

MEANINGS AND MOTIVATIONS AMONG OLDER ADULT

MALL WALKERS:

A QUALITATIVE ANALYSIS

by

Harriet H. Duncan

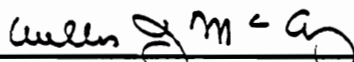
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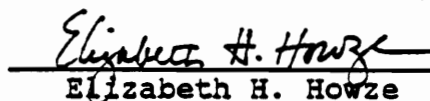


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(ABSTRACT)

This study employed the grounded theory methodology suggested by Strauss and Corbin (1990) to analyze and explore the meaning of and motivation for mall walking among a group of older, rural, independently living adults. Interviews were conducted with 14 respondents aged 62-81 and participant observation was conducted at a rural mall.

Mall walking was initially motivated by three conditions: (a) expert-directed advice, (b) self-determined goals, and (c) the invitation of significant others. Four major factors encouraged continued participation in mall walking: (a) the need to create work roles after retirement, (b) fear due to perceived vulnerability in the community, (c) social supports from family and peers, and (d) a sense of membership in a community of older adults that was generally time and place specific. Members of this mall community shared activities, routines, rituals, beliefs, and a sense of belonging.

Despite medical disorders, all of the respondents said their health was good. After initially responding to medical advice to walk, walkers paid little or no attention to medical problems. These older adults did not continue to mall walk in response to expert medical direction. This finding suggests that health promoting activities should not rely on the continuing influence of medical advice to encourage adherence or ongoing participation in health promoting activities, and should instead attend to the social constructs of health and wellness.

An important implication for future research is the finding that mall walking was a quasi-work activity, not exercise. Walkers created "work" routines and roles that replaced those lost upon retirement. The equation of mall walking with work has implications for both the design and the implementation of health promoting activities for older adults.

DEDICATION

This dissertation is dedicated to the memory of

Anna Jane Dolores Hutt Hindinger

and

David Theodore Hindinger

my mother and my father

ACKNOWLEDGEMENTS

Long ago, before modern guides to navigation, sailors used the light from a bright pole star to guide their voyage into the unknown and to bring them safely home. Shirley Travis has been such a guiding star during my voyage of discovery into research. Without her kind, calm, and insightful guidance, I could never have completed the voyage home. I was most fortunate to have had Shirley and Jim McAuley as the co-chairs of my dissertation committee. Jim McAuley has always been a steady and reliable source of advice and support during my years at Virginia Tech. I also wish to express my gratitude to Katherine Allen, Libby Howze, and Mike Sporakowski, my other committee members, for sharing their valuable time and knowledge.

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Finally, to Fred who dug me out of the blizzard of the century so that I might print and deliver this document. What can I say? You are the wind beneath my wings.

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MEANINGS AND MOTIVATIONS AMONG
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CHAPTER I

Introduction

Cars are parked outside bearing license plates that read "Granmaw & Granpaw", "Retired", and "God Bless America". Even though it is only 7:30 a.m., the smell of freshly baked cookies is already in the air. No, it isn't Grandmother's house, but grandmothers and grandfathers are certainly here. Grab your walking shoes and get ready to enter the world of mall walking U.S.A.

Overview

This chapter provides an overview of the research project and an introduction and brief discussion of the research problem. Abbreviated discussions of the project purpose and significance are also offered in this introduction. The chapter concludes with a list of research questions used to guide this qualitative inquiry into the meanings of and motivations for mall walking.

In order to understand mall walking, a new phenomenon spreading across the country, this study employed a paradigm that (1) challenges the old stereotypes of aging as a period of life accompanied by disease, decline and deficit (Garfein & Herzog, 1990; Rowe & Kahn, 1987) and (2) describes the complex meanings of and motivations for mall walking (Duda &

Tappe, 1989). Specifically, this study focused on a community of mall walkers in southern West Virginia whose members consisted of rural, independently living, older adults 60 years of age and older.

