The Impact of Multiple Roles on the Health of Middle-Aged Women:

Their Lived Experiences - Their Words

By

Diane M. Dietterle

A Master's Research Project

Presented to
Oregon Health Sciences University
School of Nursing
in partial fulfillment of
the requirements for the degree of
Master of Science

April 23, 1997

APPROVED:

[redacted]

Mary Ann Curry, R.N., W.H.C.N.P., D.N.Sc., F.A.A.N.
Professor

[redacted]

Linda Robrecht, R.N., C.N.M., D.N.Sc.
Associate Professor

[redacted]

Christine A. Tanner, R.N., PhD, F.A.A.N.
Professor

[redacted]

Beverly Hoeffer, R.N., D.N.Sc., F.A.A.N.
Interim Associate Dean for Graduate Studies

ACKNOWLEDGMENTS

The story begins when the girl is six. She was a wiry powerhouse of energy who often found it hard to sit in one place or think about one topic for very long - The world was such a fascinating place, after all. The girl's parents, Marv and Dorothy, along with her younger brother, Michael, were the center of her world which was filled with love and caring.

Marv's career prompted three moves during the girl's first year of school. This was a very confusing time for her. Each of the girl's three teachers said different things and she could not say the alphabet or understand numbers like the rest of the children in her class. She felt embarrassed and conspicuous when she could not answer the teacher's questions, her red hair always made her somewhat of a focus and easy to pick out in the class.

Throughout grade school the girl's teachers told her parents that she was so nice to have in class, but, she was a little "slow". The girl was always placed in the lowest reading group. This was humiliating to her. She hated reading the same boring words, "Look Dick. See Jane. See Jane run. Run Jane. Run, Run, Run...." Why did Jane always have to run from Dick, anyway?

In the fifth grade, the girl read her first book. It was about the life of Dr. Albert Schweitzer. He reminded the girl of her grandfather, also a physician, who she idealized. The girl became very excited and decided she would become a doctor. However, her parents and grandfather believing what the teachers had said about her slowness, encouraged her to follow the traditions of the day. They told the girl in loving ways that medical school would be too hard for her. She was encouraged to think about something like teaching or nursing to

provide back-up income until she married and had a family, at which time she would surely stay home and be with her children.

The girl's confidence in herself plummeted, reaching a low in the sixth grade. As luck would have it, the girl had a new teacher, Mr. Elrod, that year. He tested the girl and found she was at least two years behind her classmates in basic skills. She was flunking the sixth grade. Mr. Elrod met with the girl's mother and explained the situation and how to help her. Dorothy was heart sick, no one had explained how serious and correctable the situation was. From that day forward, the girl and mother spent hours and hours working on her basic skills. Towards the end of sixth grade the girl made her first "C" on a history test. She was ecstatic and proceeded to show her friends how all of her hard work had finally paid off. Her classmates responded by showing their "A" and "B" papers. The girl then knew she really was not very smart. How could she have worked so hard and only gotten a "C" when her friends had not studied at all and gotten "A's" and "B's" ? Mr. Elrod told the girl that she must not listen to the other children and keep working to catch up.

Throughout junior high and high school the girl continued to work hard. She received support and love from her family which had expanded to encircle a wonderful sister, Cynthia, and brother, Patrick. Along the way, a few very special teachers saw that the girl was intelligent and had great potential. Their belief sustained her and provided the impetus to rise above the scores from the yearly state and national intelligence exams which always showed her to be behind the average for her age. The girl had to study twice as long as her friends and spent many a tearful night with her mother trying to understand concepts that her fellow classmates already understood, in order to get the same grades. To the amazement of many, she managed to have a "B+" average upon graduation from high school.

The girl became a woman and went on to graduate from an AA degree Nursing program as the president of her class and represented her school for Student Nurse of the Year in California.

Soon after, she married a very traditional man and five years later gave birth to a beautiful daughter, Alison. The husband always discouraged the woman from doing anything outside the home. For fourteen years she constantly battled to move forward with her career and meet her husband's requirements. Along the way the woman paid special attention to her daughter's education to make sure she believed in herself and was never in the "slow reading" group.

In 1983, the woman decided to take the advice of several nurse role models and went back to college against her husband's wishes. She graduated with honors receiving her BSN and divorce decree in 1985. She also met and fell in love with a most wonderful man, Philip, who believed in her and encouraged her to follow her heart and "Go for it!"

With the love and support from her family and friends, the woman applied for and was accepted into graduate school and the Women's Health Care Nurse Practitioner Program at OHSU in the summer of 1995. True to form, the woman had scored lower than average on the GRE entrance exam and was on a probationary status the first quarter.

It is now 1997, the woman's path has twisted and turned up and down many winding trails embracing rich friendships. She has circled around and through a wide range of life's deep and painful as well as rewarding experiences during graduate school. The woman has learned much about herself and other women her age through this research project which unfolds not only the impact of multiple roles on middle-aged women's health, but the meanings behind them which is what life is all about.

This project is dedicated to my father, Marv, and brother, Michael, both of whom died last summer during its development. Without the support and love of my family, very special friends and teachers, I would not have been able to present this rich body of knowledge for the improvement of women's health and wellness.

I express heartfelt thanks to each of the women in this study who gave their precious time to provide the words and wisdom through their stories to make this project possible.

My research is also dedicated to Christine Tanner, Mary Ann Curry and Linda Robrecht who believed in me and provided great insights as I sifted through countless hours of chatter to find the "true talk" which I have shared and present to you, the reader, on the pages to come.

I would like to express my appreciation for the DHHS PHS Health Resources and Services Administration Nurse Traineeship Awards I have received throughout my two years of study at OHSU. The contributions of Linda Robrecht, Mary Ann Curry, Christine Tanner and Judith Chandler to the design of this study and the interpretation of the findings is acknowledged. The original proposal was co-developed with Judith Chandler. In addition, the original Interview Guide, Demographics Form, and Health History Form were co-developed. Prior to initiation of any research, Chandler and I revised the original proposal described above. It was divided into two separate studies, approved by the IRB and given separate IRB numbers. We have worked completely independently since the revised approval by the IRB in order to preserve the scientific merit and independence of our projects.

ABSTRACT

TITLE: The Impact of Multiple Roles on the Health of Middle-Aged Women: Their Lived Experiences - Their Words

AUTHOR: Diane M. Dietterle

APPROVED: _____
Mary Ann Curry, R.N., W.H.C.N.P., D.N.Sc., F.A.A.N.
Professor

The purpose of this exploratory study was to identify and examine the multiple roles middle-aged women occupy in our contemporary Western society and the impact these roles have on their perceptions of psychological and physical health. An interpretive phenomenological approach captured the lived experiences of this cohort by enabling the participants to share their life stories and give accurate meanings to their understanding of "multiple roles", "health" and "middle-age".

A convenience sample of 4 middle-aged (35-65 years of age), Caucasian, middle income women were chosen from a rural population along the central Oregon Coast to participate in an informal, unstructured, group interview with one follow-up session. Both interviews were audiotaped, transcribed, and analyzed for recurrent themes and paradigm cases.

Findings suggest that the many roles middle-aged women engage in (spouse / partner, professional business person, parent, care giver, home manager, dietician, friend and community service volunteer) blend to form the "work" they do. These roles create their "life's work" and are influenced by those close to them. The roles of these women are constantly moving and fluctuating to gather those significant to them, weaving them into their life's center. Even with the constant time crunch, financial concerns, and continual family conflicts and needs, they usually enjoy what they do. Work is a source of self-esteem. Social support through family and friends plays a key factor in how they balance their roles and enhances or detracts from their ability to

stay healthy. Results of this study provide new insights into the meaning multiple roles have for women and their perceptions of how these roles impact their health. This understanding paves the way for reevaluation of current health care practices in caring for middle-aged women.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1: Introduction

The purpose of this exploratory study was to examine the multiple roles middle-aged women occupy in our contemporary Western society and the impact these roles have on their perceptions of psychological and physical health.

Relatively little is known about the health needs and concerns of middle-aged women with the exception of reproductive issues and the experiences of menopause (Bruenjes, 1994; McKinlay, Triant, McKinlay, Brambilla, and Ferdock, 1990; Nolan, 1986; Thomas, 1995). The paucity of research in this area is alarmingly disproportionate considering that middle-aged women comprise one of the fastest growing subgroups of the population. It is estimated that by the year 2000, the number of mid-life women between the ages of 35 - 64 will be approximately 42% of the female population (Duffy, 1988). Although women live longer than men, they will live their middle and elder years with more chronic and disabling conditions - in many cases, three or more (Thomas, 1995).

Furthermore, much of what is claimed to be "understood" about women has been obtained indirectly through studies using adult men as both the primary subjects of research, and as the "gold standard" of health (Adesso, Reddy, and Fleming, 1992; Geary, 1995; McBride and McBride, 1994; McKinlay et al., 1990; Rose, 1990). Historically, male functioning and behavior has been considered the norm from which women deviate, and therefore, women's health has been understood only in comparison to male health, often distorting phenomenon that is uniquely female (McBride and McBride, 1981). The multiple roles middle-aged women occupy are different from those of middle-aged men and therefore must be studied from women's perspectives to comprehend the effects of those roles on health.

The literature is notably sparse on studies of the many roles middle-aged women assume in our society and the impact these roles have on overall health status. The research available regarding women's roles focuses primarily on the effects of these roles on marital and family relationships, especially the role of paid worker, and fails to consider the impact of these roles on women themselves (McKinlay et al., 1990; Woods, Lentz, and Mitchell, 1993). Debate continues as to whether the assumption of multiple roles has a beneficial or detrimental effect on women's health (Baruch and Barnett, 1986; Froberg, Gjerdingen, and Preston, 1986; Waldron and Jacobs, 1989).

Middle-age is the time when women are enacting the largest number of roles in their lives: labor force participant, partner, mother, and often care-giver to aging family members. Oberndorf (1992) reports that by the beginning of the twenty-first century, 80% of all women in the United States 25-64 years of age will be in the labor force while simultaneously remaining in the role of principle caretaker of family members. In addition, this decade has seen multiple changes that uniquely impact this cohort of the population.

Many women are now choosing education and entry into professional careers first and postponing motherhood until their late 30's and early 40's. In 1989, the number of first births to women aged 35 and older was 46.3 per 1,000 compared to 12.4 per 1,000 in 1975, and by 1990, the rate of first births to women 40-44 years reached 1.2 per 1,000 (Quimby, 1994). Coinciding with the change in maternal age and childbearing is the increase in the population of elders who are living longer with chronic illnesses. Most mid-life women will be called upon to care for these family members. Quimby (1994) reports that this additional role will require 20-28 additional hours per week. Russo (1990) estimates that 72% of the 2.2 million people caring for the 1.2 million elderly persons living at home are women.

Furthermore, this care is almost always provided without financial compensation or validation.

Women have historically been, and continue to be, the primary care givers and supportive nurturers to their families while simultaneously maintaining their own jobs in the labor force. This trend will obviously continue for middle-aged women as they wait longer to bear children while their parents and other extended family members live longer. Instead of redistributing role responsibilities, women report that they still assume the major responsibility for household, children, and family, while continuing to "bring home the bacon". The physical and psychological impact of the tremendous contributions middle-aged women make to these roles is largely ignored (Nolan, 1986). We have yet to ask women themselves to tell us their stories in hopes of understanding the true impact of multiple roles on women's health.

Research Questions

In addition to the studies described above, this researcher's personal observations of middle-aged women in a variety of settings over the past twenty-seven years as a health care professional have provided the framework for inquiry into the issues of multiple roles and their relationship to women's health. Through the process of conducting this study, the researcher examined and described the lived experiences of a particular cohort of rural middle-aged women with regard to their life roles in an attempt to gain an understanding of the following questions: "What is the meaning of the multiple roles that middle-aged women occupy? "How do they interpret the impact of these roles on their health?"

Significance to Nursing

A phenomenologic approach to inquiry adds to the body of nursing knowledge and utilizes the holistic framework of the profession. The concept of wholeness, or holism, is integral to the discipline of nursing. This belief sets nursing apart from the traditional methods of science which are inclined to embrace a reductionist approach to research (Chinn and Kramer, 1995). A holistic view is essential to understanding individuals, families, and communities, and the impact every aspect of women's lives has on health and health outcomes. Knowledge based on a holistic perspective is vital to providing preventive care that is beneficial and has meaning for women. Nurses, most of whom are women with multiple roles, can benefit from this study as providers of health care, as consumers of health care, and as politically responsible professionals.

Women overwhelmingly constitute the greatest proportion of the health care profession in both western and folk traditions, yet most decisions about health care are made by men. Leuning (1994, p.6) points out that "nursing came of age in a society that did not value women or women's experience". Nurses today have taken on additional complex roles as health care providers while still embracing the nurturing and caring qualities that are the essence of the profession. Yet medical care management and cost-containment programs increase workloads, decrease time allotted to care, and minimize the significance of nurturing and caring to healing. In this way, the nursing profession mimics what has historically happened to women in our western society. The same patriarchal prejudice that has repressed women, devalued their roles, and made redistribution of role responsibilities so difficult, has similarly plagued the nursing profession.

CHAPTER 2: Review of the Literature and Conceptual Framework

This chapter includes a review of the literature and supported the need for this study. The philosophical underpinnings were conceptualized within a framework grounded in feminist theory.

The literature has a preponderance of information on the subject of roles and their effects on health. The selection, however, is limited when the focus narrows to the effects of multiple roles on the health of middle-aged women.

In addition, the majority of research dealing with roles has been based on traditional scientific research with philosophical underpinnings of "logical posititivism" by men. Logical positivism is based on a "reductionist" approach which "reduces human experience to only the few concepts under investigation, and those concepts are defined by the researcher rather than emerging from the experiences of those under study" (Polit and Hungler, 1995, p. 14). Thus, in most studies dealing with women's roles, the roles and concepts behind the roles were defined by the researcher prior to initiation of the research project. The women under study usually had no say in what the roles themselves meant.

Controversy continues to exist relating to two diametrically opposed hypotheses describing the effect of multiple roles on a woman's overall health. The "expansion hypothesis" sits on the side of optimism expounding the benefits of multiple roles while the "scarcity hypothesis" emphasizes 'role stress' or 'role overload' and the negative impact that multiple roles have on women's health (Baruch and Barnett, 1986; Froberg, Gjerdingen, and Preston, 1986; Waldron and Jacobs, 1989; Hibbard & Pope, 1993 a.). Research supporting both hypotheses exists in the literature prompting studies of women's multiple roles and health to shift from examination of the number of roles on health outcomes to studying the

health effects of specific role combinations, patterns, and characteristics (Froberg et al., 1986).

Studies of women in contemporary society show that women reap the same benefits as do men from engagement in multiple life roles (Baruch and Barnett, 1986; McKinlay et al., 1990). Types of roles and quality of experience within the roles may be the predictor of well-being rather than the number of roles alone (McKinlay, 1990; Thomas, 1995; Hibbard & Pope, 1993 a.).

Baruch and Barnett (1986) studied 238 Caucasian, middle-aged women to ascertain role involvement, role quality, and the impact of both aspects on three psychological factors associated with well-being: self-esteem, depression and pleasure. Intercorrelations between the three psychological variables were found to be highly significant predictors of well-being. In addition, the number of roles a woman occupied was significantly associated with the well-being indices studied. Self esteem and overall pleasure with life was increased in relation to the number of roles occupied, while depression decreased with multiple roles.

When regression analysis was performed to control for age, education, and income, the quality of each role - not the quantity - best predicted the psychological well-being of these women. The only exception was the motherhood role, which neither increased or decreased well-being scores. The role of paid worker outside the home was the most significant predictor of increased self-esteem. The authors suggest that multiple role involvement may actually be a prerequisite to health.

Thomas (1995) used a secondary analysis approach to examine psychosocial correlates of health in middle-aged women using Baruch and Barnett's (1986) sample. Thomas evaluated the degree to which the following six variables impacted psychosocial health: locus

of control, well-being, role quality, stress, social network ties, and optimism. Regression analysis found stress to have the strongest adverse effect on health status. Thomas described "vicarious" stress which involves taking on the stress of significant others as being common in women and may account for the identification of women as being more stressed than men in much of the literature.

Limitations to the generalizability of the findings of both studies exist due to the homogeneity of the sample. In addition, the cross-sectional nature of the studies restrict prediction of the direction of relationships between variables. For example, women with high levels of self-esteem may create more satisfying roles. The inverse may also be true. Women with multiple satisfying roles may develop increased self-esteem.

Social support has long been accepted as having positive influences on health (Tilden, 1985). While acknowledging the beneficial potentials of social support, Tilden and Galyen (1987) challenge the biased idea that social support systems and family are always positive influences on the individual. The authors begin with a review of the literature and point to studies which illustrate both positive and negative aspects of social support.

Tilden and Galyen (1987) further describe the development of a conceptual framework which incorporates social exchange and equity theories in order to make evident the stress producing components of interpersonal relationships. Based on this conceptual framework, it was determined that support encompasses the following events which may actually cause stress: cost (debts incurred such as favors), conflict (contention or discord), reciprocity (the idea of a reciprocation with tangible or emotional exchange), and equity (perception of balance in a relationship). The development of the CARSS Scale (Cost and Reciprocity of Social Support) to measure these events along with field testing and pilot

studies of the tool is described with references to Tilden (1984) and Tilden & Stewart (1985). According to the authors, the CARSS takes about 15 minutes for the participant to complete and is a self-report questionnaire booklet containing questions regarding social support network size, sources of social support and 25 Likert scale questions related to cost, conflict, reciprocity, and equity which are answered for the top 5 support persons.

The authors suggested that spouses and relatives were cited with greatest frequency as the top 5 support persons in all of their work with the CARSS (Tilden, 1984; Tilden & Stewart, 1985; Galyen, 1985). Comparison of Galyen's (1985) study consisting of an ill population of cancer patients with a prior sample of healthy individuals revealed that the healthy population had more friends listed as fourth and fifth sources of support compared to ill and older persons who often were restricted to relatives. Health care providers were not listed among the inner network of support for either group. Authors emphasized the importance of further research with accurate measuring of social support steering away from the idea of the exclusively "benevolent" nature of social support.

