

HEALTH BELIEFS AND PRACTICES OF 'REGULARS' AT THE RURAL BAR

by

Kathy Palm Jorgensen

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

of

Master

of

Nursing

MONTANA STATE UNIVERSITY
Bozeman, Montana

April 2006

©COPYRIGHT

by

Kathy Palm Jorgensen

2006

All Rights Reserved

APPROVAL

of a thesis submitted by

Kathy Palm Jorgensen

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.

Jean Shreffler-Grant, PhD, RN
Committee Chair

Approved for the College of Nursing

Elizabeth Nichols, DNS, RN
Dean

Approved for the College of Graduate Studies

Joseph Fedock, PhD
Interim 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 paper 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 paper in whole or in parts may be granted only by the copyright holder.

Kathy Palm Jorgensen

ACKNOWLEDGEMENTS

My deepest appreciation to my committee chair, Dr. Jean Shreffler-Grant, for her guidance, support, patience, and expertise with this thesis. I am grateful also to my committee members, Deanna Babb and Doris Henson, for their support, encouragement, and guidance.

Thank you to my husband and daughter for their ongoing support and patience with my perpetual quest for knowledge. I will be ever grateful to my colleagues, professors, and co-workers for their insight and support.

Finally, I am especially indebted to the men who were willing to share a part of their lives with me. They have contributed to nursing knowledge and may have influenced health care more than any of us realize.

TABLE OF CONTENTS

ABSTRACT.....	viii
1. INTRODUCTION	1
Background and Significance	4
Conceptual Framework.....	5
Purpose.....	10
Definitions.....	10
2. REVIEW OF LITERATURE	13
Alcohol and Health Problems	13
Health Care Use	15
Rural Alcohol Use.....	16
Psychosocioeconomic component	17
Provider Choice	21
Cognitive Social Theory	24
Summary	26
3. METHODOLOGY	28
Project Design and Data Collection.....	28
Project Design.....	28
Sample Selection.....	28
Instrument and Data Collection	29
Human Subjects Approval	30
Data Analysis	31
4. RESULTS	32
Demographics	32
Health Beliefs and Practices	35
Cognitive Social Theory	40
Symbolizing Capability	40
Familial and Social Transmission Models	40
Vicarious Capability	44
Forethought and Self-Regulatory Capability	44
Self-Reflective Capability.....	45

TABLE OF CONTENTS – Continued

4. DISCUSSION.....	47
Summary.....	50
Limitations.....	51
Recommendations for Further Study.....	52
Conclusion.....	53
REFERENCES.....	55
APPENDICES.....	67
Appendix A: Interview Guide.....	68
Appendix B: Subject Consent Form.....	72
Appendix C: CAGE Questionnaire.....	75
Appendix D: AUDIT Questionnaire.....	77

LIST OF TABLES

Table	Page
1. Income categories of participants	34
2. Distance to health care facility.....	35

ABSTRACT

Montana has one of the highest per capita rates of alcohol consumption. While alcohol use in rural areas has not been documented to be higher than in urban areas, rural residents have been recognized as having unique perspectives on health. This study was designed to explore the health beliefs and practices of rural men who regularly frequent the local bar. Understanding the perspective of this group may add to the body of knowledge used by Advanced Practice Nurses to work effectively with these men.

Interviews with ten men from four rural communities with no local health care facility were undertaken to explore the health beliefs and practices of this group. Bandura's Cognitive Social Theory was chosen as the theoretical framework to address how these men perceived health, health care, and health care providers as well as their own ability to control their wellness.

The participants identified lack of pain and ability to function in daily tasks as being healthy. Most of the participants (90%) believed they had a great deal of control over their own well-being with physical activity being the most common self care activity. They avoided health care until unable to manage the illness or injury themselves then would choose a provider based on word of mouth, convenience, cost, and "knowing" the provider. Participants demonstrated an ability to change lifestyle patterns if they perceived the change to be important.

Participants would avoid or not return to a provider who was rude, judgmental, or did not provide adequate pain control. Most named the bar as a place for socialization. Subjects were aware of the risks of smoking and excess alcohol but did not plan to change these activities in the absence of symptoms of disease.

This study suggests that providers would be well served to a) assess the health care priorities of the 'regular' and tailor care to those perceived risks, b) make an effort to 'know' the patient by assessing social situation and lifestyle, c) portray an open, friendly, non-judgmental demeanor, and d) provide specific, clear information about personal risks/symptoms of disease with individualized suggestions about self-help measures.

CHAPTER 1

INTRODUCTION

Alcohol has been so ubiquitous in the societies of the world that as of 1970, there were only three known societies unfamiliar with fermentation, the Australian Aborigines, the Tierra del Fuegos, and the Eskimos (Falk, 1970). It is recognized that excessive alcohol intake is associated with maladies ranging from aggressive irrational behavior and cardiomyopathy to drinker's nose leading to decreased quality of life and lifespan. (Babor, Higgins-Biddle, Saunders, & Monteiro, 1999; Graham, 2003; Kelleher, 1997; White, and Nanchahal, 2004). However, moderate drinking is associated with an overall modest increase in lifespan (Gunzerath, Faden, Zakhari, & Warren, 2004) and "Drinking patterns are as important as total consumption in terms not only of alcohol's benefits but also of its harmful consequences" (pg. 830-1). There is evidence that even brief interventions of 5-20 minutes by a health care provider can moderate the alcohol consumption of drinkers (Babor, 1996; Fleming, 1997). Drinkers also can learn to control their intake in the public setting through community awareness projects (Beurden, Reilly, Mitchell, & Beard, 2000; Worden, Flynn, Merrill, Waller, & Haugh, 1989).

Montana is ranked 10th in average per capita alcohol consumption of 2.8 gallons per individual 21 years old or over despite ranking 44th in population in the U. S. Wyoming and New Mexico share this ranking with Montana for per capita alcohol consumption. There are about 2300 active on premises liquor licenses in Montana according to D. Koon of the Montana Tavern Association (personal communication, January 10, 2005).

This means that there is a liquor license for every 300 people over the age of 18 in Montana. Based on this data, alcohol use and its consequences will affect the practice of the Family Nurse Practitioner (FNP) treating clients in rural Montana. Intervening with the problem drinker will require that the FNP screen for alcohol problems and provide appropriate education, counseling and referral for the client risking and/or suffering the consequences of excess alcohol use. In order to do this, the FNP will need knowledge about the health beliefs and practices of clientele likely to have alcohol related disorders

Katovich and Reese (1987) described 'regulars' as a self-identified group in a bar to which one gains access by specific activities, attendances, and behaviors determined by the membership. Although, there is little research on 'regulars' in the rural bar, Campbell (2000) describes similar behaviors and roles among frequent after work drinkers in rural taverns in New Zealand. These men are often found in the local tavern, form a hierarchal, exclusive social structure (Hunt & Satterlee, 1987), and exhibit structured behaviors. They tend to consume significant amounts of alcohol, presumably putting them at risk for the negative health consequences associated with excessive alcohol use.

Men are generally accepted as the primary patrons of most drinking establishments (Campbell, 2000; Falk, 1970; Gatti, 2003; Hunt et al, 1987; Mandelbaum, 1965; Marshall, 1979). Patterns of alcohol consumption tend to peak in adolescence and young adulthood when drinking may be viewed as a part of the process of normal development (Muthen and Muthen, 2000; Quigley and Marlatt, 1996; Wells, Horwood and Fergusson, 2004). However, drinking patterns of middle-aged adults tends to be stable even in the

face of stressful life events (Perreira & Sloan, 2001; Temple & Leino, 1989). Older adults tend to maintain or decrease levels of alcohol consumption with the passage of time (Mirand & Welte, 1996; Moos, Schutte, Brennan, & Moos, 2004). Of the 5-7 % of the population with diagnosable alcohol abuse or dependence, less than 10% seek treatment and the success rates of various treatment programs tends to be so low that some sectors are now recommending harm reduction as opposed to abstinence (Marlatt, 1997; Parker-Pope, 2002; Stockwell, 2001). Harm reduction involves resuming or developing a pattern of non-harmful alcohol use. There has been research to indicate that patients choosing moderation can be successful and some of these patients progress to choosing abstinence (Ambrogne, 2002; Hodgins, 2005; MacMaster, 2004; Sobell & Sobell, 1995).

Rural dwellers have been recognized as a culture suspicious of “outsiders” (Lee, 1998). Further, at-risk drinkers in rural communities perceive a lack of privacy in primary care (Fortney, Mukherjee, Curran, Fortney, Xiatong & Booth, 2004). Rural populations (Leight, 2003), poor men (Treadwell & Ro, 2003) and men (Meyer, 2003) have all been suggested to be vulnerable populations in relation to access to and use of health care resources. Schmidt (1994) and Shreffler (1999) emphasized that to be effective research techniques need to be culturally sensitive in rural/frontier populations. Therefore to best serve rural men who drink to excess, nursing is well-advised to have, at least, a rudimentary understanding of the health beliefs and practices of this hard to reach population.

Background and Significance

It is the role of the nurse practitioner to assess all aspects of the individual's health including physical, mental, social, and emotional wellness. To be most effective, the FNP will need to understand community functions and roles of the individual in the community. Knowing that rural residents tend to view "outsiders" as less trustworthy, it will be important for the FNP to be aware of what constitutes "acceptability" of health care and health care providers in the rural setting. ". . .acceptability reflects an opinion, a judgement, and personal preferences on the part of consumers" (Shreffler-Grant, 2006, p. 172). Thus to effectively access this population, the FNP will need to look at relational skills and public perception as well as competence and accessibility.

Understanding that men have a variety of motives for drinking (Gire, 1999; Woldt & Bradley, 2002) and that at-risk drinkers have some specific personality characteristics (Grande, Wolf, Schubert, Patterson, & Brocco, 1984; Wolff & Wolff, 2002) will aid the FNP in providing the most appropriate care to these individuals. As well, there is a strong emotional and social component to the drinking patterns of men who attend the tavern that will impact intervention (Kuntsche, Rehm, & Gmel, 2004). Attendant pressures to drink and drink well as exemplified by "consuming such large quantities of beer and yet maintaining the appearance of total sobriety and self control" (Campbell, 2000, p. 571) will be important for the FNP to acknowledge in order to be effective. Despite the known negative social, economic, and health effects of excess alcohol use, there is some disagreement about how much of the effect is due to alcohol and how much

is due to attendant behaviors and social circumstances (Barrett, 1995; Mortensen & Reinische, 2003; Rehm, Richter, & Elton, 1993; Stanridge, Zylstra, & Adams, 2004). Alcohol consumption was found to be more acceptable for men at a bar with friends, at a party at someone else's home, for a husband out to dinner with his wife, with friends at home, and for a woman out at a bar with friends (in that order) than with co-workers at lunch, when driving a car or for a parent spending time with young children in the work of Greenfield & Room, (1997). Therefore, the FNP will need to continue to do the entire history and physical recognizing all of the factors that can contribute to ill health in any client. Because there has been a documented J-shaped curve relating moderate alcohol use to improved outcomes for a number of disease processes (Kesse, Clavel-Chapelon, Slimani, vanLiere, & the E3N Group, 2001; Stanridge, et al, 2004; White, et al, 2004), the FNP will want to determine the actual amount of alcohol intake on a regular basis as well as the pattern of intake (Stenson, 2004). Rehm et al (2004) further suggested that social and environmental context affect substance use and abuse obviating the necessity of a complete social history.

Conceptual Framework

What the individual perceives as health, how important good health is to the client, and how much influence that person believes they have over their own life (Armitage, 2003) are important components of the choices made. The work of Newsom et al (2005) suggested that health behaviors of North Americans are highly individualized. In their review of several studies, Cohen, Kaplan, and Salonen (1999) reported conflicting data

regarding socioeconomic status and relationship to smoking, health behaviors and mortality. Specifically, they noted that the “lowest and highest SES (socioeconomic status) consumed the most alcohol and exercised the most” and “Relations between health practices and perceived poor health were more consistent . . . than were relations between health practices and SES”. (p. 464). Mortensen et al (2003) suggested that socioeconomic status may be more significant than alcohol use in health related problems. Essentially, the FNP will need to recognize the complexity of these interrelationships and the factors relating specifically to the client in question. Knowing that the ‘regular’ comes from a particular cultural and social context may help to formulate a realistic plan for the individual seeking assistance.

Bandura’s Cognitive Social Theory (CST) offers some explanation of how people make choices in their lives (Bandura, 1989; Perry, Baranowski, & Parcel, 1990; Resnick; 2004). To understand some of the health related behaviors in which people engage, Bandura’s Cognitive Social Theory (CST) will serve as the conceptual framework in this study. In this theory the person, environment, and behavior (Figure 1) are all continually interacting and affect each other, not always equally, in a process called reciprocal determinism (Perry, 1990).

Bandura recognized that human behavior is complex and shaped by many factors. Humans have a number of unique capabilities. People are able to symbolize through language development and writing abilities (symbolizing capabilities). The language we learn to use affects our perception of our world, our values, and beliefs (Bandura, 1989).

