Dimensions of health and rural resident's health care resources
by Lorinda Marie Doede

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University

Abstract:
This study explored dimensions of health and selected demographics that may influence the rural resident's choice of help-seeking resources. Hand-delivered or mail questionnaires were given to a convenience sample of 315 people in the Northern rural states. Dimensions of health included the concepts of psychological well-being, general well-being, and hardiness. The demographic concepts included age, gender, education, income, employment status, marital status, distance from neighbor, and rurality. The help-seeking resources were categorized into five categories: spouse (partner/significant other); family (parent, child/children, family member); informal (friend, neighbor, co-worker, spiritual advisor); formal (professional, agency, self-help group); and no one preferred or self-care.

Although the sample scored as moderately hardy, as healthy psychologically and physically, the analyses of these data indicate dimensions of health and selected demographic variables vary in explaining help-seeking resources chosen by participants. Participants reported they would first go to their spouse for help, then family and informal resources. The least selected choices were formal resources and self-care. As in previous studies, results indicate women visited formal resources more frequently than men; and those who were older sought formal resources more frequently than the younger generations. Correlation analysis indicated: the psychologically healthy were less likely to rely on their spouse; the single were less likely than the married or those with a partner to report a healthy psychological status; the working reported higher levels of general well-being and utilization of informal resources than the non-working; those who were older reported more pain and more concern about their health; the more educated the higher level of general well-being, less pain reported, and stronger scores of hardiness; and the higher the income, the more hardy, physically and psychologically healthy the rural resident.

Implications of this study indicate understanding rural residents' definition of health and help-seeking resources is imperative for the health care profession. A major goal of rural nursing is understanding the rural resident's perception of health and who is an acceptable resource for help. Such information will facilitate avenues by which the rural nursing profession can enhance and integrate acceptable health care resources which include the spouse, family, informal, and formal resources.

DIMENSIONS OF HEALTH AND RURAL RESIDENTS' HEALTH CARE RESOURCES

by

Lorinda Marie Doede

A thesis submitted in partial fulfillment
of the requirements for the degree

of

Master of Nursing

MONTANA STATE UNIVERSITY
Bozeman, Montana

April 1993

APPROVAL

of a thesis submitted by

Lorinda Marie Doede

This thesis has been read by each member of the thesis committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

4-14-93
Date

Jean N. Gullicks
Chairperson, Graduate Committee

Approved for the Major Department

April 19, 1993
Date

Julie E. Johnson
Head, Major Department

Approved for the College of Graduate Studies

4/27/93
Date

R L Brown
Graduate Dean

STATEMENT OF PERMISSION TO USE

In presenting this thesis in partial fulfillment of the requirements for a master's degree at Montana State University, I agree that the Library shall make it available to borrowers under rules of the Library.

If I have indicated my intention to copyright this thesis by including a copyright notice page, copying is allowable only for scholarly purposes, consistent with "fair use" as prescribed in the U.S. Copyright Law. Requests for permission for extended quotation from or reproduction of this thesis in whole or in parts may be granted only by the copyright holder.

Signature Lorinda M. Doede

Date 4-22-93

ACKNOWLEDGMENTS

I gratefully acknowledge my loyal "cheering committee" which consists of my family and many friends, who supported and encouraged me throughout my project. Special thanks also to the rural dweller participants who were willing to spend time on the questionnaire resulting in the completion of my thesis and adding to the field of nursing research.

I wish to thank the members of my thesis committee for teaching me patience, insight, and endurance throughout this project, Dr. Jean Gullicks, Dr. Mary Burman, Dr. Ramona Marotz-Baden, Dr. Julie Johnson, and Dr. Clarann Weinert.

TABLE OF CONTENTS

TABLE OF CONTENTS--Continued

LIST OF TABLES

LIST OF TABLES--Continued

LIST OF FIGURES

ABSTRACT

This study explored dimensions of health and selected demographics that may influence the rural resident's choice of help-seeking resources. Hand-delivered or mail questionnaires were given to a convenience sample of 315 people in the Northern rural states. Dimensions of health included the concepts of psychological well-being, general well-being, and hardiness. The demographic concepts included age, gender, education, income, employment status, marital status, distance from neighbor, and rurality. The help-seeking resources were categorized into five categories: spouse (partner/significant other); family (parent, child/children, family member); informal (friend, neighbor, co-worker, spiritual advisor); formal (professional, agency, self-help group); and no one preferred or self-care.

Although the sample scored as moderately hardy, as healthy psychologically and physically, the analyses of these data indicate dimensions of health and selected demographic variables vary in explaining help-seeking resources chosen by participants. Participants reported they would first go to their spouse for help, then family and informal resources. The least selected choices were formal resources and self-care. As in previous studies, results indicate women visited formal resources more frequently than men; and those who were older sought formal resources more frequently than the younger generations. Correlation analysis indicated: the psychologically healthy were less likely to rely on their spouse; the single were less likely than the married or those with a partner to report a healthy psychological status; the working reported higher levels of general well-being and utilization of informal resources than the non-working; those who were older reported more pain and more concern about their health; the more educated the higher level of general well-being, less pain reported, and stronger scores of hardiness; and the higher the income, the more hardy, physically and psychologically healthy the rural resident.

Implications of this study indicate understanding rural residents' definition of health and help-seeking resources is imperative for the health care profession. A major goal of rural nursing is understanding the rural resident's perception of health and who is an acceptable resource for help. Such information will facilitate avenues by which the rural nursing profession can enhance and integrate acceptable health care resources which include the spouse, family, informal, and formal resources.

CHAPTER 1

INTRODUCTION

Background of Study

Health is an important aspect of life. Throughout a lifetime, perceptions of health vary. This influences the choice of health care resources. These choices affect people individually and collectively, including their family, their social network, and the day's work. Factors that influence healthful living are social mores, the environment, occupational choices, religious beliefs, and one's culture (Jarvis, 1981). For example, farmers and ranchers consider health relative to its functional value (Lee, 1986; Lee, 1991). Consequently, the farmer may believe his land comes first and that men should be tough, not complainers. Rather than see a doctor about stomach pains, he may choose to get the seed planted in the fields, endure the pain and follow the neighbor's advice of self-care. Therefore, changes and adaption in a day's routine must be considered when health care is needed.

People have a variety of help-seeking resources available to them. The resources include self, family, friends, neighbors, physicians, nurses, nurse practitioners, physician assistants and others. The use of these help-seeking resources varies among individuals and across the life span.

Studies showed that informal care was used more than formal care in rural areas (Bartlome, Bartlome, & Bradham, 1992). Many factors influence help-seeking choices, including health and hardiness traits. Age, gender, income, education, socioeconomic status, ethnicity, insurance coverage, increased availability of physicians, religion, a telephone in the household, and the distance from neighbors may play a role in the decision for health care. In order to promote or maintain health of clients, particularly in rural areas, nurses need to have an understanding of help-seeking and its correlates.

Purpose

The purpose of this study was to explore dimensions of health that may influence the rural resident's choice of help-seeking resources. Dimensions of health include the concepts of psychological well-being, general well-being, and hardiness. Moreover, the influence of demographic variables were explored. Specifically, this study focused on the following questions.

Research Questions

1. How do rural residents perceive their mental and overall health status?
2. What is the level of hardiness in rural residents?
3. What type of help-seeking resources do rural residents report they would turn to for help?
4. What is the relationship between dimensions of health and help-seeking resources?

5. What is the relationship between demographic variables and the dimensions of health and help-seeking resources?
6. What are the relationships among demographic variables, dimensions of health, and help-seeking resources?

Significance of Study

A major concern of rural health care professionals is acknowledging and addressing the health needs and problems of rural people (Bigbee, 1991). Health care providers implement health services in rural areas but may find that residents do not utilize them. Health care providers may consider their services to be needed in a rural setting while residents in that area may not consider the health care services beneficial for their choice of a help-seeking resource. Studies need to be done considering health perceptions, beliefs, and health care preferences of residents in rural areas in order to better facilitate health care resources.

Rural populations are unique because of physical barriers such as lack of transportation, distance to health care and other resources, isolation and lack of health care providers. Physical barriers may affect the psychological aspects of rural residents. These barriers may prevent rural residents from seeking professional health care, perhaps lowering health expectations.

Moreover, rural residents are thought to possess individuality and hardiness (Bigbee, 1991). These are requirements for survival in geographically isolated areas, in part because so few, if any, health care resources are close. In the last decade, researchers found that

rural residents defined health as the ability to work and to do what needs to be done (Weinert & Long, 1987). Being able to work was more important than being pain free, attractive, or in better overall health. Rural residents considered themselves healthy because they can get a full day's work done. The definition of being healthy included the capability to work, in spite of the inability to hear well, see well, or ambulate well due to the aging process, illness or injury. Instead of seeking professional care for help, rural residents relied on other resources first. Such routes for help-seeking included self-reliance and the use of informal resources, such as the family, the neighbor, or a local retired nurse. Often self-care and informal resources satisfied the inquiring rural residents. On other occasions, people sought professional help on their own accord or because of the recommendation of a lay person.

Personality characteristics associated with rural residents may have an impact on health and health practices. Rural families were more self-sufficient and perform more services for themselves as opposed to relying on specialists (Bushy, 1991). However, the rural work ethic and attitude of hardiness or self-reliance may deter some families from seeking health care. It is not known at this time how these dimensions of health influence help-seeking resources.

Conceptual Framework

The conceptual framework focuses on the influence of dimensions of health and demographic variables on the rural residents' choice of health care (Figure 1). The dimensions of health explored in this

study include the rural resident's psychological sense of well-being, the perception of general well-being, and hardiness. It was anticipated that these factors influence choices in health care.

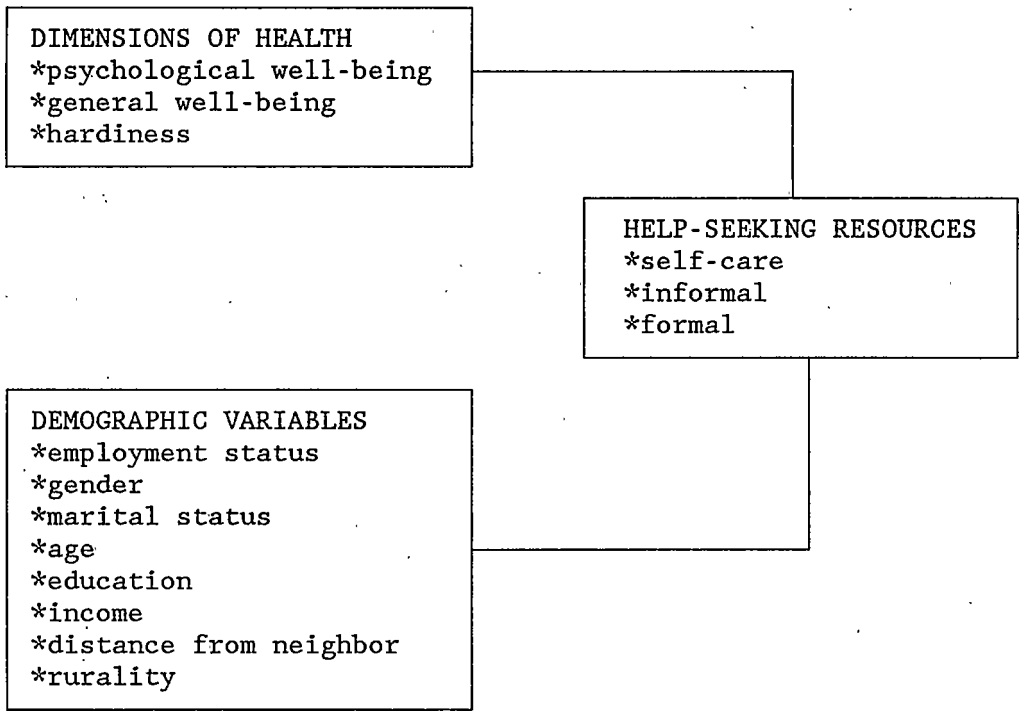


Figure 1. Model of the dimensions of health and help-seeking resources.

Definitions

Brief definitions of the dimensions of health and help-seeking resources follow. Further explanation is in the literature review.

Dimensions of health were divided into three categories. It is thought that these dimensions of health influence the choice of resources. Definitions of terms used in this study are as follows:

Psychological well-being: The participants' perception of their own mental health.

General well-being: The participants' perception of their general health status.

Hardiness: The participants' perception of their capability to embrace and grow with the opportunities in every experience.

Help-seeking resources were divided into three categories.

Self-care: Defined as managing or relying on oneself for resolving health needs.

Informal resources: Defined as nonprofessional care, such as the neighbor, friend, family, or spouse.

Formal resources: Defined as professional care, such as the health clinic, hospital, doctor's office, other agencies and self-help groups.

Rural residents: Defined as people residing in the Northern states of Montana, Washington, Wyoming, and North Dakota.

Demographic data were explored to see if gender, age, marital status, education, distance from the neighbor, rurality, income, or employment status influence the choice of resources.

CHAPTER 2

LITERATURE REVIEW

Health

Health, has been defined in a variety of ways by nurses (Smith, 1981; Weinert & Long, 1990). Smith (1981) divided these various concepts of the nature of health into four models: (1) eudaimonistic, (2) adaptive, (3) role-performance, and (4) clinical. All four models are interdependent, yet differ in view and significance.

The eudaimonistic model views health as holistic (Smith, 1981). The holistic picture produces the characteristics of wholeness, unity, and individuality. In this model, an individual has a sense of general well-being and a sense of intrinsic fulfillment and growth. On the opposite end of the spectrum, illness is a condition that prevents or hinders the state of self-fulfillment and development.

In the adaptive model, an individual's health is viewed as the state in which one can effectively interact or flexibly adapt to the physical and social environment (Dubos, 1965). Thus, an inability to cope with certain changes produces disease or illness.

