to various diseases and life-style patterns and set goals based on percentages of persons engaging in health promotion and healthier lifestyles by the year 2000. Edington (1986) noted that health promotion is a long term cost saving strategy. Keelor (1985) encouraged business managers to implement health promotion programs in an effort toward cost containment. Specific strategies involved in implementation of health promotion programs were discussed and included health risk appraisal, group support, feedback, and rewards. Benefits of health promotion noted frequently in the literature are: (a) decreased absenteeism, (b) cost containment in terms of insurance claims and disability, (c) less turnover, and (d) improved morale and

productivity (Fielding, 1982; Reinertsen, 1983; Seamonds, 1982; Walker, 1987; Whitmer, 1984). Authors who document benefits of health promotion often cite large corporations as examples of successfully implemented programs.

A national survey of private worksites with 50 or more employees was conducted to determine the presence or absence of specific health promotion activities. At least one type of health promotion activity was reported by 65.5% of surveyed worksites. The most frequent activities were found to be smoking cessation activities and health assessment activities. In addition, the larger the worksite, the higher the likelihood of some type of health promotion activity (Fielding & Piserchia, 1989).

Frank-Stromberg (1986) discussed the implementation of a qualitative study with ambulatory cancer patients for the purpose of discovering the health-promoting activities of ambulatory cancer clients. Frank-Stromberg concluded that there was evidence that it was possible to be healthy at the same time one has cancer. The clients involved in the study were implementing health-promoting activities. These clients wrote in a health diary on a daily basis. Among the activities noted in the diary was evidence of nutritional awareness, stress management, social health, and exercise.

Health Promotion Related to Small Businesses

The majority of the literature related to health promotion in small businesses revealed that specific businesses have implemented programs patterned after those of "big"

business (Erfurt & Holtyn, 1991; Ostwald, 1989; Rothman, 1989; "Small Business Creative," 1987; Solomon, Portnoy, Dashton, Rogus, and Tuckermanty, 1983). These programs typically involved some combination of the following elements, which are normally components of programs reported to be successful in large businesses: (a) education and assessment geared toward reducing cholesterol, blood pressure, and weight, (b) smoking cessation, (c) exercise programs, and (d) stress management. While reported to be successful, there are no longitudinal studies that show pertinent statistics, due to the short period of time that the programs have been implemented. Solomon et al. (1983) noted 80% participation by employees, with 79% of those participating meeting their goals for improvement.

Macrina and Smogor (1986) discussed the general state of health promotion programs in small businesses and noted that a major problem in attempting to carry out health promotion activities is limited resources. These researchers noted that the benefits for employees of small businesses are as applicable as those for large businesses; however, the structure of the programs for small businesses may need to be different. According to these authors, what is needed is the identification and development of characteristics of small business that can be utilized in developing effective programs.

A project, sponsored by the USDHHS Office of Disease Prevention and Health Promotion (Yenney, 1984), described

the opinions of a group of owners and managers of small businesses with regard to health promotion. There were forty-nine participants from six cities in the United States. There was no representation from the southeastern region of the United States. The approach that providers of health promotion should take in designing and marketing health promotion programs for small businesses was discussed. The conclusion of the small business owners was that they desired health promotion programs. The owners felt that health promotion would be difficult to implement and desired programs in easy to implement steps.

The Health of Working Women

The leading causes of death in adult women are the same as for adult men and include cancer, heart disease, injuries, and stroke (Healthy People 2000, 1990). The incidence of death from cancer, suicide, and motor vehicle accidents is predicted to continue to increase for professional women (Woods, 1981).

There continues to be an increasing number of women in the labor force, including an increase in women in management and women entrepreneurs (Baron, 1984). Working women have simultaneous role demands that lead to role overload, role conflict and depression (McBride, 1990; Nieva & Gutek, 1981; Woods & Woods, 1981). These role demands involve parenting and caring for elderly relatives, with women performing these caretaking responsibilities more often than men (McBride, 1990).

Working women encounter stress at the workplace and at home. In dual career marriages, studies have shown that women continue to take on more of the household responsibilities than men (Gilbert, Holahan & Manning, 1981). These numerous responsibilities can lead to role strain as well as emotional and physical health problems. Allen and van de Vliert (1984) stated that if individuals are not successful in reducing role strain, there might be serious consequences for the physical and psychological health of the individual. Working women, often by necessity, must put the needs of others before their own. Therefore, they usually have little time left for taking care of themselves (Osborne, 1991).

Lewis and Cooper (1988) suggested that in the management of multiple roles stress management programs might be effective in dealing with management of multiple roles. Hall (1972) proposed a model of coping with role conflict for women that included three types of coping: (a) structural role redefinition, (b) personal role redefinition, and (c) reactive role behavior.

Gilbert, Holahan and Manning (1981) compared women using role redefinition and role expansion as strategies to cope with simultaneous role demands. It was found that the degree of conflict resolution was somewhat higher and the level of conflict slightly lower for women implementing role redefinition. The authors noted that there was considerable stress caused by conflicts between professional and maternal roles, although women derived high life satisfaction from

both roles. Conclusions from the study included suggestions to assist women with multiple roles. These conclusions encouraged women to differentiate internal and external aspects of role conflict within the family and society, evaluate the influence of social norms on their personal experience, consider and negotiate major and minor parental role responsibilities, and explore facilities and resources to assist them with their needs.

Johnson and Johnson (cited in Woods & Woods, 1981) suggested methods of dealing with multiple roles. These methods include: (a) establishing a hierarchy of importance among roles, (b) insulation of some roles from observation, (c) receiving mutual support from peers, (d) compartmentalizing roles, (e) delegation of some roles, (f) elimination of some roles, and (g) role bargaining.

CHAPTER III

Methodology

The purpose of the study was to explore what women working in small businesses were doing with regard to health promoting activities.