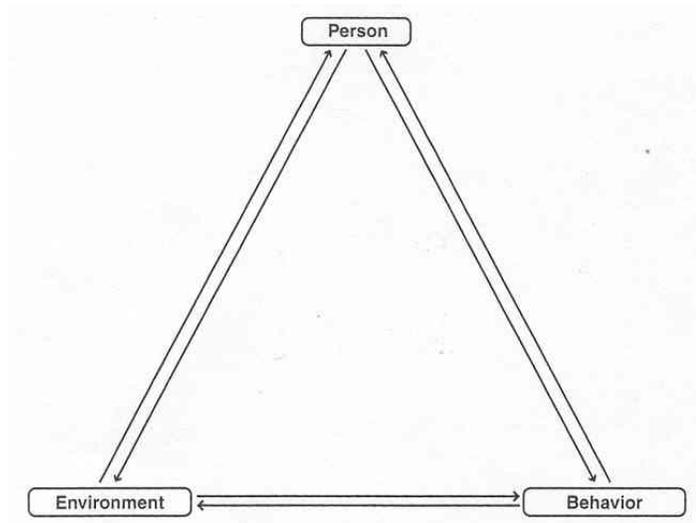


Figure 1 – Reciprocal Determinism

People are able to learn vicariously with their perceptions of social reality strongly influenced by these observational experiences (vicarious capabilities). This vicarious learning is affected by the attention paid to specific events, how much and what is retained, as well as what in the circumstance is valued by the observer. It is also possible to develop an understanding about emotional responses by observing the behavior of others. Much gender role development occurs via vicarious learning.

Forethought capability is another human function. People are able to anticipate the result of their behaviors. Humans are also able to recognize that different outcomes are possible in response to the same actions. Based on previous experiences, people expect certain responses to specific behaviors (expectancies) thus tending to act in a way that would be likely to produce to expected outcome.

People are able to choose to moderate their own behavior for various reasons (self-

regulatory capability). This self regulation is the result of the development of moral standards and is influenced by prevailing social and moral standards. Acceptable behavior is reinforced physically and socially with family and peers having strong influence on what is deemed acceptable behavior. Changing one's behavior is also strongly influenced by self-efficacy. Perry (1990) stated "self-efficacy is the most important prerequisite for behavior change" (p. 174). Do these individuals believe that they can effect a change in their health status by engaging in certain behaviors or do they believe that some life events are inevitable? Do they have a belief that powerful others will make a difference? Some of this self-efficacy is the result of their personal mastery experiences and some may be due to vicarious learning. Resnick (2004) noted "self-efficacy is highly context or situation dependent" (p. 112).

Bandura theorized that people are able to look back and evaluate previous actions and their results on self and others (self-reflective capability). An individual is able to conceptualize possible variant results of an action based on previous experience, values, and beliefs. A person can watch another's actions, see the results and postulate how a different approach might work, whether the benefits of the action are worth the risks involved, and if the action and results are acceptable. This reflection is subject to internal morals, persuasion from others, and to logical evaluation. Family and society are postulated to be the primary means of transmitting values and beliefs within the population through a process called familial and social transmission modeling. Social persuasions serve as reinforcements to vicarious learning and personal mastery of specific situations. Verbal and non-verbal judgements of others can influence beliefs and

practices (Resnick, 2004). Thus, it would seem logical, that people who spend a significant amount of time with cohorts at the rural bar would be influenced to some degree by those associates. This assumption is supported by the works of Campbell (2000), Hunt et al (1987), and Katovich (1987). Therefore, the rural nurse practitioner will be well served by understanding this social context in aiding the consumer to change behavior within the group dynamic.

The nurse practitioner will need some understanding of the client's perception of health (expectancy) in order to help that person achieve his/her wellness goals. In general, rural residents have been found to define health in terms of being able to complete daily tasks, to function (Long, 1993). Since rural men are rural residents, one would suspect that this definition may apply. However, this may be a group with unique views or values which will need to be understood.

SCT recognizes that beliefs can change based on situation, feedback, and cognition. In other words, accepted behavior can change depending on the thought processes occurring within the individual (person), the particular action (behavior), and the social context (environment). Each aspect (person, behavior, environment) affects the other two domains. The degree and direction of this influence will change with each activity. A behavior deemed acceptable at the tavern may be completely unacceptable at the local church. An unacceptable behavior within the tavern tends to be quickly quashed by negative feedback from peers (Campbell, 2000; Gatti, 2003, Hunt et al, 1987; Katovich, 1987).

Purpose

The intent of this study was to explore the health beliefs and practices of ‘regulars’ at the rural bar. These individuals (regulars) are often perceived as heavy drinkers with poor health habits who are responsible for a significant portion of the social ills of the community and, in later years, become expensive health care consumers due to the chronic health problems associated with excessive alcohol use. The rugged, independent individualist is an image associated with this group in their younger years. Understanding the beliefs and practices of these men will aid the FNP in developing an appropriate approach to treatment, formulating effective care plans, and making acceptable referrals. Using semi-structured interviews, this work sought to describe the perceived personal efficacy related to health, knowledge of personal health risks, positive and negative health practices, and methods of determining when and where to access formal health care among ‘regulars’ at the rural bar. Interviews of 10 individuals who frequented rural taverns three or more days per week were conducted. These interviews sought information about health practices and expectancies as well as acceptability of health care providers to these individuals.

Definitions

“Regulars”

The term “regulars” is not given a definition that works well for nursing or medical research in the work of Katovich (1987), Wall, Thrussell, and Lalonde (2003) or

Campbell (2000). Therefore, for this study, “regulars” were initially identified by bartenders who work in excess of 25 hours per week, with additional potential participants being identified by snowball technique. A minimum requirement was the presence of the individual in the establishment for 1 hour or more than 3 times per week. Since there are documented differences in the drinking behaviors, alcohol expectancies, and outcomes between men and women (Fillmore, 1987b; Makela & Mustonen, 2000; Satre & Knight, 2001; Treno, Alaniz, & Gruenwald, 2000; Wall, et al, 2003; Weisbeck, 2003; Wilke, 1994), this study will include men only.

Since drinking patterns tend to change over time (Fillmore, 1987a; Harnett, Thom, Herring & Kelly, 2000; Kunz & Graham; 1998), peak in late adolescence/early adulthood (Chen & Kandel, 1995; Muthen et al, 2000; Quigley et al, 1996; Wells, Horwood, & Fergusson, 2004), tend to be stable in the middle years (Perreira et al, 2001; Temple et al, 1989), and decline with aging (Mirand et al, 1996; Moos et al, 2004), participants in this study will be aged 30-55 years. There is some conjecture that drinking levels may decrease with age due to chronic health problems (Barrett, 1995; Mirand et al, 1996). There is an increased incidence of health problems related to drinking in older people and these drinkers were more likely to have been warned to decrease their intake than younger drinkers (Makela & Mustonen, 2000). Fifty-five years is chosen as the upper age limit on the premise that most men, at this age or younger, will be less likely, than older men, to be experiencing large numbers of chronic health problems that would influence their drinking and health behaviors.

Rural

The Bureau of Census definition of rural will be used. “Under this definition, all persons living . . . in places (cities, towns, villages, etc.) with a population of 2500” (United States General Accounting Office, 1993) or less outside of an urban area are considered rural. This is also consistent with the definition used by the United States Department of Agriculture as a completely rural population. Modifications to these definitions in 2003 changed the designations only by excluding areas associated with a metropolitan area. These modifications affected the status of only two areas in Montana, Missoula County and Carbon County. Cascade County and Yellowstone County remain metro areas, therefore, these four counties will not be included in this study.

Bar

Bar will be an establishment that primarily serves alcohol. Other services such as gambling, food or gasoline may be offered. Various terms such as tavern, saloon, joint, or liquor store may be used to describe the business wherein the consumption of alcohol occurs.

CHAPTER 2

REVIEW OF LITERATURE

In this chapter, a review of literature is presented relating to health problems and health care utilization of alcohol users, rural alcohol users, and psychosocial components of alcohol use. Literature related to provider choice and acceptability as well as literature regarding cognitive social theory with regard to alcohol and behavior is summarized.

Alcohol and Health Problems

Excessive alcohol intake is strongly correlated with negative health consequences, however, moderate drinking may have health benefits. White et al (2004) in a study of men and women in England and Wales quantified alcohol consumption and its consequences. Their research found that, due to the reduction in ischemic heart disease deaths, men who drink moderately may actually have a reduced death rate after age 65. This study indicated that drinking above 21 units/week (a unit is 9 g of alcohol which is approximately equivalent to one shot of distilled spirits, 12 ounces of beer, or 5 ounces of wine) was clearly associated with years of life lost. Fleming (1997) defined problem drinking as more than 14 drinks per week for men. Rehm, Gmel, Sempos, and Trevisan (2003) in their synopsis of the physical consequences of alcohol use found support for the J-shaped curve of alcohol use. That is, light to moderate drinkers experience benefits from alcohol use greater than abstainers or heavier drinkers with the incidence of morbidity and mortality increasing with the amount of alcohol consumed on a regular basis. This work suggested the pattern of drinking, specifically binge drinking, as well

as consistent heavy drinking has a negative health influence. The consequences of the pattern of drinking is well established in the literature (Mukamal et al. (2005), Trevisan et al. (2003), San Jose, Van Oers, De Mheen, Garretsen, and Mackenbach (2000), and Rehm et al. (2001). That sick former drinkers and other confounding factors may unnecessarily skew the mortality and morbidity results of the abstainers is argued by Fillmore et al. (1998). This possibility was considered in the work of Leino (1998) which found no evidence “that abstinence is associated with greater mortality risk than light drinking” (p. 205), Mukamal et al (2005) finding no difference between long-term abstainers and drinkers of less than 2 drinks per day for risk of ischemic stroke, and Trevisan et al (2003) who found that regular drinkers had slightly lower risk of non-fatal myocardial infarction than life-time abstainers and binge drinkers.

Despite such confusing results, Rehm et al. (2001) demonstrate a clear relationship between excessive alcohol intake and nearly 70 disease processes. Rehm, Ficher, and Elton (1993) found a relationship between alcohol intake, smoking, and increased mortality and Gunzerath, et al. (2004) found a significant relationship between diminished physical health and heavy drinking. While Stanridge et al. (2004) found “no compelling reason to recommend cessation of alcohol consumption in individuals who have demonstrated a pattern of moderate and non abusive consumption” (p. 664), the acceptable maximum of consumption of alcohol tends to be as little as $\frac{1}{2}$ a standard drink per day. Thus, the preponderance of the research literature strongly suggests that excessive alcohol use is a risk factor for decreased wellness.

Health Care Use

Reid et al. (2000) studied health services use by veterans over 65. A U-shaped trend was noted between alcohol use and use of health care services using the CAGE (Appendix A) screening tool. McPherson (2004) found that loss of life related to alcohol in young men tended to be from accidents. However, loss of life related to alcohol in older men was generally due to chronic diseases such as cancer, stroke, and ischemic heart disease which require larger health care expenditures. Thornquist, Biros, Olander, and Sterner (2002), in studying medical costs of alcohol abusers, found emergency department utilization of nearly 6% per year “related to acute or chronic alcohol use and its complications” (p. 305) and that these patients were expensive in terms of medical care provided. Polen, Green, Freeborn, Mullooly, and Lynch (2001) in a study of health care use found that current drinking patterns had little effect on short term health care costs. They hypothesized that current drinkers may not seek medical care on a regular basis. In a study of health maintenance organization medical use, Rice et al. (2000) concluded that “nondrinkers with a drinking history use more services because they are sicker than other nondrinkers and current drinkers” (p. 3). This study seems to support the argument by Fillmore et al (1998) about sick abstainers skewing the J-shaped curve of health consequences of heavy alcohol use and abstention from use of alcohol. Nonetheless, it is apparent from the research literature that heavy alcohol users and binge drinkers tend to be less healthy and utilize more health care dollars than light to moderate drinkers and long term abstainers.

Rural Alcohol Use

As early as 1976, research was being conducted about rural alcohol abuse. Smith et al. (1976) found that abusers tended to be less religious, older, and have a lower educational level than non-abusers. Nietert, French, Kirchner, Han, and Booth (2004) found no overall difference in the health care costs of urban versus rural drinkers although the rural drinkers tended to use the emergency room and be hospitalized more than their urban counterparts. Conversely, Booth, Kirchner, Fortney, Ross, and Rost (2000) found that rural at-risk drinkers tended to have more chronic medical problems, more severity of illness, and more frequent alcohol disorders than their urban counterparts. Furthermore, the rural residents tended to have lower educational levels and experience more problems with access, cost, and acceptability of treatment services. Their findings suggested that rural drinkers may wait until experiencing significant physical or social consequences before seeking treatment and that social support is important to seeking care. Catalano, Dooley, Wilson, and Hough (1993) found that employment was negatively correlated with alcohol abuse. In their work with low income rural adults seeking treatment for alcohol disorders in Montana and Colorado, Smith, Haynes, and Pearson (2000), found that pressure from employers and friends to obtain treatment had more effect than intervention from health care providers or family. Conversely, Babor (1996) found “Brief interventions [by health care providers] are consistently robust across health care settings and sociocultural groups” (p.948). Whitlock, Plen, Green, Orleans, and Klein (2004) suggested that intervention is useful with the risky alcohol user.