The role-performance model visualizes healthy people as those who effectively accomplish their tasks connected with work or family responsibilities (Smith, 1981). In this view of health, people are

able to produce a maximal output in social roles whereas illness is the failure in performance of their roles.

The clinical model portrays health as the absence of signs or symptoms of disease or disability (Smith, 1981). Conversely, the presence of signs or symptoms is an indicator of illness.

Smith (1981) suggested concepts of health can be resolved into these four distinctive types. However, all four models of health are interrelated, although they can be viewed separately. The clinical model views the physiological aspects of a person. The other three health models concentrate on the psychological qualities of life, rather than focusing on only clinical status. The clinical model is the narrowest model, yet the definition of health requires the addition of the other models (role-performance, adaptive, eudaimonistic) of health. Healthy people are viewed as having no signs or symptoms of disease within the physiological system. With this viewpoint people who have signs and symptoms of a disease cannot be considered healthy no matter how productive or creative they are in life. If people do have signs and symptoms of a disease, they can be considered healthy using another model of health.

The role-performance model added the social and psychological aspects to the dimension of health in the clinical model (Smith, 1981). If nothing in a person's condition prevents "doing a day's work" or the effective performance of their role, then they are considered in healthy condition.

The adaptive model incorporated both the clinical model and the role-performance model (Smith, 1981). From this viewpoint, people are

considered healthy when they engage in effective interaction with the physical and social environment. Changing situations are seen as a challenge and a time of growth. According to this concept, if people are free of disease, yet fail in effective social functioning, they are not considered healthy.

The eudaimonistic model encompasses all three preceding components of a model of health; those being the clinical, role-performance, and adaptive models. The eudaimonistic model conceptualizes health as the ideal, holistic person who has the capacity to continue being creative, to continue refining the senses, and to resume growing and developing with life's experiences. Weinert and Long (1990) suggested Smith's (1981) model of health describes the views of the rural population.

Neuman (1982) diagrammed health on a continuum from wellness to illness. The state of health is seen as an individual's wellness and functioning as a state of optimal stability. Health was further defined by Neuman as the best possible health state at any given time. Neuman viewed health as a flexible interaction or a state in which a person is able to make corrective or adaptive responses to the environment. King (1981) defined health as the dynamic life experiences of a human being, which suggests continuous adjustment to stressors in the internal and external environment. This adjustment requires the optimum use of one's resources to achieve the utmost potential for daily living. She also defined health as the ability to function in social roles. King's (1981) predominant view of the concept of health is functional ability. In other words, absence of health means an inability to function in one's expected role (Chinn &

Jacobs, 1987; Fawcett, 1989; Parse, 1987). This view coincides with the health model of Smith (1981). All of these definitions can be tied together because of the commonality of health perceptions.

Psychological Well-Being

A person's psychological sense of well-being is one aspect of health studied in this research study. Self-confidence in judgments about health occurs when a person has a positive mental attitude. A person's mood may vary over time according to life situations which could affect the psychological sense of well-being. If people feel hopeless during a period of time, decisions may be different than when they feel hopeful about a particular situation.

Non-normative and normative life cycle transitions are experienced in all individuals and families which require adjustment and adaption (McCubbin & Figley, 1983). These transitions in life can influence a person's psychological sense of well-being. Non-normative events are those associated with accidents, crises, and catastrophic events which generally can neither be anticipated or expected (Figley & McCubbin, 1983). Normative events are those associated with normal life transitions that are fairly predictable such as birth, adolescence, marriage, and death (McCubbin & Figley, 1983). Although considered normative events, these changes still require ongoing adjustment and adaptation by family members and the family system. Often the normal transitions require just as much adjustment as a sudden extraordinary event (McCubbin & Figley, 1983). Bereavement brought about by a non-normative or a crisis event, a loss, or a major transition, is

believed to cause an excess utilization of the health care system. Depression among the bereaved can precipitate or exacerbate physical and psychologic dysfunction, leading to increase use of formal resources (McHorney & Mor, 1988).

Studies show that women are more likely than men to seek help for mental health problems; the better educated are more likely than the less educated to seek professional help from mental health specialists; and the younger and middle-aged people are more likely than the older people to seek professional mental help (Veroff, Kulka, & Douvan, 1981). Research studies from 1957 to 1976 suggested that people's attitudes about seeking formal mental health care had changed. By 1976, people were more likely to seek professional help for an emotional problem than in 1957 (Veroff et al., 1981).

General Well-Being

When people consider their general health, a broader paradigm incorporates the physical as well as the psychological status. One's perception of self health is the view of a general health sense of well-being which may be different from the health provider's perception. People may have a chronic disease or a physical disability, yet rate themselves in good health because of their overall perception and definition of health. Others may rate themselves in poor health because of their overall perception and definition of health.

Attitudes about health have been found to influence the use of help-seeking resources. Kessel and Shepherd (1965) studied health

attitudes of people who seldom consulted a doctor. Those who hadn't seen a doctor for ten years were not neglectful of their health and were even rated lower for emotional disturbance than those who had recently visited a doctor. Most often trivial ailments were not seen as an illness. This attitude reflected opinions about their own health. Attitudes about their past, present and future were favorable and they were less worried about health, i.e., they considered themselves healthy. The late adulthood study by Battistella (1971) concluded that persons having positive attitudes towards their own health and the effectiveness of medicine delayed getting professional help less than persons with a negative attitude.

Hardiness

Hardiness is a relatively new concept in health care which encompasses the ideas of adaptation, resilience, resistance, determination, optimism and assertiveness (Lee, 1983). This personality trait cannot be described in pictures or words, but it produces positive health effects for people when it functions as a moderator to stressful life events. On the other hand, this characteristic may be harmful if people ignore danger signals in their health or do not comply with medical advice.

According to The American Heritage Dictionary hardiness means (1) being rugged and strong; (2) being courageous; and (3) brazenly daring (Berube, 1985). The adjective, hardy, is often used in the description of cultivated plants. When a plant is considered to be hardy it means the plant is capable of surviving unfavorable conditions

such as weather extremes or drought. The concept of hardiness is applied to the bold and daring adventurers who conquered land and sea. Even animals that are sturdy and endure hardship are considered to be hardy. Likewise, hardiness emphasizes independence, self-care and self-reliance which seems to represent rural culture (Bigbee, 1991).

Kobasa (1979) was the first to suggest that persons who do not fall ill despite considerable stress have a strong, hardy personality trait. According to Kobasa, the concept of hardiness serves as a buffering or moderating factor in the stress-illness relationship. In other words, persons under high levels of stress may not develop an illness if they possess a hardy personality trait as a health-protective buffer (Bigbee, 1991; Pollock and Duffy, 1990).

Kobasa, Maddi, and Kahn (1982) proposed that "hardiness is a constellation of personality characteristics that function as a resistance resource in the encounter with stressful life events" (p. 169). Three characteristics of hardiness are commitment, control, and challenge. Thus, according to these researchers, a hardy person is one who demonstrates all three traits.

Commitment is the tendency to become involved in, rather than alienated from, various activities of life. Of particular importance to health is the strong sense of commitment to self, which motivates active involvement in promoting one's health and confidence in dealing with health problems (Bigbee, 1991; Kobasa et al., 1982; Pollock and Duffy, 1990).

The characteristic of control is described as the tendency to feel one has a definite influence in the varied experiences of life and acts

rather than feels helpless. This enhances stress resistance by increasing the likelihood that events will be seen as a natural growth from one's own decisions and actions and not as overwhelming experiences (Kobasa et al., 1982). An event can be stressful only if the individual perceives it that way (Lazarus, 1966; Pagana, 1990).

Challenge is described as the perception of change as a part of life and that the anticipation of changes means growth rather than insecurity. Challenge means learning to cope in order to bring about a willful transformation rather than preserving and protecting the former life. This coping flexibility also encourages growth (Kobasa et al., 1982).

Kobasa's studies showed that people with the three characteristics of hardiness (commitment, control, and challenge) were able to keep healthy in spite of stressful events in life (Kobasa, 1979; Kobasa, Maddi, & Courington, 1981; Kobasa et al., 1982). Furthermore, hardiness has its greatest health-preserving effects when stressful life events mount. More research needs to be done to understand how hardiness is developed and how it plays a role in other resistance resources.

Demographic Variables

Research has shown various findings in studies addressing help-seeking and utilization of health care services. The elderly consumed more health resources (Coward & Lee, 1985; Davis, 1983; Hulka & Wheat, 1985; McKinlay, 1972; Ward, 1977), but were least likely to seek professional mental help (Veroff et al., 1981). Further studies

indicated there is no relationship between psychological distress and the decision to seek medical care among the Medicare population (Berkanovic & Hurwicz, 1989). Women visited the doctor more than did men (Hulka & Wheat, 1985; McKinlay, 1972). One study indicated that for a certain set of symptoms such as cancer, the association between gender seeking health care services was comparable (Marshall, Gregorio, & Walsh, 1982). Another study indicated that the less well-educated were more inclined to visit the doctor (Sharp, Ross, & Cockerham, 1983) in comparison to another study which indicated the better educated were more likely then the less educated to seek professional help from mental health specialists (Veroff et al., 1981).

Blacks and nonwhites have more positive attitudes toward visiting doctors than whites. The lower social class and nonwhite racial groups experienced more doctor visits and hospitalizations (Hulka & Wheat, 1985). Blacks and the less educated were more inclined to think that symptoms such as repeated indigestion were serious enough to warrant the care of a physician (McKinlay, 1972; Sharp et al., 1983).

Research has shown insurance coverage with Medicare and Medicaid increased the utilization of health care services (Hulka & Wheat, 1985; Roemer, 1976). Increased availability of physicians also increased the utilization of health care services (Coward & Lee, 1985; Davis, 1983; Hulka & Wheat, 1985; Roemer, 1976). The Jewish population sought health care services more than Protestant and Catholic populations (Mechanic, 1963). Having a telephone in the household affected health utilization by increasing the convenience of making scheduled appointments (Wolinsky, 1982).

Rurality varies in both social and environmental characteristics (Carlson, Lassey, & Lassey, 1981). The census statistics not only determines the degree of rurality, but also includes analysis of the social and environmental circumstances at the particular time and place. For example, a rural county of 150 people may be located a short distance from a major urban center, yet be considered urban in lifestyle and occupation, as the dwellers commute to work. Small towns may be immediate suburbs of cities and therefore have close access to medical and other health care services. A town of 10,000 may be located a long distance from a major urban area, affecting the availability of medical services, occupations, and type of lifestyles. Rurality may affect the type of help-seeking resources rural residents choose. Spouses or partners, families, neighbors, and friends most likely would be the first resource available in an emergency or urgent situation.

Literature suggests the rural population is generally poorer, older and less likely to have health insurance (Rosenblatt & Moscovice, 1982). Health services are less available in rural communities and the health care accessible tends to cost more (Rosenblatt & Moscovice, 1982). Rurality can effect communication and transportation patterns, the networks and interactions between family, friends, and neighbors, and the availability or lack of specialized services (Cordes, 1985).

Clearly, demographic variables influence help-seeking. For this particular study the focus was on age, gender, marital status, education, distance from the neighbor, rurality, income, and employment status which were considered to be important in the rural population.

Help-Seeking Resources

Help-seeking resources are represented in the range of activities that people initiate to promote or restore their own health. Help-seeking resources include self-care, the use of informal resources, such as the family network or lay people, and the use of formal resources, such as health care professionals. The decision for self-care, informal resources, or formal resources is the result of previous experiences and present perceived seriousness and duration of the problem. For example, a study on a Medicare population showed people were more likely to seek medical care for musculoskeletal illness episodes, such as arthritis, as compared to musculoskeletal injury or respiratory illness (Hurwicz & Berkanovic, 1991). Respiratory episodes are shorter in duration and are more often self treated than musculoskeletal episodes. The decision to restrict activity, drink extra fluids, take aspirin and seek recommendations from friends and family for a respiratory episode may be a result of previous experience that has been satisfactory. If the episode does not resolve and the duration is longer than expected the person may then seek medical care. Both characteristics of the person and characteristics of the illness affect how people respond to illnesses in help-seeking behavior (Hurwicz & Berkanovic, 1991).

Self-care, a help-seeking resource, represents the range of behaviors exhibited by individuals to promote or restore their health (Dean,1989). For the purpose of this study, self-care was defined as self-management of health, illness or injury and self-reliance. The

term self-care has been defined in many ways, from self-observation to symptom labeling to deciding on choice of treatment which may include not taking action or taking action by seeking professional care (Bentzen, Christiansen & Pedersen, 1989). Self-care, seen as the basic level of non-professional care, suggests the individual chooses no care or follows through with care activities to maintain or improve health. In many cases, self-care does not take the place of professional care, but instead, compliments it in reaching optimum health (Bentzen et al., 1989; Dean, 1981). Self-care addresses activities such as self-medication, stress reduction, life-style changes, including dietary and exercise changes, and attitudinal adjustments. People learn effective self-care and self-treatment strategies (Alonzo, 1979).

Informal resources, family members and friends, or those who are significant to individuals, are another kind of help-seeking resource. Individuals interact with friends and family members in specific social situations to assist in the performance of health related behaviors, including decisions to seek and comply with professional care (Dean, 1989; Levin, Katz, & Holst, 1976). The term "lay consultation" refers to seeking counsel from people other than health professionals about health problems. Members of the lay network assist in deciding on courses of action for self-care measures and whether to seek professional care (Furstenberg & Davis, 1984). The lay network can consist of several people or only one person and may be consulted more frequently than health experts (Booth & Babchuk, 1972). The more anxious an individual is about the severity of a health problem, the availability of interpersonal resources, and the potential effect of

the problem on the individual's financial resources, the greater importance of the lay network for advice and counsel.

In studies of help-seeking resources in a life threatening crisis, lay consultation significantly affected the patient seeking medical help (Alonzo, 1986). Less life-endangering illness encouraged individuals and other lay people to continue in a pattern of self-treating. A certain amount of self-treatment was deemed necessary before medical care could be validated. Alternatively, family and lay people helped to avoid excessive self-treatment and encouraged the need for medical care (Alonzo, 1986). In an urban adult study by Brown (1978), people who had a supportive informal network or had social support and resources within their community, such as family and friends, were more self-reliant and perhaps were more able to bypass professional help.