Overview of Grounded Theory

Grounded theory was chosen as the research approach for this study. The basic aim of the grounded theory approach is the discovery of theory from data obtained systematically (Glaser & Strauss, 1967). As categories and relationships among categories are discovered, phenomena can be explained in light of the emerging theory (Strauss & Corbin, 1990). Hutchinson (1986) noted that grounded theory is a useful approach if little is known about a topic and few theories exist to explain behavior. Grounded theory is also useful when the existing research does not adequately reflect the perspective of the subjects (Bowers, 1988).

The grounded theory approach to data analysis was developed by Glaser and Strauss (1967). The origin of grounded theory is based on pragmatism and symbolic interactionism. A problem and solutions are considered from the standpoint of the reality of the subjects as data are gathered through observations and interviews.

Techniques used in grounded theory include theoretical sampling, making constant comparisons among the data, and coding the data. Bowers (1988) noted that "as data are collected and analyzed, the interview questions, research questions, and hypotheses change. This leads to changes in data collected, and subjects sampled" (p. 45). Strauss and Corbin (1990) stated that the rationale for the grounded theory approach is based on an underlying assumption that "all of the concepts pertaining to a given phenomenon have not been yet identified, at least not in this population or place, or if so, then the relationships between the concepts are poorly understood or conceptually undeveloped" (p. 37). Another assumption noted by Strauss and Corbin (1990) is that the research question has never been asked in quite the same way, so it is impossible to determine the variables which do or do not pertain to the area of research. Strauss and Corbin (1990) stated that "this reasoning creates the need for asking a type of question that will enable us to find answers to issues that seem important but remain unanswered" (p. 37).

In using the grounded theory approach, the researcher must develop theoretical sensitivity in dealing with the data. Theoretical sensitivity is the ability to recognize what is important in the data and give it meaning (Strauss & Corbin, 1990). Techniques recommended by Strauss and Corbin (1990) for development of theoretical sensitivity include: questioning, analysis of individual words, sentences, and

phrases, close-in and far-out comparisons, the flip-flop technique, and waving the red flag. These techniques help to guard against researcher bias, which can threaten the validity of the study.

The researcher, using the grounded theory method, continues the ongoing interviewing, literature review, analysis of data, categorizing, coding, formulating new interview questions, and theoretical sampling until a point of saturation is reached. Saturation occurs when the researcher notes the use of the same terms and phrases repeatedly, with no new categories emerging from the data.

Instrumentation

The instrument for the study was the researcher. The element of creativity was enhanced through use of the researcher as instrument. Strauss and Corbin (1990) noted that this creativity is the basis for new insights that emerge from the data.

Interviews were conducted using an investigator developed interview guide (Appendix A). The interview guide was pilot tested on three women prior to beginning the study to determine whether the questions would elicit the desired information. Based on the pilot test, the wording of two of the questions was altered to enhance subject understanding. One question appeared to elicit duplicate information and was changed to a probe. As the theory began to be developed, questions were added to the interview guide to focus on emerging concepts (Appendix B).

The researcher followed specific techniques and procedures of analysis as outlined by Glaser and Strauss (1967), Strauss (1987), and Strauss and Corbin (1990). Techniques and procedures included data collection, theoretical sampling, making comparisons among emerging concepts, categorization, memoing, sorting, theoretical saturation, and integration of the theory. Strauss and Corbin (1990) noted that "the systematic techniques and procedures of analysis of the grounded theory approach enable the researcher to develop a theory that meets the criteria for doing 'good' science: significance, theory-observation compatibility, generalizability, reproducibility, precision, rigor, and verification" (p. 31).

The Subjects

Females 30-54 years of age employed full time in businesses in a southeastern urban community with 50 or fewer employees and no formal program of health promotion conducted by the businesses were invited to participate in the study. The original subjects were selected from members of one of the chapters of the Business and Professional Women's Organization in a southeastern urban community. Subsequent subjects were referred to the investigator by the original subjects. Age of the sample was based on data to support homogeneity of the sample with regard to developmental level of human beings (Sutterley & Donnelly, 1973). Employment data reveal that women in this age range have the highest full time employment (U.S. Bureau of the Census, 1991).

The descriptive data for the subjects was obtained from the Demographic Questions Form completed by each subject (Appendix C). The subjects included women in the age range of 30-54. Data pertaining to the frequency of each age range is included in Table 1.

Table 1

Age of Subjects

Frequency	Age Range
1	30-35
2	36-40
4	41-45
1	46-50
2	51-54

All of the subjects reported completion of one year of college or higher. Eight of the subjects reported being married. Two subjects reported being single. Frequency of each of the ranges of annual household income is displayed in Table 2.

Table 2

Range of Annual Household Income

Frequency	Range of Income
2	$25,000-$40,000
2	$40,000-$60,000

Table 2 (continued)

Frequency	Range of Income
3	$60,000-$80,000
2	$80,000-$100,000
1	Over $150,000

Dependents living at the homes of the subjects were children. There were no elderly relatives reported as dependents living in the subjects' homes. Five of the subjects reported no dependents living at home. Three subjects reported having one child at home as a dependent. Two subjects reported having two dependent children living in their homes.

The subjects were employed in a variety of positions and settings. Table 3 contains a list of the nature of employment and positions/titles of the subjects.

Table 3

Nature of Employment and Position

Nature of Employment	Position/Title
Law Firm	Legal Assistant
Day School	Owner
Service Business	Office Manager
Law Library Consulting	Legal Research Consultant
Social Services	Personnel Manager
Photography	Photographer

Table 3 (continued)

Nature of Employment	Position/Title
Childcare	Worker/Assistant
Christian Education	Consultant
Manufacturer	Controller
Computer Software Sales	Customer Service Representative

The subjects all worked full time. The actual number of hours worked per week ranged from 35-72 with a mean of 40.5. All of the businesses were located in a southeastern urban community. Three of the subjects reported working out of their homes located within the community. The other seven subjects worked in offices located within the community. The number of employees reported by the subjects ranged from 1-50 with a mean of 19.7. With the exception of two subjects reporting only one employee, the subjects all reported a different number of employees.

Setting

The setting for the interviews consisted of mutually agreed upon places that ensured an atmosphere conducive to a confidential interview. Six interviews were conducted in the work places of the women. Three interviews were conducted in the women's homes. Two interviews were conducted in restaurants.