Affordability and accessibility of care is a common rural health care issue. As noted by Weiner (1995), rural residents have more chronic disease and disability than urban dwellers and one in six rural families lives in poverty compounding the problems of distance and lack of providers in rural areas. Garkovich and Harris (1994) noted that “Rural counties are three times more likely to be classified as ‘medically underserved’ than are urban areas” (p. 10) and residents are less likely to have social and health care programs to meet their needs. Celluci, Vik, and Nirenberg (2003) found that rural alcohol users drank in amounts similar to urban users but were less likely to seek inpatient treatment, more likely to be engaged in dangerous occupations, and less likely to seek help. However, empathy and understanding of the rural context were found to be important to rural alcohol users seeking help and to effectiveness of treatment services.

Psychosocioeconomic Component

A synthesis of studies of behavioral characteristics and familial influences from around the world, suggest that early childhood behavior is moderately predictive of the risk of alcohol and other drug dependence but is affected by family and culture (Rose, 1998). Similarly, Engels, Vermulst, Dubas, Bot, and Gerris (2005) found that problem drinking in young men was related to childhood aggression and low levels of family functioning. Family traditions and adult modeling impacted children in numerous and various ways in the study conducted by Ferrins-Brown et al. (1999). Children reared in a home where alcohol was a part of family life tended to incorporate that pattern into their adult lives. If both parents drank, there tended to be a perception of a satisfactory marriage although, at times, this contributed to a sense of abandonment if the parents did

not attend children's functions. If only one parent drank, negative consequences and familial strife were readily recognized by the children. When parents used alcohol as a coping mechanism, there was a tendency for children to adopt this coping strategy in their adult years. Toumbourou et al. (2004) suggested that drinking patterns on the transition from high school to post high school are predictive of adult drinking trajectories. Although some life events (such as becoming a parent) were found to influence drinking behaviors slightly, the greatest predictors for baseline annual intake and frequency of five drinks or more at one event were the best predictors of ongoing annual intake and frequency of drinking five or more drinks per occasion (Paradis, Demers, and Nadeau, 1999).

Hiller-Strumhofel and Kulkosky (2001) found that alcohol intake in rats was influenced by light and dark. They hypothesized that like food and drink intake, alcohol intake is influenced by circadian rhythms. Dawson (1996) noted an association between time that drinking occurs and social consequences. This investigation hypothesized that there is a correlation between social consequences and amount of alcohol intake rather than a circadian rhythm effect. Although early (6 AM-3 PM) drinking was associated with negative work consequences in Dawson's (1996) study, Roman, Blum, and Martin (1992) found evidence of co-workers 'enabling' problem drinkers on the job in some instances. This dichotomy is not unexpected according to Room and Makela (2000) as drinking and acceptable drinking behaviors are culturally defined. So, while drinking patterns may be influenced by circadian rhythms, consequences of temporal drinking patterns seem more related to social and employment norms.

Drinking patterns and context influence frequency and severity of aggression as noted in the work of Wells and Graham (2003). Indeed, Campbell (2000) suggested that verbal ‘cockfighting’ is part of the male social norm of the regular pub drinker. The male role was found to be strongly associated with quantity and frequency of alcohol use in the work of McCreary, Newcomb and Sadava (1999). Falk (1970), Mandelbaum (1965) and Marshall (1979) found drinking to be more consistently acceptable among males in cultures throughout the world. Drunken driving was noted as a typically male behavior in the work of Makela and Mustonen (2000). Levant and Habben (2003) suggested that rural men may be more traditional in their role than their urban counterparts. McCreary, Newcomb, and Sadava (1999) suggested that a traditional male role orientation may be a predisposition to alcohol related problems. Further, rural residents may suffer more social and economic consequences of alcohol use due to fewer employment opportunities and lack of anonymity (Kelleher & Robbins, 1997).

Greenfield and Room (1997) found that there are specific situations in which drinking and drunkenness are socially acceptable and that “drinking is a highly enclaved activity in social life” (p. 45). “Social availability indicators were consistently related to alcohol consumption. Being part of a social network in which alcohol was usually available, feeling obligated to consume alcohol . . . reporting being motivated to drink alcohol for social reasons, and friends’ and family’s alcohol consumption” (p. 497) were all related to participants alcohol consumption in the study conducted by Abbey, Scott, and Smith (1993). Orcutt (1993) noted not only that there are rituals surrounding group drinking activities but that solitary drinkers were substantially less social than group drinkers

although the numbers were very small and the study was limited to college students. In Europe, binge drinkers found “pressure from peers was one of the strongest influencing factors for binge drinking and seemed to outweigh parental influences, especially from late adolescence onward.” (Kuntsche, Rehm, & Gmel, 2004, p. 113).

Caswell, Pledger, and Hooper (2003) noted a stronger relationship between education and quantity of drinking than socioeconomic status and quantity of alcohol consumption. Barrett, Anda, Croft, Serdula, and Lane (1995) posited that protective cardiovascular effects of moderate alcohol consumption may be due to physical activity and other health practices. Rouillier, et al (2004) noted a strong association between such variables as occupation, diet, smoking, residence, and body mass index when drinkers were assessed in relation to type and amount of alcohol intake. They also found “low drinkers and abstainers had similar characteristics” (p. 74). Conversely, Newsom, McFarland, Huguet, and Zani (2005) found no significant relationship between diet, smoking, exercise, and alcohol consumption in North America. When looking at drinking patterns in the U. S., Knupfer (1989) found that “The idea that if one drinks at all, the goal must be to get drunk is probably more prevalent in the lower SES (socioeconomic status) groups”(p. 1315). Consequences of alcohol use, however, were found to be moderated by age, marital status, education, and employment in the work of Kunz and Graham (1998). Brujin, Korzec, Arndt, and van den Brink (2003) found the amount of alcohol consumption was not a valid indicator of alcohol use disorder in a group of wine drinking men who were functioning well in the community.

Alcohol use may be the result of certain psychological characteristics or psychological traits that may influence the expression of alcohol effects. Thurber, Snow, and Thurber (1989) noted that a gregarious alcoholic has an increased likelihood of being poorly socialized. Crum and Pratt (2001) suggested drinking to cope may be more common in anxious persons. Wang and Patten (2001), however, found that major depression was less of a predictive factor of increasing alcohol use in men than in women. In studying drunken driving offenders, Woldt and Bradley (2002) found that respondents drank to cope with negative emotions, for interpersonal facilitation, enhancement, and social motives. While Grande et al (1984) stated “studies indicate that the diagnoses of alcoholism, drug abuse, and antisocial personality show substantial interrelatedness” (p. 458), Powell and Peveler (1996) in their study of patients receiving treatment for alcohol dependence stated “Alcohol dependent patients are clearly not a homogenous group” (p.310). They suggested that different subgroups need different treatment approaches but that personality disorders were seldom documented in the clinical notes.

While there are may be certain characteristics associated with regular drinkers, it is clear that this is a heterogenous group. This heterogeneity may be enhanced or diminished by limiting the focus to rural regular drinkers. Based on the literature, there seems to be a social component to regular drinking behaviors as well as physical consequences.

Provider Choice

To be effective, the health care practitioner must first see the client. What then causes a person to decide to be seen and how does that individual choose a particular provider?

In her work with rural Appalachian women, Schmidt (1994) found that providers “knowing” the client and being willing to work with the family as well as the client was essential to the success of the provider in the community. Similarly, comments made by clients in Shreffler-Grant’s (2006) work on acceptability, emphasized the importance of the provider knowing the patient. Both of these researchers noted that trust is an important component of the provider being accepted in the rural community. Weinert and Long (1987) stated “Continuity of providers, a thorough understanding of informal help systems, and the involvement of indigenous persons as both workers and consultants appear to be factors of paramount concern when dealing with rural families” (p. 454). A patient’s perception of disrespect or unfairness influenced the likelihood of the patient delaying care and/or following advice of the provider in the work of Blanchard and Lurie (2004). This problem was particularly prevalent among minorities in their study.

In their work on healthy rural communities, Hornberger and Kuckelman (1998) found that rural residents identified accessible and technologically adequate healthcare as an important component of a healthy community. Rural residents recognized the need to support local health care facilities and were more likely to do so if located further from a large treatment facility (Shreffler, Capalbo, Flaherty, & Heggem, 1999). Borders and Rohrer (2001) found that “Individuals who had a family physician in their county were about 99 percent less likely to migrate” out of county for specialty physician care. Their work supported marital status as a predictor of choosing to remain locally for care or migrating to large centers with married people being more likely to migrate out of area

for care (p. 43). Miners' (1988) work suggested that access to care is influenced by family structure and income sources.

Hsu, et al. (2003) noted that patient trust is an important factor in the provider patient relationship and patients were more satisfied with their care when they felt they had chosen their primary care provider as opposed to being assigned a provider in a managed care environment. "Shorter office waits, having a specific clinician at the primary care site, better perceived choice of PCPs (primary care providers), and a longer duration of relationship with the primary care practitioner were associated with higher ratings of the patient-PCP relationship" (p. 270) in the work of Forrest, Shi von Schrader, and Ng (2003).

In their study of women's preference of gynecologic provider, Schmittziel, Selby, Grumbach, and Quesenberry, (1999) found that if women had an established provider, they preferred to continue with that provider for their gynecologic care and that previous experience with a type of provider was the strongest indicator of future provider preference. Consistent with findings of Borders, et al (2001) and Forrest, et al (2002), Sharma, Haas, and Stano (2003) found financial considerations had a stronger influence than attitudes in provider choice between medical and chiropractic physicians. MacGregor (1972) and Young and Larson (1970) have found that rural dwellers tend to socialize and shop in near proximity to their place of residence.

It would seem, then, that provider acceptability and financial considerations are important components of provider choice. Provider choice is influenced by a myriad of

factors other than acceptability and finances, however. In this review of literature, no research was found regarding provider choice or acceptability among at-risk drinkers.

Cognitive Social Theory

Cognitive social theory, social learning theory, and cognitive social learning are all terms used to discuss Bandura's cognitive social theory in a variety of texts and articles cited here. Social learning theory has been investigated in the naturalistic bar setting. Wall, et al (2003) looked at alcohol expectancies (what participants expected to occur) in relation to outcomes and found that participants generally experienced the outcomes expected except they had less risky and aggressive behaviors than predicted. There were notable gender differences with men tending to drink more than they had intended. Satre and Knight (2001) found differences in consumption patterns and expectancies between men and women and younger cohorts and older cohorts. Men expected more positive outcomes from alcohol consumption than women and older cohorts having less positive and negative expectancies than the younger cohorts. Correlations were found between the amount of alcohol consumed and the subjects expectancy of how much would alcohol be consumed but no correlation was found between whether a person planned to drink and initiation of alcohol use. In their study of treatment subjects maintaining abstinence from alcohol, Jones and McMahon (1996) found no increased abstinence when expectancies were weighted for value among 151 subjects. They recognized that all expectancies could not be evaluated and that individual differences not considered could have skewed their results. As well, self-efficacy, environment and specific behaviors were not incorporated into this study. When looking at drinking practices of college age subjects, Evans and

Dunn (1995) found that “subjects who drank more and endorsed more alcohol-related problems maintained strong alcohol expectancies, utilized avoidant emotion-focused coping strategies, and judged themselves inefficacious with regard to resisting an urge to drink” (p. 190).

In a study of health behaviors of young people, Steptoe and Wardle (2001) found that a high chance locus of control was correlated with a lower likelihood of adopting healthy behaviors such as exercise, eating breakfast, moderate alcohol consumption, fruit intake, avoiding fat, and fibre intake. A chance locus of control indicates neither the participant nor powerful others have control over outcomes. An external locus of control suggests that someone or something else has control of the situation while an internal locus of control can be associated with self-efficacy. Those with high internal locus of control were more likely to participate in healthy behaviors. Looking specifically at social learning theory and drinking behavior, Evans and Dunn (1995) found a relationship between low self-efficacy and increased alcohol consumption. Holyfield and Ducharme (1995) in their study of alcohol beliefs and drinking contexts found that alcohol expectancies and outcomes were significantly related to social context as well as to reasons for drinking. Men were more likely to drink alcohol when they were with larger numbers of people and were more likely to drink when with friends than with family or neighbors. Men who drank for social enhancement, to reduce negative affect, or in “masculine” contexts had more drinking problems. These patterns were markedly different in drinkers who experienced negative consequences of drinking behaviors with these men tending to work alcohol into their social context and having alternate

expectancies regarding alcohol use. “. . .drinking to modify affect emerges as the single most important influence on . . . indicators of problem drinking and outcomes” (p. 790). Frone, Russell, and Cooper (1993) found alcohol expectancies varied only by age, formal education and private self-consciousness. Older subjects, those with more education, and those with increased self-awareness were better at predicting the amount of their alcohol intake and the effect it would have on them. Those with depression and more frequent/recent alcohol use were less able to predict the results of their drinking behaviors and alcohol intake. They hypothesized, however, that their results could be limited by not looking at drinking patterns (only overall consumption) and that the questionnaires did not differentiate general vs. specific expectancies.