Although the qualitative aspects of the experience of physical activity have meaning throughout the lifespan, knowledge of these meanings and motivations among older adults is sorely lacking (Sloan, 1989). Kleinman has urged an increased awareness of the "positive meaning-seeking engagement" present in activity, arguing that with aging the experience of activity becomes increasingly qualitative (1989, p. 64). He also suggested that the current "pervasive compulsion to measure performance in quantitative terms" (1989, p. 64) reflects futile attempts to recapture the past, or even a denial of aging. A qualitative exploration of mall walking activity among older adults is an appropriate response to these concerns because it is a nonmathematical way to conduct research that explores the meanings of an experience to the individual.

This study employed grounded theory methodology to explore how the actions, interactions, and motivations of older adult mall walkers created the phenomenon of mall walking. Employing grounded theory methodology permitted the researcher to uncover how extant theories that initially framed the researcher's view, such as symbolic

interactionism and social cognitive theory, might be extended and applied to the new and varied situations experienced by an aging population (Strauss & Corbin, 1990). Grounded theory methodology was also appropriate to the initial goals of the investigation to understand the psychological and sociological meanings given to mall walking by older adults (Spradley, 1979; Strauss & Corbin, 1990).

Introduction To the Research Problem

*

Since the late 1800s the United States has experienced two clearly defined demographic trends. The first is a marked increase in life expectancy, and the second a concomitant increase in the number of Americans aged 65 and above. Estimates indicate that between 1980 and 2020 the aggregate number of older adults will double, from approximately 23 to 45 million (Hendricks & Hendricks, 1986). Now people who reach the age of 65 are expected to live into their 80's (Public Health Service, [PHS], 1990).

How satisfactorily people experience an extended lifespan is more problematic. While gains made in longevity and population may seem impressive, this limited view obscures the point that there are many ways to grow old. Some of these ways are much less desirable than others (Guralnik, 1985). Longevity without health has little meaning or attractiveness for most humans. Many older

adults seem not as concerned about dying as they are about enduring living with impaired functional abilities (Buchner & Wagner, 1992). It is maintaining the ability to engage in active living that seems vitally important in making a long life worth while.

Although it is a commonly held misconception that most disorders seen in old age are inevitable, there are many disorders that can be prevented or at least controlled. A positive association between healthy aging and physical activity was noted in Healthy People 2000 (PHS, 1990). Physical activity, even if initiated later in life, can improve health and reduce the risk of disability (PHS, 1990).

* Research has documented the psychological and physiological benefits of exercise among the elderly (Duda & Tappe, 1989; Howze, Smith, & DiGilio, 1989). Therefore, the benefits of exercise are no longer the only critical questions to be researched. An increasingly important matter for research is why most adults apparently reduce their level of physical activity as they age, while some older adults do not (Prohaska, Leventhal, Leventhal, & Keller, 1985). The emerging research questions reflect the need to understand the motivations for and meaning of the regular practice of physical activity by older adults (Dishman, 1982).

The Surgeon General's Committee on Health Promotion and Aging recommended studying the behavioral and environmental factors that affect whether a person initiates, adopts and maintains a physical activity (Abdellah & Moore, 1988). Among life style choices, patterns of physical activity and marriage significantly impact individual health and longevity (Berkman & Breslow, 1983; Fries, 1980). Differences in exercise behaviors have been shown to exist for individuals with and without significant others who support their exercise habits (Ross, Mirowsky, & Goldsteen, 1991). Therefore, exploring the social and psychological dimensions that influence older adults' participation in, and adaptation of, physical activity is relevant to the health of the nation's aging population.

Research Problem

Walking is the most popular physical activity for 37.2% of Americans 55 or older (Staff, National Commission on Aging, 1991). In recent years, walking in an enclosed mall has become a popular choice of many aging adults who enjoy the safe, inexpensive, and generally accessible features of malls. Yet most of the research exploring the meaning of and motivation for physical activity has focused only on participants in supervised adult fitness programs conducted in clinics and laboratories. There is little published research that addresses phenomena such as mall walking,

among community dwelling older adults. Consequently, very little is known about the experiences of exercisers such as mall walkers who, nevertheless, participate in regular physical activity (Berger & Hecht, 1989; Spirdusco, 1989; Kimiecik, Jackson, & Giannini, 1990). Because of this lack of information, health promoting activities for healthy older persons are often inappropriately based on information derived from infirm or younger age groups (Dishman, 1989; Morgan, Dallosso, Bassey, Ebrahim, Fentem, & Arie, 1991).