Data Collection

Prior to data collection, approval for the study was obtained from the Institutional Review Board (IRB) at The

University of Alabama at Birmingham (UAB) (Appendix D). This approval was to assure protection of human subjects.

The researcher attended a Board meeting of the Business and Professional Women's Organization of a southeastern urban community to present the purpose of the research. Permission was obtained from Board members to contact members of the group and invite them to participate in the study. A list of 20 members who, according to the Board Members, met the age criteria of the study was obtained.

Members were told at two subsequent meetings of the entire organization and through an organizational newsletter that some members would receive an invitation to participate in the study. Letters were sent to the 20 women inviting them to participate (Appendix E). Two women initially responded to the letter by indicating that they would participate. Follow-up phone calls were made by the researcher to women who did not respond to the letter. Five women agreed to participate after contact by letter or phone call. Other names were recommended by the women when interviewed. The researcher called these women to invite them to participate. Theoretical sampling was incorporated into this procedure by inviting participation from the women who were recommended when they met the criteria that was needed to verify emerging concepts, or broaden the sample. Attempts were made to ensure cultural diversity of the sample when possible. One woman subject was African American and one was Hungarian.

Upon reading the letter of invitation, all participants signed the consent statement and completed the demographic form. Interviews were audiotaped. The interviews were transcribed by a transcriptionist who agreed verbally to maintain confidentiality. The transcriptionist was supplied only with the initials of the women along with the tapes. The women were not identified by name on the tapes. The completed demographic information forms were seen only by the researcher. The recordings were erased upon completion of the study and identifying information deleted from the demographic forms.

Eleven women participated in the interview process. One transcript was not analyzed due to the subject no longer meeting the criteria for full time employment at the time of the interview. The transcripts of ten interviews formed the data base for the study.

Data Analysis

Data analysis was conducted using the constant comparative method described by Glaser and Strauss (1967) and Strauss and Corbin (1990). The transcripts of the interviews were reviewed and analyzed. Line by line analysis including word, sentence, phrase and paragraph analysis of each interview, was done to identify emerging categories, subcategories and their properties. Comparison of one interview with another was done to determine common categories. The data was coded using three types of coding: (a) open coding, (b) axial coding, and (c) selective coding.

Open coding involved breaking down, examining, comparing, conceptualizing and categorizing data, including the consideration of properties and dimensions of categories. Axial coding was undertaken for the purpose of putting the data back together in new ways, after open coding, by making connections between categories. Making connections between categories was achieved by using the paradigm model: considering causal conditions, context, intervening conditions, and action/interaction and consequences among concepts, in relating subcategories to a category (Strauss & Corbin, 1990).

Selective coding was employed to consider only those categories that had a direct effect upon the phenomenon of implementing health-promoting activities. The emerging theory was further developed through tracing conditional paths and constructing a conditional matrix. The core category was selected, and the relationships between the core category and other categories were defined. Process was determined. Explicating the story line was a technique that was useful in identifying process as well as solidifying relationships among categories.

As major concepts were identified, the literature was consulted to search for validation of concepts. For example, when "multiple roles" emerged as the main hindering factor for women attempting to implement health-promoting activities, the literature pertaining to women's multiple roles was again consulted. As the concept "flexible time

management" emerged, the literature related to components of health promotion programs was reviewed to look for "time management," "flexible time management," or related concepts. The final steps used in selective coding included laying out and validating the theory.

Many of the techniques recommended by Strauss & Corbin (1990) to enhance theoretical sensitivity were utilized to guard against researcher bias. The techniques used were: (a) questioning, (b) word, sentence and phrase analysis, (c) flip-flop technique (imagining the opposite for comparison), and (d) waving the red flag (closely looking at words that indicate extremes). Additionally, reflexive notes were written after each interview. A decision trail was kept in a notebook which consisted of dated documentation of decisions as they were made.

As categories were identified, questions were added to the interview (Appendix B) to focus on instances of the phenomenon which seemed to be emerging. For example, after the second interview, the question "Tell me what motivates you to do the health-promoting activities" was added to focus on how the women were attempting to deal with hindering factors in order to implement health-promoting activities. As the theory emerged to include how women deal with multiple roles as a hindering factor, the question "Tell me how you deal with what hinders you" and a probe "How do you manage in spite of these things?" was added.

As each interview was coded, memos based on that interview were written. Four types of memos were utilized: (a)

operational notes: thoughts about the procedure of data collection, (b) code notes: the actual product of coding the interviews including categories, subcategories, properties and dimensions, (c) theoretical notes: ideas, thoughts, and examples as they occurred about emerging categories and relationships among the categories, and (d) diagrams: preliminary models or visual representations of categories and relationships among categories, including the conditional matrix.

As analysis progressed and the theory began to emerge, the research question changed to focus on the process of action/interaction that was discovered by the researcher. Not only were the health-promoting activities of the women identified, but the process of dealing with multiple roles as a hindering factor in order to implement health-promoting activities emerged. As the theory took shape, the research question changed from: "What are the health-promoting activities of women employed in small businesses?" to "How are women employed in small businesses handling responsibilities associated with multiple roles in order to implement health-promoting activities?" Strauss & Corbin (1990) noted that the initial research question starts out broadly and becomes narrowed and more focused as concepts and relationships are discovered. Bowers (1988) also noted that as data are collected, the research question changes. Strauss & Corbin (1990) stated that in grounded theory "there is action/interaction which is directed at managing, handling,

carrying out, responding to a phenomenon as it exists in context or under a specific set of perceived conditions" (p. 104).

Saturation began to occur as the seventh interview was analyzed. Interviews eight, nine, and ten were useful in ensuring saturation, filling in the gaps, and solidifying the theory. Three of the subjects met with the researcher a second time to verify concepts, definitions, and propositions. This served to validate the theory.