Courtenay, McCreary, and Merighi (2002) posited that “men are less likely than women to perceive themselves as being at risk for illness, injury and a variety of health problems” (p. 221) and were more likely to engage in riskier behaviors believing they had less control over their future health and that their actions would contribute to good health. Attitudes and roles play a part of the use of alcohol among men. According to McCreary et al (1999), “the more traditional attitudes men hold, the more alcohol they consume” (p. 117).

Summary

Alcohol use, misuse, and dependence have been present in most societies throughout documented history. Prevalence of alcohol use in Montana is one of the highest in the United States. There are multiple significant, long term health maladies related to

extended excessive use of alcohol even with varying definitions of “moderate” alcohol use.

It is recognized that the development of alcohol misuse or dependence is multifactorial with strong social influences. However, brief assessments and interventions by health care providers can moderate these behaviors and thus, perhaps, the negative health consequences of long term alcohol misuse.

There is, however, little understanding of the health beliefs and practices of the male, rural at-risk drinker. A cohort of drinkers, called ‘regulars’ has been identified in the literature who may be at-risk drinkers and who have a specific social milieu affecting their behaviors including health behaviors, perhaps their beliefs as well.

Primary care providers can assess problem drinking with tools like the CAGE (Appendix C) and AUDIT tool (Appendix D). Further, it has been shown that intervention by primary providers can impact drinking behaviors. However, to be most effective, the provider will need an understanding of the consumers’ health beliefs and practices as well as the social context of their health behaviors to develop an appropriate and effective intervention with the client.

CHAPTER 3

METHODOLOGY

This chapter delineates the methods used to conduct this research project such as data collection and project design. It includes a description of the population sample, survey instrument, and human subjects protection methods. Data analysis is also discussed.

Project Design and Data CollectionProject Design

The purpose of this study was to explore the health beliefs and practices of “regulars” at the rural bar. A descriptive design was used to identify the phenomenon of interest, the variables related to this phenomenon, and to describe those variables. Interviews guided by the conceptual framework were used to collect these data. The researcher then reviewed the findings for recurrent themes and concepts to glean theoretical meaning that provided implications for future research and practice.

Sample Selection

Participants were initially identified as regulars at a rural bar by a proprietor/bartender known to the researcher. Convenience sampling was used. Ten interviews were conducted in four different rural towns in Montana. It was recognized that this was a small sample subject to biases therefore the researcher made an effort to be aware of

and to describe potential biases in the sample. Although the sample was designed to avoid participants with chronic medical problems, there were no criteria to screen for or specifically exclude participants with such conditions. When such a participant was included, it may have added to the richness of the data.

After the initial participants were identified, they and the bartender were asked about other potential participants in the study. Participants were contacted by phone or in person depending on distance from the researcher to request their participation and schedule an interview time and place.

Instrument and Data Collection

A semi-structured interview was chosen as the data collection tool for this study. The investigator developed a list of questions related to the theoretical framework and literature review. Demographic data were collected to permit description of the sample. Questions were perused and refined with the assistance of committee members with a rural research background (Appendix A, Interview outline).

Each participant was contacted by phone or in person with a time and place being set for the interview to take place. The bartender in most cases contacted the subject first, sometimes arranging the time and place of the interview. At other times, the bartender obtained initial consent of the subject to participate in the interview then provided the researcher with the participant's contact information. The site of the interview was chosen with attention to privacy and relative quiet. The interviewer chose a time and place to interview that the participant was unlikely to be intoxicated. Although this did

not occur, the plan was to reschedule or cancel the interview if the participant appeared to be intoxicated.

Participants were informed of precautions to insure privacy, the freedom to discontinue participation at any time, and that the interview might take one hour or more at the time of initial contact. Risks and benefits of participation were revealed to participants immediately prior to the interview. Permission was obtained for audiotaping of the interview either at initial contact or just prior to the interview. Note taking during the interview was avoided but was used when the recorder malfunctioned. Participants were not identified on the audiotape as a hired transcriptionist was utilized. The consent form (Appendix B) was reviewed and signed before the interview proceeded. None of the interviews were conducted by phone.

Human Subjects Approval

Consideration for the rights of human subjects was included in the planning of the study. The project proposal was approved by the Montana State University-Bozeman Human Subjects Committee on January 6, 2006.

Benefits of participation in the study included adding to the body of nursing knowledge related to health care beliefs and practices of 'regulars' at the rural bar. This knowledge may help health care providers provide more sensitive and effective care to this group of clients. The interview allowed the participants to express their concerns about quality of health care, effective health care providers, and health care choices in

rural communities. It gave participants the opportunity to voice their beliefs and concerns about health care in their geographic area.

Potential risks included potential invasion of privacy and use of the participant's time. Participants were assured that information would be coded to guard their privacy, that they would not be identified individually in the results, and that they could withdraw from the interview and/or study at any time.

Data Analysis

Thematic analysis was used as a method of organizing and describing the results of this qualitative work (Polit, Beck, & Hungler, 2001). Extensive field notes were taken to add to the development of this work. Interviews were reviewed and assessed for recurrent words, phrases, and concepts. Congruence of the use and meaning of these words, phrases, and concepts was sought and described.

CHAPTER 4

RESULTS

Ten subjects who frequented the local rural bar regularly were interviewed over a time frame of two months by the graduate student researcher. A convenience sample was used. Seven participants were recruited by bartender referral, two by snowball technique, and one by referral from a friend of the investigator. Seven of the interviews were conducted in the bar, one at the participant's office, and two were conducted in participant's homes. Interviews took from 30-60 minutes. Notes were taken regarding the first five interviews as there were problems with functioning of the recorder. Field notes and extensive verbal and hand-written notes were written the day of these interviews to expand and preserve the information missed by not having recording capabilities. Five interviews were recorded and transcribed. Identifying information was removed and the data were coded for recurrent themes. Congruence with the theoretical framework and literature search was noted, as were variances.

Demographics

The participants ranged in age from 38-52 years with a mean of 44. All of the participants were male as required by the criteria of the study. Subjects were all Caucasian. Four of the participants were divorced and single with two having been married only once, one having been married twice, and one having been married three times. Four subjects were currently married with two of them having been married once before. Two subjects had never married and did not mention being in any long term

relationship. One of the participants had completed school through his junior year in high school. Nine participants had graduated from high school with three participants having had some training as Emergency Medical Technicians. Three participants had a college degree and two had a post-high school training certificate. Five of the participants were currently employed, one was retired from the Army but did work at odd jobs in the community, one was living on the proceeds of his lottery winnings, one was a full-time parent, one was seeking employment, and another worked when work was available but was not actively seeking employment. Three of the unemployed participants said that local residents hired them for various jobs to help them out. Occupations (even if not currently employed) were machinist, outfitter/carpenter/bartender, construction worker, hardware store owner, plumbing/heating, retired Army, computer maintenance, ski patrol/construction, materials manager/rancher, and miner. Income categories are listed in

Table 1.

Income Categories	n	%
<\$10,000/year	1	10%
\$10-20,000/year	1	10%
\$20-30,000/year	2	20%
\$30-40,000/year	1	10%
\$40-50,000/year	4	40%
Unknown	1	10%

Time of residence in the rural community varied from 1 year to lifetime. Seven of the participants were Montana natives. Of the seven who were Montana natives, two spent some time out of the state in military service, three had lived in Montana essentially all of their life and one returned to Montana as an adult after spending his childhood in

California. The three participants who were not Montana natives chose to move to Montana after having been to the state previously. All specifically chose to move to small communities. Two of the participants currently had Veteran's Administration (VA) benefits. One participant had insurance through his wife's employment. None of the other seven participants had current insurance coverage. Three of these uninsured participants mentioned accessing health care more often when they did have health insurance. One of the participants had multiple health problems which were managed by the VA and he reported accessing care regularly by traveling a distance of 77 miles to the closest VA facility. The other participant with VA benefits did get some management of his hypertension but did not discuss regularly accessing health care other than for his blood pressure. Although several other participants did mention some illnesses, no other participant reported regularly accessing health care.

Five of the participants lived less than 30 miles from a primary care facility. The other five participants lived 40 miles or more from any health care facility. All but one lived 50 miles or more from an urban area with a major hospital.

Table 2. Distance to health care facility for study participants

<u>Number of participants</u>	<u>Miles to primary care</u>	<u>Miles to major hospital</u>
4	26	55
1	28	28
3	--	75
2	40	58
<u>Mean distance</u>	<u>21.2</u>	<u>58.9</u>

Participants came to the bar just to visit, to play pool, darts, or cards, to see friends, to eat, and for social events. Time in the bar was rated as one hour to an entire afternoon or evening and varied depending on day and activity occurring at the bar. Most of the

participants could not or would not quantify their alcohol intake. Five were beer drinkers, one drank vodka and orange juice, two drank whiskey, and two drank a variety of beverages. Quantities consumed and amount of time in the bar were variable and were influenced by other activities in their lives. One participant mentioned spending less time in the bar due to getting older and to the fact that his wife was not well. In response to the question, “How often are you in here?” he responded, “Usually not for very long because my wife is in a cast and a wheelchair and a walker so I try to get home and take care of business.” He said he was not in the bar as much anymore “Just because we’re getting older and we are doing a lot to our house.”

Health Beliefs and Practices

The 30-55 year age range was chosen for this study on the assumption that most of these individuals would not yet be experiencing significant long term health problems. Most of the participants defined health as being able to function and/or not being in pain. This is consistent with the rural definition of health noted by Long (1993). Two of the men mentioned formal preventative health care. One stated that it had been since 1992 that he had any preventative health care and thought it might be a good idea to see how he was doing. He had a family history of hyperlipidemia and was aware that increased his risk. The other man who spoke of wellness care said,

I know you need to watch your cholesterol and there’s a bunch of different things. I think it is those high blood pressure, that kind of stuff that’s the one that sneak up on you because you don’t watch it. I think they ought to do a once a year physical for next to nothing to make people go in there and do it. You know, I think if you get your blood pressure checked all the time. I mean, I just had this friend who was diagnosed with leukemia and she is going through all this stuff,

you know. I am like if that ever happened to me, I don't go to the doctor. They are not going to find out about it until it is probably too late. That's what scares me.

The other eight participants generally talked of managing most illnesses or injuries themselves. If the illness or injury could not be managed by themselves or informal sources and interfered with functioning, then they would seek formal health care.

One participant described injuring his leg on a Friday, finishing the day, working all day Saturday, then presenting to the clinic for care. He was found to have three fractures in his leg requiring pinning and plating. He had planned, prior to that hospital visit, to return to work on Monday. Another described delaying care for a tendon injury, "How long did it take before I went in? I was on the job another week before I actually got to the point where I couldn't . . . It was a week before I went in and they looked at it . . . It still occasionally bothers me and it is going to be forever. It is one of those things." In response to the question, "how bad does it have to be for you to go in and be seen?" one participant responded, "Where it was stopping me from going to work. If I couldn't go to work, then I need to go see somebody to get that taken [care of]." Another said if it couldn't be fixed with duct tape or super glue, he would go in. Inability to work or unmanageable pain were regularly given as causes for seeking formal health care. Ninety percent of the participants mentioned cost as a reason for delaying or avoiding health care. Half of the participants talked about management of illness such as using super glue for lacerations, self medicating for pain, or other self care techniques before accessing formal health care.

Nine participants considered working hard or being active as their primary preventative health behavior. One man “goes to the woodpile” [splitting logs with an axe] every day for his exercise. Two participants walked their dogs together on a near daily basis. One participant hiked and skied regularly as his exercise. The remaining five participants simply “work hard” as their physical activity.

Five participants talked about diet as a part of maintaining wellness and one mentioned “she’s [wife] feeding me that health crap.” One participant talked about eating only fresh fruits and vegetables he had prepared himself and avoiding foods with preservatives. Another expressed an awareness of fat intake and the potential dangers of fast food. One participant described seizure-like activity after being on a drinking binge and eating very little for several days. He was flown to the urban hospital where he remained for several days for stabilization and assessment. It was learned that he suffered from a low potassium level. Subsequently, he made it a point to choose foods that are high in potassium especially when he was drinking in large quantities. He did not, however, describe changing his drinking habits as a result of this incident.