Purpose of the Study

Walking is a form of physical activity already engaged in by most adults. Walking has been called a "routine exercise" (Hovell, Sallis, Hofstetter, Spry, Faucher, & Caspersen, 1989, p. 956) because, ever since childhood, most people incorporate walking into every day living. Walking generally requires little effort or specific equipment. Moderate-intensity physical activity such as walking conveys health benefits to adults and has been found to be associated with increases in both psychological and physical well being in older adults (Hird & Williams, 1989; Ostrow, 1983; Piscopo 1985; Taylor, Sallis, & Needle, 1985). Unfortunately, despite the beneficial influence of exercise on the psychological and physical well being of older adults, older adult participation in physical activity is extremely low. It has been estimated that only 10-20% of

those over 65 years of age are physically active at a level recommended in the U.S. 1990 Objectives for the Nation (Powell, Thompson, Caspersen, & Kendrick, 1987).

Important public health effects might be achieved by finding ways to encourage a sedentary population to become moderately active (Hovell et al., 1989). In order to effectively encourage participation in physical activity among older adults it is necessary to listen to what older adults who do participate in moderate-intensity physical activities have to say about the experience. The psychosocial factors that underlie and influence these feelings must be identified. Uncovering contextual, sociological and psychological factors that may act to constrain, or enhance, physical activity in older adults would inform efforts to encourage appropriate participation in health promoting physical activity by older adults (Ewart, 1991).

Therefore, the purpose of this study was to explore the meaning of and motivation for mall walking among rural, independently living older adults. As will be discussed later in greater detail, the theoretical sensitivity of the researcher toward medical models of care, prior research on health-promoting behaviors, and the social climate of enclosed walking malls exerted a unique influence on the project design and implementation.

Significance of the Study

Health in older adults is increasingly influenced by multiple physiological, behavioral, and social factors (O'Leary, 1985). One of the more popular theoretical perspectives from which to consider these multiple factors is social cognitive theory (SCT). SCT postulates that cognitive, physiological, social, and environmental factors all interact as reciprocal influences upon each other to influence behavior in a probabilistic, noncausal manner (Bandura, 1986). In later adult years, certain environmental, social and biological factors may constrain or affect physical activity. Among these factors are transportation, lack of social companionship, multiple chronic conditions, and care-giving responsibilities. In order to better apply theories such as SCT to the world of the older adult, these factors need to be studied and incorporated into theoretical frameworks (Dzewaltowski, 1989). Dzewaltowski (1989) indicated that situational and environmental factors may be particularly significant to the practice of physical activity among older adults.

SCT is interactionist in perspective and emphasizes the importance of subjective perceptions. A major tenet of social cognitive theory is self-efficacy. Perceived self-efficacy refers to a subjective belief in one's capacity to mobilize the motivational, physiological and cognitive

resources necessary to take the course of action needed to meet given situational demands (Bandura, 1991). Self-efficacy is behavior-specific and based on cognitive, environmental and social influences. Self-efficacy is an important concept in this study because it is strongly influenced by the individual's cognitive interpretation of his or her interaction with others (Hofstetter, Sallis, & Hovell, 1990).

An extensive literature has developed which links habitual physical activity, disease reduction and improved physical functioning in younger and middle-aged Americans (Dishman, 1982; Hofstetter, Hovell, & Sallis, 1990; McAuley & Jacobson, 1991). These findings suggest self-efficacy and social support are important mediators of physical activity in the younger and middle-aged populations. Although not numerous, extant studies also support the argument that self-efficacy is an important mediator of physical activity among older adults (Howze, Smith & DiGilio, 1989; Kaplan, Atkins, & Reinsch, 1984; Sallis, Pinski, Grossman, Patterson, & Nader, 1988). For these reasons SCT was chosen to inform the concepts of this study even as the investigator remained sensitive to the unique environmental, physiological, situational, and other factors that older adults may attribute to their involvement with mall walking activity.