Assumptions

The assumptions for this study were:

1. Working women were participating in health-promoting activities.

2. The women were able to articulate their health-promoting activities and how they carried out the activities.

3. The researcher as instrument was able to eliminate bias and preconceptions.

4. Small businesses are not providing formal health promotion programs for their employees.

Limitation

The limitation to this study was:

1. Reports were not found of the use of Grounded Theory as a research method to assess health-promoting activities in small businesses.

CHAPTER IV

The Theory

Theory Statement

Using flexible time management to handle the responsibilities associated with multiple roles experienced by women led to the implementation of health-promoting activities which resulted in positive outcomes. Positive outcomes then served as motivating factors for women to use flexible time management again in order to implement health-promoting activities. The implementation of health-promoting activities and the resulting positive outcomes led to an increase in awareness. This theoretical statement answers the revised research question: "How are women employed in small businesses handling responsibilities associated with multiple roles in order to implement health-promoting activities?" A visual model was developed to illustrate this process (Appendix F).

Flexible Time Management

Flexible time management was the core category. It originated from the category labeled strategies. Subcategories included: (a) organizing, (b) prioritizing/making choices, (c) scheduling, (d) managing time, (e) making time, and (f) flexibility with time.

Flexible time management meant more to the subjects than simply scheduling time for specific activities and breaking activities into manageable components. It was a strategy used daily for handling the many responsibilities that go along with multiple roles. Flexible time management for the women involved: (a) organizing, (b) prioritizing/ making choices, (c) scheduling time for priority activities, (d) breaking each day into manageable chunks, and (e) being flexible with time and scheduling by looking for alternate times to do activities.

Flexible time management can best be illustrated by the words of the women in the following quotations:

> I just have to do what comes first and what needs to come first and a lot of times my schedule changes, you know, depending on your children or your business but I try really hard to work toward a goal at doing it but if I don't, from 9-10 I'll try to do a little extra sit-ups or do a little extra time for myself . . . .

"I ride my bike every night for the 30 minutes that the evening news is on. If I don't get home in time to catch the six o'clock news then I always stay up and do the ten o'clock news . . . . "

> I try to be flexible with my schedule. For instance, I try to schedule exercise around things that have to be done . . . I'll exercise for 10 minutes before my child gets down and has breakfast or after he's had breakfast I'll take 10 minutes and do exercises, and then as soon as I'm back from school, I'll walk for thirty minutes and then do 15-20 minutes of exercise . . . and then I have to get ready to go to work.

"I just try to be flexible with the schedule and fit it in wherever I can . . ."

Flexible time management involved organization and planning but not rigid adherence to a structured schedule.

When there was rigid adherence to structure, then there was an opposite effect: health-promoting activities were often not implemented. This is illustrated in the words of one of the women when discussing times when she was not able to implement health-promoting activities:

> I don't deal with what hinders me - sometimes it flusters me . . . I think my being a structured person might have something to do with it . . . I am very habitual - I do the same things every morning in the same order . . .

There is agreement in the current literature that time management generally involves planning a schedule, listing and prioritizing tasks, and breaking large tasks into smaller components (Levy, Dignan & Shirreffs, 1992; Turner, Sizer, Whitney & Wilks, 1992). There were no instances found in the literature of the incorporation of flexible time management or time management into health promotion programs. The available literature on women's multiple roles did not report the use of flexible time management or time management to deal with the responsibilities of multiple roles. According to Piechowski (1992), the more control a woman exerts over demands in her environment the more mentally healthy she will be. Time management may be seen as one way of exerting control. Baron (1984) mentions women using time wisely to manage in the workplace and suggests that women expand the use of this idea to their home life. In contrast to techniques suggested in the literature involving altering roles, the women subjects were using flexible time management, a strategy external to the roles.

Based on its absence in the available literature, flexible time management appears to be a previously undiscovered concept.

Health-Promoting Activities

The original research question asked: What are the health-promoting activities of women employed in small businesses? The health-promoting activities identified by the women were: (a) exercising, (b) eating well, (c) relieving stress, (d) participating in pleasurable activities, (e) sleeping, and (f) taking medication.

Examples of health-promoting activities noted by Pender (1987) included exercise, nutritional eating practices, development of social support, and use of relaxation or stress management techniques. The subjects in this study saw taking medication as a health-promoting activity. This is in contrast to what Pender (1987) believes. Based on Pender's (1987) model, taking medication would be classified as health-protecting behavior where emphasis is on defending an individual against illness or injury.

Exercise

Aerobic exercise was the form of exercise most of the women participated in. The methods of aerobic activity included walking outside, using equipment such as a stationary bicycle, Nordic track, or stair master, and a step aerobics class. Other forms of exercise identified were stretching and toning/weight lifting/body shaping. Frequency of exercise varied from daily to two times per week. One

woman said, "I try to walk two miles a day three, four to five days a week. And I try to exercise at least 20 minutes also every day during the weekdays . . . mostly stretching, toning, body shaping . . . ." Another stated, "I have a riding bicycle that I ride every night for the 30 minutes that the evening news is on."

The aerobic activity varied in intensity as noted from the following quotations. One woman stated: "We try to walk the track maybe twice a week . . . about 1 mile." Another said,

> I work out to a step aerobic, twice a week and then the other days I do the stair master and then I go to the track. I have a fitness center that I work out at. I do the stair master about 20 minutes and the track about 45. In step aerobics I try to make it an hour but sometimes it's cut short.

Eating Well

Eating well meant to the women subjects eating regularly, avoiding fats, eating fruits and vegetables, and baking and stir frying as preferred cooking methods. The women attempted to "eat well" on a daily basis. One woman summed all of this up when she said,

> I try to eat three real meals a day instead of skipping them . . . I am trying very carefully to watch my diet. I'm making a conscious effort to eat at least five servings of vegetables a day and a couple of servings of fruit and stay away from the fatty foods and the heavy meats.