Seven (70%) of the participants used tobacco, four smoked and three used chew tobacco. Though all recognized that tobacco use was not a healthy behavior, none expressed any immediate plans to quit smoking. One participant had quit smoking once in the past and would again “if I could find a hypnotist.” One participant had smoked but quit after developing hypertension.

Another participant mentioned that he had been told that his blood tests reveal liver damage with possible decreased liver function. “I’m probably an alcoholic. My father

was.” He quit drinking alcohol for several years after a disorderly conduct charge but resumed drinking for unclear reasons in amounts comparable to before he quit. He was aware that alcohol was not healthy with a damaged liver but did not feel badly so had not changed his drinking behavior as a result of health concerns.

A participant mentioned that he drank vodka and orange juice after quitting another combination. “I just quit because I used to drink beer. It was affecting my health because I was drinking beer and Yukon and root beer [schnapps] mixed together and it was messing with my health, the way I was taking care of myself.” It was “making me feel bad and making me not want to eat.” Consequently, he had moderated his drinking pattern. Working as a part-time bartender, he had gone to a course for bartenders where they described the body’s ability to process alcohol. “I still drink but just slower, not as much cause I went to a class. And if you only drink one drink an hour, you’re okay. Sure, it is may be not good but it’s better than drinking four drinks an hour.”

One participant had a history of hepatitis A and hepatitis C. He was hospitalized years ago for treatment of hepatitis. If he was aware of a problem with alcohol and a history of hepatitis, he did not mention it. He did, however, quit smoking when he learned he had high blood pressure, “The day I found out I had high blood pressure, I quit smoking. Right off the bat. Cold turkey. Bam. It has been nine years, eight years.”

Another participant had a uvuloplasty due to sleep apnea. He had been urged friends to been seen as they had noted he was falling asleep during conversations. His wife had

pressured him to be seen as she noted he quit breathing in his sleep. When he dozed off working with a piece of power equipment in front of a customer, he finally agreed to be seen. He did not tolerate continuous positive airway pressure so opted for a uvuloplasty.

Consistent with the work of Shreffler-Grant (2006) and Schmidt (1994), “knowing” and/or being known by the health care provider was important to 60% of the participants. One other participant mentioned trusting the provider. One participant said, “I would love to have a family doctor, you know, somebody that learns my history and I would know because it is hard to go in there and for them to go, yeah, he does have asthma or whatever.” Another chose to see a provider 82 miles away rather than accessing care at a town 40 miles away because he knew and was known to the provider farther away. Three subjects (30%) also mentioned choosing care that was convenient.

One participant would probably not return to the local office if it reopened because,

I think I had the incorrect prognosis out of there, which was affiliated with my blood pressure and that was something very important and what was happening there could have been, I think I was but it could have been, creating my high blood pressure from being given the wrong deal, which I understand could happen anywhere it is just my preference now was not to go there. Just, you know, maybe it was a personal thing.

Another felt there was better quality of care in a larger center and it was worth the trip. If it is bad enough to need formal care, it warranted a trip to “town” (the larger urban center 55 miles away). Three participants said they would not return to a provider who was rude, short, impersonal, or judgmental. Three men complained of providers lecturing, not listening, and not being sensitive enough to the pain of the patient. To quote one participant, “I came in for a sore finger. I don’t want to hear about my smoking. Telling me to quit, how helpful is that?”

A variety of sources were consulted in making choices about which health care provider to be seen by the participant. Four participants “knew” their provider from exposure through family, friends, or previous experience. Two were directed to health care by their wife. One simply avoided health care but would go where it was convenient. Word of mouth or friends was listed by three participants and one participant mentioned a grapevine within the Veterans’ Administration (VA) about which provider was best.

All of the participants mentioned cost as a barrier to accessing health care. Distance was a concern for only two participants and this concern was more in terms of time lost from work and/or cost of gas than access to emergency care. Four participants talked about accessing local health professionals like nurses or volunteer ambulance crew for informal advice. All three participants who had medical training mentioned being sought out by local residents for health care advice and/or first aid treatment.

Cognitive Social Theory

Symbolizing Capability

Symbolizing capability is the ability to form ideas into words. It is incorporated into a person’s language and world view. This capability was not addressed in this study.

Familial and Social Transmission Models

Most of the participants did not identify any particular traditions within the bar. One participant mentioned peer pressure to drink and the use of alcohol to facilitate interaction with the opposite sex. The researcher noted that, in the bar setting most participants asked the researcher if she minded if they had a drink and offered to buy her one when they first sat down for the interview. None of the participants, however, asked

if they could smoke. One participant already had a drink when the researcher met him at the bar. Otherwise none of the participants had any alcohol before the interview began and four subjects had no alcohol during the interview. One man interviewed in the bar had no alcohol during the interview, the two interviewed at home drank no alcohol, and the individual interviewed in his office had no alcohol during the interview.

One participant detailed some behaviors that would not be acceptable at the local bar, “peeling their clothes off or something, big party, hoo ha, dance, just having fun but that was an isolated incident. Those people were taken down off the bar, you don’t do that again and maybe you don’t come back here anymore.” Another participant talked about different drinking groups in the bar, “The hardcore drinkers as you might well expect. Are here to drink. The snowmobilers are here to have a good time and have a beer, whiskey and the young people who come up here that are here to ski” are here for a few drinks and gone. In a town with several bars, a participant described the character of the various establishments. One bar was well known for its excellent, inexpensive breakfast, and an older male crowd. Another bar where middle aged people tended to be found, occasionally had live music on Friday and Saturday nights. Another was described as a nice bar with a lovely dinner club attached. There was a bar known as Menopause Palace informally for the older crowd that tended to frequent that tavern. And there are several other bars that share clientele although certain groups tend to go more to one than another. This would be consistent with Bandura’s assertion that environment influences behavior or that certain persons would seek specific environments.

Only one participant verbalized pressure to drink or to accept drinks in the tavern setting. While observing in the bar setting, the researcher noted that if one person bought another a drink, the other person generally bought the next drink for the first buyer.

In towns where there was more than one participant, each participant knew all the other participants before the interviews occurred and each participant in these towns knew of the other participants' inclusion in the study. Ninety percent of the participants mentioned visiting or socializing as a reason for attendance at the bar. One talked about there always being some kind of an event occurring at the bar.

They always have something going on. You know, they just had their anniversary, their one year anniversary thing. There is a Super Bowl there. I mean, with every holiday there is something going on down there. Trust me. There is not a whole lot else to do in town.

Three of the interviews took place on Super Bowl weekend and two of the bars in that town were having Super Bowl events. In still another town, when there are events, "In our town here, you can have it at the bar, he does cater for different things and different events or the old school house down there, the senior center. If it is a big event and is going to require a lot of room for people to be, they can have it there."

Familial modeling was cited by eight of the participants regarding a variety of behaviors. One participant described adding water to his father's mixed drink as soon as he was tall enough to reach the faucet. His father was abusive and his mother "just kind of went along with it, I guess." He left home by the age of 15 but did finish high school. He was quite proud of that accomplishment. Another participant described his father as a 'proud drinker.' "I mean just a happy, proud man in the bar drinking all the time. That is what my dad was. He was. Got to go to the bar to see his buddies. That would be my

reason mainly.” One of the participants still drank occasionally with his father and brother since his father lived in the area again. He was also friends with the bar owner and golfed with him. Still another participant described how his father and uncle modeled drinking behaviors for him and his brother.

My brother and I, I mean . . . My dad drank all the time, he and my uncle . . . And that is where we basically learned how to work and how to drink. You know, my brother and I have regular jobs and after work we go to work. We go hay or whatever but we generally have a beer in our hand on our second job. You know, we have talked about it. We would get so much more done if we didn’t even have one beer, just get out there and work and then have a beer but we incorporate our fun and working at the same time. It is just what we have done for 20 years.

One man was drinking at the bar with his son the day of the interview. After the interview, he brought his girlfriend’s four year old to the bar/restaurant to watch an event in the street. He bought an orange juice for the child in the same type of cup that he had his vodka and orange juice. He was careful to keep the child in the restaurant portion of the building. Finally, one individual thought he might be an alcoholic following in the footsteps of his father.

Family is apparently not the only influence in behaviors but behaviors may affect interaction with family. The two participants who did not mention family drinking behaviors did not have ongoing contact with their families. One chose to be hundreds of miles from most family members stating they get along better that way. The other simply did not mention family relationships.

Two men mentioned the influence of their grandfathers. One participant who was raised by his grandparents said his grandfather called alcohol, “the devil’s brew and

would run anyone who brought it on the place off.” That participant began drinking after leaving home and mentioned his grandfather “would turn over in his grave” if he knew of the participant’s current drinking patterns. The other man began using chew tobacco in response to challenges from his grandfather.

My grandfather lived down the street and I remember him when I was a very small child. He always used to tease me and one day I thought, I am just going to toughen up and do that [use chew tobacco] and I did and over the years I have kind of just stayed with it. I have never smoked or anything like that.

He started chew tobacco at about the age of twelve in response to that teasing. These findings suggest male role modeling may be an important factor in drinking behaviors and tobacco use and lends support to environment influencing person and behavior.

Vicarious capability

The previous examples are congruent with Bandura’s theory of learning by observation. The participant who began chew tobacco as a result of his grandfather’s teaching described spending large amounts of time as a child in the bar his grandfather owned. This participant was incensed that Child and Family Services had been called when he and his wife took their infant son to pool leagues in the tavern with them while the child was still small enough to be in an infant seat. He felt the child was safer there than with a babysitter who had sick children. Six of the participants specifically mentioned drinking with their fathers or modeling their drinking behaviors after male members of their family.

Forethought capability and self-regulatory capability

Six participants mentioned changing their behavior as a result of some event. One said that he went “dry for seven or eight years” after a disorderly conduct charge, another

detailed changing his choice of alcohol and moderating his intake after feeling unwell, and still another talked of quitting smoking after learning he had hypertension. A participant shared that he helped to mix drinks for his father as soon as he was tall enough to reach the faucet. He was, however careful to note that he was not abusive to others like his father had been. Nonetheless, he drank enough to precipitate a hypokalemic seizure at one time in his life. Hence, he increased his fluid intake when he overindulged in alcohol and made it a point to get more potassium in his diet. Still another thought he should have a checkup and have his cholesterol checked as he had a family history of hyperlipidemia. The participant who had a conflict with Child and Family Services no longer takes his child to that town. Consistent with Cognitive Social Theory, these men demonstrated the ability for forethought and have a sense of self-efficacy as well as an expectancy that the changes would have a positive effect.

Self-reflective Capability

None of the participants said a powerful other directed or influenced a change in their behavior. Participants were unimpressed with dire predictions from provider of adverse events.

My father smoked, he never chewed for years and years and years. He had an unrelated incident, he had an epileptic episode here at the house and they looked through his lungs and they could not find a thing. He smoked the nastiest unfiltered Pall Mall cigarettes like you couldn't believe. I tell you there for awhile he might have been up to one or two packs a day depending on what he was doing. He quit. The doc said well we don't see anything in your lungs, there is a little spot here, a little dark spot there. The doc said well you used to dry drill in the mines, you didn't use any water so you got all that dust flying in the air, was a diesel guy working on diesel equipment plus worked in the tire department, welded everything that you could weld from aluminum to cast iron, all these different things. Could any of those been a factor on those little black spots that were there that didn't seem to grow and didn't seem to move? The medication he

was on for his epilepsy episode he had, he went on Dilantin and that caused a reaction, like pneumonia, in his lungs and, in fact, ultimately that is what killed him.

Two participants shared stories of timing their doses of medication on the Patient Controlled Anesthesia pump to be sure they did not miss any potential doses of their medication demonstrating conscious choices and reinforcing the acceptability of their behavior. Individuals made considered choices about their health care and their choice of health care provider. One participant chose to call an ambulance, “Because I knew I couldn’t sit in the pickup for 60 miles. I couldn’t sit upright. I absolutely could not hardly stand to sit upright. I had an idea [what was wrong]. I knew I was going to live. I knew I was going to survive.” The participant who thinks he may be alcoholic like his father has chosen not to change his drinking behavior as he feels OK and it does not interfere with his daily functioning. Health risks are interpreted through the lens of their own perception. The tobacco users are aware there are risks but that these risks do not apply to them or are in the distant future. While understanding nutrition is important, most of the participants did not mention specific dietary changes or habits. Most participants were aware physical activity is important but did not set aside a specific time for exercise, rather they worked hard.

CHAPTER 5

DISCUSSION

Each of the men in the study frequented the local bar regularly. Each added his own unique perspective to this study of the beliefs and practices of regular patrons of the rural bar. Amount of alcohol intake by these participants was not clear. A number of themes, however, emerged consistently from participant to participant. These themes and findings will be reviewed in this chapter.