Bruenjes (1994) emphasizes the importance of social support in a grounded theory methodology based study using a convenience sample of 7 middle aged women to determine their definition of health and how they achieved health. The importance of social support is eloquently blended into a description of woman's health as a "symphony". The woman, as conductor of the orchestra of life, is often at the mercy of her audience and patrons (family and support systems)...If one of the audience or patrons is allowed to take over the baton, health will no longer belong to the woman; but will be the result of another's attempt to orchestrate it. (p 26)

McKinlay et al. (1990) examined prospective data gathered over a four year period on a randomly sampled cohort of 2,000 middle-aged women taken from her 1987 study. Telephone interviews (once every nine months) provided information for the study. Topics included information on employment history, education, age, health, insurance, menopausal status, use of prescription drugs, psychological symptoms, physical symptoms, and chronic conditions. The four roles of spouse, parent, worker, and care giver for an elderly parent were addressed. Seventy-five percent of the sample was employed outside of the home. Fifty percent occupied three roles while ten percent performed all four roles. Results supported a healthy worker effect which indicated that work may even be beneficial in the face of stress from performing nurturing roles. The dominant role affecting health was that of care giver. Stress resulting from the roles of spouse and mother played a key factor in negative health outcomes.

Hibbard and Pope (1987, 1992, 1993a, 1993b) utilized a longitudinal design to study various aspects of women's roles and their relationship to health in several studies. The purpose of the initial study was to assess women's roles, interest in health, and health behaviors. Two subsequent studies evaluated the relationship between women's roles to morbidity and mortality. A final study looked at discontinuities in work patterns, marital status, and the effects of both variables on health. All participants in the above mentioned studies were sub-samples from a survey conducted by Pope (1976) for a large HMO in the Northwestern United States. Telephone interviews and medical records from the original random sample provided the data for all the subsequent studies.

In 1987, Hibbard and Pope studied 1155 women between the ages of 18 and 64 and found that the roles of parent, spouse and employee were significantly related to health

interest. Older women (45-64 years of age) viewed parental and marital status as most significant where as younger women (18-44 years of age) focused on parental status and employment. Those with younger children from both groups had greater interest in health issues. In addition, non-employed women had greater health concerns than employed women.

Hibbard and Pope's 1992 study sample consisted of 1140 women from the original cohort. Findings indicated that employed women who receive social support at work have lower risk of death over a 15 year period than those women who hold jobs which do not provide access to social support. Thus, social support at work appears to provide a "health protective" factor which helps to explain the health status differences between employed and non employed women.

To examine the employment histories of women, marital status, and health status, Hibbard and Pope (1993 b.) studied 556 women (again from the original cohort). In addition to a telephone interview, and review of medical records, participants in this study responded to a questionnaire designed by the researcher. The findings suggest that women experience greater stress related to discontinuities in marital status than in employment status.

Finally, Hibbard and Pope (1993 a.) used a random sample of 2,502 men and women from the original cohort to study the relationship of specific roles (spouse, parent and worker) to their health. Findings indicated that married women who experienced equality in decision making and companionship in marriage received protective benefits against death. In addition, a supportive environment in the workplace was found to be..."protective against death, malignancy and stroke among employed women..." (p.217). In contrast, the role of spouse for men was not a significant predictor of health outcomes in this sample and work

stress increased the risk of ischemic heart disease among these employed men. The parental role was not found to be a significant predictor of health status for either men or women.

Although Hibbard and Pope's studies provide some insight into the effects of multiple roles on women's health, bias is inherent in studies using sub-groups of the same cohort over time. It is also may be difficult to apply results of these studies to the "younger end" of middle-aged women today because all of the subjects for the series of studies described above were sub-samples from a survey conducted by Pope in 1976.

The study of women in rural communities is extremely limited (Bigbee, 1990; Bushy, 1994; Mansfield, Preston and Crawford, 1988). The definition of "rural" or "non-metropolitan" is associated with many myths. The terms are difficult to define and in a state of change. People in rural areas embrace diverse and often complex lifestyles which add to the challenge of understanding and coordinating health care and other services to rural populations. Non-metropolitan communities make up about one-fourth of the U.S. Population and approximately 30% of all U.S. women (Bushy, 1994; Extension Specialist, 1991).

In her article on health care delivery to women within rural settings, Bushy (1994), describes the typical rural lifestyle as having the following components:

* greater spatial distances between people and services;
* an economic orientation related to the land and nature (agriculture, mining, lumbering, fishing, all of which are classified as high-risk occupations);
* work and recreational activities that are cyclic and seasonal in nature; and
* social interactions that facilitate informal face-to-face negotiations because most, if not all, residents are either related or acquainted. (p. 69)

Mansfield, Preston and Crawford (1988) did a comparison of the psychological well-being between a population of rural and urban women in Philadelphia through phone interviews. The sample consisted of 75 "highly rural" women and a comparable group of 78 urban women of similar socioeconomic and educational status. Participants were broken into three age groups: 30 - 44, 45 - 65, and over 65. A trained interviewer asked a series of lickert-type questions dealing with the variables of stress, strain, tension, exhaustion and life satisfaction. Women who worked outside the home were asked additional questions regarding possible work-related stressors.

Findings revealed that the most prevalent source of stress for both rural and urban women was that of family and friends. In addition, the number of children living at home, as well as increased socioeconomic status, predicted more stress for rural women. Since this was not so with the urban group, the authors suggest that: "the better educated rural woman is more likely to be at odds with her more traditional culture as she takes on new roles" (Mansfield, Preston and Crawford, 1988, p.30).

Mansfield, Preston and Crawford (1988) compared their work with research done by Bigbee (1985 and 1987)) regarding rural women's changing roles and stressful life-events among rural and urban women. The authors' findings suggest that urban and rural women report similar types of stress with similar intensity. They emphasize that the significance of the similarities is remarkable because the populations for Bigbee's studies and their study were from different states. Mansfield, Preston and Crawford (1988) further caution researchers to be cognizant of the characteristics of the communities under study and not just the designation of rural or urban.

Bigbee (1990) utilized a cross-sectional comparative design to evaluate the similarities and differences in stressful life events between an urban and rural group of Wyoming women using modified versions of Norbeck's Life Experiences Survey (LES) for Women and Wyler's Seriousness of Illness Scale. She built on her earlier studies done in 1985 and 1987. She based her 1990 findings on the responses contained in the returned questionnaires from 80 rural and 77 urban participants. The majority of both urban and rural respondents were between 19 and 50 years of age, white, married, employed outside the home with a monthly income range of $1,000 to $2,999, and at least a high school education for both themselves and their spouse.

Findings indicated that equal levels of stress occurred in rural and urban women. This contrasts sharply to the common belief that rural life is a calm and relaxed existence. Bigbee (1990) speculates that rural women's poor access to care may actually be causing an under reporting of health related problems within this cohort.

Limitations of both Mansfield, Preston and Crawfords' (1988) and Bigbee's (1990) studies center around the non-generalizability to other populations and the use of questionnaires which, although valuable, can often limit the scope and depth of the findings. Additionally, the questions may contain researcher bias and channel specific types of responses.

Summary of the Literature Review

Although the literature is replete with research related to analysis of certain physiological and psychosocial issues related to women's health, there are many gaps and biases in studies on women's life roles and health. Menopause and gynecological issues which are assumed to be of paramount importance to women do warrant quality research;

however, the substance of middle-aged women's health goes much deeper. The women in Bruenjes' (1994) study made no mention of menopause or gynecological issues. Instead they focused on issues regarding..."balancing, prioritizing, evaluating, moderating, and choosing in the process of living health"(p.30). As Bruenjes (1994) states," Nurses need to become aware of the process of living health undertaken by middle-aged women and to include spiritual, physical, emotional, environmental, and relational components in their assessment and understanding of women's health" (p.22). Women must be studied within the context of their daily lives and sought out as experts on the issues surrounding their own health (Woods, 1993; Oakley, 1993). Understanding the effects multiple roles have on women's health through women's perspectives will fill gaps in the literature and enhance health care for this age group. Women living in rural settings, as well as from various minority and ethnic populations, must also be given the opportunity to share their views as experts within the research arena. This approach will pave the way to a better understanding of the similarities and differences in the types and effects of multiple roles on women's health within different cohorts and populations (Bushy, 1994).

Philosophical Underpinning

Rose (1990) writes in her phenomenological study based on feminist underpinnings that: "the voices and experiences of women have been excluded from much of the knowledge about women" (p.59). Not until the feminist movement resurfaced in the 1960's did women start insisting on theory development that viewed and supported the female as unique and worthy of study. Until that time the male dominant social structure placed little value on research focused on women. Long standing assumptions about women's health have been based on patriarchal standards that historically viewed male physiology and behavior as

normative and therefore deserving of the lion's share of research dollars (McBride and McBride, 1981; 1994; Ward, 1995). Feminist perspectives have also illuminated nursing phenomenon uncovering "layers of patriarchal prejudice that have repressed women and the profession for years" (Leuning 1994, p.6). Feminist theory evolved from the premise that women must be studied in the context of their lived experiences as the only means of gaining accurate accounts of the true issues, concerns, and needs of women (Bruenjes, 1994; McBride and McBride, 1981; 1994; Worell & Etaugh, 1994).

Worell and Etaugh (1994) reviewed sources of feminist thought and identified key issues essential to conceptualizing women's lived experiences. The following themes from her report are supported by the purpose, research question, and methodology of this study:

* Valuing women as legitimate targets of study,
* Studying women apart from the standard of male as norm
* Encouraging questions that are grounded in personal experiences of women researchers
* Exploring research questions that are relevant to women's lives...
* Constructing methods of research that target issues of importance to women's lives such as...gender role beliefs..., and
* Studying women in the context of their lives and natural milieu...(p. 447)

The phenomenological approach also incorporates the requirement of feminist inquiry that treats the participants and researchers as equal partners in the research process (Bruenjes, 1994). This approach allows for a more direct, rich, and meaningful exchange of thoughts and information which is the heart of communication and understanding.

CHAPTER 3: Methods and Analysis

Contents from this chapter contain information on the methods used to extrapolate and examine themes that emerged when women in the study described the multiple roles they live and the daily activities they engage in which impact their perceptions of physical and psychological health. The research design, participants, setting, measures, and procedures are addressed in detail.

Design

A phenomenological approach was used to capture the lived experiences of middle-aged women as a means of understanding their personal realities from a humanistic perspective. Neufeldt and Guralnik (1988) defines phenomenon based on Kantian philosophy as, " a thing as it appears in perception as distinguished from the thing as it is in itself independent of sense experience" (p. 1013). Phenomenology is a philosophically derived method of inquiry which allows for the exploration of phenomenon as it is actually experienced by the participants (Benner, 1994). The phenomenologist's approach emphasizes the inherent complexity of all humans, the belief that humans create and define their own reality, and the understanding that the truth is a composite of these realities (Polit and Hungler, 1995).

Interpretive Phenomenology was chosen in favor of the more common empirical and structured qualitative methods of research because of the unique potential of extracting background meanings of life events through shared stories. The free-flowing, non-structured format allowed the process of natural inquiry to unfold with a minimum amount of imposed structure. Empirical approaches as well as many qualitative studies using structured

questionnaires often reduce important phenomena to measurable variables in such a way that the holistic perspective so important to nursing inquiry is lost.

Phenomena are fully understood only in the context of their dynamic interplay with other human factors. The phenomenological approach allowed the information obtained to be directed by the participants with minimal involvement of the researcher, thus reflecting more closely the actual lived perceptions of the participants. Phenomenology is based on accurately capturing the reality of daily lived experiences which can only be verified by those telling the story. This process ensured that the researcher had accurately described the participant's true experiences of multiple roles and had identified valid themes.

Participants

Participants were selected from two neighboring counties, situated along the central Oregon Coast. Both areas are considered rural by the Oregon Economic Development Department (1997). The principal industries are lumber, fishing, agriculture and tourism.

A convenience sample of 4 women between the ages of 35 to 60 years was selected. This age range is typically found in the literature as representing middle-age and was chosen for that reason. A somewhat homogeneous sample of Caucasian middle to upper-middle class women employed outside of the home was chosen because homogeneity was desirable within the scope of this study. Homogeneity enhances the potential of extracting similar themes, often more common among cohorts of a particular population and culture. In addition, similar groups often create the potential for extracting richer information due to the "cuing phenomenon"- a natural occurrence that results when people with similar life experiences share their realities with others (Morgan, 1993).

The researcher understands the bias inherent in a sample with these characteristics. While redundant themes are more likely to be extracted from stories within a homogenous group, the results will not be generalizable to women not fitting the characteristics of the selected sample. Interpretation, however, was less difficult with an articulate group having similar characteristics to the researcher's background. In addition, researcher will be working frequently with middle-age women of similar backgrounds to the cohort studied as a Women's Health Care Nurse Practitioner in a rural coastal area.

Professional and personal acquaintances residing in rural settings along the central Oregon coast assisted in obtaining a snowball sample of middle-age women for the study. The researcher did not know any of the participants prior to the beginning of the study other than through casual contact which is often unavoidable in rural settings. All participants were English speaking. Marital status consisted of currently married or partnered. All participants had been divorced at least once. They varied with respect to parental status: childless, children currently living in the home, and children grown and living out of the home. Non-English speaking, as well as women with a disability preventing them from verbally communicating were excluded.

Table 1. Demographics

Number of Participants	4
Participant's Ages	
Range	38 - 58 yrs
Mean	45.5 yrs

Table 1. *(continued)*

Employment	
Work outside of the home	4
Work inside of the home	0
Hours employed per week (range)	40 - 60
Annual Family Income Range	$20,000 - $60,000
Range of percent family income contributed by participant	50% - 66%
Marital Status	
Single	3
Separated, living with new partner	1
Household Composition	
Spouse only	1
Spouse & 2 children	2
Partner & 2 children	1
Participants assisting in providing care for	
elderly person outside of household	1
Participant's most important support person/group	
Spouse/Partner	4
Participant's second most important support person/group	
Daughter	2
Sister	1
Friend	1

Table 1. *(continued)*

Participant's third most important support person/group	
Friend	1
Son	1
Family	1
None	1
Participant's fourth most important support person/group	
Aunt	1
Mother	1
Co-workers	1
None	1
Participant's fifth most important support person/group	
Father	1
None	3

The Health History Forms (Appendix A) were reviewed. This information was not placed in table format for confidentiality reasons. Results indicated that this cohort of women considered themselves to be in good to excellent health with a total of 6 visits to a medical provider (M.D.) and 3 visits to a naturopath within the previous 12 months for the usual types of health needs for this population. Current medications, hospitalization histories, past or current chronic problems, and significant family histories were typical for this age group.

Settings

Interview 1: A private residence was donated for the evening. Located off the main highway, in a rural town it provided more anonymity for the participants than the churches or community center which are easily observable by local residents. It was the most central and convenient location for participants who came from a variety of locations. The older home had a light, open, airy, cozy feeling. The interview took place in the small living room which was open to the kitchen/dining area. The bathroom was close by down a hallway.

The interview area was set up with comfortable chairs, couch and rocking chair circling around a large coffee table covered with a colorful table cloth. A burning candle and the tape recorder were placed in the center of the table. The setting provided a safe and secure atmosphere conducive to the sharing of personal experiences. The somewhat tense and apprehensive faces the researcher observed upon answering the door relaxed into soft smiles and more relaxed facial expressions as they sipped hot cider and became accustomed to the new environment and faces before them.

Interview 2: Because of scheduling conflicts and the fact that two of the four participants were interviewed by phone, the researcher's home was chosen for the site of the second small group interview (two participants). Located in a private setting, it was relatively convenient for the participants and provided a warm, cozy atmosphere similar to the meeting place for Interview 1. The meeting took place at the dining room table with participants seated in padded supportive chairs. The tape recorder was in the center of the table. Both participants commented on how comfortable they felt in this setting. This was evident in their relaxed manner and the choice to move their chairs close together rather than spreading them a larger distance which was possible given the large size of the table.

The two phone interviews were conducted from the researcher's apartment in Portland and the participant's individual residences. The interviews were scheduled in advance so that the participants could be assured of not being interrupted and creating a comfortable and confidential atmosphere in which to talk. A speaker phone was used by the researcher and the tape recorder was placed by the phone. The researcher was the only one present in the apartment at the time of each of the interviews and the participants were advised of this prior to the start of the interview to insure them of the confidentiality of the conversation.

Measures

Several instruments were created to enhance the interviewing process as well as the researcher's understanding of the participant's current health status, the number and types of life roles occupied, and general characteristics of the sample. All instruments used to collect data were developed with input and guidance from committee members and are described in the following paragraphs. In addition, the original Interview Guide (Interview Guide 1), Demographics Form, and Health History Form discussed below were co-developed with Judith Chandler.

An initial interview guide for Interview 1 (Appendix B) including a Sample Question with Answer and Probe Questions (Appendix C) and a Follow-up Interview Guide for Interview 2 (Appendix D) provided the guidelines for the interviewing process. The guides consisted of open-ended, unstructured questions. They served only as a means to keep conversation focused on the research purpose. For example, the concept of "multiple roles" may be understood by asking the following question: "Describe what a typical day is like for you in detail from the time you get up in the morning to the time you go to bed at night." All interview guide questions were reviewed by nurse experts in the fields of women's health

and/or phenomenological research for validity and appropriateness in addressing the research question. Time constraints prevented field-testing of the initial interview guide.

Participants did not know the questions prior to the group meeting. Each interview guide question was read and explained to the participants and repeated as needed. Clarifications and probe questions were used throughout both sets of interviews and proved invaluable in obtaining accurate interpretation of the interview guide questions. Refer to pages 40, 49, 51, 53, 56, 57 and 58 within this manuscript for actual examples of dialogue with the interviewer using these techniques.

All participants were given the opportunity to fully communicate their experiences related to each question and had the opportunity to share their stories and thoughts numerous times during both interview sessions. Minimal structure was imposed based on the understanding that rich information is obtained when participants are given the opportunity to articulate their experiences and views in their own personal way.

The Demographics Form (Appendix E) and Health History Form (Appendix A) were designed to provide the researcher with basic information about the participants, the roles they occupied and general status of their health. In addition, demographics and health histories were measured as a context to assist in analysis of the interview dialogues and the effectiveness of both interviews. Neither form was reviewed by the researcher until both interviews were completed. This approach was devised in order to prevent researcher bias during the actual interviews. Comparison of information obtained in the forms with the transcribed dialogue then helped to validate the effectiveness of the interviewing process and the participant's level of comfort in sharing personal information.

Procedures and Data Collection

The researcher was given the names of seven potential participants who had expressed an interest in the study through the researcher's various contacts. Each was called by phone and the study was briefly described. Two were unable to participate because of time and scheduling conflicts. Five verbally accepted and a cover letter (Appendix F) along with the, Health History, Demographics, and Consent forms (Appendices A, E and G) were mailed. A follow-up phone call was made to each woman to confirm receipt of the documents and to make sure she was still interested in being a part of the project. One potential participant changed her mind stating that she wanted to be a part of the research, but was concerned about the risk of losing confidentiality in such a small community. She was involved in a lot of counseling work and was concerned that she might know some of the participants. The woman was thanked and assured that her concerns for "small town politics" were well-understood by the researcher even though the group was to be conducted in an ethical and confidential manner. The researcher requested that the woman destroy the forms sent to her and thanked her for considering participation in the study. Anonymity is a large problem for rural residents who participate in any type of social function (Bushy, 1994).