Activities Directed Toward Relieving Stress

Activities directed toward relieving stress included: self hypnosis, seeking solitude, getting away to visit family, taking a break, taking time for self, and household

projects. Frequency of these activities ranged from daily to weekly. One woman explained seeking solitude when she said, "I vegetate. I turn the world off. I go home and shut the doors. I turn the phone off and I don't talk to people." An example of taking time for self is seen in this woman's explanation:

> . . . it's therapy to the mind. First of all, what I do is I put on paper what I need to do to get it out of my mind for the next day and then I turn on some good music or I read depending on my mood at that time. That's my relaxation.

One woman was involved in relieving stress by doing major household projects as she noted that to relieve stress "more than anything else I do stuff around the house, like big stuff, knocking down walls, painting, hammering and digging in the yard, so physical in a focused kind of way."

Pleasurable Activities

Pleasurable activities were perceived by the women as health-promoting. Activities identified were reading, playing bridge, going places with a spouse, and volunteer work. The idea of pleasure was noted by the women who said, "I go and I read somewhere because I like to do that" and "We enjoy ball games so we go to football games." That these activities were seen by the women as health-promoting was noted when a woman said, "We play a lot of bridge, and it's probably good for you . . . ." The frequency of pleasurable activities ranged from daily to weekly.

Sleeping

The perception of enough sleep was seen by the women subjects as a health-promoting activity. The amount of

sleep that the women felt they needed ranged from 6-8 hours nightly. The idea of sleep as a health-promoting activity was summed up by one women when she stated, "I know I need a lot more sleep than most people do. If I don't get sleep, I look bad, I feel bad, and I'm a nasty person."

Taking Medication

The women subjects perceived that the medications that they took served as health-promoting activities by preventing symptoms and helping them feel healthy. One woman noted that to avoid a severe allergy to pollen in the spring she took an antihistamine daily during the spring season. Another woman saw her daily anti-seizure medication as health-promoting. Vitamins were particularly important to one woman: "I take vitamins every morning . . . instead of just a regular multi-tab I take an iron supplement and a calcium supplement as well as a multi-vitamin."

Multiple Roles

The concept of multiple roles was derived from the category labeled influencing factors, with a subcategory labeled hindering factors. The responsibilities of multiple roles experienced by the women subjects were perceived as a hindrance to their being able to implement health-promoting activities. These women worked full time at their jobs. Additional roles identified by the women were caretaking for children and/or for aging parents or relatives, and implementing household responsibilities including cooking, cleaning house, laundry, buying groceries, running errands,

paying bills, and working in the yard. One woman was also a student going back to school for a college degree.

Household Responsibilities

The women subjects elaborated on their household responsibilities: ". . . everything. Car maintenance, renovating, anything in the house, repairs, cleaning, cooking, laundry, buying groceries, whatever . . ."

> I do a fair amount of cooking . . . there's not a whole lot of heavy housecleaning that I have to do. I usually do all the yard work mowing and things like that . . . . I do most of the laundry . . . I'd say the majority of the grocery shopping . . . .

Household responsibilities occurred on a daily basis. Women who were married reported that while they received some help from spouses, they took care of the majority of household responsibilities. One woman said, "I handle most of the household chores. My husband will do the laundry, but he's convinced that three articles is a full washer, so I do it. I clean, I'm the one who looks after the bills." Other women said, "Laundry, cooking, straightening, basic cleaning, and carpooling are my responsibility."

> He is real good to help me as far as washing the clothes, he takes the garbage out, . . . he'll cook every now and then if I'm sick . . . I just do the basic - just a little vacuuming, a little dusting, the cooking, the washing. He does the yard work. I do get out there and plant a few flowers every once in a while, but he takes care of the yard outside.

The literature supports this. McBride (1990), in a discussion of the stresses associated with multiple roles of women stated, "those who are employed outside the home must also deal with the stresses associated with their occupational

role, often without any reassignment of household responsibilities such as shopping, cleaning, cooking and ironing" (p. 381). Household responsibilities along with a full time job are time consuming and perceived as getting in the way of doing health-promoting activities as evidenced by the following statements of the women:

> I work for a law firm which means it can get exciting when you get ready for trial. We had one recently and it was Thanksgiving weekend. Everybody else got a four day weekend. I got Thursday so I cooked the family dinner. Friday I did the housecleaning. Friday night I got a call from my boss. I worked eight hours Saturday, fourteen hours Sunday and Monday I worked from 8:00 a.m. in the morning till 3:30 in the morning Tuesday.

". . . the pressure of time and having meetings or work that has to be done keeps me from doing activities . . . ."

Caretaking

Caretaking was perceived by the women subjects as a major responsibility. Caretaking included caring for children, aging parents or relatives and in some cases both children and relatives, and occurred on a daily basis. A single mother of two school age boys reported

> We do little league, tutoring classes and then usually get home and throw in a load of clothes and get laundry together and cook and get everything ready for tomorrow, and probably by 9:00 try to have the children in bed, spend a little time with them . . .

The nature of caretaking for aging parents and relatives was illustrated by the following statement from one of the women:

> I have an 86 year old aunt that doesn't live with me, but I'm responsible for and I have an 89 year old father who doesn't live with me but he calls me for everything, you know, even if he's planning to read the

> Bible or his Sunday school lesson you know I have to get on the phone and tell him to spell a word to me and sometimes that gets stressful.

According to the literature, adult women are the principal caregivers for elderly relatives. It has become a normative experience but is stressful (Brody, 1985).

Positive Outcomes/Motivating Factors

The positive outcomes resulting from the implementation of health-promoting activities were perceived as motivation by the women to continue using flexible time management to be able to implement health-promoting activities again.

The concept labeled positive outcomes/motivating factors was derived from the category labeled influencing factors, with a subcategory of helpful factors. The positive outcomes/motivating factors included: (a) increased energy, (b) weight control/improved appearance, (c) increased self esteem, (d) feeling healthy/feeling better, and (e) less prone to depression. The women perceived these factors as directly resulting from implementing the health-promoting activities.

Increased Energy

The women subjects noticed an increase in energy that was particularly related to exercise. One woman noted that she exercised to "keep myself healthy and energized." Another woman subject responded, "what motivates me to do them (exercises) is that I feel like that after I exercise I have more energy and that my energy level is at a higher peak . . . ."

