

ABSTRACT

Title of Document: "BUT I'M JUST A LITTLE VOICE:"
EXPLORING FACTORS THAT AFFECT
RURAL WOMEN'S MEANING MAKING OF
EMPOWERMENT AND HEALTH

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This research study explores how empowerment can be incorporated as an element of health communication campaigns to positively affect rural women's everyday health activities. This study questions how rural women make meaning of empowerment and health, the factors that affect rural women's empowerment, and how health communication campaigns may bolster individual and community empowerment. Building from multiple theoretical—including empowerment theory, the situational theory of publics, the theory of planned behavior, the social cognitive theory, and a socio-ecological perspective—this study explores empowerment as a critical link in health communication and public relations theory. Dimensions of individual empowerment such as self-efficacy and perceived behavioral control were explored in more depth, as were other factors that affected empowerment, including social support, religiosity, and involvement as a construct of the situational theory of publics.

This study employed a qualitative research method to explore empowerment through these rural women's lived experiences. Research was conducted through 41 qualitative, in-depth interviews with women residing in a small rural community; 15 of these women also participated in photovoice as a research method.

Findings from this research demonstrate the importance of multi-level and multi-faceted socio-ecological approaches to health communication campaigns, involving communication at many levels such as the individual, organizational, and community levels. As findings from this research highlight, rural women's notions of empowerment may be impacted by their community and social interactions, their religious involvement, and their experiences with personal and family health problems. Physical and structural factors in women's lives also left them with feelings of powerlessness in certain health situations, suggesting the need for health communication campaigns to also address larger changes in structure and policy. Based upon the research findings and the prior literature, a model is proposed to aid in understanding of the factors that influence women's feelings of empowerment.

**“BUT I’M JUST A LITTLE VOICE:” EXPLORING FACTORS THAT AFFECT
RURAL WOMEN’S MEANING MAKING OF EMPOWERMENT AND HEALTH**

By

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Dissertation submitted to the Faculty of the Graduate School of the
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Dedication

To my husband, Jason, for always “empowering” me; this would not have been possible without you and your constant support.

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Chapter 1—Introduction

In public health, there has been an increasing focus on health disparity research and policy. Health disparities are defined as differences in access to health care and quality of health care; differences in the incidence, prevalence, morbidity, and mortality rates of health problems; and differences in the burden of health-related problems in relation to ethnicity, race, gender, class, or geography (Kamble & Boyd, 2008). Despite the increasing focus, these disparities still exist and severely affect many groups of individuals (Cummings & Jackson, 2008), including rural populations, who have largely been overlooked by public health campaigns (Campo, Askelson, Spies, & Losch, 2008).

Rural women, in particular, face their own specific health challenges related to health disparities such as higher morbidity and mortality rates for many types of chronic disease and mental health problems and unique healthcare challenges such as access to healthcare, lack of insurance, and higher poverty rates (Gamm, Hutchison, Dabney, & Dorsey, 2003; McGlaun & Cochrane, 2010; Pistella, Bonati, & Mihalic, 2000). Scholars have shown that rural women's mental health is impacted by their self esteem (Chase & Dyer, 2008) and call for the need to empower these rural women to improve their health and the health of their communities (Balit, 2004; Coward, 2006). In order to more fully understand the problems that plague rural women and the context in which health disparities occur, there is a need to consider the unique perspectives of this marginalized populations (Hankivsky & Christofferson, 2008) within the level of their specific community setting (Hornberger & Kuckelman, 1998).

With a new focus on the social factors that influence health inequalities and disparities, the World Health Organization established the Commission on the Social Determinants of Health in 2005 to study this phenomenon (Schofield, 2007). Social determinants still appear to be controversial in the field of health, however, as many health professionals and researchers believe that too much focus on the social determinants draws away from the actual biological and lifestyle choices that individuals make (Forde & Raine, 2008).

One such social determinant of health is individuals' empowerment. Theoretical development in empowerment has shown that empowering marginalized populations can help to reduce health disparities and encourage healthy behavior among previously "powerless" populations (Wallerstein, 2006). Empowerment is certainly not a new concept and is one that has been applied in many disciplines, including sociology and social work. However, empowerment in health communication has been explored mostly in interpersonal health education settings (Rindner, 2004) or in patient-provider healthcare contexts (Minkler & Cox, 1980; Li-Chun, I-Chuan, & Chieh-Hsing, 2004). Studies on how public health campaigns and mass-mediated communication campaigns can empower individuals still remain limited and there is little consensus on how to operationalize empowerment into health promotion programs (Laverack & Wallerstein, 2001).

Additionally, further understanding regarding the concept of empowerment is needed to understand which factors affect empowerment and how individuals' empowerment is affected by their communities and social situations. Bandura (2004) calls for the need to devote more research and scholarship to influencing individuals'

control over their healthful practices and developing models for how to improve community health at local levels. Incorporating ecological perspectives to the study of empowerment furthers understanding regarding how community levels and community empowerment connect to the individual and her perception of empowerment.

Additionally, Zimmerman (1995) states that one universal measure of empowerment may not be appropriate; instead, empowerment may be unique to different populations, different settings, and for different communication goals. This conceptualization of empowerment lends itself well to exploratory qualitative research to first develop a model of empowerment for rural women and their everyday health activities. Additionally, factors that have been shown to affect empowerment and health, particularly in rural women—such as religiosity and spirituality, social networks, and involvement with health (Coward, 2006)—are explored for their connection to empowerment in this unique context.

The purpose of this study is to explore how empowerment can be incorporated as an element of health communication campaigns to positively affect rural women's everyday health activities. This study explores in depth how rural women make meaning of empowerment and how their views of empowerment affect their health and their engagement with health and health communication campaigns. Exploring these questions contributes to larger theory development that highlights factors that affect empowerment as a construct of health communication and public health campaigns.

This study offers exploratory theory development, borrowing from multiple theories—including empowerment theory, the situational theory of publics, the theory of planned behavior, the social cognitive theory, and a socio-ecological perspective—and seeking to explore how empowerment could feasibly be a critical link in public relations and health communication theory. Several bodies of literature and disciplines inform this study, including public relations, health communication, media, psychology, and sociology.

Through 41 individual in-depth interviews with women residing in a small, rural community, this research explored how these women made meaning of empowerment and health, how communication campaigns could affect these women's empowerment, and other factors that affected empowerment. Some of these women also participated in photovoice research and answered additional questions through the taking of pictures, providing a unique glimpse into their meaning making and lived experiences as rural women.

Findings from this research demonstrate the need for ecological approaches to health communication campaigns for rural women, focusing on a variety of levels, such as individual, organizational, and community levels, and to shift the focus away from only the individual for health communication campaigns that aim to empower communities. This research highlights that rural women's notions of empowerment may be impacted by their community and social interactions, their religious involvement, and their experiences with personal and family health problems. Physical and structural factors may also leave women feeling powerless in specific health situations, suggesting the need for health communication campaigns to also

address larger changes in structure and policy. Based upon the research findings and the prior literature, a model is proposed to aid in understanding of the factors that affect women's feelings of empowerment (see Figure 1, page 215).

Chapter 2—Literature Review

Public Health Communication Campaigns

Evidence is accumulating to support the proposition that mass media campaigns can be effective in producing positive health outcomes provided that evidenced-based principles of campaign design are practiced (Hornik, 2002). Several meta-analyses of mediated health campaigns support this notion of success; however, this success largely depends on the intended campaign goals and the principles of campaign design (Derzon & Lipson, 2002; Noar, 2006; Snyder et al., 2004).

Defining public health campaigns. As Rogers and Storey (1987) state, “(1) a campaign intends to generate specific outcomes or effects, (2) in a relatively large number of individuals, (3) usually within a specified period of time, and (4) through an organized set of communication activities” (p. 821). Rice and Atkin (2002) updated this definition of campaigns to state that public campaigns are:

- (a) purposive attempts; (b) to inform, persuade, or motivate behavior changes;
- (c) in a relatively well defined and large audience; (d) generally for noncommercial benefits to the individuals and/or society at large; (e) typically within a given time period; (f) by means of organized communication activities involving mass media; and (g) often complemented by interpersonal support (p. 427).

To expand on Rice and Atkin’s definition, campaigns do not always have behavior change as a directly-targeted outcome. Instead campaigns may seek to create awareness, increase knowledge, change attitudes, or to increase empowerment.

A brief history. Rogers and Storey (1987) and Noar (2006) outline the historical progression of public health campaigns and their effects. According to these scholars, the 1940s and 1950s were the era of “minimal effects” where campaign efforts largely fell short and scholars struggled to understand reasons for these shortcomings. The 1960s and 1970s brought about a new era that emphasized the potential success of campaigns, which was furthered by programs such as the Stanford Heart Disease Prevention Program (Noar, 2006; Rogers & Storey, 1987). The 1980s and 1990s brought about the “moderate effects” era, where more campaign successes were visible and campaign planners began to understand what makes campaigns effective. Noar (2006) suggests that 2000 and beyond should be considered the “conditional effects” era where greater campaign successes have been observed as campaign planners implement knowledge from prior generations about principles of effectiveness. However, despite these greater successes in the “conditional effects era,” campaign failures also still abound.

Principles of effective campaign design. Most studies on the effectiveness of campaigns, stress the importance of good campaign design principles. To maximize campaign effectiveness, campaign planners should follow evidence-based practices (Mendelsohn, 1973). As Snyder (2007) states, to change behavior, campaigns should “pay attention to the specific behavioral goals of the intervention, target populations, communication activities and channels, message content and presentation, and techniques for feedback” (p. S32). Noar (2006) stresses that effective campaigns should use formative research and pretest messages, use a theoretical foundation, segment audiences, tailor message design, strategically place

messages and use appropriate channels, and conduct process and outcome evaluations. Many of these principles are not new ideas to campaign planning; Hyman and Sheatsley in 1947 also stressed the importance of audience research in implementing successful campaigns.

Measuring effects of public health campaigns. Many studies (Noar, 2006; Snyder et al., 2004) show that health communication campaigns have effects, but these effects often are small. Meta-analysis studies show that communication campaigns on average create around 8 to 9 percent change in the desired outcome for the desired population (Snyder & Hamilton, 2002; Snyder et al., 2004). These effect sizes become even smaller when examining campaigns without policy enforcement as an element of the equation (Snyder & Hamilton, 2002). Snyder et al. (2004) found that the average change in behavior for campaigns involving policy enforcement was 17 percent; whereas, the average change for those not involving enforcement ranged from 3 to 5 percent, depending on campaign type.

As Randolph and Viswanath (2004) state, the success of mass media campaigns is varied from campaign to campaign and often hard to measure. Snyder and Hamilton (2002) show that this change depends upon the type of change that campaigns are targeting. Campaigns that were targeting adoption of a new behavior were the most likely to change behavior (12% average change), followed by campaigns for cessation of a behavior (5%), and prevention campaigns (4%) (Snyder et al., 2004). However, campaign findings were also contextual. For example, Snyder et al. (2004) found that prevention campaigns were more effective than cessation campaigns for addictive behaviors. Also, Derzon and Lipsey (2002), who

studied drug abuse prevention literature, found that, although there were overall significant effects, campaigns targeted towards youth had the least effects compared to those focusing on parents and retailers. Salmon and Atkin (2003) note that the effectiveness of campaigns also depends upon the type of targeted outcome. For example, campaigns have stronger influence on cognitive outcomes, less influence on attitudes, and even less influence on actual behaviors.

Several limitations have been noted with measurement of effectiveness. As Rice and Atkin (2002) note, few studies distinguish short-term from long-term effects of communication campaigns, making it hard to determine whether the effects that are found are lasting effects or only temporary. Individual campaign evaluations often show significant effects within a several month to one-year time period (e.g., Zimmerman et al., 2007); however, little evidence shows long-term changes in behavior. Vidanapathirana, Abramson, Forbes, and Fairley (2005), through a meta-analysis of HIV campaigns, found that, while mass media interventions had significant immediate effects on HIV testing behavior, no long-term effects on HIV testing behavior through any of the studies were evident.

Despite meta-analyses that show significant effects for public health campaigns, effects from meta-analyses are limited by the weak evaluations of many campaigns. Weak evaluations can make understanding difficult about whether or not campaigns have had the intended effects. As Noar (2009) states meta-analyses are limited by the “weak outcome evaluations of many campaigns. In some cases, meta-analyses have excluded more studies than they have included due to the weak designs that have been applied in many campaign studies” (p. 2). Noar et al. (2009) found

through a review of the effects of HIV/AIDS mass communication campaigns over the last decade, that the majority of “well-controlled” campaign studies did have significant effects on behavior change or behavioral intentions. For many of the campaigns in their study, however, weak experimental designs of the evaluations made it hard to determine if the outcome measures were really measuring the influence of the campaign.

In addition to the planned effects of a campaign, campaigns may also have unintended effects that may be detracting from the actual intended effects (Cho & Salmon, 2006, 2007). Unintended effects of campaigns may be more detrimental than the actual intended effects. These effects can include creating confusion or misunderstanding, inflated perceptions of risk, desensitization, reactance, a sense of blame, reinforcement of existing beliefs, creating negative or stereotypical social norms, and increasing power imbalances (Cho & Salmon, 2007).

Salmon, Post, and Christensen (2003) highlighted one such unintended effect when a social marketing campaign in Michigan intended to reduce domestic violence influenced policy change and created laws that resulted in the increase in arrests of battered women. As Salmon, Post, and Christensen (2003) stated, “In more than 90% of the cases, women being battered will defend themselves, and police ended up arresting them as a result of the change in laws. Another unintended consequence was that women were less likely to contact the police when they were being beaten because their partner would face jail and prosecution if the incident were reported” (p. 37). Salmon and Murray-Johnson (2001) also cite the case of a campaign that was measured to be effective in changing attitudes, but that served to decrease information

gain in the treatment population and increased information gain in the control population. Despite evidence of these unintended effects, they are hard to measure empirically as they are mostly unanticipated and cannot be measured through pretest-posttest designs (Cho & Salmon, 2007).

Noar et al. (2009) state that although mass media campaigns for HIV/AIDS did show significant effects and can be good tools to raise awareness, the shift in campaigns towards changing behavior requires that interpersonal communication be a part of campaigns as well. Models such as the socioecological model (McLeroy, Bibeau, Steckler, & Glanz, 1988; Sallis & Owen, 2004) stress the importance of multiple levels of impact, such as mass media, interpersonal communication, and influence on policy. As Snyder et al. (2004) showed in their meta-analysis, campaigns that included some element of policy change were much more likely to influence behavior change in the intended populations. Abrams and Maibach (2008) suggest that mass media campaigns that seek to change the greater environment and have an indirect influence on prioritized populations may have equal or greater potential to change health behaviors.

Public health campaigns and mass media campaigns show limited effectiveness when practiced with sound design principles, according to several meta-analyses; however, this depends on campaigns' intended goals and contexts. Public health campaigns appear to be more effective in creating awareness, knowledge, or even attitude change, but also still limitedly effective for creating behavior change. Evidence suggests that mass media campaigns will create 5 to 10 percent behavior change on average in their intended population for the specifically targeted behavior

(Snyder, 2001). This effectiveness, however, can be hard to measure and can also produce unintended consequences. Campaigns are perhaps the most effective when they also incorporate methods beyond mass communication alone such as interpersonal communication, policy work, and influence at multiple levels within the population's environment.

Ecological Approaches to Health Campaigns

Health disparities and the need for ecological approaches. In the area of health, the consequences of institutionalized systems of power that inherently privilege individuals elevated in the hierarchy can perhaps be seen the most clearly. Also, in public health work, there has been an increasing focus on health disparity research and policy and how approaches to health communication can address these disparities.

Health disparities are defined as differences in access to health care and quality of health care; differences in the incidence, prevalence, and morbidity and mortality rates of health problems; and differences in the burden of health-related problems in relation to ethnicity, race, gender, class, or geography (Brennan Ramirez, Baker, & Metzler, 2008; Kamble & Boyd, 2008).

Despite the increasing focus on social determinants of health and health disparities, these disparities are persistent and severely affect many groups of individuals (Cummings & Jackson, 2008). Marginalized populations (Dutta, 2005; Ford & Yep, 2003), or those falling outside of dominant power structures, are those most likely to be impacted these disparities. These populations are often those marginalized due to their social position; these groups face inequalities due to their

socioeconomic status, gender, geographic location, race, ethnicity, sexual orientation, or other factors. These social factors tend to create barriers to positive health conditions, such as safe and healthy housing conditions, healthy food options, strong educational programs, and safe neighborhoods. Health disparities caused by social determinants of health have been shown to negatively influence health and worsen health conditions for marginalized populations (Brennan Ramirez, Baker, & Metzler, 2008). For example, low socioeconomic status is an increased risk factor for heart disease, diabetes, arthritis, cervical cancer, mental illness, and other chronic diseases (Pleis & Lethbridge-Çejku, 2007).

Previous explanatory paradigms for these health disparities have focused on “scientific” factors such as biological race or sex factors and lifestyle choices to explain health disparities. However, the World Health Organization has encouraged a new focus on the social factors that influence health inequalities and disparities and established the Commission on the Social Determinants of Health in 2005 to study this phenomenon (Schofield, 2007). Research on social determinants of health disparities suggests that individuals’ health is impacted by social and environmental factors, including “unjust social structures” in addition to individual biological factors (Schofield, 2007; Schulz & Northridge, 2004; Schulz, Parker, Israel, & Fisher, 2001; Schulz, et al. 2005). Social determinants of health are factors in the social environment that affect the health of communities and of individuals. The study of social determinants of health is still somewhat controversial, however, as many health professionals and researchers believe that too much focus on the social determinants

draws away from the actual biological and lifestyle choices that individuals make (Berkman, 2009; Forde & Raine, 2008).

Addressing health disparities and resulting health problems through health communication can be a challenge because health communication is typically targeted at specific individuals and groups and typically not at larger societal problems. Weber and Parra-Medina (2003) note that in biological or positivist traditions of health study, the individual serves as the unit for analysis, obscuring the role that larger social structures play in creating health disparities. As Schulz and Northridge (2004) note, health “disparities are created and sustained through dynamic processes that are implemented through legal, political, and economic systems” (p. 467). These disparities are affected by unequal social relationships due to differences in individuals’ or groups’ access to resources such as quality health care and health education, as well as individuals’ environmental exposures (Baker, Metzler, & Galea, 2005; Schulz & Northridge, 2004). Addressing social determinants of health provides promise to reducing health inequalities and disparities (Williams, Costa, Odunlami, & Mohammed, 2008). Few current studies have taken a message based approach to studying social determinants of health (Viswanath & Emmons, 2006); however, as these approaches are typically targeted towards individual behavior change, rather than messages to affect the larger community or environmental structures.

In order to more fully understand the problems that plague individuals and the context in which health disparities occur, there is a need to consider the unique perspectives of “populations whose social and health realities remain at the margins

of health inequities research” (Hankivsky & Christofferson, 2008, p. 278). Health promotion or communication initiatives are often targeted at the individual and may fail to take into account these unequal relationships or power imbalances that may prevent individuals from feeling empowered to act or to take on healthy behaviors.

Taking an ecological approach. An ecological approach is often required to change health behavior and have this change sustained, as multi-level campaigns are the most effective in creating sustainable behavior change (Abroms & Maibach, 2008; Snyder et al., 2004). Socio-ecological theory—sometimes described as a model, a paradigm, or a perspective—lends understanding to health communication and promotion and may provide insight into how an empowerment initiative could be most effective (Stokols, 1996).

As Green, Richard, and Potvin (1996) state, “health promotion is relatively young, but ecology is not” (p. 270). Lewin (1951), considered the father of ecological psychology, stressed that the outer environment has influence on the individual. Barker (1968) furthered this notion through the study of environmental psychology, noting that behaviors could be predicted better from the situations and environment surrounding the behavior than from individuals’ characteristics. An ecological perspective focuses on the interrelationship between organisms (e.g., individuals) and their environment, examining individuals’ transactions or behavior with their physical and sociocultural surroundings or environment (Burke, Joseph, Pasick, & Barker, 2009; Stokols, 1992; 1996). Media and individuals are part of the larger equation, but there are other factors that must be considered for effective health

promotion as well, and media may have an impact on these other factors, in turn having an impact on the individuals whose behavior change is sought.

Many current theoretical perspectives focus solely on the individual and deemphasize the environment surrounding that individual (Burke et al., 2009). As Lewin (1943) noted as a heuristic for thinking about individual behavior, $B = f(p, e)$, or behavior is a function of the person and the person's environment, meaning that individuals' behaviors are also influenced by their environment. As Burke et al. (2009) state, the socio-ecological model is different from most other health communication theories in that social context is traditionally not examined as a major influencer of individual behavior and health outcomes, perhaps because individual messages and behavior change are easier to quantify and measure. "While behavioral science seeks to understand, explain, and often change human behavior through the adoption of healthier lifestyles, behaviors, and attitudes, the theories employed have an individual, cognitive focus, largely abstracted from social context" (Burke et al., 2009, p. 56S).

The ecological approach has been growing in popularity and has increasingly been called a theory or model for health communication and promotion. A socio-ecological perspective stresses the importance of influence at multiple levels including individual, interpersonal, institutional, community, and society levels (McLeroy, et al., 1988; Sallis & Owen, 2004). These multiple levels of influence are interdependent and affect one another with reciprocal causation effects among levels (McLaren & Hawe, 2005). According to a socio-ecological approach, it is not sufficient for one level of the socio-ecological model to be affected, such as

individual behavior—a sound communication approach also seeks to affect policies and organizations that can support these initiatives. Social ecological models stress that behaviors “both shape and are shaped by the social environment” (Glanz & Bishop, 2010, p. 403). Ecological models can prevent a reductionist approach to thinking about health communication that may lay blame on the individual without acknowledging the larger environment at play (Green, Richard, & Potvin, 1996): a socio-ecological approach factors in the many times the individual does not have the power to change her circumstances alone, and shifts attention and blame from the individual to the larger social domain as well. This is not to say that the individual has no role in her health, but instead that the individual’s role is just one of the many pieces that will factor into the equation.

According to McLeroy et al., (1988), the socio-ecological model includes five main levels of influence: (a) intrapersonal or individual, (b) interpersonal, (c) institutional or organizational, (d) community, and (5) public policy. These levels are conceptualized as concentric circles nested within one another (McLaren & Hawe, 2005). For example, the intrapersonal or individual level would be the innermost circle, with the interpersonal level surrounding this circle, the institutional circle surrounding the interpersonal level and thus also the individual level, etc.

Bronfenbrenner’s (1979) conceptualization of the ecological model was somewhat different than McLeroy et al.’s (1988) focusing on the levels of: (a) individual, (b) microsystem, (c) mesosystem, (d) exosystem, and (e) macrosystem. In Bronfenbrenner’s conceptualization, the microsystem included peers and interpersonal interaction, as well as community interaction with churches, schools, work, and

health systems with which individuals had direct relationships. Here the mesosystem referred to the connection between different structures found in the microsystem and the indirect influence and direct influences through these connections. The exosystem referred to media, politics, industry, etc., and the macro system referred to the larger attitudes and ideologies of the culture.

McLeroy et al.'s (1988) updated conceptualization shows the intrapersonal level as the internal individual characteristics that can influence health behavior (e.g., knowledge, awareness, attitudes, etc.). The interpersonal level reflects the interpersonal and small primary group interactions (e.g., family, friends, and influential peers). The institutional or organizational level of influence focuses on the influence of social institutions with formal and informal rules and regulations. The community level highlights the social networks and norms that exist either formally or informally among groups and organizations. Lastly, the policy level highlights local, state, and national policies and laws that influence behavior. This model does not focus as strongly on "culture," but does acknowledge the shared norms and meanings among community members within the community level.

All of these levels can influence health behavior, whether directly or indirectly (Grzywacz, & Fuqua, 2000). Mediated campaigns can target one or multiple levels of the model simultaneously, or media may be used to target some levels, while other forms of intervention are used to target other levels (McLeroy et al., 1998; Sallis & Owen, 2004). To illustrate, the U.S. Department of Health and Human Services (1995) provides an example of a woman delaying a recommend mammogram. In this example, the woman could delay the mammogram due to: individual level factors

such as fear of finding out she has cancer, interpersonal factors such as friends who believe a mammogram is not important, institutional factors such as her medical provider not telling patients her age about the test, or policy factors such as lacking insurance coverage which would enable her to afford the fee. In this example, the woman's behavior and decision not to get a mammogram was affected by multiple factors, not just one factor at a certain level. These levels might also influence or affect one another, increasing interpretations of barriers. As another example, affecting structural and policy concerns, such as creating safe communities and parks with walking trails and places to exercise can help to reduce environmental health inequities and provide lower-income, urban individuals with a chance for more physical activity to lower their risk of obesity (Glanz & Bishop, 2010). The social ecological model stresses that people both influence and are influenced by their environment and by other individuals around them—the concept of reciprocal relationships and reciprocal causation (McLaren & Hawe, 2005).

Media advocacy as part of an ecological approach. As indicated above, research in public health communication campaigns has indicated the necessity of shifting from a focus on individual change to a focus on social change, encouraging communities to find their voice on health issues and define the problems together; media advocacy has been suggested as one such way to shift this focus (Wallack, 1994). As Wallack (2002) states, “Media advocacy is the strategic use of mass media in combination with community organizing to advance healthy public policies.” Media advocacy promotes social and political changes through addressing social determinants of health and promoting social justice in public health (Altman et al.,

1994; Wallack, 2000, 2002). Media advocacy emphasizes social, economic, and political roots of health problems that affect individuals, rather than individual behavior. These social determinants of health have been underutilized in media campaigns (Wallack, 2002). “Media advocacy is a tactic for community groups to communicate their own story in their own words to promote social change. It is a hybrid tool combining advocacy approaches with the strategic and innovative use of media to better pressure decision makers to support changes for public health policies” (Wallack, 1994, p. 421).

Wallack (1994) discusses the “information gap” versus the “power gap.” Traditional public health campaigns focused on individual behavior change emphasize the “information gap,” suggesting that there is a lack of information about health needed for individuals to make healthy behavior choices. The “power gap,” on the other hand, is the focus of media advocacy, suggesting that there is a power imbalance between the “haves and the have-nots” and that the power of the media can help to decrease this power imbalance for marginalized, disenfranchised groups (Altman et al., 1994; Wallack, 1994).

Advantages to an ecological approach. The advantages of the ecological approach have been quite evident. As mentioned above, multi-level campaigns and communication approaches have been most effective at creating behavior change (Abrams and Maibach, 2008; Snyder et al., 2004). Focusing on individual behavior alone is often not enough as environments (and individuals’ notions about those environments) may highly constrain health behavior even which individuals are motivated to make a behavioral change (Glanz & Bishop, 2010). Snyder et al. (2004)

reveal in a meta-analysis of health communication campaigns, that campaigns that were the most effective were those that also focused on influencing policy.

Ecological approaches can more effectively help to create sustainable behavior change. Additionally, ecological approaches can be more effective in reaching underserved and marginalized populations as they may not have the community or structural resources in place to make the desired behavior changes (Fahrenwald & Stabnow, 2005), which can be especially important in the case of rural women.

Ecological models can help to prevent a reductionist approach that may blame the individuals without also acknowledging the larger sources that constrain them (Green, Richard, & Potvin, 1996).

Limitations of an ecological approach. Green, Richard, and Potvin (1996) note that despite the potential that the ecological perspective brings to health communication, there are also many limitations with this approach. Due to the complexity of socio-ecological models, testable hypotheses would reduce the environment to terms too simplistic (Green, Richard, & Potvin, 1996). Most ecological models have not been empirically validated in their entirety. As Stokols (1996) notes, an ecological perspective is composed of many different theories and may be more like a meta-theory or a paradigm from which to practice. Additionally, many different ecological models have emerged, each one with slight different conceptualizations (McLaren & Hawe, 2005); as to date, there has been no consensus on one single social ecological model.

Ecological approaches to mass mediated health communication that focus on multiple levels and the individual as well as the environment may have the most

impact on individuals' health behavior. Mediated communication that focuses on multiple levels beyond the individual level—including interpersonal, institutional/organizational, community, and policy—can help to reduce barriers for individuals and empower them to make the desired health behavior changes.

Ecological approach to empowerment. Zimmerman (1995; 2000) calls for research on the contexts of empowerment, as well as an understanding of the larger ecological processes that are occurring. As Zimmerman states, “The information gathered using an ecological framework may help identify those aspects of the interactional component of psychological empowerment that are contextually appropriate and culturally relevant, and should also help stimulate research on empowerment at multiple levels of analysis” (1995; p. 725). As Wallerstein (2006) notes, empowerment strategies are most likely to be effective when also combined with strategies that seek to influence policy change and also create greater equality and empowerment at macro levels.

Empowerment through Health Communication

Empowerment of publics and audiences can lead to positive health outcomes, and has been described as a viable public health strategy (Wallerstein, 2006). A large base of research highlights the negative effects of lack of control or powerlessness on health; conversely, much research has also highlighted the effects of empowerment in improving health (Bergsma, 2004; Wallerstein & Bernstein, 1988). Rissel (1994) states that empowerment should, arguably, be a goal of all major health campaigns. The use of empowerment as a strategy to help improve public health has primarily

focused on marginalized, socially excluded, or “powerless” populations (Wallerstein, 2006).

Theoretical perspectives for empowerment. Israel, Checkoway, Schulz, and Zimmerman (1994) define empowerment as “the ability of people to gain understanding and control over personal, social, economic, and political forces in order to take action to improve their life situations” (p. 152). The concept of “power” drives the conceptualization of “empowerment” (Boehm & Staples, 2002), implying that individuals or communities could increase their notions of power. Lukes (2005) describes both “power to”—individuals’ ability to control their own actions through personal empowerment—and “power over”—the visible and invisible, hegemonic power that exists over individuals, put in place by systems, organizations, or other people.

Much of the work on health empowerment has stemmed from the teaching and writings of Brazilian educator Paulo Freire. Health scholars have applied Friere’s works on empowerment education to health education and promotion in a variety of contexts (Bergsma, 2004; Li-Chun, I-Chuan, & Chieh-Hsing, 2004; Minkler & Cox, 1980; Minkler & Wallerstein, 2002; Rindner, 2004; Wallerstein & Bernstein, 1988; Wallerstein, Sanchez-Merki, & Dow, 1997). Freire’s teachings on empowerment education focus on the premise that education is not neutral; individuals who are marginalized or oppressed—those that may face powerlessness or lack of control in other aspects of life based upon their life situations—bring this feeling of powerlessness with them into educational settings and interactions with health professionals (Freire, 2000/1970, 2004/1992, 2008/1974; Wallerstein, 1992).

Freire promotes education that allows marginalized and oppressed individuals to become aware of the forces that restrict them and to challenge these forces, as opposed to education that reinforces this notion of powerlessness and treats these individuals as objects or as those to be subjugated by the health educator (Wallerstein & Bernstein, 1988; Wallerstein, 1992). In Freire's concept of empowerment education, the publics (not the health promotion professionals) should define the health problems of the community (Bergsma, 2004).

Empowerment is both a process and an outcome (Laverack & Wallerstein, 2001; Rissel, 1994). According to Wallerstein (2006), "empowerment is recognized both as an outcome by itself, and as an intermediate step to long-term health status and disparity outcomes" (p. 4). As Zimmerman (1990) states, empowerment can shift and changes over time. Individuals can have varying levels of empowerment: "It is not an absolute threshold that once reached can be labeled as empowered" (Zimmerman, 1990, p. 170).

Haley, Johnson Avery, and McMillan (2008) show that health messages can positively influence meaning making of empowerment. Currie and Wisenberg (2003), however, state that, "we do not imply that the researchers or trainers can empower women. For us, empowerment is about women and men taking control over their lives... Outsiders cannot empower women: only women can empower themselves to make their own choices or to speak on their behalf" (p. 896). Gruber and Trickett (1987) also state that the institutional structure that puts individuals and groups in power works to undermine the very idea of empowerment—that those with power could give power to others. Swift and Levin (1987), however, argue that at the

individual level of empowerment, or psychological empowerment, an increase of power to one individual or group does not mean that another group or individual would decrease in power. This conceptualization might be different, however, at different levels of empowerment, such as the community or institutional levels of empowerment.

Levels of empowerment. Empowerment is thought to occur at three levels: the individual, community, and organizational or institutional (Currie & Wisenberg, 2003; Israel et al., 1994; Laverack & Wallerstein, 2001). Community empowerment has been defined along a continuum, beginning with individual empowerment, then small group development, organization building, organization partnering, and, ultimately, social and political action (Laverack & Wallerstein, 2001; Rissel, 1994).

This research project explores primarily on individual level empowerment as individual women's lived experiences are being explored through interviews, but as women's individual empowerment is inextricably linked to other levels of empowerment, the study also explores other levels of empowerment, such as community and organizational empowerment. Garcia et al. (2010) state that, "Addressing health and wellness solely at the level of the individual is insufficient, since individual change alone does not address the spectrum of contextual issues that impact the health and wellness of the population" (p. 679). As Wallerstein (2006) notes, individual empowerment, although an individual, psychological construct, is linked with a sense of community. Also, as Minkler and Wallerstein (2002) note, Freire's notion of conscientization—the community consciousness that develops through structured dialogue about the problems that community members face

(Freire, 2008/1974)—is the link between individual and community empowerment and sustaining community change efforts for the long term.

Individual/psychological empowerment. Individual empowerment refers to individuals' ability to have control over their lives (Israel et al., 1994). At the individual level, empowerment may include feelings of efficacy, perceived control, and participatory behavior (Zimmerman, 1990).

Psychological or individual empowerment has been measured as a trait that is intrapersonal or internal to individual (Peterson et al., 2006). Zimmerman (1990) calls for a need to distinguish between psychological empowerment and individual empowerment. The “psychological” notion of individual empowerment is to “understand how what goes on inside one's head interacts with what goes on in one's environment to enhance or inhibit one's mastery and control over the factors that affect one's life” (Zimmerman, 1990, p. 174). As Zimmerman notes here, individually oriented notions of empowerment consider empowerment to be a personality variable and often to fail to acknowledge the ecological and contextual considerations that the psychological notions of empowerment embody.

Empowerment at the individual level includes: “(1) personal efficacy and competence, (2) a sense of mastery and control, and (3) a process of participation to influence institutions and decisions” (Israel et al., 1994, p. 152). The individual level is linked to other levels, such as organizational and community levels, in that these levels can influence individuals' perception of their personal control over health situations and their interpretations of social support.

Although empowerment has been compared to (and may include) concepts such as self-efficacy, self-esteem, locus of control, and perceived behavioral control, scholars agree that empowerment is a larger concept (Perkins & Zimmerman, 1995; Zimmerman, Israel, Schulz, & Checkoway, 1992). Zimmerman et al. (1992) measure psychological empowerment through measuring various elements of perceived control in a community context, different from perceived behavioral control, which is an element of the Theory of Planned Behavior. In this conceptualization, empowerment is seen as a continual process, influenced by participation with others and an understanding of one's environment.

Johnson, Worell, and Chandler (2005; Worell, 1996) describe a psychological empowerment model that includes factors of “(a) perceptions of power and competence, (b) self-nurturance and resource access, (c) interpersonal assertiveness, (d) awareness of cultural discrimination, (e) expression of anger and confrontation, (f) autonomy, and (g) personal strength and social activism” (p. 118).

Gutiérrez, DeLois, and GlenMaye (1995) also studied how human service workers made meaning of empowerment; these human service workers served the health needs of specific populations including women, gay and lesbian populations, individuals of color, and older adults. The human service workers interviewed defined empowerment in practice more as a process of individual or psychological empowerment, focusing on: (1) control—both as perceived control and concrete resources/means, (2) confidence—described here in terms of self-efficacy or self-esteem, (3) power through creating structures or systems of change, (4) choices—allowing multiple venues or options for change, such as community supports or

structures, individual routes, etc., and (5) autonomy—the ability to act independently and of one’s own accord.

Community empowerment. Wallerstein and Bernstein (1988) described community empowerment as “a social action process that promotes participation of people, organizations, and communities in gaining control over their lives in their community and larger society” (p. 380; Minkler & Wallerstein, 2002). As Wallerstein and Bernstein note, empowerment is not about achieving power over others, but rather empowering all parties to be able to work together to promote change. Rissel (1994) states that community empowerment is considered to be a collective phenomenon, but one that includes an individual psychological component.

Israel et al. (1994) define community for purposes of community empowerment as a specific location or domain that has some sort of membership, common language and rituals, shared norms and values, mutual influence among community members, shared needs, and shared emotional connection. While Israel et al. (1994) note that communities may be bounded within geographic areas, communities may also exist outside of any such geographic ties, such as specific cultural or ethnic groups who are separated by geographic distance.

Israel et al. (1994) state that an empowered community is one in which community members (both individuals and organizations) collectively shared skills and resources to meet respective needs. As Laverack and Wallerstein (2001) note, although community empowerment for health has received increasingly more scholarly attention, there is little consensus on how to operationalize community empowerment into health promotion programs.

Self-efficacy as a dimension of empowerment. Self-efficacy is often studied as an element of empowerment. Wallerstein (1992) notes that self efficacy is an aspect of psychological or individual-level empowerment. Efficacy, first conceptualized by Bandura (1977, 1986), is individuals' beliefs about their own ability or capability to perform a particular action. Self-efficacy is one of the most studied theoretical constructs in health communication, and studies found that increasing individuals' confidence in their ability to take action helps to lower perceived constraints (Baranowski, Perry, & Parcel, 2002). Self-efficacy is part of many theories, including Bandura's social cognitive theory (Baranowski et al., 2002), the health belief model (Rosenstock, Strecher, & Becker, 1988), and the extended parallel process model (Witte, 1992).

Bandura's (2001, 2004) social cognitive theory states that perceived self-efficacy acts as a core determinant of health. The other personal factors that act as determinants of health include *knowledge* about health risk and benefits, *skills*, *outcome expectations* about the potential positive or negative outcomes of health behaviors, the health *goals* of individuals, *emotional coping*, and *self-control* (Bandura, 2004; Baranowski et al., 2002). Environmental factors that influence health include social, institutional, and physical factors that may act as perceived *facilitators* and *impediments*, influencing the ability to perform health behaviors (Bandura, 2004). A central idea of the social cognitive theory is that of *reciprocal determinism*, the idea that the individual and the environment have continuous influence upon one another; in this conceptualization, the person, the behavior, and the environment are all influencing one another simultaneously. "Behavior is not

simply the result of the environment and the person, just as the environment is not simply the result of the person and the behavior. Instead these three components are constantly influencing each other” (Baranowski et al., 2002, p. 168). As Bandura (2004) notes, although efficacy is an important concept for understanding the performance of healthy behaviors, external social factors must be considered as part of the mix. Individuals and their health behaviors do not exist within a bubble, and researchers must pay attention to other influences as well.

Self-efficacy is different from response efficacy—a component of the extended parallel process model (Witte, 1992)—in that response efficacy is the belief that the recommended behavior will have the desired effect. The construct of response efficacy is similar to the concept of outcome expectations in Bandura’s social cognitive theory (2001). For example, an individual might have high self-efficacy if she believed she could perform the act of regularly brushing her teeth; however, she may have low response efficacy if she believed that brushing her teeth did not make a difference in the health of her teeth, rather that chewing gum might perform the same function.

Scholars suggest that self-efficacy can be influenced through a variety of ways (Bandura, 1997; Baranowski et al., 2002). One such way is performance mastery experiences, where individuals can begin by taking small, easy steps to improve their health, and then, once individuals successfully achieve the small steps, they can begin taking more difficult steps. Performance mastery allows individuals to feel success at small tasks and gain confidence in their abilities. Another way to increase beliefs about efficacy is through watching others’ experiences or through watching

demonstrations; watching others succeed can help individuals to see that the behaviors are achievable. Other ways to increase self-efficacy are through positive, confidence-inducing statements, suggesting that others believe in the individuals' ability to perform the behavior, and through diminishing of negative emotional arousal, such as fear, which may be interfering with efficacy (Bandura, 1997; Bandura, 2002).

For example, when considering rural women's health, women may not believe that they are actually able to take protective measures for their health such as exercising, eating healthier foods, or visiting the doctor regularly. Beliefs such as those about exercise can be countered by showing rural women through observing others exercise that exercises can actually be very simple and easy to do, or by giving women very small tasks or exercises at which they can succeed, giving them confidence in their abilities to continue.

Increasing efficacy to create behavior change. Folta et al. (2009) implemented a heart healthy intervention program designed to change rural women's everyday health behaviors such as healthy eating and physical activity; the intervention focused on skill building activities in order to increase women's self-efficacy. Folta et al. (2009) found significant changes in women's healthy behaviors prior to program and also found that women increased in their self-efficacy.

Collie et al. (2005) found that low self efficacy in rural women was related to difficulties interacting with medical professionals; in Collie et al.'s research, emotional venting and social support were not related to difficulties interacting with healthcare providers, only efficacy. Hermstad et al. (2010), however, found that the

home environment played a large role in healthy eating behaviors for women, and higher self efficacy led to greater beliefs about healthy home environments.

Maibach, Flora, and Nass (1991) found through a community health campaign with minimal contact that both individuals' preexisting notions of self-efficacy related to their health as well as the self-efficacy messages promoted by the community campaign positively affected individuals' adoption of regular exercise and health eating habits. Results from this study suggest that self-efficacy is preexisting and internal, but that it can also be influenced by mediated health messages.

Perceived behavioral control as a dimension of empowerment. Perceived behavioral control, an element of the theory of planned behavior, is another dimension that has been studied for its relation to empowerment. The theory of planned behavior is an extension of the theory of reasoned action (Albarracín, Johnson, Fishbein, & Mullerleile, 2001; Montano & Kasprzyk, 2002; Myers & Horswill, 2006). In the theory of reasoned action (Ajzen & Fishbein, 1970; 1980), perceptions of *attitudes* and *subjective norms* towards performing a behavior influence individuals' *behavioral intentions*, which directly predict individuals' actual behaviors. In the revised version of the theory, the theory of planned behavior, *perceived behavior control* also affects behavioral intention, similarly to attitudes and subjective norms, which in turn impacts behavior (Ajzen, 2002; Ajzen & Madden, 1986).