The remaining four participants each completed the confidential Health History, Demographics, and Consent Forms (Appendices A, E, and G) prior to the beginning of the group interview. Completed Demographics and Health History Forms were sealed in manilla envelopes and were not viewed by the researcher until the interview process was complete. This prevented any researcher bias in directing conversation. Data from the Demographics and Health History Forms were extrapolated after both interviews were completed.

The start of each interview session began with a brief introduction, review of the research purpose, the importance of adhering to confidentiality by all participants and a reminder that the conversations were being taped. In addition, the researcher stated that she was open to any questions or the need for a break at any time during the process.

Interview 1, a small group interview consisting of 4 participants was held during the month of October 1997 and lasted approximately 3 hours. Small group meetings, rather than individual interviews, emulate a comfortable, natural environment for storytelling and lively conversation (Benner, 1994; Benner, Tanner, Chesla, 1996; Tanner, Benner, Chesla, and Gordon, 1993). This concept guided the choice for a group session. The Interview Guide discussed in the Measures Section was used by the researcher to assist in initiating discussion. Probes and clarification were used as needed to gain more accurate and detailed information regarding areas of significance expressed by the participants in order to extract true meanings of dialogue. Van Manen (1990) states that the phenomenologic interview serves the following purposes:

> ... (1) It may be used as a means for exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of human phenomenon, and (2) the interview may be used as a vehicle to develop a conversational relationship with a partner (interviewee) about the meaning of an experience... (p. 66)

The open-ended questions used throughout the session captured the scope and nature of role-related issues that emanated from the natural progression of shared experiences. The interview was audiotaped in its entirety and transcribed verbatim partly by the researcher and partly by a professional transcriber hired for this purpose. The researcher chose not to

videotape the meetings. Morgan (1993), suggests that video cameras do not add to the quality of the group, may distract from it, and can also be perceived as threatening. Field notes were taken during the session and incorporated into the transcription to prevent loss of significant nonverbal communication cues which would have been lost with audio taping alone.

Preparation for the interview and its analysis was based on the following four components necessary for phenomenologic inquiry (Munhall, 1994; Polit and Hungler 1995, p.98):

1. Bracketing: Identification of preconceived beliefs and opinions of the researcher in order to prevent bias in guiding questions or probes. The researcher actively refrained from using identifying or suggestive terms relating to personal beliefs or preconceived ideas regarding the research topic obtained from the literature review.
2. Intuiting: Researcher was aware of the importance of being open-minded and only interpreting the meaning of the phenomena as seen by the respondent. Nurse experts in the field of Phenomenology assisted in controlling for this potential bias.
3. Analysis: Categorizing and extrapolating meanings was done after data had been transcribed.
4. Description phase: With assistance of nurse experts and study participants (via follow-up interviews), the researcher identified and described the phenomena.

After the data (transcriptions) from the first interview had been analyzed by the researcher with the input of a phenomenological expert in the field, a second interview guide, Interview Guide 2 (Appendix D), was created. The questions used incorporated the most

salient themes extracted from the initial interview. Participants were then sent a letter to schedule a follow-up group meeting (Appendix H). Last minute changes in schedules prevented the entire group from meeting as they had in Interview 1.

Interview 2, the follow-up interview, consisted of one group interview with 2 participants and two separate individual telephone interviews each lasting approximately one hour. These interviews followed the same format as Interview 1 with the exception of using Interview Guide 2 (Appendix D). The purpose of the follow-up interviews was to verify and elaborate on the data obtained from Interview 1.

Participants were prolific in sharing stories and daily events centered around the open-ended questions from both interview guides. It was beneficial for this researcher to experience the differences in an initial small group interview, follow-up group and individual follow-up telephone interviews.

Analysis

All transcribed tapes, field notes, and information obtained from the follow-up interviews were analyzed for essential meanings. Recurring themes were identified and "tagged" to be grouped and linked together for analysis across interviews. (Tanner, Benner, Chesla, and Gordon, 1993; Munhall, 1994).

Exemplars of actual dialogue were extracted from the transcriptions to convey meanings of the themes that emerged from the data. Prototype paradigm cases were selected and examined for the extent to which they typified many of the life stories the participants shared relating to the impact of multiple roles to perceptions of health. Additional paradigm cases were included as examples of how the phenomenological process changed either the participant's or the researcher's understanding of multiple roles, middle-age, and women's

health. The researcher analyzed the shared stories looking for situations that captured compelling experiences. Results and interpretations of the findings are described in Chapter 4.

In the initial group interview, there was a sense of members getting to "know" and feel comfortable with each other. Descriptions and stories started out more on a factual level and as the evening progressed, members revisited some of their initial descriptions going into more detail and sharing more intimate information. Some stories that were painful/difficult for the woman to tell were only hinted at with the first interview and were then explained and explored more deeply in the follow-up interviews. Phrases like, "I don't want to go there now" or "That's another story" made it clear that the participant did not feel comfortable sharing at that time.

Participants in this small group size, as Tanner, Benner, Chesla, and Gordon (1993) described in their work with small group interviews, engaged in rich conversation heading in many different directions as each member's story triggered or "cued" recollections for other members in the group as suggested by Morgan (1993). Throughout the group conversations the women used good eye contact and various phrases such as "uh huh", "mm hum" and "you know " to check in with the conversation and often ended with an incomplete sentence at which point the next participant filled in the words. It appeared that most of the "you knows" and "mm hums" were connected. However, the risk of misunderstanding does exist. Although both participants in the phone interviews sounded receptive and provided very good information, it was difficult for the researcher to assess pauses and changes in voice tones without actually seeing the person. If the researcher had not met and begun to "know" the participants with the initial group interview, the phone interviews would have been of little

value. On the other hand, certain individuals might be more open in sharing intimate concerns over the phone.

Observations of the relaxed affect, immediate warmth and openness of members in the second group interview to share stories of a deeper more emotional nature, which was not present until the end of the first interview, points to the importance of "knowing" from both the interviewer and participant's perspectives and supports the importance of "knowing the patient" (Tanner, Benner, Chesla, and Gordon, 1993). Because the researcher and participants began to know each other at a deeper level, it set up possibilities for all group members to begin seeing meanings in different ways with new dimension and insight. This process is termed "engaged practical reasoning" and happens through "prolonged engagement" in conversations (Benner, Tanner and Chesla, 1996, p.21)

The Health History and Demographics Forms (Appendices A and E) were helpful in analyzing the quality of the interview process and resultant dialogues which correlated well with responses on both of the forms. Although the Health History Form reflected the participants' descriptions of health issues within the interview dialogues, it had no broad questions relating to psychosocial, body image, health habits or personal safety and abuse issues which might have added to the overall knowledge base. However, it is common for women to negate and keep sensitive issues such as child abuse covered and hidden deep within until they have developed a sense of trust and know the information they share will be treated with compassion and confidentiality.

Protection of Human Subjects

This study was undertaken with permission of the Institutional Review Board/Committee on Human Research (IRB) and in keeping with protocols to protect human

subjects. Each participant was given a full verbal description of the study and signed a consent form (Appendix G) to participate. The researcher and transcriber kept confidential all information obtained during the data collection process. Names of participants were not divulged in any context of the research project. During data collection and analysis, audiotapes were kept in a locked file and used only by the researcher and transcriber. No identifying information was transcribed or shared. Participants were given a code number on all transcripts. Audio-taped information was destroyed after data analysis was completed.

The health history and demographics forms (Appendices A and E) were mailed to each participant prior to the scheduled interviews with instructions that they be completed and returned in the pre-stamped and addressed envelope provided. Participants who failed to return the forms via mail within two business days of the group session were contacted by phone and reminded to bring them to the session. Forms were coded and linked to each participant prior to mailing. To protect anonymity, the list of participants and corresponding code numbers were kept in a locked file separate from audiotapes and manuscripts. Code numbers were linked to subjects voices on the audiotapes after transcription was complete. Only the researcher, and research committee members had access to this information.

Participation in this study required a contribution of the participants' time. Some participants may have found the sharing of experiences difficult, uncomfortable, or emotionally upsetting. Conversely, participants may have benefited personally from this study through sharing their experiences with others. Serving as a participant contributed to new knowledge formation that may benefit women and their health care providers. There was no charge for participating in this study. Although no reimbursement or compensation was agreed to be given to participants as a result of their involvement in the study, this researcher

chose to give each participant a small gift and thank you card for their time, energy and the rich body of information they gave to this research project.

CHAPTER 4: Results and Discussion

The following information focuses on the results of the project along with discussion and interpretation of the findings. It includes a description of the data (transcription dialogue) in relationship to the research question. A detailed account of the processes involved in identification of the specific categories / themes with exemplars and selection of the paradigm stories is given. Description and interpretation of the most salient examples of dialogues and themes along with how they relate to current research thinking make up the body of this chapter. The chapter concludes with interpretation of the data which answer the research questions.

Prior to interview 1 and after further discussion and input from Committee members, the initial research question proposed: "What perceptions do middle-aged women have regarding the relationships of the multiple roles they occupy to their overall physiological and psychological health?", was put into two separate questions to more clearly reflect the path of phenomenological inquiry. The two questions are: "What is the meaning of the multiple roles that middle-age women occupy?" and "How do they interpret that these roles impact their physical and psychological health?"

Description and categorizing of the transcribed dialogue from Interviews 1 and 2 in relationship to the research questions was a long process which began with listening to and transcribing the tapes. Those portions of tapes transcribed by a professional transcriber were listened to again by the researcher and compared to the transcriptions. The transcriptions were then placed on the computer in a format so that each line was numbered and space to the right of each line was left for writing notes. Notes were made regarding the ideas and possible themes emerging from the conversations. Each committee member was given a copy

of the transcriptions as they were completed. The transcriptions were read again and a second document was developed in a computer file. The researcher began cutting and pasting themes with definitions and exemplars along with paradigm cases in various sections as they emerged. The data were periodically reviewed with committee members for relevance. Suggestions from Committee Members such as: "Why are they telling the story? "Why are they doing this?" "What does it mean to them?" were incorporated into the evaluation process. Each review of the data revealed interesting findings and meanings. The volumes of transcription lines often led the researcher down a confusing, non-productive and time-consuming path of attempting to merely go line-by-line, pull out themes and put them in a category. Munhall (1994) reminds students of phenomenology not to:

> ...take an interview apart line by line, away from the individual, away from life and the landscape, away from the horizon and the background...the fundamental aim of phenomenology...is to be more human, to understand the meaning of our humanness, to answer that question: " What does it mean to be human?" (pp. 95-96)

Adhering to Munhall's (1994) suggestions along with the fact that Phenomenology means a new way of thinking about a phenomena in order to uncover and get one layer closer to the true meaning (Van Manen, 1990), large blocks of "think time" were used to look at the entire concept of multiple roles. This process helped to clarify what the roles meant as a whole to the women in the study. The initial interview clearly demonstrated the large number of roles this cohort of women participated in, but, why they worked so hard at these roles was unclear. Because this was critical to the understanding of phenomena under study, this thought formed the basis for the second set of open-ended Interview questions. One key question, "What is the meaning of work?", changed the course of the data analysis

process from identification of numbers of small roles to what the meaning of the roles as a whole were for the woman.

Selecting the most illustrative typical life stories from the volumes of dialogue proved to be equally as challenging as uncovering the "meaning of work". The participants talked at length with hints of important issues during the first session and became even more verbose with the second interview. Van Manen (1990) validates this challenge with interpretation when he thoughtfully describes the story of a comment made by his mother who had been staying with him on an extended visit and was preparing to leave the next day: "We haven't really talked" (p. 24). Van Manen went on to explain how they had talked at length about a variety of subjects and had visited many people having a wide variety and range of conversations. However, they had not had time and space for the "true talk", the "important talk" which they did have the next day as they took a walk along the river.

Sorting out the "chatter" from the "true" or real talk which has the most meaning to the individual and clearly reflects the essence of the conversation required additional large blocks of time. Periodic "check-ins" with committee advisors and other experts in the field helped to validate the appropriateness of selected illustrations for the definition of themes and meanings.

Phenomenology is often mistakenly believed to be about individual experience and is hence, private, subjective and idiosyncratic. In fact, it is about common meanings and concerns because the participants live in a shared culture. This is a study of common, purposely chosen excerpts which typify the experiences of the group. Details, of course, vary. The excerpts and stories along with commentaries from the researcher provide the evidence for the themes and illustrate them. The "true talk" of the participants, discussed in

future paragraphs, beat out the rhythms and flow of the multiple roles which make up the heart of these women's lives.

After the "whole meaning" became more apparent, the researcher separated the components of the research question apart, identified key themes impacting each of the parts and described and interpreted them based on excerpts from the data. Examples of this process are illustrated in the remainder of this chapter. Several analyses related to multiple roles emerged: 1.) Major role types 2.) Factors affecting role functions such as social support, self-support and time. 3.) Meaning of multiple roles in the lives of these women. In addition, several themes emerged in relation to the meaning of middle-age and the meaning of health. 4.) Finally, the relationship between middle age, multiple roles and health will become evident as data and themes are interpreted and presented in relation to the research questions: "What is the meaning of the multiple roles that middle-age women occupy?" and "How do they interpret that these roles impact their physical and psychological health?" Four sub-headings have been used to clearly illustrate the sequence of events described above in evaluation and interpretation of the data: Multiple Roles, Middle-Age, Health, and Answers To The Research Questions: Relationship Between Middle-Age, Multiple Roles and Health.

Multiple Roles

Major Role Types

Multiple roles were categorized into eight major role types:

1. Spouse/partner
2. Professional business person
3. Parent
4. Care giver to parent/others

5. Home manager

6. Dietician

7. Friend

8. Community service volunteer

Each one of these larger roles has multiple sub-roles which radiate around and through them. These sub-roles are numerous and will become evident in the examples presented. In depth discussion of sub-roles is unwarranted for the purpose of this study and would take away from the meanings sought in the research questions.

The first prototype story describes some of the many roles this woman lives each day when her husband is out of town. It gives a flavor of the range of typical roles the women in this cohort engage in. It also demonstrates some factors affecting her role functions such as social support, self-support and time. In addition the meaning of some of these roles begins to emerge.

Participant: Oh -- a typical day. It's slowed down to a great halt. I've done that. I just had to do that because it was just crazy...typically I get up at 7:00. My kids...the girls are starting to get ready. My daughter gets up at 6:30 and I normally hear her when she's in the shower and I start waking up. And I have two real typical days because one is when my husband is home. It totally changes the household. But it's pretty basic...during the week with the kids at home. They are very self sufficient. They get themselves ready for school. I get up and have to have my coffee first. I have to have that time and I take it...the morning is my most favorite. I have lots of energy in the morning. After I get that initial woke up thing. And I always turn the news on. I have a t.v. in the kitchen and I sit there and get the story. I love looking at the ocean. The setting is just kind of real nice and I appreciate that in the morning. I have about an hour after I get up and the kids leave. And it's usually, "Do you have lunch money? Do you have gas?" And it gets pretty hairy as they're walking out the door, so to speak.

Even though this woman savors her morning coffee as a special time for herself, in reality she is listening to the TV news and has one ear out to make sure her kids are getting ready for school. Women with children do not have a true sense of alone time as long as their children are around and need attention. A self-support behavior common to all of the

participants that had children in this study centered around using coffee time as alone time. Their first cup of coffee was often the only break in the day to: "...Clear my head." and provided an opportunity for personal reflection. It is interesting to note that the only participant without children did not mention this. The role of parent does not permit "alone time" in the true sense of the word.

Participant: ...After they leave, it's just pretty much alone time... I either look at a newspaper or look at some things I got in the mail the day before. Or dive into the books and get deposits ready or, you know, the business stuff. I'm always in the business stuff, both ends, both sides. And I've got three checking accounts I have to keep balanced....And that's difficult. And money is real stressful right now, real stressful. We have a pretty good income coming in, but within the last few years, the bills and what have you are so overwhelming, there's really never enough to go around. And then I put quite a bit into the store and so I'm starting to feel the effects of that. And so that's real stressful and so by the time I put on my -- then I get ready for work. And I kind of have to wrap up things around the house. And boot the cat out. And feed the dog and ...make sure the doors are locked and what have you. It's kind of this normal routine every morning.

This woman has some "alone" time before going to the shop. However, she has many tasks (sub-roles) and activities to accomplish with a sense of inadequate time to get everything done. She has many bills to pay and concerns regarding finances and the amount of money she has invested into her business.

Participant: ...I leave the house about 9:30. And drive to <city>, which is <number of miles>. It's pretty basic....I'm pretty well even keel....by the time I get to the store -- and if I go to the grocery store, or...get a cafe mocha or whatever,...drop off movies the kids had the night before...then I get to the store and it really depends on me... what I do that day. Because I can choose -- like today, I just sat and worked on the computer all day long, which was very quiet....But then other days if I take and move one thing around in that store, I'll tear the whole store apart and I will -- six hours later I will be so exhausted, I feel like I moved across town. And then that's my creative process...This store, it's like interior designing and creating all day long. And for me, I've always had artist in me, always been creative...And no matter what I touch, I can make it look great. And I have these friends that can do that everyday. But I need quick fixes...I couldn't do that sort of thing every day. But I wished I could. You know? I've got four hundred projects that I've got going. I watercolor. I tole paint. And I keep myself involved in so many different projects that I remain dangerous and never get anything done... So I thought, "Ahh,"...I have all this time at the store and I've got this neat little place in the back that I can finish these projects, but I always want to...start more. So that can be pretty stressful to me. I'm constantly on the prowl. And then this

creative thing, this creative processing is more of a mind thing, I think with me. Because my mind is always going a hundred miles an hour. I made five phone calls today, and got the whole town upset about what we're going to do for Christmas in <name of city/town>. I mean not upset, but you know, everybody's wheels turning and they're going, "Ladies...." And you know their trick or treaters not even out there yet. I'm sure they thought, "Who is this broad?" <laughter>...I'm just going a hundred miles an hour like that everyday because I want to do something....I want to get people into the store and to buy all my stuff. And I want to make four hundred dollars today. So I'm just constantly driven -- you know, by money. Money, money, money. And yet being creative...I took watercolor and in the back of my mind I'm thinking, "All right. I'm going to paint this watercolor and it's going to be absolutely wonderful. I'm not even going to have to take this for two years. I'm going to be good at it right away. And it's wonderful. I love it. It's great. I'm just going to bring it and sell it in the store. And I promised my husband on <day of the week> -- I close the store on <day of the week> -- I'm going to take watercolor for me to relax, enjoy. So he doesn't know that I'm painting like crazy to sell. So, you know, it's just this monetary thing. So stressed out...I go home exhausted just trying to determine, you know, what -- and I feel like I have the best of both worlds...I have really carte blanc and the opportunity to do anything I want. But I don't know what that is, yet. You know, so I'm searching, searching, searching...my daughter usually comes a bit...that's the way the day is spent, pretty much...You know, I do complete some things that I do, but I've slowed down a lot during this last couple weeks. Traffic in the store. Traffic on the streets is pretty slow . I've learned to leave things alone in the store so I don't tear things apart. Unless some things sells or new merchandise comes in...