Some research has shown that persons who are more socially isolated may seek medical care when signs and symptoms are evident, because of feelings of apprehension, insecurity and helplessness (Battistella, 1971). Communication with the family and neighbors may alleviate the isolated person's feelings by defining the symptoms in non-serious and familiar terms (Battistella, 1971). Often, the lay individual's interactions with the person seeking advice produces health related behaviors including choices from self-treatment to compliance with professional care (Dean, 1989).

Formal resources offer another choice. People may choose to seek professional care on their own accord or from the advice of the family network or lay person. The types of help-seeking resources can range

from phoning a nurse or physician about the problem, being visited by a home care nurse, or traveling to professional health care providers. Health care professionals need to preserve people's confidence in their own health care. A part of preserving confidence is educating people about signs and symptoms of disease that require medical attention.

These determining factors and how people regard symptoms, as well as how sensitive they are to discomfort, likely affect whether health care services will be sought (Hulka & Wheat, 1985; Mechanic, 1972). Dimensions of health influencing people's choices need to be further studied in well rural residents to determine the utilization of help-seeking resources.

In summary, the literature suggests that general well-being or people's evaluation of their physical and mental health affects their definition of health and that traits of hardiness exhibit positive effects on the definition of health. The literature also suggests that psychological-well being, general well-being, hardiness and the selected demographic variables (employment status, gender, marital status, age, education, income, distance from neighbor, and rurality) may influence people's choices of help-seeking resources.

CHAPTER 3

METHODOLOGY

Design

The goal of this study was to explore and describe how dimensions of health influence the help-seeking resources for rural residents. This study is an exploratory descriptive study, using mail and hand delivered questionnaires.

The study is part of a larger set of studies called The Montana Family Cancer Project (MFCP). The MFCP at Montana State University College of Nursing has examined help-seeking resources of rural families managing cancer. The Montana Family Cancer Project received the first Eagles Art Ehrmann Cancer Fund Grant (referred to as the Montana Family Survey) in Montana on December 7, 1991. Major goals of the Montana Family Survey were to maximize the validity of current data and to establish scale ranges for residents on the existing tools used in the larger study. The Montana Family Survey (MFS) focused on residents of several rural states and facilitated comparison of rural individuals managing cancer with rural healthy individuals in the larger study. The study was a portion of the Montana Family Survey examining dimensions of health and help-seeking resources.

Population and Sample

The population consisted of rural residents. A broad array of Northern rural residents with a variety of occupations and residences were sought to participate in this study for the purpose of a community sample of rural residents. A convenience sample of 315 participants was obtained for the MFS.

"Rural resident" participants were defined as men and women, 20 years and older, who reside in the Northern states of Montana, Washington, Wyoming, and North Dakota. The researcher introduced the study and encouraged participant involvement. Women's groups, men's groups, church groups and other known community groups as well as individuals were approached.

Data Producing Instruments

The questionnaire used in the Montana Family Survey included a variety of measures. This study used selected tools from the MFS that measured help-seeking resources, health perceptions and hardiness traits.

Psychological Well-Being

Psychological well-being was defined as the participants' perception of their own depression and was measured using the Center for Epidemiologic Studies-Depression Scale (CES-D) (Radloff, 1977), (see Appendix A). The CES-D consists of a 20-item four-point Likert-type scale designed to measure depressive symptomatology in the general population. The questions cover symptoms of a depressed mood which

include feelings of guilt, worthlessness, hopelessness and helplessness. Psychophysiologic manifestations also are measured by asking about loss of appetite and sleep disturbance (Radloff, 1977). The CES-D scale is designed to measure the current ("this week") level of symptomatology, which is expected to vary over time and in a cyclic manner in the face of certain life events (Keyser & Sweetland, 1985; Radloff, 1977). The twenty items are summed for a total score of zero to 60. The higher the CES-D score, the greater the depressive symptomatology. Scores of 16 or higher indicate the severity of depressive symptoms (Radloff, 1977). The score reflects depressive symptoms and emotional distress only and is not compared with a clinical diagnosis of depression. The score of 16 is intended as a cutoff point to identify high-risk groups (Turner & Avison, 1989). Persons with a score of 16 have at least six of the twenty symptoms in the CES-D scale and have experienced them for most of the previous week or for a short periods of time (Comstock & Helsing, 1976). The alpha coefficients range from .84 to .90 which reflects a high internal consistency (Radloff, 1977). For this study, the alpha coefficient was .88.

General Well-Being

The definition of general well-being incorporated the participants' perception of their current health status (see Appendix B). Participants' were asked to rate their perception of health in terms of "excellent", "good", "fair", or "poor". Self-ratings of general health are among the most commonly used measures of health status (Ware, 1976). These rating are measures of general

health because they do not focus on a specific health status characteristic. Instead they are linked to a wide range of physical and mental health concepts as well as health and illness behaviors (Davies & Ware, 1981).

Hardiness

The hardy personality has a three dimensional constellation: control, commitment, and challenge (Kobasa, 1979; Kobasa, et al., 1982). The concept of hardiness was measured using a revised version of the scale developed by Kobasa, Maddi and Kahn (1982) (see Appendix C). This 20-item instrument consists of two parts. The first part is a four-point Likert-type scale in which the participants choose the present degree of attitude to which they agree or disagree (0-STRONGLY DISAGREE to 3-STRONGLY AGREE). The second part has six items in which participants choose between two statements (either A or B) which best represents their attitude. Control is measured by absence of powerlessness, commitment is measured by absence of alienation, and challenge is measured by absence of need for security. A score for the instrument is obtained by summing the total scores. The range of possible scores will be from -18 to +18. High scores indicate a lack of hardiness and low scores indicate hardiness. The original and shorter version of the hardiness instrument have been used in numerous studies. The revised 20-item measure has a reliability of .86, which correlates with the original measure at .89, and has been shown to duplicate all the major findings of the original scale (Lambert & Lambert, 1987). For this study the alpha reliability was .75.

Help-Seeking Resources

Help-seeking is defined as the range of activities a person engages in to promote or restore health. Resources available in help-seeking include self-management of health problems, informal resources such as the family network, and formal resources such as professional health care providers. The tool used to assess the participant's help-seeking resources was the Personal Resource Questionnaire (PRQ-85) (Brandt & Weinert 1987). It consists of two parts and only the first part was used in this study (see Appendix D). The PRQ-85, Part I, is used to assess who the respondent would turn to in case of urgent needs or a crisis situation involving an illness, injury or psychological concern. There are ten questions dealing with specific needs. Help-seeking resources in response to the specific needs include parent, spouse/partner, other relatives, friends, formal services such as spiritual and professional help, and no one or self-care.

For each of the specific help-seeking resources including the category of "no one", percents were calculated for the number of times each was used for the ten health needs. For example, the "parent" index was calculated based on the number of times parent was identified as a resource for the ten health needs. Twelve specific indicators were calculated. The "other" category for the ten health needs was coded into one of the first twelve resources. The twelve indicators were collapsed into the categories of spouse/partner/significant other, family, informal resources, formal resources and no one. The category of spouse or partner or significant other was analyzed separately. The category of family resources include parent, child or children, and a

relative or family member. The category of informal resources include friend, neighbor or co-worker and spiritual advisor (minister, priest, etc.). The category of formal resources include professional (nurse, counselor, social worker, employer, etc.), agency, and self-help group. The category of self-care is indicated by the selection of no one (prefer to handle it alone). Data from the selection no one (no one available) were collapsed and were analyzed separately.

Demographics

Demographics were addressed last (see Appendix E). Information includes participant's age, gender, education (highest degree or number of years), perception of distance from a neighbor, rurality, marital status, occupation, employment status and income.

Rurality was assessed using the rurality index (Weinert, Bork, & Bender, 1990). The rurality index reflects the accessibility to emergency care and the county population. Accessibility to emergency care varies for people who live in the same county.

Description of Procedure

The procedures for the Montana Family Survey were as follows. Data were generated for the Montana Family Survey by having participants voluntarily fill out questionnaires that took approximately 45 minutes to complete. The MFCP staff introduced the study and encouraged participant involvement. Women's groups, men's groups, church groups and other known community groups as well as individuals were approached and asked to participate in the study.

When mailed, a cover letter was enclosed with the questionnaire. The letter explained that the participant provided critical data to the study and emphasized that accurate responses were imperative to the success of the study. If the questionnaire was hand delivered, the researcher was informative about the study, and also provided a letter with written information about the study. The returned questionnaire was considered consent to participate. The researcher showed appreciation for the efforts of completing the questionnaire in a letter and stressed the importance of the participant's data contribution to the study's outcome.

The questionnaires were numbered and participants' names and addresses were collected when they received a questionnaire. A sign-out sheet for names and addresses coincided with the number on the questionnaire. This helped the researcher keep track of unreturned forms and allowed reminder notes and/or thank-you notes to be sent to the participants. Code numbers and data were not associated with or stored with names.

A postcard prompt was sent to each participant who had not returned the questionnaire in two weeks. If there was no response, a second prompt letter was sent to encourage the participant to either complete the booklet or return the blank booklet. A thank-you letter was sent to all who had returned the completed questionnaire.

If the booklet was mostly completed, the questionnaire was used for data analysis. If many pages or items were missing, usability was addressed on a case-by-case basis.

Data Analysis

Descriptive statistics were used to summarize the characteristics of the community sample. Research questions one to three, which dealt with psychological well-being, general well-being, hardiness, and type of help-seeking resources, were analyzed using descriptive statistics such as means, percentages, and frequencies. The Pearson's *r* correlational analysis of health dimensions and help-seeking resources was used in testing research questions four and five, which dealt with relationships between dimensions of health and help-seeking resources and relationships between selected demographic variables and the dimensions of health and help-seeking resources. Multiple regression analysis was used in research question six to examine the relationships among demographic variables, dimensions of health, and help-seeking resources.

Human Subjects

This study was a secondary analysis of data that were being generated by the Montana Family Survey, a sub-study of the Montana Family Cancer Project federal grant number 5 R01 CA46330. This secondary analysis was approved by the Human Subjects Committee at Montana State University, College of Nursing (see Appendix F). Permission was obtained for use of the data from Dr. Weinert, the principal investigator on the MFCP (see Appendix G).

Participants were men and women, 20 years and older, living in sparsely populated states. The sample included 315 participants who could read and write English.

There were no physical, social, or legal risks involved from participating in the MFCP Montana Family Survey. Minimal psychological risks may have been involved from answering some of the questions concerning participants' attitudes about their families and functioning.

Confidentiality was protected in the MFCP Montana Family Survey. Names and identifiers were kept separate from data in a locked office where only Montana Family Cancer Project staff had access. Confidentiality was assured as there were no names used on the questionnaires; only identification numbers were stamped on the questionnaires. Only aggregate data were reported. Participation was completely voluntary and participants could choose to not answer questions if they did not want to.

There were no direct benefits for the participants in the MCFP Montana Family Survey. The participant's interest, time, and information were acknowledged and appreciated. Individuals may have felt an indirect benefit from the satisfaction they had contributing to nursing research and having evaluated their own lifestyle.

The risks for participation in the MCFP Montana Family Survey were minimal in relationship to the potential benefits in knowledge gained about lifestyles of rural residents. The information will provide further knowledge for planning health care services in rural areas.

CHAPTER 4

RESULTS

The purpose of this study was to explore dimensions of health that may influence the rural resident's choice of help-seeking resources. The influence of demographic variables on the rural resident's choice of help-seeking resources was also explored.

The first section of this chapter is the description of the sample. The second section is the findings of dimensions of health and help-seeking resources rural residents use in different situations. In the third section, the relationships among demographic variables, dimensions of health, and help-seeking resources are described. The significance level was .05 for all statistical tests.

Sample Description

Descriptive statistics were used to summarize the demographic data. Means were determined for all of the key variables: gender, age, education, income, neighborly patterns and residency patterns. The sample was composed of 315 rural residents with a variety of occupations and residential locations. The Northern rural states represented in the sample were Montana (95%), Washington (3%), Wyoming (1%), and North Dakota (1%). There were 224 women and 91 men. Ninety-eight percent were caucasian and seventy-five percent were married. The age of the participants ranged from 21 to 84 with a mean of 46.8

years. The residents' years of education ranged from 7 to 24 years with a mean of 15 years.

The employment status of the sample was varied (see Table 1). Almost half the sample worked full-time for pay and forty percent (n=127) worked as full-time homemakers, full-time homemakers with part-time jobs or helpers on the farm/ranch, full-time students or full or part-time students with jobs. The mean for hours per week worked for pay was 37.78 hours. A small percent were unemployed due to age, disability, and inability to find suitable work because of where they lived.

Participants worked in the following occupations: health services (28%); educational services (17%); agricultural production/livestock/ services (10%); clerical, cleaning, catering, consulting services (3%); trucking/warehousing/postal service (3%); executive/legislative/ general government/military (3%); depository institutions (3%); personal services (3%); self-employed (3%); finance/taxation/monetary policy (3%); and other occupational categories (22%). The total annual family income levels ranged from less than $15,000 to greater than $80,000. Fifty-one percent of the sample made less than $30,000 (see Table 1).

The majority (58%) of participants described the area where they lived as a city/town (see Table 1). Twenty-three percent described the area as outside city limits, 17% as farm/ranch area, and two percent as suburban.

Table 1. Employment status, income, and description of residential area.