One participant described health as well-being of mind and body in concert with the person's environment, two talked about regular checkups in terms of monitoring blood pressure and laboratory tests, and eight (80%) described health as not being in pain and being able to perform daily tasks. These findings are consistent with the concept of health described by Long (1993). Eight participants (80%) would attempt various kinds of self care before seeking formal health care when ill or injured which is consistent with the work of Polen, Green, Freeborn, Mullooly, and Lynch (2001). Two participants expressed an awareness that regular checkups were important. None of the participants, however, reported regular checkups. Ninety percent (n=9) of participants thought exercise was important to good health although they simply worked hard as their exercise regimen. Five (50%) reported some knowledge that nutrition was important to good health. Seventy percent (n=7) were aware of risks of tobacco use. Two participants acknowledged risks associated with excess alcohol intake. The participants' knowledge about a healthy diet, adequate exercise, and appropriate alcohol intake was unclear and was not assessed in this study.

Participants chose formal health care infrequently yet valued a provider who “knew” them, was competent, personable, and non-judgmental. This desire for an acceptable provider is consistent with the findings of Shreffler (2005). Therefore, it would likely serve the provider well to try to “know” the client by showing interest in aspects of the person other than their health. Thirty percent would not return to a provider who was rude, short, or unkind. Thirty percent would not return to a provider who lectured them or were not cognizant of pain control. Thus, a provider would want to be careful to be factual and avoid being judgmental with these clients as with any other client. Providers were chosen by word of mouth or friends by 30% of participants. Cost of care was a potential barrier to care for all participants. Distance to health care was a concern more in relation to missed work or cost of gas than to emergency access to a provider.

Family and social modeling was recognized as a factor in health behavior by most subjects. Male role modeling was the only modeling described by the participants. At least two participants consciously made a choice not to follow the model of an adult male member of their family, however. As well, it is noted that there was a social component to the use of alcohol by most of the participants and some indication that the bar may be a site of rural social activities for families.

Participants demonstrated the ability to learn from the behavior of others. One participant changed his behavior after attending a bartending class. Another consciously chose not to be abusive, avoiding the role model of his father. These findings suggest that these men are able to modify their behavior if they believe it is of relevance to them. The nurse practitioner could facilitate positive changes by tailoring preventative messages to

the priorities of the client. Since ‘tips’ were appreciated by some of the participants, it would be likely that individualized self-help instructions would be appreciated by these men. Choice of health care provider was influenced by word of mouth as well as input from family as was the decision to seek formal health care.

Behavior change was influenced by the participant’s belief that the change would impact their health (expectancy). They were not impressed or influenced by uninvited pressure from providers to change behaviors they did not perceive as a problem. It is unlikely then that their behavior will change unless they believe it is a risk. Only one participant described changing alcohol intake for health reasons. He did so, not because of the advice of a provider but because he felt unwell. Two participants were aware of potential concerns related to alcohol use but chose not to change their intake patterns. Three participants changed their lifestyle in response to other factors. One drank more nonalcoholic fluids when he was drinking alcohol, another tried to eat better when drinking to excess, and another quit smoking in response to a diagnosis of high blood pressure. Being cognizant of the person’s belief of the cause of their illness will aid in assessing their health care needs from their unique perspective.

Nine (90%) of the participants believed they had more than 50% control over their own health. This self-efficacy (self-regulatory capability) was evidenced by one participant quitting smoking, another who quit drinking for several years, and the participant who made it a choice to eat fruits and vegetables without preservatives that he had prepared himself.

These abilities to change behaviors demonstrate that these participants had self-reflective capabilities. They were able to evaluate their own behaviors and make appropriate changes for their own well-being. These participants made reasoned choices about their own risks of illness and priorities regarding personal health care.

Summary

This study was an exploratory study, purposely small in size, to allow personal interviews with a very specific cohort of rural residents. The participants were males between the ages of 38 and 52 who were residents of rural communities. Most were not being seen for chronic health problems but had some experience with health care in the region. Distance to provider was mentioned as a concern by only two of these rural residents. Participants wanted reasonable cost for services and a personable, competent provider who knew them.

Family behaviors regarding alcohol use and intake were an influence on the drinking behaviors of a number of the participants. Socialization was given as a reason for attendance at the rural bar. There was evidence of sharing health care experiences among bar patrons as well as opinions about health care providers and health risks.

Participants expressed an awareness of diet, exercise, not smoking, and moderate alcohol intake as being contributors to good health. Thus, they demonstrated an ability to learn vicariously.

These participants also had the ability for forethought (expectancy) and self-regulation. Several had made efforts to modify their lifestyle for reasons including not feeling well, being diagnosed with an illness, or in response to family needs.

No participant reported changing lifestyle specifically on the recommendation of a health care provider. Using their self-reflective capability, they made their own assessment of their health care risks and needs. Several mentioned preferring information giving and ‘tips’ on health care from the provider rather than a ‘lecture.’

Limitations

All of the participants lived in rural Montana communities without a health care facility in the community. It may be that men in a rural community with a health care provider or facility would have different beliefs or behaviors. A number of participants expressed concern about giving the ‘right’ answers to the investigator so there is a concern about social desirability bias.

The researcher noted that interviews conducted in the bar setting seemed less formal and interviewees more relaxed. While not in the immediate vicinity during the interview, cohorts were present at the bar and aware of the participant’s inclusion in the study. Participants who were interviewed in home or office were more serious and seemed more focused. It is impossible to determine what effect, if any, the setting of the interview had on the nature of the information shared.

If the researcher was recommended by a person known to the participant the interview was readily scheduled. If there was more than one intermediary between the researcher and the participant, no interview could be obtained. It is not known if there was an inherent difference between the beliefs and practices of men who agreed to participate and those who did not.

All of the participants resided in rural communities in the western half of Montana. All participants were Caucasian between the ages of thirty and fifty five. Caution should be exercised in applying these findings to any other age groups or gender.

Recommendations for Further Study

A number of research questions were identified in this preliminary study. None of the communities had a provider within the community. Borders and Rorher (2001) found rural residents with a family physician were less likely to go out of county for health services. Does the presence of a consistent provider in the community increase health care use in this cohort as well? Consistent with the findings of Booth, Kirchner, Forney, Ross, and Rost (2000), these men experienced problems with cost and acceptability of health care. Would low cost or free health care influence these men to access health care more frequently? Is the rural concept of health truly rural, or is it an artifact related to poverty, education, or gender? How can the health care provider personalize risk communication without being perceived as lecturing? Further research might identify how much these men understand about nutrition, exercise, and health levels of alcohol intake. Only one participant recognized peer behaviors within the bar setting. Research into the social dynamics of bar attendance and means of changing alcohol consumption behaviors might aid in reducing the physical and social risks of excessive alcohol use. Research into familial behaviors regarding alcohol use and investigation into difference between siblings who drink to excess and those who do not may provide insight into changing familial drinking patterns. And, finally, research into rural social institutions could offer ways to move rural events away from being alcohol centered. Answers to

these questions would inform nursing practice in rural areas and have implications for the effective care of this at-risk population.

Conclusion

Alcohol has well-known negative effects on health when used to excess. There are also documented social consequences of excessive alcohol use. Research into the social milieu of rural alcohol use is, however, limited. Further, studies regarding positive health behaviors of men who drink have produced mixed results.

This study suggested that rural men who regularly frequent the bar did believe that they have a significant amount of control over their health and could choose to change their behavior when they believed it was to their benefit. They were not receptive to unsolicited predictions of consequences of personal behaviors from health care providers. They exhibited the rural tendency to prefer a provider that they knew and trusted. Perceived rudeness, judgmental attitudes, lecturing, or impersonal behavior would prevent them from returning to a provider. The challenge facing the rural provider is how to “know” a clientele who rarely chooses to be seen and to personalize health care risks to effect behavior change without being perceived as “lecturing.”

While it is clear that this can be a challenging population, it is evident that they do have some concern for their health and are willing to make selected changes in behavior to avoid pain and disability. Assessing the health care priorities and perceived risks of the client will help the provider tailor care to the expectancy of the patient. Having some knowledge of the community and the nature of drinking behaviors will help the provider to “know” the client as well as exhibiting interest in the client about their life aside from

health issues. Providers are well-served to be open, friendly, and non-judgmental with all patients but it may be especially important with this population. After assessing the client's perceptions of their needs, offering specific self-help suggestions may help the client participate in their own wellness without being seen as "lecturing." This awareness can aid the health care provider in framing education to meet the needs and expectations of this unique group.

REFERENCES

- Abbey, A., Scott, R., & Smith M. (1993). Physical, subjective, and social availability: their relationship to alcohol consumption in rural and urban areas. *Addiction*, 88, 489-499.
- Ambrogne, J. (2002). Reduced-risk drinking as a treatment goal: What clinicians need to know. *Journal of Substance Abuse Treatment*, 22, 45-53.
- Armitage, C. J. (2003). The relationship between multidimensional health locus of control and perceived behavioural control: How are distal perceptions of control related to proximal perceptions of control? *Psychology and Health*, 18(6), 723-738.
- Babor, T. F. (1996). A cross-national trial of brief interventions with heavy drinkers. *American Journal of Public Health*, 86(7), 948-955.
- Babor, T. F., Higgins-Biddle, J C., Saunders, J B., & Monteiro, M G. (1999). AUDIT: The Alcohol Use Disorders Test, Guidelines for Use in Primary Care (2nd ed., pp. 7, 17). World Health Organization, Department of Mental Health and Substance Dependence.
- Bandura, A. (1989). Social cognitive theory. In R. Vasta (Ed.), *Annals of child development*, Vol. 6. *Six theories of child development*, (pp. 1-60). Greenwich, CT: JAI Press.
- Barrett, D. (1995). The association between alcohol use and health behaviors related to the risk of cardiovascular disease: The South Carolina Cardiovascular Disease Prevention Project. *Journal of Studies on Alcohol*, 56(1), 9-15.
- Beurden, E. V., Reilly, D., Dight, R., Mitchell, E., & Beard, J. (2000). Alcohol brief intervention in bars and taverns a 12-month follow-up study of Operation Drinksafe in Australia, *Health Promotion International*, 15(4), 293-302.
- Blanchard, J., & Lurie, N. (2004). R-E-S-P-E-C-T: Patient reports of disrespect in the health care setting and its impact on care. *The Journal of Family Practice*, 53(9), 721-730.
- Booth, B., Kirchner, J., Fortney, J., Ross, R., & Rost, K. (2000). Rural at-risk drinkers: Correlates and one-year use of alcoholism treatment services. *Journal of Studies on Alcohol*, 61(2), 267-277.
- Borders, T. F., & Rohrer, J. E. (2001). Rural residence and migration for specialty care. *Health Care Management Review*, 26(3), 40-49.

- Brujin, J., Korzec, A., Arndt, T., & van den Brink, W. (2003). The discriminant validity of alcohol use disorder in well-functioning men with hazardous alcohol use. *European Addicition Research*, 9, 182-187.
- Campbell, H. (2000). The glass phallus: Pub(lic) masculinity and drinking in rural New Zealand. *Rural Sociology*, 65(4), 562-581.
- Casswell, S., Pledger, M., & Hooper, R. (2003). Socioeconomic status and drinking patterns in young adults. *Addiction*, 98, 601-610.
- Catalano, R., Dooley, D., Wilson, G., & Hough, R., (1993). Job loss and alcohol abuse: A test using data from the epidemiologic catchment area project. *Journal of Health and Social Behavior*, 34(3), 215-225.
- Celluci, T., Vik, P., & Nirenberg, T. (2003). Substance abuse in the rural community. In Stamm, B. Hudnall (Ed.) *Rural Behavioral Health Care: An Interdisciplinary Guide*, (pp. 53-65). Washington, D.C., American Psychological Association.
- Chen, K., & Kandel, D. (1995). The natural history of drug use from adolescence to the mid-thirties in a general population sample. *American Journal of Public Health*, 85(1), 41-47.
- Cohen, S., Kaplan, G. A., & Salonen, J. T. (1999). The role of psychological characteristics in the relation between socioeconomic status and perceived health, *Journal of Applied Social Psychology*, 29(3), 445-468.
- Courtenay, W. H., McCreary, D. R., & Merighi, J. R. (2002). Gender and ethnic differences in health beliefs and behaviors. *Journal of Health Psychology*, 7(3), 219-231.
- Crum, R., & Pratt, L. (2001). Risk of heavy drinking and alcohol use disorders in social phobia: a prospective analysis. *American Journal of Psychiatry*, 158(10), 1693-1700.
- Dawson, D. (1996). Temporal drinking patterns and variation in social consequences. *Addiction*, 91(11), 1623-1635.
- Engels, R., Vermulst, A., Dubas, J., Bot, S., & Gerris, J. (2005). Long-term effects of family functioning and child characteristics on problem drinking in young adulthood. *European Addiction Research*, 11, 32-37.