The participant enjoys the creative end of her work and feels compelled to keep expanding these avenues. However, there is another concern that is driving her, money. She tries to use all of her creative skills to draw business to her shop and stimulate other small businesses to plan early for decorations and ways to have traffic stop in town. She is concerned about her business surviving. Rural businesses such as this are termed "high risk" by Bushy (1994) because they are dependent upon land and nature and are cyclic/seasonal in nature. Concerns about financial loss and relationships to work create high levels of stress (Bigbee, 1990; Mansfield, Preston and Crawford, 1988).

Participant: ...I 've been closing like at 5:00...I used to stay there until 7:00...I pick up my daughter at <community center>. She goes there after school...I guess I've been kind of worried and stressed... that it's an OK place for her after school. But then I think well, you know, live in <city's name> and do as <city's name> does...I pick her up at 5:00, and we go home and it's just the girls and I. And it's real peaceful. We're all like kids when dad's gone. And I can say, "Uh huh. Yeah... 'really easy after all the kids I've had at home.' And my

<teenage> year old daughter is a very, very big help. All my kids. I feel like sometimes I just continue to search and search and search for, you know what that is. And my kids have been real self sufficient in helping. If it wasn't for them... I wouldn't be able to do a lot of what I do. And they've been a big help. Then evenings are really, you know, pretty quiet. We do talk about what happened in the day. And just kind of, you know, bring it all together and share what has happened with other people and how they've influenced their lives. And it's like we're re-grouping -- the three of us, just girls, regroup. And then we, you know, take a big deep breath and it's usually...every man for himself in the food department. Just kind of whatever....Everybody kind of eats something different. And then we usually go to bed. I'm not a t.v. watcher. In fact, I very seldom sit in my living room. So I can -- you know, I sit at the kitchen table. We do this kitchen table thing at our house. And then go up to bed like by 9:00, if it's just the girls and I. I did have for a long time, and when school started I quit, I had one or the other sleeping with me every night while dad was gone. And then it got to be where it was a big fight. And they'd argue. And they'd bet. And they'd trade chores. And you know, who got to sleep with mom. And it got to be a nightmare. So when school started back up, I said, "That's it." And our youngest...slept with us until she was <age>. Just this last six months we have really gotten her out of our bed. It was wonderful. I'd do it all over again. But it's been a transition to get her out. So I've been enjoying sleeping by myself. You know, it's been really nice when I could sleep by myself. And on the nights when <husband> is there, he snores terribly so I don't get a lot of sleep with him there. Because I'm not used to him anymore. But typically... that's it. It's pretty stress-free. As far as physical working and things like that. It's low-key. It's just that I can make my own self crazy...Because I think that I have the opportunity to turn things around financially. So it's like, "What's happening here?" What can I do? So that's where my stress is.

The participant shares concerns regarding child care and the lack of choice in a small community. She also points to how much positive support she receives from her daughters. The fact that she had them take turns sleeping with her implies the loneliness and isolation she feels when her husband is gone. Her daughters are her friends. There is little time or opportunity to meet with other friends her own age. Even if she had the time, the selection pool of women with common interests is minimal in rural settings versus more largely populated urban areas. Finally, she speaks to the real heart of her stress regarding the family's financial situation, "It's just that I can make my own self crazy...Because I think that I have the opportunity to turn things around financially. So it's like, "What's happening here?" What can I do? So that's where my stress is." This is a classic example of "vicarious stress" referenced in Chapter Two which Thomas (1995) describes as a common phenomena in

women. Additional examples of this type of stress were noted in other dialogues with this participant as well as other members of the group.

Another interesting phenomena occurs with the need to make money as described above. Even when small business owners and independent contractors impacted by tourism and seasonal influences are doing well financially, they often feel compelled to work even harder if business is good in anticipation of slow-downs. Alternatively, when business is slow, they feel they must work hard to drum up business or be there "just in case" a customer shows up. This researcher has personally experienced the phenomenon while working as a real estate broker in a small coastal community. It has been verbally confirmed with other small business owners and independent contractors over the past eight years that this researcher has lived along the rural central Oregon Coast. Bushy's (1994) findings regarding stress related to economic survival in rural communities connected with the environment and tourism are made evident again.

Interviewer: So you're feeling that from a financial sense, even though you're able to be creative and have your store, which I hear you really enjoy. On the other side there's stress...you'd mentioned stress.

Participant: Because I really make it work. Yeah. And you know, I say that and people comment in the store, "Oh, this is so darling. How did you get it?" And my motto has become and, you know, they'll laugh, is that, you know, if it wasn't so much fun I'd have to call it work. Well, it is so much fun, and it is work. You know? So, you know, and I think I've crossed the line. But I've started to pull back because I recognize that. Because I was killing myself. I was never spending any time at home anymore- And the house and all that stuff. And started losing sight of that normal routine at home. Because I have always worked at home. Always been self-employed. Always been there. And this is the first time that my business isn't behind my house or right in my house with Sea Gulls. Now I get up and physically move.
But yet for -- so it's real different for me, since May, to get up and I have to go somewhere, when I'm not used to going somewhere else.

The participant validates the value and enjoyment placed on her career. She realizes that she has gone overboard in her attempts to make more money and is working to achieve

balance. She is feeling guilty about the long hours she is away from her children working in her shop. Previously, she worked out of the home where she could be available and had a more flexible schedule. When you own a business, it appears on the surface that there is flexibility. However, if finances are tight, there is no money for extra help. The shop owner has to stay open to make money. This can be very isolating, especially on days when no traffic comes through town. Loneliness, isolation and tremendous financial worries can be the trade off for the "peaceful rural life" compared to the "hustle and bustle" of the city. She enjoys her career. The stress is around household management issues and finances.

Factors Affecting Role Function.

Factors affecting role function are centered around three areas for this cohort of women:

1. Social support which comes from family, friends and community. Table 1 lists the social support persons for the women in this group.
2. Self-support defined as those behaviors, actions/non-actions and habits which the individual perceives as making themselves feel better and get through the day with their particular situation(s) and life circumstances. These behaviors have short and long-term consequences for the individual's over all health which can be positive, negative, or a blending of both. Examples include: meditation, exercise, eating, drugs/alcohol, commute to work, coffee break, creativity/art, sleep, reading, watching TV, smoking and use of health care providers.
3. Time and the relationship to technology, speed, and the amount of work to be accomplished. These three components all intertwine with the multiple roles this cohort of women live each day.

The second prototype story from the same woman who gave the first paradigm now gives the readers a much different flavor of a typical day when her husband is home for the weekend. The changes in social support and the effects on this woman are quite dramatic. It also illustrates self-support practices and time issues.

Participant…I hate people, that you know... <pause> nap, < laughter> I hate that right now. You know, a perfect example, I got home, we were closing the store last night, and we had a pizza delivered to the store. And I said, "You guys go on ahead, I don't want that smelly stuff in the store." I says, "You guys..., him <husband> and the two girls <daughters>, you guys go home and eat. I'll close the store. I'll do the little book thingy and then I'll be home. Because I don't mind reheating the pizza, I don't mind." So, I get them out of here, you know...he says, well we have <family movie>, we just bought <family movie>. <grade school age daughter's name>...we'll watch <family movie> and kind of have a little family moment tonight. I went , "All right." So, I close the store and did all of this stuff, you know. And by the time I got home, the kitchen was a mess! < said with great emphasis>. It was just a mess! And < grade school aged daughter's name> was running around doing something... and <older daughter's name>, who is <teen-aged>, she was sleeping and <husband's name>, he was in the living room and he was sleeping. The dog hadn't been fed. The laundry, <husband's name's> laundry, because he has to leave in the morning, he works in <city long distance away>, so his laundry was still sitting there, I had started it yesterday morning and he didn't keep it going. I had to do the dishes and move all of this espresso crap from the stove even to put a piece of pizza in the oven. And I was teed off!

...And they're sleeping! I'm thinking, <states her own name>, why can't you let this stuff go? And heat your pizza and go in there and flop your butt on the couch! Why can't you do this! I can't!...but they can and that just really irritates me! <laugh>... it's about <pause> you know, being able to manage your time and I'm just kind of not good at that...I'll just drive myself and drive myself and drive myself! Because the stuff has to be done, so <pause, sigh>...Today, I had to go down to get a hair cut, I just had to! I was, it was just awful! It was a mess, I couldn't stand myself anymore. So, I flew down there in my car. I mean I know I flew! And I got there, and I know my foot was tapping, you know, saying "hurry up, hurry up, hurry up!" And finally, you know, he finished it off and I flew back. I thought about, when I was in there I thought about stopping off at the flea market, because they were open today. And I just flew right by there and I said, "Nope, I'm just going to get right back to the store." <pause> And, these phone calls coming in, right! <referring to problems related to an expensive defective piece of equipment she was trying to return> So, I just flew back there. And by the time I got to the store, you know, I don't even remember driving there so fast! But, I don't remember taking any time to enjoy that stupid hair cut! And I should have <slight laughter>, you know but I just was due back, so <pause>, the time management thing, that's a biggy, it's a tough one. <pause>

The two stories from this participant clearly illustrate the impact and fluidity of social support. There is a dramatic difference in household (family) dynamics when her husband is

in town and living at home versus living away from home as he does during the week. The first story illustrates the great social support she receives from her older year daughter and the fun she has with her daughters when they are alone together. She misses her husband who resides and works out of town during the week. Even though she is happy for him to return on the weekends, she has mixed feelings. She has a hard time adjusting to his snoring which impacts her health through loss of sleep. The many changes that take place in the social support unit as a whole when he is home along with disruptions in usual patterns leads to problems with time management. Changes in expectations increase the number of roles and work-load escalates using up more time. This makes her angry and resentful with increased feelings of stress.

The above findings are right in line with Tilden and Galyens' (1987) findings. The first paradigm of her typical day illustrates the positive social support she receives from her daughters. The second story, illustrates the "darker side" of social support. The take home message from these examples is two fold: First, social support can and does change from various degrees of positive to negative depending on the needs of those providing the support. Second, women as head managers of the household, often feel compelled and obliged by personal and societal expectations to take on the daily household tasks left undone by others because home is a reflection of themselves. They not only take on the stress (Thomas, 1995), but they take on the jobs. In addition, they feel mad about it. This negatively affects their health.

There is obviously a need for better communication and sharing of household tasks to improve health for the entire family. This points to a focus on family theory to get at the root of social support issues.

The hair cut episode illustrates self-support that didn't work out as planned. She was attempting to make herself feel better from the evening before. However, store coverage was an issue and she felt so pressured for time that she failed to enjoy much of the experience. The outing could have been more positive if she would have taken the time to plan. However, she needed a quick fix to feel better about herself, something she could immediately see.

Time management and just not having enough hours in the day to get everything done are illustrated here and flow as a strong, deep undercurrent in numerous dialogues with all of the group members creating a sense of being out of control and always racing to keep up. The extra tasks and roles involved with being a part-time wife put this woman over the edge. The literature, numerous popular magazines, self-help groups and consulting firms all continually present various aspects of the problems with time management and ways to solve the problem.

A good example is found in the UTNE Reader (1997 March-April) which devoted a series of articles to various aspects of time management and slowing down. Walljasper (1997, March-April) suggests that, "...the major cause in speed up of life is not technology, but economics." (P. 42) He points to the importance of taking time to experience what we are doing instead of the fast paced trend to "arrive and depart". Participant 1 must have been the inspiration for Walljasper's article.

Although technology is a factor, time management for this woman and this cohort of women centers around a large number of roles. Many of the roles middle-aged women take on are roles that no one else wants because they are time consuming, often involve non-

glamorous labor, have no monetary value and are difficult to time regulate. Hence, role overload and difficulties with time management.

Caregivers are priceless (Oberndorf, 1992). Yet, respite is a complex issue. Either a woman needs to have enough money to hire help, which is not an option for many women, or she relies on her social support system. Therefore, assisting women with time management must center around her family / support systems. Time constraints around family schedules, their willingness to support women in their multiple roles, cost constraints with insurance, and managed care's focus on quick visits and medication fixes make the issue complex and challenging at best.

Meaning of Multiple Roles.

Each role a woman lives is significant and meaningful from a variety of perspectives within her world. These internal perceptions then radiate out to influence her perceptions of the world around her and in turn, how the outer world (family, society, culture) perceives and responds to her. In depth discussions of the many multiple roles lived by this cohort would fill volumes of pages. For the purpose of this study, the roles of parent and professional career person will be explored and will give a clear perspective of the meanings these two major roles have in the lives of this particular cohort of women.

Parenting

The choice to parent or not to parent and the meanings associated behind the role are determined by many factors and vary greatly from woman to woman even within this very small cohort. Timing, finances, circumstances, physiological, chronological, and psychological factors as well as social and familial influences impacted each of these women

differently. The meaning they placed on the role and the adjustments they made had long term influences on their lives and health as well as those close to them.

Participant A: ... My childlessness, is not a sorrow anymore...I think that the reason for that is dealing with everybody else's troubles. I just really don't care, which was a piece of why my first marriage broke up. Because he cared and I really didn't care. He thought that wasn't very nice of me not to care...You know, the last person with a certain last name and... since then, he's had to adopt. He's sixty years old and he has a third grader... I cannot feature that. I'm still glad I'm not there, that didn't happen to me. <laughter>

Participant C inquired, "So did you not have children by choice?"

Participant A: "Who knows?... Considering that he and his second wife didn't have any, I would guess that it was not choice...If it happened, it was OK... It was just a happenstance... I'm not a terribly religious person, but if God -- if nature didn't mean for it to happen, and it didn't happen, fine... Don't mess around with <pause> that.
...the only time I was ever in the hospital, nobody in my family knows...I made a decision at about forty or so that I did not want to be pregnant. Up until then it hadn't mattered... so I had a tubal ligation....Well, that's probably not appropriate to tell my mother <laughter>.

Participant B interrupts: And I went with my mother when she had hers done....we were in agreement on that one.

Participant A: ...My mother's child-oriented, you know? And bothered us a lot about when were we going to have kids, until it became obvious we weren't...I think there was familial pressures....Outsiders would sometimes say things. You know, I can remember some young man one time saying, "Well, you know adoption is always an option." And then I hadn't asked. <laughter> And I'm, "Yeah, well, OK." I'm not that old. But, it could happen, fella....I don't think it has any -- had any health ramifications at all. Even mental health, because I can handle that. Kids at school have from -- now that I'm as old as I am, they still ask occasionally, "Why didn't you ever have kids?" And if I'm in a smarky mood I say, "Have you ever heard of sterility?" And then I don't elaborate and they just don't dare ask because they think, "Oh dear," They've trodded (sic) on my toes. But, you know, and then if I feel like telling them, it's like, "... I didn't really have them because I have all of you." ...But I don't think it really ever affected me mentally... I have very little patience with people who think that they're not whole if they didn't have any.

Participant C: Now see, I see somebody that's never had children physically and maybe even emotionally, more together.

Participant A: I don't think more.... Maybe it's just different..I mean, some people really have the urge and they should have some.

Participant C: ...people that haven't had children, they've just got this, you know, whatever. And I don't know where it even came from, but --

Participant A: Well, there's a distraction that we haven't had.

Participant C: Well, or that you haven't been...run through the mill or something. You know, sometimes I feel like I've just been run through the mill.

Participant A: Well you have. I can't see how a woman works all day --

Participant C interrupts: Physically and emotionally.

Participant A: -- and goes home and does full motherhood... It's just...got to be the most exhausting thing in the world.

Participant C: It gets you.

Participant B: I tell my kids that if I could go back and do it over again, they wouldn't be here. But I wouldn't give them up for anything...If I had the opportunity. But if I knew what I know now, I wouldn't want to have children. But that was a decision I made. There's just too many other things that I might have liked to have done differently, but they were an obligation. Not one that I disliked at all, but one that made some difference in what you choose to do with your life. <pause>

Participant C: I'd have had twelve and gone tax exempt.

Participant D: I come from a family of older parents. My mom was 40 when she had me. I was their middle daughter. My dad was 50... it doesn't feel strange to me at all to have a small child around. It is exhausting, however. And it -- I think it puts a whole other set of demands on a person and I realize now why you're supposed to have children in their twenties, not in their forties, because physically it's -- you've got to really be in pretty good shape.

Participant B: ...I grew up fast. And my son was born when I was 17. When my kids were little I went to school full time and worked full time. I decided I didn't want to be one of those moms that had to survive on A & W or Burger King or something so I decided to do that and I had to work 8 to 5 and be home in the evenings and on weekends with them, um--. So I spent most of the time with my kids when it's important. When they're home, I'm home for all the important stuff..."

The following two paradigms deal with the theme of adoption and illustrate the transition in group process from Interview 1 and Interview 2 regarding "knowing" and being comfortable in sharing an intimate life experience. The stories also demonstrate the fact that a casual short conversation often does not divulge the true depth and impact that a particular role really has.

The first paradigm demonstrates how women take on roles to support the ones they care about. The roles often have both negative and positive components for the woman taking on the role. However, to her, there is no real choice because it is someone she cares for who needs help and there is a child at stake.

Interview 1

Participant: I have a...<child> left at home that we adopted. So sometimes I think, "Uh, what did we do here?" You know, my friends are having a really good time right now coming back together, husband and wife, the kids are all leaving, and I've got years <said with great emphasis> left, which isn't all that great. So that's a little frustrating sometimes. I'm real tired of having that little one at home. But it's OK. I would, you know, I'd do it all over again, even with those circumstances, which is another story.

The researcher identified a bias in her own evaluation of this woman's choice to have a child late in life. This was uncovered during the initial evaluation of the first interview transcripts and prompted more specific questioning during the second interview when the time seemed appropriate. The woman gave a hint about the complexity of <child's> adoption in Interview 1 when she described her disappointment in missing out on many of the activities of people her age whose children were grown and she still had a young child at home. She said, "I'm tired of having that little one at home. But it's OK...I'd do it all over again, even with those circumstances, which is another story."