Variable	Frequency	Percent
Employment Status		
Full-time for pay	155	49
Full-time homemaker	35	11
Unemployed	33	11
Full-time homemaker/part-time job	31	10
Part-time for pay	21	7
Full-time homemaker/helper with ranch	18	6
Full-time student	11	3
Full or part-time student/work for pay	11	3
Income		
Less than $15,000	56	18
$15,000 to $19,999	25	8
$20,000 to $24,999	39	13
$25,000 to $29,999	37	12
$30,000 to $34,999	40	13
$35,000 to $39,000	15	5
$40,000 to $49,999	36	12
$50,000 to $59,999	25	9
$60,000 to $69,999	15	5
$70,000 to $79,999	8	3
Greater than $80,000	13	4
Description of Area		
City/town	168	58
Outside city limits	72	23
Farm/ranch	53	17
Suburban	5	2

The majority of the participants lived next door or within a few blocks of their neighbors (see Table 2). A minority of the participants considered neighbors as very distant emotionally. Eighty-one percent considered they were between somewhat distant to somewhat close to the neighbors. Sixty-eight percent of the participants reported visiting their neighbors from a few times each week to every few weeks.

Table 2. Distance from neighbor, emotional relationship, and visiting pattern.

Variable	Frequency	Percent
Distance from neighbor		
Next door	148	54
Within a few blocks	45	16
Less than a 1/2 mile	28	10
Between a 1/2 mile and 1 mile	16	6
Between 1 and 3 miles	24	9
Between 3 and 5 miles	7	3
5 miles or more	7	3
How close emotionally to neighbor		
Very distant	10	4
Somewhat distant	38	14
Middle of the road	101	37
Somewhat close	83	30
Very close	43	16
Visit neighbor		
Almost never	29	11
Once a month	32	12
Every few weeks	60	22
Once a week	53	19
Few times each week	75	27
Daily	26	9

On the average, participants had seven relatives within fifty miles (see Table 3). Participants had lived in their present home on the average of 118 months or 9.8 years and had been state residents for an average of 29 years.

Table 3. Number of relatives within fifty miles and patterns of residence.

Variable	n	Mean	SD
Relatives within 50 miles	312	7.27*	14.01*
Length of time in present home (months)	314	117.99	131.10
Number of moves in past 5 years	315	1.90	1.23
Years lived in the state	315	28.53	20.89

* Includes participants who had no relatives within 50 miles.

Dimensions of Health

The first research question was: How do rural residents perceive their mental and overall health status? The CES-D Scale was used to assess mental health on depressive symptomatology. Scores of 16 or higher reflect the severity of depressive symptoms that are characteristic of levels observed in cases of clinical depression (Radloff, 1977). Findings in this sample indicated participants reported minimal depressive symptoms with a mean of 9.3 (see Table 4). A report summarizing the basic findings on depressive symptomatology for the civilian non-institutionalized U.S. population in 1974 to 1975 showed approximately 17.3% of the U.S. population, ages 25 to 74 years acknowledged depressive symptomatology on the CES-D Scale. Results indicated the noninstitutionalized U.S. population group studied may be at a relatively greater risk of becoming clinical cases of depression (National Center for Health Statistics, 1980). Questions in the CES-D scale cover current ("this week") symptoms of a depressed mood which include feelings of guilt, worthlessness, hopelessness, and helplessness. The participants' overall sense of psychological well-being was positive with a mean score of 9.3 in comparison to a study indicating the mean score for rural residents was 8.5 (National Center for Health Statistics, 1980).

Likewise, participants in this sample perceived their general well-being as positive (see Table 4). General health was rated good to excellent by eighty-three percent of the sample and fifty-eight percent of the sample reported from little to some pain. Fifty-three percent

Table 4. Description of participants' health and hardiness.

Dimensions of Health	Total Score	n	Mean	SD
Psychological well-being	0 to 60	300	9.3	8.00
General well-being				
*overall health	4	314	3.3	0.70
*pain in past 3 months	4	315	2.3	0.83
*concern about health	4	314	2.1	0.90
*compare health to 1 year ago	4	314	3.1	0.73
Hardiness	-18 to 18	287	.0	3.80

of the sample reported concern about their health in the past three months. Sixty-seven percent perceived their health now to be similar to their health one year ago.

The second research question was: What is the level of hardiness in rural residents? The participants in this study were in the middle range of hardy with no extreme scores which ranged from -8.41 to 10.30 (see Table 4). Lower scores indicate a higher level of hardiness considering the scale score range of -18 to +18. Results indicated the participants were not considered nonhardy, nor were they considered extremely hardy. The more hardy individuals in the study most likely reported positive psychological well-being and general well-being. A recent study, which used the shortened-item version of Kobasa's original 71-item hardiness instrument, showed a random sample of participants living on a ranch or farm to have a total hardiness score in the range from -6.0 to + 6.0, with a mean of .00 and SD of 4.17 (Lee, 1991).

The third question was: What type of help-seeking resources do rural residents report they would turn to for help? Each of the ten

situations as reported on the PRQ-85 was examined. Frequencies and percentages were calculated and ranked according to the help-seeking resources most frequently chosen to least frequently chosen (see Table 5).

The first situation addressed what help-seeking resource the participants would use when experiencing urgent needs (crisis). The second situation addressed what help-seeking resource the rural residents would use when needing help for an extended period of time in caring for a family member who is sick or handicapped. The third situation addressed what help-seeking resource the participants would use if they were concerned about their relationship with their spouse, partner, or significant other. The fourth situation addressed what help-seeking resource the participants would use for a problem with a family member or friend. The fifth situation addressed what help-seeking resource the participants would use for financial problems. The sixth situation addressed what help-seeking resource the participants would use if they felt lonely. The seventh situation addressed what help-seeking resource the participants would use if they were sick for a week and unable to carry out usual activities. The eighth situation addressed what help-seeking resource the participants would use for help if they were upset and frustrated with the conditions of their life. The ninth situation addressed what help-seeking resource the participants would use if they were having problems with their work. The tenth situation addressed what help-seeking resource the participants would use if they needed someone to talk about day-to-day personal concerns (see Table 5).

Participants could choose as many help-seeking resources as desired for each of the situations. In eight out of ten situations, rural residents reported they would first ask their spouse, partner, or significant other for help. In the third situation (relationship problem with partner) and the sixth situation (lonely), the participants reported they would first seek a friend as a resource for help. The second help-seeking choice in the ten situations was a relative or family member. A small percentage of the categories "no one available", "agency", "self-help group", and "no one preferred" or self-care were reported as choices for help-seeking resources.

Table 5. Participants' type of help-seeking resources in ten situations on the PRQ-85, Part I.

Resources	n	Percent*
Situation 1 (Urgent needs/crisis)		
Spouse/Partner/Significant Other	236	74.9
Friend	187	59.4
Relative/Family Member	152	48.3
Parent	130	41.3
Spiritual Advisor	112	35.6
Child/Children	105	33.3
Professional	93	29.5
Neighbor/Co-worker	79	25.1
Self-Help Group	20	6.3
Agency	7	2.2
No One Preferred	9	2.9
No One Available	0	0

Table 5. Continued.

Resources	n	Percent*
Situation 2 (Caring for a family member)		
Spouse/Partner/Significant Other	194	61.6
Relative/Family Member	170	54.0
Professional	156	49.5
Friend	114	36.2
Parent	106	33.7
Child/Children	96	30.5
Spiritual Advisor	64	20.3
Agency	64	20.3
Neighbor/Co-worker	42	13.3
Self-Help Group	29	9.2
No One Preferred	4	1.3
No One Available	1	.3
Situation 3 (Spouse/partner relationship)		
Friend	142	45.1
Spouse/Partner/Significant Other	121	38.4
Spiritual Advisor	108	34.3
Professional	106	33.7
Relative/Family Member	80	25.4
Parent	68	21.6
Child/Children	46	14.6
No One Preferred	32	10.2
Self-Help Group	25	7.9
Neighbor/Co-worker	22	7.0
Agency	3	1.0
No One Available	2	.6
Situation 4 (Family/friend problem)		
Spouse/Partner/Significant Other	201	63.8
Friend	164	52.1
Relative/Family Member	124	39.4
Spiritual Advisor	106	33.7
Parent	103	32.7
Professional	89	28.3
Child/Children	66	21.0
Neighbor/Co-worker	35	11.1
No One Preferred	17	5.4
Self-Help Group	17	5.4
Agency	12	3.8
No One Available	1	.3

Table 5. Continued.

Resources	n	Percent*
Situation 5 (Financial problem)		
Spouse/Partner/Significant Other	151	47.9
Parent	109	34.6
Relative/Family Member	83	26.3
Professional	70	22.2
Friend	47	14.9
No One Preferred	33	10.5
Child/Children	31	9.8
Agency	25	7.9
Spiritual Advisor	17	5.4
Neighbor/Co-worker	10	3.2
No One Available	7	2.2
Self-Help Group	5	1.6
Situation 6 (Lonely)		
Friend	228	72.4
Spouse/Partner/Significant Other	205	65.1
Relative/Family Member	160	50.8
Child/Children	141	44.8
Parent	116	36.8
Neighbor/Co-worker	83	26.3
Spiritual Advisor	70	22.2
Professional	30	9.5
Self-Help Group	22	7.0
No One Preferred	18	5.7
No One Available	4	1.3
Agency	2	.6
Situation 7 (Sick for a week)		
Spouse/Partner/Significant Other	234	74.3
Friend	150	47.6
Relative/Family Member	108	34.3
Child/Children	105	33.3
Parent	84	26.7
Neighbor/Co-worker	80	25.4
Professional	28	8.9
Spiritual Advisor	14	4.4
Agency	7	2.2
No One Preferred	6	1.9
Self-Help Group	2	.6
No One Available	1	.3

Table 5. Continued.

Resources	n	Percent*
Situation 8 (Upset with condition of own life)		
Spouse/Partner/Significant Other	199	63.2
Friend	148	47.0
Relative/Family Member	111	35.2
Parent	89	28.3
Spiritual Advisor	84	26.7
Professional	66	21.0
Child/Children	64	20.3
Neighbor/Co-worker	36	11.4
No One Preferred	27	8.6
Self-Help Group	24	7.6
Agency	4	1.3
No One Available	2	.6
Situation 9 (Problems with work or home)		
Spouse/Partner/Significant Other	210	66.7
Friend	147	46.7
Neighbor/Co-worker	95	30.2
Relative/Family Member	77	24.4
Professional	72	22.9
Parent	64	20.3
Child/Children	45	14.3
Spiritual Advisor	35	11.1
No One Preferred	18	5.7
Agency	5	1.6
Self-Help Group	5	1.6
No One Available	2	.6
Situation 10 (Day-to-day concerns)		
Spouse/Partner/Significant Other	216	68.6
Friend	193	61.3
Relative/Family Member	96	30.5
Child/Children	79	25.1
Parent	74	23.5
Neighbor/Co-worker	58	18.4
Spiritual Advisor	45	14.3
Professional	25	7.9
No One Preferred	15	4.8
Self-Help Group	10	3.2
No One Available	5	1.6
Agency	1	.3

* Note. Participants could check more than one; therefore, percents do not add up to 100.

In Table 6, each participants' selections of help-seeking resources were ranked. Ten questions in the PRQ-85 asked participants who they would choose as a help-seeking resource in ten different situations. The participant could choose as many help-seeking resources as desired. All data were ranked according to the help-seeking resources most frequently chosen to least frequently chosen. For example, of twelve help-seeking choices, spouse was the most frequent choice in the situations of a crisis, help for a sick family member, family or friend problem, financial problems, sickness for a week, upset with conditions of own life, problems with work or home, and day-to day concerns.

Table 6. Ranking of participants' choices of help-seeking resources for specific situations on the PRQ-85, Part I.

	Situations									
Resource	1[a]	2[b]	3[c]	4[d]	5[e]	6[f]	7[g]	8[h]	9[i]	10[j]
Parent	4	5	6	5	2	5	5	4	6	5
Child/Children	6	6	7	7	7	4	4	7	7	4
Spouse/Partner	1	1	2	1	1	2	1	1	1	1
Relative/Family	3	2	5	3	3	3	3	3	4	3
Friend	2	4	1	2	5	1	2	2	2	2
Neighbor/Co-worker	7	9	10	8	10	6	6	8	3	6
Spiritual Advisor	5	8	3	4	9	7	8	5	8	7
Professional	8	3	4	6	4	8	7	6	5	8
Agency	11	7	11	11	8	12	9	12	11	12
Self-Help Group	9	10	9	10	12	9	11	10	10	10
No One Available	12	12	12	12	11	11	12	11	12	11
No One Preferred	10	11	8	9	6	10	10	9	9	9

[a] Crisis
[b] Help for sick family member
[c] Spouse/partner relationship
[d] Family or friend problem
[e] Financial problems
[f] Lonely
[g] Sick for a week
[h] Upset with conditions of own life
[i] Problems with work or home
[j] Day-to-day personal concerns

For further analysis, the help-seeking resources were categorized into five groups: "spouse", "family" (parent, children, and family member), "informal" (friend, co-worker, neighbor, and spiritual advisor), "formal" (professional, agency and self-help groups), and "no one" (self-care) (see Table 7). The categories reflect those in the conceptual framework except that informal resources were differentiated into spouse, family, and informal resources. Scores were calculated that reflected use of each of the five resources from no use to use in all ten situations. For example, the family score was calculated as follows. For each of the ten situations, if one or more family members (parent, child or children, relative or family member) was checked as a resource, a total score of one was given for the situation. The scores for the ten situations were summed for a total score for family. If the total score for the ten situations was zero, family members would not be used for any of the situations. If the total score was ten, family members would be used in all ten situations. The categories of spouse/partner, informal, formal, and no one were scored likewise.

Results indicated over half the sample reported they would choose the spouse as a health resource for eight to ten of the ten situations (see Table 7). Eighteen percent reported they would not turn to a spouse or partner. Many of these were single (26%). Over one-third (37%) of the sample reported they would choose the family resource (parent, child, and/or family member) in six to eight of the ten situations, thirty-nine percent chose informal resource (friend, co-worker, neighbor, and/or spiritual advisor) in seven to nine of the ten situations, and forty-two percent chose formal resources

(professional, agency, and/or self-help group) in one to three of the ten situations. Approximately two-fifths of the sample reported a preference to rely on self-care in one to three of the ten situations (see Table 7). These results indicate rural residents consider their spouse or partner, friends and family as important help-seeking resources.