- Evans, D., & Dunn, N. (1995). Alcohol expectancies, coping responses and self-efficacy judgements: A replication and extension of Cooper et al.'s 1988 study in a college sample. *Journal of Studies on Alcohol*, 56(2), p. 186-193.
- Ewing, J. (1984). Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association*, 252, 1905-1907.
- Falk, G. (1970). The contribution of the alcohol culture to alcoholism in America. *British Journal of Addiction*, 65, 9-17.
- Ferrins-Brown, M., Dalton, S., Maslin, J., Hartney, E., Kerr, C., & Orford, J. (1999). "Have a sip of this": The impact of family on drinking patterns of untreated heavy drinkers living in the West Midlands, UK. *Contemporary Drug Problems*, 26(3), 413-437.
- Fillmore, K., Golding, J., Graves, K., Kniep, S., Leino, E. V., Fomelsjo, A., et al. (1998). Alcohol consumption and mortality. I. Characteristics of drinking groups. *Addiction*, 93(2), 183-203.
- Fillmore, K. M. (1987a). Prevalence, incidence and chronicity of drinking patterns and problems among men as a function of age: A longitudinal and cohort analysis. *British Journal of Addiction*, 82, 77-83.
- Fillmore, K. M. (1987b). Women's drinking across the adult life course as compared to men's. *British Journal of Addiction*, 82, 801-811.
- Fleming, M. (1997). Physician advice can make a difference for problem drinkers. *Alcoholism & Drug Abuse Weekly*, 9(15), 4.
- Forrest, C. B., Shi, L., von Schrader, S., & Ng, J. (2003). Managed care, primary care and the patient-practitioner relationship. *Journal of General Internal Medicine*, 17(4), 270-277.
- Fortney, J., Mukherjee, S., Curran, G., Fortney, S., Xiaotong, H., & Booth, Brenda M. (2004). Factors associated with perceived stigma and treatment among at-risk drinkers. *Journal of Behavioral Health Services and Research*, 31(4), 418-430.
- Frone, M., Russell, M., & Cooper, L. (1993). Individual differences in differentiation among alcohol expectancy domains. *Addiction*, 88, 1119-1126.
- Garkovich, L., & Harris, R. (1994). Health and health care in rural America. *Choices: The Magazine of Food, Farm & Resource Issues*, 9(3), 8-13.

- Gatti, S. I. (2003). Fuzzy navels and slippery nipples: A sociolinguistic reading of the cocktail menu. *The Journal of American Culture*, 26(1), 104-110.
- Gire, J. T. (2002). A cross-national study of motives for drinking alcohol. *Substance Abuse & Misuse*, 37(2), 215-223.
- Graham, K. (2003). The yin and yang of alcohol intoxication: Implications for research on the social consequences of drinking. *Addiction*, 98, 1021-1023.
- Grande, T. P., Wolf, A. W., Schubert, D. S. P., Patterson, M. B., & Brocco, K. (1984). Associations among alcoholism, drug abuse, and antisocial personality: A review of literature. *Psychological Reports*, 55, 455-474.
- Greenfield, T., & Room, R. (1997). Situational norms for drinking and drunkenness: Trends in the US adult population, 1979-1990. *Addiction*, 92(1), 33-47.
- Gunzerath, L., Faden, V., Zakhari, S., & Warren, K., (2004). National Institute on Alcohol Abuse and Alcoholism report on moderate drinking. *Alcoholism: Clinical and Experimental Research*, 28(6) 829-847.
- Harnett, R., Thom, B., Herring, R., & Kelly, M. (2000). Alcohol in transition: Towards a model of young men's drinking styles. *Journal of Youth Studies*, 3(1), 61-77.
- Harwood, G. (2005). Alcohol abuse: Screening in primary care. *The Nurse Practitioner*, 30(2), 56-61.
- Hiller-Strumhofel, S., & Kulkosky, P., (2001). Chronobiological regulation of alcohol intake. *Alcohol Research & Health*, 25(2), 141-148.
- Hodgins, D. (2005). Can patients with alcohol use disorders return to social drinking? Yes, so what should we do about it? *Canadian Journal of Psychiatry*, 50(5), 264-265.
- Holyfield, L., & Ducharme, L. (1995). Drinking contexts, alcohol beliefs, and patterns of alcohol consumption: Evidence for a comprehensive model of problem drinking. *Journal of Drug Issues*, 25(4), 783-799.
- Hornberger, D., & Cobb, A. (1998). A rural vision of a healthy community. *Public Health Nursing*, 15(5), 363-369.

- Hsu, J., Schmittiel, J., Krupat, E., Stein, T., Thorn, D., Fireman, B., et al. (2003). Patient choice: A randomized controlled trial of provider selection. *Journal of General Internal Medicine*, 18(5), 319-325.
- Hunt, G., & Satterlee, S. (1987). Darts, drink and the pub: The culture of female drinking. *The Sociological Review*, 35(3), 575-601.
- Katovich, M. A., & Reese, W. A. II. (1987). The regular: Full-time identities and memberships in an urban bar. *Journal of Contemporary Ethnography*, 16(3), 306-343.
- Kelleher, K. J., & Robbins, J. M. (1997). Social and economic consequences of rural alcohol use. In *Rural Substance Abuse: State of Knowledge and Issues*, (pp196-219). Rockville, MD, United States Department of Health and Human Services .
- Kesse, E., Clavel-Chapelon, F., Slimani, N., vanLiere, M., & the E3N Group (2001). Do eating habits differ according to alcohol consumption? Results of a study of the French cohort of the European Prospective Investigation into Cancer and Nutrition (E3N-EPIC). *American Journal of Clinical Nutrition*, 74, 322-327.
- Knupfer, G. (1989). The prevalence in various social groups of eight different drinking patterns, from abstaining to frequent drunkenness: Analysis of 10 U. S. surveys combined. *British Journal of Addiction*, 84, 1305-1318.
- Kuntsche, E., Rehm, J., & Gmel, G. (2004). Characteristics of binge drinkers in Europe. *Social Science & Medicine*, 59, 113-127.
- Kunz, J. L., & Graham, K. (1998). Drinking patterns, psychosocial characteristics and alcohol consequences. *Addiction*, 93(7), 1079-1090.
- Lee, H. J. (1998). Concept comparison: Old-timer/newcomer/insider/outsider. In H. J. Lee (Ed.), *Conceptual Basis for Rural Nursing*, (pp. 149-155). New York, NY: Springer Publishing Company.
- Lee, H., and Winters, C. (2004). Testing rural nursing theory: Perceptions and needs of service providers. *Online Journal of Rural Nursing and Health Care* 4(1) [Online]. Available: http://www.rno.org/journal/issues/Vol-4/issue-1/Lee_article.htm
- Leight, S. B. (2003). The applications of a vulnerable populations model to rural health. *Public Health Nursing*, 29(6), 440-448.
- Levant, R., & Habben, C. (2003). The new psychology of men: Application to rural men. In B. Hudnall Stamm (Ed.), *Rural Behavioral Health Care: An*

- Interdisciplinary Guide*, (pp. 171-180). Washington, DC: American Psychological Association.
- Liu, Q. (1998). The influence of local church participation on rural community attachment. *Rural Sociology*, 63(3), 432-450.
- Long, K. A. (1993). The concept of health: Rural perspectives. *Rural Nursing*, 28, 123-130.
- MacGregor, M. (1972). The rural culture. *New Society*, 19, 486-489.
- MacMaster, S. (2004). Harm reduction: A new perspective on substance abuse services. *Social Work*, 49(3), 356-363.
- Makela, K., & Mustonen, H. (2000). Relationships of drinking behaviour, gender, and age with reported negative and positive experiences related to drinking. *Addiction*, 95(5), 727-736.
- Mandelbaum, D. G., (1965). Alcohol and culture. *Current Anthropology*, 6(3), 281-293.
- Marlatt, G. A., (1997). Harm reduction works. Retrieved from <http://www2.potsdam.edu/alcohol-info/ExpertOpinion/HarmReductionWorks.html>
- Marshall, M. (1979). *Beliefs, behaviors & alcoholic beverages*. Ann Arbor: University of Michigan Press.
- McCreary, D., Newcomb, M., & Sadava, S. (1999). The male role, alcohol use, and alcohol problems: A structural modeling examination in adult women and men. *Journal of Counseling Psychology*, 46(1), 109-124.
- McPherson, K. (2004). Disaggregating the health consequences of alcohol by age and sex. *Addiction*, 99, 661-662.
- Meyer, J. (2003). Improving men's health: Developing a long-term strategy. *American Journal of Public Health*, 93(5), 709-711.
- Miners, L. (1988). Individual vs. household determinants of the demand for medical care: A study of rural families. *Lifestyles: Family and Economic Issues*, 9(1), 33-54.
- Mirand, A. L., & Welte, J. W. (1996). Alcohol consumption among the elderly general population, Erie County, New York. *American Journal of Public Health*, 86(7), 978-984.

- Moos, R. H., Schutte, K., Brennan, P., & Moos, B. S. (2004). Ten-year patterns of alcohol consumption and drinking problems among older women and men. *Addiction*, 99, 829-838.
- Mortensen, E. L., & Reinisch, J. M. (2003). Social status, not alcohol, may be deciding factor in health risks. *Nutrition Health Review: The Consumer's Medical Journal*, 88(5), 5.
- Mukamal, K., Ascherio, A., Mittleman, M., Conigrave, K., Camargo, C., Dawachi, I. et al. (2005). Alcohol and risk for ischemic stroke in men: The role of drinking patterns and usual beverage. *Annals of Internal Medicine*, 142(1), 11-20.
- Muthen, B. O., & Muthen, L. K. (2000). The development of heavy drinking and alcohol-related problems from ages 18-37 in a U.S. national sample. *Journal of Studies on Alcohol*, 61(2), 290-306.
- Newsom, J. T., McFarland, B. H., Kaplan, M. S., Huguet, N., & Zani, B. (2005). The health consciousness myth: Implications of the near independence of major health behaviors in the North American population. *Social Science & Medicine*, 60, 433-437.
- Nietert, P., French, M., Kirchner, J., Han, X., & Booth, B. (2004). Health services utilization and cost for at-risk drinkers: Rural and urban comparisons. *Journal of Studies on Alcohol*, 65(3), 353-363.
- Orcutt, J. (1993). Happy hour and social lubrication: Evidence on mood-setting rituals of drinking time. *Journal of Drug Issues*, 23(3), 389-408.
- Paradis, C., Demers, A., & Nadeau, L. (1999). *Contemporary Drug Problems*, 26, 53-73.
- Parker-Pope, T. (2002). Kicking the habit (sort of): New theory lets smokers smoke, alcoholics drink. *The Wall Street Journal*, July 2, 2002. Retrieved 12/20/04 from http://global.factiva.com/en/arch/print_results.asp.
- Perreira, K. M., & Sloan, F. A. (2001). Life events and alcohol consumption among mature adults: A longitudinal analysis. *Journal of Studies on Alcohol*, 62, 501-508.
- Perry, C. L., Baranowski, T., & Parcel, G. S. (1990). How individuals, environments, and health behavior interact: Social learning theory. In K. Glanz, F. M. Lewis & B. K. Rimer, Eds., *Health Behavior and Health Education: Theory, Research and Practice*, (pp. 161-186). San Francisco, CA: Jossey-Bass.

- Polen, M., Green, C., Freeborn, D., Mullooly, J., & Lynch, F. (2001). Drinking patterns, health care utilization, and costs among HMO primary care patients. *The Journal of Behavioral Health Services & Research*, 28(4), 378-399.
- Polit, D., Beck, C., & Hungler, B. (2001). *Essentials of nursing research: Methods, appraisal, and utilization* (5th ed.). Philadelphia: Lippincott.
- Powell, G., & Peveler, R. (1996). Nature and prevalence of personality disorders among patients receiving treatment for alcohol dependence. *Journal of Mental Health*, 5(3), 305-315.
- Quigley, L. A., & Marlatt, G. A. (1996). Drinking among young adults. *Alcohol Health & Research World*, 20(3), 185-195.
- Rehm, J., Fichter, M. M., & Elton, M. (1993). Effects on mortality of alcohol consumption, smoking, physical activity, and close personal relationships. *Addiction*, 88, 101-112.
- Rehm, J., Gmel, G., Sempos, C., & Trevisan, M. (2002). Alcohol-related morbidity and mortality. *Alcohol Research & Health*, 27 (1), 39-51.
- Rehm, J., Monteiro, M., Room, R., Gmel, G., Jernigan, D., Frick, U., et al. (2001). Steps towards constructing a global comparative risk analysis for alcohol consumption: Determining indicators and empirical weights for patterns of drinking, deciding about theoretical minimum, and dealing with different consequences. *European Addiction Research*, 7, 138-147.
- Reid, M., Voynick, I., Peduzzi, P., Fiellin, D., Tinetti, M., & Concato, J., (2000). Alcohol exposure and health services utilization in older veterans. *Journal of Clinical Epidemiology*, 53, 87-93.
- Resnick, B. (2004). Self-efficacy. In S. J. Peterson & T. S. Bredow, Eds., *Middle Range Theories: Application to Nursing Research*, (pp. 97-124). Philadelphia, PA: Lippincott.
- Rice, D., Conell, C., Weisner, C., Hunkeler, E., Fireman, B., & Hu, T. (2000). Alcohol drinking patterns and medical care use in an HMO setting. *The Journal of Behavioral Health Services & Research*, 27(1), 3-16.
- Roman, P., Blum, T., & Martin, J. (1992). 'Enabling' of male problem drinkers in work groups. *British Journal of Addiction*, 87, 275-289.
- Room, R., & Makela, K. (2000). Typologies of the cultural position of drinking. *Journal of Studies on Alcohol*, 61(3), 475- 490.