Behavioral intentions (Hale, Householder, & Greene, 2002) are individuals' intentions to perform the actual specific behavior in question. The closer the behavioral intention is to the actual behavior, the more likely that this behavioral

intention would accurately predict the behavior. For example, a reported behavioral intention that a woman plans to buy apples, carrots, and celery sticks for snacking when she goes to the grocery store tomorrow is more likely to actually result in the individual performing this behavior.

The concept of *attitude* is defined specifically as individuals' attitudes towards the actual behavior being studied, such as healthy eating, exercising, regular visits to a healthcare provider, or regular dental care. Attitudes toward the behavior are both a product of individuals' behavioral beliefs and individuals' evaluations of behavioral outcomes (Ajzen & Fishbein, 1970; 1980; Montano & Kasprzyk, 2002).

Subjective norms are made of individuals' normative beliefs—their perceived beliefs about whether or not referent others comply with the specific behavior—and individuals' motivation to comply—their specific desire to comply with the behaviors of specific referent groups (Montano & Kasprzyk, 2002).

When the theory of reasoned action was modified as the theory of planned behavior, the construct of *perceived behavioral control* was developed. Perceived behavioral control is defined as “people's perception of the ease or difficulty of performing the behavior of interest” (Ajzen, 1991, p. 183), and takes into account that behaviors may not always be within individuals' control or may not be perceived to be controllable.

Perceived behavioral control is measured indirectly by *control beliefs* and *perceived power* (Montano & Kasprzyk, 2002). Control beliefs are individuals' perceptions about the control they have for certain constraining or facilitating conditions and the likelihood of occurrence; perceived power is individuals'

perceptions of conditions that might make performing behaviors easier or more difficult. Perceived behavioral control may be affected by internal factors, such as beliefs about skills and abilities, or external factors, such as time, opportunity, and dependence on others (Ajzen, 1991). Ajzen and Madden (1986) found that the inclusion of behavioral control as a construct more accurately predicted behavioral intentions than did the theory of reasoned action. Because of the predictive ability of perceived behavioral control, knowledge of specific facilitating or constraining conditions affecting control can be helpful in designing public health campaigns (Montano & Kasprzyck, 2002).

In a new version of the reasoned action approach (Fishbein, 2008) which combines both the theory of reasoned action and the theory of planned behavior, Fishbein labels perceived behavioral control as “efficacy.” Meyers and Horswill (2006) found that self-efficacy and attitudes predicted behavioral intentions and actual behavior for sun protection; however, in this context, subjective norms and perceived behavioral control did not predict intentions or behaviors. Norman and Hoyle (2004) also found that self-efficacy and attitudes were predictive of individuals’ intentions to perform breast self-examinations to prevent breast cancer. Although perceived behavioral control was correlated to self-efficacy, Meyers and Horswill found that self-efficacy was a more powerful predictor of intention and behavior than perceived behavioral control and believed these two constructs could be measured differently. Trafimow, Sheeran, Conner, and Finlay (2002) also found in their meta-analysis that efficacy (described as perceived difficulty) predicted intention and behavior better than did perceived behavioral control. Motl et al.

(2005), however, found that perceived behavioral control was a significant predictor of physical activity. Hagger, Chatzisarantis, and Biddle (2002) argued that although perceived behavioral control and self-efficacy may be measured differently, self-efficacy and individuals' past behaviors are important additions to the model.

Although there is some conflicting evidence about which construct—perceived behavioral control or self-efficacy—is more effective in given health situations, most scholars agree that the concepts contain different elements for measurement and affect individuals in different ways. Both constructs are important for understanding the larger concept of empowerment. As Zimmerman (1990) points out, empowerment has been a challenge to define, as it takes on different forms for different contexts and individuals, and because empowerment operates at different levels of analysis (i.e., the individual level and the community level). Understanding both self-efficacy and perceived behavioral control as elements of empowerment can help to strengthen understanding of the individual level of empowerment and how empowerment might be included in public health campaigns.

Drawing upon the literature on empowerment—including factors such as individual empowerment, including perceived behavioral control and self-efficacy, and factors such as community empowerment—the following research question is addressed:

RQ1: How do rural women make meaning of empowerment?

Empowerment as an element of health campaigns. The majority of research exploring the effectiveness of empowerment strategies has focused on how empowerment can be employed through participatory processes, interventions, and

the building of community capacity (Wallerstein, 2006). Little research, however, has explored how empowerment can be employed through health communication campaigns and mass media messages. As Egbert and Parrott note, "health communication specialists have determined that perceived self-efficacy is a critical component of successful behavior change, yet few health communication campaigns have capitalized on this construct by making it the focus of health promotion messages" (2001, p. 230).

Garcia et al. (2010) found that empowerment of women for positive health outcomes has been employed most commonly at the individual, interpersonal, and community levels of social ecology. This study argues that more emphasis of empowerment via media messages and health communication campaigns is needed.

Campo et al. (2008) developed a campaign using print and radio ads to influence colorectal screening in rural populations; use of these types of media was effective in influencing behavior change for rural audiences. Campo et al. (2008) suggest segmenting audiences for health campaigns via rural and urban segment, in addition to other factors, something which the authors argue has rarely been done.

McFarlane and Fehir (1994) found that a 5-year program, which sought to empower mothers through media, health clinics, social service agencies, local policymakers, schools, churches, and local businesses, had significant effects on women's individual self-esteem and perceived power, as well as community power and esteem. Additionally, Sternberg and Hubley (2004) find evidence that mass media campaigns do have an effect on men's involvement with women's health issues, which can lead to empowerment of women; however, they reveal that there is

no consistent evidence that men's involvement leads to the empowerment of women. Despite media's ability to empower women; however, media also creates further stereotypes of gender inequality (Kiran, 2004).

Audiences in rural communities can be harder to reach because of their remoteness and lack of access, at times, to various types of mainstream media; however, Campo et al. (2008) found that adding elements of posters and postcard in rural clinics also helped to gain exposure, as there are fewer, more centralized clinics in these areas, and rural residents are more likely to come in contact with these messages. Additionally, interpersonal communication, such as communication with positive social networks and health care providers, can also contribute to the effectiveness of health communication campaigns for rural women (Campo et al., 2008; Campo et al., 2010).

Reger et al. (2002) found that a mass media campaign that sought to influence individuals' perceived behavioral control and encourage walking as a form of physical activity in a rural community was successful both in increasing perceived behavior control and in increasing walking as a form of physical activity.

Egbert and Parrott (2001) found that rural women faced several challenges that affected their self-efficacy related to performing routine detection practices for breast and cervical cancer. Factors that influenced women's confidence included peer norms, limited time, and feelings of embarrassment. Factors that influenced both confidence and beliefs of the difficulty of the detection practices included knowledge and family norms.

Powe (2002) found that health messages that included elements of cultural and self-empowerment influenced significant change in preventative screenings. Culturally appropriate initiatives that focus on empowering participants have been shown to be successful in rural populations (Mayer-Davis et al., 2004).

As shown here, still little is known about how to effectively incorporate individual and community empowerment into larger communication campaigns. As such, the follow research question is asked:

RQ2: How can communication campaigns create a sense of empowerment in rural women?

Community-based participatory approaches to empowerment.

Empowerment can perhaps be most effective when publics are part of the process. Balit (2004) suggests forms of communication should be participatory in nature in that the rural women should help to develop the communication initiatives based upon their priorities or needs. Much work on empowerment also focuses on participatory research processes and encourages involving participants in all phases of planning, implementation, and evaluation for empowerment initiatives (Ginossar & Nelson, 2010; Pistella, Bonati, & Mihalic, 2000; Wallerstein, 2006). Through a community-based participatory research program designed to empower rural and urban women, Romero et al. (2006) found that the program caused significant changes in the psychological empowerment of the women, including self efficacy, relational power, and perceived control at organizational and community levels.

Community-based participatory research approaches seek to equitably involve community members as partners (Israel, Eng, Schulz, & Parker, 2005). Culture-

centered approaches to health communication also stress the importance of involving publics in the health communication initiative from beginning to end (Dutta, 2007; Dutta & Basu, 2008). Community media approaches, which allow community members to participate in creating of media, messages, and campaigns, can also help to empower participants (Ginossar & Nelson, 2010; Wallerstein, 2006). For individuals who have access to the Internet, digital media may be a particularly powerful form of media in building communities and allowing community participation in creation of media.

However, not all scholars agree that communication participation and empowerment are wholly positive additions to communities. Braunack-Mayer and Louise (2008) state that community empowerment can be “ethically contentious” and should be seen as a process, not as an outcome. These scholars call for a Reflective Equilibrium Community Empowerment approach to better address ethical dilemmas that may arise in health empowerment, by ensuring that both “top down” and “bottom up” approaches are used. For most scholars, participatory strategies are at the base of empowerment; however, effective empowerment strategies should also build capacity in publics to be able to redress power differences (Wallerstein, 2006).

Factors Affecting Empowerment

Little is known about factors that affect empowerment. Although preliminary models exist regarding factors that affect individual and community empowerment (Wallerstein & Bernstein, 1988; Wallerstein, 1992), these models have not yet been effectively tested. Factors that with a potential impact on empowerment and health, particularly in this rural Appalachian woman population—such as religiosity, social

networks and community involvement, and involvement with health (Coward, 2006)—are explored for their relation to empowerment in this study. In addition, scholars have suggested that understanding of empowerment will be different for different populations in varying settings (Zimmerman, 1990). As such, this study also explores through grounded theory development, other factors of importance that may emerge as affecting rural women’s empowerment for health. To this extent, the following research question is asked:

RQ3: What factors can affect rural women’s meaning-making of empowerment?

Religion, empowerment, and health. Research shows that religion may also have an impact on rural women’s sense of empowerment and their everyday health activities. Religion may be especially important for rural women’s health, as scholars have shown that rural women are more likely to seek receive religious community support than are men (Dollahite, Marks, & Goodman, 2004). Higher levels of religiousness have been found among groups such as older adults, individuals with less education, and women (Pargament, 2002). Also, religion may be especially important for groups and individuals who have been historically disempowered or marginalized; for these individuals, religion may be seen as a source of optimism and strength (Pargament, 2002).

For rural women, religious involvement may be one of women’s only strong social support networks available to them (Garrison, Marks, Lawrence, & Braun, 2004). However, most of the relationship between health and religion has not been explained scientifically; scholars cite the need for further conceptual development

regarding the relationship between religion and health (McCullough & Willoughby, 2009).

Domains of religion's effect on health. Conceptualizations of religion in public health have shown religion to contain both public and private elements, including the social practices of religion as well as private practices such as prayer and Bible reading (George, Larson, Koenig, & McCullough, 2000). George et al. (2000) highlighted 10 key domains of religion that have been shown to affect health. These domains are as follows:

1. Religious affiliation or membership in a religious group
2. Religious history including upbringing, past experiences, and turning points
3. Religious participation in formal religious organizations and activities
4. Religious private practices such as prayer, meditation, reading religious materials, watching religious programming
5. Religious support offered by one's religious organization
6. Coping using religious beliefs to deal with stressful experiences
7. Religious beliefs and values
8. Commitment to religion, including the importance assigned to religion and how much religion affects other elements of life, such as personal values and behavior
9. Religious motivation for regulating and reconciling relationships, such as forgiveness or atonement

10. Religious experiences, such as individuals' personal experiences with the divine (George et al., 2000, pp. 105-106).

Religious commitment and involvement. Chatters (2000) finds through a systematic review of religion and public health that religion positively influences physical health as well as a sense of personal well-being and adjustment. Individuals' religious involvement, in terms of attending and participating in formalized religious institutions and services, has been found to be associated with increased perceptions of social support, which in turn positively affects indicators of health (van Olphen et al., 2003).

In Chatters' review, religious involvement, such as regularly attending religious services was associated with increased healthy behaviors and lifestyle and with decreased risky behaviors. George et al. (2000) found that although multiple elements of religion were related to the prevention of illness and disability and longevity of life, attendance at religious services was the strongest predictor of both prevention of illness and life longevity. However, Matthews et al. (1998) in a review of commitment to religion and health outcomes that, in at least one of the studies, commitment to religion was actually negatively related to the mortality of older adults. Matthews et al. (1998) acknowledge that, overall, commitment to religion appears to positively affect health; however, the relationship between commitment to religion may not be direct or completely straightforward and is one that needs further exploration.

Religious commitment is also related to individuals' perceived disability. For example, Matthews et al. (1998) note that as individuals' commitment to religion

increased, they were less likely to perceive they had a disability until a greater level of physical illness was present. In other words, individuals with greater commitment to religion required a greater level of physical illness to perceive themselves as disabled.

Perhaps even more strongly than its association with physical health, religious involvement has been shown to directly affect positive mental health outcomes (Aranda, 2008; Garrison et al., 2004; Koenig, 2001). Specifically religious involvement is associated with life satisfaction (Green & Elliott, 2010; Levin, Chatters, & Taylor, 1995), reduced likelihood of depression (Ai, Dunkle, Peterson, & Boiling, 1998; Garrison et al., 2004; Idler, 1994; Koenig, Hays, George, & Blazer, 1997; Koenig, Moberg, & Kvale, 1988; Meador et al., 1992; Smith, McCullough, & Poll, 2003; Strawbridge et al., 1998), decreased likelihood of abuse and dependence on alcohol and drugs (Amoateng & Bahr, 1986; Amodeo, Kurtz, & Cutter, 1992; Francis, 1994; Gorsuch, 1993; Hill, J. Angel, Ellison, and R. Angel, 2005; Koenig et al., 1994). Religion is also associated with increased social resources and positive attitudes about one's self (Chatters, 2000).

Religion and coping. As stated earlier, religion affects health through individuals' religious coping behavior, which has been shown to be an important part of the link between religion and health. Religion has also been shown to positively influence the outcome of illness and disease (George et al., 2000). Of the various dimensions of religion, religious coping has been shown to have the strongest association with recovery from illness (George et al., 2000; Matthews et al., 1998).

Fiori, Brown, Cortina and Atonucci (2006) also found older adults used religion to cope more positively than did younger adults, finding that this changed with age.

According to Miller, McConnell, and Klinger (2007) positive religious coping involves a stable relationship with God that bestows a sense of purpose and connectedness to others. Horning, Davis, Stirrat, and Cornwell (2011) found in a study comparing individuals with high and low religion levels and individuals with no religion (i.e., atheist or agnostic) that highly religious individuals were more likely to use methods of religious coping; whereas, individuals with no religion were more likely to use substances for coping. Religious individuals also reported more social supports than individuals who were not religious.

Private elements of religion. In addition to religion as a formalized, often social, institution, van Olphen et al. (2003) found that private religion, in terms of individuals' faith and prayer, was also related to increased mental health and decreased depressive symptoms. Aranda (2008), however, found that private prayer was not significantly related to lower rates of depressive symptoms, although Aranda had originally hypothesized that private prayer would be associated with lower risk of depression. Ultimately Aranda concluded that more research was needed regarding private elements of religion. As Chatters (2000) states, qualitative research on religion and health is increasingly important to understand how these two constructs are linked, due to the discontinuity between scientific and religious perspectives.

Negative effects of religion on health. Researchers more recently have begun to highlight the negative effects of religion on health, in addition to the positive effects (Flannelly, Ellison, & Strock, 2004). Negative effects include maladaptive

religious coping, such as passive coping where individuals surrender control of their problems to a divine power, beliefs that health problems are deserved as punishment for religious wrongdoing, and feelings of anger or abandonment from a higher power.

Although some have argued that religion can negatively affect health and discourage medical visits due to religious beliefs that individuals' health is in the hands of a higher power, research does not support that religion has a negative effect on health overall and instead research is conflicting. As George et al. (2000) state, "we have found no evidence that religion can harm health in representative samples of community residents or in systematically sampled clinical populations" (p. 110). However, as George et al. state, there may be specific subpopulations that are harmed by religious beliefs that discourage them from seeking medical care. Negative religious coping involves a less stable relationship with God and a struggle for spiritual meaning (Miller, McConnell, & Klinger, 2007). More research is needed with specific subpopulations, such as rural Appalachian women, to understand how their religious involvement specifically affects their health.

Pargament (2002) suggests that religion is a more complex concept that psychologists have studied thus far, stating that religion is neither inherently good nor bad, but instead has the potential both to help and harm. However, Pargament (2002) notes that religion is most helpful to groups that are socially marginalized and for those who make religion more fully a part of their lives. According to Pargament (2002) positive effects of religion are linked to internalized religion based on a secure relationship with a higher power; whereas, negative effects of religion are linked to imposed religion that involves an uncertain or insecure relationship with a higher

power. Lastly, Pargament (2002) notes that religious beliefs may be especially helpful in times where individuals are pushed to extremes or beyond their means.

Why religion affects health. Scholars have also explored why religion affects health; however, as religion is a complex phenomenon, there is still much debate about why religion has the effects that it does on health (Krause, 2010). Religion may have an impact on health due to specific religious beliefs that guide health behavior, such as prohibition or discouragement of alcohol consumption, smoking, drug use, violence, or promiscuous sexual behaviors (George et al., 2000). Some religious views also convey that the body is a sacred vessel that must be protected and treated with respect (George et al., 2000). Green and Elliott (2010) found that individuals with fundamentalist religious beliefs tended to report being happier than individuals with more liberal religious beliefs; however, individuals with more liberal religious beliefs tended to be healthier than those with fundamentalist beliefs.

Religion and social support. Religion may also affect health through social support; individuals who participate actively in church organizations report to have greater social networks, more social interaction, greater aid from their social networks, and greater satisfaction with social support (Ellison & George, 1994; Zuckerman, Kasl, & Ostfeld, 1984). However, despite the seemingly obvious connection of religion to social support through participation in religious organizations, only a small part of the relationship between health and religion is explained by social support (Idler, 1987; Zuckerman et al., 1984).

Coherence hypothesis. Another possible explanation for the connection between religion and health is the coherence hypothesis (George et al., 2000), which

suggests that religion affects health by allowing individuals to find a sense of meaning and coherence in their lives, which allows them to cope better. This hypothesis does not assume that the relationship between health and religion will always be positive, in that individuals may often endure pain and suffering that may be a sign of other health problems. Instead of seeking medical treatment, individuals may see this as part of their burden to bear (George et al., 2000). The coherence hypothesis accounts for more of the connection between religion and health than other hypotheses tested (George et al., 2000).

Religion and control, efficacy, and empowerment. Scholars have specifically studied the effect of religious involvement on individuals' control, efficacy, and empowerment. Evidence regarding religion's effect on empowerment is not consistent and results are mixed. Scholarship in this area shows the need for further research to clarify effects. Additionally, the factors and conditions under which religion positively affects empowerment may depend on contextual factors, such as the population and the community.

Some scholars have noted that women may feel less empowered or feel that they have less individual control over their health due to other environmental and societal factors; as a result, women regain some sense of control through religious empowerment or their beliefs that a higher power has control over their lives, even when they do not (Fiori et al., 2006). Women may use religion to help increase their sense of internal control and provide them with empowerment.

To illustrate the contextual and cultural importance of the study of religion, Gesler, Arcury, and Koenig (2000) have found that religion is especially important

for the rural older adults and their health; however, the authors find that how religion affects health varies greatly by where individuals live and their cultural belief systems, even when they share the same basic religious beliefs. Gesler, Arcury, and Koenig (2000) note the need for focusing on specific health beliefs in the locations in which individuals live and other environmental factors such as the economic situation in the locality and individual and collective experiences.

McCullough and Willoughby (2009) suggest that a missing piece of the connection between religion and health is self control and self regulation. As they show, religious self-control and self-regulation may partially mediate the association between religion and health and risk taking behavior.

Although perceived behavioral control is an important construct in psychology and health behavior, studies on religion and health show that “God-mediated control” also affects health (Koffman et al., 2008; Krause, 2010) and can do so in a positive way. While highly religious individuals place a great deal of faith and control in a divine power, religious individuals also espouse religious self control, which affects health (McCullough & Willoughby, 2009).

Ellison (1993) found that religious involvement positively influenced Black Americans’ self esteem, but did not have a significant relationship to empowerment or individuals’ perceptions of self-control or personal mastery. Others have shown that individuals who had internalized religious goals were more likely to report higher self esteem (McCullough & Willoughby, 2009).

Miller, McConnell, and Klinger (2007) do not find evidence of a positive relationship between religiosity and individuals’ self efficacy; however, they do find

that negative forms of religious coping lead to decreased self efficacy. Other scholars have found, however, that religious goals that were seen as sanctified by the religious doctrines generated more self efficacy than goals that were not sanctified (McCullough & Willoughby, 2009).

Wink, Dillon, and Prettyman (2007) found gender differences in this religious sense of self control, suggesting that religion's impact on self control may depend on population and contextual factors. Religiosity and spirituality in older women was connected to their retained sense of self control, even when in poor physical health; however, the same was not true for older men (Wink, Dillon, & Prettyman, 2007). Religion also led to high life satisfaction in women and involvement in life activities.

Despite the positive evidence of religion's influence on empowerment, other scholars also note the need for caution. As Maton (2001) notes, religion has historically had disempowering effects for some individuals: "At their worst, organized religions have systematically oppressed, excluded, disempowered, and harmed the 'other' (e.g., women; homosexuals; all those not privileged by the prevailing religious ideology) throughout the centuries. Fortunately, the evolution of religious ideologies, and the emergence of alternative, empowering, spiritually based settings, have served, in some cases, to counter the negative influences of religion" (pp. 610-611). Maton (2001) still cautions, however, that we should acknowledge both the positive and negative influences and potential of religion to affect health and work to strength the positive influences on health.

Religion and community empowerment. Notions of religion as a source of empowerment are contradictory to the teachings of Freire and the notions of

empowerment described above. Freire (2008/1974) describes three types of consciousness that affect empowerment. First, Freire (2008/1974) describes a “magical consciousness” where individuals attribute happenings to a higher power, which they cannot change (p. 39); As Freire describes, magical consciousness creates fatalism as individuals believe they cannot change factors around them. Freire’s notion of “magical consciousness” is similar to religious involvement, where individuals believe a higher power has control over their health. Freire (2008/1974) also describes two other types of consciousness: “critical consciousness,” which is where individuals critically assess their surroundings through empirical evaluation based in the reality of this world, and “naïve consciousness,” where individuals ignore facts or believe they have control unrealistically. Freire (2008/1974) describes the desire to move away from magical and naïve consciousness and towards critical consciousness in education to empower individuals through dialogical approaches. While Freire’s ideas may seem to suggest moving away from religion to provide empowerment (as religious involvement may equate magical consciousness), literature on religion and health suggests that religion should not be ignored for the positive influence it might have on health.

Maton and Wells (1995) state that religion can lead to “group empowerment” or community empowerment for health; religion may help to create power for groups that are otherwise marginalized or lacking power in other social contexts. Religion may help marginalized populations to increase their psychological or material power through a group empowerment process that provides financial, spiritual, and human support (Maton & Wells, 1995).

However, religion has also been a source of oppression for some groups, creating higher prejudice and discrimination towards these individuals, and a fundamentalist religious orientation has been shown to be associated with higher levels of prejudice towards other marginalized groups (Hunsberger, 1995). Prejudice is unrelated to specific orthodox beliefs, but instead is related to individuals' openness to change and the ways in which individuals hold their religious beliefs (Hunsberger, 1995).

Religion can lead to prejudice, but can also lead to tolerance and acceptance, depending on the individual and depending on the religious belief systems and extremism of the particular religion (Hunsberger & Jackson, 2005). As Maton and Wells (1995) note, alternate forms of religion have emerged over time that have helped to empower disenfranchised groups, such as the development of the African American church, the liberation theology movement in Latin America which radically re-envisioned the Catholic church to liberate the poor from oppression, and the feminist theology movement in North America.

Religion may also lead to collaborative community control, where individuals share control for situations with others (Krause, 2003). In religious settings, this is sometimes evidenced by fellow church members or congregants helping each other to take care of a sick loved. Like collaborative control, God-mediated control implies a sense of collaborative control between the individual and between God (Krause, 2003; 2011). Lastly, religion may also result in another type of control—secondary control. This type of control may be more evident later in life when older adults increasingly lose control in their lives. For example, older adults who are no longer

able to drive, other fellow church members may transport them to doctor visits, grocery stores, or other needed essentials. Although these older adults might not personally be in control of their transportation and some of these aspects, they have secondary control through others that help them (Krause, 2011).

Religion in health campaigns and programs. Thyer (2006) states that religious social programs have long been criticized and met with contempt as public health and social work historically shifted towards scientific and positivist approaches to research and practice. However, as Thyer (2006) states, faith-based social programs have produced positive, measurable social results and should be more carefully considered. Thyer (2006) also notes that there are a variety of faith-based programs: some with spiritual goals, some with social goals, and some with mixed goals. According to Thyer (2006), all of these types of programs have the potential to produce positive social results. The incorporation of health into religious programs should be considered as a worthy goal, particularly for individuals already participating in these religious programs.

Matthews et al. (1998) recommend that religion be incorporated into doctor-patient communication and also health be incorporated into religious settings. For example, Matthews et al. (1998) recommend that doctors should ask patients if their religion or faith is helping them to handle their illness, and, if so, how they can help to support their religious commitment. Medical care providers should recognize that religion may be an important coping factor for many individuals and is important to take into account in individuals' care plans. In terms of incorporating health into religious settings, physicians can refer individuals to talk to church leaders or clergy

about health problems as a supplement to their other medical care (Matthews et al., 1998). Faith-based health programs or communication initiatives within the faith-based community setting may also help to reach out to populations that are otherwise hard to reach (Underwood and Powell, 2006).

Powe (2002) found that information modified to include culturally appropriate religious messages encouraged more behavior change than traditional, generic messages for health screenings. Underwood and Powell (2006) also stress the need for faith-based health programs, education, and outreach efforts to be tailored to the religious beliefs and practices of the faith community and to address the health needs and concerns of the congregants. Scholars suggest that incorporation of health programs and campaigns into faith-based communities should come from within the community and should be aided by health educators and communicators only as requested by the community.

To further understand how religion affects rural women's meaning making of empowerment and health, and to make sense of a sometimes contradictory body of literature regarding religion, health, and empowerment, the following research question will be addressed:

RQ3.1: How does rural women's religiosity relate to their meaning-making of empowerment?

Involvement with health and the situational theory of publics. Another factor that may influence women's sense of empowerment is their involvement with their health and with health issues. Involvement has been conceptualized as a construct of the situational theory of publics (Grunig & Hunt, 1984; Grunig, 1997), a

public relations theory that predicts if and when publics will communicate about issues and move on a continuum from being a non-public to being an active public. The situational theory is based on the conceptualization of a public provided by Dewey (1927) as a group of individuals connected through identification with an issue (Guy, Williams, Aldridge, & Roggenkamp, 2007). Publics may not yet be formally organized, or may not be aware that they are in fact publics, but they have the ability to form or organize at any point and have the potential to change or constrain an organization (Guy et al., 2007).

The situational theory of publics helps public relations professionals understand how to segment publics. In some organizational issues, activist publics are less desirable as they may negatively impact the organization; however, in other settings, such as public health campaigns, activist publics are encouraged to become active on the health issue and become involved. Creating “active” publics can also help organizations to engage stakeholders and publics in relationships with the organization (Kim, Ni, & Sha, 2008).

Three key independent variables. Three key variables provide understanding as to publics’ communication behaviors. These three independent variables are involvement, problem recognition, and constraint recognition (Grunig, 1997). Involvement, as it is studied in the situational theory of publics, is publics’ identification and association with particular issues. Involvement here is different from how involvement is conceptualized in other disciplines such as marketing and psychology, in that involvement is an intrinsic factor that is affected by individuals’ prior experiences, family history, etc. (Aldoory & Sha, 2007). Involvement is not

something that can be manipulated through messages to publics, but instead is something which publics already possess.

Problem recognition is the extent to which publics recognize the issue and are aware of the problem (Grunig, 1997). Problem recognition can be impacted through messages and communication to publics. The last variable, constraint recognition refers to publics' perceived barriers to taking action on a problem or issue.

Constraints could derive from psychological or emotional sources: For example, low self-efficacy has commonly been described as a barrier or constraint in health communication literature that affects publics. Perceived constraints could also derive from physical barriers, such as rural women's lack of transportation to access healthcare or lack of healthcare insurance.

Communication behaviors. The three key independent variables of the situational theory of publics (i.e., involvement, problem recognition, and constraint recognition) can affect two dependent variables—information processing and information seeking—which describe publics' communication behaviors in regards to an issue (Grunig, 1997). Information processing describes publics' likelihood of processing information that they passively receive about an issue. Publics are most likely to receive and process this information through mass media (Aldoory & Sha, 2007). Individuals with low involvement are still likely to process information that they receive in this fashion. Information seeking describes publics actively searching for information about an issue. Information seeking draws from a variety of sources beyond mass media alone, such as interpersonal communication, digital

communication and social media, etc., as publics are on an active search for more information about an issue.

Categorization of publics. Grunig (1997) describes four categorizations of publics: non-publics, latent publics, aware publics, and active publics. Non-publics are just as they sound—not a public. Non-publics do not have involvement with an issue and therefore are unlikely to become a public unless something in their own lives gives them a sense of involvement with the issue. Latent publics are publics that have medium to high involvement but that have low problem recognition, not being aware of the issue. Latent publics may have high or low constraint recognition. Aware publics are publics that have medium to high involvement and have medium to high problem recognition, but that perceive high constraints. Aware publics are not likely to become active publics until their constraints are lowered. Active publics are publics that have medium to high involvement, high problem recognition, and low constraint recognition. These publics are most likely to actively seek information about the issue and communicate with the organization.

Grunig (1997) also describes “hot-issue” publics, which are publics that become active about issues that are prevalent in news media and are very timely and popular. Member of a “hot-issue” public will not necessarily have the same level of involvement with similar issues, despite their involvement with a “hot issue.” This public forms mainly because of the vast media coverage and attention afforded to the “hot issue.”

Situational theory of publics and health. The situational theory of publics and its variables have been applied in varying health contexts to understanding

segmentation of publics for health contexts (Aldoory, 2001; Dimitrov, 2008; Grunig & Ipes, 1983; Muturi, 2005; Pavlik, 1988; Springston, 1997; Thomas, Smith, & Turcotte, 2009; Vardeman & Aldoory, 2008). Research on the situational theory of publics as it applies in health contexts shows that properly designed health messages can increase problem recognition and lower perceived constraints for publics; however, as involvement is an intrinsic characteristic of publics, publics should be categorized by level of involvement prior to public health campaigns (Aldoory & Sha, 2007).

Aldoory (2001) studied involvement as a construct of the situational theory of publics as it related to women and their health. In this study, level of involvement with health was influenced by media, and minority women did not view media as reflecting their identities or health concerns. In Aldoory's research, women's experiences with media, interactions with healthcare providers and insurers, and discourses with friends and family, influenced their meaning making of health. Women viewed health through the lens of their everyday health activities, their perceptions of their own avowed identities, their preferences for information, and their perceptions of their own health.

Vardeman (2006), in her study of the situational theory of publics and women's perceptions of cervical cancer, found that control was a cultural factor that affected women's categorization as publics. Control in this study was defined as empowerment and self-efficacy. Sha (2006) studied cultural identity and how this relates to the segmenting of publics, specifically within the framework of the situational theory of publics. Sha found that cultural identity impacted publics'

perceptions of involvement and problem recognition and was a concept that helped to provide predictive validity to the situational theory of publics and to the segmenting of publics.

Aldoory and Bonzo (2005) highlight how the situational theory of publics is similar to other more commonly used health communication theories, such as the health belief model, diffusion of innovations theory, and the extended parallel process model. The authors discuss how to integrate concepts from these theories to develop effective approaches to public health campaigns for injury prevention.

To further understand how rural women's involvement with their health affects their empowerment and health—and possibly their health behaviors—the following research question will be addressed:

RQ3.2: How does rural women's *involvement* with their health relate to their meaning-making of empowerment?

Importance of social networks and social support on empowerment.

Heaney and Israel (2002) distinguish between social support and social networks: social support is described as the assistance that individuals receive through their social relationships and interpersonal communication; whereas, social networks are the web of relationships individuals have, representing different social connections and contacts. Individuals may receive a variety of social support, including emotional support (i.e., love and empathy), instrumental support (i.e., the provision of actual tangible resources, such as money or food), information support (i.e., advice and shared information), and appraisal support (e.g., constructive feedback or praise) (Heaney & Israel, 2002).

Scholars have shown that perceptions of empowerment are directly related to individuals' connection to their communities and their sense of community (Zimmerman, 1995, 2000). Coward (2006) suggests that women feel more empowered when they have higher levels of involvement with their communities, have more social connections within their communities, and have more opportunities to care for others in their community or to care for loved ones. Additionally, Egbert and Parrott (2001) have found evidence that family, peers, and other social networks heavily influence perceptions of efficacy. When women in their study perceived that others were engaging in the behavior, the women were more likely to gain confidence and perceive the behavior to be less difficult. This concept is similar to the "observability" concept in the Diffusions of Innovations framework (Rogers, 2003). Individuals that can observe others performing the behavior or using the innovation, may be more likely to try it themselves or gain increase confidence.

Krummel, Humphries, and Tessaro (2002) found that women's perceptions of family support and family norms influenced healthy eating behavior and women's perceptions of efficacy and empowerment. While social and family relationships can positively influence health, Currie and Wisenberg (2003) also show the negative effects they can have on women. For example, married men have been shown to be healthier than their single counterparts, while married women actually have poorer health than single women.

Drawing upon this literature in social support and its potential effect on individuals' perceptions of empowerment, this study asks the following research question:

RQ3.3 How do rural women's social connections relate to their meaning-making of empowerment?

Rural Women and Health

Rural women face unique health challenges (Coward, 2006), which empowerment of women may help to overcome. Scholars call for the need to empower rural women to improve socioeconomic conditions and community health (Balit, 2004) and suggest that rural communities should be understood at the level of the specific community in order to best provide health services and resources (Hornberger & Kuckelman, 1998). Campo et al. (2008) states that campaign planners have largely overlooked rural populations as audiences, despite the health disparities that rural populations face. In order to more fully understand the problems that plague rural women and the context in which health disparities occur, there is a need to consider the unique perspectives of "populations whose social and health realities remain at the margins of health inequities research" (Hankivsky & Christofferson, 2008, p. 278).

Defining "rural" populations. Rural areas are defined as isolated areas with low population density or unincorporated areas (Ricketts, Johnson-Webb, & Taylor, 1998). Approximately two-thirds of U.S. citizens live in urban areas; although cities only occupy around two percent of the geographic region within the country (Howarth, 1996).

Federal definitions of "rurality" are important for identifying and awarding funding and categorizing U.S. citizens (Ricketts, Johnson-Webb, & Taylor, 1998). The U.S. Office of Management and Budget (2000) defines rural territories as fringe

(less than or equal to 5 miles from an urban area), distant (more than 5 miles and less than 25 from an urban area), or remote (more than 25 miles from an urban area). The 2000 Census classified urban areas or urban clusters as densely populated areas that have at least 1,000 people per square mile and surrounding areas with at least 500 people per square mile. Conversely, the 2000 Census defined “rural” as all territories, populations, and housing located outside of urban areas and urban clusters. Counties and census tracts may be classified as partly urban and partly rural; however, most Federal definitions of geographic location for funding and classification purposes define areas and populations as either urban/metropolitan or rural/nonmetropolitan.

Goldsmith, Puskin, and Stiles (1993) developed the Goldsmith Modification of rural to identify rural areas nested within larger counties classified as metropolitan, where residents were divided from the urban areas by distance of other physical barriers. This method of classifying rural areas within counties allows for greater specificity of defining rural populations (Ricketts, Johnson-Webb, & Taylor, 1998), and encouraged development of codes that would more accurately identify rural populations, such as the Rural Urban Commuting Area (RUCA) codes provided by the Economic Research Service of the U.S. Department of Agriculture (USDA) and the Health Resources and Services Administration's Federal Office of Rural Health Policy (Morrill, Cromartie, & Hart, 1999).

RUCA codes identify rural areas by zip codes and census tracts as opposed to county-level areas, providing a more detailed level of classification. As Morrill, Cromartie, and Hart (1999) state:

The frequent use of county-based metropolitan definitions results in significant policy inequity and discontent. For example, populations who are clearly rural do not qualify for (rural) federal programs and funds because they are located in counties whose boundaries include urban areas. Likewise, some populations that can only be thought of as urban qualify for rural programs because they are located in nonmetropolitan counties, although they live on the outskirts of urban areas in adjoining metropolitan counties (p. 729).

Using RUCA codes to identify rural areas can help to ensure that counties that may have a largely rural population adjacent to a smaller metropolitan area are not misclassified as metropolitan.

Health disparities among rural women. Evidence is mounting to show that some important health disparities exist among urban and rural populations (Gamm et al., 2003). Largely, rural residents across the U.S. have a poorer health status than their urban counterparts, including higher rates of obesity, higher rates of disability and limited mobility, and higher morbidity and mortality rates (Bennett, Olatosi, & Probst, 2008). Nationally, rural health leaders have identified rural health priorities as access to quality health services, heart disease, stroke, diabetes, mental health and mental disorders, and oral health (Gamm & Hutchison, 2003). According to Centers for Disease Control and Prevention obesity data (U.S. CDC, 2011), sections of the southeast and rural Appalachia have some of the highest rates of obesity and diabetes in the United States: CDC data shows that over 80% of Appalachian counties have high rates of diabetes and obesity.

In addition, rural residents are more likely to be uninsured or underinsured. Rural women have been shown to be less likely than their urban counterparts to report having preventive health services such as a pap smear within the last three years or recommended mammograms (Bennett, Olatosi, & Probst, 2008). According to Haley, Johnson Avery, and McMillan (2008) rural women face additional barriers, such as increased fatalism about illness, overreliance on religious faith, and mistrust of the healthcare system, which may cause them to delay seeking healthcare or treatment.

As some scholars have noted, rural women face many unique challenges related to healthcare, such as distance from healthcare services, shortage of healthcare providers, lower rates of insurance, and higher rates of poverty (Gamm et al., 2003; McGlaun & Cochrane, 2010; Pistella, Bonati, & Mihalic, 2000). In addition to these barriers, women in rural communities are older than their urban counterparts, have lower incomes, and are less educated (McGlaun & Cochrane, 2010).

Rural residents seek out health differently than urban residents, have less knowledge about national resources, and are more vulnerable to particular types of disease and injury (Campo et al., 2008). As McGlaun and Cochrane (2010) state, these higher rates of chronic disease for rural women exist for heart disease and cancer; rural women also are at greater risk for diabetes and diabetes cases carry greater risk of death in rural areas. Rural women have higher incidence of depression, and Hillemeier, Weisman, Chase, and Dyer (2008) state that self esteem impacts mental health in rural women.

Obstacles to healthcare also stem from geographic, demographic, and cultural conditions present in rural areas that may affect both the rural women seeking services and the providers in communities that would deliver these services (Gamm, et al., 2003). Due to these obstacles, women with chronic illness face additional barriers in gaining access to treatment and ongoing management of their illnesses (McGlaun & Cochrane, 2010). Scholars have found that the closeness of rural communities, while it can act as a support network, also acts as a hindrance to health behavior changes as individuals seek to maintain the status quo (Campo et al., 2008).

Currie and Wisenberg (2003) highlight that gender functions as a major social determinant of health status. As they state, women feel the pressure to be the keepers of the family, and with that pressure comes added stress and health problems. Balit (2004) suggests that gender perspectives should be incorporated into the planning, implementation, and evaluation of communication initiatives, and participatory research should be used to determine the empowerment needs of rural women.

Empowerment and rural women. Empowerment strategies offer great promise in working with socially excluded populations (Wallerstein, 2006) and may be especially appropriate for working with rural women. Research has shown that empowerment of women affects women's health indicators and the overall health of the communities in which women live (Kar, Pascual, & Chickering, 1999; Varkey, Kureshi, & Lesnick, 2010). Efforts to empower women have shown impacts on women's health and the health of their families and children (Wallerstein, 2006). Garcia et al. (2010) argue that major advances and critical measures of women's healthcare should focus on women's self-empowerment to address their health.

Also, as Boehm and Staples (2002) found in their research, “Instead of contributing to one uniform general theory of empowerment for all populations [there is a] need for different sets of assumptions and predictions for different populations.” Similarly, Egbert and Parrott (2001) note that self efficacy is affected by circumstances that are constantly in flux and may affect different individuals in different ways. Factors that affect perceptions of self efficacy may change in different contexts and with different individuals. This suggests the need for audience-specific research that takes into account the unique circumstances and situations that affect individuals. To better understand the empowerment needs of rural women, specific research is needed that examines the unique contexts that affect these women. Taking these factors into account can help to ensure that messages are tailored appropriately and effectively for audiences. Balit (2004) also notes the particular need for gender-sensitive communication in rural areas. Systematic and comprehensive studies focusing on these different assumptions will further understanding about specific publics and their particular empowerment needs.

As Rissel (1994) states, isolated rural communities are one of the groups with the largest deficit of empowerment and also the greatest barriers to achieving empowerment, particularly community empowerment. As Khamphakdy-Brown et al. (2006) describe, “the essence of empowerment is to expand women’s sense of ‘power within,’ and also requires cognizance of women’s sociocultural and economic context, including emphasis on the influence of linguistic and cultural isolation, significance of the father figure, socioeconomic status, religious values, and experiences of racism from outside sources” (p. 41). Pistella, Bonati, and Mihalic

(2000) found that rural women were empowered through greater access to community services and social services.

To further understand how rural women understand their health and how this understanding of their health relates to other factors of their empowerment, the following research question is addressed:

RQ4: How does rural women's meaning-making of empowerment relate to their meaning-making of health?