Table 7. Description of participants' choices of help-seeking resources in the ten situations on the PRQ-85, Part I.

	Categories of Resources									
	Spouse/ Partner		Family		Informal		Formal		Self-Care	
Total Score	n	%	n	%	n	%	n	%	n	%
0	56	18	18	6	24	8	86	27	239	76
1	12	4	20	6	17	5	49	16	38	12
2	3	1	14	4	15	5	48	15	14	4
3	8	3	24	8	21	7	33	11	8	3
4	8	3	20	6	22	7	26	8	5	2
5	19	6	27	9	27	9	20	6	4	1
6	14	4	38	12	37	12	16	5	4	1
7	26	8	44	14	34	11	15	5	0	0
8	44	14	35	11	45	14	14	4	2	1
9	70	22	29	9	44	14	6	2	1	0
10	55	18	46	15	29	9	2	0	0	0
	Mean=6.2 (SD=4.0)		Mean=6.0 (SD=3.0)		Mean=6.0 (SD=3.0)		Mean=3.0 (SD=3.0)		Mean=1.0 (SD=1.4)	

Relationships Between Dimensions of Health and Help-Seeking Resources

The fourth research question was: What is the relationship between dimensions of health and help-seeking resources? Pearson

correlations were used to determine the relationships between dimensions of health and help-seeking resources. The spouse, family, informal, formal, and no one total scores were used in these analyses.

The results indicate that psychological well-being and spouse had a significant, but small inverse relationship (see Table 8). In the CES-D scale, the higher scoring reflects greater depressive symptoms. Findings in this study suggest those who are more depressed rely less on their spouses as a help-seeking resource. Concern about health was positively and significantly associated with the selection of a formal resource (professional, agency, and self-help group). Comparing health to one year ago had a significant positive relationship with the selection of informal resources (friend, neighbor, and spiritual advisor). A majority (67.8%) considered their health to be about the same as compared to one year ago. Those concerned about their health sought a formal resource while those who compared their health to one

Table 8. Correlations between dimensions of health and help-seeking resources.

Dimensions of Health	Help-Seeking Resources				
	Spouse	Family	Informal	Formal	No One
Psychological Well-Being	-.23**	-.03	-.05	.06	.05
General Well-Being	.04	.07	.08	-.07	.004
Pain	-.07	-.01	-.06	.02	.01
Concern about Health	-.10	.04	.05	.15**	-.02
Comparison of Health to One Year Ago	.01	-.001	.12*	-.09	-.04
Hardiness	-.03	.04	-.07	-.09	-.01

* $p = \leq .05$ ** $p = \leq .01$

year ago as about the same sought an informal resource. Overall, the dimensions of health had a negligible to small relationship with the rural residents' choice of help-seeking resources.

The fifth question was: What are the relationships between demographic variables and the dimensions of health and help-seeking resources? These relationships were examined using Pearson correlations and t tests.

Table 9 shows correlations of age had a weak inverse relationship with general well-being, a weak positive relationship with pain, and a weak positive relationship with concern over health. These results may indicate those who were older had a lower sense of well-being, experienced more pain and were more concerned about their health than the younger participants. Years of schooling or education had a weak positive relationship with general well-being, a weak inverse relationship with pain, and a small correlation with hardiness. A sense of well-being, less experience of pain, and a total score indicating hardiness was reported by those who had more education. Distance from a neighbor had a weak inverse relationship with pain. Income had a weak inverse relationship with psychological well-being and hardiness but a weak positive correlation to general well-being. The higher the income, the more hardy and physically and psychologically healthy the participant was, or the healthier the participant, the better the income because they could work. There were no correlations with rurality to dimensions of health.

Table 9. Correlations between demographic variables and dimensions of health.

	Health Dimensions					
Demographics	Psycho-logical Well-Being	General Well-Being	Pain	Concern about Health	Comparison of Health	Hardiness
Age	-.03	-.19**	.13	.12*	-.07	-.09
Education	.01	.19**	-.14**	-.08	-.07	-.25**
Neighbor	-.01	.08	-.13*	-.09	.003	-.03
Rurality	-.03	.03	-.09	.05	-.04	.01
Income	-.18**	.16**	-.10	-.09	-.11	-.20

* $p = \leq .05$ ** $p = \leq .01$

Age, with a mean of forty-seven years in this sample, had a slight inverse relationship to spouse, family, and informal help-seeking resources (see Table 10). Education had a small correlation with informal and formal help-seeking resources. Income had a small correlation to spouse and formal resources. Rurality had no correlation to participant's choice of help-seeking resources.

The most significant correlations were between age and informal help-seeking resources and income and spouse, partner, or significant other help-seeking resources. Results indicate those who were older were less likely to rely on the family, spouse, or informal sources for help-seeking resources. Reasons for this may be that spouses and friends have died, families may live a distance away, or perhaps physician-patient relationships have been established.

The higher the income, the more likely the rural resident chose the spouse, partner, or significant other as a help-seeking resource.

Results indicate the better the income, the more likely the spouse, partner, or significant other was chosen as a help-seeking resource. The correlation between income and spouse may be a spurious relationship. Income appeared to be a confounding variable in relation to age and marital status. Income was not significant in the help-seeking resource of spouse regressed on hardiness, age, marital status, general well-being, psychological well-being, income, and employment. The significant variables were age, marital status, and psychological well-being. Therefore, the correlation between income and spouse in Table 10 may simply be a result of chance. Replication of the study would determine whether the relationship between income and spouse was merely happenstance or a characteristic of the relationships found in other studies (Woods & Catanzaro, 1988).

Table 10. Correlations between demographic variables and help-seeking resources.

	Help-Seeking Resources				
Demographics	Spouse	Family	Informal	Formal	No One
Age	-.14*	-.18**	-.28**	-.04	.07
Education	.09	-.08	.16**	.18**	.09
Neighbor	.005	-.06	.02	.002	.09
Rurality	-.03	.05	-.11	-.10	.03
Income	.35**	-.09	-.02	.13*	.04

* $p = \leq .05$ ** $p = \leq .01$

T tests were employed to examine the differences in reported dimensions of health and help-seeking resources between men and women,

those who were working and non-working, and those who were married and those who were not married. There were no significant differences between men and women on the dimensions of health (see Table 11). The results indicated there was little difference between men and women's reports of psychological well-being, general well-being, pain, concern about health, comparison of health to one year ago, and hardiness.

Table 11. Average scores for gender regarding responses to dimensions of health.

	Men (n=91)		Women (n=224)		
Variable	Mean	SD	Mean	SD	T
Psychological Well-Being	8.74	(9.62)	9.62	(8.54)	-2.89
General Well-Being	3.25	(0.68)	3.26	(0.67)	0.14
Pain	2.36	(0.84)	2.32	(0.84)	-0.40
Concern about Health	1.98	(0.83)	2.09	(0.93)	0.95
Comparison of Health to One Year Ago	3.04	(0.68)	3.16	(0.76)	1.28
Hardiness	-.26	(4.03)	.10	(3.70)	0.80

* $p = \leq .05$ ** $p = \leq .01$

Results of the t test indicated there were differences between men and women in using help-seeking resources. Women were more likely to seek formal resources than men (see Table 12). The women participants also were more likely to seek the family as a resource as compared to the men participants.

Table 12. Average scores for gender regarding responses to help-seeking resources.

	Men (n=91)		Women (n=224)		
Variable	Mean	SD	Mean	SD	T
Spouse	6.69	(2.20)	6.06	(3.74)	-1.39
Family	4.98	(3.00)	6.33	(3.00)	3.68**
Informal	5.69	(3.25)	5.90	(3.00)	0.54
Formal	2.20	(2.40)	2.83	(2.70)	1.97*
No One	0.68	(2.00)	0.52	(1.30)	-0.93

* $p = \leq .05$ ** $p = \leq .01$

Results indicated working people had a greater sense of general well-being or health, less pain, were less concerned about their health, and were less hardy than the non-working people, which includes the retired, disabled, and unemployed (see Table 13).

Table 13. Average scores for employment status regarding responses to dimensions of health.

	Working (n=282)		Non-Working (n=33)		
Variable	Mean	SD	Mean	SD	T
Psychological Health	9.41	(8.10)	8.94	(8.11)	0.32
General Well-Being	3.30	(0.64)	2.97	(0.71)	3.10**
Pain	2.29	(1.01)	2.73	(0.80)	-3.90**
Concern about Health	2.01	(0.90)	2.39	(0.90)	-2.30**
Comparison of Health to One Year Ago	3.14	(0.80)	3.00	(0.73)	1.10
Hardiness	0.14	(3.62)	-1.23	(3.80)	2.00*

* $p = \leq .05$ ** $p = \leq .01$

The working group were more likely to choose their spouse or significant other as a resource as compared to the non-working group (see Table 14). Another difference was the working group was more likely to choose the informal resources as compared to the non-working. This may be because working individuals may have more friends and co-workers as a help-seeking resource as compared to the non-working.

Table 14. Average scores for employment status regarding responses to help-seeking resources.

Variable	Working (n=282)		Non-Working (n=33)		
	Mean	SD	Mean	SD	T
Spouse	6.46	(4.01)	4.39	(3.54)	3.12**
Family	5.98	(3.50)	5.64	(3.01)	0.61
Informal	5.99	(3.10)	4.55	(3.00)	2.61**
Formal	2.64	(3.00)	2.73	(2.61)	-0.20
No One	0.54	(2.01)	0.82	(1.40)	-1.10

** $p = \leq .001$

Single people had poorer psychological well-being or reported more depression symptomatology than those who had a partner (see Table 15). Individuals who have a spouse, a partner or significant other have a greater sense of psychological well-being.

Table 15. Average scores for married and single status regarding responses to dimensions of health.

Variable	Married (n=236)		Single (n=78)		
	Mean	SD	Mean	SD	T
Psychological Well-Being	8.62	(9.73)	11.66	(7.40)	-3.90**
General Well-Being	3.26	(0.65)	3.26	(0.71)	0.08
Pain	2.33	(0.91)	2.33	(0.82)	-0.03
Concern about Health	2.02	(1.00)	2.14	(0.90)	-1.01
Comparison to Health One Year Ago	3.10	(0.80)	3.13	(0.73)	0.30
Hardiness	-0.12	(3.54)	0.05	(3.85)	-0.13

* p = ≤.05 ** p = ≤.01

As expected, those with a partner were more likely to turn to their spouse or partner as a help-seeking resource than the single participants (see Table 16). Singles were more likely to choose informal resources than those with a partner.

Table 16. Average scores for married and single status regarding responses to help-seeking resources.

Variable	Married (n=236)		Single (n=78)		
	Mean	SD	Mean	SD	T
Spouse	7.67	(3.20)	1.91	(2.50)	16.48**
Family	5.78	(2.72)	6.47	(3.10)	-1.76
Informal	5.57	(2.71)	6.60	(3.10)	-2.62**
Formal	2.71	(2.70)	2.49	(2.60)	0.70
No One	0.55	(1.32)	0.63	(1.40)	-0.43

* p = ≤.05 ** p = ≤.01

The sixth question was: What are the relationships among demographic variables, dimensions of health, and help-seeking resources? Multiple regression analysis was used to examine the relationships of demographic variables, and dimensions of health, on help-seeking resources. Based on the conceptual framework and preliminary correlations, the following independent variables were selected to be included in the regression tables: psychological well-being, general well-being, comparison of health to one year ago, and concern about health, hardiness, employment status, gender, marital status, age, education, and income (see Table 17). General well-being, hardiness, rurality, pain, and distance from neighbor had very low, nonsignificant correlations with help-seeking resources. Each help-seeking resource (spouse/partner, family, informal, formal, no one) was examined separately.

Table 17. Correlations of dimensions of health and demographics with help-seeking resources.

	Spouse	Family	Informal	Formal	No One
Psychological Well-Being	-.23**	-.03	-.05	.06	.05
General Well-Being	.04	.07	.08	-.07	.004
Pain	-.07	-.01	-.06	.02	.01
Concern about Health	-.10	.04	-.05	.15**	-.02
Comparison of Health to One Year Ago	.01	-.00	.12*	.08	-.07
Hardiness	-.03	.04	-.07	-.09	-.01

Table 17. Continued.

	Spouse	Family	Informal	Formal	No One
Employment[a]	.17**	.09	.13*	.01	-.06
Gender[b]	.08	-.17**	-.05	-.14*	.05
Marital Status[c]	.68**	-.01	-.13*	.04	-.02
Age	-.14*	-.18**	-.30**	-.04	.07
Education	.09	-.08	.16	.18**	.09
Income	.40**	-.10	-.02	.13*	.04
Distance from neighbor	-.005	-.06	.02	.00	-.09
Rurality	-.06	.05	-.11	-.10	.03

* $p = \leq .05$ ** $p = \leq .01$
[a] dummy coded (0=working, 1=nonworking)
[b] dummy coded (0=women, 1=men)
[c] dummy coded (0=married, 1=single)

The help-seeking resource of spouse was regressed on hardiness, age, marital status, general well-being, psychological well-being, income, and employment status (see Table 18). Fifty percent of the variance in spouse was accounted for by the independent variables. Significant independent variables were age, marital status, and psychological well-being. These findings suggest that younger rural residents, those who were married or had a partner, and those who had higher mental health chose the spouse or partner as a help-seeking resource.

Table 18. The help-seeking resource of spouse regressed on hardiness, age, marital status, general well-being, psychological well-being, income, and employment.