- Rose, R. (1998). A developmental behavior-genetic perspective on alcoholism risk. *Alcohol Health & Research World*, 22(2), 131-144.
- Rouillier, P., Boutron-Rualt, M., Bertrais, S., Arnault, N., Daudin, J., Bacro, J., et al. (2004). Drinking patterns in French adult men. *European Journal of Nutrition*, 43(2), 69-76.
- San Jose, B., Van Oers, J., DeMheen, H., Garretsen, H., & Mackenbach, J. (2000). Drinking patterns and health outcomes: Occasional versus regular drinking. *Addiction*, 95(6), 865-872.
- Satre, D. D., & Knight, B. G. (2001). Alcohol expectancies and their relationship to alcohol use: Age and sex differences. *Aging & Mental Health*, 5(1), 73-83.
- Schmidt, L. M. (1994). Outreach efforts in Appalachia require sense of cultural traits. *Addiction Letter*, 10(8), 1-3.
- Schmittiel, M. A., Selby, J. V., Grumbach, K., & Quesenberry, C. P. (1999). Women's provider preferences for basic gynecology care in a large health maintenance organization. *Journal of Women's Health & Gender-Based Medicine*, 8(6), 825-833.
- Sharma, R., Haas, M., & Stano, M. (2003). Patient attitudes, insurance and other determinants of self-referral to medical and chiropractic physicians. *American Journal of Public Health*, 93(12), 2111-2117.
- Shreffler, M. J., (1999). Culturally sensitive research methods of surveying rural/frontier residents. *Western Journal of Nursing Research*, 21(3), 426-435.
- Shreffler, M. J., Capalbo, S. M., Flaherty, R. J., & Heggem, C. (1999). Community decision-making about critical access hospitals: Lessons learned from Montana's medical assistance facility program. *The Journal of Rural Health*, 15(2), 180-188.
- Shreffler-Grant, M. J., (2004). "Acceptability," one component in choice of health care provider. In H. J. Lee & C. A. Winters, Eds., *Rural Nursing, Concepts, Theory, and Practice*, (pp. 166-176). New York, NY: Springer.
- Smith V., Haynes, G., & Phearson, G. (2000). The demand for substance abuse treatment among adults in low income households in Montana and Colorado. *Consumer Interests Annual*, 46, 164-169.
- Smith, W., Varvel, W., LeUnes, A., Christensen, L., Crouch, B., & Shaw, R. (1976). Rural Alcohol Abuse. *Annals of the New York Academy of Sciences*, 273, 659-664.

- Sobell, M., & Sobell, C. (1995). Controlled drinking after 25 years: How important was the debate? *Addiction*, 90, 1149-1153.
- Stanridge, J. B., Zylstra, R. G., & Adams, S. M. (2004). Alcohol consumption: An overview of benefits and risks. *Southern Medical Journal*, 97(7),664-672.
- Stenson, J., & Martin, A. (2004). How much you drink makes a huge difference. *Health*, 18(1), 54.
- Stephoe, A., & Wardle, J. (2001). Locus of control and health behaviour revisited: A multivariate analysis of young adults from 18 countries. *British Journal of Psychology*, 92, 659-672.
- Stockwell, T., (2001). Harm reduction, drinking patterns and the NHMRC drinking Guidelines. *Drug and Alcohol Review*, 20, 121-129.
- Struss, G. E., Jr., (1999). The impact of the loss of a high school upon a community's culture. *Dissertation Abstracts International*, 60 (4), 1075A, (UMI No. DA9924653).
- Temple, M., & Leino, E. V., (1989). Long-term outcomes of drinking: A 20-year longitudinal study of men. *British Journal of Addiction*, 84, 889-899.
- Thornquist, L., Biro, M., Olander, R., & Sterner, S. (2002). Health care utilization of chronic inebriates. *Academic Emergency Medicine*, 9(4), 300-308.
- Thurber, S., Snow, M., & Thurber, J. (1989). Antecedents of gregarious alcoholism: An a priori model. *Journal of Clinical Psychology*, 45(1), pp. 168-171.
- Treadwell, H. M., & Ro, M., (2003). Poverty, race and the invisible man. *Journal of Public Health*, 93(5), 705-710.
- Treno, A. J., Alaniz, M. L., & Gruenwald, P. J. (2000). The use of drinking places by gender, age and ethnic groups: An analysis of routine drinking activities. *Addiction*, 95(4), 537-551.
- Trevisan, M., Dorn, J., Falkner, K., Russell, M., Ram, M., Muti, P., et al. (2003). Drinking pattern and risk of non-fatal myocardial infarction: A population-based case-control study. *Addiction*, 99, 313-322.
- United States General Accounting Office (1993). *Rural development: Profile of rural areas*. Fact Sheet for Congressional Requestors (FAO/RECD-93-40FS). Pp.26-30. Washington DC.

- Wall, A., Thrussell, C., & Lalonde, R. N. (2003). Do alcohol expectancies become intoxicated outcomes? A test of social-learning theory in a naturalistic bar setting, *Addictive Behaviors*, 28, 1271-1283.
- Wang, J., & Patten, S. (2001). A prospective study of sex-specific effects of major depression on alcohol consumption. *Canadian Journal of Psychiatry*, 46, 422-425.
- Wells, J. E., Horwood, L. J., & Fergusson, D. M. (2004). Drinking patterns in mid-adolescence and psychosocial outcomes in late adolescence and early adulthood. *Addiction*, 99, 1529-1541.
- Wells, S., & Graham, K. (2003). Aggression involving alcohol: Relationship to drinking patterns and social context. *Addiction*, 98, 33-42.
- Weiner, J. (1995). Rural primary care. *Annals of Internal Medicine*, 122(5), 380-390.
- Weinert, C., & Long, K. A. (1987). Understanding the health care needs of rural families. *Family Relations*, 36, 450-455.
- Weisbeck, G. A. (2003). Gender-specific issues in alcoholism – introduction. *Archives of Women's Mental Health*, 6, 223-224.
- White, I. R., Altmann, D. R., & Nanchahal, K. (2004). Mortality in England and Wales attributable to any drinking, drinking above sensible limits and drinking above lowest-risk level. *Society for the Study of Addiction*, 99, 749-756.
- Whitlock, E. P., Polen, M. R., Green C. A., Orleans, C. T., & Klein, J. (2004). Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: A summary of the evidence for the U. S. preventive services task force. *Annals of Internal Medicine*, 140, 558-569.
- Wilke, Dina. (1994). Women and alcoholism: How a male-as-norm bias affects research, assessment, and treatment. *Health & Social Work*, 19(1), 29-35.
- Woldt, B. T., & Bradley, J. R. (2002). Structural equation modeling of drinking motives in male DUI offenders. *Journal of Drug Education*, 32(1), 69-79.
- Wolff, M. W., & Wolff, K. A. (2002). Personality characteristics as a function of frequency and type of substance abuse. *Adolescence*, 37(148), 705-717.
- Worden, J. K., Flynn, B. S., Merrill, D. G., Waller, J. A., & Haugh, L. D. (1989). Preventing alcohol-impaired driving through community self-regulation training. *American Journal of Public Health*, 79(3), 287-290.

Young, R. C., & Larson, O. F. (1970). The social ecology of a rural community. *Rural Sociology*, 35 (3), 337-355.

APPENDICES

APPENDIX A

INTERVIEW GUIDE

I am trying to determine what people value as far as health and health care providers. In particular, I am interested in the health beliefs and practices of men who regularly frequent the rural bar. It seems these unique individuals such as yourself may have very specific beliefs and values that would be important for health care providers and others to know about. Any identifying information will be removed before any publication occurs. With your permission, I would like to tape this interview to be sure that I am accurate in recording your interview. Would that be OK?

How long have you lived here?

Which bar do you regularly frequent?

What do you do there?

Who do you usually spend time with?

Are there traditions within the group?

Do you spend time with family there?

How often are you there?

How long do you usually stay?

What do you drink?

How much do you drink?

What does good health mean to you?

What do you do to take care of yourself? To maintain your health?

How much control do you think you have over your health?

Are some health problems inevitable?

What kinds of health problems do you manage independently?

Do you consult a non-professional person when you do not feel well? If so, who?

If you were not sure if you should see a health professional, with whom would you discuss that decision?

How do you decide when to see a health professional?

How do you decide who to see?

How do you decide to see a local provider?

How do you decide to go out of town?

How do you determine if the provider is worth seeing again?

What would cause you not to go back to a provider?

What has been your most positive health care experience?

What has been your most negative health care experience?

What would you like to tell me about your local health care resources?

Is there anything else you would like to share with me?

APPENDIX B

SUBJECT CONSENT FORM

Subject Consent Form for Participation in Human Research at
Montana State University

Health Beliefs and Practices of 'Regulars' at the Rural Bar
Kathy Palm Jorgensen, RN, MSU-Bozeman FNP Student
Great Falls Campus, 406-771-4450
Jean Shreffler-Grant, Committee Chairperson
Missoula Campus, 406-243-2540

You are being asked to participate in a study about the health care beliefs and practices of men who regularly frequent rural bars. The reason for this research is to start to determine how people choose to care for themselves, how they choose their health care provider, and how a provider can best work with these individuals. You were identified as a possible participant because you can provide the unique perspective of a 'regular' at the local bar.

Agreeing to participate, means you are agreeing to an interview that may take one to one and a half hours of your time. Some people feel uncomfortable being interviewed or talking about themselves. Benefits to you include assisting in efforts to provide more patient centered, effective health care. With your permission, the interview will be taped to allow me to pay closer attention to what you are saying rather than concentrating on taking notes.

Your answers to these questions will be kept strictly confidential. Each participant will be identified by a code. The researcher will remove identifiers such as names and towns before combining information into the final report. All questionnaires, consents, and audiotapes will be secured in a locked file cabinet in the College of Nursing for 5 years.

You may decide not to participate in the study at any time, even if you have already begun the interview. You may decline to answer any question at any time. There will be no cost or reimbursement to you for participating in this study. The researcher covers any costs. You may ask questions of the interviewer at any time. The Chairperson of the Montana State University Human Subject Review Committee, Dr. Mark Quinn, Missoula Campus, 406-994-5721, can answer additional questions about the rights of human subjects.

In the event your participation in this research directly results in injury to you, medical treatment consisting of essential counseling or psychiatric evaluation will be available at the participant's expense, but there is no compensation for such injury available. Montana State University cannot be held responsible for injury, accidents, or expenses that may

occur as a result of your participation in this project. In addition, Montana State University cannot be held responsible for injury, accidents, or expenses that may occur as a result of traveling to and from your appointments at the site of data collection. Further information about this treatment may be obtained by calling Kathy Jorgensen at 771-4450 or 799-9747

AUTHORIZATION: I have read and understand the discomforts, inconvenience and risk of this study. I, _____(name of subject), agree to participate in this research. I understand that I may later refuse to participate, and I may withdraw from the study at any time. I have received a copy of this consent form for my own records.

Signed: _____ Witness: _____
Investigator: _____ Date: _____

APPENDIX C

CAGE QUESTIONNAIRE

CAGE Questionnaire

Have you ever felt you ought to **C**ut down on your drinking?

Have people **A**nnoyed you by criticizing your drinking?

Have you ever felt bad or **G**uilty about your drinking?

Have you ever had an **E**ye-opener drink first thing in the morning?

Two or more positive answers suggest an alcohol use disorder and indicates further evaluation is indicated (Ewing, 1984).

APPENDIX D

AUDIT QUESTIONNAIRE

The AUDIT Questionnaire

1. How often do you have a drink containing alcohol?
2. How many drinks do you have containing alcohol on a typical day when you are drinking?
3. How often do you have six or more drinks on one occasion?
4. How often during the last year have you found that you were not able to stop drinking once you had started?
5. How often during the last year have you failed to do what was normally expected from you because of drinking?
6. How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?
7. How often during the last year have you had a feeling of guilt or remorse after drinking?
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
9. Have you or someone else been injured as a result of your drinking?
10. Has a friend, relative, or health care provider been concerned about your drinking or suggested that you cut down?

Scoring: In question 1-8

Never = 0

Monthly or less = 1

2-4 times per month = 2

2-3 times per week = 3

4 or more times per week = 4.

Questions 9 and 10

No = 0

Yes, but not in the last year = 2

Yes, during the last year = 4

A score of $>$ or $= 8$ indicates a strong likelihood of hazardous or harmful alcohol consumption (Harwood, 2005)