Summary of Research Questions

A summary of the above research questions from the literature is also listed here. Based upon the preceding review of the literature related to empowerment and rural women's health, the following research questions are asked:

RQ1: How do rural women make meaning of empowerment?

RQ2: How can communication campaigns create a sense of empowerment in rural women?

RQ3: What factors can affect rural women's meaning-making of empowerment?

RQ3.1: How does rural women's religiosity relate to their meaning-making of empowerment?

RQ3.2: How does rural women's *involvement* with their health relate to their meaning-making of empowerment?

RQ3.3 How do rural women's social connections relate to their meaning-making of empowerment?

RQ4: How does rural women's meaning-making of empowerment relate to their meaning-making of health?

To address these research questions, a variety of research methods are described in the following chapter.

Chapter 3—Method

To explore empowerment as a construct for health campaigns, the methods of in-depth qualitative interviewing and photovoice were used to provide insight into the meaning-making of rural women. As Zimmerman (1990) notes, qualitative research is needed to further understand and explore the conceptual and ecological factors that influence empowerment. Harvey (2010) states that although qualitative methodologies have contributed to our understanding of rural women's health issues and are one of the better ways to understand rural women and their lived experiences, there are few published studies that have used these methods.

Qualitative research provides an opportunity for researchers to go beyond numbers and gain individual and collective feedback regarding perceptions and ideas not easily obtained through quantitative research. When asking *how* or *why*, qualitative research provides a platform for increased understanding (Denzin & Lincoln, 2003). Qualitative interviewing provides a richness of data that can further understanding of how rural women view and construct their everyday health activities and the power or lack thereof they have over these activities. Boehm and Staples (2002) state that, “when formulating empowerment theory, researchers should listen more attentively to the voices of consumers, who should be directly involved in specifying the processes and outcomes which they believe are most empowering for themselves” (p. 458). Qualitative research that openly seeks to engage rural women and learn about their meaning making processes of empowerment can help to ensure that outside ideas of empowerment are not arbitrarily forced upon participants.

Interviewing

The primary method of research for this study was semi-structured, in-depth interviews. Interviews, as opposed to other forms of qualitative research such as focus groups, are especially important for research with rural women. As Pistella, Bonati, and Mihalic (2000) state, confidentiality with rural women about sensitive health issues is extremely important. For some women, fears of loss of confidentiality create barriers to their use of health services for more sensitive topics such as pregnancy or sexual health issues (Pistella, Bonati, & Mihalic, 2000).

Rubin and Rubin (2005) state, “If what you need to find out cannot be answered simply or briefly, if you anticipate that you may need to ask people to explain their answers or give examples or describe their experiences, then you rely on in-depth interviews” (pp. 2-3). In-depth interviews can allow for a unique richness of data in relation to the contexts affecting individuals and their meaning making processes, including their perceptions of identity and empowerment. The semi-structured interview allows participants’ voices to emerge and provides more freedom in the discussion with participants; here the participant can guide the conversation to the elements that she finds most important (Rubin & Rubin, 2005).

However, despite the desire to avoid interviewer control and allowing participants’ voices to emerge, Fontana and Frey (2003) note that, “increasingly qualitative researchers are realizing that interviews are not neutral tools of data gathering but active interactions between two (or more) people leading to negotiated, contextually based results” (p. 62).

Photovoice as a Method to Empower Research Participants

Qualitative interviews can provide great depth in understanding women's meaning making processes of empowerment and health. Zimmerman (1995; 2000); however, calls for research on the contexts of empowerment, as well as an understanding of the larger ecological processes that are occurring. As Zimmerman states, "The information gathered using an ecological framework may help identify those aspects of the interactional component of psychological empowerment that are contextually appropriate and culturally relevant, and should also help stimulate research on empowerment at multiple levels of analysis" (1995, p. 725).

Exploring rural women's meaning making of their environments can lend further understanding to the factors influencing empowerment. As Zimmerman (1990) states, creative research approaches may be required to fully explore the concept of empowerment, as it is culturally and contextually defined.

Photovoice was employed as an additional method to understand women's lived experiences through their eyes and their views of their surrounding environment. As Wallerstein and Duran (2006) show, community-based participatory research can serve as a mechanism to understand and empower communities. In this research study, by giving participants cameras to document their surroundings and health problems through their own eyes, individuals' voices can be empowered. This method of giving research participants cameras has been termed "photovoice" (Wang, 1999). Photovoice has been described as a participatory action research strategy for women's health, and has been described as having main goals of reflecting community strengths and problems, promoting critical dialogue and

knowledge, and reaching policymakers (Wang, 1999). As Lorenz and Kolb (2009) state, visual data gathered by research participants through means of photovoice can identify problems and strengths within the larger health system that are typically omitted through other means of data collection.

As Wright, Darko, Standen, and Patel (2010) state, using visual research methods can empower participants as part of the research process. When researching public and community health problems for health communication campaigns, methods such as photovoice can provide valuable insight into what Wright et al. (2010) call the “back regions” of participants’ lives that qualitative researchers are not able to discern through more typical forms of qualitative research.

Procedure

Sampling. A total of 41 in-person, in-depth interviews were conducted using purposive, convenience, and snowball sampling strategies to recruit rural women as research participants in the Appalachian region of southwestern Virginia. Interviews were stopped once the data reached a saturation point where clear themes in data emerged and participants’ responses fell within these themes. Of these 41 interviews, 15 women chose to take part in longer two-part interviews, in which they took pictures using the photovoice method between the first and second interviews.

The specific county—Bland County—in which the interviews took place was defined as rural through the 2000 RUCA codes provided by the Economic Research Service of the U.S. Department of Agriculture (USDA) and the Health Resources and Services Administration's Federal Office of Rural Health Policy (Morrill, Cromartie, & Hart, 1999). RUCA codes allow for a more precise measure of rural areas than

other systems such as the Urban Influence Codes from the Office of Management and Budget and the USDA. RUCA codes are conceptualized similarly to Urban Influence Codes, but are more precise in that rural areas are identified by zip codes and census tracts as opposed to county-level areas, providing a more detailed level of classification.

The majority of the women in the rural population being studied were Caucasian women of low to middle-class income, and as such, the majority of research participants were also Caucasian with low to middle-class income. Women over the age of 18 were invited to participate in the study; however, as the average age of women in rural communities is higher than that of women in urban areas, the majority of participants were middle-aged (30 to 55) or above, with approximately a quarter to a fifth of the women interviewed being classified as young women (ages 18 to 29).

Participant recruitment. As rural women may be mistrusting of outsiders and strangers (Dibartolo & McCrone, 2003; Fahs, Findholt, & Daniel, 2003), I relied heavily on references and informal contacts to help build rapport in the participant recruitment process and to reach out to women that may not be easily accessible for more mainstream research. To recruit participants, I coordinated with a center in the community that maintains a dental clinic, clothes closet, a food pantry, and a Head Start educational program to help have access to potential research participants in the community. Employing snowball sampling, participants were also asked to refer other community members that might be interested in participating in interviews, and additional interviews were conducted in women's homes in the community.

As the center serves a variety of low-income and resource-deprived community members and also hosts a larger number of community volunteers from varying economic backgrounds, working with the center provided an opportunity to speak with a wide range of women in the community with diverse life experiences. The center is in contact with individuals with a lower socioeconomic status who often have the greatest health needs and lower levels of empowerment; working with the center provided access to otherwise hard-to-reach populations in a familiar and comfortable setting for these women.

The food distribution service was open one day each week. Bland County residents were allowed to come once a month to pick up food boxes. Neighboring Wythe County residents were allowed to come once every two months. Families using the food pantry's services must meet a low-income requirement as per USDA requirements for food pantry food; if individuals qualified for food stamps, they automatically qualified to receive food from the food pantry. Families received food to supplement what they already get from EBT cards or food stamps. Families picked up a dry box with cereal, canned food, peanut butter, juice, cooking oil, etc., and a cold box with refrigerated food (e.g., milk, cheese) and frozen food (e.g., frozen bread, frozen dinners, chicken, desserts, etc.) The first week of my visit to the area, the food pantry had between 140 and 150 families pick up food boxes the one day of the week the food pantry was open.

The clothes closet at the center was open routinely two days a week. Unlike the food distribution service, the clothes closet did not have an income requirement, although most individuals who come to the clothes closet were in need for one reason

or another (e.g., low-income, some type of family emergency). During my visit, the number of families that visited varied depending on the winter weather; the last week I was there, between 60 to 70 families visited the clothes closet each day it was open. Families were limited in the number of pounds of clothing they could take in one visit and the number of highly-sought after items, such as new underwear, unused children and adult diapers, coats, children's clothing, bed sheets, and towels. However, families were not limited in the number of visits they could make. The clothes closet, while well stocked in some areas, was greatly in need of large and extra large size clothing.

The free dental clinic at the center was open five days a week January through March. A dentist who specialized in extractions and oral surgeries was on hand during this time. During the first week of my visit, individuals who were coming in for routine cleanings were generally sent to the community college of a neighboring county, where dental hygienist students had a classroom facility to clean community members' teeth. Later during my visit, a dental hygienist came to the dental clinic to also clean community members' teeth at the clinic. A denture-model maker also came during my visit to make free dentures for community members; this particular individual had been coming to work at the clinic for over 20 years. The waitlist for dentures was generally two to three years. While I was there, the dentist usually saw between 15 to 20 patients a day.

The community Head Start program was funded through a community association, which also received government support. Although housed at the center, the program was not a formal part of the center and was not funded by the center.

Between 20 to 30 children between the ages of 4 to 5 were typically enrolled in the program. The program had regular teachers, administrators, bus drivers, and cafeteria workers; however, some of these women served multiple roles. Parents of children also routinely volunteered to help out with the program in the classroom setting, preparing food, or even at times with transportation of children.

Incentives and assistance to the community in which the research was conducted were provided as a measure of goodwill and to build rapport with the community center assisting with the research. As mentioned above, this community center provides a variety of services such as free dental health services, a “clothes closet,” a food distribution service, a Head Start educational program and construction and renovation services to individuals in need. This organization is in continuous need of donated items such as food and clothing supplies, medical supplies for the dental clinic, and donations to support the center, construction work, and the funding of dentists to work at the free health clinic. I worked with other non-profit organizations to solicit donations for the center, and upon my visit to conduct research, provided the center with clothing items, food, medical supplies, and a monetary donation to help them continue the work they are doing in their community, with the goal of making our relationship mutually beneficial for me, as the researcher, and for the communities, as research participants.

Interview structure. Based on participants’ availability and level of comfort, women were able to choose between two types of interviews: a one-time in-depth interview or a two-part longer interview in which they were given a camera and asked to take pictures using the photovoice research method. Because women in the

research study often had limited transportation or limited time, providing women with an option for interview type allowed more types of women to participate in the research despite their availability or their comfort with cameras.

Interviews were conducted in-person at the community free dental clinic, the Head Start school program, the clothes closet, the food distribution center, and the main office for the community center that ran these programs. Additionally, a few interviews were conducted in participants' homes. All interviews were held in private locations, such as private, quiet meeting rooms. The single interviews lasted approximately an hour; whereas, the two-part interviews lasted between an hour to an hour and a half total. In the second part of the two-part interviews, women discussed the photos they had taken and why they chose the particular photos that they did.

Interview protocol. Interviews followed a semi-structured interview protocol developed with open questions and follow-up probes (Rubin & Rubin, 2005) (see Appendix A). The interview protocol served as a guide throughout the interview process, but also offered flexibility, allowing participants to expand upon their own stories and lived experiences as they saw fit. All questions were asked unless the participant had addressed the question in an earlier answer and provided satisfactory depth of response. Additional measures were taken to build rapport prior to the interviews, such as broad conversation-starting questions to ease any tension and allow participants to speak more naturally about their health, as well as gaining general background information about the research participants, such as how long they had lived in the area, their family makeup, etc. (McCracken, 1988; Rubin & Rubin, 2005; Spradley, 1979).

Questions were arranged in an unfolding method so participants were first asked to describe their day-to-day actions and routine, a recent family health situation and a recent personal health situation, and their notions of health in their own words. More specific questions and more sensitive questions were not mentioned until the end of the interview when the participant felt more comfortable with the interview, unless the participant brought up these topics earlier in the process. Questions included topics such as rural women's perceptions of their everyday lives and everyday health activities, perceived social support, meaning making of health, outside influences on health, involvement with health, constraints on empowerment and control, recognition of health problems, perceived empowerment, and perceptions of religion and spirituality (see Appendix A for the specific questions to be asked).

Questions for each section of the interview guide drew upon existing research studies and conceptualizations of the constructs being asked about. To explore perceived social support, participants were asked questions such as, "Could you describe for me your relationship with others in your community?", "Do you participate in any organizations in your community? Could you describe these?" and, "Could you share with me any stories about others you might know of who have 'taken control' over their health?" To explore meaning making of health, participants were asked questions such as, "How would you describe your health in general?", "What, do you believe, influences your health?", and, "What does the word "health" mean to you?"

To explore empowerment, elements such as perceived behavioral control and self-efficacy were asked about. To explore perceived behavioral control, participants

were asked questions such as, “How much do you think you are in control of your own health?”, “Do you think you could do anything personally to improve your health? Why or why not?”, and “Do you think you could do anything personally to prevent or reduce your health risks? Why or why not?” To explore self-efficacy, participants were asked questions such as, “How confident are you in your ability to know what to do to improve your health?”

Based upon the situational theory of publics (Grunig, 1997), participants were asked questions about their constraint recognition, problem recognition, and involvement. To explore constraint recognition, participants were asked questions such as, “What, do you believe, influences your health?”, and, “What are some things that may prevent you from taking steps towards healthier behaviors?” To explore problem recognition, participants were asked broad questions such as, “How would you describe your health in general?” and, “What are some of the ‘healthy’ things that you do?” and also more specific questions such as, “What do you think are the health problems that most affect your community?” and “What about your health is important to you today?” To explore involvement, participants were asked questions such as, “How important is your health to you?” and, “How connected do you feel to the idea of ‘health’?”

Women participating in the camera interviews through the photovoice research method were asked to, “Answer as many of the following questions as you can through photos” (see Appendix C). Women were told that, “Pictures can be of people, places, items, media, or anything else that is appropriate.” Women’s cameras had a total of 27 photos, and women generally took anywhere from one to 4 photos to

address the questions posted to them. Women were asked questions such as what influenced their health, what health meant to them, what encourage or prevented them from being healthy, what about their health was most important to them, and where they found health information.

Pretest. As Hung (2001) states, pretesting offers advantages to researchers by helping them to prepare for fieldwork and eliminate inappropriate questions from the interview guide. Many of the theoretical elements of the interview guide were based upon previous scale development for these constructs. Although these items were developed from the literature on these concepts, translating these questions to an open-ended, semi-structured format had the potential to change the intended meaning and affect the type of data being collected. For this reason, pre-test interviews were especially important. To assist with development of the interview protocol, five pretest interviews were conducted via phone and in-person with rural women through a convenience sample. Based upon the pretesting results and the feedback from these women, the wording and the language of the interview protocol was adjusted to ensure that interview questions were clear to participants and covered the appropriate theoretical concepts. In the field research questions and wording were also adjusted throughout the process to use language that was more familiar and appropriate to the women being interviewed.

Incentives. Women participating in the one-time interview met with the researcher only once and received a gift card to a popular area grocery store in the amount of \$20 as well as a gift bag of incentive food and health items. These items were given as an incentive to participate in the research process. The gift bags

participants received included food items such as fresh fruits (i.e., grapefruit, oranges, bananas, and apples), cereal boxes, oatmeal, granola bars, mixed nuts, raisins, whole wheat peanut butter crackers, and popcorn. Gift bags also included non-food health items such as hand sanitizer wipes, pocket-size tissue pouches, lip balm, and hand lotion. Women participating in the two-part interviews, which required more effort and participation, received a \$10 grocery store gift card and gift bag on our first meeting, and a \$20 gift bag at the date of the second interview. At the end of the interview process (whether a single interview or a two-part interview), women were offered a variety of educational materials about women's health and family health available for participants to keep and read (see Appendix A, end of questionnaire).

Makeup of research community. Community characteristics and demographics available from U.S. Census and county school and economic data help to understand the research community and social and environmental factors that may affect the research participants and may inhibit or promote healthy behaviors and community empowerment. Data such as education rates, income, unemployment rates, race, ethnicity, gender, etc. help to contribute to the larger picture of the community.

As of the 2009 Census estimate, less than 7,000 people lived inside the county boundaries. According to 2000 Census data, there were 19 persons for every square mile in the county, compared to 178 persons for every square mile statewide. While the population statewide has increased over 11% from 2000 to 2009, the population in the county has decreased by more than 1% from 2000 to 2009.

According to Census data, 94% of the county residents are White and 4% are Black; other races and ethnicities reported in the Census data are less than 1%. The county has a higher percentage of adults (17%) than the percentage statewide in Virginia (12%); and a lower percentage of children under 18 (18%) than the state percentage (23%). The county has a lower percentage of women (45%) than the percentage statewide (51%).

According to 2000 Census data, 9% of county residents have earned a Bachelor's degree or higher, compared to 30% of state residents. County schools enroll just over 900 students in elementary, middle, and high schools. The county has two schools Bland and Rocky Gap, both of which have all grades K-12 together in the same building (Bland County Schools, 2011).

Less than half of county residents (49%) are employed in the labor force compared to around 67% of the state population. Census data from 2000 also show that 25% of county residents are on disability, compared to 14% of residents statewide. According to 2008 Census data, 15% of the county population lives below the poverty line, compared to 10% of the population statewide. The median household income of county residents in 2008 was \$39,841 compared to \$61,210 statewide.

The mean travel time to work for county residents in 2000 was 33 minutes compared to a mean travel time of 27 minutes for state residents; although there is very limited traffic in the rural area, jobs within the county are limited, and residents who work often have to drive further to reach their jobs. Just over a third (36%) of

the working population lives and works in the county (Virginia Economic Development Partnership, 2010).

Within the county, five dentists and three physicians maintain a rotating practice; one dentist has a full-time practice. One 60-bed assisted-living facility is located in the county. Hospitals are located in a few of the nearby counties (Virginia Economic Development Partnership, 2010). The county is home to around 30 churches, all of which represent denominations of the Protestant Christian faith; Catholic churches are located in neighboring counties, as is a Jewish synagogue (Virginia Economic Development Partnership, 2010).

Consent and confidentiality. IRB approval was received from the University of Maryland's Institutional Review Board to conduct the research (see Appendix C). Before the interviews began, participants were asked to sign the IRB-approved consent form, with information about the purpose of the interview, guaranteeing confidentiality, and allowing permission to audiotape the interview, if they so agreed. Participants were given the option to decline being audiotaped during the interview; however, all participants agreed to be audiotaped. All resulting data was handled according to IRB guidelines.

Women's pictures were used to complement the data analysis and as a tool to aid further discussion. Participants were told that pictures of places or people that may be identifiable would not be published or made publicly available to help protect their identities. Participants' specific identities have been kept confidential for the purposes of this research and audiotapes and transcripts have pseudonyms or identity

keys in place of participants' real names. Participants' names were not associated with direct quotes or mentioned anywhere in the research reporting.

Data Analysis

Each interview was audio-taped, and audiotapes were fully transcribed to assist in the collection and analysis of data. Observer comments were added to the transcripts to include reflexivity, observations of general themes, weaknesses in the research process, and suggestions for modifying future interviews. Notes were also taken at the conclusion of each interview to record immediately emerging themes or points for follow-up in future interviews. Reflexive memos were written to reveal preconceptions and assumptions about the research and to highlight personal biases and possible limitations to the study (Rubin & Rubin, 2005).

Harvey (2010) states that a grounded theory approach is especially effective as a method to understand rural women and their lived social experiences related to health and well-being. Originated by sociologists Glaser and Strauss (1967), a grounded theory approach to data analysis allows for theory to be inductively derived from the study of the phenomenon. Corbin and Strauss (2008) most recent work in grounded theory states that although grounded theory was originally conceptualized as a method to develop theory, not work from existing theory, grounded theory has been applied to date as a method for analysis for scholars who wish to working from existing theory and perhaps expand this theory or look for new or emergent themes. As these scholars note, this approach is “not just limited to persons who want to build theory” (Corbin & Strauss, 2008, p. x). A grounded theory approach may also be

taken to explore emergent themes in health problems and then later match these findings with other theoretical work.

Interviews were analyzed using a constant comparative approach to allow for the emergence of additional themes that contributed to overall understanding and exploration (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Potter, 1996; Strauss & Corbin, 1998). A constant comparative approach from a grounded theory perspective allowed data collection and analysis to be done fluidly and jointly, building research themes as the data collection progressed (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1998), and interviews were coded keeping the emerging themes from other interviews in mind. In the constant comparative method, incidents in the data—such as significant events, actions, or interactions—are compared again prior incidents and later compared to new incidents within the same category (Strauss & Corbin, 1998).

Themes were analyzed line-by-line through open coding of interview transcripts, photographs, notes, and memos (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Because this study was driven by theoretical research questions based on concepts of empowerment, self-efficacy, perceived behavior control, social support, involvement, and religion, the research questions served as initial themes to group similar concepts under. Themes were coded specifically based on expectations from the theoretical constructs, while still being open to the possibility of new themes. Emergent themes that did not fit within the theoretical frame were coded separately using open coding via a grounded theory approach (Glaser & Strauss,

1967; Potter, 1996; Strauss & Corbin, 1998) and were coded via in-vivo codes using the participants' own words and descriptions as the codes (Corbin & Strauss, 2008).

ATLAS Ti qualitative analysis software was used to assist in coding of the data and support the analysis. The use of software can greatly aid the coding and analysis of data, but should be used mainly as a supplement to the researcher's own research-driven analysis and interpretation (Corbin & Strauss, 2008). Software programs such as ATLAS Ti assist in the organization of data pieces, grouping of coded themes, and easy searching for coded quotes and data pieces. While ATLAS Ti cannot serve as a replacement for the actual researcher and the researcher's interpretive analysis, ATLAS Ti can serve as a very useful tool to support in data analysis.

After coding the data relevant to the theoretical propositions, open coding of the data was done using a grounded theory approach to analysis for any emergent data that did not fit into the existing theoretical propositions. Open coding, is usually done through line-by-line analysis, paragraph analysis, or document analysis; using line-by-line analysis as my point of analysis allowed for a deeper, more thorough look into the data (Corbin & Strauss, 2008). Using ATLAS Ti, codes were created through each relevant participant statement or section relevant to a particular topic; these specific codes were saved in ATLAS Ti and used to code similar pieces of data in other transcripts, which matched these codes.

Emergent themes from the open coding were labeled as categories, based upon their properties and dimensions. Using axial coding, categories from the open coding were then grouped under similar categories based upon category dimensions

and the existing theoretical constructs, if appropriate. Again, emergent categories that did not fit within this framework were coded as new categories. During open coding, the categories are fractured, and during axial coding, they are put back together again (Corbin & Strauss, 2008). Axial coding helps to put categories with subcategories as appropriate and helps to identify the relationships between categories and their connections. For example, in ATLAS Ti codes related to specific themes, such as a theme of “family health,” could then be grouped under this category together.

The last stage in the coding process, selective coding, goes one step beyond axial coding and is the final step to creating “theory” (Strauss & Corbin, 1998). Categories were then related back to the core category. For example, using ATLAS Ti, themes such as “family health” might be related to larger theoretical constructs such as women’s social support and social connections. Open sampling of the data was then used for open coding, relational sampling for axial coding, and discriminate sampling for selective coding. Themes that emerged were then matched to existing theoretical constructs, if appropriate. Using the ATLAS Ti software, connections of themes at various levels of meaning could then be observed. ATLAS Ti was used to extract quotes based upon these coded larger theoretical themes.

Validity and Reliability

Validity refers to whether a construct is actually measuring what it is intended to; whereas, reliability refers to the concept of the ability to repeat the research with the same results (Gravetter & Forzano, 2006; Kvale, 1995; Wolcott, 2005). This study, in particular, focuses on the lived experiences and meaning making of women in their communities as the unit of analysis. As such, this study does not claim to

measure larger theoretical constructs for their predictive ability, but rather these theoretical constructs as they are a part of women's lived experiences and offers an exploratory look at larger theoretical constructs that may affect empowerment and women's health.

The debate about whether or not validity and reliability are relevant and important for qualitative research is quite robust, with qualitative scholars espousing varying viewpoints. Wolcott (1994) states that a quantitative research definition of validity has been forced upon the frame of qualitative research, oftentimes, and does not work for qualitative research. Some scholars argue that this idea conflicts with the worldview within which qualitative research is housed (Dallimore, 2000; Wolcott, 1994); however, other scholars would argue that the concepts of validity, particularly, and reliability, somewhat, still apply to our understanding of qualitative research (Miles & Huberman, 1997; Silverman & Marvasti, 2008). These concepts, however, may have to be revised to better fit the needs of qualitative research (Kvale, 1995; Dallimore, 2000).

Qualitative research stems from an interpretive worldview, which suggests that "truth" is subjective and cannot exist independent of individuals and groups of individuals and their meaning making processes (Rubin & Rubin, 2005). In the interpretive worldview, meanings are constructed and co-constructed between the researcher and the researched (Kvale, 2005). Individuals' "truths" may be shared, as in cultural views of "truth" or may be more individualized, internal "truths" that individuals espouse. In this interpretive worldview, the construct of validity as it has

been described in positivistic research may seem irrelevant as there may be no objective, independent measures for how to study individuals' or groups' "truth."

Quantitative research holds no "golden key" to validity (Silverman & Marvasti, 2008). Instead, validity is equally important for both qualitative and quantitative research. Although qualitative research often explores the social world, which is constantly being constructed and co-constructed, Silverman and Marvasti (2008) state that implying that validity is not relevant for qualitative research is like saying that there are no stable or static elements of the social world and there is no systematic way to study these. Additionally Silverman and Marvasti (2008) state that all research is interpretive, both qualitative and quantitative. In both forms of research, the researcher(s) makes decisions about what to study (or not study), what to analyze (or not to analyze), how to analyze, and ultimately, what the researcher(s) believe to be important (or not important). Even though quantitative notions of validity and reliability can help to control for threats to these elements, the researcher must be considered in any type of research.

Qualitative research is fraught with the potential for error, just as is any other method, if not done thoroughly and systematically. Triangulation, constant comparison, and member checks can help to guide the validity of research, but we have a responsibility as qualitative researchers to note our role in the research and how this influences the research. The notion of validity for qualitative research is different from that of quantitative research, but definitely not irrelevant.

Kvale (1995) discusses ways to enhance validity in qualitative research, suggesting three types of validity essential for qualitative research: craftsmanship,

communicative, and pragmatic. As Kvale (1995) describes, craftsmanship validity is the way in which scholars craft research and follow rigorous approaches to research. Kvale states that “validation comes to depend on the quality of craftsmanship in an investigation, which includes continually checking, questioning, and theoretically interpreting the findings” (p. 27).

A rigorous research approach, such as the framework that a grounded theory constant comparative method provides (Corbin & Strauss, 2008; Strauss & Corbin, 1998), contributes to craftsmanship validity. As Kvale (1995) states, verification is build into grounded theory research and analysis through continual checks into the credibility and trustworthiness of the findings and comparison of data points throughout the process. By using a rigorous and systematic approach to data collection and analysis, this study allows for continuous checking and comparison of researcher effects and evaluates sources of potential bias. Qualitative and interpretive studies may be “valid” and “rigorous” if criteria and systematic approaches are followed (Deetz, 1973; Dallimore, 2000).

Kvale states that construct validity applies in qualitative research, but this concept does not refer to the accuracy of our measures, instead “a construct and its measurement are validated when the discourse about their relationship is persuasive to the community of researchers” (p. 22). This is what Kvale describes as communicative validity. Following this logic, this study explores lived experiences of women, a common construct and type of measurement studied in the interpretive worldview. Findings from this research are valid, in that this study explores women’s lived experiences with empowerment and health at the unit of analysis. These

findings are subjective as they are portrayed through the lens of women's experiences; however, this subjective nature of the findings is necessary to explore individual women's meaning making. The subjective nature of research does not negate validity when women's lived experiences are the goal of the research.

Member checks are a way for qualitative researchers to ensure that insight gained from research participants matches participants' intended meaning. When qualitative researchers interpret data, they can lose sight of the intended meaning from participants; member checks ensure that both the researcher's interpretation of meaning and the research participants' meaning making is included in the analysis. Through member checks, I worked with participants to ensure that their perceptions and intended meanings were reflected clearly in the resulting findings. I constantly questioned my own definitions and interpretations of participants' responses, and checked these definitions and interpretations with participants. For example, I asked participants what health meant to them, instead of assuming that participants would have the same definitions or meanings for health that I would as the researcher. I also asked for clarifications when I was unsure of participants' responses or meanings and would check my interpretations with participants to be sure that I had understood participants' intended meanings. I allowed participants to speak for themselves openly and in their own words as they described family health situations and their own health encounters.

Similar to Kvale's notion of craftsmanship validity, Silverman and Marvasti (2008) note that internal validity in qualitative research can be gained through triangulation, constant comparison, and member checks. Triangulation can involve

the inclusion and analysis of multiple sources of data, such as interviews, observation, and documentation to address the same research problem (Yin, 2003). Triangulation can also involve inclusion of multiple varying viewpoints, including varying researcher and varying participant viewpoints. Triangulation can help to assure that researchers look at all sides of the problem and not merely a surface view. In this research study, triangulation of data helped contribute to the chain of evidence and increased validity of the information gathered (Yin, 2003). By obtaining photos from women's own vantage point, this study was able to not only explore women's meaning making through their shared stories about health, but also through women's own eyes as they viewed and took pictures of elements around them. Additionally, to increase validity of the findings, I have been transparent in the methods I used to interpret data and below am reflexive regarding my own personal thoughts and biases throughout the research process and my position as a researcher. Dallimore (2000) suggests that validity in qualitative research should show "accuracy" in that it reflects the active voice of the participants and that it shows both the role of the researched and the researcher, acknowledging this.

Constant comparison is a method for increased craftsmanship validity which Miles and Huberman (1994) and Strauss and Corbin (2008) also discuss. Constant comparison involves constantly comparing findings that are emerging from research back to the theory being addressed, to existing research categories, and to other data collected. This method can ensure that findings are theoretically grounded and building upon existing findings. This study employed a constant comparative

grounded theory approach to data analysis to enhance the validity of the research finding.

Questioning is another important part of craftsmanship validity (Kvale, 1995). In craftsmanship validity, researchers should be sure to acknowledge the perspectives of the participants in their actual voices, as well as the role that the researcher plays in interpreting the research. By being transparent about the involvement in and assumptions about the research and questioning the researcher's role and influence with participants in this study, this study furthers the craftsmanship validity of the research.

Lastly, Kvale (1995) discussed pragmatic validity, which in essence is the validation of the work through its ability to provide actionable results. The notion of pragmatic validity discusses the importance of collaborative action research where researchers and participants together develop and apply knowledge, and involves the delicate balance of power between the researcher and the researched (Kvale, 1995). By incorporating photovoice as an additional research method in this study and encouraging women to openly share their stories about their health problems and experiences and about their larger community, this study sought a more collaborative approach to the research, providing participants with more power in the research process and power to define their own community problems and how they would suggest to take action. Participants were not told what problems in their own communities were and then asked what steps they had taken; rather, participants had the opportunity to provide their own insight into the problems as well as the solutions.

Reliability and generalizability. While concepts of validity are somewhat controversial in qualitative and interpretive research, concepts of reliability are perhaps even more controversial. Miles and Huberman (1994) state that reliability are relevant to qualitative research; however, the concept of "generalizability," which is a part of external validity, is not as relevant for qualitative research. Generalizability refers to the representativeness of a sample to a larger population and the ability to make assumptions or inferences about the larger population, based upon what is known about the sample. With research that is so embedded within particular contexts and settings, repeating studies with identical results in different populations or in different settings may be problematic. Qualitative research generally focuses on the depth of the data, the individuals' and groups' meaning making, and the contexts within which individuals and phenomena are located. However, over time, theoretical concepts may emerge that are applicable to larger populations and consistent across populations and contexts. This is what Miles and Huberman (1994) call "transferability" stating that the theoretical concepts that are being studied through qualitative research are transferable to other research and have external validity in the notion of the concepts themselves, much like construct validity.

Reflexivity. As mentioned prior, reflexivity in research is one way to highlight craftsmanship validity in research (Kvale, 1995). A good researcher realizes that her own life experiences and biases have the potential to affect the research questions and the research findings. Researchers must become mindful of their own context as a researcher, including the theoretical perspectives that influence their work and the researcher's particular context and position based upon the

researcher's identity and social position (i.e., factors such as race, class, gender, language, education, and culture) (Roulston, 2010). As Corbin and Strauss (2008) note, "Though some analysts claim to be able to 'bracket' their beliefs and perspectives when analyzing data, we have found this impossible. Bias and assumptions are often so deeply ingrained and cultural in nature that analysts are often unaware of their influence during analysis" (p. 85). Corbin and Strauss (2009) instead state that researchers should acknowledge their biases and experiences in the analytic process to enhance the quality of the analysis and the subsequent findings.

I discuss my own background and life experiences here to be transparent about potential biases I may add to the research based upon my life experiences and my relationship to the research and the research participants (Smith, 1987). Also, by explaining my journey as the researcher and connection to the research problem, readers may better understand the importance of the research study and the need for the research (Wolcott, 2008).

As a researcher, I come from the perspective of a white woman in my late 20s from a rural background and a Protestant religious upbringing. Raised as part of a farming family, I grew up working on my family's farm in the foothills of the Appalachian Mountains. As a graduate student pursuing a doctoral degree, I now live in a progressive, urban area.

In my research, I am interested in the lived experiences of women, particularly disadvantaged and marginalized women, which has brought me to my current research study on rural Appalachian women. Because of my background and upbringing as a rural woman with limited financial resources, I am particularly

interested in the lived experiences of these women, and hope women can feel comfortable speaking with me as the researcher.

While there are certainly many types of disadvantaged and marginalized women, conducting research with marginalized women of varied racial and ethnic backgrounds as a white researcher may hinder the depth and openness of the interview data. Women that do not identify with me as the researcher may be hesitant to talk to me about personal details or other aspects of their lives, which they may feel I would not understand. Instead conducting research with rural Appalachian women—women who look and talk more like I do—may help women to feel more comfortable talking with me about their health, their families, and their communities.

However, despite having a connection to the women in rural Appalachia, these women still may have a hard time identifying with me due to my position of power as a researcher and as a woman pursuing advanced graduate studies in the form of a doctoral degree. As shown in the Census data listed above for this county where interviews were conducted, less than 10% of county residents in the area of data collection have obtained a bachelor's degree or higher. Also, although I was raised in a family with limited financial means and a farming background, my own father held dual white-collar jobs as a public school teacher and a minister; as such, my life experiences and educational opportunities may be quite different from many of these women.

By keeping these factors of my identity in mind when interacting with research participants through memoing, journaling, and conversations with my research advisor, I was able to critically reflect upon how my research may be

affected by my own inherent assumptions about the participants and their backgrounds and beliefs. Despite my preexisting beliefs about these women, many of the findings that emerged were surprising to me and challenged these notions. Being open to emergent themes and acknowledging preexisting biases allowed me to find interesting insights that I might otherwise have ignored. Additionally, I was careful not to impose my own beliefs and interpretations on the interview results provided by these women (Emerson, Fretz, & Shaw, 2011). Through my journal entries and memoing, I was able to acknowledge these biases and balance the validity of the data through a commitment to craftsmanship validity (Kvale, 1995).

Additionally, understanding of my role as the researcher was of utmost importance, as I served as the instrument to collect the interview data from these women and also the lens with which the research was analyzed. Ensuring that I could build rapport with research participants was essential to ensuring that I could collect quality data from research participants. In terms of the visible and audible aspects of my identity, I seemed somewhat similar to participants (e.g., my skin color, the clothing I wore, and my accent). Other more invisible aspects of my identity that came up in conversation, such as my status as a graduate student and researcher and my residence in an urban area; however, clearly highlighted how I was different from the research participants.

In writing up the research results, I sought to avoid “Othering” and continuously negotiated how to present the participants’ own words and which words to privilege at which time (Fine, 1995). Women were very open with me in their discussions of their health and their family’s health and at times treated me as a

counselor or a friend, occasionally becoming emotional. Other types of qualitative research have stressed the importance of emotions in such research (Collins, 2000), stating that “emotion indicates that a speaker believes in the validity of an argument” (Collins, 2000, p. 263). Similarly, researchers should also acknowledge their emotional states and experiences as part of the research process.

Chapter 4—Results

Findings from this study indicate the importance of a variety of factors, which affected these women's interpretations of empowerment in their own lives, such as these women's inner determination, knowledge, self-efficacy, and perceived behavioral control (see Table 1 in Appendix D). Findings suggest that health communication campaigns can empower rural women through focus on multi-channel, multi-level communication and information through sources such as mass media (e.g., television, magazines, and Internet), organizational communication through religious organizations, and interpersonal communication with doctors, family, and friends. In addition, campaigns might empower women through incorporating their ideas for community change, bolstering community support, highlighting community members' health successes, and employing identifiable sources with which community members can connect and relate. Factors which affected women's empowerment included women's religion, social support, sociodemographic status, resources and constraints, community participation, and volunteerism.

Before discussing the specific research questions in more detail below, here I provide a brief summary of the health problems that these women described as affecting them and their communities. These health problems are described more in detail and through participants' own words below in RQ3.2, as women's health problems influenced their involvement with health. Overall, these women reported many of the same health problems in their communities and many women had experienced the same types of health problems in their own lives, although women's

health problems tended to depend on their age and generation. Older women experienced more chronic health problems, such as cancer, diabetes, high blood pressure, heart disease, kidney disease, arthritis, and chronic pain. Younger women experienced more health problems that are often precursors or risk factors for other health problems, such as drinking, smoking, and drug use. Women of all ages also reported especially high rates of what they called “female cancer,” with many of these women and other women in their lives having had hysterectomies—some of which were due to cancer, others due to endometriosis. Many women of all ages struggled with obesity and noticed high rates of obesity around them in their communities. Women of all ages also frequently mentioned depression and mental health problems as factors in their lives, as well as dental health problems and thyroid problems. Other health problems that were mentioned less frequently included: hepatitis, fibromyalgia, sleep apnea, and restless leg syndrome.

Many women mentioned having many varied types of health problems simultaneously. For example, as one White middle-aged woman states, “Well, I’ve had a lot of surgeries. I’ve had knee surgery. I’ve had gall bladder surgery. I’ve had a hernia surgery... I’ve got the health problems with the high blood pressure and the thyroid problems.” This woman’s story was typical of many who had experienced multiple types of health problems. Another middle-aged Black woman’s story illustrates an ongoing struggle with health problems with health that many middle-aged and older women were experiencing:

I’m a diabetic. I’ve had cancer three times... I had the uterus, I had the stomach, and some part down there... I was in the cancer clinic for three years

in Richmond... I had a 36 pound tumor on me, too. Last year I had eight surgeries. I had different things, some of it was coming from my blood, some of it was coming from my thyroid, and some of it was coming just in general from being a woman and my age, I mean.

These women had experienced quite a few health problems and hardships and their meaning making of empowerment was often intertwined with these life experiences and the ability that these women believed they had to make a difference in their own lives and their own health.

RQ1: How do rural women make meaning of their empowerment?

Women make meaning of their health empowerment in terms of their everyday health problems and the problems that affect their families and their communities. These women's perceptions of empowerment can perhaps best be understood through the lens of their lived experiences with health problems, also described in much more detail under RQ3.2. Women's meaning-making of empowerment and also women's descriptions of self-efficacy and perceived behavioral control are described here.

Inner determination. For these women, empowerment is much more than financial or social resources, although lack of resources did affect many women in the community. Many women who had experienced traumatic or stressful life events felt empowered to get through these based upon their inner strength and determination, which was related to women's faith and—to a lesser extent—social support, but often unrelated to their economic means. To illustrate how empowerment is not entirely

dependent upon resources or social position, one older woman—Nancy¹—told the story of how her husband fell ill and died, and how she was determined to help him get better prior to his passing.

Nancy is a White woman in her late 60s, does not drive, has low income and low education, and lives alone (now that her husband has passed) in her mobile home park, although her sister and sister-in-law live in nearby mobile homes. Nancy takes medication for depression, among other prescriptions, and she has beaten cancer and endometriosis. When Nancy found out her husband had prostate cancer, she was worried about him, but when she found out she had cancer, she says, “I just thought he's beating it. I'm gonna' beat it. And they told me that I could have surgery, and I thought get that thing out of here now.” Nancy was not worried about herself and her own ability to make it through cancer.

Later, Nancy's husband fell ill with pneumonia and his heart weakened. Nancy took him to the hospital for a check-up because of his condition. She said, “He walked in but then he didn't walk out... I stayed there with him in the hospital the whole 21 days he was there. I was right there with him. I didn't leave him.” Nancy eventually brought her husband home in a wheelchair. She says, “[*The hospital*] did therapy, but then they quit, said he wasn't responding good enough. And then I brought him home and we did therapy, and they said he wasn't responding again. And I cried all evening, and I said, ‘he's gonna' walk.’” The home therapist who was trying to help Nancy's husband walk again told her that the therapy wasn't working; however, Nancy wouldn't give up. She says, “And I got him up the next

¹ Nancy is a pseudonym for the woman's real name, which has been kept confidential for the purposes of this research.

day, and me and this therapist would walk him, maybe as far as here to this bathroom together, and I got him up the next day and put him against my body, put my arms around him, and I walked him the length of the trailer and back. I had him where he would walk, but he'd get weak and go down on me sometimes." Nancy was told that her husband was not responding to therapy, doctors had given up on his treatment, but Nancy would not give up: "Pretty much just on my own, I guess just more or less [*in*] my mind, I took it upon myself that I was going to make him walk or get him to walk."