Improved Appearance/Weight Control

The women subjects felt that exercise and eating well contributed to the improvement of their appearance and to weight control. One woman stated: "I fit in my clothes and that keeps me motivated." Another said, ". . . and there is always that you go and try on last year's slacks and they don't fit and you think . . . I need to do something about this. So you know, a little vainness too I guess."

Increased Self Esteem

The women perceived that increased self esteem resulted from implementation of health-promoting activities because they were taking care of themselves. One woman stated, "in my mind I really do want to do things that are good for me, to take care of me." In explaining how exercise increased her self esteem one of the women stated, ". . . it's great for self esteem, and I think that brings out a whole different personality, motivation, and feeling good about yourself changes your whole characteristics of that person . . . ."

Feeling Healthy/Feeling Better

All of the health-promoting activities were perceived by the women subjects as an overall contribution to feeling healthy and feeling better. When discussing visiting her family, which one woman did routinely on weekends to relieve stress, she stated, "I know I'm just gonna have fun and relax and you know that motivates me just knowing that I'm gonna relax." When discussing eating well and aerobic activity, one woman noted, "I do them so I can feel better."

Relating getting enough sleep to feeling better, one woman said, "I get seven hours of sleep at night and with that I can pretty much guarantee that I won't feel bad."

Less Prone to Depression

The women subjects perceived that when they implemented health-promoting activities they were less prone to depression. One of the women had noticed that walking made her "more mentally alert and emotionally stable." Another put it this way: "I feel better and I am less prone to be depressed . . . . I have found that it has a big effect on my mental attitude."

Awareness

The women subjects were aware of the idea that health-promoting activities generally led to positive outcomes. Initially, this awareness came about through a previous or current threat to the woman's health, a threat to the health of a family member, or the acquisition of knowledge. Further awareness came about as a result of the positive outcomes of implementing health-promoting activities. Awareness involved valuing and believing.

A Previous or Current Threat to the Woman's Health

One woman stated, "I have dysautonomia and one of the things that they said would help more than anything is to exercise." Another woman stated that she found out a year ago that she had a "colon problem" and she now regulates the amount of fat in her diet.

A Threat to the Health of a Family Member

One of the women had been participating in the care of her father who had recently undergone heart surgery. She felt that one of the reasons she initiated health-promoting activities for herself was due to her father's illness. Another woman was married to a man with diabetes and "heart problems." She stated, ". . . it made me aware of the fact that I need to watch my health more so that I wouldn't go through what he's going through."

Acquisition of Knowledge

The women subjects noted that they knew about the benefits of health-promoting activities because they had heard or read information or experienced it firsthand. One woman summed this up by saying: "with all the information you hear about cholesterol, and exercise and women . . . I know it is the right thing to do." Another woman noted that she had seen results because she had been doing exercise for almost ten years, and knew it worked. One woman who had not experienced a threat to her health or that of a family member or the acquisition of knowledge about benefits of health-promoting activities stated about exercise: "if somebody said to me . . . if you don't do this, then you're going to be desperately ill or if somebody said to me you will feel a lot better and I really believed it, then I probably would." These examples show evidence of extent of awareness as a property of the concept. For example, one woman might experience more awareness than another.

The model of health promotion proposed by Pender (1987) supports that increased knowledge is a factor in participating in health-promoting activities. Pender (1987) notes that previous experiences with health-promoting activities as well as acquisition of knowledge and skills increases the ability to carry out health-promoting activities and increases well-being.

Definitions

Flexible Time Management - a strategy for handling the responsibilities associated with multiple roles. Components of flexible time management include: (a) organizing, (b) prioritizing/making choices, (c) scheduling time for priority activities, (d) breaking each day into manageable chunks, and (e) being flexible with time and scheduling by looking for alternate times to do things.

Health-Promoting Activities - any action directed toward increasing the well-being or improving the health of an individual. Components include: (a) exercising, (b) eating well, (c) relieving stress, (d) participating in pleasurable activities, (e) sleeping, and (f) taking medication.

Multiple Roles - responsibilities resulting from numerous relationships and activities that one experiences in life. Components include: (a) working at a job, (b) caretaking for children, and/or aging parents or relatives, and (c) implementing household responsibilities.

Positive Outcomes/Motivating Factors - the results of implementation of health-promoting activities; increases the desire to use flexible time management in order to experience the outcomes repeatedly. Components include: (a) increased energy, (b) weight control/improved appearance, (c) increased self esteem, (d) feeling healthy/feeling better, and (e) less prone to depression.

Awareness - valuing and believing that comes about through: (a) a previous or current health threat to an individual, (b) a threat to the health of a family member, or (c) the acquisition of knowledge.

Propositions

1. Women working in small businesses can identify multiple roles that exist in their lives.

2. Women working in small businesses perceive the responsibilities of multiple roles as hindering them in implementing health-promoting activities.

3. Flexible time management is a strategy used by women working in small businesses to handle the responsibilities of multiple roles.

4. Using flexible time management enables women working in small businesses to implement health-promoting activities.

5. Implementing health-promoting activities leads to positive outcomes for women working in small businesses.

6. Women working in small businesses perceived positive outcomes as motivating factors in using flexible time management repeatedly.

7. Women working in small businesses using flexible time management to handle responsibilities of multiple roles in order to implement health-promoting activities leading to positive outcomes/motivating factors is a cyclical process.

8. The implementation of health-promoting activities and the resulting positive outcomes leads to an increase in awareness for women working in small businesses.

9. For health-promoting activities to be implemented, women working in small businesses must use flexible time management to handle responsibilities of multiple roles in their lives.

CHAPTER V

Conclusion, Implications, Recommendations

Conclusion

The conclusion of the study was that women working in small businesses who used flexible time management to handle responsibilities of multiple roles were implementing health-promoting activities. The positive outcomes resulting from implementation of the health-promoting activities served as motivation for the women to continue to use flexible time management. Thus the process can be viewed as cyclical.