Variables	b	Beta	T	P-Value
Hardiness	0.01	0.01	0.24	.814
Age	-0.05	0.19	-4.04	.001
Marital Status[a]	5.32	0.63	14.00	.001
General Well-Being	-0.20	-0.04	-0.84	.403
Psychological Well-Being	-0.06	-0.14	-3.10	.003
Income	0.08	0.09	2.00	.063
Employment[b]	-0.50	-0.04	-0.80	.425
R^2 = .50				

[a] dummy coded (0 = single, 1 = married)
[b] dummy coded (0 = working, 1 = non-working)

The help-seeking resource of family was regressed on gender, general well-being, hardiness, age, and psychological well-being (see Table 19). Nine percent of the variance in family was accounted for by the five independent variables. Significant independent variables were gender and age. The findings suggest that younger individuals and women are more likely to turn to their family as a help-seeking resource.

Table 19. The help-seeking resource of family regressed on gender, general well-being, hardiness, age, and psychological well-being.

Variables	b	Beta	T	P-Value
Gender[a]	1.46	.22	4.00	.001
General Well-Being	0.10	.02	0.38	.703
Hardiness	0.03	.04	0.61	.541
Age	-0.05	-.21	-4.00	.001
Psychological Well-Being	- .02	-.05	- .85	.394
R^2 = .09				

[a] dummy coded (0 = men, 1 = women)

The help-seeking resource of informal was regressed on comparison of health a year ago, age, marital status, hardiness, general well-being, psychological well-being, and employment status (see Table 20). Thirteen percent of the variance in informal resources was accounted for by these independent variables. The findings suggest that younger and single participants were more likely to seek informal resources.

Table 20. The help-seeking resource of informal regressed on comparison of health, age, marital status, hardiness, general well-being, psychological well-being, and employment.

Variables	b	Beta	T	P-Value
Comparison of Health	0.45	.11	2.00	.058
Age	-0.05	-.25	-4.00	.001
Marital Status[a]	-1.30	-.18	-3.16	.002
Hardiness	-0.07	-.09	-2.00	.129
General Well-Being	-0.20	-.04	- .73	.467
Psychological Well-Being	-0.02	-.10	-1.12	.265
Employment[b]	0.80	.08	1.21	.226
R^2 = .13				

[a] dummy coded (0 = single; 1 = married)
[b] dummy coded (0 = working, 1 = non-working)

The help-seeking resource of formal was regressed on education, psychological well-being, gender, income, concern about health, hardiness, and general well-being (see Table 21). Ten percent of the variance in formal was accounted by all the independent variables. Significant independent variables were education, gender, and concern about health. The findings suggest that women, those with more education and those more concerned about their health were more likely to seek formal resources.

Table 21. The help-seeking resource of formal regressed on education, psychological well-being, gender, income, concern about health, hardiness, and general well-being.

Variables	b	Beta	T	P-Value
Education	.20	.22	3.60	.001
Psychological Well-Being	.01	.02	0.40	.688
Gender[a]	.80	.13	2.36	.020
Income	.06	.09	2.00	.117
Concern about Health	.40	.14	2.16	.032
Hardiness	-.03	-.05	-0.80	.426
General Well-Being	-.35	-.09	-1.37	.173
R^2 = .10				

[a] dummy coded (0 = men; 1 = women)

The help-seeking resource of "no one" or self-care (prefer to handle it alone) was regressed on hardiness, general well-being, and psychological well-being (see Table 22). Because the sample was small, the findings indicated that hardiness, general well-being, and psychological well-being had minimal influence on the participants' preference to handle situations alone.

Table 22. The help-seeking resource of no one preferred or self-care regressed on hardiness, general well-being, and psychological well-being.

Variables	b	Beta	T	P-Value
Hardiness	-.01	-.03	-.51	.607
General Well-Being	.02	.01	.14	.893
Psychological Well-Being	.01	.06	.92	.357
R^2 = .00				

In summary, the purpose of the multiple regression analysis was to describe the strength of the relationship between multiple independent variables of the dimensions of health and demographics and each one of the dependent variables of help-seeking resources. Results indicated weak to strong relationships. For example, the least strong relationship (9%) was the help-seeking resource of family regressed on gender, general well-being, hardiness, age, and psychological well-being. Significant independent variables were gender and age. The strongest relationship (50%) was the help-seeking resource of spouse regressed on hardiness, age, marital status, general well-being, psychological well-being, income, and employment. Significant independent variables were age, marital status, and psychological well-being. Both examples indicated there was a relationship between dimensions of health, demographics, and help-seeking resources.

CHAPTER 5

DISCUSSION

The purpose of this study was to explore dimensions of health that influenced the rural residents' choices of help-seeking resources. The dimensions of health included the concepts of psychological well-being, general well-being, and hardiness. The influence of demographics (employment status, gender, marital status, age, education, income, distance from neighbor, and rurality) on rural residents' choices of help-seeking resources also was explored. A cross-sectional analysis was conducted on participants in four Northern rural states. The convenience sample consisted of 315 participants. The findings, in relation to the study's research questions and conceptual framework, are summarized in this chapter. Implications for nursing and recommendations for future research are included.

Ten situations in the Personal Resource Questionnaire (PRQ-85, Part I) were used to determine what personal resources rural residents would use in each situation. Twelve resources were identified in the PRQ. In the conceptual framework, resources were categorized into three categories. The categories included self-care, informal, and formal. However, to provide a better understanding of the twelve possible choices of resources, the choices were categorized into five categories. The categories included spouse (partner or significant other), family (parent, child, family member), informal (friend,

co-worker, neighbor, spiritual advisor), formal (professional, agency, self-help group), and no one preferred (self-management of health, illness or injury and self-reliance).

Participants in the Northern rural states reported the first choice of a help-seeking resource would be the spouse or partner or significant other. The second choice of a help-seeking resource was reported as a friend, neighbor, co-worker, or spiritual advisor and the third choice of a help-seeking resource was reported as the parent, child or children or a family member. Of the ten situations in the PRQ-85, Part I (see Appendix D), the spouse, partner, or significant other was chosen as the help-seeking resource eight situations out of ten situations. In two situations, if the rural residents were concerned about their relationship with the spouse, partner, or significant other and if they felt lonely, they chose to seek the resource of a friend. These findings suggested participants sought their spouse or partner, family, or informal resources before they sought a formal resource. These findings are consistent with literature (Long & Weinert, 1989).

Dimensions of health (general well-being, psychological well-being, hardiness) and demographics (gender, age, education, income, employment status, distance from neighbor, marital status, rurality) are correlated with help-seeking resources (spouse, family, informal, formal, and no one) chosen by rural residents. Literature supports these findings and suggests the general need to redefine health status in comprehensive rather than unidimensional measures in predicting health care resources utilized (Wolinsky, 1982).

According to Kobasa (1979), hardiness serves as a health protective buffer. People who possess a hardy personality are not as likely to develop a stress related illness as people who are not hardy (Bigbee, 1991). Participants showed no extreme scores of hardiness or nonhardiness. These findings indicate that the more hardy participants reported a positive mental and physical status. Further research needs to address whether the hardy personality serves as a protective mechanism for rural residents as well as urban residents.

Single participants in the study reported more depressive symptomatology as compared to the married participants or those with a partner. The results indicated that single people felt more depressed if there was not a partner or significant other in their lives. However, the single participants reported they were more apt to turn to an informal resource than the married, indicating their friends, neighbors, co-workers or spiritual advisor were help-seeking resources. Participants who were married or had a partner reported they would rely less on their partners as help-seeking resources if they had more depressive symptoms.

People in the working force reported higher levels of general well-being and utilization of informal resources than nonworking people. Having a purpose in life and job satisfaction most likely would influence a person's health status. Furthermore, being part of the work force may have a positive influence on a person's psychosocial as well as physical functioning. Literature supports that employment status and depression are significantly related for both men and women (Turner & Avison, 1989). Employment would provide more opportunities

to make friends and socialize which would impact the availability of informal resources. Those not working (11%) reported more pain and more concern about their health with greater hardiness scores indicating more hardiness. A majority of the non-working participants were retired. These findings indicated people who were not employed may have had more time to be aware of their health status or may have been less healthy. Although the sample was small, results indicated retirement had a positive effect on hardiness reports.

Income influenced the participant's choice of help-seeking resources. The higher the income the more likely the participants were to seek the help-seeking resources of spouse, partner, or significant other and formal resources. Those who have a higher income may be able to afford insurance, thereby, influencing their decision to seek formal care. Literature supports these findings and suggests insurance coverage is a factor which increases the utilization of health care services (Hulka & Wheat, 1985; Roemer, 1976). Studies also showed that the less income, the more doctor visits and hospitalizations (Hulka & Wheat, 1985). This study showed fifty-one percent of the participants reported an income under $30,000 per year. Further studies are required to explain if increased doctor visits and hospitalizations are due to Medicaid and Medicare coverage or if, because of lack of money, people wait until they are very ill before seeking formal resources.

Women were more likely to seek the family or formal resources. According to the literature, women visit the doctor more than do men (Hulka & Wheat, 1985; McKinlay, 1972). It may be argued that increased visits indicate women are more interested in health and knowledge about

health or that they have more time and have a greater flexibility in scheduling as compared to men (Cleary, Mechanic, & Greenley, 1982). Another possibility is that men and women may recognize and report health differently according to specific needs, but not differ in help-seeking tendencies (Cleary, et al., 1982). When studying gender differences, care must be taken to identify the choice and utilization of resources related to gender specific needs such as pregnancy.

Perhaps women were more likely to seek family resources than men because of traditional roles in society where the mother is considered the nurturer and family oriented, whereas the father is considered the breadwinner. Twenty-seven percent of the participants were homemakers with ten percent who reported working part-time outside the home. With the increase of women entering the working force and perhaps a decrease of nearby extended family because of societal mobility, role sharing in response to family systems may change (Bomar, 1989). Future studies may identify changes in men and women's selection of help-seeking resources.

Age had a significant influence on help-seeking resources chosen and the status of general well-being in this study. Those who were older reported more pain, more concern about health, and a lower sense of general well-being. Those who reported more concern about their health were also more likely to seek a formal resource. Participants who were older and reported more pain and more concern about their health sought professional care.

Research must consider the disruption of support networks for those who are older. Those who are older may prefer formal resources and are less likely to choose spouse, informal and family as resources.

Most reasonably, older participants' spouse and agemates may be deceased or unable to talk about health due to living alone and lack of capabilities. Family and informal resources encourage those who are older to visit a physician. Those who are older may have faced chronic rather than acute illness and have developed a stable relationship with a physician (Cleary et al., 1982; Furstenberg & Davis, 1984). For those who were older, a stable relationship with a physician was a consistent finding in studies addressing help-seeking and utilization of health care services (Coward & Lee, 1985; Davis, 1983; Hulka & Wheat, 1985; McKinlay, 1972; Ward, 1977).

Participants with more education had higher levels of general well-being and hardiness, and fewer reports of pain. Also, they were more likely to seek informal and formal resources. An earlier study found the less educated were more inclined to visit doctors than seek informal resources (Sharp, Ross & Cockerham, 1983).

In this study, rurality did not appear to influence participants' choice of help-seeking resources. Most likely, rurality had little significance because the majority (58%) of the rural residents described their area as a city or town in which the neighbor lived next door.

Implications for Nursing

Understanding rural residents' definition of health and help-seeking resources is imperative for the health care profession. A major goal of rural nursing is to understand the rural resident's perception of health and acceptable resources for help. Such information will facilitate avenues by which the rural nursing

profession can enhance and integrate acceptable health care resources which include self-care, spouse, family, informal, and formal resources.

For example, placing a health care service in a rural area may not be feasible if residents prefer to use their spouse or partner, family or informal resources first. Studies by Long and Weinert (1989) have emphasized the reliance of rural dwellers (residents who live in sparsely populated counties of 5.9 to fewer than .5 persons per square mile) on family and informal systems for health care. If formal care is chosen, rural residents may not see distance to health care services as a barrier. Instead they may prefer to travel to a larger medical facility or to their personal health care provider. The rural nursing profession should not assume what distance means to the rural resident. People in rural states can live long distances from health care services and still not see themselves as isolated or the services as inaccessible. Since 17% of participants in this study described their area as a farm or ranch, they may not see formal resources as feasible in their area. If communities perceive they are too small to have formal resources, attention should focus on what the residents perceive as needs.

Rural residents' characteristics, common activities, interests, and their perceptions of their own roles and others' roles have a great effect in shaping and choosing help-seeking resources. Nursing theory must focus on rural residents' paradigm of help-seeking resources in guiding nurses to work within this context.

In studying the rural residents' definition and perception of essential help-seeking resources, knowledgeable decisions made by

health care management could prevent failure of programs and excess medical costs to the government. Most importantly, nurses can encourage and facilitate avenues that people choose for their help-seeking resources. At times these avenues may seem unlikely resources, especially in rural areas, when these avenues are neighbors, bartenders, or the local fire department. However, the goal is to promote the health and wellness of people. Further research and further validation of rural residents' concepts are needed for continuing the development of rural nursing theory and guiding rural nursing practice.

Recommendations for Future Studies

Further studies should continue examination of the dimensions of health. Developing measurements that accurately evaluate an individual's perception of health and help-seeking resources would enhance health related research. Qualitative, as well as quantitative, research measures would embellish the nursing theory because definitions would be from the perspective of rural residents.

In this study, there were more women then men participants. Reasons that may explain this unequal distribution are that women were more available and were more interested in participating in this study. Second, rural areas have a higher ratio of women to men (Bushy, 1991). Third, a women's convention held at the Montana State University campus provided a convenient sample of rural residents. Many of the women commented that their husbands were too busy or would not be interested in filling out the questionnaire. The sample was a convenience sample

which also placed limitations on the generalizability of the findings and may not have ensured a full array of rural residents. In future studies, a sample with a more equal distribution of men and women would be beneficial. Random samples should be used to allow generalizability of the findings.

Longitudinal studies should be conducted to determine differences in the perception of health and available help-seeking resources as people age. Another interesting study would be determining changes in perception of health and help-seeking resources amongst different generations over time. More detailed studies must be conducted to determine differences in gender and reported health status or symptoms. For example, separate studies would be necessary to more clearly understand how men and women identify themselves as sick and then study the choice of help-seeking resources.