Nancy relied on her inner drive and determination as well as her deep religious faith and was able to help her husband have a better quality of life for the remainder of his time. Eventually her husband passed away in her arms at home: "[I] took care of him for 10 months and he died in my arms in the house. Six years yesterday. Yeah, six years yesterday." To help deal with her husband's passing, she began volunteer work with her sister-in-law at the local clothes closet; her sister-in-law provided her with transportation to volunteer as she lived over an hour away in a rural area with no main roads. Nancy says, "I love my volunteer work very much and meeting the people. God blessed me to meet people like [*the other volunteers*]. My life is very blessed. My belief in God influences my health."

Knowledge. Some women described that knowledge and education was needed in order to create community change and help individuals to feel like they had more control. For example, one White middle-aged woman says, "I think... like with myself... education [*is important*]. Like with this disease. You know it's all out there if you're interested to find out. Like how important exercise is and everything."

This woman had described having a family health problem, but that her family did not know much about the health problem initially and were unsure about what they could do to improve their health.

However, for many women, knowledge alone was not sufficient for empowerment and women's beliefs that they had control. For example, as one White younger woman described, "I know the problem and I know how to fix it. I just can't get it done. It's very frustrating for me... I sometimes feel helpless. That's the best way I can describe it, frustration and helplessness." Also, health information and communication did not always translate to actual behavior change for health. For example, one White older woman who had participated in a Weight Watchers program in another county told how she had learned to make a healthy diet soup to eat to watch her weight. As she said:

Okay I was motivated the other day when I was at the grocery store. I thought well, I've got to diet. [I have a] Weight Watchers book, and there's a soup you make, and I guarantee if you eat that soup along with a little something every day you'll lose weight. I bought me a zucchini. I bought me a head of cabbage... I had to have some garlic... and chicken broth... And I was going to make me some of that soup. I've still got the stuff in there but I haven't made it yet. My willpower hasn't kicked in yet, (*laughs*) but I will, I will.

As this woman illustrates, she had good intentions for making her diet soup, had the information on what to do and how to make it, had the financial resources, went so far as to buy all of the supplies, and as a retired woman living alone, she had the time to make the soup; however, she had not yet gotten the "willpower" to make the soup.

Other women told similar stories feeling that they had the knowledge about health problems or health actions, often through their doctors or through experiences with friends and family. This knowledge and awareness of problems helped women to feel more in control, but often did not motivate women to take actions for their health.

Self efficacy. Tying into this idea of knowledge, many women described having self efficacy for health actions and behaviors, such as eating healthy, exercising, taking their medications, or otherwise managing their health. These women believed they would know how and would be able to take small everyday health actions, but that self efficacy in this case was not enough to help them make a change in their everyday health actions. Much of the health information that women had seen around them on television or in magazines that they hoped to try for their health (e.g., diets and exercises) incorporated elements of self-efficacy. For example, this information made the activities appear easy, showing that the activities were doable or achievable. However, as described above, although some women perceived health activities to be easy to do, they often did not take actions to follow through with these activities.

Self efficacy was a part of empowerment for these women, however. Confidence, as part of the larger concept of self-efficacy, affected these women's attitudes about self efficacy. Some women felt very confident in their knowledge about their own bodies and their own health, although this was not the norm. As one older White woman stated:

When you've lived as long as I have, sometimes you know just as much about your body as the doctor does. I had a neighbor one time and she'd gone to the

doctor, and I said “Well what did he say was wrong with you,” and she says “Well, he couldn’t find anything. And I say, “Well, did you tell him what was wrong with you?” And she says, “No! That’s why I went to *him!* He was supposed to tell me what's bothering me.” (*laughs*) They can't tell you what's bothering you, if you don't tell them.

Although most of these women felt somewhat confident that they had the ability and the knowledge to take the needed steps to make corrective actions for their health, there was still something “missing” for these women, such as the strength and encouragement that came through social and religious connections. For example, as one White, middle-aged woman says, “I know how to [*improve my health*]. It’s just getting the willpower to do it. It’s kind of like I need a mentor and somebody to do it with me. Kind of like a buddy system. Like come on and let’s do this. It’s sad, but that’s what I need.” Other participants seemed less confident in their abilities, answering hesitantly about their control and confidence in their abilities. For example, another Black, middle-aged woman answers, “I think so... I think I know what to do now. I just . . . I don’t know why I don’t do it.”

Some women used this perceived confidence about their own health and their own bodies as a justification for not going to visit the doctor. For example, an older White woman not originally from the area, but who had lived there for the last 30 years, felt confident in her ability to manage her health, as she took care of most of her health problems on her own and routinely hiked the Appalachian Trail for fun and exercise. As she says, “Well, I don’t go to the doctor because I don’t fix what’s not broken. And if I do get a cold or something, I do it myself. I take Echinacea or herbs

or stuff. I will not go to a doctor. I'm non-compliant." These women who were confident in their own health abilities and knowledge felt that would be able to take care of themselves for everyday health and minor health problems. As another White older woman says, "I feel like I'm able and capable of taking my medicine the way I should take it. I try never to forget it. And if I have some little problem that I don't need to go to the doctor for I have medication or I can get medication over-the-counter that will help that."

Perceived behavioral control. Participants also made meaning of their empowerment through their beliefs about their personal control in health situations. Many women felt that had control or a large amount of control over their health and the factors that affected their health. Some felt health incidents would always happen and could not be avoided: For these women, there were just too many unknowns that could not be predicted or be avoided. Most women had some perceived mix or balance of beliefs about their own control versus God's control over health, as discussed later under RQ3.1 in relation to how religiosity related to women's meaning-making of empowerment: While most women felt that they had control over some aspects of their lives, they also felt that God was in control of other aspects.

Some women described that many health problems were almost entirely in the individual's control and believed that people did not take enough personal responsibility for their own health and instead blamed these on other factors outside of their control. For example, one White younger woman says:

I'm really bad, but when people like my neighbors will talk about health, well [they say] like "I have emphysema." I'm like, "Well, quit smoking..." I want to have a lot of compassion for them, but it's really difficult. Sometimes, you know, "I'm dying of emphysema," or "I have cancer," well cancer you can't help, but "I am overweight," which, you know, hey, I can't say nothing about that because I eat junk food all day. "Don't eat the junk food. Take a few steps outside and take a few breaths..." If you can purposefully manage your health, you should.

Other participants mentioned described control as psychological and was all about one's attitude. As one White middle-aged woman says, "It's in your mind. It's being positive."

Another woman illustrates this concept of individual control by talking about how her doctor only has some control over her health, but that she ultimately has the majority of control over her own health. As this White, older woman says, "I mean I don't care how good a doctor he is or anyone trying to help you, if you don't cooperate they can give you all the medicine in the world and it is not going to help you, so it only makes sense that you do have control over it."

Most of these women also acknowledged that there were aspects of their health that were beyond their control. For example, as one White, younger woman says, "Now there are things that are beyond your control; there are things beyond my control that affect my health... Like water retention or when I had my car accident and broke my neck and broke my back... I was in a nursing home for three years, you know... I can't do anything about it. They're beyond my control." Although these

women believed that individuals should take more responsibility for control over their own health, they were also realistic about some factors being beyond their control.

Women who suffered from mental illness, however, often felt that they had little control over a large portion of their lives. Around a third of the women participating in the research described taking some type of medication for anxiety, depression, bipolar disorder, or another mental health condition. From among this group, women with more severe mental health problems felt this affected their sense of control. For example, a White, middle-aged woman suffering from anxiety and depression who received continuing community mental health services said she had no control over her health. As she said, “I feel all the control I had is gone. I’ve tried doing about anything and I’ve done all the doctors tell me to do,” but as she said, nothing seemed to help her. She felt frustration and a sense of helplessness as a result.

Another White, middle aged woman suffering from anxiety and depression says she has control over some aspects of her health, but not her panic attacks and anxiety. As she says, “Some of it is under [*my*] control... but as far as the panic attacks and that sort of thing, I can be sitting at home relaxing watching TV and one could just come out of the blue. You know, basically I have no control other than taking my medication which I do every day, but still sometimes that doesn’t control it.” This same woman went on to say that she often avoided places such as gyms or community centers to workout because she was afraid she might have a panic attack. She also felt this way about doctor’s offices, and was approached for the interview

while waiting outside of a doctor's office for a friend to have a check up. She had not gone inside the doctor's office with her friend due to her anxiety.

RQ2: How can communication campaigns create a sense of empowerment in rural women?

Women's responses regarding how they found out about health information, what influenced their health decisions, and their thoughts about control over health, suggested that communication campaigns and programs need to focus on a variety of communication channels and sources. Women had their own ideas about how to empower their communities and were empowered by community support and observing others' successes.

Focusing on multi-channel information. Women described getting health information from a variety of interpersonal and mass media communication sources. When asked to take pictures of what influenced their ideas about health and where women got information about health, many women took pictures of their magazines, televisions, computers, their family and friends, their churches, their medications, themselves, or their doctors' offices.

Media influence. Women mentioned being influenced by media when it came to their own personal health problems, such as their weight and their body image. For example, when asked about how often she thought about health, one White, younger woman stated, "I do all the time. Every day. Especially if you're watching TV and you see those little skinny girls, but I long to be skinny." Another White, middle-aged woman says, when she thinks about someone healthy, she thinks about, "someone that's not overweight and, you know, that doesn't have a lot of

things wrong with them, you know, like, you know Tom Cruise or Brad Pitt. They look pretty healthy to me. (*Laughs*).” These women were affected by entertainment media’s portrayal of what is beautiful and healthy and often felt very overweight compared to these standards. One White, middle-aged woman shares the story of her young cousin that wanted to look more like a model, “I have a cousin who had this issue and she’s over six feet tall and she’s had the gastric by-pass twice and she looks like a walking skeleton with skin stretched over her because she’s over six feet tall, but she thinks she looks really good like this and everybody else is saying, ‘Oh my gosh.’” As this woman says, media creates an unrealistic and unhealthy stereotype about beauty and health, which many young women in the community aspire to.

These women’s interpretations of the community problems they faced were also influenced by what they had viewed recently in media. For example, as one younger, White woman states about the problem of obesity in her community, “I would say obesity would be up there in the community. We’re not as bad as Huntington. Did you see the documentary? It was the cooking show... they have on Fox... Jamie Oliver - Food Revolution. So they said that Huntington was the most obese city in the U.S. or something. I think that is one of the problems here.”

In addition to being influenced about their ideas of health and beauty via entertainment media, participants also mentioned passively receiving health information from television media, especially programs such as Oprah, where they watched Dr. Oz and shows such as “The Doctors” and reality television shows such as “The Biggest Loser” and “Jamie Oliver: Food Revolution.” These women did not actively seek health information via television media, but rather consumed this

information as they happened across it while watching television for entertainment purposes. Many women mentioned that they did not have cable television, and more women mentioned shows that aired on broadcast networks. For example, one White, middle-aged woman that took a picture of her television as a source of information said, “Dr. Oz, he tells you what health is, and then you’ve got what the media tells you health is... not just health, but what beauty is.” Another White middle-aged woman describes “The Doctors”: “On TV ‘The Doctors,’ I watch ‘The Doctors’ you know where they get on there and talk about things, and I learn a lot about how to stay healthy, and what to do if you have a toothache... put cayenne pepper on your jaw and it absorbs when you do that.” Another Black, middle-aged woman says she watches television a lot and her sister accuses her of “watch[ing] Dr. Oz like gospel every day (*laughs*).”

Some women said that media did not have much influence on them and their thoughts about health, as they did not trust health information from television, the Internet, or other media sources. For example, as one young, White woman says, “Well I definitely don’t trust stuff on TV, and definitely not... getting on the Internet. Researching under university would be much more accurate.” As this woman described, she would trust information from universities, but was not trusting of television and the Internet. Another White, middle-aged woman illustrates that she trusted information if it seemed to match what she already believed or saw around her, “I will look up things and read and see what they say, and if it follows along with what I’m seeing, then I kinda’ trust what it is saying but I have to see something before I trust it.”

Even though women mentioned observing programs, PSAs, and other information about health on TV, almost none of the women could cite specific instances where they had actually followed through on any information they had gained from these campaigns or programming. For example, one White, older woman said, “I watch things on TV about it about health and things that you can do, but I’m like a procrastinator and I don’t follow-up very good.” Another White, middle-aged woman mentions that she sees, “Advertisements like to get your flu shots, different things for stomach problems, a lot of asthma commercials...” Interestingly these ads were all related to problems that this woman was experiencing in some aspect of her life; she noticed these ads because she had higher involvement with these problems. However, this woman says these advertisements do not make her interested in taking any actions for her health, and that she does not trust this information. Another White, older woman mentions watching “The Biggest Loser,” and says the program makes her think about her health, but ultimately the actions are too hard for her to follow through on:

Well I watch the Biggest Loser, and when I’m watching that I think, “Well, you know, I could watch how I could eat better,” and “I know I need to walk more,” and “I’m hoping it will stay warm so I can get out and start walking a little bit.” But like I said I can’t walk much on account of my feet and legs get to hurting. And I sit down and rest. I know I can start eating better.

Doctors as health sources. Women also turned to their doctors as sources of health information. When women were asked to take pictures of where they usually found health information and what influenced their health, many women took pictures

of their doctors or their doctors' offices. Other women described getting information from their doctors, nurses, and health care providers about health in general or particular health conditions. Women generally described going to their doctors first for health information prior to researching this information on their own, if women took this extra initiative. For example, one White, middle-aged woman says, "The doctors would give us information. They would usually get it off online, and you know find things. So they have given me many printouts on things." This woman did not go online for any information on her own; however, her doctor retrieved information for her from the Internet.

Women were very trusting of their doctors when they received health information from them. One White, middle-aged woman describes her trust of doctors, "If the doctor tells you to do something then you do what he tells you to do. If you've got a good doctor and he says 'walk' or do this or do that, do it... and that's what I do and pray a lot." Some women trusted their doctors because they had maintained long relationships with the same doctor in the community and felt like the doctor was a family friend. Undergoing many health experiences and problems with the same doctor, women generally felt as though they knew and trusted their doctors. For example, one White older woman says:

I trust my doctors... he's a character. He just laughs, and he's so friendly and he's a wonderful surgeon. And if he thinks he can't do what's supposed to be done, he'll send me down to [*neighboring county hospital*]. I don't have to worry. And when they're gone... oh... if they leave before I do, if they are deceased before me, I guess I'll have to hunt around and find one like 'em.

Although women trusted their healthcare providers, they also avoided visiting these healthcare providers at other times due to lack of insurance. For example, one White, middle-aged woman says she would go to “the Internet” if she needed health information, since, “we don’t have the [*insurance*]... I don’t have a family doctor at this time.”

Also, as described above, many women and their families were often hesitant to visit their doctors unless they had a very serious health problem. Some of these women did not go to the doctor very often themselves and assumed a more passive role in the family’s health. As one self-described overweight, young White woman states:

I usually don’t go to the doctor and stuff like that unless maybe I’m on death’s door, but I get a lot of my information from the doctor. If I have to go, if I have checkups, I’ll go to the doctor and then they’ll tell me this is good, this is borderline and stuff like that. I usually don’t get sick. My husband never gets sick other than having high blood pressure and stuff like that. Like I said I don’t go to the doctor unless I have to unless I have an appointment or I have a checkup because like I said I hardly ever get sick.

Family and friends as health sources and influencers. Other women, when asked to take pictures of where they received health information from or what influenced their health, took pictures of their families and loved ones. These women indicated that their families and loved ones provided them with guidance and information regarding their health. Many other women mentioned in interviews getting health information from friends or family members. For example, one older

White woman says that she received information about her husband's medication condition through "our daughter. She teaches here in [county], so she stays researching all the time. Especially with her son and her [having the condition]." Another White, middle-aged woman mentions that she recently has had problems with kidney stones and bladder infections and has been taking cranberry as a supplement; when asked where she learned about this remedy, she said, "Probably my mom. Years ago, probably. [My friend] had some of the cranberry capsules so I got those from her." This woman learned about cranberry as a home remedy through her lived experiences and upbringing and also received this home remedy from a friend.

Religious organizations as health sources. Participants who were highly religious and involved with their church organizations also sought out health information from their churches and turned to their pastors for information and for comfort. For example, as one older, White woman says, "Well, if I had a real health problem, the first place I would talk to would be my Pastor."

Some women who took pictures of where they received health information from or what influenced their health took pictures of their churches, artwork in their homes such as crosses or depictions of Jesus hung on the walls in their homes, or Bibles. Pictures of this type were not as common overall, as most women took pictures of their doctors or media sources; however, women involved in religious organizations were more likely to take pictures of this type. These women explained that their beliefs about health were heavily influenced by their faith, their religious beliefs, and their religious organizations.

Through similar and identifiable sources. Many women mentioned that they paid more attention to health information if this health information came from someone they identified with, such as women that appeared to be like them. These women were more critical of figures with whom they felt like they had less in common. For example, one White, younger woman mentioned seeing Michelle Obama recently on television promoting healthy eating. When asked about how she felt about Michelle Obama as a spokesperson, she said: “I don’t know ‘cause I probably would just change the channel, ‘cause she is able to do it, because we’re paying her to announce this stuff. No wonder, I mean taking one \$100 and something out of my taxes every time.”

Some women expressed that they did not trust health messages that were unrealistic or did not match their perceived community reality. For example, another young, White woman mentioned about seeing Michelle Obama on television promoting healthy eating:

It kind of annoyed me, like, I was watching TV the other day, and it started talking about serving size portions and it fit your hand... It was Michelle Obama. And I was like, “Right. (*says with sarcasm*) Like *you’re* going to eat a serving that fits in your hand.” It is like they are preaching to you but they need to practice what they preach.

In this particular instance, the woman felt as though she was being talked down to and was being told to do something that Michelle Obama herself was not doing.

Bolstering community support and empowering “little” voices. Some women expressed the need to spread the word about problems in their community so

people could work together. For example, as one middle-aged Black woman said about health problems she was observing in her community around her, “[*Maybe*] people like you can spread the word you know what I’m saying and then like a little person like me can be there to help, you know.” Interesting in this particular quote is that the woman described herself as a “little person” perceiving that she had little power on her own, but that the researcher instead would have much more power than she would.

Other women expressed the need for more communication in their shared community and also transferred power to me as the researcher. For example, one middle-aged, Black woman says, “For example, like you—people look up to you ‘cause your taking this survey and that’s getting the word out a little bit more than people just leaving it alone or whatever happens, happens. [*We need*] people like you to strengthen it or do something about it that’s what I mean about communication.” This woman also perceived that the researcher had some sort of power that she did not have, and that the researcher could help everyone to start communicating about health to solve community problems.

Another Black, middle-aged woman says, “I like to get out there and talk to people. I like to get out there and see what the problems is. I like say, ‘What’s your idea of stopping this?’ or ‘What can we do to prevent it or make it better?’ But I’m just a little voice so…” This woman was involved in community health problems and saw herself as a community leader, but she believed her voice was “a little voice” that may not be able to make much impact.

Showing community members' health successes. Women who were able to observe individuals in their community make drastic, positive changes for their health felt either empowered or frustrated. Some women felt empowered, because they felt if others like them could make a change, then they could too. Others felt frustrated because they had been trying to make a change, such as losing weight or quitting smoking, but had not been successful in their efforts; these women felt as though they may not have the motivation or willpower to make a change and seeing others who had changed was frustrating for them.

As one middle-aged, White woman stated about her friend's amazing health transformation that surprised people in the community:

[*My friend*] had a problem last year. She was just pretty much bedfast. She had two surgeries on her back and she ended up in worse condition than she was before she had the surgery. Well, the biggest thing was, I mean, she was overweight. She's lost, gosh, I'm not sure how much weight... she was in the hospital for over a month... I mean people were just amazed when they saw her before and she was like an invalid. And she had fallen and fallen and fallen, and it was ridiculous and after she got the right help and lost weight and got things under control and people were, like, they had given her up for dead.

This woman suffered from anxiety disorder and panic attacks, and she said observing her friend overcome such an extreme health situation had given her hope that she could eventually cope better with her health problems.

Another middle-aged, White woman shares the story of how her 23-year-old son lost well over 100 pounds. As she states, his major weight loss has encouraged others to try to lose weight as well: “[*My son*] has lost quite a bit of weight. Well, he’s actually gone to 170 pounds and he weighed like 300 something... So everybody’s trying. If he can do it, everybody’s like, ‘Oh, we can do that.’ It’s much harder to do than you know.” This particular woman stated that her son had inspired others, but also acknowledged that losing weight may not be as easy for others as it was for her son.

Another middle-aged, White woman highlights her husband’s success with quitting smoking, which empowered her to take a stand and also quit smoking. Although she had considered herself to be the healthier of the two in terms of her smoking habits, her husband had quit due to another health problem. As she describes:

Yes, he quit smoking. He was a three pack a day, three and a half, sometimes four packs for 20 some years. And then he stopped cold turkey. It’s been a little over 2 months... He’s done great... And at the time, though, I was still smoking. I don’t smoke but maybe a pack or two a week, but now I don’t smoke at all. I quit. I thought if he did that, then I can do that... I used to preach at him because he smoked so much, and I felt because I didn’t smoke that much I was better, and he was the one that needed to quit, and then it was kind of like the roles were reversed and then it was like, “You really need to quit.”

Incorporating women's ideas for community change. Many of these women offered up ideas for ways to improve their community's overall health. Some of these women were initially hesitant to offer their opinions as they did not feel they were qualified to offer their opinions on the matter; after some encouraging, however, these women shared their thoughts. For other women, it was evident that they had thought about these issues quite a bit and talked about them with others. For example, as one White, older woman notes:

There's a sewing factory up here, an old sewing factory... it would be real good if we could like make that into like a community center especially for the children and the kids here because there's a lot of drugs and alcohol. One of the reasons is because there's nothing to do here. So, it would be kind of neat if there was like you know they could put a pool or something in there. You know something where kids could go after school and have something to do. I think that would help.

Other women also mentioned the need for community centers and expressed that they had thought about this notion before. For example, as another White, middle-aged woman notes:

I don't know where it would be at yet, [*but*] I would like for us to have maybe like a small wellness center somewhere here in this community. Where... kids could go swimming... they do have the walking track down on the fairgrounds and stuff, but like this time of year, you know, it's too cold to, you know, especially for older people and little kids... Just something that could

be done that wouldn't cost a lot of money because people in this community don't... there's not much job opportunity.

Other women expressed similar ideas about needing a place indoors as a community center to exercise and get together. As one White, older woman says, "I wish this empty building, I wish this county would buy that or I wish [name] would donate it... I mean that building's sitting there going to waste. It could be a community center for youth and for the people here where they could have the exercise equipment or things. That's what I would like to see because we don't have any of that here."

Other women mentioned attending programs outside of the community that had helped them to have more control over their weight and health and to increase their willpower. For example, an older, White woman who attended Weight Watchers in a neighboring county with a town center says, "I think when you go to Weight Watchers they help you to have willpower. Because you have to pay to go, and you think, 'Well if I'm going to pay to come down here and do Weight Watchers, I'm certainly going to stick to my diet.' And they encourage you." This woman also stressed the importance of the social support that this program provided for participants.

Another young Black woman stressed the importance of "having things for the kids to do because they sit in the parking lot and talk... and turn to drugs and stuff." She tells the story of two women who were struck by a car and killed recently by teens behaving recklessly and reiterates the need for "bringing things in like community centers, like YMCAs, like Brothers and Sisters things." As she says,

“there’s no like stores... they took Old Navy away” from the neighboring county. She also says there are not many educational opportunities for youth in the area, “There’s nothing to put into doing to expand their education. Most [*youth*] have to leave to go to other cities to get employment or to get their education.”

As noted in RQ3.2, women were concerned with obesity as a community health problem. Some women talked about how the community had acknowledged the weight problems and attempted to address them. As one White, young woman says, “I know there’s weight problems [*that*] also affects the community. They tried to do a weight walk, last summer I think, and not a lot of people showed up for it. The people that was overweight they did show up and we did walk and stuff. Weight is a major thing.” Women suggested that community events had been helpful and educational; however, community programs were few and far between. Women tried to maintain their activities and knowledge they had learned through programs, such as exercise routines and watching their diets, but most women who had participated in programs of these types did not follow through.

RQ3: What factors can affect rural women’s meaning-making of empowerment?

In addition to the three factors that were specifically explored in more detail and addressed in research questions RQ3.1 to RQ3.3—religion, involvement, and social support—a few other themes emerged regarding factors that influenced women’s empowerment. These emergent factors affecting women’s lived experiences of health and empowerment included women’s sociodemographic status (i.e., age, income, education, gender, race, etc.), resources and constraints, and

community participation and volunteerism. Some of these factors—particularly community-level factors, such as access to medical care and community health services—affected community empowerment as well as individual empowerment.

Sociodemographic status. Factors such as women’s age, income level, gender, race, and education impacted women’s beliefs about their empowerment. Some factors such as education and racial and ethnic differences were hard to assess in this research as most women did not have college-level education and most women were white. Other factors such as income level and age differences had a more obvious effect.

Low income and financial resources. Differences in women’s sense of empowerment could be seen when it came to differences in how they interpreted the adequacy of their income; this was particularly evident in women’s thoughts about healthcare and their ability to control more physical factors that affected their health. Women from a higher class status in terms of income typically did not mention these physical factors and constraints, compared to women of lower incomes.

As many of the women in this research study were affiliated with charitable need-based programs, many had low incomes and were in situations where they found themselves having to make hard decisions between medical care and other items in their lives. For example, one White, younger woman says she has seen information about vitamins on television and would like to begin taking vitamins, but as she says:

They’re way too expensive, you know... my Medicare and Medicaid pays for my medicine, then all I have to do is pay a co-pay of five bucks or ten

dollars.... Now, what's it gonna' be, food or vitamins? Yeah, I could take vitamins and starve myself... Do I go get milk, bread, or do I buy my medicine? It's like, "You poor people can't afford to be healthy."

For example, one White, middle-aged woman described a lack of income and resources as being particularly problematic for individuals who may have limited transportation. As she said, it was sometimes hard for two people in a single family to work:

I think money and stress has a lot to do with [*health*] in this area... there's not that much opportunity in this area. A lot of our families in this community only have like one vehicle, so it's kind of hard for both of them to work if they only have one vehicle. Plus gas, you know. It's just hard.

Another woman described these income problems in her community as affecting individuals' decisions regarding choosing to purchase insurance or choosing to visit doctors. As this White, younger woman stated:

Well, not enough money. Not enough income. High premiums to pay for medical. The biggest thing, I think, is dental and vision. I can't get new glasses even though I need them. I can't get teeth worked on unless I can get fitted in to the free clinic which doesn't have a dentist all the time. In my community, I see a lot of older people choosing between medicine or food. And it's either/or when you can't get both.

Another single, middle-aged, White mother described her personal struggle with financial resources and how she was unable to pay her bills. This woman says:

Right now I'm in crisis because of no money. I'm trying to get my oil to heat the house. Then you have your electricity. The mortgage is cheap \$200 but it's \$700 electric and \$4.95 a gallon for kerosene.

Other women mentioned not being able to afford to attend the local gym or have access to transportation to get there, as this gym was in a neighboring county and a far drive for many women. As one White, younger woman said about why she didn't exercise, "I used to lift weights and be in an exercise [*class*]. . . I would love to have a trainer. (*laughs*). Be able to get to the gym, you know, that kind of thing, but, you know, I can't afford to go to classes, can't do that kind of thing. Just the money restriction is very depressing, actually it's very frustrating, too." Some women walked for exercise in the warmer months, but wished they had the money to afford to join a community center or gym to walk in the winter time. As one White, younger woman said, "During the summer time I was walking with another lady in the community. In the winter time we don't walk because it's cold. I wish that we had like a gym or something here that we could walk inside. I know that [*the neighboring county*] they have a community center where you can become a member and exercise, but that costs money."

Financial constraints were a huge factor in women's descriptions of their eating habits as well. For example, women that received food stamps and also received food from the community food distribution centers described that they sometimes just had to take what food they could get, and this often did not include expensive fresh fruits and vegetables. For example, as one White, younger woman on food stamps states, "I don't get enough food stamps to go out and buy healthy food,

you know. If I could, I'd buy apples or bananas to snack on but... I prefer eating healthy stuff but I don't. I eat terrible, whatever is cheap." Another White, younger woman talked about the food boxes she received from the food distribution center:

I'm grateful for the food boxes; I'm grateful for the food stamp program; I really am, but a lot of the food boxes do not give you healthy food that you're supposed to eat. They give you things that sustain you, things that fill you up, like pastas, potatoes, that kind of thing because that's what you need... If you want to eat healthy, you got to be a little richer. You know, what goes further for a dollar? Four boxes of macaroni or an apple? How are you going to feed your family on one apple, you know?

Others mention limiting the meals they ate in a day for fear that they would not have enough food. For example, one White woman in her 30s says, "I'm diabetic and I am terrible 'cause I usually don't eat breakfast and I usually don't eat lunch... I just wait 'til dinner cause we don't usually have enough food to eat."

Some low income women, however, did not perceive their financial constraints to have an impact on their ability to eat healthy foods. Because of the rural area and the land available, other women with garden areas described eating healthy because they grew their own fruits and vegetables. As one White, middle aged woman said, "I grow my own garden. There's great food I grow. So we do eat out of that. I can my own tomatoes, green beans, apples, applesauce, so we have real good whole foods." Another White, middle-aged woman says, "We always have a big garden and I garden and can my fruits and everything my vegetables and fruits." Another low income older, White woman who did not have her own gardening space

worked together with her adult children to have access to healthier food options after some problems with her health and gall stones:

We're having a big garden this year. And we're gonna' be raising the chickens.... and we're gonna' can and freeze our own food, our garden stuff. We'll have our own eggs. Oh yeah we're doing all this because for one thing, I think there's a lot of [*bad*] things in canned food.

Even when women did not have access to garden spaces themselves, they often knew of family or friends that did have garden spaces and were willing to share with them, if these women were interested in gardening.

Racial and ethnic differences. Women in the research varied little by race or ethnicity mainly because of the demographic make-up of the area: As shown above in the Census data for the area, 94% of the county residents were white. However, a few women participating in the research were Black and mentioned “color” in their interviews. One Black, middle-aged woman described discrimination against “color” in her community:

It is just a common thing. But you know what, I don't hold too much against it. When I worked in a restaurant I had people not wanting me to touch them, don't, you know, like wait on them. They didn't want me to give their money back, but that is okay because I am from the city and when you are from the city you have a better open mind than these people here... I have no control over that; do you see what I'm saying? And it is in their roots. It is still in their roots, you know.

As this woman described she had “no control” over how people responded to her race or her “color,” and she accepted the discrimination as a way of life in a rural setting such as this. She further went on to describe that she had seen “black and whites” together in cities “like it ain’t nothing,” but that this behavior would be criticized or talked about in her community.

This woman did not seem to let this perceived discrimination impact her empowerment or her health, and she actively worked with other individuals in the community of varying races and ethnicities and attempted to be a bridge, of sorts, for fellow community members to come together. As this woman described, her racial differences actually positively affected her notions of her own empowerment and the role she had to play in her community. For example, she said:

The way I am in my community, I help everybody I don’t care, you know? I don’t care what color you are. I don’t care what church you go to. I mean I judge people from the heart not the color, I don’t see color. I have pajama parties and we have black, white, Mexican, and we walk in the stores and we have a ole’ good old time... They say, (*whispers*) “What happened?” and I say, “Girl I’ve been busy!” (*laughs*) I leave it open for them [*to assume*]. But you know but it’s my babies. It’s nobody’s business. I just like being there for them.

As this woman described, when she would take children of varying races and ethnicities out with her in public, others would whisper, gossip, and wonder if they were really her children and wonder about their racial or ethnic makeup. As she

describes, she just shrugs it off and jokes saying she has “been busy,” as if they were all her biological children.

Generational differences. This meaning-making also depends on the cultural differences in the community often occurring by age groups. Many of the younger women and mothers referred to the “old timey” generation and how their health beliefs and practices were different because they were “old timey.” Although, these younger women talked about how the “old timey” folks had diets that weren’t as healthy, such as eating pork fat (i.e., lard) and other unhealthy items, they also spoke about how these “old timey” women were often healthier for their age than the women of the younger generations.

As one middle-aged, White woman said about the “old timey” people, “The old timey people, though, they have good diets. They eat their collards. They have the apples that they’ve made applesauce [*from*]. And I’m watching this, biscuits and gravy going ‘ewww’, but how can you be 86 years old, and he’s eating the same thing every morning?” As another young, White woman states about her grandmother’s cooking, “I always went to my grandma’s house, and she would cook in lard and, you know, the ‘old-timey’ stuff.” Some “old-timey” women talked about making homemade foods from scratch, and most of their food was fried. Biscuits, gravy, bacon, sausage, and eggs were very common foods for breakfast, and many women ate these regularly. As another middle-aged, White woman says, “For breakfast I love gravy, eggs, sausage, or bacon.” Another older, White woman says, “I like bacon and eggs [*for breakfast*] and they won’t kill you because I’ve been eating them for seventy six years.”

Besides cooking styles, women described the “Old Timey” generation as being more hesitant to visit the doctor and promoting more natural home remedies.

As one White, younger woman states,

My grandma she had the tumor in her stomach and she actually...she's ole timey, so she was taking all the stuff she grew up on to try to get rid of her stomach problems and stuff, but actually it was also too late for her. My grandma could afford it, but she was ole timey and all of the ole timeys didn't go to the doctor you know and stuff unless it was too late for them or something was really, really bad. She was trying to cure everything with vinegar or something like that.

As evidenced in the quote above, women from the “old timey” generation often felt empowered to try their own health remedies, which might be different from traditional notions of health or what was promoted by health educators or doctors. For example, as one older, White woman stated, “Isn't there something that actually says don't feed the kids before six months... feed them just milk? That's a bunch of bull. What do you think they did back in the old days? I fed mine the day they was born chocolate pie. And they ain't dead. No, they are not.”

Women from the “old timey” generation were more likely to have been raised on a farm than their younger counterparts, and many of them experienced a different way of life as a result and thought about their ways of life as “healthy” compared to modern notions of healthy food. For example, as one older, White woman says:

We were raised poor, but, on the farm and we worked hard. We ate right because we raised what we ate, you know... We had our own meat, had hogs,

had cows, had chickens. Mama sold the cream. Had to get money for things we needed, sugar and stuff, but . . . [*Raw milk's*] real healthy... If you raise it out in the country it's still a whole lot safer and a whole lot better than what you can buy when they do all doctoring they do to it.

Many of these women from the “old-timey” generation believed that they knew how to be healthy through gardening, raising their own meat and eggs, and providing their own dairy sources. For these women, they derived strength and confidence in what they believed to be healthy from the traditions of their families and the history of the area. For example, as another middle-aged White woman says, “Well, we eat healthy. We try to raise our own meat. Have our own [*goat*] milk... And our own eggs if we can, and we raise our own vegetables, and we don't buy a lot out of the store.”

Family and community caretakers and volunteerism. Women often made meaning of their health and their empowerment through the social roles they played in their community and in their families. For example, the majority of women in the interviews were caretakers, oftentimes of many others. These women played many roles in their own lives as mothers, wives, daughters, grandmothers, great-grandmothers, employees, teachers, and more. Women described their health actions and empowerment often through the lens of one of these roles, identifying with their role within the family unit, within the community, or within their workplaces.

Women's caretaker roles within their families and within their communities often gave them a sense of individual and community empowerment.

Family caretakers. In many of these family roles, women described themselves as the caretakers of the family, especially those that were mothers, wives, and grandmothers. Women looked after their children and also assumed primary caretaker roles of their grandchildren, nieces, nephews, friends, and sometimes great-grandchildren. As one young, Black woman illustrates, “I try to be a caretaker because I try to worry about everybody and try to take care of everybody and make sure everything gets done to help them. I guess I worry about everybody, but myself. I worry about my kids. I have to make sure they’re healthy. I worry about my husband. I worry about my dad.” This woman describes being empowered to take care of the loved ones in her family and feeling a sense of obligation to do so; however, this drive to take care of others at times affected her own health as she neglected to attend to her own health issues in efforts to take care of them.

As evidenced above, women described putting the needs of their family and loved ones before their own needs. For example, a single, middle-aged, White mother described putting her children’s needs above her own and at times sacrificing her health for her children’s health: “I put everyone before me.... You lose yourself as a mom.” Another White, older woman talks about her family’s health and describes her role as a mother of a daughter battling cancer, “My oldest daughter just had cancer surgery. She had ovarian cancer, and I’m the one that took her to the doctor. I’m the one that took her to the hospital. I’m the one that was there with her the whole time, and I talked to her doctor and I talked to her surgeon.”

As another example of how women took care of their families and extended families, a middle-aged, White woman says, “I get up all hours of the night, all hours

of the day. I've been trying to help take care of two grandbabies, and I've raised four daughters on my own." Another middle-aged, White woman described taking care of "six kids" each day: "Just two are my grandbabies, two of them I kind of adopt—they are kind of slowly going back with their mom, and the other two are my cousins 'cause their mom had surgery on her back."

Women often had children at a very young age, and many women had very limited periods in their adult lives when they did not serve as mothers or primary caretakers. For example, as one young, White mother says: "I got pregnant right out of high school; then 13 months later I had my other son." Another young, White mother had just graduated high school and her baby's father was away at college, leaving her the primary caretaker of her young child: "He comes down usually every week. Sometimes it's two weeks before he can come down, but I understand. But as soon as he gets out of college he's going to start helping out more, because I didn't want him to quit college when I found out that I was pregnant because he only had two more years to go."

Women provided meals for their families and encouraged their loved ones to visit the doctor and to take care of their health. Women also mentioned that the men in their lives did not visit the doctor regularly or go for check-ups. As one older, White woman stated about her husband, "You have to make him go. He is supposed to go every year for a colonoscopy and you just have to. Sometimes he goes two or three years [*and*] he won't go. I don't think especially men they don't go to the doctor when they get something the matter with them. They just wait." As evidenced in this woman's quote, however, women often saw themselves as motivators or

encouragers for their husbands and family members when it came to health. As another middle-aged, White woman states about her husband and her family, “Well I do what I can for them. I can’t do it [*for them*] you know. I have to sneak and make [*my husband’s*] appointments and tell him the doctor’s called and all that, but I have to push them too.” Another middle-aged, White woman also describes this phenomenon. As she says about her husband, “He doesn’t like to go to the doctor, so the nurse called me and she said, ‘You make him go, because he is a walking stroke.’”

Other older women assumed the primary caretaker for an ailing spouse and spent their time devoted to their partner. For example, as an older, White woman said about her husband, “He is in kidney failure; he has polycystic kidneys, and so I spend my day... he doesn’t demand it, but just to please myself... I get up when he needs to. I don’t make commitments. So if he’s having a good day, I go volunteer and do things in our church.” This woman was active in her community and through volunteering with her church; however, this was dependent upon her husband’s needs and health condition for the day and whether or not she felt he needed her to take care of him.

Community caretakers and volunteerism. Women also took care of neighbors and others in the community that did not have family or loved ones to take care of them. Also, as described under RQ3.3 in regards to women’s social connections, women volunteered in their communities, with some of the women volunteering at the community center where the interviews took place. Women who

volunteered described this as a source of empowerment and a way to help out others when they could not help themselves.

When women were asked to take pictures of “what influences your health” or “what makes you want to be healthy,” many of the women who volunteered at the community center where the interviews took place took pictures of the center buildings and facilities, fellow volunteers, or people they had helped. These women explained that coming to volunteer helped them to have a sense of purpose, and that they enjoyed being able to give back to others.

Some of the women who volunteered said they did so because they had been helped once by the center’s programs and services. For example, one older, White woman said she volunteered at the center because the center had helped her and her husband at a time in their lives when they had lost their employment; she now volunteered at the center so she could give back to others as the center had once done for her. Another middle-age divorced White mother who volunteered at the center had lost her employment due to factory worker layoffs; she was in the process of applying for other jobs—such as a job as a rest area worker and a job as a cashier at McDonalds—and volunteered at the center most days in the meantime. She had been a volunteer prior to losing her employment, but now devoted more time to volunteering to stay active and involved; the center was providing recommendation letters for her job search to help her find new employment. As this woman said, “Right now since I’m unemployed—I am looking for a job—right now I have more free time than I like, but working here, volunteering here really takes up a lot of it and helps me from going stir crazy.”

However, volunteering and serving as a community caretaker was not always empowering for women. For some women this created a sense of sadness and frustration when they were volunteering, but were unable to help the individuals they were working with in the capacity that they desired. For example, one middle-aged, Black woman shares the story of how she and her community members are taking care of a neighbor who is in the final stages of cancer:

Well we have a dude right now that's in stage IV [*cancer*]... and he lives right across the street from me... and the tumors are crawling out of his ears and he's got them all in the back of his head... and they are all over his body. And to see that boy he's black and blue, he can't eat, he can't drink. We go over and clean his house, sanitize, we just tell him to get up, and we get little things—we took up a collection of \$25 and give it to him. We put books at his door... So we been checking [*on*] him and trying to make him comfortable. And he's got family but he has nobody... He was 300 pounds but he is down to 98 pounds. He can't get no help, so he is just dying. He has been going through this for 5 years... To see a young person 23 years old with cancer and can't do nothing... that is sad.

This woman describes the situation as being very sad and something that is out of her control, yet she still helps this person and desires to improve his quality of life when she can. This sadness and frustration also does not inhibit her from volunteering in other areas of her life. For example, she says, “I have youth, and I go to Bible study and then I go around and call everybody and see if they need anything. There's a

couple of people in wheelchairs and can't help themselves, and I'll call and get a list and go to the store and drop it off.”

Constraints affecting empowerment. Women also described larger community barriers to their health and empowerment, such as a lack of financial resources for the community, lack of access to healthcare and medical treatment, and lack of insurance. Women largely believed these to be physical barriers compared to larger societal barriers. Women felt most strongly that these physical and structural barriers were the issues that affected them daily and inhibited them from seeking or receiving care. A few women also mentioned some other individual factors such as a lack of time and a lack of knowledge as affecting their health and empowerment, as described earlier in the findings; however, these findings are somewhat contradictory and not consistent for the majority of women.