The researcher did not pick up on this hint. From the researcher's perspective, the woman made an active choice to adopt the baby. Most people adopt babies because they plan to and want to. Adoption and its real meanings to this woman became evident in the paradigm "change case" from Interview 2 illustrated below. The story tells us much more about the tremendous impact the adoption had on her entire world and social support system. It also points to the importance of the need for practitioners to "know" their patients in order to facilitate the sharing of crucial information. Only after the second interview was midway

to completion, did this woman feel she knew the researcher and other participant well enough to entrust them with this confidential information which helped to give a much clearer picture of what being an adoptive parent meant to her and those around her.

Interview 2

Interviewer: ... What prompted you to adopt a child, a younger child? Was this something that was by choice, or by happenstance...?

Participant: Some of each. <Child> is my sister's <child>...When she <sister> was pregnant, we knew... she was doing drugs and everything. We lived in California... She had made comment that if when she had the baby and there was anything wrong with it, I was going to get it...That was her thinking. Anyhow,... she had...child and when <child> was 5 weeks old, she brought <child> to us.
There was nothing wrong with <child>, <child> was absolutely perfectly fine...She just... couldn't have this baby and do drugs, too. And...she brought <child> to us with a duffle or a pillow case full of old ratty clothes and said, you know, it was, <pause> her and I sat at the kitchen table and I said, "All right,...let me take care of <child> for you..." But first I offered for her to come and stay with us and "I'll help... get you into treatment. Get you back on your feet...or do whatever we can to help you." "No!" She didn't want to do that.

...She had two children,... <other child's name> is <age> now, <other child> was four at the time. In fact, <other child> turned four the weekend that they were there. And she wanted me to take both and I just couldn't <gestures with hands> I worked! I mean I had to go to work on Monday, this was Saturday...I told her I would keep <baby's name>, that I would take <baby>. And she gave me her <pause> <name of state medical card>. She <referring to sister> lived in <name of state>. She gave me her <name of state> medical card...and signed this little piece of paper saying that if anything, you know, major medical or whatever, that I had control. This was like, <child's name> was born <date>. So this must have been < approximately 2 months>... We had decided that on... <day of week>... When she said, ok, I'm leaving...with the <other child> on <three days later> to go back. And <for three days before she left>, she never touched <baby> again. <pause>... I mean, I took care of <baby>. She <sister> went out at night and you know, whatever. But I took care of <baby>.

Anyway, she left and it was like BOOM! <said with dramatics> I had to get a crib. I had to get diapers, I had to get bottles, I had to get clothes. I had to get a car seat. I had to get everything! ...Plus, I go to work. So, it was just a whirlwind...! And, I mean we did it...we just did it... And we were in a stage in our lives that our other kids were self-sufficient.... Everyone was in school. ... we did...whatever... <pause>... And then here comes this infant. And what we remember most about <adopted child's name> is how much baby L-O-V-E <baby> brought back into the house <said with expression and feeling>...It was just wonderful...Because that was really missing... <pause>

So that was a lot of fun. And then it...was Christmas day. <pause> My sister called and said, "I want<baby> back." <pause> And we said, "RIGHT!" <slight laugh> "It's not going to happen."... And so between the next day and just 48 hours, we got,... a restraining order...temporary custody and all that...It took 4 years and $20,000 later. <pause>...We had to terminate her parental rights and...go to court...The psychological evaluations cost us twelve hundred...We just went through H-ELL! But, if I had to do it over again today, I would say, "Ok, let's go, we'll do it..." <pause> <deep sigh> ...You do what's put in front of you. And you just do it. It was a lot of money... We're still paying...We'll pay on it for the rest of our lives...We lost a house over it. Well, who cares!...Who cares? ... I think that there's probably a LOT more families out there that need to probably do what we did.

NOW with <adopted child's name> <child's name> is just like any of the other kids...a pain and... all that good stuff... I thank god sometimes for <Older high school child>... carts <child> all over...and <name> really is a big <help>... and picks up the slack for me.

Because one thing I do know is that I don't have that energy <said with a questioning tone at the end and pause> for a child anymore...I did when <child> was a baby.
But...<different ages of her adopted child as development took place> and the going here and the going there and taking <child> to the movies and all that, I don't have that energy anymore! ...That get-on-the-floor-and-play childrens' games and sit at the table and... the crafts... I just don't have... I did with my other kids. But, I didn't work when they were little... I waited 'til they went to school. And, ...so that's... tough having one that age. But <older children>...I just thank god... they're helping raise <child's name>.

This is a clear example of the mental and physical energy involved in parenting. The woman, can tell the difference in her level of energy and fitness from when she was a much younger parent with young children to now as an older parent with a young child. In addition, she points to how critical her older children are in helping her cope with this large and very important role. It is a good example of positive social support which is vital to her overall health.

...One thing I do know now, is that... our best friends <pause then adds for many years>. Their kids now are our older kids ages and they're...gone. One has moved out and the other kid, he's a senior. And so our friends... They're the same age as we are... I'm hearing their stories about how they're going away for weekends. They're going to the home show. They go out to eat or they're going out to breakfast. And they're doing all these weekend things together! They're coming back together. <pause> And were still home watching <child's movie>! <laughter>... We're still at home with this child!... We have not entered that realm of that <husband> and I are still not coming back together because our kids are

leaving. We're...not there, yet. We have no clue, I have no clue what that feels like. But I can hear it! And I, It's like, "I know I'm supposed to be there!" <pause> So, ... maybe this child has done that for me - kept me just an infant, myself. I don't know <pause>

This dialogue expresses the participant's sense of loss and feeling "left out" as far as not having time and space to experience "middle-years" as her friends are.

If it came up, I definitely would do it all over again. You know, I mean I look at <adopted child>. And I think, god, how BLESSED you are to not be where I k-n-o-w you would be right now.

The woman is confirming and validating her decision to adopt (take on / accept the roles as mother), even with the sacrifices she made, in order to give <adopted child's name> a good start in life. This is long, hard and very worthwhile work for which she receives no payment and very little recognition. It provides an excellent example for research done by McBride and McBride (1981, 1994) and McKinlay et al (1990) who point to the large amount of care giver work women do which is often not validated or recognized either monetarily or through expressions of appreciation. The strokes must come from a few who know the true story and the woman herself, a sad commentary for such important work.

Interviewer: Does <child> ask about...<child's mother>?

No,... That's coming up...<child> knows <child> is adopted...<child> doesn't... know it's my sister, yet. ...That's probably nearing... We're probably getting close to that... I don't know how I'm going to handle that one. You know, I don't know. <pause>

The participant's concerns about how she will cope with the difficult task of telling <adopted child> the entire truth about <child's background/true parents> background has been and will continue to be a major source of stress which she has had to keep to herself. A knowledgeable health care provider would be able to help this woman deal much more healthfully with the stress associated in her unique situation. However, obtaining this type of knowledge from a patient takes time and establishment of mutual trust. Something which is

fading and becoming a thing of the past with managed care - a sad commentary on the meaning of health care for both conscientious providers and their patients.

Another participant interjected: From talking to at least one of my students who is adopted...She's a blind adoption. She has no knowledge of background...She's a senior now, and just the of day, the kids were talking about genetics and it was like, well, "What if someday I fell in love with somebody that was genetically my brother? Because, I don't know where I came from...Before she thought about that, I know she has thought about health issues. If you don't know your genetic background, you don't know what you might be prone to. And so, there will be some point at which probably much later, she may want to know for those reasons... Genetically...

Adoptive mother's response: Well, see <pause>...you know, I'm technically the child's aunt...<Laugh>...Even today, we were sitting because...<adopted child's name was with her>...And we were sitting there and the receptionist...says, 'Boy!... you sure can tell you guys came from the same mold...Your profiles are dead on, exact!'...They probably are!...I don't care when <child> finds out that...my sister is the biological mother. I don't want the day, it's just going to break my heart when <child><pause> I think it's going to break <child's> heart. <laugh with tearing eyes>. I think it's going to break <child's> heart when <child> finds out that I'm really the aunt. That's what breaks my heart... Or, maybe I'll handle it as, "I would have been"<pause>... "I'm your mother and had things not been the same, < pause> I would have been your aunt.

Other participant interjects: I have a very good friend whose one daughter adopted the other daughter's child and the children at I suppose around 13 or thereabouts, they figured it out for themselves. That...I'm really her daughter...<pause> but it doesn't seem to make any big difference to them... And they're all close! And have all intermingled all the time. Rather than, I assume, you and your sister don't have contact.

This participant was doing her best to empathize and give support to the woman giving her examples of "adopted" situations she was experienced with. Unfortunately, no one can really know unless they are actually living the story as the women makes very clear below:

Adoptive participant's response: No, because she's been in prison and I mean...this is a horrid life...She lives on the streets to this day. And in bars and what have you. But, I think that's the scary part, too. Is... the four years when we went, the court battle... you know. And CSD...was involved and with a fear of losing <child>. I'm not kidding you, we... had talked to people about going underground! ... So <child> wasn't taken, I mean it was desperate! ...And I was so afraid that... my sister was...going to get custody back...It was just devastating! ...Those fears are still really there and they shouldn't be now...You know, ...And I've talked to my sister once or twice...since all that. I happened to- My mom was

talking to her on the phone one day a few years... ago. And I don't know what made me pounce. And I said, <pause> "I want to talk to her." So I went back into my bedroom and I shut the door and got on the phone and I said, "Ok, mom, hang up." And I said, ... "How are you?" She said, "Fine." That was the first time I'd like talked to her in <many years> <pause>...And she said, "I'm fine." And I said, "Well, I just want you to know <pause> that <adopted child / her child> is very, very well taken care of." And then I started <crying>...and then she started, too and then she said, "I know that." <said with great tenderness and feeling>
... I said for what it's worth... <pause> You don't deserve to live this way. As my sister, I love you and I hope that you can see your way through someday to get better because you deserve that...That's been pretty much it since the last time I talked to her...I KNOW <said with emphasis and feeling> there's no fear of her coming to get <adopted child> now. But, I fear <pause>. Maybe it's just normal fear of losing <adopted child> to her someday...When <adopted child's name> is old enough... I see all of ...<the shows on TV> with these wonderful reunions and ,"Oh mom!" and I mean I hate those! And then I think, well they have a right for that... But, I don't like 'em... <laughter> "Because, I'm on the other side! ...I'll cross that bridge when I come to it. <pause>... I think most, what I search for is that, I HOPE that when that day happens,... I'm together enough, I want to be together enough, emotionally, to be able to support <adopted child> through this meeting...Because, if I am resentful and I'm scared and whatever, then, I'm going to project those things... Then it will just be a fight, you know <slight laugh> and I don't want that! ...So, I hope that I... have the poise and... the respect for <adopted child's name> when that happens, ...<pause> And, we'll get through it.... <pause>

Interviewer: It sounds like you're thinking all the right things and it seems like those fears would be <pause> anyone would have them.

Adoptive participant: ...I just have to remember that... But, sometimes they can <pause> get you <laugh> so <pause> <sigh>...<child's name>is very special. <pause>.

The last paragraphs of this moving story poignantly illustrated the grief and sense of loss this woman had in relation to her sister on the one hand and the fear of losing her adopted child back to her sister, who is dysfunctional, on the other. In addition, she is worried for her <adopted child's> mental health and safety when <child> is told the truth. There is a great concern for a loss of many years of one of her life's most important works - her <age> year old adopted child.

Shared experiences within the paradigm deepened the level of understanding and meaning of adoption for each woman and this researcher. All of those who read this research

project will remember these stories which will enhance the meaning and understanding of adoption in their world as well.

Professional business person

Professional Business Person is another key role type for this cohort and was explored as a second example to illustrate the meanings of multiple roles. Findings point to the fact that although professional work is required for financial survival, that it is for the most part beneficial adding to self-esteem, sense of creativity, and often provides reprieve from other major roles centered around caregiving and home management. In addition, because professional work is such a big part of one's life and retirement may not be an option, it is important to find rewarding and enjoyable work, even if it means some financial loss and creates extra work and stress.

Although any professional work has some stress associated with it, the major factors influencing quality and job satisfaction centered around time issues, the demands of other roles such as spouse and parenting and finances - being able to survive as illustrated below:

Participant D: ... we're starting another business...it's interesting because it's a business that my husband and I are actually starting together. Whereas <name of business> is something that he just worked in to -- a magical development. But this is something that we're working together on. And that makes it. Partnering with him is an excellent thing...He and I are finding that we have time to work together on this new project. But I'm looking at him and he's 48 and I'm almost 47 <pause>. Are we nuts? Are we nuts!! To be starting something on this scale now - It's like we're supposed to be, you know, cruisin' this way (gesture). We're not supposed to be going this way (gesture). But I don't know if that ever stops. It goes in one of our realities. We aren't ever going to be able to retire. We will work 'til we drop. So we might as well be working in something we like to do."
...And being self-employed,... I don't have job skills that will allow me to be hired by anybody. The things I can do are so, I mean, esoteric -- are so whatever that they really have no value except in a very small window there. Except maybe the cooking but everything else is really... I've always been basically self-employed or also an artist so there was that way of making into a living whatever it was that I was doing that way rather than being hired by someone. Consequently there isn't retirement or health benefits.

Participant A: I think of my job as being a break away from work. So, it's like I go to work to get away from work as a break in the day.

Interviewer: So, do you find working outside the home fulfills any particular needs for you that working in the home does not fulfill?

Participant A: "Sanity"

This participant's comment points to the positive aspects of professional work outside the home and agrees with many researchers (Hibbard and Pope, 1992; McKinlay et al, 1990).

Participant B: ...I'll tear the whole store apart and I will -- six hours later I will be so exhausted, I feel like I moved across town. And then that's my creative process. And it is a creative process. This store, it's like interior designing and creating all day long. And for me, I've always had artist in me, always been creative, and with graphic design. And no matter what I touch, I can make it look great...I've got four hundred projects that I've got going:. I watercolor. I tole paint. And I keep myself involved in so many different projects...I have projects from a year ago and I continue to buy new projects... I have all this time at the store and I've got this neat little place in the back that I can finish these projects, but I always want to start more. So that can be pretty stressful to me. I'm constantly on the prowl. And then this creative thing, this creative processing is more of a mind thing, I think with me. Because my mind is always going a hundred miles an hour. I made five phone calls today, and got the whole town upset about what we're going to do for Christmas in Edisonville. I mean not upset, but... everybody's wheels turning and they're going, 'Ladies....' And you know... trick or treaters not even out there yet. I'm sure they thought, "Who is this broad?" <laughter> But, you know, I'm just going a hundred miles an hour like that everyday because I want to do something. I want to do something and I want to get people into the store and to buy all my stuff. And I want to make four hundred dollars today. So I'm just constantly driven -- you know, by money. Money, money, money. And yet being creative. You know? I took watercolor and in the back of my mind I'm thinking, "All right. I'm going to paint this watercolor and it's going to be absolutely wonderful. I'm not even going to have to take this for two years. I'm going to be good at it right away. And it's wonderful. I love it. It's great. I'm just going to bring it and sell it in the store. And I promised my husband on <day> -- I close the store on <day> -- I'm going to take watercolor for me to relax, enjoy. So he doesn't know that I'm painting like crazy to sell. So, you know, it's just this monetary thing. So stressed out... I go home exhausted just trying to determine, you know, what... I feel like I have the best of both worlds. I feel like, you know, I have really carte blanc and the opportunity to do anything I want. But I don't know what that is, yet. You know, so I'm searching, searching, searching.

Although the participant really enjoys her creative work, she feels compelled to use her creativity to make money and this is frustrating to her. Creativity (without spirituality)

influenced by serious money concerns and keeping the business going. She wants to be able to paint for joy of painting, but, feels compelled to do and make anything she can to financially survive. Her husband sees the need for her to relax and take time for herself. She feels obligated/compelled to paint to sell to help out with the finances. Financial needs create stress- "I feel like, you know, I have really carte blanc and the opportunity to do anything I want. But I don't know what that is, yet." It appears to others and herself she has all of this time. However, when financially insecure and self-employed, it is difficult to give yourself permission to rest and have quality time for yourself. Thus, she has more projects than she can handle and her mind is always working to find ways to make the store more successful.

In another conversation Participant B revealed that she loved her work and felt it gave her self-esteem. She enjoys her professional career. She even likes that kind of stress. The problems are around finances and family care.

Participant B: I'm always driven to make more money... But...I think the success level is more important <pause>... It's that quick fix of success when you have a good day and when you accomplish the things in your work... And that is satisfying in that I think <pause> I've always worked. I've always told my kids... Love what you do. Because if you don't, your not going to be able to prioritize that at home...Home stuff is tough and it is...demanding... So... the hard work for me, is building that business and putting in the long hours and doing everything right so the business is successful... <pause>

Interviewer: And so for you, you feel that you get the reward or the success, feeling of success <Participant B begins before Interviewer can finish>

Participant B: That's where my number one <pause> source of self esteem comes from. And I believe second is probably my family. I'm proud of them and my family is a wonderful source of self esteem. Uh, but they're individuals and they take a lot of credit, too. I just can't sit back and go, "Well, they're wonderful" because of me...that's not real...<pause>...My self-esteem has always come from my job and work <said with emphasis: dynamic voice and enthusiasm>. And work that means to me to be hard-driven to make that statement that this is successful <brief pause>

Participant C: It's an identity < Stated as a validation of what Participant B was saying>

Participant B: It's an identity thing, yah. It's who I am...To be able to create this...Everything is...almost even a visual statement, too

Interviewer: Mm hum

Participant C: Sure it is.<nodding with good eye contact throughout this conversation>

Participant B: I get such recognition for the visual things that I do.

Participant C: Mm hum

Interviewer: Uh hum

Participant B: And...that's constant strokes daily. And that's what drives me...It's work because...you put in a lot of hours. Physical...you're moving things around and that kind of stuff ...Then hassles like <describes problems with merchandise ordering, faulty equipment> ...<laughing>...become a hassle. That becomes work and that becomes your stress because you're trying to do things to make your business better.<pause>

The next exemplar illustrates the fact that issues centered around child care is one of the stressors associated with professional work, not the job itself. Sharing child care with spouse to cover for different work schedules, although beneficial to the child/children, can interfere with quality time for spouses. Leaving child/children in day care facilities can create increased anxiety and worry as well as feelings of guilt for parents and behavioral problems for children in certain situations.

Participant D: And the difficulties that he and I have had in our relationship have been related to not working together rather than working, because as a team we're free but when he started having to be at work and I'd be at home and then I took over and he'd leave. And it took years of this trade off, you know, where he'd be at work, I'd be with <child>, I'd be at work bla, bla . <Child> now at an age where <child> in school a little more regularly. <Child> is not actually in the public schools, yet. We want to know that<child> is going to be happy with it.

Work stress does not necessarily impact health in a negative way if their are good stress-reduction plans in place, such as Participant A describes below. She has an hour commute to and from her job. (Note, she has a very responsible, high-stress type of job in most peoples' eyes)

Interviewer: You are a <type of profession> right?...Is there anything that you want to elaborate on that might give some insight about just how...the type of work you do might affect you...?"