Another suggested study would be to compare urban and rural residents' definitions of health and then examine their choices of help-seeking resources. For example, rural and urban residents may have differences in hardiness levels and reports of psychological and general well-being. If there are differences in the urban residents' reports from rural residents, choices of help-seeking resources may also vary. Expanding the knowledge base of nursing theory with people's perceptions of health and help-seeking resources provides a stronger support for integration of the peoples' needs and acceptable health care provision by health care workers.

REFERENCES CITED

Alonzo, A. (1979). Everyday illness behavior: A situational approach to health status deviations. Social Science and Medicine, 13(A), 397-404.

Bartlome, J., Bartlome, P, & Bradham, D. (1992). Self-care and illness response behaviors in a frontier area. The Journal of Rural Health, 8(1), 4-12.

Battistella, R. (1971). Factors associated with delay in the initiating of physicians' care among late adulthood persons. American Journal of Public Health, 61(7), 1348-1361.

Bentzen, N., Christiansen, T., & Pedersen, K. (1989). Self-care within a model for demand for medical care. Social Science and Medicine, 29(2), 117-123.

Berkanovic, E., & Hurwicz, M. (1989). Psychological distress and the decision to seek medical care among a medicare population. Medical Care, 27(11), 1058-1070.

Berube, M. (1985). The American heritage dictionary (2nd ed.). Boston: Houghton Mifflin Company.

Bigbee, J. (1991). The concept of hardiness as applied to rural nursing. In A. Bushy (Ed.). Rural nursing: Volume I. (pp.39-58). Newbury Park: Sage Publications, Inc.

Booth, A., & Babchuk, N. (1972). Seeking health care from new resources. Journal of Health and Social Behavior, 13, 90-99.

Bomar, P. (1989). Nurses and family health promotion: Concepts, assessment, and interventions. Baltimore: Williams & Wilkins.

Brandt, P., & Weinert, C. (1981). The PRQ: A social support measure. Nursing Research, 30(5), 277-280.

Brown, B. (1978). Social and psychological correlates of help-seeking behavior among urban adults. American Journal of Community Psychology, 6(5), 425-439.

Bushy, A. (1991). Rural nursing: Volume I. Newbury Park: Sage Publications, Inc.

Carlson, J., Lassey, M. & Lassey, W. (1981). Rural society and environment in America. New York: McGraw-Hill Company.

Chinn, P., & Jacobs, M. (1987). Theory and nursing: A systematic approach (2nd ed.). St.Louis: The C.V. Mosby Company.

Cleary, P., Mechanic, D, & Greenley, J. (1982). Sex differences in medical care utilization: An empirical investigation. Journal of Health and Social Behavior, 23(2),106-119.

Comstock, G., & Helsing, K. (1976). Symptoms of depression in two communities. Psychological Medicine, 6, 551-563.

Cordes, S. (1985). Biopsychosocial imperatives from the rural perspective. Social Science Medicine, 21(12), 1373-1379.

Coward, R., & Lee, G. (1985). The elderly in rural society. New York: Springer Publishing Company.

Davies, A., & Ware, J., Jr. (1981). Measuring health perceptions in the health insurance experiment. Santa Monica: The Rand Corporation.

Davis, R. (1983). Aging: Prospects and issues (3rd ed.). Los Angeles: The University of Southern California Press.

Dean, K. (1981). Self-care responses to illness: A selected review. Social Science and Medicine, 15(A), 673-687.

Dean, K. (1989). Self-care components of lifestyles: The importance of gender, attitudes and the social situation. Social Science and Medicine, 29(2), 137-152.

Dubos, R. (1965). Man adapting. New Haven: Yale University Press.

Fawcett, J. (1989). Analysis and evaluation of conceptual models of nursing (2nd ed.). Philadelphia: F.A. Davis Company.

Figley, C., & McCubbin, H. (1983). Stress and the family: Coping with catastrophe (Volume II). New York: Brunner/Mazel, Publishers.

Furstenberg, A., & Davis, L. (1984). Lay consultation of older people. Social Science and Medicine, 18(10), 827-837.

Hulka, B., & Wheat, J. (1985). Patterns of utilization: The patient perspective. Medical Care, 23(5), 438-460).

Hurwicz, M., & Berkanovic, E. (1991). Care seeking for musculoskeletal and respiratory episodes in a medicare population. Medical Care, 29(11), 1130-1144.

Jarvis, L. (1981). Community health nursing: Keeping the public healthy. Philadelphia: F.A. Davis Company.

Kessel, N., & Shepherd, M. (1965). The health and attitudes of people who seldom consult a doctor. Medical Care, 1, 6-10.

Keyser, D., & Sweetland, R. (1985). Test critique (Volume II). Kansas City: Westport Publishers, Inc., (pp. 144-160).

King, I. (1981). A theory for nursing: Systems, concepts, process. New York: John Wiley and Sons.

Kobasa, S. (1979). Stressful life events, personality, and health: An inquiry into hardiness. Journal of Personality and Social Psychology, 37(1), 1-11.

Kobasa, S., Maddi, S., & Courington, S. (1981). Personality and constitution as mediators in the stress-illness relationship. Journal of Health and Social Behavior, 22(4), 368-378.

Kobasa, S., Maddi, S., & Kahn, S. (1982). Hardiness and health: A prospective study. Journal of Personality and Social Psychology, 42(1), 168-177.

Lambert, C., & Lambert, V. (1987). Hardiness: Its development and relevance to nursing. IMAGE: Journal of Nursing Scholarship, 19(2), 92-95.

Lazarus, R. (1966). Psychological stress and the coping process. New York: McGraw-Hill Book Company.

Lee, H. (1983). Analysis of a concept: Hardiness. Oncology Nursing Forum, 10(4), 32-35.

Lee, H. (1986). Rurality, stress, and perceived health in farmers and ranchers. Unpublished manuscript, Montana State University, College of Nursing, Bozeman.

Lee, H. (1991). Relationship of hardiness and current life events to perceived health in rural adults. Research in Nursing and Health, 14, 351-360.

Lee, H. (1991). Definitions of rural: A review of the literature. In A. Bushy (Ed.). Rural nursing: Volume I. (pp.7-20). Newbury Park: Sage Publications, Inc.

Levin, L., Katz, A., & Holst, E. (1976). Self-care. New York: McGraw-Hill Book Company.

Long, K., & Weinert, C. (1989). Rural nursing: Developing the theory base. Scholarly Inquiry for Nursing Practice, 3, 113-127.

Marshall, J., Gregorio, D., & Walsh, D. (1982). Sex differences in illness behavior: Care seeking among cancer patients. Journal of Health and Social Behavior, 23(3), 197-204.

McCubbin, H., & Figley, C. (1983). Stress and the family: Coping with the normative transitions (Volume I). New York: Brunner/Mazel, Publishers.

McHorney, C., & Mor, V. (1988). Predictors of bereavement depression and its health services consequences. Medical Care, 26(9), 882-893.

McKinlay, J. (1972). Some approaches and problems in the study of the use of services-an overview. Journal of Health & Social Behavior, 13(2), 115-153.

Mechanic, D. (1963). Religion, religiosity, and illness behavior: The special case of the Jews. Human Organization, 22(3), 202-208.

Mechanic, D. (1972). Public expectations and health care. New York: John Wiley & Sons, Inc.

National Center for Health Statistics. (1980). Basic data on depressive symptomatology, United States, 1974-1975. Vital and health statistics: Data from the National Health Survey, Series 11 Number 216, DHEW publication No. (PHS) 80-1666. Hyaltsville.

Neuman, B. (1982). The Neuman systems model. Norwalk: Appleton-Century-Crofts.

Pagana, K. (1990). The relationship of hardiness and social support to student appraisal of stress in an initial clinical nursing situation. Journal of Nursing Education, 29(6), 255-261.

Parse, R. (1987). Nursing science: Major paradigms, theories, and critiques. Philadelphia: W.B. Saunders Company.

Pollock, S., & Duffy, M. (1990). The health-related hardiness scale: Development and psychometric analysis. Nursing Research, 39(4), 218-222.

Radloff, L. (1977). The CES-D scale: A self-report depression scale for research in the general population. Applied Psychological Measurement, 1, 385-406.

Roemer, M. (1976). Rural health care. St.Louis: The C.V. Mosby Company.

Rosenblatt, R., & Moscovice, I. (1982). Rural Health Care. New York: John Wiley and Sons.

Sharp, K., Ross, C., & Cockerham, W. (1983). Symptoms, beliefs, and the use of physician services among the disadvantaged. Journal of Health and Social Behavior, 24(3), 255-263.

Smith, J. (1981). The idea of health: A philosophical inquiry. Advances in Nursing Sciences, 3(3), 43-51.

Turner, R., & Avison, W. (1989). Gender and depression: Assessing exposure and vulnerability to life events in a chronically strained population. The Journal of Nervous and Mental Disease, 177(8), pp.443-455.

Veroff, J., Kulka, R., & Douvan, E. (1981). Mental health in America: Patterns of help-seeking from 1957-1976. New York: Basic Books, Inc.

Ward, R. (1977). Services for older people: An integrated framework for research. Journal of Health and Social Behavior, 18(1), 61-70.

Ware, J., Jr. (1976). Scales for measuring general health perceptions. Health services research, 11, 396-415.

Weinert, C., & Long, K. (1987). Understanding the health care needs of rural families. Family Relations, 36, 450-455.

Weinert, C., Bork, R., & Bender, L. (1990). The rurality index. Unpublished manuscript, Montana State University, College of Nursing, Bozeman.

Weinert, C., & Long, K. (1990). Rural families and health care: Refining the knowledge base. Journal of Marriage and Family Review, 15(1 & 2), 57-76.

Wolinsky, F. (1982). Assessing the effects of the physical, psychological, and social dimensions of health on the use of health services. The Sociological Quarterly, 23 (Spring), 191-206.

Woods, N., & Catanzaro, M. (1988). Nursing research: Theory and practice. St. Louis: The C. V. Mosby Company.

APPENDICES

APPENDIX A

CES-D

CES-D
Center for Disease Control

This series of questions is about your feelings and how often you experienced them in the PAST WEEK. Answer each question, but do not spend a great deal of time on any one question.

	RARELY OR NONE OF THE TIME (LESS THAN 1X/DAY)	SOME OR LITTLE OF THE TIME (1-2 DAYS)	MODERATE AMOUNT OF THE TIME (3-4 DAYS)	MOST OR ALL OF THE TIME (5-7 DAYS)
Q-1. I was bothered by things that usually don't bother me	0	1	2	3
Q-2. I did not feel like eating; my appetite was poor . . .	0	1	2	3
Q-3. I felt that I could not shake off the blues even with help from my family or friends	0	1	2	3
Q-4. I felt that I was just as good as other people . . .	0	1	2	3
Q-5. I had trouble keeping my mind on what I was doing	0	1	2	3
Q-6. I felt depressed	0	1	2	3
Q-7. I felt that everything I did was an effort	0	1	2	3
Q-8. I felt hopeful about the future	0	1	2	3
Q-9. I thought my life had been a failure	0	1	2	3
Q-10. I felt fearful	0	1	2	3

	RARELY OR NONE OF THE TIME (LESS THAN 1X/DAY)	SOME OR LITTLE OF THE TIME (1-2 DAYS)	MODERATE AMOUNT OF THE TIME (3-4 DAYS)	MOST OR ALL OF THE TIME (5-7 DAYS)
Q-11. My sleep was restless . .	0	1	2	3
Q-12. I was happy	0	1	2	3
Q-13. I talked less than usual .	0	1	2	3
Q-14. I felt lonely	0	1	2	3
Q-15. People were unfriendly .	0	1	2	3
Q-16. I enjoyed life	0	1	2	3
Q-17. I had crying spells	0	1	2	3
Q-18. I felt sad	0	1	2	3
Q-19. I felt that people disliked me	0	1	2	3
Q-20. I could not "get going" .	0	1	2	3

APPENDIX B

HEALTH AND HEALTH CARE

HEALTH AND HEALTH CARE

==========

Q- 1. In general, would you say your health is excellent, good, fair, or poor?

1 POOR
2 FAIR
3 GOOD
4 EXCELLENT

Q- 2. During the PAST THREE MONTHS, how much pain have you had?

1 NO PAIN AT ALL
2 A LITTLE PAIN
3 SOME PAIN
4 A GREAT DEAL OF PAIN

Q- 3. During the PAST THREE MONTHS, how much has your health worried or concerned you?

1 NOT AT ALL
2 A LITTLE
3 SOMEWHAT
4 A GREAT DEAL

Q- 4. How does your health now compare to your health ONE YEAR ago?

1 MUCH WORSE
2 A LITTLE WORSE
3 ABOUT THE SAME
4 A LITTLE BETTER
5 MUCH BETTER

APPENDIX C

HARDINESS

HARDINESS SCALE
(Kobasa)

The items below are attitudes with which you may or may not agree. As you will see, many of the items are worded very strongly. This is so you can decide the DEGREE to which you agree or disagree. To the right of each item is a scale which ranges from strongly disagree "0" to strongly agree "3". CIRCLE the number which most closely indicates what you feel. Please read the items carefully. Be sure to answer all on the basis of the way you feel NOW. Do not spend too much time on any one item.