Access to health care, medications, and treatment. Because of the rural nature of the community, women had limited access to medical doctors and particularly healthcare specialists. Many of the women saw a family nurse practitioner regularly operating at a clinic in the county, instead of a medical doctor. For example, one White, older woman describes her health care provider and the other doctors in the county: “Well, the nurse practitioner I see is right over here. She's right up the road. Now she's really nice, she really is, and she does see a lot of patients. And there's a doctors' office in [*nearby community*] and they have two 'doctor' doctors, and the rest is nurse practitioners over there.”

Others mentioned that they had to drive very far distances to see a specialist. For example, one White, younger woman says, “I have to drive 60 miles or 70 miles

or 80 miles to go see a doctor to do this and then... I would have to drive 90 miles to therapy for this, and I'm like, 'I can't do that.' When you don't have transportation, you don't have transportation... It's very frustrating." As this woman illustrates, traveling long distances was especially frustrating for women who did not have their own modes of transportation and had to rely on others to transport them to doctor visits.

Women also had to drive long distances to seek alternative medical opinions when they could not get satisfactory medical attention from their regular healthcare providers. For example, one White, younger woman with a persistent health problem—a suspicious lump—did not feel that her doctor had satisfactorily diagnosed the problem. She says, "Well I don't know what to do about that because I've tried everything. I've tried warm baths. I've tried soaking it. Mom even put some of her special muscle cream stuff on it. That didn't work. The only thing that helps the pain—but it knocks me out and it's bad and I don't do it because I don't want to get addicted—is the pain pills the muscle relaxers." This woman was asked if she had sought another medical opinion about the lump to which she quickly responded, "I don't want to go to Doctor [name]. I heard he wasn't very good. Not around here, I mean I'd have to go far off, and that's just time consuming and I don't really have time for that." This woman had a relationship with her doctor, but did not trust the other local doctor and felt that driving to seek another medical opinion would be too far out of her way and too time consuming.

Other women sometimes were not referred to a specialist, even when others had recommended to them that they should be. For example, one middle-aged

woman, White who had been struggling with her weight and diabetes as a result of her weight says that she has never been sent to see a nutritionist, even though she believes she should have been: “See, I’m a diabetic. I have never been sent to a nutritionist. I think that would help, you know. I think they could help you more and at least show you what to eat. Well, I know what I should eat, you know.”

Some women also expressed frustration with their doctors because their doctors were not addressing their health concerns adequately, were overbooked and had limited availability, or were not qualified as a specialist in the area they were having the health problem. For example, one younger, White woman expressed her frustration when she went into the doctor about a health concern: “Well it makes me aggravated cause they are just assuming and they don’t even know what it is and as far as they know that could be a cancer bump or something, and I could die at any point in time or something.” As another White, younger woman said about specialists’ availability, “I can’t get in to see my gynecologist because she is plumb booked with pregnant women cause [*another doctor*] stopped delivering babies and stuff everybody transferred over there.”

Some women also mentioned that doctors were hesitant to give medications to patients who needed them because of abuse of medications in the area, such as pain medication. For example, as one White, middle-aged woman says:

I know there’s a lot of misuse of medicines from criminals or patients or, you know, people in general in the community but, I think they [*doctors*] take it out on the good patients because they’re not, sometimes, given the medicines they need. I see a lot of my neighbors in pain. I’ve [*seen*] a 75-year-old

woman who got dog bit, and they won't give her nothing for pain because they're afraid that she'll get hooked. Like, she's 75 years old, you know. She might lose her leg, and you're worried about her being in pain.

Another younger, White woman mentions a similar problem with not being prescribed anxiety and depression medication: "The main biggy in my life along with an anxiety disorder I lost my doctor because he quit practicing, and I can't find a doctor that will give me my Zanax back, so it's very annoying."

Other women mentioned that doctors were overprescribing drugs to patients and that this was causing problems. A few women mentioned that the only physician-run practice in the county seat had been closed because the doctor's medical license had been revoked for overprescribing pain and other medications. A White, middle-aged woman who was having back problems tells about her visit to the doctor and her belief in the over-prescription of medication:

They overprescribe here. I have three prescriptions in there (*points to purse*)... She [*doctor*] prescribed 180 [*painkillers*]. I took one. I couldn't spit out the food, I couldn't swallow the food, and I had to sit down for 4 hours. And, I said I'm not going to take this. She wanted me to take it three times a day for a week... I went back to her... and said I'm not going to take these pills. I want a treatment. She gave me a treatment and she prescribed me Valium.

Another White, older woman also describes her thoughts about the over prescription of pain medication: "I think the doctors prescribe them too readily. When I had my eye removed, they prescribed me oxycodone, and when I had this

shoulder done, I got some more oxycodone. I think you could get addicted, and I have an addictive personality, so I'm afraid to take them. But I think the doctors are prescribing them too much."

Another educated, middle-aged, White woman not originally from the area, but who had been in the area for close to 20 years and had family from the area, said that doctors did not routinely conduct blood panel tests. She expressed frustration that it was sometimes hard to get a routine physical or a check-up with nothing was wrong:

I got on Medicaid [*and*] I wanted a blood panel because I haven't had anything checked like your thyroid, your liver, your pancreas. I wanted everything checked; I wanted the whole works while I had coverage. There's a few clinics here but [*when*] I went in there asking for a blood panel they would say, "why?" They haven't [*done a blood panel*] in years. Maybe if you have a great insurance plan. But I had to ask. And they said why are you here? What brings you here today? I want a check up. Can you check me out?
(laughs)

This woman laughed because as she said, the concept of a check-up or wanting a blood panel test as a preventive health measure did not seem to be understood by her doctors. She felt as though preventive health measures were not valued as they should be.

Lack of health insurance. Barriers to health insurance and affordable medical care caused other health problems for women. For example, as one woman—a young, White mother—stated about her hysterectomy a few years prior,

she had a tumor on her uterus because she could not have surgery due to her insurance. As she says, “I had a tumor on my uterus. They watched it for a while and went through all the steps with the insurance. The insurance wouldn’t pay just to straight out have surgery, so I had to go and be put back on birth control pills... by the time they did the surgery it was like softball size.” Because of insurance concerns and approval, this woman had to delay her needed medical treatment and ended up having a complete hysterectomy, instead of what might have been a less invasive surgery had the procedure been done earlier.

Another younger, White woman tells a similar story about health insurance and access to care and describes how her mother would not go to have her kidneys examined because of insurance concerns. As she says, “She was in stage four kidney failure before she actually found out... she could have [*had*] a kidney transplant. My brother had a kidney. That was really aggravating because six months after she first found out she had kidney problems she passed away... My parents didn’t go to the doctor until it got really, really bad.” Another middle-aged, White woman who worked at an area state park and whose husband worked at a factory described her and her husband’s challenges with health insurance. This woman described finding a lump in her breast and being concerned about the lump as her mother had died from breast cancer. When asked about whether or not she gets mammograms, she said, “No. It costs money to do that. We don’t have health insurance. We had health insurance up until 3 years ago. We lost our jobs and lost all health insurance. So from that point for the last 3 or 4 years, no we haven’t been to the doctor.”

Another middle-aged, White woman mentions that her overweight daughter had been diagnosed with severe sleep apnea and had been prescribed a breathing machine; however, she wasn't able to keep the breathing machine due to insurance constraints. As this woman describes, "And she had all that done and they put her on one of those breathing machines at night, but she couldn't afford to keep it because of their insurance. That bothers me because I wish there was some way I could pay for that for her because she really needs it." This woman, however, had limited money and was not able to afford to pay for the breathing machine for her daughter either.

Women described larger problems with insurance in the community and stated that most of the community members they knew—especially women—did not have health insurance unless this was provided through the government through Medicare or Medicaid. As one White, middle-aged woman says, "There's so many people that can't afford it [*insurance*], and there's so many people that can't afford to buy their medicine. I feel so sorry for them. I'm a lucky person because I get Medicare, and I also have insurance through the mines because my husband [*now deceased*] was in the union and it pays for all my medicine." As this woman illustrates, she feels extremely "blessed" and "lucky" because she has insurance and Medicare when others in her community do not. Other women, however, who were on Medicare or Medicaid had basic insurance, but often felt that their coverage was not adequate. For example, as one younger, White woman illustrates, she has had a painful lump in her breast for 20 years that concerns her and at her age, her Medicaid will not pay for regular mammograms or for her to have the lump removed: "It kind of frustrates me, in this area, in general, and I understand why Medicare and Medicaid do this, but

especially for women... I can't have a mammogram... It causes pain and I've had it for almost 20 years. They [*doctors*] know it's there... because of Medicare and because of these insurance issues, I can't have it taken out."

Access to community centers and resources. As illustrated above, many women believed that their communities needed recreational centers and facilities where they could go to exercise, focus on their health, or just come together as a community. A few other women, however, noted that the community facilities were not what was missing, but rather that there was some other unknown factor that affected communities. For example, one older, White woman says, "Well, we have the facilities. Like our church, we provide a big park with ball goals and a sand volleyball court and everything, but it's usually empty. So it is provided. And then each little community pretty well has their own thing... Some days in the summer we see quite a few people using it, but it is there if people would use it..." This woman went on to describe that the churches recreational facility was open and available to the entire community; however, community members largely do not utilize the facilities.

RQ3.1: How does rural women's religiosity relate to their meaning-making of empowerment? Women mentioned religion and their belief in God very early on in the interviews without yet being asked about religion or being prompted. Religion played a large role in the worldview of most of these rural women. Women's religious views and beliefs were largely empowering for them, and most women expressed that their religious beliefs and connection to religion positively affected their health. Religion positively affected women's empowerment; most

women who had faith in God/religiosity felt more empowered because God was behind them in support of them.

Religious involvement. Most women described themselves as “religious;” although, women’s religious involvement varied greatly. Some women were very involved with one church where they took leadership roles, taught Sunday School, sang in the choir, led youth groups, and more. For example, as one White, older woman says, “I go to church, a real good Church of God. We have a Manna house once a month and we had it this past Tuesday and I work up there from nine to eleven and fill boxes and things and I enjoy doing that and I go to church Wednesday nights... Then I go to church on Sunday morning and Sunday night and I sing specials. I sing by myself and I also sing in the choir so I’m involved a lot with church you know.” Another White, middle-aged woman describes her involvement similarly, “Right now I’m really involved in our church, the youth group in our church... I love to help out the ministry center.” Other women participated in religious groups outside of the actual church as a result of their religious involvement, such as regional church groups or religious associations.

Some women attended church passively, either attending one church occasionally or attending different churches at different times. For example, one White, older woman says, “I don’t have one specific church I go to different churches. I go to a lot. I’ve studied with different churches but I read my Bible and I believe in Heaven and Hell you know.” Another White, middle-aged woman says she goes, “when I can,” but doesn’t go sometimes because of “Being tired. Just if I have off [*work*] on a Sunday, I’m too lazy.” Another White, middle-aged woman that

used to go to church regularly also says she goes when she can; with a young child and her husband working third shift, she says it is hard to still attend regularly:

We do go to church, but with my husband working third shift it's hard. My little boy, I'm ashamed to say, he doesn't mind in church... It's bad to say, but I haven't been to church in a while. [*My husband*] works Sunday nights and Wednesday nights and that's when church is here. I do go to church. I am in a church, but I don't go as often as I'd like to because I can't.

Other women used to participate in church, but for one reason or another had stopped attending church over time. These women usually had not stopped attending due to a change in their religious beliefs, but rather some other change in their lives around them. For example, one White, middle-aged woman says she used to attend church regularly before she started suffering from depression and anxiety. Another middle-aged, White woman mentions that she stopped attending church after a new minister came to the church; she says, “[I] used to and then the preacher that had been our preacher forever left and then I didn't care for the other preacher that came in. So, kind of no, [I] haven't.”

A few women mentioned not attending church and did not describe themselves as very religious; however, they still espoused religious beliefs. For example, as one middle-aged, White woman says, “No, I go [*to church*] very seldom. I got burned on churches so I just go for what I think.” This same woman, however, says about her religious beliefs, “I think Jesus Christ no matter what you got and no matter what you need, now He... will not put no more on you than what you can bear. He will answer your prayers but not in your time in His time.” Another White,

middle-aged woman talked about her belief in God, but did not go to church and said, “I’m not big on organized religion... I guess there’s not anything wrong with it, but I’m not big on organized religion.”

Social support. Religion also served as a function of social support, which is described more below in RQ3.3. Religion often fostered social support in that individuals who were actively involved in their religion and faith also attended church services and were part of a church community. Women expressed that they could call on their church community if they were in need of assistance and they expressed that they had positive role models in their church community. For example, one older, White woman describes having regular contact with her “church family;” as she says, “I have a good family at church, a pastor, and we just call each other and talk and go out and eat or whatever, you know.” Another older, White woman describes her “church friends” as being there for her when she needed them, but different from her family and other friends. As she says, “Of course I have church friends, but they’re not people that I have associated with in general, but I feel comfortable with them coming here and visiting.”

Coping and coherence. Women’s religion helped them to cope with difficult situations, such as the loss of loved ones or persistent chronic illness, and gave them meaning in their lives. Women said that religion gave them “peace of mind.” As a young, White woman says, “If I pray about something I feel better about it whether it affects the outcome or not.”

Another middle-aged, White woman said about her religion and coping:

Now, I'm a very religious person. That's the only thing that helps me.

Because my youngest daughter had her children taken away from her because of drugs. She was on drugs so bad. She had her kids two of them taken away from her. And my middle daughter's got the oldest one, and she's the foster parent, my oldest daughter. And I thought I was going to go crazy. It's been going on now close to 4 years, the going to court and everything. And I just prayed about it, and I told God, I said, "God, I'm leaving it up to you. Just take my burden and bear it on your shoulders, because I can't bear it no more." And he did. I deal with it real good now.

As this woman explains, when her burdens were too much to bear on her own, she turned to her religion and her relationship with God and asked God to help her carry her burdens. This same woman had buried three husbands who died of heart attacks and had faced serious health problems of her own recently.

Another older, White woman talked about her belief in God was helping her to cope with her daughter's health problems:

My daughter she's not doing well she's just 49 and she's got so much wrong with her and she's gained so much weight. She weighs over 350 pounds and she is on so much medication and she don't walk hardly any... I worry about her but I know I shouldn't. I should put it in God's hands... I know that God is going to take care of us no matter what.

Other women described the "coherence hypothesis," where individuals believe that religion helps to give them meaning or a higher purpose in their lives. For example, one young, White woman says, "God saved my life three times so I'm

here for a reason. I flipped a truck five times and slid 100 foot and the top of the cab was below here and my head was through the cross over. I should have died. If I would have a seat belt on, I would have died, and I'm here for a reason."

Another single middle-aged, White woman emphasizes the coherence hypothesis as well in stressing that her religion gives her something to live for: "People say, 'What have I got to live for?' But, if you read and look around you, you have a lot to live for. I have that problem a lot 'cause I have a lot of depression." As this woman describes, her religion helped her to overcome her depression and gave her something to live for, even when other people seemed to be questioning what she had to live for in her life.

God-mediated control. Religion sometimes helped women to feel that they had more personal control over their lives and very clearly empowered them through their faith. For example, one middle-aged, Black woman said:

Well sometimes I lay in the bed and I cry, and I pray to God to get me up because I don't feel like getting up. All I want to do is lay there and feel sorry for myself, but you can't do that. You have to reach for the Bible and put it on your heart and pray real, real hard and God will give you the strength you know. He has gave me the strength. 'Cause a lot of days I didn't feel like getting up. I didn't want to see people. I wanted to stay in the dark..

This woman felt that God gave her "the strength" to get up and face life and overcome her moments of depression and darkness. Other women shared similar unprompted stories.

In other instances, women “let go” of some of their power and control and turned this control over to God to a divine power. For example, a younger, White woman describes being injured in a car accident and not being able to fully recover. This woman describes attempting to be patient and allowing God to help her recover:

I was hit with my mom by a drunk driver... It shattered my knees and broke my collar bone and all that stuff. Then it went from being a size 12 or 14 somewhere like that to... [*much larger size*]. I was longing to be skinny again to be able to not complain because my legs ache or my knees ache or my feet hurt or something like that, but like I said God has a plan for everything, so I've just got to take it in stride.

Another young, White woman described this God-mediated control through her attempts to take care of her family and loved ones and their health. As she says, “I guess you can say that I'm trying to take care of everybody to make sure everything works out the way I want it to work out, but the Man upstairs ain't going to let it... He may have different plans for all of us.” This woman acknowledges that is attempting to have control over her life, but that, ultimately, her attempts may be in vain based upon God's plans for her and her family.

Even women who were not highly religiously involved had some notions of God-mediated control. For example, one middle-aged, White woman says, “Whatever He's got in store for you happens to you for a reason to make you stronger for something else better... Let me give you an example I had a granddaughter at two, and she got cancer and she died at four and they said she'd never walk, talk ever again she was paralyzed on one side she did.” Although this woman does not attend

church regularly and is not highly religiously involved, she still believes that God is acting on her behalf in her best interests preparing her for “something else better.” In this woman’s story, if it had been fully in her control, she would have chosen that her granddaughter live; instead her granddaughter died, but she still considered it to be miraculous as her granddaughter lived longer than expected and had a better quality of life than expected.

Another older, White woman illustrates this balance of control as well—trusting in God, but also taking personal responsibility and control for her health. As she says, “Well, I think we should always be concerned about our health. God can't answer all our prayers. We might pray for him to do something for us but he ain't going to say yes to everything we pray for. But yes, we need to be concerned about her health.”

Religious beliefs. As another dimension of religion, women’s religious beliefs also came into play. Most women did not describe themselves as “absolutist” in their religion; in other words, women did not express that only their religion was right or that all others should convert to their religion. For example, as one White, middle-aged woman says, “I believe in God, and I think you know I don’t put other people down for their religion because anybody that’s trying... And I think if you are raised a certain denomination then chances are you are going to stay that.” Women also said that they tried to avoid passing judgment on others and did not perceive themselves to be better than others. For example, as one older, White woman says, “But I don't consider [*myself*] to be a perfect person because there's none of us perfect. And I can't sit here and say I never have faults, and I don't do things wrong

because I'm sure I do, and I'm sure other people think I do. But at least when you go to bed at night and ask God to forgive you any sin that you have done, then yes I'm a Christian.” Another young, White woman stressed that she did not take the Bible too literally: “I believe that there is a God out there and I believe most of the things that Mom believes except for I don't believe the Bible is one hundred percent accurate because after it has been passed down so many years, people rewrite.”

Most women's religious beliefs were strongly associated with healthy behaviors and encouraged them to care more about their health. For example, one highly religious middle-aged, White woman says, “Well, I think my body's a temple to God, and I think that. I've never smoked. I've never drank. I've never done drugs. And, I think that's what I should do. I should do it better for myself. I just think you lean on Him for help.” Another White, middle-aged woman, for example, said her religion made her “more concerned” about her health: “I don't know it seems like if I don't do my part He can't do His.” Other women made very similar remarks. For example, another young, Black woman said, “It makes you more concerned [*about your health*] when you have more of a religious or a certain religion in your life, because you know that it doesn't want to do harm to your body. God put me here and he gave you a body, and he says it's up to you to take care of.”

A few women said that their religious beliefs made them less concerned about their health. For example, one White, middle-aged woman says, “[*I'm*] probably less concerned because God's going to take care of it, and if it's my time, it's my time. That's just my belief. If it's your time to go, you're going. It don't matter what you're doing or where you're at.”

Interestingly, women's religious beliefs gave them a considerable amount of trust in their doctors. Women believed that God gave the doctors their knowledge, and their trust in God created their trust in the doctors. As one White, middle-aged woman said about her doctors, "I have enough commonsense to know that if there is something bad wrong with me that I can depend on God, but also He gives us the knowledge and the sense to go to a doctor because he gave them [*doctors*] the wisdom on how to help us." Another White, middle-aged woman stated, "I feel like God has gave them [*doctors*] the knowledge and the understanding to help us, or they wouldn't be nothing like a doctor if he didn't. He put that up there in their little brains." As another White, older woman said, "I think that an honest doctor is someone that wants to help people... I think He [*God*] guides them, and like I said they are special people. They are not selfish. They try to help people, and is someone that is dedicated to their work, and you know what I'm talking about. And I think that there are blessed people." This woman not only had trust in her doctors because of her faith, but also held a high opinion of her doctors as selfless, honest people.

Other women expressed that God would heal them through their doctors. Another White, middle-aged woman gave an example of how not trusting in doctors and their divine power to heal, was a mistake:

I had a cousin... and she was a Jehovah's Witness and she was in the hospital and needed a blood transfusion. She wouldn't let them give it to her and she died, so, I mean, I don't believe in that sort of thing . . . I believe sometimes

God can give doctors the ability to help you . . . the doctor can't heal you.

God can heal you through that doctor.

Some women who had very high religious involvement believed in the power of miraculous healing; however, for most of these women, their notions of divine intervention in their health did not preclude them from also seeking worldly medical help. For example, one White, middle-aged woman tells the story of divine intervention in her health:

I'm a very strong believer in God, and I'm a real strong believer that he heals people because he healed me of a disease I had. Underneath my right arm a big knot came out... and I had people in our church to pray for me and other denominations to pray for me, and when I went back to the doctor... he checked me, and he says, "Well, I know it was there..." They were going to send me to [*the*] hospital it was so bad. They couldn't do the surgery over here. He said "I know it was there and you know it was there, but it's gone now." And he said, "I just don't know what happened." My husband was alive then, and he spoke up and says, "Well I know what it was. God healed her."

As evidenced in this woman's story, even though she believed in the power of prayer, had many individuals praying for her, and believed her lump was miraculously healed, she still returned to the doctor for a follow-up check up and trusted in the doctor to diagnose whether or not the lump was gone.

Another White, older woman describes a similar miraculous healing of a tumor: "They diagnosed it that I had a tumor and they sent me [*away*] for radiation

treatment for a week before I had the surgery, but when they operated they didn't find no tumor, they didn't find no cancer. They drew fluids from all parts of my body of course to check and said everything was gone. Of course I attribute that to a Higher power." Similarly this woman, although she believed in the ability of a divine power to heal her, went through the medical system first to be diagnosed and examined.

As mentioned earlier under RQ3, financial constraints affected women's empowerment; however, for some women their faith helped them to overcome financial constraints. For example, an older woman describes a miraculous encounter that affected her resources through God providing for her financially. This single White, middle-aged woman said she often lived paycheck to paycheck and relied on God to help her make it through the tough times. As she says, "I have so much faith in God. Like if I need to pay a bill to somebody, and I don't have the money to pay the bill and it has to be paid, I always start praying and telling him, 'God, you've done it for me before, do it for me now. I have faith in you.' And He takes care of everything." This woman went on to tell how she had experienced many specific events such as these in her life, and how she trusted in God to provide for her.

Factors affecting religion. Factors such as class, distance, and accessibility, also played a role in women's religious involvement and how often they attended church. For some women, religion seemed to have a class divide. Some religious organizations expected a certain type of attire or fancier clothing. Some women mentioned, however, that their religious organizations accepted individuals of all types, no matter what they wore or how they looked. One White, older woman illustrated this gap in perception of appropriate attire for church through an old joke:

[*My church*], it's non-denominational. Everyone's welcome so it's kind of like a joke that I read one time about this real fancy uppity snooty people church, you know, in the city, and everybody dressed real fine and everything. And one Sunday this bum comes in the church and sits down, and he doesn't smell too good, and his clothes and his shoes are dirty, and everything and everybody's just kind of, you know... And they ask the preacher to say something to him... So the preacher told him he was welcome to come back here and worship with us but you really need to... "Talk to God and see what God tells you about what you should do before you come back next Sunday." Next Sunday, he showed up smelly with his dirty clothes on. The preacher took him aside and said, "Didn't we have a little discussion while you were leaving the church last Sunday that, you know, you're welcome to come here to church but you need to clean yourself up a little bit?" He said, "Yessir, I sure did." He said, "What did God say?" He said, "God told me he don't know how people dress here 'cause He's never been to this church!"

The woman laughed as she told this story. She explained that God would not be part of a church that judged people based upon their clothing or discriminated against them.

Also, as evidenced above under religious involvement, women that worked shift jobs or blue collar jobs or whose husbands worked these kinds of jobs, often did not have the weekends available to them to attend church. Women with small children and without childcare available in the church were also hesitant to bring their children to church, as they thought the children would be disruptive.

Distance and accessibility also played a role in attendance at churches.

Although there were not a large number of residents in the county, there were many churches for the women to attend. For example, as one White, middle-aged woman says, “There’s more churches [*here*] than there is any place to buy anything.” Other women mentioned having to travel to be able to participate in particular churches or religious organizations. For example, as one young, White woman states, “I actually go to church in [*the neighboring county*] because I’m Catholic, and there’s not a Catholic Church in [*this county*].” Other younger women sometimes left the area to attend church where there were more youth involved. For example, one older, White woman says, “They have a young preacher over there and they are involved so much with the youth and we have a lot of people from [*here*] that’s left and gone to their church over there, and I think that’s wonderful because you have to go where the children get the most out of learning.”

RQ3.2: How does rural women’s involvement with their health relate to their meaning-making of empowerment? Women’s involvement with their health varied by the number of personal and family health problems they had experienced, their age, and their roles as caretakers for others. Generally, younger women or women with fewer health problems were not as involved with their health. These women said that they rarely searched for health information, stopped to think about their health, or identified with information they saw about health.

For example, a young, White mother says that her health is “extremely important” to her, but that she didn’t think about her health very often. Another young, White woman with very few health problems but who was trying to lose

weight, said she thought about her health, “Maybe a couple of times a week.” She says that information about health does not usually get her attention, although she’s “more aware now of some of the health issues than I was in my teens. I don’t think I’m as aware as I probably should be with preventative things.” Even young women with serious health problems in their lives often did not feel involved or connected to the idea of health. For example, one young, White mother with Hepatitis and a compromised immune system, said, “I really don’t look at health information.” Another young, White woman, said her health is “not very important to me, because I have more important things, top priorities... Like I have a daughter now. I mean before I was able to worry about my health but I can’t now because she has health problems so she has health problems and she comes first and my job comes next because I have to work so I can take care of her.”

Middle-aged women who lived healthy lifestyles and had few health problems also mentioned that they did not think about their health as often or actively search for information. These women did not look for information for the same reasons that younger women did not: they had experienced no major health problems and had no concerns. For example, as one middle-aged, White woman says, “Well, I guess, we don’t think about it a lot and we don’t do a lot of research [*about our health*], but we’re always reading where we can and always trying to find out new things when we can. Just in our eating and everything, that’s our approach.” This woman described a more passive approach, in which her family was interested in trying new things for their health if they passively came across them while reading. This

woman's family ate healthy and grew most of their own foods, although not specifically for health reasons.

Other women mentioned that they thought about their health a lot because of the factors around them and that health was a constant part of their lives. For example, one middle-aged, White woman joked, "I think about it every day especially when I go to town and can't fit into those skinny jeans." Other middle-aged and older women with health problems said they thought about their health "daily" and "every day." As one White, middle aged, self-described "disabled" woman suffering from anxiety, depression, states, "I think about it all the time. I even dream about health."

Women's own life experiences with health problems and their loved one's health—especially for middle-aged and older women—affected their involvement with health. A White, middle-aged woman explains how she became more involved with her health, "Being with my mom and seeing what she went through and everything. It really makes you think more. I'd say you think about it more. You think about problems that could arise. You get aches and pains that you didn't have before and you think, 'Okay is this something serious?'" As another White, middle-aged woman who had experienced some recent family health problems said, she thought about health, "about everyday. Especially with my kids and stuff. And I know I'm not getting any younger and especially with what happened to my husband. I'm like, 'Geez,' you know. It kind of scares you and makes you realize you know, you're not promised tomorrow."

Another White, older woman says her health is "very important. Right now it's worrying me a lot. It seems like the older I get the more I worry about it, which I

guess I should have worried about it years back more and maybe I wouldn't be in such shape that I'm in now. I watch things on TV about it, about health, and things that you can do, but I'm like a procrastinator and I don't follow-up very good." Other women reiterated this point and stressed that they cared about their health a great deal and felt involved, but that they did not take action on their thoughts and concerns to make healthy behavior changes. For example, a White, middle-aged woman says, "I think I care about it a whole lot but if I did, you know, I would do some things like that at least."

As mentioned, women often felt involved with health because of the health problems they or their loved ones were experiencing. Women reported many of the same health problems in their communities and many women had experienced the same types of health problems in their own lives, including chronic health problems, such as cancer, endometriosis, diabetes, high blood pressure, heart disease, kidney disease, arthritis, and chronic pain, and precursors or risk factors for other health problems, such as dental health problems, drinking, smoking, and drug use.

Obesity and healthy eating. Obesity is a growing problem in many rural Appalachian communities. Many women mentioned obesity as a problem in their community and were visibly obese and described themselves as "overweight," "obese," "carrying a few extra pounds," etc. Excess weight and women's eating habits and lifestyles were also big influencers of many other health problems, such as heart disease, diabetes, blood pressure, and even mental health.

The many women who were overweight shared very personal stories about how their weight made them feel and how their weight prevented them oftentimes

from doing other things that they had wanted to do with their lives. For these women, their weight was something which they were constantly aware of and that impacted their lives greatly. For example, one White, younger woman shared her struggle with her weight and how this prevented her from attending school because of fear she would not be able to fit into the school desks. She expanded by talking about how self-conscious this made her and how she could not fit into rides at amusement parks:

Well, I feel self-conscious about myself and, yes, I know I'm heavy set and stuff like that, but... like I feel out of place... One time my husband and I went on a vacation before we had kids, and I felt so bad because I could not fit on a ride... And I cried and stuff, because I don't like going to amusement parks because I'm afraid that someone might say something or point at you or stuff like that."

Many of the overweight women that described themselves as obese had been struggling to lose weight, trying many different options, such as diet pills, gastric bypass surgery, Lap-band surgery, and a few had tried programs such as Weight Watchers that were outside of the immediate community. For example, as one young woman, White tells her struggle with weight and her attempt to take diet pills:

They told me if I shed some weight that I wouldn't have high blood pressure any more. It's so hard you know. They say, well when you get older it's going to be even harder and stuff. I've tried diet pills and they worked, but then they would make my blood pressure go so high to where I would have to stop taking them. It would elevate my blood pressure to where my head felt like it was going to pop off.

As shown in this woman's story, she was caught in a vicious circle. Doctors told her to lose weight to lower her blood pressure, but her blood pressure was preventing her from taking the diet pills that she was trying to use to lose weight.

Another young, White woman describes her struggle with trying to lose weight and why losing weight is so important to her after seeing her mother-in-law pass away from factor related to her weight:

My mom, she's helping me out with [*Weight Watchers*]. It's hard to lose the weight. I'm 26 years old. They said that the younger you are the easier it is to lose weight, but I've found out that I can't lose it. I've tried everything. I even tried starving myself for a week, but it didn't work. I didn't lose nothing. My mother-in-law was 372 lbs. when she passed away. She was a big woman. I saw what it did to her.... I don't want to be like that. I'm getting close enough to where I know I need to back off and lose the weight.

Women also felt that society's expectations towards eating were not realistic for them or their lives. As one older, White woman said about society's promotion of healthy eating, "You can't eat your good ole' things that you want to eat. They'll say you can, but you have your recipes and everything. I just don't think it's worth it. I'm happy the way I am. If people don't like my fat, I don't care."

Women also mentioned seeing obesity in their communities at an earlier age and were concerned about the health of their children. For example, one White, middle-aged woman who worked with children at a local Head Start programs describes the changes she has seen in her community and her work:

Especially in the schools, even the children we have here at Head Start.

Three, four, and five, [*their*] weight is quite large. But they'll tell you all they do is watch TV or video games. At the first of the [*school*] year when we come in, and it's just beautiful outside, and we'll go outside [*for recess*].

They will actually cry to go inside. The first couple of weeks they say, "Can we go inside and watch TV now? We're hot, hot, we're tortured." [*After*] five minutes they're ready to come back inside and watch TV and cool off.

Substance use and abuse. Women mentioned smoking, drinking, and drug use in their lives. More women described smoking as affecting their personal health than drinking or drug use; however, women were often affected by drinking and drug abuse through family members and loved ones that had problems with substance abuse. Substance use and abuse also affected many women's health in negative ways and was a risk factor for other diseases.

Smoking was common among young and old women and their family members. Women also noted health complications from smoking. For example, an middle-aged, Black woman who smokes says, "I have bronchitis. I'm constantly plagued... When I have one, it takes me months to get rid of it, but that's because of smoking. I have cut down a lot, you know, I mean five cigarettes a day is better than a pack a day, so I'm doing really good. I think I'm doing good."

Another middle-aged, White woman describes her family smoking in her home, even though she does not: "I'm not a smoker, but my daughter smokes and my grandson, and I try to have them stay away from me when they smoke, but it's impossible. My rule was when I bought the house this past December, you go outside

and smoke. I don't want nobody smoking in my house because the grandchildren are coming." Even though this woman did not smoke and did not want her family to smoke in her house, she ultimately found that she had limited power to prevent them from smoking in the house and eventually succumbed.

Some women turned to substance use as a mechanism for coping in other areas of their lives and felt that these substances gave them a source of empowerment and strength. For example, one middle-aged, White woman, who described smoking a pack of cigarettes a day for over 20 years, said that she smoked as a way to calm her nerves and cope with her father's death. As she says, she turned to smoking instead for taking anxiety medication, which the doctors prescribed to her:

With the stress, I've got to have something. And that's why I picked up smoking. My father passed away and they give me nerve pills. Well, I hated that. Just that down effect, and, for some reason, I picked up cigarettes, and that helped. So I put the nerve pills down and said, "Here you can have these." I'll just smoke. And they're like, "Well, that's worse for you." Yeah, but at least I can function.

Other women who had quit found that they started back smoking to cope with some other area of life. For example, a young, White woman said she quit smoking temporarily while pregnant, but "had to" start smoking again after she had her baby to cope with the stress: "Well when I was pregnant I quit smoking, but after I had [*my daughter*] with the stress of the new baby and everything I had to have a cigarette to de-stress a little cause I was getting a little aggravated with her, and she could feel the tension." Another middle-aged, Black woman tells a similar story about how she quit

smoking, but then started back smoking after her husband died, “I’ve only been smoking for the last six years, ‘cause I stopped smoking, and then when my husband died, I started smoking again.”

Other women had smoked earlier in their lives but were able to quit. Some of these women quit smoking because of other health problems they saw emerging in their lives. For example, one White, middle-aged woman said, “I don’t believe in smoking ‘cause smoking will kill you. It will kill you. I know from experience. I smoked years ago and almost died. I quit smoking and now I feel good... I didn’t know I had bronchitis and that time, and I, oh, I stayed in and out of the hospital with pneumonia and stuff. Smoking will kill you.”

Others quit smoking because their partners or loved ones had quit and encouraged them to quit as well. For example, another White, middle-aged woman who had smoked regularly for many years and had quit said, “I don’t smoke at all. I quit. I thought, if he did that [*husband quit*], then I can do that. For like a month, though, I continued to smoke. He was even coming and standing in the same room, and he was like, ‘You really need to put those down. Do you realize?’”

Alcohol use and abuse seemed to be more common among the men in the community. Women described that their spouses, fathers, sons, and brothers struggled with alcohol addictions. Some women mentioned that they drank alcohol as well, although they rarely called themselves “alcoholic.” For example, one young, White woman describes her father’s use of alcohol: “My dad is an alcoholic so he has jaundice and stuff. He went to the doctor and his kidneys and liver has... they’re still functioning... but they’re gone, to being an alcoholic all of his life. He’s only

53.” Another woman says, “I’ve got a son that is an alcoholic, and he just got out of prison for alcohol.” Another White, older woman talks about her son’s struggle with alcohol and her son’s father’s struggle: “I pray for my son everyday that he will quit drinking, and he quits [*for a while*] but without God’s help I don’t think he can make it, because he’s been hurt because his father died—he was an alcoholic.” In this woman’s story, her son was drinking to cope with the loss of his father; ironically, his father died from the very thing that the son was using to cope.

Drug use and abuse was more common amongst the younger generations than the older generations. For example, one middle-aged, White woman describes the drug and alcohol use of young people in the community: “Right now it’s with the young people. I think the drugs is really bad. I think alcohol, but mainly drugs, and I think it’s prescription drugs. I think they get started on them at home or maybe with a football injury or something. I have some close friends who has their children are hooked on them.”

Another middle-aged, White woman describes drug problems in her community and within her own family: “I might as well say it, [*we have*] drugs in the county. And since this is confidential... I’ve got two sons that’s... I mean it’s nothing... Well, yes it is. It’s prescription painkillers. And, do you know what suboxone is? That’s a big problem with this. I mean they started on something that’s supposed to help you get off other stuff.” This woman describes that her sons were addicted to prescription painkillers, began suboxone treatments for their addiction, and then became addicted to suboxone.

Drug and alcohol use also served as coping mechanisms for individuals in the community, but then often turned into addictions. One middle-aged, White woman describes her daughter's struggle with drug use that resulted in her children being taken away from her: "Her dad died when she was 13 and she just went into... depressed... and she got on drugs real bad and had been on 'em for years and years... the bad drugs. Shooting up. Whatever the bad stuff is. I don't know what all that is. She took pills, too, but the other stuff." Another young, White mother describes herself as "a previous drug abuser," and says she has to "deal with that daily," implying that her decision to stop using drugs was a daily struggle for her.

Mental health, anxiety, and depression. Mental health was not always verbalized as a health problem by women, but mental health came out often in women's other answers. Women mentioned being depressed, taking anti-depressants, taking "nerve pills", or not having the motivation or the willpower to get up and out of the house some days. Other women mentioned being diagnosed with bipolar disorder. Many women were taking medication for depression or had other family members that were struggling with depression, although women did not always equate "depression" with health or view this as a health problem. For example, one older, White woman described her daughter's recent experience with depression, "My daughter that lives right up the road here had a son that got killed it will be two years in May right in front of her house. And I'm afraid that she is getting into a real deep depression..." As this woman described, her daughter was staying inside the home and disconnecting herself from loved ones and the community. As a result her health was severely failing.

Another White, middle-aged woman described depression in her life and attributed this to being a single mother: “I know there’s depression in my life because I’m a single mom. I drink alcohol. Sometimes I’ll smoke with that, but nothing in the public.” This woman described drinking and smoking as her way to cope with depression and with being a single mother.

Some women that struggled with depression or other mental health problems were formally enrolled in a multi-county, state-sponsored community services programs for individuals with mental health and substance abuse problems. This program allowed participants to live in their own homes, while participating in community activities to help them manage and live with their conditions and to improve their overall quality of life. As one middle-aged, White woman says, “I got depressed really depressed. After the [back] surgery, I couldn’t move and just kept getting worse so she put me with [community service board]... Probably about two or three years now... They have helped me a pretty good bit they keep an eye on me and make sure all my medicines are up to par and I talk to them.”

Another middle-aged, White woman also talked about this mental health community services program in great detail, stating that individuals with mental health problems are very visible in the community and discussing the services provided. She asks:

Have you been down there to the clubhouse [*for the mental health community program*]? ...[*The director’s*] great. And he cooks and he takes them bowling, and he takes them to the beach, and he’s like the activities director. And he’ll walk the park in town, and he’ll get them out. Yeah, and there’s a

lot of those [*mental*] conditions here, and I think because there's programs for the people here. They are either from here or they come here. I'm not sure, but I know where I grew up this wasn't visible.

Some women described how their depression first affected them, sometimes through the loss of a loved one or other factors in their environment. For example, one woman middle-aged, White woman describes the sudden loss of both of her sisters and how this affected her health: "I've been to several doctors and I told them I've been so weak, no energy, having difficulty breathing and then they did a couple of tests. More or less they came to the conclusion that it was all in my mind because I had just loss my two sisters."

Other women described that their anxiety affected their lives in terms of going to the doctor or seeking medical care. For example, one White, middle-aged woman says, "I guess one of the things, I'm always afraid they'll find something that I don't want to know anything about. And I hate sitting and waiting. I'm very impatient. I hate sitting and just waiting. I hate waiting and waiting. I have gotten up and walked out more than once."

"Female cancer" and endometriosis. Many women specifically mentioned "female cancer" and endometriosis as a problem that affected them and their communities. For example, one middle-aged, White woman when asked about the health problems that affected her community stated, "Female cancer. I think a lot of females in this surrounding area is prone to endometriosis...My oldest sister just had surgery yesterday for cancer. She's in the hospital right now... She's in her early 40's. I think a lot of females in this area have it."

Another White, middle-aged woman told her story of endometriosis and the hysterectomy she had as a result, “A few years ago I was having female problems, and I was passing clots, like big, big clots and stuff. My monthly was anywhere from five to nine days. I was just so tired all of the time. Finally I went to the doctor, and, thank God he was a good doctor, and I ended up having to have a hysterectomy. I was worried about that, but that was the best thing I ever did... I told him I wanted to keep my ovaries, but he said he had to take one of them out because it looked like little blood pockets in it. He said I had endometriosis.”

Many women were open about their very personal health stories, such as hysterectomies or “female cancer.” However, some women noted that this was a very private thing that people did not talk about openly in the community. As one young, White woman illustrated:

I hear a lot of prostate [*cancer*] and different things. And the women, I hear about cancer, but they only say, “It’s cancer,” they’ll never really go into details what type of cancer this person had. I think everybody in there [*her work place*] has had one of them [*hysterectomy*], but myself. I only know about endo[*metriosis*] and the hysterectomies and stuff because all the women out there has had them and you know had some kind of problem with that, but other than that out in the community it’s [*private*].

As this woman expressed female cancer and endometriosis may be taking place even more in the community than women are sharing with each other or sharing with me as the researcher. This woman indicated men’s cancer types, such as prostate, are more openly discussed in the community; whereas, women’s types of cancer are kept more

secretive in the open community. It is also important to note that this woman's workplace consisted of all women who were quite close, perhaps fostering the environment of sharing about their health issues more openly.