There were no indications that the women in this study were now utilizing or had previously utilized the strategies of role redefinition or role expansion to deal with multiple role responsibilities as suggested by Gilbert, Holahan and Manning (1981). The women subjects did not mention the use of methods suggested by Johnson and Johnson (cited in Woods & Woods, 1981). Rather, the women subjects saw flexible time management as a way to manage the responsibilities of multiple roles in order to implement health promoting activities without altering their actual roles. Based on Hall's (1972) model, this might be seen as reactive role behavior coping. According to Hall (1972), this type of coping is not as helpful as structural role redefinition or personal

role redefinition. It could be that the women in this study were at a stage in their lives which they felt left them little room to negotiate roles. For example, an active childrearing role or a career stage which required a certain level of attention might have been perceived as a barrier to role redefinition. Perhaps at a different stage in their lives, these options might have seemed more feasible. On the other hand, using flexible time management may represent a way of coping for these women regardless of their life situation.

It might be questioned just how healthy these women were and whether other strategies would result in a higher level of health-promoting activities or better health status. However, for the women subjects in this study, flexible time management was seen as helpful and was what worked, enabling the women subjects to implement health promoting activities, and thus experience positive outcomes.

Implications

The theory that emerged is a beginning step in developing a knowledge base about health promotion for women working in small businesses. The theory will contribute to the knowledge base for nursing in the areas of women's health and health promotion. The theory describes the health-promoting activities that the women subjects were implementing, explains how the women subjects facing the responsibilities of multiple roles coped in order to implement health-promoting activities, and predicts probable success of

implementing health-promoting activities by the women subjects. The theory enables consumers of research to see the reality of circumstances from the perspective of the women themselves. If nurses can understand this reality, then they will be better equipped to assist women working in small businesses in their endeavors toward health promotion. Nurses can assist women by teaching them how to use flexible time management to deal with the responsibilities of multiple roles in order to implement health-promoting activities. Health promotion programs could be designed specifically for women in small businesses using the theory as a guide and incorporating the concept of flexible time management into program design. The results would be improvement of women's health for the nation.

Recommendations

Nursing Research

This study should be replicated with more women to expand and refine the theory of flexible time management, and to enlarge understanding of strategies that women with responsibilities of multiple roles use to find time to keep themselves healthy. Specifically, the study should be replicated with women working in small businesses and the following variables should be sought through purposeful theoretical sampling: (a) women who are not college educated, (b) women with annual household income of $60,000 or less, (2) women with blue collar jobs, (d) women who are not married, (e) women in different age groups, and (f) women

working where there are 75-200 employees. Replication as recommended would determine whether the theory is applicable to a broader segment of women. Additional studies may also reveal if there are any negative outcomes of using flexible time management. If similar studies yield the same results, then the concept of flexible time management can be further developed.

The model developed through this study should be tested and refined. An additional study should be done to compare women working in large businesses with those working in small businesses, with regard to handling responsibilities of multiple roles in order to implement health-promoting activities.

Similar studies should also be done with women who work part time to see if the theory applies to those women also. A phenomenological study looking at working women who have been implementing health-promoting activities consistently over a period of five years would add a significant contribution to the knowledge base.

A quantitative study should be implemented once the theory is expanded and refined. The quantitative study should measure the usefulness of a health promotion program designed around the theory and implemented for women in small businesses. The study should include statistics on the improvement of participants' health and document cost savings to small businesses as a result of the program.

Nursing Education

Information based on results of this study and other similar studies should be shared with students in nursing at the graduate as well as undergraduate level. This study contributes to further development of a theoretical basis for health and wellness education. Pender, Barkauskas, Hayman, Rice, and Anderson (1992) suggest specific recommendations for incorporating concepts of health promotion nursing curricula at undergraduate and graduate levels and note that if excellence is to be reached in the area of health promotion, the learning experiences of students must be considered.

Nursing Practice

Thompson (1990) indicated that consultants specializing in wellness programs are a valuable source of information for small businesses. Utilization of nurse consultants who have acquired advanced knowledge in the area of health promotion and how it is related to women's health is needed. These nurse consultants could design health promotion programs for women employed in small businesses. The programs should be based on information gained from research studies such as this one. Flexible time management should be incorporated into the programs.

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Appendix A

Interview Guide

Interview Guide

1. Tell me about things that you do to help you stay healthy. How often do you do these things?

Probes

(a) Describe any activities that you typically engage in during a day to help you stay healthy.

(b) What things do you do that help you feel healthy?

(c) What activities do you engage in to improve your health?

(d) Are you presently taking any medication?

2. How is this working for you?

3. What hinders you or keeps you from doing these activities?

Probes

(a) Tell me how your job helps you stay healthy.

(b) Tell me how your job keeps you from staying healthy.

(c) Tell me about what effect your job has on your being able to do these activities.

(d) What else can you think of that you would like to be doing to stay healthy?

(e) If you had no barriers, and could do anything you wanted, what activities would you do to stay healthy?

(f) What would you need in order to do these activities?

4. Is there anything else that you would like to tell me about this?

Appendix B

Additions to Interview Guide

Additions to Interview Guide

1. Tell me what motivates you to do health-promoting activities.

2. How do you deal with what hinders you?

Probe

(a) How do you manage in spite of these things?

3. What roles do you find yourself in on a regular basis?

Probe

(a) Tell me about any caretaking or household responsibilities that you have.

Appendix C

Demographic Questions

Demographic Questions

I. Participant Data

Name_____

Mailing Address _____

_____

Age Range ___30-35 ___41-45 ___51-54

___36-40 ___46-50

Highest Grade Completed in School _____

II. Family Data

Marital Status _____

Range of Annual Household Income

___ Below $25,000 ___ $80,001- $100,000

___ $25,000- $40,000 ___ $100,001-$125,000

___ $40,001- $60,000 ___ $125,001-$150,000

___ $60,001- $80,000 ___ Over $150,000

Number of Dependents Living at Home (including children and adults) _____

III. Occupational Data

Nature of Employer's Business _____

Position/Title _____

Number of Hours Worked Per Week _____

Location of Business _____

Number of Employees _____

Does your place of employment offer any type of program related to employee health? ___Yes ___No

If yes, please describe briefly _____

_____

Please complete the following to assist in scheduling an interview time:

Daytime Phone Number _____

Best Day of Week for Interview _____

Best Time of Day for Interview _____

Appendix D

Institutional Review Board Approval

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM
Office of the Institutional Review Board for Human Use

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: Nancy Magnuson

PROJECT TITLE: Doctoral Dissertation

_____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).

_____2. THIS APPLICATION INCLUDES RESEARCH INVOLVING HUMAN SUBJECTS. THE IRB HAS REVIEWED AND APPROVED THIS APPLICATION ON _____ 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.