Participant A: It doesn't really, just because I have such a time frame where I can unwind. I think if I just went and say lived...a half a block from home or ten minutes from home,...all the tensions and... everything that has gone right or wrong during the day. You never know when you walk through the door. You can't really plan a day. You can't go in and say, 'Well, <pause> I'm going to do ordering today. Or I'm going to clean ten rooms in the motel today.'You just don't know. Who's been arrested the night before. You don't know who's out committing a crime as you're walking through the door...You learn to live with that and once you're accustomed to that then, shit happens, basically. <laughter> ...And it all rolls downhill. And then you just kind of go with the flow. So that's easy enough. And then you walk out. And I have the time frame enough to shut it down. So when I get home I'm ready to deal with things at home.

The detailed descriptions of parenting and professional career work described above are two of the many multiple roles this cohort of women live each day. They provide a multitude of flavors and mirrored images into the depth and multifaceted range of influences each of these two roles have on a woman's life each day. It is also clear to see how the other major role types such as spouse/partner, grandparent, care giver to parent/others, home manager, dietician, friend & community service volunteer, along with countless sub-role tasks are all interconnected. The old saying, "A woman's work is never done." is proving to be a real truth. The overall meaning of multiple roles and their relationship to this cohort's health will become clearer after the meaning of middle-age and health are explored and will be addressed in the final portion of this chapter.

Middle-Age

Middle-age is defined in the literature as somewhere between 35 and 64 years and was the basis for selecting the cohort of women in this study. Interestingly enough, this group of women did not perceive themselves as middle-aged. Even, the oldest member at age 58, intellectually knew she was there, but did not "feel middle-aged". When asked to define

middle-age, it was a difficult question for them to answer in a sentence or two. Their interpretations of the term consisted of four prevailing themes intermingled with individual meanings around each. The influencing themes were:

1. Sense of time moving rapidly
2. Perceptions based on how others see them. Also, how they see themselves in relationship to their own experiences and those of significant others in their life
3. Physical signs of aging including the mysterious menopause
4. Anticipating and preparing for the future, including the role of grandparenting.

The following exemplars guide the reader into this cohorts' views on middle-age:

Participant C: I live in <name of area>. It'll be <large number of years>... And it seems like it was about six weeks ago, actually. Time has gone by since I moved up here...But I did move up here with my oldest child who was, I guess, seven when we moved up here. And now she's <high school age>, going to be <age> and that's what kind of scares me is that I don't care if I've aged, but I look at her age and, "Holy Toledo! You know, how can that happen in such a short period of time?"

Participant A: ...Academically I know I am...But I have trouble realizing it...I'm always shocked when I see myself, like...when we're walking down some street and glimpse yourself in the mirror and I realize I'm gray haired. I used to have dark hair and I still apparently think of myself that way. There's just this gap between reality and this ingrained whatever....I used to be thinner. And this summer...and I know this isn't mentally healthy, but I was thinking, "Well, this size is OK." Well, it really isn't. I'm 30 pounds overweight by what I ought to be because I've just kept eating over the past few years.. And I thought that was interesting, too. So that's a good -- that was a good maneuver...

The above exemplars project a sense of time moving rapidly without realizing it. This relates well to Sheehy's (1995) findings suggesting that people in their early forties have a "hurry-up feeling; time seems to be running out." (p 150) She relates this to the fact that people begin to realize the limits of their own life cycle. As age progresses, time moves continuously faster, becoming more precious.

The second participant's story about looking in the mirror emphasizes the point of feeling younger than she is chronologically. Also, the idea that certain changes in body image over time are more accepted in society if you are at a certain chronological age in your life. Her own issues around weight point to the idea that middle-aged women tend to be a little chunky and that's ok because it fits the perceived image, at least for the generation of this participant. Intellectually, she knows this is not true. However, youth is thinness and beauty. Passage of time takes its toll and is out of our control. However, this concept is changing as more of the population reaches the middle years. The media is beginning to produce more ads and billboards showing active, fit middle-aged and elderly individuals and athletes.

Participant B: I don't know... I...keep thinking about my mom in this perspective to have sisters twenty years younger than I am...There's fifteen years between the two youngest. So I'm the oldest and my sister is two years younger than I am. My brother is five years younger than I am, and one that's twenty years. And so my mom's just dealing with some of the same things that I am, having had a child that late in life. So when they all move back home on her, I can sit back and laugh. <laughter> So it's kind of like, if there is a middle-age, then perhaps that's where I'm at but there's so many things -- the kids are growing up and moving on.
Being a grandparent is a valid question at this point. My son's certainly old enough to have children. My daughter's old enough to have children. I'm going to be an aunt in a few months...

Participant D: I'm getting towards that other end, of the kids starting to move out now, and I feel that empty nest syndrome thing. Middle-aged, I don't feel like I'm there yet, middle-aged-wise, but I feel like I'm approaching it. I want to be a grandma. You can say I'm a "grandma wanna be." But... I'm ready when my kids are. So I guess I'm looking forward to that but, yet, I don't consider myself close to middle-age, yet. Whatever that means.
...I still feel very young. And where that comes from, it just seems like a few years ago I was a teenager... You look like you're 25." And I get that constantly, so, you know, I suppose (slight laugh)- but yet I'm looking forward to approaching middle-age. And I always thought middle-age was like around fifty.

Participant A: ... Feeling middle-aged...yes. I'm tireder than I used to be. And I realize that but by the same token I find myself doing things like describing men who are younger than I am as older men. I met a really nice older man someplace and then I find out he's in his forties. (Laughter from all in the group.) So mentally I don't think I'm so middle-aged. But

then I do realize that I get tired faster and there are things I don't want to do anymore that I don't want to bother with. I don't go to football games, things like that.

Participant B: I'm not going to have middle-age. <laughter> I don't have time for that...

Participant A: And I have no health problems, you know, except for menopause which isn't a real problem because I take pills...It's the combination pill...It works wonderfully...It was real tough when my glasses steamed up at work. And I'd have to take them off because I couldn't see the <clients>...I would wake up at night. And that was only annoying in that I didn't get enough sleep. And then I was grumpy... So I went to the doctor and he gave me those pills. But you know I'm happy now...I didn't have those depression things and stuff <pause>- That was absent...Just the hot flashes...As far as I know. I didn't experience any others...I think I must be the only one here that's...dropped into that...

Participant C: "So far" which brought on group laughter.

Participant D chimed in: ... I've had people suggest that I should, but I usually don't feel like it. You know, I mean unless I go to the doctor and they go, "How old are you?"
I was going to ask you <looking at participant A>. How old were you when you started experiencing them? Because I get hot flashes now, but it's probably because I'm overweight <pause>. And I've always been hot blooded...

Participant A: ... Well, I don't really remember. I've been on these pills for about six years or seven. I don't know. So around fifty, maybe. <Long Pause>"

The 58 y/o participant has experienced menopause, while other group members have not. Conversations among group members with laughter and questions about when "it" is supposed to happen and exactly what menopause feels like support Sheehy's (1991) findings that women today who are facing menopause are traveling in unchartered waters with many mixed messages from family, friends, the media and health professionals.

The following two excerpts give a sense of looking to the future and being a part of it.

Participant D: I would like quality health in my sixties. And I know that if I'm going to achieve that I'd better start now....

Participant C: And then I had another child who is twelve years younger than <teenage daughter> is so I sort of have my own grand child... And it's very strange when she was born, you know, I remember carrying her in to <local grocery store> and going up to someone <participant laughing as she tells the story> and she was carrying a baby around the

same age and she looked like she was my age and I said, "It's great, isn't it?" And she said, "Yeah, I love it. I've been waiting for grandchildren forever." (Laughter by all and clapping.)

Participant A: I'm 58. And I've lived here in <Name of County> since <year>, so that's <large number of years>. And I'm a school teacher and have been teaching <large number of years>. So I'm on my second generation of kids...which is really very interesting. I have no children of my own so I have a different experience which is interesting.

Even though this participant has no children of her own, her talk centered around her second generation of students, suggests that they are her surrogate grandchildren. There is a sense of moving ahead to a future generation.

Health

Through the eyes of this cohort, health means physical, mental and spiritual wholeness, the whole - not just the parts. Influencing factors centered around the meaning of health include: finances, access to care and time. The major negative health issues perceived by this cohort to affect their health centered around stress, lack of sleep, poor diet and lack of exercise for which they used a variety of self-care measures in an attempt to maintain balance and overall physical and mental health.

Positive health imparts a feeling that one can get through the day feeling comfortable, not hurting and functioning well. It includes the ability to work hard and not feel bad. The goal is to feel "happy", sleep well at night and feel clear and rested the next morning. Having a "lift and a skip" in your step. Additionally, being thin and in good shape through regular exercise was valued as important for both physical and emotional well-being. The women emphasize the importance of having time to think, read, reflect, develop and utilize their creative talents as essential to good health.

Signs of health problems and poor self-care mean that one feels bad or stressed. Physical manifestations include: cold sores, headaches, heart palpitations, inadequate sleep, high blood

pressure, medical disasters. The stiffness and trouble getting up associated with aging indicate signs that poor health is on its' way. Being overweight, in poor physical condition with lack of exercise and a poor diet can be dangerous and cause poor health outcomes and premature death. In addition, you feel bad emotionally and others perceive you as unattractive. The following dialogue reflects this cohort's definition of health as described above:

Interviewer: ...What does health mean to each of you...?

Participant D: ...The ability to be able to do what you've got to do in a day...I mean...to not have to think about it. If I have to think about my body, it means something is wrong."

Participant C: I think I have to be physically and mentally healthy in order to get everything that needs to be done without having to think about, 'I need to take this pill or that pill, so I'm feeling vulnerable.' If I have to think about it, I mean, is something wrong?...

Participant D: It's usually because you're in pain. <laughter>

Participant C: Right, either physically or emotionally...

Participant B: ...When you're dragging and emotionally wrecked, you know that tear thing...When I'm starting to get that way, I can usually say, 'OK, something's going on here.' So I can start feeling it physically... And it means...like working hard everyday and feeling good at the same time...

Participant D: ...You work hard but you don't feel bad or something.

Participant B: ...You sleep good at night. And you get up in the morning refreshed and your mind is clear and you're... happy...I kind of strive for happy these days...The rest falls into place...I worry...about the weight issue...I've constantly got that going...If I don't do something about it, then it's going to get me...When I go to the doctor -- I just went here a month ago. And he says, 'You're healthy as an ox.' Well, it's like, 'OK'. This stress. I got this opportunity now. I'm healthy as an ox. Do something about it. Get yourself in control from here on out...It's following through in doing that...It's what's right for my body, my emotional health. And I can definitely, physically tell. whether things are going wrong...Being able to sleep well, happy... No outbreaks of the cold sore, you know, that type of thing.

Participant A: For me it would be more headaches. For me, one or two headaches would work. <laughter> Because I don't have anything like high blood pressure or, you know, palpitations or any of those things that are actually medical disasters...The aging is, you know, is getting stiff and having trouble getting up or that sort of thing.

Participant B: ...Still having that lift and skip in your step... <pause>

The Art Spirituality Class taken by participant D and described below illustrates the importance of having time to think and create as very important components of health.

Participant D: Well, I think that's what keeps me alive, is that part of my brain...I've always had the ability to daydream... Because it's like it's not so focussed and stressed as it is at work. It's more or less just allowing the time to unwind. And it is for me, a lot of times when I'm in that creative process it's sort of an out of body experience, anyway...
Because to me those things are not something we can own. But that's actually why I took that class because it was called, 'Art Spirituality' and to me, the two of those things are really related. Because any true art comes from that center of focus. And so then, you figure, OK, I'll be an artist and make my living and then all the sudden there is no spirituality and then you've got this real conflict. So what I've done to balance that all out, is try to have this existence that will satisfy the money need. And then have the time to satisfy the spiritual need, too. And a little goes a long way, anymore. I've learned to be able to even just use the thinking time to work out lots of problems. So that when I am actually there in front of what it is I'm going to be doing, <laughter> because I've been thinking about it, and thinking about it, and thinking about it. And it would be to me, the ideal existence would be to have that kind of time to just create without the pressure of having to survive somehow. And in this culture, it's not possible because your creativity and your income are really not connected unless you're hooked in with someone. I've been trying to make a living as an artist since I was 18 and it's just really hard. It's one of those things -- but I, like in terms of relating to your entire health, it's healthy for you to do what you need to do. What you feel -- that you feel a need to do. And there is a need for that.

Finances, Access to Care and Self-Care are completely intertwined. Each of these components affects the other so greatly that they will not be broken down into three different categories. The various components are reflected in the following exemplars and paradigms and will be addressed as they arise within the conversations.

Access to care for the purpose of this paper means what the individual perceives as access to care, not what health care providers and others may perceive as access to care. Access to care is influenced by finances, insurance coverage, geography, services available and ability to choose the type of health care services that meet personal needs/philosophies and sense of autonomy and control over one's life. Even for those insured, the providers desired may not be covered by the plans they are eligible for. Access to care includes the individual's interpretation

and satisfaction with the care received. If the meetings with the health care provider were not satisfactory addressing the individuals real concerns, the access to care is poor. Part of access to care is being able to communicate needs to providers and have them respond to those needs appropriately.

Small business people often cannot afford health insurance premiums and have to wait for catastrophic illness for coverage. They may be compelled to seek employment which is not desired and this detracts from their overall health. The following paradigms illustrate this point:

Participant C: ... Consequently there isn't retirement or health benefits so that's another issue, that we can't get sick because we can't afford to, I mean that's how it is. And we are also of an income bracket that will not allow us to be considered for the Oregon Health Plan, but at the same time, if we want to get health insurance, it would be four to five-hundred dollars a month which we can't afford either.. So, I mean, my biggest gripe there is that now we have to wait until we're sick. We're not being cared for on a daily basis so that we don't get sick. I mean we'd get that kind of care if we had the insurance for it, but there's no money in the system now, you've got to really think about how you're eating and living because you don't have any insurance <laugh>.

Participant D: ...We went through that....<Husband> took two years off ...<to do work for a company...About a year later, it was getting really tough in the business... Our business partners were putting in resources to help us survive: the groceries, the rent...I mean, it was awful. We had no income ourselves...We hung in there thinking... that it was going to go...<products> were successful but monetarily we weren't. So we had to make a big decision on what to do and at the tail end, my husband got sick and he had some heart trouble. He smoked like a <a lot> and being overweight...ended up in the hospital. And we had no insurance. So the hospital advised us because our income was virtually... zero...that we could apply for the Oregon Health Plan immediately. So we did. I mean we had to, it was an emergency. Up until then I just paid for you know Dr. <doctor's name>, forty dollars or whatever....if the kids got sick...We went on the Oregon Health Plan...Then we were able to relax a little bit. It was a blessing...It took care of his needs... and paid for his medication 100 percent...His medication was... 200 dollars per month...You just don't know when it's going to hit you. It just came out of the clear blue sky. So the Oregon Health Plan was wonderful for us. But -- then we got to the end of our line, too... And you're only qualified for six months at a time. Then you have to reinstate and reevaluate...A year ago... he went back to work for the company <where he had worked in the past> ...Wonderful benefits...again, but, he didn't really want to go back either...We do what we have to do to stay here. Playing as a team but we still have that ultimate dream, working together. I related when you said (looking at another participant) ...We've had more problems apart than we do working together...We were broke and everything but we got along wonderfully...Now we're pulled apart again... trying to work,...do all this stuff ...and it's hard on us.

Distances and geographics is an additional problem in rural areas and often stems around insurance plans which may only cover providers in bigger cities many miles away. In addition, rural areas often lack providers in specialty areas which necessitate travel. Privacy issues can be a challenge in small communities and individuals seeking specific forms of health care which they wish to keep confidential, will either put off seeking care or will be compelled to travel long distances to keep their privacy intact. These issues can result in inadequate, delayed care or no health care with institution of self-care practices. One participant had to drive for over one and a half hours each way in order to see a psychiatrist for a several month period while she was going through a divorce. She signed up for a night class in the same town on the days of her appointments. This was done to take advantage of the long drive and to have a reason to tell people why she was going on such a long trip frequently.

Participant: When I was separated from my first husband, I was <pause> shattered. So I went to a psychiatrist over in <large town>. And <laugh> Being the sensible person that I am, I enrolled in a night class. So, I'd go see the shrink and then I'd go to my night class...That made it a useful trip! <laughter by all>

Interviewer: And was your shrink male or female?

Participant A: He was a middle aged man, you know, older than I was...I was in my thirties, I guess... he was maybe in his fifties...You could visualize him as leaning back with a pipe in his mouth although he didn't have one. But he was portly and fatherly and had a box of Kleenex on the corner of his desk. <giggles from group>...He was a psychiatrist, rather ... a psychologist or just a counselor...I guess I visited him, I don't know how many times... but several times over a period of a few months...like four months, maybe. And he gave me some anti depressants...And then I just took myself off the pills and took myself off him...when I didn't think I needed to go anymore.

Interviewer: Mm, hmm, And did you find that he provided some support and help?

Participant A: It was just plain support, right...I remember, my best friend had recommended him, because she had gone to him when she was undergoing something disastrous...Her boss was my ex-husband's partner <pause> at the time...and he said... he was also my lawyer, and so <laugh> He said, He just didn't see why I thought I needed to go to this guy!" And she said, "It doesn't matter if he <whispering voice> heaps piles of shit on her head, if it makes her feel

better, she needs to go <laughter by all> I always liked that one! So, yes I did it for awhile. And, yes, it made me feel better!...Uh, Just emoting < not familiar with this word>...And one of his techniques was to have me write down stuff. So I wrote voluminous, some of which I just burned up last summer....This junk. And when you look at it now, it was just JUNK! <laugh> ...That I was writing down about what I was feeling and what was going on with me. And I continued to do it after I quit seeing him for my own comfort.

Interviewer: Mm, hmm, So that it did make a difference versus if you hadn't gone.

Participant: Right, and then I read Passages...That helped, too, because I had just experienced a man doing that. The perfect midlife crisis. So that was very interesting. That didn't make me alone...<pause>

Because she has no insurance, finances, or services available, Participant C describes self-care practices she uses to help care for her emotional health.

Participant C:...But my way of dealing with, um, those kinds of, like overwhelming emotional crises, has always been to revert to journals...I also discovered -- it sounds kind of silly I suppose. It's a little too new age for me to really admit to, but there's something called, "runes." Have you ever come across those?

Interviewer: No.

Participant C: They call them the Viking runes and that's what they are. There from, you know, that period of time. And they're basically -- they're these pieces of minor porcelain, and they all have different markings on them, runes, signs, whatever you want to call them.

Interviewer:...How is it spelled?