Breast cancer. Women also experienced problems with breast cancer, although this particular type of cancer was not mentioned as often as "female" cancer, a term which women generally used to talk about ovarian, uterine, endometrial, or cervical cancer. One older, White woman details her struggle with breast cancer and how frightening the experience was for her:

I went to the doctor for my normal check-up and he found a lump on my right side... they determined that it was malignant and the whole breast needed to come off. I thought 'I'm dying, I'm dying,' you know, when you hear the word 'cancer.' You know that enters my mind a lot. When something comes up wrong with me, I think it is the cancer come back... It is just in the back of your mind and when something happens, you think "I've got cancer again."

This woman emphasized that just hearing the word "cancer" made her scared because of all that she had heard about cancer and about death. She stressed that now with each new health problem, lump, or other concern, she is scared that perhaps the cancer has come back. Although this woman's cancer experience was 24 years ago, she has lived those 24 years in worry that the cancer might come back at any time. This woman had continuous involvement with cancer as a result and any time she heard information about cancer it made her pay attention.

Another described a friend of the family that was struggling with breast cancer and how this particular illness was particularly painful because of the "emotional"

and “mental” symptoms associated with a loss of “womanhood.” As this White, younger woman describes: “She’s a friend of the family, and we kind of help out. Provide her with meals and try to keep an eye on her and try to keep her spirits up. Those are the main things she really needs. I mean the physical symptoms aren’t as bad as the emotional or mental symptoms of breast cancer. It’s part of your womanhood to have your breasts cut off.”

Heart problems and high blood pressure. Many women discussed how heart disease and high blood pressure had affected them, their loved ones, and their community. For example, one middle-aged, White woman lost two of her sisters—one 34 and one 44—within the same one month period to heart failure. As she says, “In 2005, exactly this week the 27 of January, my 34-year-old sister stood up from the table and had a massive heart attack and died. Thirty days later my oldest sister who was 44 was in bed and had a massive heart attack and died.” The woman later went on to say that she had also had heart problems, suffered a minor heart attack, and “had to have a pacemaker put in.”

Another White, middle-aged woman described how, just a few days before our interview, her husband had passed out in the shower and his blood pressure was extremely high. As she says about the incident, “We still think he needs to go see a heart specialist because he’s had problems with his blood pressure spiking and stuff before... He’s had problems with this before and they put him on blood pressure medicine before, but he’s stubborn and he’s a man. He does not like to take medicine, but I think this, really I’m hoping, I hate to say it, but I’m hoping it scared

him enough...” She went on to suggest that she hoped this incident would be a wakeup call for her husband to encourage him to take blood pressure medicine.

Diabetes. Diabetes was also a very common condition that affected individuals in this community. Men and women alike had problems with “sugar,” as people called it. Most women who said they struggled with diabetes were visibly overweight. Women mentioned struggles with trying to control diabetes, because it was a condition that, when severe, required careful management of diet, shots, and pills. One older, White woman describes her husband’s diabetes, “He’s got sugar, and he don’t really watch his sugar like he should. He is on two, three shots a day, plus the pills. Which, I wish he would go to a specialist and not just a regular doctor for his sugar.” Another middle-aged, White woman describes her continuing struggle with her diabetes:

I’m supposed to be Type II diabetes. I was on two different medications pill form. Then all of a sudden the doctor says your body’s not producing enough insulin... My sugar is crazy... I can’t understand with the insulin and it’s going haywire like this.

Other women mentioned that their diabetes condition was draining for them and made them feel physically exhausted. For example, as one White, older woman says, “I don’t have the energy. I’m just tired all the time and my blood sugar is up. I just feel bad. I don’t know why I feel so tired all the time. It’s just the way I am.” This woman had accepted feeling bad as a condition of her diabetes.

Other young women that knew diabetes ran in their families were scared of the possibility that they may eventually have this illness as well. For example, one

White, younger woman says, “They did a sugar test on me, and they said it was inconclusive. I have to go back and do another one, but I’m really scared because I don’t know if I can poke myself with the needle if I have to give myself insulin. But like, my dad, and I was talking and stuff and it’s better to get it done to make sure just so you know something won’t happen to me for my kids.”

Kidney disease and kidney failure. Women mentioned kidney failure and kidney disease as affecting them and their families. Most women had not suffered from this themselves, but their husbands, children, and even grandchildren had problems to this effect. For some women these problems were hereditary and many of the people in their families struggled with this illness as well.

One older, White woman describes her husband’s struggle with kidney disease and their difficult decision for him not to have dialysis so he could have a better quality of life:

He has chose not to take dialysis because of his friends and family that did, and he felt like he could have a better life... And he gets out daily and piddles on the farm. He felt like if he had dialysis, he wouldn’t have that quality of life. At first I tried to convince him, and I said, “Please take it.” But five years later—they had said this could extend your life five to seven years—well we’re there. And we don’t talk about it. We don’t daily mention it. It’s like we have 50 years ahead of us. We’re not a crybaby family. We know God’s going to take care of it. So that’s just my life with him.

As this woman mentioned, she struggled with her husband’s decision not to have dialysis; however, she ultimately wanted her husband to have the best quality of life

possible and to be able to decide this for himself. This woman also describes that they did not dwell on the illness or the sad aspects, but instead looked towards the future and placed trust in their faith. Later this woman got very sad in the interview and described this as a daily struggle.

Another older, White woman describes her husband's kidney failure and his decision to go on dialysis. She also describes this decision as a struggle and says that they later wondered if they had made the right decision to go through dialysis. As she says about her husband, when he passed away:

He'd been on dialysis for a long time. If I had known what he was going to have to go through with, I think I would've tried to talk it him out of it, because it was so bad... twice a week. Once you start dialysis, you have to continue it. You cannot get off of it... unless you die.

Another older, White woman describes how kidney problems run in her family and have affected her daughter and grandson, as well as other children and family members:

We have found out that our daughter has it, and our grandson, he was born with one kidney, so I grieve more for him because of age, and he has the high protein in his urine, so that is the symptom of polycystic kidneys, but they haven't diagnosed him, but they did send him to a children's hospital in North Carolina, and they put him on blood pressure medication... They're just being careful.

As this woman describes, seeing her small grandchild struggle with this disease was perhaps one of the hardest things for her, knowing that he was so young and had so much life left.

Arthritis. Arthritis was a problem that affected individuals both young and old, although this affected older adults more. Younger individuals struggled more with rheumatoid arthritis. A White, middle-aged mother talks about her struggle with rheumatoid arthritis and how this affects her life:

Well, I've been battling rheumatoid arthritis...I had had my little boy and just one morning I woke up and my hands wouldn't work. I couldn't pick him up and I got to where I couldn't dress myself, and my husband at the time had to dress me and pretty much had to stay there because I breast fed our son, and I literally couldn't pick him up... I have an aunt that has been in a wheelchair since she was 21 from the rheumatoid arthritis... I just keep a positive attitude. I lost my insurance, so I take nothing for it.

Another White, middle-aged woman talked about her 23-year-old son's struggle with rheumatoid arthritis, which was especially hard for her to cope with because of his young age. He would not go to the doctor, despite her urgings and ultimately had to be hospitalized for his condition:

He was in the hospital for three days so he seems to be much better now. It took a little bit but, you know, mothers always seem to know when there is something wrong. I was like, "I know there's something." But he wouldn't go to the doctor for nothing, but finally he went. Then when he got the

medicine that was a whole different story.... I said, “I told you, you should have went.”

Women also mentioned having to watch their diets because of their arthritis. For example, a White, younger woman had rheumatoid arthritis and was told that she should not eat certain foods: “I have rheumatoid arthritis and you’re not supposed to eat greens. I do anyway because I just love greens; they’re healthy for you.” Even though this woman was told not to eat certain foods—“greens” in this case—she made a decision that the health benefits of the greens outweighed the negative affects on her arthritis.

Hepatitis. Hepatitis was mentioned by several women and something that women seemed especially embarrassed to talk about as they felt this was a stigmatized disease. As one young, White mother who had Hepatitis stated, “You hear a lot of Hep C. I went to the doctor and six out of ten patients had Hep C, so that is on the up rise right now but that’s the only one I know about right now.” This same young mother had Hepatitis B and said, “It is very private... Well you know I am not ashamed of it I did it to myself and I really don’t care who knows because if they look at me different because I have it I didn’t need them as a friend anyway.”

Another middle-aged, Black woman also discussed how she found out about her Hepatitis. She discovered that she had Hepatitis C when having blood work done for life insurance purposes. She was refused life insurance and visited her doctor to find out why:

That was really devastating ‘cause I never knew. The only reason I found out is, my daughter said, “Mom you need more life insurance,” so that’s what we

did. We applied for it and then they sent a nurse to the house to do the blood work and a few weeks later they called me back and they refused me life insurance. And I called them back and said, “Why? What’s wrong?” and she said, “We recommend that you see your doctor,” you know, but they wouldn’t tell me. It was more shocking when he said to me that I had hepatitis C, and . . . but he explained to me that it could have been there for 20 years. . . so I went on a treatment because of the liver damage that it had caused.

An aging community. Rural communities often have higher rates of older adults that suburban or urban communities do as younger generations move out of the communities in order to find sources of employment or educational opportunities.

Women in the community mentioned that their community was aging around them.

As one older, White woman stated:

I would say the people in my community are all getting old. And naturally, when you're old you're going to have health problems, but the better you take care of yourself and if you have the faith that it takes, I believe a lot in that. I know for example my church, they'll say our church isn't growing. My goodness, they're all old senior citizens. And I told the lay speaker one day, “Well, old people can't have babies to come to church. We don't have any young people to have babies to bring to church to make it grow. *(laughs)*

RQ3.3: How does rural women’s social support relate to their meaning-making of empowerment? Social connections were both positively and negatively related to women’s empowerment and health, and this largely depended on whether women’s social connections were of positive influence or not. Women’s positive

social supports encouraged them to take care of their own health by providing them someone to exercise and plan healthy meals with, encouraging them to visit the doctor, and providing them with someone to talk to and relieve stress. Although positive social connections did not cause any harm to individuals that was evident in this research, positive social connections did not always affect individuals' health positively or encourage them to take healthy actions.

Women had many types of social connections, including interpersonal and organizational connections with family, friends, neighbors, church members, and fellow employees at their workplaces. Not many women were involved in community organizations, other than the volunteers at the center, largely because there were not many community organizations in place. A few women mentioned being involved in organizations such as parent-teacher associations.

One middle-aged, White woman's story of her husband's recent "blackout" illustrates the complex nature of relationships and social support in a small rural community. As she says:

[*My coworker's*] mother and her husband live right across the road from us, so she called him to ask him if he would come across the road to make sure the kids and everything was okay. The whole community is like, you know, everybody know people here and there, so he was there and my mom and dad was there. Of course the rescue squad and everybody was there. When I got there my sister-in-law had stopped at the store, which is like a mile from us. The man at the store wanted to know what was going on and she didn't know

because she had just come from [*neighboring county*], so she came by to find out what was going on.

As this woman illustrates, the community came out for her husband's health emergency, involving neighbors, co-workers, local business men, and family. Community members volunteered to take care of her children and volunteered to help in other ways.

Desire for privacy and minimal social contact. Some women mentioned that they largely stayed to themselves and did not have many social connections outside of the home. Women who were homemakers and who did not work but whose husbands did, sometimes felt less connected to the community than their spouses and as though their relationship to the community may be mediated through their spouse. For example, one young, White woman says:

Well, we more or less stay to ourselves. We might throw up our arms to wave high or something like that or if we see someone that we know. My husband knows a lot more people around here than I do and you might say hi to them or something like that, but to go over to someone's house and do stuff like that we don't do that. We're homebodies. That's what I tell my husband. No one ever calls us you know and stuff like that... So, other than the question you asked about having the relationship with neighbors or something like that, we don't.

Another very young, White mother visiting the food distribution center illustrates this by saying, "I'm not very social. I don't have many friends, I mean they are mostly just family, or if I do talk to friends it's just on Facebook but I don't

go to somebody's house or something and visit. I honestly don't have time where I work all the time and [*my daughter*] she just sucked up all the other time I had. I don't even know my neighbors." This young woman's use of Facebook seems similar to the societal trend of more online interaction and less face-to-face communication with friends and family. Most middle age and older women; however, did not use the Internet regularly, and, if they did use Facebook, they were usually just learning how from younger family members.

Some older women also felt that their social contact with the community became more limited over time as they were not as involved with their children's schools, sports activities, or their church activities. For example, as one older, White woman says, "To tell you the truth, I don't know a lot of people in [*the*] county. Because when I grew up with my children, I knew everybody because I took my kids and we went to church. We went to basketball games and all that. Now then they've all grown up. They've had their families and I'm left out because I don't know."

Other women that suffered from depression and anxiety disorders also expressed a greater desire for privacy at times, or the desire to be alone. For example, one middle-aged single, White woman who dealt with panic attacks and anxiety said, "Well, I don't get out in the community a whole lot, you know, mainly because of the problem with my nerves. I have really bad panic attacks when I get in the middle of a crowd of people, it's like, 'Oh, Oh,' but, you know, my neighbors and my close friends, my family, I do get out and see them quite often."

Interpersonal connections. Social support often came through interpersonal connections with family and friends, and to a lesser extent, neighbors. These women

mentioned social support through interpersonal connections more often than support through organizations or other institutions.

Family and the family unit. Women interviewed came from varying types of family units. Many women were single parents, whether through divorce or being widowed; however, many of these women often had extended family support through their sisters, mothers, and daughters. Other women were unable to have children because of conditions such as having had a hysterectomy due to cancer or endometriosis. Other women were part of more traditional family units with a mother, father, and children composing the family unit.

Some women had very positive, healthy relationships and marriages with their spouses and partners. For example, as one middle-aged, White woman said about her second husband, “I mean I have a wonderful, wonderful husband. One that cooks and cleans. I’m very fortunate.”

Many women also took care of other children in their families, sometimes legally adopting grandchildren and nieces and nephews as their own. For example, as one middle-aged, White woman says, “The two children I am raising now are my grandchildren but they are legally mine. I adopted them so I’m a mother again.” Some women also lived in very nontraditional households. For example, one middle-aged White woman says, her husband “works out of town, so we hardly see each other.” she lives downstairs in her house with her son, and her ex-husband and youngest daughter live upstairs. As she says, “I know it’s a messed up situation. My ex-husband, I was first married for 24 years, and my first husband now lives with our youngest daughter and they live upstairs, so a weird situation, but it really works

because Parker has his dad upstairs, and my new husband he's fine with it now. He wasn't fine with it at first." Other women also describe nontraditional family living arrangements with extended family. For example, one middle-aged, Black woman who is also a grandmother says, "My oldest son lives here with my sister. My oldest sister, my youngest sister, and I, we all share one house. My oldest sister has the upstairs, and me and my younger sister have an apartment downstairs."

Women often had children at a young age and then sometimes again at an older age, or as mentioned above, through adopting other children. For example, one middle-aged, Black woman describes being pregnant around the same time as her daughter was pregnant, "I was pregnant, and I lost my baby in November, and then my daughter got pregnant and her son is two years old now." Several of the women interviewed were great-grandmothers prior to retirement age; for example, a 62-year-old, White woman was a great grandmother to a 5-year-old great granddaughter, and a 65-year-old, White woman was great grandmother to a young granddaughter as well.

Some widowed women had survived the deaths of their husbands or multiple husbands over time. As one older, White woman says, "After my husband passed away, I went ahead with life. I didn't sit down and moan and groan because... we had lived 53 years together and, I thought, if the Good Lord had left him here that long, I shouldn't sit around and moan and groan about it." Another older, White woman describes the passing of two of her husbands, "My [*first*] husband had a heart attack and died, and then I was single for about five years, and then I married a retired doctor and then he died after about 11 years so I'm by myself again. No, I'm single;

I'm not by myself. I've got my granddaughter and my great grandson living with me." Another older, White woman describes the passing of three of her husbands: "I've lost three husbands. I didn't tell you that I was married when I was young... and he died of a heart attack. My second husband died in my arms of a heart attack and then my third husband died of a heart attack... But a positive mind and faith in God gets you through it all. I have a positive mind."

Being a single mother was especially hard on women that did not have outside family support. As one middle-aged, White woman who did not have contact with her family described, when her husband died, she had four children: "a thirteen year old, a three year old, a ten month old and a five month old." As she describes, she only had \$800 to her name, and she survived "the best way I could." This woman was on disability and unable to work; she suffered from "hypertension blood pressure," "real bad nerves," "thyroid problems," and "a lot of depression."

Most women experienced quite a few family health problems, many of which were similar to the health problems that the women themselves faced, such as diabetes, high blood pressure, obesity, cancer, endometriosis, heart disease, anxiety, depression, dental health problems, smoking, drinking, and drug abuse.

Some women's children encouraged them to take positive actions for their health, even children that were very young. For example, one middle-aged, White woman says that her most positive influences on her health are "Probably my son and my daughter because they're very health conscious. I mean he's [*my son's*] 8 but he takes after his sister. So they say, 'Do this, Mom... Don't eat that, Mom.'" Another woman, who describes herself as around 100 pounds overweight, describes how her

sister who has recently lost over 80 pounds is encouraging her, even when she doesn't have the willpower to encourage herself. For example, as this younger, White woman says, "[*My sister*] and I went to the grocery store this morning and, you know, I'm ready to buy cookies, and she said, 'No, we're not taking any of that home.' So she's a really good influence... I keep telling her, 'Help me. Help me please.' That's why she told me this morning we're not taking that home."

Although some women had positive social encouragement to help them exercise or eat healthy, this did not always translate to actual healthy behavior. As one older, White woman stated:

Well, [*my daughter*] used to say, "Well, mommy, if you go out and walk a little bit each day, that would really help you. That would really help your back," and I would try it, and walking is good for you, but it wasn't good for me. Actually, it made my hip hurt... And I said "Well, [*daughter*] just wait until you're 83 years old and see if you feel like doing what you're telling me to do. You'll remember that, and say, well 'Mommy told me that she didn't feel like doing that.'"

Another middle-aged, White woman mentioned how her sister frequently encourages her to quit smoking. As she says, she was able to quit smoking once, but then started back again, "My sister was fussing at me yesterday about smoking and I said that's easier said than done to quit or to do. I quit one time for a year and then I started back smoking." This woman's positive social support did encourage her to make a temporary change in her health, but ultimately she went back to the unhealthy behavior.

Family also helped women to cope. For example, one White, older woman talks about how her family helped her to cope when she was going through cancer treatment: “I just coped with it. Well my family helped me through it, and at that time, I had remarried, and he was great. And my children, they stood by me and wouldn’t let me get depressed or nothing. My sisters, my whole family gave me support.”

Some women mentioned also mentioned negative partner or family relationships that influenced their health in a variety of ways. Women were also influenced by their family situations, including the situations in which they were raised and their family backgrounds.

Several women mentioned abusive relationships with a partner or spouse. Many women were separated from their spouses or their spouses were deceased. Some women described their spouses no longer being in their lives as being positive. For example, one middle-aged, White woman whose husband had passed away told the researcher, “[*My husband*] died when I was five months pregnant with [*daughter*],” to which the researcher responded, “I’m sorry to hear that.” The woman immediately said, “It’s good though, don’t be sorry. He’s an abuser.”

Some younger women also discussed being raised in single parent home with their father largely absent from their lives. For example, as one young, Black woman stated about her father:

My dad he’s always been a heavily drinker, but he had high blood pressure, and he’s never really been in my life. I’m still in his life, if that makes sense. [*My mom’s*] a single parent. She raised two girls. And like I said, he hasn’t

been there, but I've been there for him. Like I've been going back and forth to [town] and checking and making sure he's okay.

Women sometimes described their own power as if it was dependent upon others. For example, another middle-aged, White woman's husband was in prison for domestic abuse related to alcoholism. She expressed a desire to reunite her family and bring her children home from foster care; however, she was very uncertain about her ability to do so because of her husband's situation. As she stated:

I have regular counseling just for myself like domestic violence counseling... My husband is an alcoholic and he is in jail. He doesn't get out until April and so we're trying to get the family back together but in the meantime we're doing counseling... My husband where he is incarcerated, it's a bit more difficult dealing with the abuse and the alcohol... By the time he gets done pulling his time, he'll have been there 18 months. I'm hoping that gives him enough time for sobriety for a while. I'm hoping that'll keep him off of it. But there's no guarantee with someone that's an alcoholic so it's kind of trial and error... We're wanting to reunite, but, I just wonder if he's going to remain sober. I mean, that's my biggest problem, is if he will... I do still have a lot of stressful things that are going on. My children are in foster care and, you know, there are different things that's going on now, but it's not as bad, I don't think, as what it was when he was at home and making things worse.

Women were also influenced by their upbringing and the composition of the family unit as they remember from their childhood. For example, one younger, White

woman who suffered from depression and had gained a large amount of weight and subsequent health problems stated:

I'm going to have to say a lot of it was emotional problems for me and stuff like that. Not having a family that would sit down to a table and eat, and say, "Okay (*name*), how'd your day go today?" Because my mom worked. My dad was a drunk. He worked in the mines but whenever he got home, he was drunk all the time. So our meals was mostly whatever my mom could get at a hurry and we never sat at the dinner table.

Neighbors. Most women reported being friendly with their neighbors, waving hello to them and checking in on them if they were in need. For example, one White, middle-aged woman says, "I have a good relationship with my neighbors I wave if I seen them, I talk to them, especially this one lady that lives beside of me. Her husband just passed away about a year ago and I try to spend a little time with her."

Women also talked about how their neighbors helped them in return. For example, one middle-aged White woman says, "Like with all this snow, my neighbor... the husband works out of town, so when he comes in on weekends if there's snow he gets on his four wheeler and he's got to push snow everywhere. He's always pushing snow out of our driveway, his driveway. He does that kind of thing. His wife, she's a nurse. She's really good." This woman also mentioned that she "more or less watch[es] out for her because she's by herself" while her husband is away on work. Another older, White woman with no vehicle describes how her neighbors help her in times of need:

I have a good relationship with all them. They are real good neighbors. They know that if they need something they can come to me, and if I have it, I will give it to them. If I need to go somewhere and the weather is bad, I can count on the neighbors to take me or else go get it for me. Like back in January when we had the big snow one of my neighbors went and got my mail and my paper for me because I couldn't get there. One of the neighbors took me to get my groceries that I needed.

This woman volunteered at the clothes closet and the food pantry, and, although she did not drive, she was able to volunteer one to two times a week because her neighbors and friends drove her to volunteer.

One younger, White woman who had no family in the area says her neighbors are like her friends and family. She says, "Me and my fiancée usually take all of our neighbors and friends to doctors or to food boxes, 'cause they have the same problems, they get their food from food boxes, too." This woman also says that she eats dinners with her neighbors in their housing complex, "What we do is, our building and the next building, where our friends live, we do a communal dinner. So when I make soup it's in a big 18 quart pot and, 'Soup's done. We'll bring you up some.' Or that kind of thing because it's just easier to eat combined. Call up, 'Hey, you got some taters? Hey you got some carrots?' or that kind of thing and it's easier to all eat that way." This woman helped to take care of her neighbors by ensuring that they all had food to eat, but she was also able to eat better herself because other neighbors and community members contributed food to the mix.

Friends. Women mentioned knowing most of the people in their community, although they generally did not describe having many close friends that they spent large amounts of time with, other than their family members. For example, one younger, White woman says, “I have a couple of people that I still talk to that I went to high school with. Then, it’s a small town so you pretty much know everybody. I’m not really close with anybody in particular besides my high school friends.”

Some women mentioned the importance of just having friends to talk with to help them cope. For example, one younger, White mother says, “Well I wake up every morning with panic attacks like someone is sitting on my chest and it gets so bad that I throw up every morning, so I talk to [*friends*] a lot about that.”

Other people talked about relying on friends for financial support in times of need. For example, one middle-aged, Black woman says she does not have health insurance and instead she relies on her “rich friends.” As she says, “[I] mostly go talk to rich folks ‘cause I work for rich folks and I tell them look, I need you and they say whatever I need to do we’ll do it and they help me. So I am fortunate. I’m one that I know a lot of people.”

Organizational and institutional connections. Organizational and institutional connections and communication also affected women’s empowerment and health, although to a lesser extent than interpersonal connections. These women mentioned social support through their workplaces and schools. Some women also mentioned social support through community organizations.

Employment and the workplace. Many of these women did not work outside of the home and, as such, fellow employees at workplaces were not mentioned often

as sources of social support or influence. Many women interviewed were homemakers and supported by their husbands (whether their husbands were living or deceased, whether they were married or separated). Many other women were on disability, welfare, food stamps, and other Government support programs. Some women interviewed were retired from their jobs and some women were currently employed in blue collar jobs, such as factories or food service work. Women interviewed—including those now retired—had worked at places and positions such as KFC/Taco Bell, Chick-Fil-A, Dairy Queen, Denny’s, as a “truck driver,” at a “homeless shelter,” a “sewing factory,” part time at a state park, as a remedial reading instructor, and a “secretary.” Most of these jobs were out of the county, but within one of the neighboring counties.

As mentioned, most women interviewed did not have regular full time employment, even though some had worked prior. For example, as one middle-aged, Black woman says, “See I haven’t worked, I’m unemployed. I’ve always worked all my life two and three, four jobs then it got down to two jobs, then it went to three jobs, then it went down to one job then it was no job... places closing down and that kind of thing.”

Other middle-aged, White women said they and their partners were out of work on disability: “[*my boyfriend and I are*] both disabled,” “[*my husband*] doesn’t work at this time; he is disabled,” “I’m disabled,” “I’m on disability for my nerves and stuff,” and “I haven’t worked now for about 15 months. My lupus just got too bad. I’ve signed up for [*disability*].” A few women also said that their husbands and

fathers were on disability “from working in the mines.” These men that were on disability often retired early with blacklung or went out on disability.

Some young single mothers without significant financial resources worked long hours. For example, one very young single, White mother whose baby’s father was a college student away says, “I work mostly. I usually get one day off a week. I work anywhere from... the least amount that I work is probably 6 hours a day. I usually work anywhere from 8 to 9 hours. Most of the time I do doubles. I’m always at work.”

Women interviewed who worked with the Head Start program were employees of Head Start and multi-tasked as teachers, bus drivers, and cafeteria workers; these women were very close and discussed their health problems and supported each other as friends and colleagues. For example, one young, White woman with no immediate family in the area other than her spouse and children worked at Head Start and mentioned that she had no relationships or social connections in the community, “other than here [*at work*]. I have a relationship with these girls because I have to work with them all the time and stuff. We’re a close knit family we worry about each other. If we’re not there, we worry about who’s going to do my work if I’m not there.”

As another middle-aged, White woman mentions about her experience with endometriosis, her co-workers, whom she also considered to be her friends, encouraged her to visit the doctor:

I’ve always had problems with my menstrual cycle and stuff, but it was just getting worse and worse and worse. I mean I would like have a pad on and by

the time I leave my house 15 minutes here it would already be soaked and it would be in my clothes within like 15 minutes. This went on for like nine days sometimes at a time and I was just to the point...they [*points to area where co-workers are*] were like you're going to go see a doctor. I was like, "Okay," but I'm glad I did. I feel 100%, well not 100%, but a lot, lot better. I don't have to worry about it anymore.

Another middle-aged, Black woman told how a former customer from work came to check in on her when she was sick: "Like the other day this lady... I've been working at Dairy Queen for 27 years, and they closed down, and she hadn't seen me, and she knows that I stay sick and she came and rang the doorbell." She said the woman came to give her \$50 to help her out. She knew the woman through her work at Dairy Queen, but did not work with the woman.

One middle-aged, White woman who was born in the area, moved to California when she was young, and moved back to the area around 15 years prior believed she had a bit of an outsider's and insider's perspective. She believed that there were jobs to be had in the community, but that community members were not trying hard enough to get these jobs. As this woman says, the opportunities for employment are not vanishing:

I think that's an excuse. Gatorade just hired 42. I have a whole list of places... Pepsi, I mean I've applied. You just have to keep applying. And here people will apply once and they give up. Because if they work for a place, they can go get unemployment. I can't because I'm self-employed. So I have to work.... They want welfare. They want disability. They want money

and not work. They love to take the drugs from doctors, sell them, collect food, housing, and do nothing. There's a lot of it here. And you'll find that.

As this woman described, she believed that other individuals in the community gave up too easily on their job searching. This woman had found a job "working at Denny's making \$2 an hour... and then at the truck stops... getting a \$1. A dollar!" As she says, "Yesterday I worked an 8 hour day and made \$35." Although this woman believed that jobs were available, her job searching had resulted only in low-paying jobs, such as the ones she mentions above. This woman in particular believed that welfare and collecting unemployment were wrong; however, she also mentioned that she could not collect unemployment because she had been self employed prior to her current job searching.

School. Some women were going to school in person and online, mostly part time. For example, one younger, White woman said she went to "cosmetology school, and then I go to Colorado Technical University [*online*]." A few other young and middle-aged women were attending community college in neighboring counties, as there was no community college located in their county. Another middle-aged, White woman said she was going to "Old Dominion University. It's televised through [*neighboring county*]. I'm working on my Bachelor's Degree."

Community organizations. As there were not many community organizations in the county, women mentioned being involved with these types of organizations far less often. As mentioned above, most women who were involved in organizations in their communities were involved in religious or church organizations or many of the

women were involved with the community center food pantry, clothes closet, Head Start program, or dental clinic.

A few women, however, were involved in other organizations in their community as well. One middle-aged, White woman who was very active in her community states that she was involved with, “The VFW, the Ladies’ Auxiliary. We have the Hollybrook Community Center; that, I’m a member of that. And of Bland County Rescue Squad.”

Another woman that volunteered that community clothes closet describes her volunteerism at the community center has helping her to make it through the passing of her husband six years priors. As she says, her husband passed away, “Six years yesterday.... I come over here [*to the center*] in August after he died in January. And it's been a blessing to me to help me get through.”

Women who volunteered at the community center at one or multiple services—including the food pantry, clothes closet, Head Start program, or dental clinic—often spent a large part of their time volunteering. As one middle-aged, White woman says, “If I’m not volunteering at the school, then I’m either catching up things at the house or doing errands for my husband. I’m on all the committees. I do quite a bit of volunteering.”

Women who volunteered with community organizations were often likely to volunteer at multiple organizations. For example, one middle-aged White woman who regularly volunteered at the center also describes being very actively involved in many other aspects of her community, even going to school part time via distance:

Right now I'm really involved in our church, the youth group in our church. Also they're starting what's called Smart Beginnings and it's a grant that's been given to [*neighboring counties*] to help the children get ready for kindergarten. Really we're just laying the foundation right now. I love to help out the ministry center. We volunteer at the ministry center and stuff because they give so much back to community and our families here at Head Start. So, I always try to help them out especially Christmas drive and different things like that. [I] work with Social Service, some committees with Social Service. Go to school, I'm a part-time college student.

RQ4: How does rural women's meaning-making of empowerment relate to their meaning-making of health?

Women made meaning of health largely through identification with a state of feeling, or through actions they described as healthy, such as exercise and eating fruits and vegetables. Women who made meaning of health as a state of mind or feeling, believed that a positive attitude and spirituality could help them to cope and to positively sway their health. Women with poor health and lacking empowerment were happy just "staying alive" and "living longer." Women with greater empowerment were interested in an improved quality of life and, oftentimes, greater community change for health.

Women described their notions of health differently. Many women thought about health as "feeling good," "well being," not being sick, exercising, or eating fruit and vegetables. While many women saw health mainly as a physical condition based upon their descriptions of "health," others described health as a combination of

physical, mental, and spiritual attributes. For example, as one middle-aged, White woman says, “Well, there’s different kinds of health. There’s mental health, and there’s physical health, and then of course, there’s spiritual health, too, and they are all very closely related.”

Women’s strongest motivations for health were for family and for quality of life. Some women who had experienced many health problems or struggled with mental health, said that health to them just meant, “Being able to do things being able to do what you want to do.” Some women had a hard time describing “health;” for example, one woman said health is, “A lot more than just the way you feel, ‘cause I know sometimes I feel really great, but I’m not great.” Another middle-aged, White, holistic health educated woman says that causes of poor health are, “Stress. Disease. Break it up. It’s dis-eased people. It is... D-I-S-E-A-S-E. That’s diseased.”

When women were asked to take pictures about what health meant to them, most women took pictures of treadmills and exercise bikes, salads, fresh fruits, vegetables cooking on the stove, or wide open outdoor spaces. Some women also took pictures of their families, as they said health meant being able to take care of your family. Other women took pictures of people they thought looked healthy, such as women on the cover of magazines or on the television. For example, a young, White woman had taken a picture of Heidi Klum in a magazine; she says, “That’s Heidi Klum. She’s amazing, because of all the kids she has, and then she loses the weight so fast, and she looks great.” This woman’s discussion of her pictures illustrated that she also equated health with weight, even though this was not something that she had explicitly stated and not something that many women stated

explicitly either, although many of these women inferred this connection from their other responses. For example, another woman reiterated this notion of health as equated with weight through her picture of “my bikini” laid out on her bed as making her think about being healthy. Another middle-aged, White woman explicitly mentioned weight as tied to health in her answer: “Health, I think means eat the right foods. Do not get obese and get too big... Eat the right things, don’t be obese, you can control being obese if you want to control it.”

A few women described health as more than just physical health, noting mental and spiritual health as elements of being healthy. For example, one younger, White woman describes health as a “state of mind, a presence of being, and a physical wellness. I think you can be physically well and mentally sick or physically well and spiritually sick. I think all of them—your mind, soul, and body—all have to come into agreement before you have health.”

As mentioned above, some women said that being healthy meant they would be around to take care of their children. Other women mentioned that being healthy to them would mean that they could live longer or enjoy life. For example, one White, younger, low-income woman who had dealt with many health problems said, “Well, I’d like to live longer than what they expect me to. That’s a biggie. Just so I would enjoy what I have—enjoy life. I’m poor and I have to go to food boxes. I have to go to clothing pantries to get clothes, but I want to enjoy life.”

Atypical of most women in the area, a few women felt empowered because of their education or because of home remedies or health cures that had been passed down from their family members or other community members. This empowerment,

however, did not always translate into traditional dominant or medically accepted notions of health. For example, a young, White mother says her infant daughter:

...is constipated. I tried prune juice, but it's so strong it upsets her stomach and then when [*coworker*] said something about the mineral oil, I tried that, and that works fabulous and that doesn't upset her stomach at all and it helps her real good. We were having to give her baby enemas and it was awful... it was like every day a number of hard poopies. You only give a few milliliters I mean its natural they don't like the taste of it, but if you open their mouth and blow in it then she will swallow.

This young woman—and her mother who joined the conversation—were very happy and proud that they had found a solution to this problem. Solving this problem perhaps provided them with individual empowerment for future family health problems. However, this solution is not recommended by most doctors who would recommend all natural remedies first or oils such as flaxseed oil, before having infants ingest a petroleum-based product. Also, most health sources recommend enemas as a last resort and certainly not an everyday procedure.

To further illustrate how empowerment may not necessarily translate into traditional, medically accepted notions of health, some women believed in holistic, alternative health treatments. For example, one middle-aged, White woman educated in holistic health says if she needs health information she would:

...quest out my friends. That's where I get my information from. I'll call up [*my friend*] cause she's an herbalist, or I'll call her friend, she does dermal

screening, it's acupuncture or an electrical, and she'll tell you copper, what you're missing... you know your metals...

Additional Insights from Photovoice Conversations

Women who participated in the photovoice method participated in two-part interviews and talked more in-depth about their health and empowerment through pictures they took of people, places, and things that affected them (see Appendix A.2 for a full description of the photovoice assignment and subsequent interview questions). Photos served as a tool to engage in critical discussions of empowerment and health. As illustrated above in the research questions, women took pictures of their families, their homes, their neighborhoods, the food that they ate and served to their families, their pets, and other aspects of their lifestyles. Through these photos, women were able to illustrate their everyday life experiences in a way that allowed me as the researcher to actually visualize their surroundings and environment and through the participants' own eyes.

Photovoice findings revealed information that the interviews alone could not, such as the environments in which women lived, and prompted discussions of how these environments affected the women and their empowerment. For example, women who described living with a few neighbors nearby that they talked to or could rely on often took pictures of their homes and no other nearby homes could be seen in the pictures. Discussions from the interviews alone may have led me to believe that these women were closer to their neighbors than they actually were. Other women who described not being close with other neighbors took pictures of their homes located in mobile home parks or multifamily housing units. Although these women

did not describe talking to their neighbors as often, they were in close proximity with many neighbors, which may not have been discernable from the interview conversation alone. Understanding the contexts within which women lived helped to understand their points of view and sometimes highlighted discrepancies in the stories which women told.

Chapter 5—Discussion

The goal of this research was to examine rural women's meaning making of individual and community empowerment as related to these women's experiences with health and wellbeing. Through the particular vantage point of the rural women participating in this research, this study also explored how empowerment might be developed through public health campaigns. This study employed a qualitative research method to explore empowerment through women's lived experiences. Forty-one women residing in a small rural community participated in the research through in-depth interviews; 15 of these women also participated in photovoice research and answered additional questions through the taking of pictures, which provided a view of health problems and empowerment through the participants' eyes.

A combination of theoretical concepts was used to guide this research project. Dimensions of individual empowerment such as self-efficacy and perceived behavioral control were explored in more depth, as were other factors that affected empowerment, including social support, religiosity, and involvement as a construct of the situational theory of publics. This study sought to explore how empowerment could feasibly be a critical link in public relations and health communication theory, and the factors that influenced women's empowerment both at the individual and community levels. On a practical side, this research explored how empowerment, as an outcome, might be influenced by public health campaigns.

This chapter demonstrates the importance of a multifaceted approach to health communication campaigns, involving communication at many levels and focused beyond individual behavior change alone. As findings from this research show, these

women's interpretations of empowerment and health were affected by a variety of factors in their lives, including their community and social interactions, their religion, and their experiences with health problems. Physical and structural factors in women's lives also left them with feelings of powerlessness in certain health situations.

This chapter provides a discussion of the interview and photovoice findings and conclusions drawn from considerations of these findings with prior literature in health communication. First, I discuss the major result themes and offer interpretations for these results based upon prior research and scholarship. Second, I offer a proposed model for the process of individual and community empowerment, as observed with these rural women, and a discussion of how this model may be useful in health communication campaign theory.

Powerlessness

Women often felt their physical or financial constraints or other factors around them in their environments were what affected their health and prevented them from having control or power over their circumstances. Women with low financial resources often had low perceptions of their empowerment, believing in many cases that they were victims of their circumstances. Many of the women who struggled with obesity and diabetes said that they believed they would be healthier if they had the financial resources to be able to visit the local gym in the neighboring county or join a program such as Weight Watchers. These women often also felt that they did not have the resources to buy healthy food to eat. Because these women felt so constrained by their resources, some women did not try other methods of

exercise—such as home workouts or walking—and did not try limiting food portions or eating healthy diets at home.

As many of these women assumed a caretaker role for others in their families, when faced with situations in which they had limited financial resources or limited time, they were more likely to take care of the needs of their children or partners before their own health needs. These women maintained a sense of control over their families in this way; however, they often had to sacrifice their own medical care, such as other research involving low-income rural women has found (Simmons, Anderson, & Braun, 2008).

Women who faced other health problems such as depression or anxiety also struggled with feelings of control and empowerment. For some of these women, health problems seemed to stem from some of their other mental conditions such as anxiety or depression, or even mental health factors such as stress and worry. In some cases, unhealthy behaviors (e.g., smoking) were what women used to cope instead of resorting to other (sometimes prescribed) substitutes, such as prescribed medications, alcohol, or illegal drugs. Other women, however, turn to their religion and faith as a way to regain their feelings of control.

Empowerment as a Culturally-bound Concept

Empowerment was a culturally bound concept, in that participants had their own notions of empowerment and how they could become empowered. Sources of empowerment, such as religion, social support, and volunteering, were unique to the lived experiences of women in their communities and women's interpretations of empowerment were reflective of their cultural community setting and experiences.

Women's own notions of their empowerment often did not match up to the preconceived notions I had as a researcher. For example, one woman being interviewed felt empowered because she had been unemployed for some time and had finally been able to obtain an interview to possibly work at the local McDonald's restaurant. From my perspective as the researcher, I realized that I had existing biases against a job of this type, particularly one that did not carry health insurance, but for this woman, being able to obtain a job and regain some of her financial independence was very empowering.

Empowerment and Health Communication Campaigns

Public health campaigns—particularly in areas where women had lower empowerment and less perceived ability to take healthy behaviors—should be cautious about the messages that are sent. Campaign messages often target the individual or blame the individual for not changing her health behavior. When women have low empowerment, blaming them for taking health measures may leave them even more frustrated and discouraged. Communication approaches that focus on media advocacy shift the blame away from the individual and to larger political or societal factors that need to be addressed (Wallack, 1994, 2000, 2002).

Campaigns focused on individuals' behavior as the root cause for the problem may create a stigma surrounding the particular health issue, causing others in the community to blame the individuals with the problem, rather than support them. For example, a recent global health study on public health campaigns targeting obesity has shown that blame and criticism is the global norm for people who are overweight, and that public health campaigns seeking to change obesity are often perceived as

bring critical of the individuals who are overweight, while not addressing the environmental and other societal factors that affect individuals (Brewis, Wutich, Falletta-Cowden, & Rodriguez-Soto, 2011). As shown through these women's stories about their everyday health problems, issues such as obesity were especially sensitive to some women and issues which they often feel powerless to address.

Campaigns may best serve marginalized communities through a socioecological approach to health communication that does not blame the victim, but rather works to empower the community through a holistic approach to communication campaigns (Sallis & Owen, 2004). Media alone targeted towards individual behavior may not be sufficient to create a sense of empowerment in women and to empower communities. Socioecological models of health promotion that encourage multiple levels of support and resources for individuals and communities may be more effective in empowering rural women, and, in fact, health communication campaigns operating at multiple levels, including interpersonal communication, mass media, and policy change, have been shown to have greater effects on positive health outcomes (Noar et al., 2009; Snyder & Hamilton, 2002; Snyder et al., 2004).