0 STRONGLY DISAGREE
1 DISAGREE
2 AGREE
3 STRONGLY AGREE

Q1.	Most of life gets wasted in doing things that do not mean anything.....	0	1	2	3
Q2.	I find it difficult to imagine getting excited about work.....	0	1	2	3
Q3.	It doesn't matter if you work hard at your job since only the bosses profit by it anyway.....	0	1	2	3
Q4.	Ordinary work is just too boring to be worth doing.....	0	1	2	3
Q5.	I think people believe in individuality only to impress others.....	0	1	2	3
Q6.	Unfortunately, people don't seem to know that they are only creatures after all.....	0	1	2	3
Q7.	The young owe the old complete economic security.....	0	1	2	3
Q8.	A retired person should be free of all taxes.....	0	1	2	3
Q9.	New laws shouldn't be made if they hurt a person's income.....	0	1	2	3

0 STRONGLY DISAGREE
1 DISAGREE
2 AGREE
3 STRONGLY AGREE

Q10.	There are no conditions which justify endangering the health food, and shelter of one's family or one's self.....	0	1	2	3
Q11.	Pensions large enough to provide for dignified living are the right of all when age or illness prevents one from working.....	0	1	2	3
Q12.	Most people who work for a living are just manipulated by their bosses....	0	1	2	3
Q13.	Thinking of yourself as a free person just makes you feel frustrated and unhappy.....	0	1	2	3
Q14.	Often I do not really know my own mind.....	0	1	2	3

Decide which of the two statements below BETTER represents your attitude.

CIRCLE either "A" or "B" for each item.

Q15. A. Becoming a success is a matter of hard work: luck has little or nothing to do with it.
B. Getting a good job depends mainly on being in the right place at the right time.

Q16. A. As far as world affairs are concerned, most of us are the victims of forces we can neither understand nor control.
B. By taking an active part in political and social affairs the people can control world events.

Q17. A. Most people don't realize the extent to which their lives are controlled by accidental happenings.
B. There is really no such thing as "luck".

Q18. A. Sometimes I can't understand how supervisors arrive at work evaluations.
B. There is a direct connection how hard I work and the evaluations I get.

Q19. A. Many times I feel that I have little influence over the things that happen to me.
B. It is impossible for me to believe that chance or luck plays an important role in my life.

Q20. A. What happens to me is my own doing.
B. Sometimes I feel that I don't have enough control over the direction my life is taking.

APPENDIX D

PRQ-85, PART I

PERSONAL RESOURCE QUESTIONNAIRE (PRQ-85)
Brandt and Weinert

In our everyday lives there are personal and family situations or problems that we must deal with. Some of these are listed below. Please consider each statement in light of your own situation. **CIRCLE** the number before the person(s) that you could count on in each situation that is described. You may **CIRCLE** more than one number if there is more than one source of help that you count on. In addition, we would like to know if you have had this situation or a similar one in the past SIX MONTHS, and how satisfied you are with the help you received.

==========

Q-1a. If you were to experience urgent needs (crisis), who would you turn to for help? (Please **CIRCLE** all that apply.)

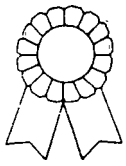
1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain) _____

b. Have you had urgent needs (crisis) in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-2a.)

c. If you have experienced urgent needs (crisis) in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED



Q-2a. If you needed help for an extended period of time in caring for a family member who is sick or handicapped, who would you turn to for help? (Please **CIRCLE** all that apply.)

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain) _____

b. Have you needed help in caring for a sick or handicapped family member in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-3a.)

c. If you have needed help in caring for a sick or handicapped family member in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-3a. If you were concerned about your relationship with your spouse, partner, or intimate other, who would you turn to for help? (Please **CIRCLE** all that apply.)

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain) _____

b. Have you had concerns about your relationship with your spouse, partner, or intimate other in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-4a.)

c. If you have had concerns about your relationship with your spouse, partner, or intimate other in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-4a. If you needed help or advice for a problem with a family member or friend who would you turn to for help? (Please CIRCLE all that apply.)

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain) _____

b. Have you needed help or advice regarding a problem with a family member or friend in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-5a.)

c. If you have needed help or advice in the past SIX MONTHS regarding a problem with a member or friend, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED

Q-5a. If you were having financial problems, who would you turn to for help? (Please **CIRCLE** all that apply.)

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain) _____

b. Have you had financial problems in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-6a.)

c. If you have had financial problems in the past SIX MONTHS to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-6a. If you felt lonely, who would you turn to? (Please **CIRCLE** all that apply.)

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain) _____

b. Have you felt lonely in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-7a.)

c. If you have felt lonely, in the past SIX MONTHS, to what extent do you feel satisfied with the help you have received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-7a. If you were sick and not able to carry out your usual activities for a week or so, who would you turn to for help?

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain) _____

b. During the past SIX MONTHS, have you been sick for a week and not able to carry out your usual activities?

1 YES
2 NO (If NO, skip to Q-8a.)

c. If you have been sick for a week during the past SIX MONTHS to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-8a. If you were upset and frustrated with the conditions of your life, who would you turn to for help?

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain) _____

b. Have you been upset and frustrated with the conditions of your life in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-9a.)

c. If you have been upset and frustrated with the conditions of your life in the past SIX MONTHS, to what extent do you feel satisfied with help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-9a. If you were having problems with your work at home or at your place of employment, who would you turn to for help?

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain) _____

b. Have you had problems related to your work in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-10a.)

c. If you have had problems with your work situation in the past SIX MONTHS, to what extent do you feel satisfied with help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-10a. If you needed someone to talk to about your day-to-day personal concerns, who would you turn to for help?

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain) _____

b. Have you needed someone to talk to about day-to-day personal concerns in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-11)

c. If you have needed someone to talk to about day-to-day personal concerns in the past SIX MONTHS, to what extent do you feel satisfied with help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

APPENDIX E

INDIVIDUAL BACKGROUND

Now here are a few questions about yourself and your family.

Q1. In what year were you born? _____

Q2. Your gender.

1. WOMAN
2. MAN

Q3. Which of the following best describes your racial or ethnic identification?

1. CAUCASIAN/WHITE
2. AFRO-AMERICAN
3. HISPANIC/MEXICAN AMERICAN
4. ASIAN AMERICAN
5. NATIVE AMERICAN INDIAN
6. OTHER (please specify) _____

Q4. What is your present marital status?

1. MARRIED
2. DIVORCED
3. SEPARATED
4. WIDOWED
5. NEVER MARRIED
6. COMMON-LAW
7. LIVING TOGETHER

Q5. What is the TOTAL number of years of school you have completed (include grade and high school as well as college or vo-tech)?

_____ NUMBER OF YEARS OF SCHOOL

Q6. What is your employment status? Please CIRCLE only <u>one</u> choice.

1. I WORK FULL-TIME FOR PAY (Includes farm/ranch work)
2. I WORK PART-TIME FOR PAY (Includes farm/ranch work)
3. I AM A FULL-TIME HOMEMAKER
4. I AM A FULL-TIME HOMEMAKER AND ALSO HELP WITH FARM/RANCH WORK
5. I AM A FULL-TIME HOMEMAKER AND WORK PART-TIME AT ANOTHER JOB
6. I AM UNEMPLOYED DUE TO MY AGE
7. I AM UNEMPLOYED DUE TO DISABILITY
8. I AM LAID OFF
9. I HAVE BEEN FIRED
10. I AM A FULL-TIME STUDENT
11. I AM A STUDENT (Full-time or part-time) AND ALSO WORK FOR PAY (Includes farm/ranch work)
12. I HAVE BEEN UNABLE TO FIND SUITABLE WORK BECAUSE OF WHERE I LIVE
13. OTHER (please specify) _____

Q7. If you answered Q-6 with a 1, 2, 4, 5, or 11 how many hours per week do you usually work for pay?

_____ HOURS PER WEEK

Q8. In what kind of business or industry do you work (retail store, custodial service, breakfast cereal manufacturing, ranch/farm?

_____

Q9. How long have you lived in your present home?
_____ LENGTH OF TIME

Q10. For this question, try to describe to a stranger from another part of our country about where you live. Your conversation may go something like this, "We live in Oakwood, OH, a community of about 35,000, which is actually an extension of Dayton, OH, a city of well over 600,000." You would place an X on line b. and 35,000 in the first blank space and 600,000 in the second blank space.

Please help us understand where you live.

a. ___ WE LIVE IN A CITY/TOWN WITH AN APPROXIMATE POPULATION OF _____.

b. ___ WE LIVE IN A SUBURBAN AREA OR A COMMUNITY THAT IS CONSIDERED AN EXTENSION OF ANOTHER MAJOR CITY. THE POPULATION OF THE SUBURBAN AREA IN WHICH WE LIVE IS _____ AND THE POPULATION OF THE MAJOR CITY IS _____.

c. ___ WE LIVE OUTSIDE THE CITY LIMITS OF A CITY/TOWN OF APPROXIMATELY _____ NUMBER OF PEOPLE. THE CITY/TOWN IS ABOUT _____ MILES FROM OUR HOME.

d. ___ WE LIVE ON A FARM/RANCH THAT IS ABOUT _____ MILES FROM A CITY/TOWN. THE POPULATION OF THAT CITY/TOWN IS _____ NUMBER OF PEOPLE.

e. ___ OTHER (Pease describe) _____

_____

Q.11. In what state and county do you live?
_____ STATE
_____ COUNTY

Q.12. How many years have you lived in the state?
_____ NUMBER OF YEARS

Q.13. In what state were you born?
_____ STATE OF BIRTH

Q.14. How many of your relatives live within fifty miles of you?
_____ TOTAL NUMBER

Q.15. Do you have a neighbor with whom you have a friendly relationship?

1. YES
2. NO

Q.16. How far away does this neighbor in Q-15 live?

1. NEXT DOOR
2. WITHIN A FEW BLOCKS
3. LESS THAN 1/2 MILE
4. BETWEEN 1/2 MILE AND ONE MILE
5. BETWEEN ONE AND THREE MILES
6. BETWEEN THREE AND FIVE MILES
7. FIVE MILES OR MORE

Q.17. How close are you emotionally to the neighbor in Q-15?

1. VERY DISTANT
2. SOMEWHAT DISTANT
3. MIDDLE OF THE ROAD
4. SOMEWHAT CLOSE
5. VERY CLOSE

Q.18. How often do you visit or call the neighbor in Q-15?

1. ALMOST NEVER
2. ONCE A MONTH
3. EVERY FEW WEEKS
4. ONCE A WEEK
5. FEW TIMES EACH WEEK
6. DAILY

APPENDIX F

HUMAN SUBJECTS REVIEW: APPROVAL FORM

FORM B

MONTANA STATE UNIVERSITY
COLLEGE OF NURSING

UNIVERSITY HUMAN SUBJECTS COMMITTEE SUMMARY

Name of Proposal: Dimensions of Health and Rural Dwellers' Health Care Resources

Name of Investigator/s: Lorinda M. Doede
(Circle one: undergraduate student/s, graduate student/s, faculty member/s)

Faculty Advisor (if student research): Dr. Mary Burman

Date of College of Nursing Review: _____

Reviewed by:
(List College of Nursing reviewers involved by names and type of committee, e.g. J. Doe, Great Falls Extended Campus Committee)

Janice D. Hausauer 5/12/92

[illegible] 5/12/92

Approved by:

Campus H.S.R. Committee [illegible] 5/12/92

Education Director [illegible] 5/12/92

Brief Description of Subjects (age, sex, health status, etc.)
(To Be Completed by the Investigator/s)

This is a secondary analysis of a data set that includes a community sample of well adults over 20 years of age.

Brief Description of Procedure (what is to be asked of or done to subjects)
(To Be Completed by the Investigator/s)

This is a secondary analysis of the Eagles' data set from Dr.Weinert's and Dr. Burman's existing data set.

[XX] Exempt Under Federal Reg. 45 CFR 46.
46.101 (2) (b) (5)
(insert number and letter as appropriate)

OR

[ ] Questionable or Ruled Not Exempt Under Federal Reg. 45 CFR 46

*Proposal sent to College of Nursing Dean for Review
on _____

FORM B

[X] Ruled Exempt by College of Nursing Dean

Julie E Johnson
Signature

5/18/92
Date

Explanation: Secondary data analysis

OR

[X] Sent to University Human Subjects Review Committee by College of Nursing Dean

5/18/92
Date

Notes: Distribution of this form: (After Exempt Ruling OR after review by College of Nursing Dean).

Original: Investigators

Copies: Campus File
College of Nursing Human Subjects Review File in Bozeman
University Human Subjects Committee through College of Nursing Assistant Deans' Office

11/16/88:F-4.POL

APPENDIX G

LETTER OF AUTHORIZATION

The Montana Family Cancer Project

Clarann Weinert, S.C., Ph.D., R.N.
College of Nursing
Montana State University
Bozeman, Montana 59717
(406) 994-6034

Lloyd Bender, Ph.D.
1-108 Wilson Hall
Montana State University
Bozeman, Montana 59717
(406) 994-4481

March 16, 1992

TO: Bozeman Campus Human Subjects Review Committee

FR: Clarann Weinert Clarann Weinert

Ms. Lorinda Doede has permission to use selected data from the Montana Family Survey which is being conducted by the Montana Family Cancer Project for the purpose of secondary analysis for her thesis. She will be examining the relationship of hardiness and health to rural's dwellers decisions to use health care resources. At the end of the project, and after a period of time adequate for her to publish the results, the data will be properly disposed of. I usually allow a year for students to publish findings from their research. Since I will be second author on the student's publications the data are protected. Please be aware that the Montana Family Cancer Project is federally funded and that the sub-study the Montana Family Survey is funded by the National Fraternal Order of Eagles and that both projects have approval from the MSU Human Subjects Committee. Secondary analysis are exempt as long as no identifiers are present; as is the case in Ms. Doede's work.

Lorinda Doede
1612 West Olive #13
Bozeman, MT 59715
March 12, 1992

Clarann Weinert, SC,PhD,RN,FAAN
College of Nursing
Montana State University
Bozeman, MT 59717

Dear Dr.Weinert,

I would like your permission to do a secondary analysis on the data collection from the Family Health Survey, which is being conducted as a part of the Montana Family Cancer Project. I am interested in using the data from the instruments: PRQ-85 Part I, Hardiness Scale, CES-D Scale, Health Care Scale Q-1, and the demographics. My thesis involves exploring dimensions of health and how they influence the rural dweller's choice of health care resources.

Thank you for your consideration.

Lorinda Doede

Lorinda Doede
Graduate Student