Participant C: R-u-n-e-s...Basically, there's like 25 or 24, or maybe there's more than that. ...And you have them in a sack...And what you do, is...you run through in your mind what's going on in your life and what the major issues are. And what you're asking for is a perspective...And what you do, is you reach into this bag and the first three runes that you touch, are the ones that you pull out...you lay them down. And they're face down so you can't see what they are. And then you turn them over, left to right. And then you go through this <book>...the book will tell you what each rune stands for and what it means if it's upside down, and all this stuff...And basically, what it allowed me to do was get that third opinion, in a way that was non <pause> negative -- non negative, if that's a word.

Interviewer: Uh huh.

Participant C: Um, there are some things that you can do that, to me, have a real -- there's a scary part about them or negative that you can't really -- unless you're very in tune with what you're doing, you can't explain away to yourself, somehow. But with these, it's never negative. It's always a growth situation that you can move through and develop from. And

there was more than one occasion when I just got to the point where I just needed that third opinion somehow. That different way of looking at my situation and it really helped. It helped me get through, all by myself. And part of what was helping me was the idea that it was, that it was a growth opportunity. And that things that I was looking at as negative, like the loss, say of an emotional partner. You know, someone that I was really connected with. That that in itself was not a negative thing because it allows for this -- this, what they call the vacuum. You know? And to me a vacuum was always, like a bad thing. But in reality, it doesn't have to be a bad thing. And so it allowed me to sort of look at my situation and go, "Okay. Well, <whew>. I can deal with this...And I did. But...I suppose if there'd been someone that I felt I could confide in, I would have done that, too...But sometimes, I think things just get so overwhelming, you don't want to talk about them.

Interviewer: Right.

Participant C: You don't want to open up about them. And I know for a fact that I can be any one of those that holds stuff like that in if it gets -- if it gets to be really bad. I can't talk about it...And so it was a good tool for me because it allowed me to work through it on my own...Maybe if I'd had -- if I'd known someone well enough, or had someone recommended to me that I would have done that. If I'd had the money. But then it was like a money thing, too.

Interviewer: Right. The access to care. Because we'd talked about that with insurance issues and everything.

Participant C: Yeah. You can't get sick. You can't get sick physically. And you can't get sick emotionally. <laughter>

The following paradigms described by the same participant regarding her two dramatically different birth experiences and what they meant to her illustrate how access to care and care delivery can impact a woman's sense of autonomy and overall health. The quality of the birth experience and the sense of control and freedom to choose can have long term effects on a woman's self esteem, satisfaction with health care providers, the type of providers selected in the future and the way she manages her health and self-care:

Participant: The thing that I was very pleased about was that we were able to have <younger child> at home with a midwife. So with <older, high-school age child>, I always thought I would have more kids. I mean I just assumed that I'd have four or five. I mean there's this big gap and I think that's where the emotions fit. But anyway, <seventeen year old daughter> was born at a Birth Center which was the closest thing to having a child at home that anyone was going to let me do. Because no one really listened to me. They all said, "Oh, it's much

too dangerous. You should not have your first child at home. So I didn't and it took her three days to be born. Because every time I went to the hospital <pause> I got scared and I stopped dilating and everything else and so they'd say, "Oh, go home." So I would go home and, "Ahhh," you know, then all of a sudden I'd be in labor again. And they'd haul me into the hospital and then I'd stop, you know, and then they stopped sending me home and they just put me up in a room somewhere. Three days later I had a baby.

With <younger child> it was totally different because even being older we really didn't run into any problems. The worst thing that happened was about three weeks before she was due my blood pressure, which was normally really low started to climb. And the midwife said this is an issue and if your blood pressure gets to a certain point you will have to have the baby in the hospital. Let's do something. And so what I did was take garlic and parsley tablets on the hour for like a day and a half with gallons of water and it went down. And so she was born at home without anything and it was work! But that's having babies, you know and it was fine. And that sort of fulfilled a need I had because I really felt like I missed out with <older, high school-age child>.

That was one of the major points about delivering at home was that we had the opportunity to experience that and then when it's taken from you- I felt totally out of control during the whole thing. The second time I was in charge. I knew what was going on. I listened to what was going on. And do it the way I wanted it done. And so that was actually a real good reason for having <baby> at home to beat that feeling, but at the same time, you know, it took me awhile to snap -- I don't know that I snapped back, but I tend to be a pretty physically active person anyway, so I -- I guess I felt maybe conscientious to have a part of my body back. It got to the point where it felt like me again. You know? In process.

The meaning and quality of health to the cohort of women involved in this study was influenced by many factors and is clearly illustrated in the above stories and paradigms. Variables influencing their health are often out of their control. The roles each woman lives have direct and indirect influences on her health. The impact of these roles on this particular group of middle-age women and their over all health is clearly evident in the answer to the research questions:

Relationship Between Middle-Age, Multiple Roles and Health

"What is the meaning of the multiple roles that middle-age women occupy?" and "How do they interpret that these roles impact their physical and psychological health?" The reader was given a strong hint for the answer to the research questions earlier in this chapter:

A woman's work is never done. Women separate their professional career, commonly called "work" by the general population, from their life's work which is a composite of all of their multiple roles and is what makes them who they are. Thus, her career is one of many multiple roles or threads which weave into her life's work.

Multiple Roles are the components of a woman's life. She lives life through her multiple roles - her work. The meaning of this work, how each woman perceives it and how well it is done in her eyes impacts her health. How she views these roles and the support she has in fulfilling them determine the meaning of life for her and influence her health. The following two paradigms clearly illustrate these points.

Participant B : For me...work is more like raising a family and then having...a job as a means of taking care of that work, I guess...Work for me is taking care of the family and making sure they have the things that they need and a good support system. And learn the values of life so -- in actuality, work doesn't really mean what I get paid for...I think of my job as being a break away from work... So, it's like I go to work to get away from work as a break in the day. And it's more, well from the time I get home in the evening until I get up in the morning, that's more work-oriented for me...It's because I feel more responsibilities here than I do when I'm...on the job...

This participant has what would be considered a very responsible, stress-intensive career. However, she considers her home responsibilities as parent and partner as being the most demanding and labor intensive which other studies have also reported (McKinlay et al, 1990; Nolan, 1986; Oberndorf, 1992; Woods, Lentz, and Mitchell, 1993)

Bruenjes' (1994) work on the meaning of health refers to the concept of orchestration: being in control, making choices, and assessing results as key factors in living health. Her phenomenological study of 7 middle-age women most closely parallels this exploratory study based on size, style and it reflects her cohorts meaning of health from their words. She illustrates this meaning through the visual imagery of a woman conducting an orchestra which is characterized by "...moderating and encouraging physical, emotional, spiritual,

environmental and personal factors to achieve a sense of harmony or being 'in tune'" When a woman is able to maintain balance, she feels healthy and maintains positive health. When one or more of the players is "off", there may be detrimental effects to the symphony and the woman's health.

The following eloquent paradigm of one participant's definition surrounding the meaning of her life's work encompasses all that has been discussed regarding the multiple roles of middle-aged women and the impact on their health. It is only fitting that the final words in this chapter should come from one of those who knows and has lived the experience:

Participant D: ...Something that influenced me right from the get-go was a situation I was living in when I was -- oh let's see, I was probably 18 or 19. I was just starting the University...It was the summer prior to that. And I got this job working for these two women that had a pottery <business/studio>. And it was a great experience for me in a lot of ways. It introduced me to different lifestyles. I had pretty much... at that point had been living on the farm, in more ways than one, and hadn't really experienced what I would consider to be a wide variety of living -- lifestyles or of cultures... We didn't have a lot of diversity where I grew up and so it was all very new and exciting. And these two women were gay. I didn't know that -- I had no idea what gay was...It had never come up...So that was very new and different. And the fact that they were supporting themselves through their art was most exciting...Most of all... I can remember it real clearly. It was written in clay... She... wrote in clay with her finger on the wall, "It's not to make a living but to make a life." And I think I've never doubted that was what it was about. It's like I never felt that I was going to be gifted with an independent <laughter> bank roll... It was up to me to make a life for myself in a way that suited me. And even though I'm not making pottery anymore, I still am making a life... And the living is, to me, secondary...I think that's part of living on the coast here...You have to work harder in a way to get by, but you get by with less because there's more here...You choose...I think when you live in an area like we're living that is so incredibly beautiful, but also... economically stressed, you have to be willing to work hard... You do have a quality of life that we don't have working in a city where you would work, I'm sure just as hard, but then also have all...that environmental stress that you would have to deal with. So what I, in my life, have tried to do is make work not work as such, but living. It's living. I'm living. And I'm making my living. And I'm living my life. And it may be a little off beat or on the edge for some folks, but I'm very happy, actually. And I'm trying to communicate to my children that...I don't believe that we can be happy if your work life is your work life and your non work life is your life. Because these days we all spend so much time working that it has to be a holistic concept. It has to be integrated or I think you would

be very unhappy and frustrated. And I... mean not that I'm not frustrated on some levels, but they tend to be in regards to creative things that I'd like to be doing that I haven't really got the time for right now.

CHAPTER 5: Summary, Conclusions, and Implications for Practice

Summary

Relatively little is know about the health needs and concerns of one of the fastest growing subgroups of the population - women in midlife. The literature is sparse in studies addressing the multiple roles middle-aged women occupy and the effects on their health from the perspectives of the women themselves.

The purpose of this exploratory study was to identify and examine the multiple roles middle-aged women occupy in our contemporary Western society and the impact these roles have on their perceptions of psychological and physical health. An interpretive phenomenological approach captured the lived experiences of this cohort by enabling the participants to share their life stories and give accurate meanings to their understanding of "multiple roles", "health" and "middle-age".

A convenience sample of 4 middle-aged (35-65 years of age), Caucasian, middle income women were chosen from a rural population along the central Oregon Coast to participate in an informal, unstructured, group interview with one follow-up session. An interview guide and subsequent follow-up guide were created and critiqued by nurse experts for validity in addressing two research questions: ""What is the meaning of the multiple roles that middle-age women occupy?" and "How do they interpret that these roles impact their physical and psychological health?"

Both interviews were audiotaped, transcribed, and analyzed for recurrent themes and paradigm cases. Description and interpretation of the most salient examples of dialogues and themes along with how they relate to current research thinking provided evidence for this thesis and is the basis for the findings presented.

Findings suggest that the major roles rural middle-aged women engage in consist of: 1.) spouse/partner, 2.) professional business person, 3.) parent, 4.) care giver 5.) home manager, 6.) dietician, 7.) friend, and 8.) community service volunteer. These roles, along with numerous sub roles/tasks blend to form the "work" they do, their "life's work" and are influenced by those close to them. The roles of these women are constantly moving and fluctuating to gather those significant to them, weaving them into their life's center. Role functions are affected by social support, self-care activities and time. Even with the constant time crunch, financial concerns, and continual family conflicts and needs, they usually enjoy what they do. The major factors perceived by this cohort to affect health centered around stress, lack of sleep, diet and exercise issues for which they used a variety of self-care measures. Work is considered a source of self-esteem, their identity. Social support through family and friends plays a key factor in how they balance their roles and enhances or detracts from their ability to stay healthy. Results of this study provide new insights into the meaning multiple roles have for women and their perceptions of how these roles impact their health. This understanding paves the way for reevaluation of current health care practices in caring for middle-aged women.

Conclusions

Within a lifetime women are given, offered and choose a multitude of different roles to embrace and live out. Each of these roles have particular meanings to the individual, her family, friends, society and culture. The roles are labeled (given names) and have specific meanings based on each individual's lived experience of the role in the context of their world or reality. The value/meaning placed on the role is based on instruction from significant others, observations of others in the same kind of type(s) of roles, their personal value

systems and the perceived benefits taking on the role may or may not bring. The roles often change or are modified by circumstances within or without of the individual's control/input. The same role (s) may have similar or very different meanings to individuals with similar backgrounds. It is also possible that people of quite different backgrounds may have similar role (s) with similar meanings.

Women tend to make plans and decisions based on those who are important to them. Women's health must be looked at in the context of the meaning her family/social support has for her because they strongly influence many of the roles a woman takes on. Visually, the woman and her health is like the hub of a wheel. The woman's roles reach in and out of this center like the spokes of a wheel. The meanings associated with each of the roles and how well they are played out in the woman's eyes and by those around her determine the strength of the whole and how well the circle of a woman's world and her health turns. This is much like Bruenjes (1994) descriptions of women orchestrating their health described in Chapter 4.

The multiple roles a woman lives each day impact her health in many ways. Although important, the number and types of roles are not as significant as the meanings each role has for her and why she takes on a particular role. She defines herself through her roles. The degree of social support, finances and the perceived options she has in taking on each role determine the positive and negative influences on her health and the type of self-care practices she incorporates into her lifestyle.

Outside observers, including health care providers, often view that a women has a choice in taking on a particular role. However, the woman may perceive that she has no choice to take on a given role. This is clearly evident in the adoption paradigm told in Chapter 3 when the participant said: "You do what you've got to do" "It was the right thing to do." Without getting

to know this woman and finding out the meaning behind her confidential and difficult situation, it would be easy to judge that she was the cause of her own problems. She "chose" to adopt a child later in life. It is easy for health care providers to make inaccurate judgements perceiving their patients as, disorganized, dysfunctional, hysterics who create their own problems. Statements such as , "I can make myself crazy and "I'm not good at time management", may very well be the participant's reflection back of what she has been told in the past by others, including health care providers. Exemplars of her roles clearly point to the fact that she is a good manager of time. She just has too many roles. Many of these roles cannot be altered and have great meaning and importance to her. In addition, self-care habits relating to eating, exercise, sleep, and creative / personal time are directly affected by the roles a woman lives each day.

Even though the selected age range for this study was based on the literature's chronological range, 3 of the 4 women in this study do not consider themselves middle-age.. Women today are undergoing substantial change without precedence. The ability to delay childbearing until the late 40's coupled with advances in medical care, technology and longevity have broken down the reliable biological clock. Sheehy's (1991,1995) popular books address the issues of menopause and the aging process and follow quite closely with some of the comments and concerns made by the women in this cohort. It appears that there needs to be a change placed on the value of chronological age since it is not a significant factor, in and of itself, to this cohort and to many interviewed by Sheehy (1991, 1995).

There are inherent biases in this project related to the nature of interpretive phenomenology. Because of the small homogenous sample size, and the similarities in age, cultural and socioeconomic backgrounds of both the researcher and committee members the findings for this exploratory study cannot be applied to the general population of middle-aged

women. However, it does clearly illustrate the meaning of multiple roles and their influences on the health of this particular group of women. In addition, this study assists in sensitizing clinicians to issues and concerns women of similar age and culture may share. Understanding the meaning each individual places on the roles of their daily lives and the perceived effects they have on health will enable health practitioners to assist their clients in achieving optimum health. For it is only through meaning that understanding can emerge.

Froberg, Gjerdingen, and Preston (1986) state, "It is the task of future research to identify variables that contribute to making multiple role involvement hazardous or beneficial to women's health" (p. 90). Further phenomenological research with different cohorts of women will add to the body of knowledge regarding the meaning of a woman's work (her multiple roles, her life) and the impact it has on her health.

Only through a clear and better understanding of the meaning and personal perceptions associated with a particular role or behavior, will we be able to intervene to assist individuals in obtaining optimum health in their world. Benner and Wrubels' *primacy of caring* as described by Chinn (1995) clearly explains the need for phenomenological research to help direct health care, particularly nursing, down its intended path:

> Caring is primary because it determines and constitutes what matters to people. Subsequently, caring creates possibilities for coping, enables possibilities for connecting with, and concern for, others and allows for the giving and receiving of help (p.3-4). Caring determines what is stressful to people and how they will cope. (p. 189)

Implications for Practice

The time crunch phenomena of our participants is also prevalent in the health care profession. Health care providers feel it in their personal lives, at work with rapid

telecommunications/ technology, and with managed care constantly cutting back and expecting higher volumes of productivity. As in one participant's comment about constantly being driven to make "money, money, money" the same holds true with our current health care system. Health care providers must be aware of our own meanings regarding time. The meaning of time to patients who took time out of their day, often with lost revenue, to see their health care provider must also be considered. Clogged waiting rooms with multiple providers seeing the same patient over time and shortened appointments add to lack of time and consistency necessary to find the true meanings behind a patient's visit. This all too typical scenario with HMOs and managed care has patients as well as their health care providers feeling frustrated and angry which further blocks communication. This spiral can lead to increased law suits, patient dissatisfaction and health care provider "burn-out".

How can we stop this downward spiral? The answer "lies in the wind" the reader may say. However, if healthcare providers see the benefits of phenomenology as illustrated through this exploratory study, the answers come from the voices of our patients. Health practitioners must listen to the words of their patients. This is done through history taking. More time for adequate history taking with a consistent provider will help to better evaluate the quantity and quality of roles a woman engages in and will help focus on the real issues behind many of her visits to her health care provider's office. Whenever a patient is seen, think: "Why are they really here? Why are they doing this? Why did they put on all of that weight? What does this really mean? What is a day like for this person?" This approach will be especially helpful with women who come to their provider with somatizing complaints related to stress or other vague complaints for which there seems to be no obvious cause.

Health care providers and patients must band together through political action and grass roots organizations to voice their concerns. Although traditional research is a valued and important aspect to continued advances in health care, phenomenology-based research needs to take a front seat next to the "old guard" of scientific inquiry. The two can be a powerful influence and will bring the balance back into health care. This will be accomplished through better identification of health care needs with reduced expenses in many unnecessary prescriptions, procedures and non-productive, repeat office visits for vague complaints.

Female primary health care providers have many personal and professional roles which make the process of providing care as challenging for the providers as the receiving of the care is for their patients. It is essential that health care professionals identify and assess their own multiple roles and the impact they have on personal and professional health and well-being. In addition, well-documented, creative planning sessions incorporating the sharing of paradigms dealing with the issues of health care delivery using a phenomenological approach can be poignantly effective in presenting need-for-change issues to the general public and decision-making bodies.

This study illustrates, supports and concludes with Oakley's (1993) passionate challenge to the health care profession:

> Knowledge of women's health is a matter of understanding that the time has come to redefine and reconstitute what knowing about health really is...Health is a holistic thing: It is a state in which minds and bodies and thinking and feeling are not divided from one another. It is also something that cannot be divided into the provinces of different groups of professionals, squabbling for ownership of different body parts so loudly that the voices of the owners of the bodies cannot even be heard. It is also a matter of locating

health where it belongs, which is on the ground, in the ways in which people live their daily lives, in the context of their daily living conditions, in the material resources with which they struggle to construct and produce their own identities and their own lives... (p.342).

REFERENCES

Adesso, V.; Reddy, D.; Fleming, R. (1992). Psychological perspectives on women's health: An introduction and overview. Washington, DC: Taylor & Francis.