These campaigns should consider the individual, community, structural, social, and political factors surrounding the health problems and health behaviors. Additionally, campaigns should focus on bolstering community resources and community members to give them a sense of collective community consciousness about how they can work together to address their health problems and challenges. As Israel et al. (1994) state:

For empowerment to be a meaningful concept, distinct from others such as self-esteem and self-efficacy, the cultural, historical, social, economic, and political context within which the individual exists must be recognized. It is possible to develop a program aimed at individual empowerment, but if this program does not consider the context in which the individual is embedded—such as the organization or community—then there is less likelihood that actual increases in influence and control and concomitant improvement in health and quality of life will occur (p. 153).

Some have said that media promotion cannot be used to “really empower anybody else... the best we can do is to help unleash the power that citizens already possess” (Wallack, Dorfman, Jernigan, & Themba, 1993, p. vii). However, individuals who are marginalized or oppressed may not be able to “unleash” their power within a societal structure that promotes health disparities and marginalization. In order to help these individuals unleash their power, societal and structural changes may need to be implemented. As Wallack (1994) notes, media advocacy can be used to promote larger societal, political, and environmental changes. Breaking away from more traditional notions of public health campaigns that focus on individual health behaviors, media advocacy can be used by community groups as a strategy to empower community voices and promote social change.

Rural women as potential community change agents. Women noticed many health problems around them and had ideas about how to address these problems, such as creating community spaces for healthy activity and community building and educating community members about certain health problems. From the

perspective of Freire's (2008/1974) critical consciousness raising, women who are interested in changing their community's health and addressing some of the health problems around them can become peer educators for their fellow community members and work to make this change happen at the community level, in addition to individuals making some own changes to their lives at the individual level.

Before these women can take on roles as peer educators; however, many of them need encouragement and support to build their own confidence and overcome their feelings of powerlessness. As illustrated in the results section, some women said that they were just a "little person" or a "little voice" compared to their perceptions of the researcher, who they believed had more power and more knowledge. Women who made statements such as this were typically women with low income or without insurance who were receiving services from either the free dental clinic, food distribution center, clothes closet, or Head Start educational programs; these women had to rely on others for vital services related to their food, health, clothing, and education and often felt frustration or helplessness because of this reliance.

Showing community members' health successes. One theme that emerged through this research was the potential of observing others' health successes to increase perceptions of self efficacy and empowerment. As Egbert and Parrott (2001) found, when women perceived that others like them were engaging in a particular behavior with success, the women were more likely to gain confidence and perceive that the health behavior was easier to accomplish. Some women in this research expressed similar sentiment by sharing stories of women in their communities who

had recently undertaken positive health behaviors, which they were also hoping to try in their lives. For some of these women, seeing their friends and family have success with an element of their health such as weight loss, quitting smoking, or making progress with a chronic disease gave them hope that they might be able to accomplish similar goals.

However, for other women, seeing others' successes made them frustrated and discouraged. Many of these women expressed that they did not have the resources to try what others had or that they had tried "everything" to lose weight or to address other chronic health problems, but to no avail. For these women, seeing the successes of others in their communities may only serve to remind them of their failed attempts. For women who feel constrained by resources and lacking in social and spiritual support, observability of others' health successes may be a factor only after their other barriers are removed and positive influences are increased.

Empowering women to question doctors. Another potential focus of a community empowerment initiative might be to empower women to question their doctors and giving them confidence to challenge with healthcare providers when they have concerns. Women placed a great deal of trust in their doctors for a variety of reasons, including their religious beliefs, their personal relationships with doctors, and their feelings of the doctor as having more power and knowledge than them in medical settings. Oftentimes, this trust and faith discouraged women from questioning doctors' decisions or seeking alternative medical help, even when they believed that more should be done for their health situation.

In regards to the findings about how women may place trust in doctors because of their trust in God, this may have important potential implications for healthcare. If women see their doctors as divinely informed and ordained to practice medicine, then women may be less likely to question their doctors or seek a second medical opinion. Additionally, in cases where women had personal relationships with longtime community or family doctors and great trust in these doctors, women were less likely to seek a second opinion or seek the advice of a specialist if their doctors had not referred them. In rural areas, such as this one where medical specialists were limited and women were restricted to one or two doctors within close proximity, this may be especially important. As described in the findings with the woman who had never been sent to see a nutritionist, despite her severe problems with diabetes and weight control, this woman was hesitant to question her doctors or ask for additional medical care because of the trust she had placed in her doctor's judgment.

Programs (Dis)Empowering Communities

The area, although impoverished in some ways, had many government, charitable, and other nonprofit programs in place. Many of the women in the study used government resources such as food stamps, Welfare, unemployment, Medicare or Medicaid, and the Head Start educational program for preschoolers. As mentioned prior, the area also had many mental health facilities and a regional community mental health service that allowed individuals who might normally be institutionalized to instead live in their homes and participate in community activities with other individuals who were also receiving services. Other individuals

participated in services such as the free dental clinic, clothes closet, and food pantry run by community nonprofit organizations.

While these government and nonprofit programs were removing individuals' physical and financial constraints in some regards, they were actually removing women's sense of individual and community empowerment in others. These programs were generally top down, from government or from nonprofit organizations to the needy community members, and, instead of feeling like these programs provided for them, women felt as though they had to rely on the larger system in which they had no say or no control. Unlike women's thoughts about religion—where many of them believed God was acting on their behalf in their best interests—women did not believe that government programs would necessarily operate on behalf of their best interests.

Community members in need of government services often felt that these programs were not enough to cover all of their medical or other health needs, but usually just enough to get them by. These women felt dependent upon these programs and sometimes reported being afraid to pursue other life or job opportunities for fear that they would no longer have the support of these programs, even though these programs were not provided for all of their needs. For example, women that used these programs, such as Medicare or Welfare, reported that they were hesitant to take jobs, even when they had the opportunity, because they did not want to lose their Medicare, Welfare, or unemployment benefits. Some women felt that these programs offered them a sense of security, or that, once they became a part

of these programs, there was no way for them to work their way out of these programs.

Religion

Women's religious involvement and commitment—both in the private and public sense—affected their beliefs about their empowerment and control and their overall health, but also affected women's beliefs about social support, which in turn impacted their beliefs about empowerment. Religion appears to have a direct effect on women's empowerment through women's God-mediated control beliefs, as well as an indirect effect through social support. Religion was individually empowering for women in that they internalized their feelings of the power and strength of God and believe this additional power to reside within them and be available to them. For many women this magnified their sense of strength and control in their lives.

Religious beliefs. Findings from this study support previous research that shows that religious beliefs can positively affect health (Aranda, 2008). Highly religious women believed that their bodies were sacred gifts from God and that they had a responsibility to protect this gift and do their part in maintaining health (George et al., 2000). In this case, women's religious beliefs also positively affected their communities, as women who were involved in church and had higher levels of religious involvement were also more likely to volunteer in their communities at community programs and services and to reach out to neighbors in need.

As George et al. (2000) describes, religious beliefs are one dimension in particular that may affect health. As seen here, many women have a unique belief that doctors are bestowed with their medical knowledge and abilities through God.

These women did not see a conflict between religion and science, and instead put trust in their doctors' abilities because of their trust in God.

Most women did not describe their religious beliefs to be absolutist or fundamentalists, despite prior research suggesting that religious beliefs of this type existed more in rural communities. Women believed in the rights of others to have their own religious beliefs and did not try to force their beliefs upon others.

Religious coping. Particularly interesting from these findings is the fact that high God-control beliefs did not appear to negatively affect women's coping, as opposed to the findings of Wallston et al. (1999). For example, as shown in the findings from this study, women used religion as a mechanism for coping and even in extreme cases, such as the case where one woman had lost three husbands due to heart failure and had other serious family health problems and issues, these women who had high perceptions of God-control beliefs still used their religious beliefs as a form of coping positively.

Coherence hypothesis. Following the coherence hypothesis (George et al., 2000), women's religion was a great source of empowerment for them. Women with strong religious beliefs often believed that their lives served a higher purpose: these women believed that they were placed on this earth for some divine reason, which was yet to be determined. As such, these women felt a sense of strength in this knowledge and a need to take care of their bodies and their families so they could fulfill this higher purpose. Women who were highly religious also believed that God would take care of them and their needs.

God-mediated control. Religion could leave women feeling powerless in other ways, however. For example, some women mentioned that they had limited control over what would happen in their lives because they had turned this control over to God. These women believed that what was meant to be would be, and that they had no control over God's plans for their lives. This sense of God's complete control allowed women to cope with the loss of a loved one or manage when they found that they had a life-threatening or prolonged illness. However, despite some women's beliefs that God had complete control over their lives, these women typically still believed that they had a responsibility to God to take care of themselves and take control of the aspects of their lives, which they did have control over. While external God-control beliefs have been thought to have negative influence because they take the power away from individuals, more recent research is showing that external God control beliefs are often positive in many situations because they give the individual an added sense of control through God's support (Koffman et al., 2008; Krause, 2010). These beliefs also helped women to cope in severe situations, such as battling a life-threatening disease or the loss of a loved one.

Religion and empowerment. Maton and Wells (1995) found that religion could be disempowering for women, as organized religion often oppressed women or held stereotypical views of race, class, and gender. However, as Dollahite, Marks, and Goodman (2004) emphasize, rural women are often more likely to participate in organized religion than their male counterparts, and women find strength in numbers through their religious participation. Religious involvement where individual expressed a direct relationship with the divine or a higher power may be more likely

to generate empowerment than religious involvement where individuals have to rely on other people as intermediaries who may mediate their sense of power. For example, women who believed that they had a direct and personal relationship with God—as opposed to a relationship to church elders who had the relationship with God and communicated to God for her—felt as though they could ask God openly for help with any of the needs in their lives.

Still, public health communicators must be cautious not to encourage individuals to give away their power and their control in reliance on others. As Freire (2008/1974) stated as an illustration of this:

I have never forgotten the publicity for a certain Brazilian public figure. The bust of the candidate was displayed with arrows pointing to his head, his eyes, his mouth, and his hands. Next to the arrows appeared the legend: You don't need to think, he thinks for you! You don't need to see, he sees for you! You don't need to talk, he talks for you! You don't need to act, he acts for you! (p. 51).

Encouraging religious individuals to rely on their religion as a source of strength or coping during difficult times is one thing; however, stating that individuals need not have any control over their lives may further the divide between the powerful and the powerless.

Despite the positive effects of religion on women's health and empowerment in this study, health communicators should still take caution with religious approaches to health, especially when these approaches are absolutist and may cause harm to others outside of the religious group. While evidence has shown that

religious involvement can have a positive effect on health and empowerment, religion may also have negative effects on individuals' personal health and on the health of others that may not conform to the dominant religious traditions in a given area. Absolutist approaches to religion may encourage discrimination against individuals outside of the faith practice; other religious practices, however, actually encourage compassion and empathy (Hunsberger, 1995; Hunsberger & Jackson, 2005).

Religion incorporated into health campaigns and programs. As bell hooks (2003) states, religion and spirituality should not be neglected in educational efforts; this is not to say “that education should enforce an inner life but rather that the inner life should not be ignored” in educational settings (p. 182). Women come to health campaigns and programs not as blank slates, but as women with their own beliefs, ideas, and lived experiences. Ignoring women's religious involvement, commitment, and beliefs or, especially, working counter to these dominant beliefs may instead cause women to be distrustful and skeptical of these programs or campaigns.

While Freire's (2008/1974) ideas and teachings on empowerment and the development of a critical consciousness, suggest moving away from religion (or types of “magical” consciousness) to provide empowerment, literature on religion and health and the findings of this study suggest that religion should not be ignored for the positive influence it may have on women's health and empowerment.

Religious beliefs in this community were largely similar and impacted by other community and environmental factors. Health campaigns and programs that focus on community empowerment, should take into account these localized religious beliefs and practices as well as the larger contextual factors in the community. As

Gesler, Arcury, and Koenig (2000) have noted, health programs incorporating religious aspects should focus on specific health beliefs in the locations in which individuals live and other environmental factors such as the economic situation in the locality and individual and collective experiences.

Incorporation of health and empowerment initiatives into existing religious programs and faith-based communities should come from community members; health educators and communicators may play a supportive role by encouraging community members and leaders and serving as a resource for community members, if needed. Education and outreach efforts should be culturally appropriate and community specific, tailored to the religious beliefs and practices of the faith community (Powe, 2002; Underwood & Powell, 2006). These health programs should also take into account the health needs and concerns most felt and expressed by the congregants, allowing faith community members to have input and power in the process while working together as a faith community to address these concerns (Underwood & Powell, 2006). In impoverished areas with otherwise marginalized populations, churches and faith communities may have an especially large role to play in organizing community members to work together for community empowerment and health.

Social Connections, Community Participation, and Volunteerism

Women's positive social connections and relationships helped them to cope with minor health problems, chronic disease, the loss of loved ones, and other stressful situations. Women's positive social supports also provided them with tangible resources, such as financial help in times of health crisis, caretakers for their

children, ride sharing, and more. Many women relied on their fellow community members and were quick to help others in times of need.

Although many women kept in regular contact with their neighbors and community members and helped others in need, a contingent of women also preferred to lead quiet private lives. These women kept to themselves and kept their health problems to themselves. Some of these women expressed a need for privacy in their lives and had more introverted personalities; others struggled with anxiety and depression when around other individuals.

Many of these women also lived far away from others and kept to themselves, leaving them isolated much of the time. For many of these women, there was no real sense of a connected community of which they believed they had a voice or a say in what went on or felt that had any real power to affect structural, social, or political aspects that affected their health. Instead women focused mainly on their individual health and their individual responsibility and control for health when they discussed health in these interviews. Public health communication campaigns have largely focused on the individual level of change, largely neglecting the other societal, community, political, and structural factors (Dutta-Bergman, 2005).

As Freire (2008/1974) describes, raising of a critical consciousness in disenfranchised communities can help community members to work together to address health problems. As evidenced in some of these women's stories, they were already reaching out to help their neighbors and friends with the health problems with which these individuals were struggling. However, this assistance came largely through social connections, such as fellow church members, neighbors, loved ones,

friends, coworkers, or family members. Coward (2006) suggests that women's sense of empowerment is increased when women actively participate in their communities and are more connected to the larger community as caretakers.

Women without healthy relationships and social connections were more likely to turn to substance use and abuse for coping or to struggle with depression or anxiety; however, some of these women did not have many positive social supports or connections because of their anxiety and depression, as opposed to the lack of social support causing the depression. Some women who suffered from depression or anxiety were hesitant to leave home or suffered from panic attacks when around others in larger public settings.

Volunteerism and community involvement. Many of the women who served as volunteers in community programs such as the center where there interviews took place seemed to believe that they had greater power to influence change in their communities, perhaps because they were able to visibly see the impact they were able to have on others in need. This finding is consistent with other research suggesting that women have greater notions of their empowerment when they are more involved in their communities, have more social connections, and assume a greater caretaker role for others in their communities as well as their families (Coward, 2006).

While some of the women volunteers came from positions of financial privilege within the community, such as a doctor's wife and a school administrator's wife, most of the women that volunteered in these programs and services were very similar to the women in which they volunteered to help. Many of the volunteers had

low income and low education levels, were divorced or widowed, were unemployed or had part-time jobs, and had to share transportation to save on transportation costs or because some did not drive or have vehicles. Low-income women with low education who used the community center's services and programs often saw themselves as dependent upon these programs and having less control; whereas, low-income women with low education who were volunteers at the community center's services and programs, saw themselves as empowered to help others and make a difference.

Involvement with Health

Involvement with health was tied to women's health behaviors, but in, these interviews, did not appear to be tied directly to women's empowerment. Involvement with health was tied to women's thoughts about the importance of health and, as a result, their health behaviors to prevent or correct health problems. For example, young healthy women were not as likely to be involved with their health or connected to the idea of health as individuals who were experiencing more health problems and had a daily struggle with health in their own lives or the lives of their loved ones. However, these young women may or may not be empowered, depending upon many other factors, such as their religious involvement and beliefs, their social support, and their perceived constraints.

Some individuals that were very involved with their health (i.e., connected to the idea of health and actively searching for health information), were empowered because they knew more about their health problems and what they were potentially facing. However, in times where women's health conditions were serious,

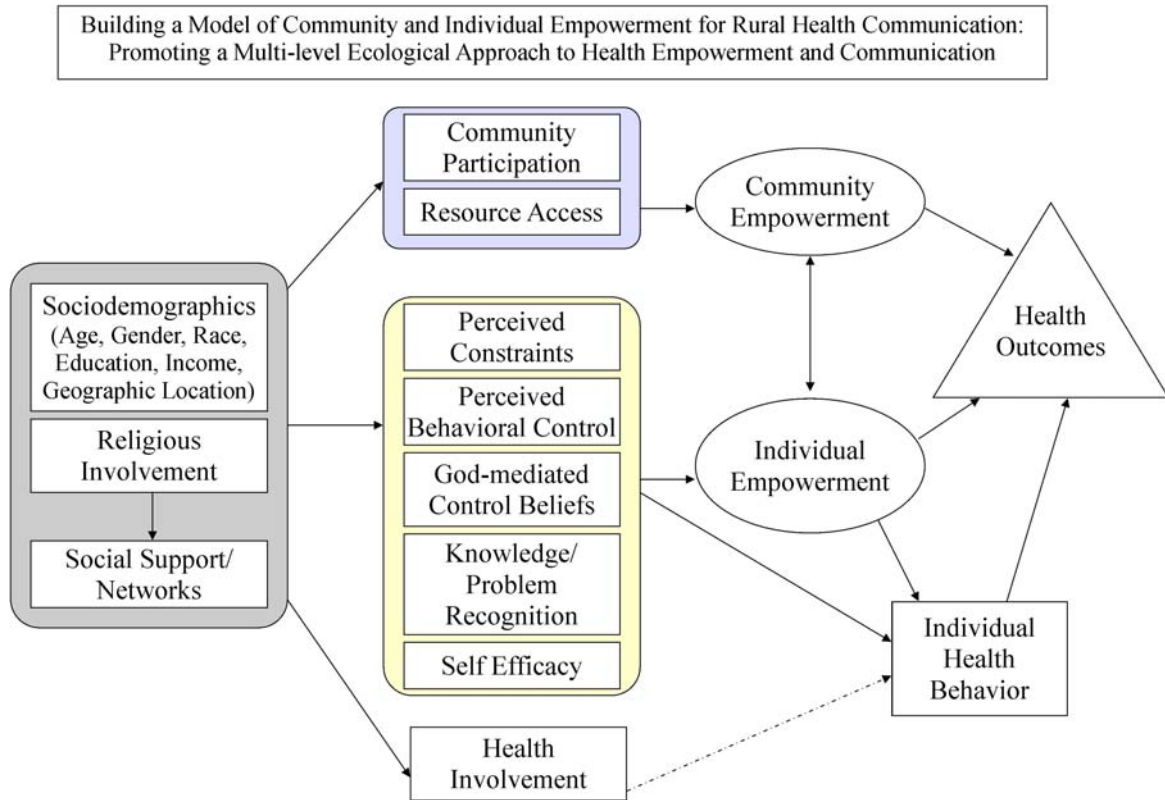
overwhelming, and stressful, health involvement—especially “information overload”—may lead to fatalism in individuals who perceive they are constrained by resources and social situations.

Women described a large array of health problems that affected them, their loved ones, and their communities. Women were more likely to feel involvement towards these health problems because of their prevalence. Community campaigns and initiatives should assess the health problems with which women are most involved prior to the initiative and work with women to address these issues together through mediated messages and other forms of community communication. By connecting to health problems with which women identify, women may be more likely to engage in the health information.

Building a Model for Empowerment Communication Initiatives

Although this study was conducted with a limited population within a specific community and contextual setting, findings from research with these rural women along with findings from previous literature suggest an emerging model for the process of individual and community empowerment (See Figure 1). Here I offer a description of this proposed model and a discussion of how this model may be useful in health communication campaign theory.

Figure 1. Communicating Empowerment Model



As described in this model of empowerment communication for rural women’s health, religious involvement, social support, and sociodemographic factors appear to affect a variety of individual and community factors, which in turn affect women’s empowerment and health. These findings are supported by prior research and exploratory model development by other authors (e.g., Wallerstein, 1992).

Sociodemographic influences on empowerment. As described in the results, these women’s lived experiences of health and empowerment were affected by their sociodemographic status (i.e., age, income, education, gender, race, etc.). Based upon the research findings, it is suggested here that sociodemographics have an impact on many of the underlying factors that affect empowerment, such as religion,

social support, resource access, etc. While not all sociodemographic factors will be relevant in every setting, these factors may lead to root barriers that prevent empowerment from developing or being cultivated or root facilitators that encourage empowerment processes (such as high income or education).

Religion's influence on empowerment. To elaborate on the above model, religion affects many functions that can lead to empowerment and to health. For example, religion affects the following elements which in turn affect empowerment: social support and social networks, community participation, resource access, perceived constraints, perceived behavioral control, God-mediated control beliefs, knowledge/problem recognition, self efficacy, and health involvement.

As evidenced by this research and by prior literature, religion affects:

- community participation by affecting participation in religious services and programs (George et al., 2000)
- social support and social networks through connections to religious programs and others in the community, reinforcing positive family values and connections (Ellison & George, 1994; George, Ellison, & Larson, 2002; Zuckerman, Kasl, & Ostfeld, 1984)
- resource access as individuals who are in need of financial resources can rely on their church communities often to help them out in times of need (Maton & Wells, 1995)
- control as both perceived behavioral control and external God-control beliefs or God-mediated control—religion often dictates the balance between these two concepts (Hathaway & Pargament, 1991; Krause 2003; 2011)

- perceived constraints, in that religion can reduce women's perceived constraints such as access to medical care, which the church community may assist with (Maton & Wells, 1995)
- self-efficacy, in that women may believe that they are able to perform health actions based upon their religious beliefs and doctrines (George, Ellison, & Larson, 2002)
- knowledge and problem recognition, in that religious beliefs may impact how individuals recognize health problems (George et al., 2000)

To expand more specifically upon how religion affects women's knowledge and problem recognition, for example, religious beliefs may dictate that some types of risky healthy behaviors should not be undertaken. Religion may also negatively affect knowledge or problem recognition by suggesting that some health problems that the medical community would acknowledge as valid are not valid according to religious health beliefs. For example, prominent televangelist Kenneth Copeland frequently uses the example of a "spiritual flu shot" for congregants, stating that a flu shot is not needed, but instead the power of positive thinking, prayer, and faith in God (Copeland, 2009). As he states, congregants should take a spiritual stand against illness and "deny its right to be in your body" for "as long as it takes," encouraging against taking medicine or going to the doctor. While this rhetoric may be empowering for individuals, giving them the belief that they can take a stand for their health with God's help, this may also be dangerous for congregants who are particularly vulnerable to disease and illness, such as older adults and young children. Forgoing taking the flu shot or going to the doctor once sick could have serious health

repercussions for these vulnerable individuals. Extreme amounts of religious empowerment may imbue individuals with a sense that they are invincible.

Social support/social network's influence on empowerment. Social support also influences a variety of factors that influence empowerment and, in turn, influence health outcomes and health behavior. Although social support might be expected to influence community level factors, such as community participation and resource access; social support also has an impact on individual factors and, in turn, individual empowerment. For example, Wallerstein (2006) and others have noted that individual empowerment, although an individual construct, has been linked with a sense of community and social support (Israel et al., 1994).

In this study, through women's social connections, they became aware of health problems and solutions through their social networks, had perceived constraints lowered through support of family, friends, and community members, and perceived greater control when they had the support of family and friends to help them cope or find solutions. Women experienced the benefits of social support through emotional support, instrumental support, informational support, and appraisal support (Heaney & Israel, 2002).

To a lesser degree, women's perceptions of God-mediated control (Krause, 2010) were also influenced by social support and networks, as the cultural norms and values of the area largely included Protestant religious values and beliefs. Even if participants did not consider themselves to be highly religiously involved, they still generally had underlying beliefs about God-mediated control as influenced through their social networks.

Health involvement. Although originally expected to have a more direct influence on women's empowerment, in these research findings women's involvement with their health did not appear to have a direct effect on their empowerment. Women's involvement with their health was often connected to their health behaviors, but this relationship was not always straightforward (represented in the model through a dotted line). For example, women who had experienced serious health problems were likely to take actions regarding these health problems and pay attention to health information that related to these health problems. However, other sociodemographic factors, such as women's ages and often their income level impacted whether women would actually seek health information or engage in preventive or corrective health behaviors. Younger women, even those with serious health problems, were less likely to think about their health routinely or take actions for their health. This effect was magnified when these younger women came from lower income levels and were the caretakers for children or other family members.

Mutual influence of community and individual empowerment. Individual empowerment may also have a direct effect on community empowerment and vice versa. Israel et al. (1994) has suggested that empowerment at the individual level is linked with community empowerment, through encouraging individuals to build the competency and social skills to act and increasing their social support, and community empowerment is linked with individual empowerment through increased individual control and confidence. As findings from this study show, women that participated in their communities through volunteer activities saw themselves as more empowered than women who were not actively involved with programs such as these.

These women volunteers were part of designing and providing services to improve the community and community resources, even though many of these women qualified through their income and life circumstances to receive the services themselves.

Added Value of Photovoice as a Research Method

Photovoice added value to this study by serving as a mechanism to aid in critical discussion of the interview questions and encourage participants to think more deeply about the issues at hand. The photovoice method allowed the women to spend more time thinking about the interview questions and how they would answer these questions through the visual images they saw around them.

Oftentimes the responses elicited from participants through photos mirrored the responses from participants through their stories; women who answered questions via the single interview and women who answered questions through the photovoice method answered the interview questions similarly. However, findings from the photovoice method, where participants had more time on their own away from the researcher to think critically and reflect upon the research questions, served to strengthen the overall data and confirm the other interview findings. Including both data from in-depth interviews and from the photovoice method allowed for an increased richness of data that otherwise would have been difficult to obtain.

Chapter 6—Conclusion

As this research illustrates, health and empowerment is a large, complex phenomena involving women, their communities, social connections, and policies that affect health. Women's individual empowerment was influenced largely through their life experiences, their social position and social connections, and their religious involvement. Physical and structural factors in women's lives were often what left them with feelings of powerlessness in certain health situations.

As noted earlier in the discussion section, the findings from this study revealed a cultural community that affected women's interpretations of health. Participants shared a set of values, beliefs, and everyday actions revolving around their lives in a rural community that often led to a devaluation of health and healthy behavior. This cultural community affected women's empowerment, as well as their health. Women who, from an outsider's perspective, may have seemed to be financially or socially disadvantaged often felt empowered in relation to other community members whom they saw as less empowered than them; this was especially true with women who volunteered in their communities in order to help others who were less fortunate.

A socioecological perspective to empowerment shows how additional levels of influence may affect rural women's empowerment and health. When implementing public health campaigns with rural women, care should be taken not to blame these women for their health problems, but rather to enhance their empowerment by building supportive networks and communities and working to change societal, environmental, and policy factors that may affect these women using

a socio-ecological approach (Sallis & Owen, 2004). Participatory approaches to building campaigns may also help to empower women, allowing them to identify the problems in their own community and work together to change these, with the support of their community members and the campaign facilitators who assist (Balit, 2004; Bergsma, 2004; Wallerstein, 2006).

Limitations of Research Study

This research study sheds light on the lived experiences and meaning making of a small group of women in one rural community. As scholars have shown the need for research on empowerment, religion, and health to be studied within the confines of specific contextual and cultural factors, this study may be better able to take into account environmental factors (Maton & Wells, 1995). However, despite the depth of lived experiences this study is able to show, these results are not generalizable to other research populations or even women from similar life experiences residing in other communities.

Additionally, this study was limited in the conceptualization of efficacy as self efficacy alone. Further research may also be strengthened by considering other elements of efficacy, such as response efficacy (Block & Keller, 1995, 1998; Rogers, 1975; Witte, 1992). Whereas, self efficacy explores individuals' beliefs about their confidence and ability to perform health behaviors, response efficacy explores individuals' beliefs about the ability of the health behaviors to produce the desired outcomes. For example, individuals may feel confident that they could perform a specific preventive health behavior, such as brushing one's teeth; however, individuals may not believe that brushing one's teeth would actually prevent cavities

based upon their other beliefs and life experiences. Exploring both of these elements of efficacy may provide further understanding for why women do not perform health behaviors, even when they have the confidence and empowerment to do so.

Photovoice limitations and challenges. Also this study employed photovoice as an additional research method to explore women's meaning making of empowerment and health. Photovoice as a research method had some limitations, however. Women were hesitant to take pictures because they did not feel like experts or did not feel like they would have anything to contribute by doing so. Much like Collie, Liu, Podsiadlowski, and Kindon (2010) found in their research, women asked questions, such as "What should I take pictures of?" wanting the researcher to provide answers to their questions, prior to them trying to answer the questions on their own through their photos. When using a method such as photovoice, care must be taken to ensure that the participants understand that they are they experts on the topic and that their opinions and voices are valuable and matter. Although photovoice has been described as a method of empowerment (Wright et al., 2010), participants may need to be empowered to a certain degree or become empowered through other research methods, before they feel comfortable becoming the "expert" and taking photos.

Lopez, Eng, Robinson, and Wang (2005) note similar challenges to the photovoice method. As they note, women, when asked to take photos, became passive research subjects and tended to surrender their power in the research process to the researchers. Women assumed that the researchers wanted certain types of photographs or had something specific in mind when researchers explained the photo

assignment; the women participants wanted to please the researchers, so they took pictures of images that they felt the researchers wanted.

The photovoice research process may be improved by devoting time to discussing the concept of photovoice through introductory meetings that stress participants' vital role as partners and experts in the research (Lopez et al., 2005). Prior to taking photos, researchers should ensure that participants feel empowered as "experts" and understand that their expertise in the project is valued and essential to the success of the project. Having follow-up meetings with research participants to discuss the photographs may also help to reveal what the participants were thinking when they took the photos; for example, did the participant take a particular photo because she felt that the researcher expected a photo of this type from her?

Suggestions for Further Research

As this research study represents a limited glimpse into the lived experiences of a particular group of women in one specific research community, future research should be conducted that explores other aspects of women's lives and provides a deeper look. Additionally, research should be conducted with other groups of women in similar and diverse communities to understand if these same theoretical constructs would apply to these women, or if they are unique only to the population studied in this research.

Deeper ethnographic research approaches or true community-based participatory action approaches could help to further understand the factors that affect women's empowerment and women's health and how women make meaning of these factors. Research of this type could help not only to further understanding, but could

also help to empower research participants to identify their own health problems within their community and to begin the process of community empowerment.

Furthermore, to explore community empowerment and how these women make meaning together as part of a larger community, as opposed to their meaning constructed as individuals, focus group research is recommended with groups of women dwelling in communities. Focus groups with women from similar social situations and shared experiences within their communities could help to provide an in-depth look at some of the larger social and environmental factors affecting women's empowerment within communities. For example, focus groups could be conducted with women participating in church organizations, women volunteering at local organizations, women who are in need of community services, women within family units, and women at their workplaces or other community settings. Research with these groups of women would provide valuable insight into community empowerment and perhaps show larger shared social meanings for these women that this research study could not.

Although some limitations were noted with the use of photovoice as a method as noted above, in this study much depth and meaning was derived from participants' stories, suggesting the need for further research in this area. Despite some challenges with the photovoice method in this research, this method has potential to contribute to the knowledge of marginalized populations and provide a unique viewpoint into research participants' lives. Limitations have been noted with other photovoice research studies and methods as well; however, these studies also acknowledge the

potential of photovoice as a method to further community change (Hergenrather et al., 2009).

Another useful exercise, which was not done in this particular study, may be to have follow-up meetings with research participants mid-stream in their photo taking to review and discuss initial photos and ensure that participants still feel empowered as experts to take photos describing their lived experiences. Mid-stream meetings would be easier to conduct if research participants were using digital cameras to take their photos. Logistically, digital cameras may be the easiest way to facilitate a photovoice research project, if research funds and equipment are available; however, in areas where researchers are working with low-income, less-educated, and particularly older populations, disposable cameras may also be helpful for participants who may be uncomfortable with digital camera technology.

Additionally, photovoice research should be further explored for the value that it may add to research studies as a complementary research method. In this research, photovoice was used as one of a combination of research methods to further insight into women's meaning making of health and empowerment. As this research has highlighted, photovoice may further discussion and critical thinking of important concepts and serve as a prompt for increased discussion in in-depth interviews. From a methodological standpoint, future research should also address how findings and results from photovoice method and resulting data are different and distinct from other forms of qualitative research methods.

This study proposed a model for understanding individual and community empowerment for rural women and a discussion of how understanding this process

could inform health communication campaign development. This model should be further explored with other rural women in varied community settings and also explored through other research means, such as a random sample survey or experiment research, to test the relationships of factors presented in this model.

Particularly the construct of involvement in this model should be considered for its relationship to empowerment and other factors that influence empowerment. Based upon the research findings in this study, other factors may exist which moderate the influences of involvement on women's health behaviors and their empowerment.

Contributions to Theory in Health Communication

This study provides a contribution to theory building in health communication by expanding upon existing literature on empowerment, religion, social support, self-efficacy, and control and combining many of these theoretical constructs to create an exploratory theoretical model (see Figure 1, page 215). Previous health communication literature on empowerment has largely been void of consideration of religion and its influence on empowerment, although religion has been studied more for its effects on perceived control and self efficacy (George, Ellison, & Larson, 2002). This model builds upon earlier conceptualizations of empowerment and factors that influence empowerment, such as Wallerstein's (1992) figure on powerlessness and empowerment. However, this model goes beyond others by suggesting additional theoretical constructs, such as religion and social support, which in turn affect a variety of mediating factors including community participation, resource access, perceived constraints, perceived behavioral control, God-mediated

control beliefs, knowledge/problem recognition, self efficacy, and health involvement. This model provides a first attempt at a more comprehensive explanation of the empowerment process and community and individual factors which may be impacted to help individuals and their communities become empowered for positive health actions and outcomes.

Lastly, future research might explore women's self perceptions of their own social positions and social roles and how these impact their empowerment and health. This research explored empowerment through the lens of women's lived experiences and stories, but did not delve into women's self perceptions or ask specific questions about how they viewed themselves. Further research could benefit from understanding how these perceptions in turn affect health and empowerment.

Contributions to the Situational Theory of Publics

Although this study focused most specifically on involvement as one element of the situational theory of publics, results from this study highlighted that other variables in the situational theory of publics were ultimately important for this study as well (Grunig, 1997). Participants in this research made meaning of their empowerment and powerlessness through a variety of factors, some of which being their beliefs about the constraints they encountered (i.e., constraint recognition) and their knowledge and awareness about health problems that impacted them and their loved ones (i.e., problem recognition). Many of these women did not experience "involvement" with their health until they or a loved one had experienced a health problem and they did not stop to think about their health or often seek or process health information until such a health problem occurred.

Findings from this study suggested that involvement was not necessarily connected to women's empowerment, as often the women with the greatest health problems and possibly fatalistic views were those that perceived the most involvement. Women with constrained resources and an overabundance of health problems were more likely to experience feelings of powerlessness, fatalism, and a lack of control. Involvement did appear to influence women's health behaviors to some extent; although, consistent with the situational theory of publics, other factors beyond involvement, such as increased problem recognition and decreased constraint recognition are also needed before women's involvement may move them to action (Aldoory & Sha, 2007; Grunig, 1997).

Implications for Health Communication and Public Relations Campaigns

Findings from this study suggest several practical implications for health communication campaigns with rural women, suggesting these women's preferred sources of health information and communication, key influencers for these women, and ways in which communication campaigns might have a larger community impact, rather than focusing solely on individual behavior change. As described here, a health communication campaign designed to positively affect individual and community empowerment should focus on multiple levels of communication (i.e., individual, organizational, community, and policy levels) (McLeroy et al., 1988; Sallis & Owen, 2004; Wallack, 2000, 2002; Wallack et al., 1993) and should be integrated through multiple channels and sources. These women described being influenced by mass media, their doctors as trusted sources of health information, family and friends, and through their religious leaders and organizations. Health

communication campaigns can work with these sources to help bolster community support and community action. Campaigns should encourage community dialogue about health issues among doctors and patients, peers, family members, and within religious organizations, and should encourage community members to provide support to others within the community.

Additionally, a participatory research action approach to identify the needs within the community, as well as community members' ideas for addressing these needs, may help to empower community members in this process. As Freire has said, the publics, not the health communicators, should define the health problems for their communities and be an active part of working together to address these problems (2008/1974; Bergsma, 2004). The women participating in this research were often hesitant to provide information about their communities, but with encouragement, these women had opinions and ideas they were able to offer about problems they saw in their larger communities and ways they thought they could address these problems.

Additionally, understanding of the emerging theoretical model here describing factors that may influence empowerment and ultimately health, can help public health campaign planners to understand the community resources that should be in place for community members to feel the most empowered to make changes for positive health outcomes. Bolstering access to community resources and social support, while encouraging women to participate in their communities can lead women to a sense of community empowerment. Additionally, increasing women's awareness of and knowledge about health problems, their self efficacy, and perceived control, while lowering women's constraints can help women to develop a sense of individual

empowerment. While involvement is usually something intrinsic that individuals bring with them based upon their life experiences (Aldoory & Sha, 2007; Grunig, 1997), highlighting women's existing connection to health problems that affect women and their communities may also lead to changes in health behavior.

Although this model provides suggestions for ways to help encourage women's empowerment and positive health behavior and possibly remove barriers such as access to resources, empowerment has to come through the participation and interest of the women themselves. As Currie and Wisenberg (2003) have stated, "only women can empower themselves to make their own choices or to speak on their behalf" (p. 896), implying that outside researchers cannot come in and empower women, but rather that women have to empower themselves. Outside researchers and health communicators can, however, assist women in building community capacity, facilitating connections among community members who seek changes, and providing open forums and tools that can be used by community members to address their own problems.

Often the adoption of evidence- and theory-based practices for health communication can be a slow, cumbersome process, taking much time and effort to realize actual change in practice. For example, encouraging doctors to talk to community members may require time to reach medical institutions and encourage doctors to speak with patients; doctors would then ultimately have limited time to speak with patients during their visits and doctors may see patients only once a year. In rural locations, doctors may see patients even less frequently, medical

recommendations may be slower to become adopted by rural doctors, and rural doctors are often overbooked and overworked, as highlighted in this study.

Several recommendations from this study; however, should be feasible recommendations that might be implemented into health communication practice more expediently. Two such recommendations that might be feasible for more immediate implementation are: 1) working with faith-based organizations and religious programs to incorporate a focus on health and empowerment that faith-based leaders help to design and plan and 2) implementing participatory approaches to health communication campaign planning. Although the field has certainly come a long way in theorizing regarding participatory approaches to health communication campaigns, practice is still severely lacking in adoption of these participatory approaches. This study accumulated further evidence for the importance of these participatory approaches and contributes to the growing body of evidence suggesting the need for a greater shift in thinking about campaign approaches. A participatory approach should incorporate community members from the very beginning of conceptualizing campaign planning and message design. Community members should help to initially identify community problems, identify approaches for working towards addressing these problems, and work with campaign planners to implement these approaches in their own communities.

Appendix A.1—Semi-structured In-depth Interview Guide: Single Interview

Guide for women who do not agree to participate using a disposable camera

Introduction and Basic Points

Good [morning/afternoon/evening], my name is _____, and I am a graduate student at the University of Maryland, College Park. Thank you for agreeing to talk with me today. Before we get started, I would like to share with you the purpose of this interview, which is to talk about health. I would like to ask you a few questions specifically about your thoughts and opinions about your health. Your answers will help me to understand about health perceptions.

(Repeat these points as necessary if individuals have questions about the consent forms they have signed)

- There are no right or wrong answers. I only want to know your thoughts and opinions, and every opinion is valuable.
- Your participation in this interview is completely voluntary. You may choose to skip a question or stop the interview at any time and for any reason with no penalty, especially if you feel uncomfortable with the question or subject. Your information will stay secure. I will not share your personal information, including your name, with anyone other else. Your name will not be linked to the information that you provide during the interview.
- *(If agreed to be audiotaped in consent form)* This interview is being tape-recorded in case I need to listen to it later to clarify something from the notes. This tape recording will not be shared with others and will be destroyed at the end of this research.
- The interview will take no more than an hour and a half.
- You will receive a \$20 gift card for participating in this interview.
- Do you have any questions before we begin?

Just to warm-up, could you please tell me a bit about yourself, for example, how long you have been living in this area?

Opening

I'd next like to ask some general questions about you.

1. Could you tell me a bit about what one typical day of the week is like for you?

- a. *Probe:* Could you recall what you did yesterday? Yesterday morning, lunch time, afternoon, evening?
2. What do you like to do in your free time?
 - a. *Probe:* How often do you feel you have “free” time?

Next I’d like to ask you about your family.

3. Could you describe for me your family and your relationship with your family?

I’d also like to ask about your community.

4. Could you describe for me your relationship with others in your community?
 - a. *Probe:* Do you participate in any organizations in your community? Could you describe these?
 - b. *Probe:* (If necessary) How about organizations such as church, activities related to your children’s schools, workplaces, etc.?
 - c. *Probe:* (If necessary) How would you describe your relationship with your neighbors and others that live near you?

Thinking about Health

Next, I’d like to begin talking about how you think about health.

1. To get us started thinking about health, please take a few moments and recall your most recent family health situation. Could describe this for me?
 - a. *Probe:* What did you do in this situation? What was your role?
 - b. *Probe:* Can you recall your thoughts during this time?
 - c. *Probe:* (If necessary) How did this situation make you feel?
 - d. *Probe:* How did you know what to do in this situation?
 - e. *Probe:* (If necessary) Where did you get your information from?