_____ 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.

X 4. EXEMPTION IS APPROVED BASED ON EXEMPTION CATEGORY NUMBER(S) 3.

DATE: 11-18-92

Russell C. Cunningham, III
RUSSELL CUNNINGHAM, M.D.
INTERIM CHAIRMAN OF THE
INSTITUTIONAL REVIEW BOARD

The University of Alabama at Birmingham
212 Mortimer Jordan Hall • 1825 University Boulevard • UAB Station
Birmingham, Alabama 35294-2010 • (205) 934-3789 • FAX (205) 934-7841

Appendix E

Letter of Consent

Letter of Consent

Dear Prospective Participant,

I am a doctoral student at The University of Alabama School of Nursing, The University of Alabama at Birmingham. I am conducting a study to look at the health promotion activities of women employed in small businesses. You are being asked to participate because you are employed in a business of less than 50 employees with no formal program of health promotion. Results of the study may help nurses better understand the health promotion activities of women employed in small businesses. This may in turn assist nurses in designing health promotion programs for women in small businesses. There are no foreseen risks to you based on your participation.

If you agree to participate an interview will be scheduled at a mutually agreed upon location and time. Each interview will be conducted privately and will be tape recorded, lasting approximately 45 minutes - 1 hour. A second interview may be scheduled for validation of data obtained. Confidentiality of all responses will be maintained at all times. Tape recordings will be transcribed, coded and then erased by the researcher. No personal identification of you will be made in the report of findings. You may refuse to participate or withdraw your participation up to 48 hours following the interview. For any questions regarding this study please contact the researcher. Your time and cooperation are greatly appreciated.

You are making a decision whether to participate in this study. Your signature indicates that you have read the information provided above, received a copy of this consent form and decided to participate.

Sincerely,

_____ _____

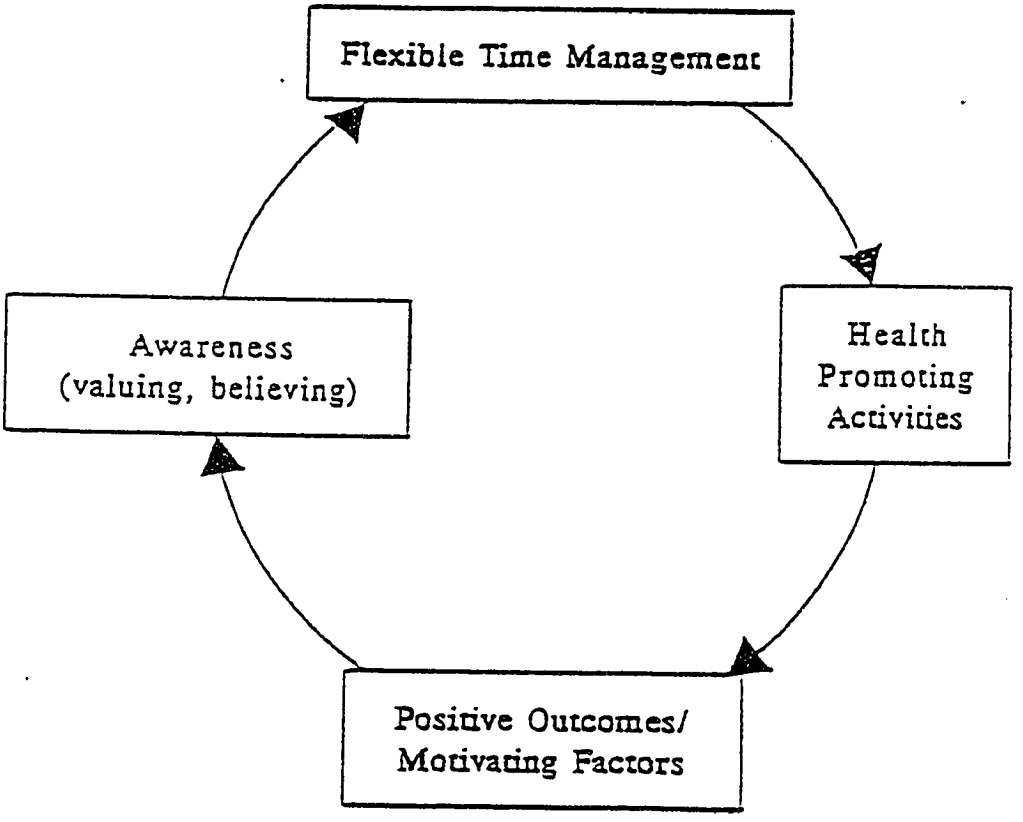
Signature of Participant Date

Appendix F

Theoretical Model

Model

Women Handling Responsibilities Associated with Multiple Roles



GRADUATE SCHOOL
UNIVERSITY OF ALABAMA AT BIRMINGHAM
DISSERTATION APPROVAL FORM

Name of Candidate Nancy Magnuson

Major Subject Community Mental Health Nursing

Title of Dissertation Flexible Time Management: Women Handling Responsibilities of Multiple Roles to Implement Health Promoting Activities

Dissertation Committee:

Carol H Miller, Chairman

Michael R. Bowen

E. Byron Chan

K. Alberta McCaleb

Brenda Roberts

Ann J Clark

Director of Graduate Program Elizabeth Stuyvenberg

Dean, UAB Graduate School W. A Bibb

Date July 26, 1993

PS-1428