Baruch, G., Barnett, R. (1986). Role quality, multiple role involvement, and psychological well-being in midlife women. Journal of Personality and Social Psychology, 51 (3), 578-585.

Benner, P. (1994). The tradition and skill of interpretive phenomenology in studying health, illness, and caring practices. In P. Benner (Ed.), Interpretive phenomenology: Embodiment, caring, and ethics in health and illness (pp. 99-127). Thousand Oaks, CA: Sage Publications, Inc.

Benner, P, Tanner, C, Chesla, (1996). Expertise in nursing practice: Caring, clinical judgment, and ethics. New York, NY: Springer Publishing Company, Inc.

Bigbee, J. (1987). Stressful life events among women: A rural-urban comparison. The Journal of Rural Health, 3 (1), 39-51.

Bigbee, J. (1990). Stressful life events and illness occurrence in rural versus urban women. Journal of Community Health Nursing, 7 (2), 105-113.

Bigbee, J.L. (1985). The changing role of rural women: Nursing and health implications. Health Care for Women International, 5, 307-322.

Bruenjes, S. (1994). Orchestrating health: Middle-aged women's process of living health. Holistic Nursing Practice, 8 (4), 22-32.

Bushy, A. (1994). Women in rural environments: Considerations for holistic nurses. Holistic Nursing Practice, 8 (4), 67-73.

Chinn, P., & Kramer, M. (1995). Theory and nursing: A systematic approach, (4th ed.). (p. 40-47) St. Louis: Mosby.

Duffy, M. (1988). Determinants of health promotion in midlife women. Nursing Research, 37 (6), 358-362.

Extension Specialist, Child Development (Spring 1991 Forum). Dispelling myths about rural communities. Family & Child Development Department, Virginia Polytechnic Institute and State University-Blacksburg. Extension Journal, Inc.ISSN 1077-5315, 29, No 1. Internet URL Http://joe.uwex.edu/test/joe/1991spring/fl.html.

Froberg, D., Gjerdingen, D, & Preston, M. (1986). Multiple roles and women's mental and physical health: What have we learned? Women and Health, 11, 79-96.

Galyen, R. (1985). The confident relationship and psychological adjustment among persons with lymphatic cancer or multiple myeloma. Unpublished manuscript, Oregon Health Sciences University, Portland, Oregon.

Geary, M. (1995). An analysis of the women's health movement and its impact on the delivery of health care within the United States. Nurse Practitioner, 20 (11), 24-35.

Hibbard, J. & Pope, C. (1987). Women's roles, interest in health and health behavior. Women and Health, 12 (2), 67-84.

Hibbard, J. & Pope, C. (1992). Women's employment, social support, and mortality. Women and Health, 18 (1), 119-132.

Hibbard, J. & Pope, C. (1993a). The quality of social roles as predictors of morbidity and mortality. Social Science and Medicine, 36 (3), 217-225.

Hibbard, J. & Pope, C. (1993b). Health effects of discontinuities in female employment and marital status. Social Science and Medicine, 36 (8), 1099-1104.

Leuning, C. (1994). Women and health: Power through perserverence. Holistic Nursing Practice, 8, 1-11.

Mansfield, P., Preston, D, Crawford, C. (1988). Rural-Urban differences in women's psychological well-being. Health Care for Women International, 9, 289-304.

McBride, A., McBride, W. (1981). Theoretical underpinning for women's health. Women and Health, 6, 37-55.

McBride, A. & McBride, W. (1994). In A.J. Dan (Ed.), Multidisciplinary research and practice (pp. 3-12), Thousand Oaks: Sage Publications.

McKinlay, S.; Triant, R.; McKinlay, J.; Brambilla, D; & Ferdock, M. (1990). Multiple roles for middle-aged women and their impact on health. In M. Ory & H. Warner (Eds.), Gender, health, and longevity (pp. 119-136). New York: Springer Publishing company.

Morgan, D. (Ed.). (1993). Successful Focus Groups: Advancing the State of the Art. Newbury Park, CA: Sage Publications.

Munhall, P. (1994). Revisioning phenomenology: Nursing and health science research. New York: National League for Nursing Press.

Nolan, J. (1986). Developmental concerns and the health of midlife women. Nursing Clinics of North America, 21 (1), 151-159.

Neufeldt, V. & Guralnik, D. (Eds.). (1988). Webster's new world dictionary (3rd ed., College) New York: Webster's New World.

Oakley, A. (1993). Women, health and knowledge: Travels through and beyond foreign parts. Health Care for Women International, 14, 327-44.

Oberndorf, M. (1992). The changing role of women in the 21st Century: Building self-esteem in our daughters. Vital Speeches of the Day, 58, 751-754.

Oregon Economic Development Department. (1997). Internet URL http://www.econ.state.or.us/

Polit, D., & Hungler, B. (1995). Nursing research and the scientific approach. In D. In D. Polit & B. Hungler, Nursing Research: Principles and Methods. (5th ed.). (p. 14) Philadelphia, PA: J.B. Lippincott.

Pope, C. (1976). Data for the 1970-71 Household Interview Survey, Research Report Series No. 1. Portland, OR: Center for Health Research, Kaiser Permanente Medical Care Program.

Quimby, C. (1994). Women and the family of the future. JOGYN, 23 (2), 113-123.

Russo, N. (1990). Forging research priorities for women's mental health. American Psychologist, 45, 368-372.

Rose, J. (1990). Psychologic health of women: A phenomenologic study of women's inner strength. Advances in Nursing Science, 12 (2), 56-70.

Sheehy, G. (1991). The Silent Passage: Menopause. New York: Random House.

Sheehy, G. (1995). New Passages. New York: Ballentine Books.

Tanner, C.; Benner, P.; Chesla, C.; & Gordon, D. (1993). The phenomenology of knowing the patient. Image: The Journal of Nursing Scholarship, 25 (4), 273-280.

Thomas, S. (1995). Psychological correlates of women's health in middle adulthood. Issues in Mental Health Nursing, 16, 285-314.

Tilden, V. (1984). The relation of selected psychosocial variables to single status of adult women during pregnancy. Nursing Research, 33 (2), 102-107.

Tilden, V. (1985). Issues of conceptualization and measurement of social support in the construction of nursing theory. Research in Nursing and in Health, 8, 199-206.

Tilden, V. & Galyen R. (1987). Cost and conflict: The darker side of social support. Western Journal of Nursing Research, 9, 9-18.

Tilden, V. & Stewart, B. (1985). Problems in measuring reciprocity with difference scores. Western Journal of Nursing Research, 7, 381-385.

Van Manen, M. (1990). Researching Lived Experience: Human Science for an Action Sensitive Pedagogy. State University of New York Press.

Waldron, I., & Jacobs, J. (1989). Effects of multiple roles on women's health-Evidence from a national longitudinal study. Women and Health, 15 (1), 3-19.

Waljasper, J. (1997, March-April). The speed trap. UTNE Reader, 41-47.

Ward, D. (1995). Women's health care: A comprehensive handbook. (pp 111-124). Thousand Oaks, CA: Sage Publications.

Woods, N., Lentz, M., & Mitchell, E. (1993). The new woman: Health-promoting and health-damaging behaviors (1993). Health Care for Women International, 14, 389-405.

Worell, J. & Etaugh, C. (1994). Transforming theory and research with women: Themes and variations. Psychology of Women Quarterly, 18, 443-450.

APPENDIX A: Health History Form

HEALTH HISTORY FORM

Code#_____

1. How would you rate your current health status?

Excellent_____ Good_____ Fair_____ Poor_____

2. Do you have regular/primary health care provider(s)? Yes_____ No_____

3. Please list type(s) of provider(s) that you use, the number of visits in the last 12 months, and the reason for use: (Examples of providers: Traditional MD, Nurse Practitioner, Physician's Assistant, Naturopathic, Homeopathic, Osteopathic, Massage Therapist etc.)

Provider	#of Visits in last 12 months	Reason for Visit

4. Are you currently on any medications (prescriptions, over-the-counter, herbs/vits)

Medication	Amount	Reason

5. Have you ever been hospitalized? Yes_____ No_____

If yes, enter date & explain reason and length of stay:

Date	Reason	Length of Stay

6. List any significant acute and/or chronic disorders/illnesses you have had or currently have. Please indicate current, past or, does not apply:

_____

_____

_____

_____

7. List the significant acute and/or chronic disorders/illnesses in your family:

Grandparents:

Father's side_____

Mother's side_____

Parents:

Mother_____

Father_____

Sister(s):_____

Brother(s):_____

Children:_____

APPENDIX B: Interview Guide

Interview Guide 1

1. Think back to a typical day in the past week. Describe what this typical day was like for you in detail from the time you woke up in the morning until you went to bed at night.
2. How did this "typical day" make you feel?
3. How do you feel that the events in your typical day:
   a. Contribute to your sense of health?
   b. Detract from you perception of health?
4. In what ways, and by whom, do you feel supported in the activities of your typical day?
5. In what ways do you feel that the level of support you receive in your typical day:
   a. Adds to your sense of health?
   b. Detracts from your sense of health?

APPENDIX C: Sample Question with Answer, and Probe Questions

Question 1: Think back to a typical day in the past week. Describe what this typical day is like for you in detail from the time you woke up in the morning until you went to bed at night.

"A typical day for me starts at five in the morning and ends about midnight. I get up, fix a cup of coffee and just sit there for 15 minutes to get myself in gear for the day. My coffee time in the morning is sacred to me. It's the only part of the day that's mine. Then I take a shower, figure out what I'm going to wear to work and get myself ready. If I don't do this first, I end up late for work because there is usually a last minute crisis getting everyone out of the house by 8:30 a.m. By 8:00 a.m., I usually have a load of laundry going, have breakfast ready for the girls and John and lunches made. Susan reminds me that I have to go with her to back-to-school night and I just remembered that I have to take to cat to the vet for a bad paw at 5:00 p.m. which means I will have to leave work early. Then I think about what am I going to fix for dinner because John has a city counsel meeting and won't be home until 10:00. By the time I get on the road which is supposed to be 8:30 a.m. like the rest of the family, it is usually 8:40 a.m. and I usually roll in to work about 9:15 a.m. My boss lets me come in late if I take the time off my lunch break. I feel like I've had a full day..."

Example Probe Questions:

* After describing what you have done so far, could you elaborate on your alone time and the importance it has for you.

* Based on your description of the morning up until arrival at work and feeling like you already had a "full day", can you identify factors that caused you to feel this way?

APPENDIX D: Interview Guide 2

1. What is the meaning of work? (We spent a lot of our conversation time at our last meeting talking about the amount of time spent working.)
   a. What is driving you to work so hard?
   b. What if any choices do you have in controlling the amount and type of work you do?
2. Think back to when your parents (your mother in particular) were Middle Aged (the age you are now) and what your perceptions of that age and her health were at that time.
   a. Did these perceptions influence you to change your approach to Middle Age or how to prepare for middle age and your health in later years.
3. Another prevailing topic at our last meeting focused on lack of time, or "TIME CRUNCH"
   a. Do you feel that this lack of time is due to the fast pace of our culture or that other factors may also be involved?
4. Just because of the time-line of our generation, many women have had some sort of mental health counseling such as for divorce, depression or other family issues.
   a. If you're ok with this, I'd like to ask you if you have had counseling/therapy at any time in your life?
   b. If yes, When?, For how long? Briefly what for?
   c. Did the intervention make a difference in your health and in what way?

5. If time: Those who have young children at home, What prompted the choice to have another child when you already had children almost grown? OR... Did you not have the choice? Would you do it again?

APPENDIX E: Demographics Form

DEMOGRAPHICS FORM

Code#_____

1. Age_____

2. Ethnic/Cultural Identification:

   African American____ Hispanic____ Caucasian____

   Asian____ Native American____ Other____

3. Highest level of education completed: _____

4. Occupation: _____

5. Employment Status:

   Working Full-time____ Hours per week_____

   Working Part-time____ Hours per week_____

   Homemaker_____

   Other_____

6. a.) Annual Family Income:_____

   b.) Amount or percentage of your contribution to annual family income:_____

7. Marital Status:

   Single_____ Married_____ Partnered_____

   Separated_____ Widowed_____ Divorced_____

8. Who lives at home with you now? (Check all that apply)

a.) Live alone_____

b.) Spouse/Partner_____

Is partner: Male_____ Female_____

c.) Children_____ Total Number_____

age_____ sex_____ age_____ sex_____

age_____ sex_____ age_____ sex_____

age_____ sex_____ age_____ sex_____

d.) Parent(s):_____ age_____ age_____

e.) In-law(s):_____ age_____ age_____

f.) Other family members(list):_____

_____

g.) Roommate(s)?_____ Total number:_____

h.) Other (specify):_____

9. Do you assist in providing care for anyone, either in your home or outside of your home? (other than employment related) Yes_____ No:_____

If yes, describe:_____

_____

_____

_____

10. List (in order of importance) the primary support persons, organizations, groups, etc. you have in your life: (example: friend, spouse, church)

a.) Does not apply, I have no support person(s)_____

b.) Most important_____

c.) Second most important_____

d.) Third most important_____

e.) Fourth most important_____

f.) Fifth most important_____

APPENDIX F: Introductory Cover Letter

October 14, 1996

Dear

Thank you so much for agreeing to participate in my study. As we discussed, I've enclosed the Demographics form, Health History form, and Consent form for you to read over and complete. Please feel free to call me if you have any questions or concerns.

Enclose the completed Health History form in the envelope labeled "Health History" and insert this along with the Demographics form and the Consent form in the large, self-addressed and stamped manilla envelope I've enclosed. Please mail no later than October 22nd to ensure I receive the documents prior to our meeting at 6:00 pm on October 28th.

If you are unable to mail the documents by October 22nd, let me know and you can bring them the night of the meeting. I will not be able to include you in the study without these completed forms. As my research guidelines require a specific number of participants in the group, please let me know well in advance if you will be unable to attend, so that I can find a replacement.

A variety of snacks and beverages will be provided to keep our energy levels up. I look forward to a great evening of sharing and enrichment for us all.

A map and directions to our meeting place in <location> are enclosed.

Thanks,

Diane Dietterle, RN, BSN
OHSU Graduate Student
WHCNP Program

Phone: 503-224-7166

APPENDIX G: Consent Form

IRB # 4274

Approved 09-20-96

OREGON HEALTH SCIENCES UNIVERSITY

Consent Form

TITLE. The Impact of Multiple Roles on the Health of Middle-Aged Women: Their Lived Experiences - Their Words

PRINCIPAL INVESTIGATOR(S).

Diane M. Dietterle, RN, BSN, graduate student, OHSU (503) 224-7166

Mary Ann Curry, RN, DNSc, WHCNP, FAAN, Research Committee Advisor, OHSU

(503) 494-3847

PURPOSE.

You have been invited to participate in this research study because you are a Caucasian woman between 35 and 65 years of age. The purpose of this study is to identify and examine the multiple roles middle-aged women occupy in our contemporary Western society and the impact these roles have on psychological and physical health. You will participate in one small group interview session and will be contacted by the researcher after data analysis is complete. Follow-up contact will be via telephone, personal contact, or small group session depending on participant's availability and time constraints of the study.

PROCEDURES.

If you agree to participate in this study you will be asked to fill out a confidential health history form and a demographics form. These forms will be mailed to you with a self-addressed return envelope approximately two weeks prior to the beginning of the study. You will be requested to complete the forms and return them in the envelope provided within one week of receipt.

You will also be asked to share your life experiences regarding the roles in your life such as paid worker, partner, spouse, mother, etc... in a small group interview of 3 - 4 other participants. An informal interview guide will be used to elicit information regarding the multiple roles in your life. For example, you will be asked to describe what a typical day is like for you and what this typical day makes you feel like. The group session will be audiotaped and the researcher may take written notes during the session.

After data analysis is complete, you will be asked to be available for follow-up contact, either by telephone, in-person contact by the researcher, or via a second group meeting with the same participants. Method of follow-up will depend on participant availability and time constraints of the study. Follow-up contact will last no longer than one hour and will also be audiotaped. RISKS AND DISCOMFORTS

Participation in this study will require a contribution of your time. Some participants may find the sharing of personal experiences difficult, uncomfortable, or emotionally upsetting. There may be other unanticipated risks from participation in this study.

BENEFITS.

You may or may not personally benefit from participating in this study. However, by serving as a subject you may contribute new information which may benefit patients in the future.

ALTERNATIVES.

The alternative to participation in this study is to choose not to participate.

CONFIDENTIALITY.

Neither your name nor your identity will be used for publication or publicity purposes. Audiotapes will be transcribed with all personal identifying information deleted and no identifying information will be linked to your responses from demographic or health history forms. Audiotapes and field notes will be kept in a locked file and reviewed only by the nurse investigators. Following completion of data analysis, all audiotapes will be erased. It is expected that you will respect the confidentiality of other participants and not share any information outside of the group session. According to Oregon law, suspected child or elder abuse must be reported to the appropriate authorities.

COSTS.

There is no charge for participating in this study. No reimbursement or compensation will be given to you as a result of your involvement in the study.

LIABILITY.

The Oregon Health Sciences University, as a public institution, is subject to the Oregon Tort Claims Act, and is self-insured for liability claims. If you suffer any injury from this research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, its officers, or employees. If you have further questions, please call the Medical Services Director at (503) 494-8014.

PARTICIPATION.

Participation in this study is voluntary. You may refuse to participate, or you may withdraw from this study at any time without affecting your relationship with or treatment at the Oregon Health Sciences University. If you decide to stop participating, the information you have already given will be destroyed. You will be informed of any new information throughout the study that may affect you regarding this research study and your participation. Mary Ann Curry, RN, DNSc, WHCNP, has offered to answer any other questions about this study (503) 494-3847.

If you have any questions about your rights as a research subject, please contact the Oregon Health Sciences University Institutional Review Board at (503) 494-7887. Your signature below indicates that you have read the foregoing and agree to participate in this study.

Signature of Participant: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Investigator(s): _____ Date: _____

_____ Date: _____

APPENDIX H: Follow-Up Letter

January 25, 1997

Dear

The holidays are over, whew! As discussed during our October 28, 1996, group meeting, I'm contacting you to begin making plans for our final group or individual phone interview meeting for sometime in mid February. Monday, February 17th (day or evening) is a good possibility for me. However, I can make arrangements for other times, especially for phone interviews.

I've enclosed a copy of the consent form, including your signature, just to make sure you have a complete copy. I want to thank you so much for working with me on this project. It is very much appreciated!

I will contact you, along with the other group members, by phone the first week in February to establish an exact meeting place and time.

Warmest Regards,

Diane Dietterle, RN, BSN
OHSU Graduate Student
WHCNP Program

Phone: 503-224-7166