(If the health situation did not involve them...)

2. Could you recall a time in your life when you have been particularly concerned about your own health?

- a. *Probe:* Why was this a concern for you?
- b. *Probe:* How did you feel about this?
- c. *Probe:* What actions did you take? Why or why not?

Now I'd like to ask some more general questions about your health?

- 3. How would you describe your health in general?
 - a. *Probe:* What are some of the "healthy" things that you do?
 - b. *Probe:* What are the healthy things you do every day?
- 4. What does the word "health" mean to you?
 - a. *Probe:* When you think about your health, what comes to mind?
- 5. How important is your health to you?
 - a. *Probe:* How connected do you feel to the idea of "health"?
 - b. *Probe:* How have your thoughts about your health changed over time?
 - c. *Probe:* What about your health is important to you today?
- 6. What, do you believe, influences your health?
 - a. *Probe:* What do you believe influences the way you feel about your health?
 - b. *Probe:* What are some other things around you that might affect your health?
 - c. *Probe:* What are some things that encourage you to be healthy?
 - d. *Probe:* What are some things that may prevent you from taking steps towards healthier behaviors?
- 7. How would you describe the health of your family?
 - a. *Probe:* What types of "healthy" things does your family do?
- 8. What do you think are the health problems that most affect your community?
 - a. *Probe:* How do these health problems impact you personally?

- b. *Probe:* How do you think these health problems could be addressed?

Communication about Health: Campaigns

Next I'd like to talk about the information about health that you might see around you. I'd like for you to take a few moments and think about any information about health might have seen or heard on television, the radio, on the internet, in magazines or newspapers, or other places in your community recently.

1. Can you recall any information about health you might have seen or heard that made you want to do something about your health?
 - a. *Probe:* Can you describe this information?
 - b. *Probe:* How did these messages make you want to do something about your health?
2. Can you recall any information about your health you might have seen or heard that **did not** make you want to do anything about your health?
 - a. *Probe:* Can you describe this information?
 - b. *Probe:* What about this message didn't make you want to do anything about your health?
3. What kinds of information would you most like to see/hear in messages about health problems that most affect you or your community?
 - a. *Probe:* How could these messages encourage you to make changes for your health?
 - b. *Probe:* Is there anything missing from health messages that you would like to see? If so, what?
4. If you needed information about your health, where would you go?
 - a. *Probe:* Where do you usually find health information?
 - b. *Probe:* Which sources of health information do you trust the most?

Empowerment, Perceived Behavioral Control, and Efficacy

Still thinking about your health, let's talk about a few health issues.

1. How much do you think you are in control of your dental health or the care of your teeth and gums?

- a. *Probe:* Do you think you could do anything personally to improve your dental care? Why or why not?
 - b. *Probe:* What could you do specifically to improve your dental health?
 - c. *Probe:* Do you think you could do anything personally to prevent or reduce your risks of dental problems? Why or why not?
 - d. *Probe:* What could you do specifically to reduce your risk?
2. Thinking about the health issues we talked about earlier, you mentioned you were concerned about [*insert health issue*]. How much do you think you are in control of [*insert health issue*]?
- a. *Probe:* Do you think you could do anything personally to improve [*insert health issue*]? Why or why not?
 - b. *Probe:* What could you do specifically to improve [*insert health issue*]?
 - c. *Probe:* Do you think you could do anything personally to prevent or reduce your risks of [*insert health issue*]? Why or why not?
 - d. *Probe:* What could you do specifically to reduce your risk?
3. Thinking about your overall health, how much do you think you are in control of your own health?
- a. *Probe:* Do you think you could do anything personally to improve your health? Why or why not?
 - b. *Probe:* What could you do specifically to improve your health?
 - c. *Probe:* Do you think you could do anything personally to prevent or reduce your health risks? Why or why not?
 - d. *Probe:* What could you do specifically to reduce your risk?
 - e. (Probe if necessary for specific health actions, such as: eating healthy, regularly visiting the doctor, dental care, stress and mental health, hygiene, substance use, etc.)
4. Could you share with me any stories about others you might know of who have “taken control” over their health?
- a. *Probe:* (*If yes to above question*) Who? What have they done?

- b. *Probe: (If yes to above question)* Could you also see yourself doing similar activities? Why or why not?
- 5. How confident are you in your ability to know what to do to improve your health?
 - a. *Probe:* Why do you say that?
 - b. *Probe: (If they feel confident)* What has helped you to feel confident?
 - c. *Probe:* What do you think might help you to feel more confident?
- 6. Thinking back to our earlier discussion of health messages, how do you think messages about your health could help you to increase your sense of control over your health?

Religiosity

I'd now like to ask you a few questions about your views on religion.

- 1. How would you describe your connection to religion?
 - a. *Probe:* Please describe any religious organizations/events you participate in.
- 2. How do you think religion affects your health?
 - a. *Probe:* Why do you say this?
 - b. *Probe:* Could you provide any examples?

Closing

We have reached the end of the questions I have prepared for our talk today. Is there anything about your health that you feel I left out or did not ask about that you feel would be important for me to know?

Thank you for taking the time to talk with me today. Would you be willing to be contacted again in the future should I need to conduct a follow-up interview at a later date?

For more information about easy steps you can take to improve your health, I have a few materials you can take with you (*will have printed copies of:*
<http://www.cdc.gov/family/tipsgen.pdf>, <http://www.ahrq.gov/ppip/healthywom.pdf>,
<http://www.ahrq.gov/qual/beprepared.pdf>,

http://www.cdc.gov/family/minutes/five_minutes.pdf,
<http://www.womenshealth.gov/pub/pg.cfm>).

You can also visit the Centers for Disease Control and Preventions' website on health tips for you and your family at: <http://www.cdc.gov/family/tips>.

Appendix A.2—Semi-structured In-depth Interview Guide: Two-part Interview

Guide for women who agree to participate using a disposable camera

Interview 1

Introduction and Basic Points

Good [morning/afternoon/evening], my name is _____, and I am a graduate student at the University of Maryland, College Park. Thank you for agreeing to talk with me today. Before we get started, I would like to share with you the purpose of this interview, which is to talk about health. I would like to ask you a few questions specifically about your thoughts and opinions about your health. Your answers will help me to understand about health perceptions.

(Repeat these points as necessary if individuals have questions about the consent forms they have signed)

- There are no right or wrong answers. I only want to know your thoughts and opinions, and every opinion is valuable.
- Your participation in this interview is completely voluntary. You may choose to skip a question or stop the interview at any time and for any reason with no penalty, especially if you feel uncomfortable with the question or subject. Your information will stay secure. I will not share your personal information, including your name, with anyone other else. Your name will not be linked to the information that you provide during the interview.
- *(If agreed to be audiotaped in consent form)* This interview is being tape-recorded in case I need to listen to it later to clarify something from the notes. This tape recording will not be shared with others and will be destroyed at the end of this research.
- *(If agreed to use disposable camera in consent form)* As we discussed earlier, this is the first of two interviews we will have. At the end of our discussion today, I will give you a disposable camera and we will arrange a way for you to drop the camera off or for me to pick the camera up from you before our next interview.
- This first interview will take no more than half an hour. Our second interview will take around an hour.
- You will receive a \$10 gift card for participating in our interview today. You will receive a \$20 gift card and a small gift bag at our follow-up meeting.
- Do you have any questions before we begin?

Just to warm-up, could you please tell me a bit about yourself, for example, how long you have been living in this area?

Opening

I'd next like to ask some general questions about you.

1. Could you tell me a bit about what one typical day of the week is like for you?
 - a. *Probe:* Could you recall what you did yesterday? Yesterday morning, lunch time, afternoon, evening?
2. What do you like to do in your free time?
 - a. *Probe:* How often do you feel you have "free" time?

Next I'd like to ask you about your family.

3. Could you describe for me your family and your relationship with your family?

I'd also like to ask about your community.

4. Could you describe for me your relationship with others in your community?
 - a. *Probe:* Do you participate in any organizations in your community? Could you describe these?
 - b. *Probe:* (If necessary) How about organizations such as church, activities related to your children's schools, workplaces, etc.?
 - c. *Probe:* How would you describe your relationship with your neighbors and others that live near you?

Thinking about Health

Next, I'd like to begin talking about how you think about health.

1. To get us started thinking about health, please take a few moments and recall your most recent family health situation. Could describe this for me?
 - a. *Probe:* What did you do in this situation? What was your role?
 - b. *Probe:* Can you recall your thoughts during this time?
 - c. *Probe:* (If necessary) How did this situation make you feel?

- d. *Probe:* How did you know what to do in this situation?
- e. *Probe:* (If necessary) Where did you get your information from?

(If the health situation did not involve them...)

- 2. Could you recall a time in your life when you have been particularly concerned about your own health?
 - a. *Probe:* Why was this a concern for you?
 - b. *Probe:* How did you feel about this?
 - c. *Probe:* What actions did you take? Why or why not?

Now I'd like to ask some more general questions about your health?

- 3. How would you describe your health in general?
 - a. *Probe:* What are some of the "healthy" things that you do?
 - b. *Probe:* What are the healthy things you do every day?
- 4. How important is your health to you?
 - a. *Probe:* How connected do you feel to the idea of "health"?
 - b. *Probe:* How have your thoughts about your health changed over time?
 - c. *Probe:* What about your health is important to you today?
- 5. How would you describe the health of your family?
 - a. *Probe:* What types of "healthy" things does your family do?
- 6. What do you think are the health problems that most affect your community?
 - a. *Probe:* How do these health problems impact you personally?
 - b. *Probe:* How do you think these health problems could be addressed?

We have reached the end of the questions I have prepared for our talk today. Is there anything about your health that you feel I left out or did not ask about that you feel would be important for me to know at this time?

As mentioned earlier, to prepare for our second interview I would like to give you this disposable camera. Between now and our next interview, I would like for you to take some pictures of things that influence your health; please use the sheet with the camera as a guide for your picture taking (*go over the guidelines as listed below*). As mentioned in the consent form you received, these pictures will not be published or shared with others, but instead will be used to aid our next discussion and the writing of my research report.

I'd like to go ahead and schedule our next meeting time. I will be available the week of _____. Are there any times this week that would be good for you to meet?

Guidelines for picture taking (*to be handed to participants*)

Answer as many of the following questions as you can through photos. Pictures can be of people, places, items, media, or anything else that is appropriate. These pictures will not be made public for others to see.

1. What influences your health?
2. What does the word "health" mean to you?
3. What makes you want to be "healthy"?
4. What prevents you from being "healthy"?
5. What about your health is important to you?
6. Where do you usually find health information?

Your camera will take 24 pictures total. For each question, you may take anywhere from 1 to 4 pictures.

When you are done with your camera, please place this in the envelope provided and return to the agreed upon location listed on the envelope.

Interview 2

Introduction and Basic Points

Thank you for meeting with me again. Today, I'd like to ask you a few more questions about your health and talk about the photos you took since we last met. As before, I'd like to audiotape our interview for note-taking purposes. Is this still okay? As a reminder, your participation in this interview is completely voluntary. You may skip a question or stop the interview at any time and for any reason with no penalty,

especially if you feel uncomfortable with the question or subject. At the end of our interview, you will receive a \$20 gift card and a small gift bag of food items.

Camera Activity

First, let's talk about the pictures you took, using the questions you were given as a guide for our discussion.

The first question was:

1. What, do you believe, influences your health?
 - a. *Probe:* Can you explain what you were thinking when you took these photos?
 - b. Is there anything else you would like to add, about what influences your health?
 - c. *Probe:* What do you believe influences the way you feel about your health?
 - d. *Probe:* What are some other things around you that might affect your health?

The second question was:

2. What does the word "health" mean to you?
 - a. *Probe:* Can you explain what you were thinking when you took these photos?
 - b. Is there anything else you would like to add, about what health means to you?
 - c. *Probe:* When you think about your health, what comes to mind?

The third question was:

3. What makes you want to be "healthy"?
 - a. *Probe:* Can you explain what you were thinking when you took these photos?
 - b. Is there anything else you would like to add about what makes you want to be "healthy"?

- c. *Probe:* What are some things that encourage you to be healthy?

The fourth question was:

- 4. What prevents you from being “healthy”?
 - a. *Probe:* Can you explain what you were thinking when you took these photos?
 - b. *Probe:* Is there anything else you would like to add about what prevents you from being “healthy”?
 - c. *Probe:* What are some things that may prevent you from taking steps towards healthier behaviors?

The fifth question was:

- 5. What about your health is important to you?
 - a. *Probe:* Can you explain what you were thinking when you took these photos?
 - b. Is there anything else you would like to add about what about your health is important to you?

The sixth question was:

- 6. Where do you usually find health information?
 - a. *Probe:* Can you explain what you were thinking when you took these photos?
 - b. Is there anything else you would like to add about what about where you usually find health information?
 - c. *Probe:* If you needed information about your health, where would you go?
 - d. *Probe:* Which sources of health information do you trust the most?

Communication about Health: Campaigns

Next I'd like to talk about the information about health that you might see around you. I'd like for you to take a few moments and think about any information about health might have seen or heard on television, the radio, on the internet, in magazines or newspapers, or other places in your community recently.

1. Can you recall any information about health you might have seen or heard that made you want to do something about your health?
 - a. *Probe:* Can you describe this information?
 - b. *Probe:* How did these messages make you want to do something about your health?
2. Can you recall any information about your health you might have seen or heard that **did not** make you want to do anything about your health?
 - a. *Probe:* Can you describe this information?
 - b. *Probe:* What about this message didn't make you want to do anything about your health?
3. What kinds of information would you most like to see/hear in messages about health problems that most affect you or your community?
 - a. *Probe:* How could these messages encourage you to make changes for your health?
 - b. *Probe:* Is there anything missing from health messages that you would like to see? If so, what?

Empowerment, Perceived Behavioral Control, and Efficacy

Still thinking about your health, let's talk about a few health issues.

1. Thinking about the health issues we talked about earlier, you mentioned you were concerned about [*insert health issue*]. How much do you think you are in control of [*insert health issue*]?
 - a. *Probe:* Do you think you could do anything personally to improve [*insert health issue*]? Why or why not?
 - b. *Probe:* What could you do specifically to improve [*insert health issue*]?
 - c. *Probe:* Do you think you could do anything personally to prevent or reduce your risks of [*insert health issue*]? Why or why not?
 - d. *Probe:* What could you do specifically to reduce your risk?
2. Thinking about your overall health, how much do you think you are in control of your own health?

- a. *Probe:* Do you think you could do anything personally to improve your health? Why or why not?
 - b. *Probe:* What could you do specifically to improve your health?
 - c. *Probe:* Do you think you could do anything personally to prevent or reduce your health risks? Why or why not?
 - d. *Probe:* What could you do specifically to reduce your risk?
 - e. *(Probe if necessary for specific health actions, such as: eating healthy, regularly visiting the doctor, dental care, stress and mental health, hygiene, substance use, etc.)*
3. Could you share with me any stories about others you might know of who have “taken control” over their health?
 - a. *Probe: (If yes to above question) Who? What have they done?*
 - b. *Probe: (If yes to above question) Could you also see yourself doing similar activities? Why or why not?*
4. How confident are you in your ability to know what to do to improve your health?
 - a. *Probe:* Why do you say that?
 - b. *Probe: (If they feel confident) What has helped you to feel confident?*
 - c. *Probe:* What do you think might help you to feel more confident?
 5. Thinking back to our earlier discussion of health messages, how do you think messages about your health could help you to increase your sense of control over your health?

Religiosity

I'd now like to ask you a few questions about your views on religion.

1. How would you describe your connection to religion?
 - a. *Probe:* Please describe any religious organizations/events you participate in.
2. How do you think religion affects your health?
 - a. *Probe:* Why do you say this?

- b. *Probe:* Could you provide any examples?

Closing

We have reached the end of the questions I have prepared for our talk today. Is there anything about your health that you feel I left out or did not ask about that you feel would be important for me to know?

Thank you for taking the time to talk with me today.

For more information about easy steps you can take to improve your health, I have a few materials you can take with you (*will have printed copies of:*

<http://www.cdc.gov/family/tipsgen.pdf>, <http://www.ahrq.gov/ppip/healthywom.pdf>,

<http://www.ahrq.gov/qual/beprepared.pdf>,

http://www.cdc.gov/family/minutes/five_minutes.pdf,

<http://www.womenshealth.gov/pub/pg.cfm>).

You can also visit the Centers for Disease Control and Preventions' website on health tips for you and your family at: <http://www.cdc.gov/family/tips>.

Appendix B—Interview Invitation Script
(via phone call, email, or in-person)

Hello. My name is Lucinda Austin. I am a graduate student in the Communication department at the University of Maryland. As part of my graduate program, I am conducting confidential interviews with women living in rural areas to discuss their perceptions about health and their everyday health activities. I received your contact information from [*State community center, if appropriate. If from another participant, state “from another individual in your community who has participated in this research.”*]

Your participation in the interviews is important to help understand the barriers to health that rural women face. If you are interested in participating, the interview will be conducted in person and will last approximately 1 ½ hours. Your participation in this interview is completely voluntary and all information you give me will be kept confidential. If you choose to participate in this research, you will receive a \$20 gift card to a local grocery store of your choosing and a gift bag of assorted food items. Would you be interested in participating?

[*If no...*] Thank you for your consideration. If you should decide later you would like to participate, you may reach me at 540-998-3849 or my email at llaustin@umd.edu. Thank you again.

[*If yes...*] I will be visiting your area the week of XXXX. Would you be available at any point during this week to meet for an interview? If so, what time is most convenient for you? What location would be most convenient for you? I could come to your home or we could meet somewhere in the community that would be convenient to you, such as [*name community centers or other locations that would be convenient to participants and offer privacy for the interview*].

When we meet, I will provide you with a form stating the details of the interview and the research report and whom you can contact with any questions. I will also ask that you sign a form granting me permission to audiotape our interview for note-taking purposes.

I would like to send you a confirmation for our interview. Could you please tell me your email address and/or mailing address to send you a confirmation?

Thank you very much for agreeing to participate in this research. If you should have any questions or concerns prior to our interview, you may reach me via phone at 540-998-3849 or via email at llaustin@umd.edu.

Thank you.

[*If she expresses any concern over confidentiality, I can explain to her that she can even provide me with a pseudonym, if she is comfortable with that. I will explain my process of storing, destroying, and reporting data, if I feel she is*

pressured by the issues of confidentiality. I will also let her know that she may stop participating in the interview at any point if she feels uncomfortable.]

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Appendix C—IRB Application and Consent Form

Principal Investigator/ Project Faculty Advisor <i>(NOT a student or fellow)</i>	Dr. Linda Aldoory	Email Address	laldoory@umd.edu
		Telephone Number	301-405-6528

Student Investigator	Lucinda Austin	Email Address	llaustin@umd.edu
		Telephone Number	540-998-3849

Project Title	Rural Women’s Perceptions of Health
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Department/ Unit Administering the Project	Communication Department
Where to send Approval Documents	Dr. Linda Aldoory 2130 Skinner Building University of Maryland
Check if this is	Student master’s thesis <input type="checkbox"/> OR Dissertation research project <input checked="" type="checkbox"/>

Funding Agency(s)	N/A
ORAA Proposal ID Number	N/A

Target Population: The study population will include (Check all that apply): N/A

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> pregnant women | <input type="checkbox"/> neonates | <input type="checkbox"/> individuals with mental disabilities |
| <input type="checkbox"/> minors/children | <input type="checkbox"/> prisoners | <input type="checkbox"/> individuals with physical disabilities |
| <input type="checkbox"/> human fetuses | <input type="checkbox"/> students | |

Exempt (Optional): You may suggest this protocol meets the requirements for Exempt Review by checking the box below and listing the Exempt category(s) that may apply. Please refer to the Exempt Category document for additional information.

Exemption Category(s):
Rationale:

Date **Signature of Principal Investigator [REQUIRED]**

Date **Signature of Co-Principal Investigator**

Date **Signature of Student Investigator**

Date **Signature of IRB Liaison/Department Chair [REQUIRED]**

Print Name _____
Title _____
(Please print name of IRB Liaison/Department Chair)

Rural Women's Perceptions of Health

1. Abstract:

The purpose of this study is to explore how empowerment theory can be incorporated into health communication campaigns and media messages to influence rural women's everyday health activities. This study will explore in greater depth how rural women make meaning of empowerment and how their views of empowerment affect their health and their engagement with health campaigns. Exploring these questions can contribute to larger theory development that includes empowerment as a construct of health communication theories and public health campaigns. Additionally, findings from this research study may be used to understand how to empower rural women to improve their health, and how intersectional and ecological approaches to data collection and analysis can further understanding of the notion of empowerment.

Up to 75 in-depth interviews with rural women will be conducted to explore these women's meaning making of health and empowerment. No deception will be involved and all participants interviewed will be at least 18 years of age. Interviews will be in person and will be audio-tape recorded. Women will have the option to decline being audio-tape recorded; participants who decline audio taping will still be included in the study. All participants will be rural women as defined by U.S. Census Rural Urban Commuting Area Codes, will reside in the United States, and will be recruited through convenient and purposive means. Standard methods to protect privacy will be maintained. The identities of participants will remain confidential.

2. Subject Selection:

a. Participants will be rural women residing in the U.S. who will be referred by community health centers, health workers at universities and other community locations, and by other individuals in the study through snowball sampling. Most participants will reside in southern Virginia, southern West Virginia, and rural Maryland. Other participants may include residents of rural Louisiana, Mississippi, and Colorado, depending on access. Individuals will be phoned and asked if they are willing to participate in the study (see attached script as a supporting document). The nature of the project and their potential participation will be explained. If participants are willing, a time and place convenient to them will be set up, where an informed consent form will be signed by them before the interview begins.

b. All participants will be over the age of 18 and able to live independently in their homes. "Rural" will be defined by U.S. Census Rural Urban Commuting Area Codes and the zip codes of the women living in these rural communities. Candidates will not be chosen according to any specific racial, ethnic, religious, social, or economic characteristics; although, a mix of these characteristics is desired.

c. Diverse participants are desired, as in maximum variation sampling, to ensure that a variety of voices are heard through the research. However, because this is a convenience, snowball sampling method, participants will not be specifically recruited for characteristics beyond living in "rural" areas. "Rural" women are desired for the research because they face unique health challenges due to the rural settings in which they live, and little is known about how to empower these women.

d. A maximum of 75 participants will be interviewed.

3. Procedures:

Participants will be interviewed for approximately 1 ½ hours on one occasion. Before the interview begins, participants will be informed of the study and read the informed consent form. Participants will be informed of the interviewer's wish to audiotape the interviews for purposes of accuracy and note-taking; however, participants will have the right to decline being taped. After participants sign the consent form, the interview will begin. An semi-structured interview guide (see Appendix) of open-ended questions will be used by the student researcher, who will conduct interviews in person. While the interviews will have some formal questions regarding specific theoretical concepts, much of the questioning will depend on the actual interview candidates. After stating the area of discussion, the interviewees will be encouraged to continue speaking on areas of interest or knowledge to them, unless the interviewees stray from the research topic.

4. Risks:

This study presents limited risks to participants. Interviews will be audio-taped, which may threaten the anonymity of participants; however, in all interviews, the identities of participants will remain confidential and audio files will be stored in a secure location. Additionally, participants may feel uncomfortable discussing their health or specific health problems they have had in the past. Participants will be told that their participation is voluntary and that they can decline to answer specific questions or to end their participation at any time without penalty.

5. Benefits:

Participants will receive several benefits for participating in this research. Each woman who is interviewed will receive a \$20 gift card to their favorite grocery store, a gift bag of assorted healthy snacks, and information about small steps they can take to improve their health and local resources available to them. In addition to the direct benefits participants will receive, participants may receive a variety of indirect benefits. Results of this research may help the investigators learn more about how public health campaigns can help to empower rural women to improve their health. This research should also add to the current body of knowledge on empowerment and rural women's health. Lastly, when possible, the researchers plans to coordinate donations of money, food, clothing, and other supplies to local community centers serving women in the rural areas where the research is conducted. These donations may not directly impact the participants, but may help the overall communities in which these rural women live.

6. Confidentiality:

Standard methods to protect privacy will be maintained at all times. The identities of participants will remain confidential. Signed consent forms will be stored separately from data so participants' identities cannot be tied back to responses. Only the Principal Investigator and the Student Investigator will have access to the names of participants. Pseudonyms will be used for participants, and data, including the audio recordings and digital transcripts, will be securely stored in the Principle Investigator's locked office in a password protected file on her office computer and home computer. Hard copies of data, such as the consent forms, will remain in the Principal Investigator's file cabinet in the locked office. All data will be destroyed (i.e., shredded or erased) when use is no longer needed but not before a minimum of five years after collection.

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7. Consent Process:

Potential participants will be provided a brief summary of the research requesting their participation and informed consent forms (see Appendix). There is no deception in the information, which will be presented in plain language. Standard UMD consent forms will be used—the informed consent form will contain information about the study, the investigators, participants' rights, and contact information for the Principal and Student Investigators. Participants will be informed that participation is voluntary. All participants will receive a copy of the consent form for their records. Participant privacy will be guaranteed by asking for consent and holding the interviews in a private area away from others.

8. Conflict of Interest:

There is no conflict of interest.

9. HIPAA Compliance:

Not applicable.

10. Research Outside of the United States:

Not applicable.

11. Research Involving Prisoners:

Not applicable.

SUPPORTING DOCUMENTS

Each copy of the application must include the IRB application cover sheet, the information required in items 1-11 above, and all relevant supporting documents including: consent forms, letters sent to recruit participants, questionnaires completed by participants, and any other material that will be presented, viewed or read to human subject participants.

For funded research, a copy of the Awarded Grant Application (minus the budgetary information) must be included. If the Grant has not been awarded at the time of submission of this Initial Application, a statement must be added to the Abstract Section stating that an Addendum will be submitted to include the Grant Application once it has been awarded.

NUMBER OF COPIES

Please send 1 original application including the signed cover sheet to:

**IRB Office
0101 Lee Building
College Park, MD 20742-5125**

Project Title	<i>Rural Women’s Perceptions of Health</i>
Purpose of the Study	<i>This research is being conducted by Dr. Linda Aldoory, Principal Investigator, and Student Investigator, Lucinda Austin, a PhD student at the University of Maryland, College Park. We are inviting you to participate in this research project because you are at least 18 years of age and reside in a rural area. The purpose of this research project is to explore how rural women view their health and the health of their communities. This research may be used to help improve the health of women in rural communities.</i>
Procedures	<i>The interview involves a face-to-face conversation that will be audio recorded. The time of the interview will vary depending on the answers, but will be about one and a half hours long. Questions will focus on topics such as your day-to-day activities, how you view health and the health of your family, and information about health you have noticed in your community. By participating in this research, you will receive a \$20 gift card to a local grocery store of your choosing and a gift bag of assorted healthy snacks.</i>
Potential Risks and Discomforts	<i>There may be some risks from participating in this research study, such as feeling uncomfortable answering questions about your health. If at any time in the interview you feel uncomfortable, you may opt not to answer the questions or discontinue the interview. Also, there is a potential for the loss/breach of confidentiality should the data somehow become compromised, although data will be protected to the full extent possible.</i>
Potential Benefits	<i>The benefits to you include receiving information about how you can take small steps to improve your health. We hope that, in the future, other people might benefit from this study through improved understanding of the barriers that rural women face in regards to their health.</i>
Confidentiality	<i>We will do our best to keep your personal information confidential. To help protect your confidentiality, your identity will not be revealed in this research. Through the use of an identification key, only the researchers will be able to link your identity to your data, and only the researchers will have access to the identification key. If a report or article is written about this research project, your identity will be protected to the maximum extent possible. Your information may be shared with representatives of the University of Maryland, College Park or governmental authorities if you or someone else is in danger or if we are required to do so by law. <i>This research project involves making audiotapes of the interview that will be made solely for the purposes of transcription. Only the interviewers will have access to these tapes and they will be destroyed after information has been gathered and within the next five years.</i></i>

	<p>___ I agree to be audiotaped during my participation in this study.</p> <p>___ I do not agree to be audiotaped during participation in this study.</p>	
<p>Right to Withdraw and Questions</p>	<p><i>Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.</i></p> <p><i>If you have questions, concerns, or complaints related to the research, please contact the investigators: Dr. Linda Aldoory at 301-405-6528, laldoory@umd.edu, or Lucinda Austin at 540-998-3849, llaustin@umd.edu. Either investigator can also be reached at the address: 2130 Skinner Building, University of Maryland, College Park, MD 20724.</i></p>	
<p>Participant Rights</p>	<p><i>If you have questions about your rights as a research participant or wish to report a research-related injury, please contact:</i></p> <p align="center"> University of Maryland College Park Institutional Review Board Office 0101 Lee Building College Park, Maryland, 20742 E-mail: irb@umd.edu Telephone: 301-405-0678 </p> <p><i>This research has been reviewed according to the University of Maryland, College Park IRB procedures for research involving human subjects.</i></p>	
<p>Statement of Consent</p>	<p><i>Your signature indicates that you are at least 18 years of age; you have read this consent form or have had it read to you; your questions have been answered to your satisfaction and you voluntarily agree to participate in this research study. You will receive a copy of this signed consent form.</i></p> <p><i>If you agree to participate, please sign your name below.</i></p>	
<p>Signature and Date</p>	<p>NAME OF SUBJECT [Please Print]</p>	
	<p>SIGNATURE OF SUBJECT</p>	
	<p>DATE</p>	

Appendix C.2—IRB Addendum and Revised Consent Form

UNIVERSITY OF MARYLAND COLLEGE PARK
 Institutional Review Board
Addendum Application

Protocol Number	10-0728
Protocol Title	Rural Women's Perceptions of Health
Risk Classification (<i>check one</i>)	<input type="checkbox"/> Greater than Minimal Risk <input checked="" type="checkbox"/> Minimal Risk

Principal Investigator	Dr. Linda Aldoory	Email Address	laldoory@umd.edu
Address for Approval Letter	2130 Skinner Building University of Maryland	Telephone Number	301-405-6528

Student/Co-Investigators	Lucinda Austin	Email Address	llaustin@umd.edu
Telephone Number	540-998-3849		

To ensure an accurate and streamlined review of your Addendum Application, please provide the following information:

- 1) State what is being proposed and where in the protocol and/or consent what was changed.

This addendum proposes that research participants be given the option to participate in a single interview (as approved in the original IRB) or a series of two shorter interviews where the participants would receive a slightly larger stipend and would be asked to take pictures prior to the second interview of things that affect their health and how they make meaning of health. If participants chose to participate in two interviews and take pictures, they would be given a disposable camera at the end of the first interview and asked to return the camera prior to the second interview. The researchers would develop the film prior to the second interview and the pictures would be discussed during the second interview. Pictures would later be used in data analysis/reporting, but pictures would not be published or made publicly available to help protect participant's identities in the event that participants take pictures of places or people that may be identifiable. Pictures would be stored in the researchers' locked offices in a locked file cabinet and would be destroyed after the research was complete.

2) Provide the rationale/justification for the change.

These changes have been made because the dissertation research committee believed that allowing participants to take photos of factors that influence their health will allow the researchers to better see women's meaning making and perspectives through their own eyes.

3) State what impact the change has on risks to participants. Please state the number of currently enrolled participants and if the change in risk will require re-consent. If the changes will not require re-consent, please state why.

Addition of cameras does have some change in risk as participants may take photos of objects or people that may be identifiable and may link the data back to the participants. To safe guard against this, researchers will not publish the photos, which will only be used to guide the interview discussion and used in data analysis and reporting. Actual photos will be stored in a locked file cabinet in a locked office and destroyed once the research project is completed. No participants are currently enrolled, so re-consent will not be required.

4) State whether the change has an impact on the scientific integrity of the study, (i.e. decreases, increases, no impact).

This change in data collection should increase the scientific integrity of the study. Allowing participants to take time to think through issues affecting their health before the follow-up interview should ensure that responses have been more carefully thought out. The addition of cameras to research is an innovative technique that lends more context to participants' responses and helps the researchers to see problems through the participants' eyes.

5) List the documents included with the application that have been modified (consent forms, flyers, data collection forms, surveys). State what has been changed in each modified document.

The following modified documents have been included with this form: consent forms, recruiting script, and interview guides. In addition, a new document has been added: picture taking instructions.

- The consent forms have been modified to ask if participants agree to take a camera to take pictures with and extra information has been added about measures to safeguard picture data. Participants have the option to refuse to take pictures.
- The recruiting script has been modified to ask if participants would be willing to participate in a two-part interview and take a camera to take pictures with.
- The interview guide has been modified into two versions: one version is the same as the original IRB; the other has been split into a two-part interview, with some questions in the first interview and the remainder of questions as well as an activity discussing the photos in the second interview. Only the new two-part interview guide has been provided here.
- The picture taking instructions will be given to participants who agree to take a camera and take pictures.

Interview Invitation Script
(via phone call, email, or in-person)

Hello. My name is Lucinda Austin. I am a graduate student in the Communication department at the University of Maryland. As part of my graduate program, I am conducting confidential interviews with women living in rural areas to discuss their perceptions about health and their everyday health activities. I received your contact information from [*State community center, if appropriate. If from another participant, state "from another individual in your community who has participated in this research."*]

Your participation in the interviews is important to help understand the barriers to health that rural women face. I am conducting two types of interviews. If you are interested in participating, you may choose whichever format you would be most comfortable with. One format would involve a series of two interviews: a short initial interview and a longer follow-up interview, totaling around 1 ½ hours. For this interview format, you would be given a disposable camera and asked to take pictures of things around that you influence your health. If you choose to participate in this research, you will receive a \$10 gift card to a local grocery store of your choosing on our first meeting, and a \$20 gift card and a gift bag of assorted food items on our second meeting. Would you be interested in participating in this type of interview?

[*If no...*] The other interview format will only require one in-person meeting and will last approximately 1 ½ hours. If you choose to participate in this research, you will receive a \$20 gift card to a local grocery store of your choosing and a gift bag of assorted food items. Would you be interested in participating?

[*If no...*] Thank you for your consideration. If you should decide later you would like to participate, you may reach me at 540-998-3849 or my email at llaustin@umd.edu. Thank you again.

[*If yes...*] I will be visiting your area the week of XXXX. Would you be available at any point during this week to meet for an interview? If so, what time is most convenient for you? What location would be most convenient for you? I could come to your home or we could meet somewhere in the community that would be convenient to you, such as [*name community centers or other locations that would be convenient to participants and offer privacy for the interview*].

When we meet, I will provide you with a form stating the details of the interview and the research report and whom you can contact with any questions. I will also ask that you sign a form granting me permission to audiotape our interview for note-taking purposes.

I would like to send you a confirmation for our interview. Could you please tell me your email address and/or mailing address to send you a confirmation?

Thank you very much for agreeing to participate in this research. If you should have any questions or concerns prior to our interview, you may reach me via phone at 540-998-3849 or via email at llaustin@umd.edu.

Thank you.

*NOTE: Email invitation will contain the same information.

[If she expresses any concern over confidentiality, I can explain to her that she can even provide me with a pseudonym, if she is comfortable with that. I will explain my process of storing, destroying, and reporting data, if I feel she is pressured by the issues of confidentiality. I will also let her know that she may stop participating in the interview at any point if she feels uncomfortable.]

Project Title	<i>Rural Women’s Perceptions of Health</i>
Purpose of the Study	<i>This research is being conducted by Dr. Linda Aldoory, Principal Investigator, and Student Investigator, Lucinda Austin, a PhD student at the University of Maryland, College Park. We are inviting you to participate in this research project because you are at least 18 years of age and reside in a rural area. The purpose of this research project is to explore how rural women view their health and the health of their communities. This research may be used to help improve the health of women in rural communities.</i>
Procedures	<i>The interview involves a face-to-face conversation which will be audio recorded. The time of the interview will vary depending on the answers, but will be about one and a half hours long over one meeting or over the course of two meetings. Questions will focus on topics such as your day-to-day activities, how you view health and the health of your family, and information about health you have noticed in your community. You will be asked questions such as, “How would you describe your health in general?”, “What, do you believe, influences your health?”, and “How confident are you in your ability to know what to do to improve your health?” By participating in this research, you will receive a \$20 gift card to a local grocery store of your choosing and a gift bag of assorted healthy snacks. If you choose to participate in the two-part interview, you will also receive an additional \$10 gift card.</i>
Potential Risks and Discomforts	<i>There may be some risks from participating in this research study, such as feeling uncomfortable answering questions about your health. If at any time in the interview you feel uncomfortable, you may opt not to answer the questions or discontinue the interview. Also, there is a potential for the loss/breach of confidentiality should the data somehow become compromised, although data will be protected to the full extent possible.</i>
Potential Benefits	<i>The benefits to you include receiving information about how you can take small steps to improve your health. We hope that, in the future, other people might benefit from this study through improved understanding of the barriers that rural women face in regards to their health.</i>

Confidentiality	<p><i>We will do our best to keep your personal information confidential. To help protect your confidentiality, your identity will not be revealed in this research. Through the use of a pseudonym or false name in place of your real name, only the researchers will be able to link your identity to your data. If a report or article is written about this research project, your identity will be protected to the maximum extent possible. Your information may be shared with representatives of the University of Maryland, College Park or governmental authorities if you or someone else is in danger or if we are required to do so by law.</i></p> <p><i>This research project involves making audiotapes of the interview that will be made solely for the purposes of transcription. Only the interviewers will have access to these tapes and they will be destroyed after the research and within the next five years.</i></p> <p>___ <i>I agree to be audiotaped during my participation in this study.</i></p> <p>___ <i>I do not agree to be audiotaped during participation in this study.</i></p> <p><i>If you are participating in a two-part interview, the research project involves providing you with a disposable camera to take pictures of the things that affect your health and how you view health. These pictures will be used only for our discussion and to help the researchers better understand the participants' responses. Only the researchers will have access to these pictures and they will be destroyed after the research and within the next five years.</i></p> <p>___ <i>I agree to use a camera to take pictures during my participation in this study.</i></p> <p>___ <i>I do not agree to use a camera to take pictures during participation in this study.</i></p>
Right to Withdraw and Questions	<p><i>Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.</i></p> <p><i>If you have questions, concerns, or complaints related to the research, please contact the investigators: Dr. Linda Aldoory at 301-405-6528, laldoory@umd.edu, or Lucinda Austin at 540-998-3849, llaustin@umd.edu. Either investigator can also be reached at the address: 2130 Skinner Building, University of Maryland, College Park, MD 20724.</i></p>

University of Maryland College Park

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Initials _____

Date _____

<p>Participant Rights</p>	<p><i>If you have questions about your rights as a research participant or wish to report a research-related injury, please contact:</i></p> <p align="center"> University of Maryland College Park Institutional Review Board Office 0101 Lee Building College Park, Maryland, 20742 E-mail: irb@umd.edu Telephone: 301-405-0678 </p> <p><i>This research has been reviewed according to the University of Maryland, College Park IRB procedures for research involving human subjects.</i></p>	
<p>Statement of Consent</p>	<p><i>Your signature indicates that you are at least 18 years of age; you have read this consent form or have had it read to you; your questions have been answered to your satisfaction and you voluntarily agree to participate in this research study. You will receive a copy of this signed consent form.</i></p> <p><i>If you agree to participate, please sign your name below.</i></p>	
<p>Signature and Date</p>	<p>NAME OF SUBJECT [Please Print]</p>	
	<p>SIGNATURE OF SUBJECT</p>	
	<p>DATE</p>	

Guidelines for picture taking *(to be handed to participants participating in the two-part interview, after the end of the first interview)*

Answer as many of the following questions as you can through photos. Pictures can be of people, places, items, media, or anything else that is appropriate. These pictures will not be made public for others to see.

7. What influences your health?
8. What does the word “health” mean to you?
9. What makes you want to be “healthy”?
10. What prevents you from being “healthy”?
11. What about your health is important to you?
12. Where do you usually find health information?

Your camera will take 24 pictures total. For each question, you may take anywhere from 1 to 4 pictures.

When you are done with your camera, please place this in the envelope provided and return to the agreed upon location listed on the envelope.

Appendix D—Table Listing Major Results Themes

Table 1: Summary of Major Results Themes

RQ1: Meaning Making of Empowerment
Inner Determination
Knowledge
Self Efficacy
Perceived Behavioral Control
RQ2: Creating Empowerment through Communication Campaigns
Multi-channel Information
Media Influence
Doctors as Health Sources
Family and Friends as Health Sources and Influencers
Religious Organizations as Health Sources
Through Similar and Identifiable Sources
Bolstering Community Support and Empowering “Little” Voices
Showing Community Member’s Health Successes
Incorporating Women’s Ideas for Community Change
RQ3: Factors Affecting Meaning-Making of Empowerment
Sociodemographic Status Factors
Low Income and Financial Resources
Racial and Ethnic Differences
Generational Differences
Family and Community Caretakers and Volunteerism
Family Caretakers
Community Caretakers and Volunteerism
Constraints Affecting Empowerment
Access to Health Care, Medications, and Treatment
Lack of Health Insurance
RQ3.1: Religion’s Relation to Empowerment
Religious Involvement
Religious Social Support
Coping and Coherence
God-mediated Control
Religious Beliefs
RQ3.2: Involvement’s Relation to Empowerment
Involvement through Health Problems
Obesity and Healthy Eating
Substance Use and Abuse
Mental Health, Anxiety, and Depression
“Female Cancer” and Endometriosis
Breast Cancer
Heart Problems and High Blood Pressure

Diabetes
Kidney Disease and Kidney Failure
Arthritis
An Aging Community
RQ 3.3: Social Support's Relation to Meaning-Making of Empowerment
Desire for Privacy and Minimal Social Contact
Interpersonal Connections
Family and the Family Unit
Friends
Neighbors
Organizational and Institutional Connections
Community Organizations
Employment and the Workplace
School
RQ4: Meaning-Making of Health
Types of Health
Physical Health
Spiritual Health
Mental Health
Health as Healthy Actions
State of Mind

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