Social interaction and other sources of social support, particularly a spouse, are also considered to be among the most important influences on exercise self-efficacy. Thus, identification of the contribution made by spousal and other social support to the initiation of, and adherence to, regular programs of physical activity is salient to this study (Dishman, Sallis, & Orenstein, 1985; O'Brien & Vertinsky, 1991).

Knowledge gained from this study will allow socially and contextually informed hypotheses for future testing. Such testing could lead to a theoretical foundation on which to base health promoting policy and activity programs for an active, aging adult population.

Guiding Research Questions

Consistent with qualitative data-collection techniques, a set of questions were used to guide the investigation, rather than to generate testable hypotheses. (Appendix A) The primary questions that guided this investigation were:

1. What are the meanings and motivations attributed by older adult mall walkers for their participation in the mall walking community?
2. What are the motivations and meanings that older adult mall walkers relate for their adoption of, and continued participation in, mall walking?

3. How do older adult mall walkers indicate they feel family and friends motivate their mall walking activities? What meanings do family and friends have for older adult mall walkers in the context of this experience?
4. How do older adult mall walkers describe physiological, situational and environmental factors that influence their participation in mall walking?
5. How do older adult mall walkers situate the experience of mall walking within the broader context of their personal lives?

CHAPTER II

Review of the Literature

Overview

This chapter provides an overview of the theoretical and research literature. The literature reviewed initially informed the development and implementation of the study and assisted in the interpretation of the results. The review had the goal of illuminating relevant categories and relationships discovered during the research process as the study's theoretical framework developed (Strauss & Corbin, 1990). The literature included in the following sections comes from gerontology, psychology, sociology, medicine, nursing and health education sources. The chapter is divided into four major sections. Section one provides an overview of symbolic interactionism and the explanation for the choice of a theoretical perspective. Section two introduces social cognitive theory and enriches the discussion by introducing such important constructs as reciprocal determinism and self-efficacy. Section three offers an extensive review of the role of social support for health promoting activities. Because so much of the previous research on health promotion has found a strong relationship between social support and exercise, this section is rather lengthy. The chapter concludes with a

review of the situational factors that are known to effect physical activity.

Theoretical Framework: Symbolic Interactionism

Little has been reported about motivation for behaviors that promote health in midlife and old age (Duda & Tappe, 1989; Prohaska et al., 1985). Because qualitative research methods may be effectively employed to explore meanings, motivations, and other subjective aspects of individual lives (Berg, 1989), grounded theory methods were selected for this study. In the long run, this approach also enables the researcher to develop hypotheses for future testing (Strauss, 1987; Strauss & Corbin, 1990).

In the past, lack of theoretical or conceptual frameworks have limited the application and usefulness of research on participation in physical activity (Dzewaltowski, 1989). While Dishman et al. (1985) categorized determinants of exercise as personal, environmental, or characteristic of the exercise, the caveat was offered that "because most available research has been pragmatic, not theoretical in origin, data have been generated by different methods, from different populations, with somewhat different outcomes in mind" (p. 161). These methodological problems have resulted in a lack of standardization in defining and assessing determinants of physical activity (Dishman et al., 1985), and little

research has explored the meaning of the experience of physical activity to the participants themselves.

The theoretical perspective of symbolic interactionism provides the most logical framework for this study because the study concepts are assumed to be interactionist in perspective. Symbolic interactionism allows the researcher to construct social reality from the reports of individuals who interpret their world through, and in, social interaction (Manen, 1990). This study employed the grounded theory method, which Strauss and Corbin (1990) have termed interactionist in philosophy, to explore meanings and motivations among older adult mall walkers. These meanings and motivations are believed by the researcher to be constructed by mall walkers' interpretations of their social world and the process of people, or groups of people interacting (Berg, 1989; Blumer, 1969).

"The core task of symbolic interactionists as researchers . . . is to capture the essence of this process for interpreting (or attaching) meaning to various symbols" (Berg, 1989, p. 7). The research of Jaber Gubrium (1975) and Arlie Russell Hochschild (1973) captured the creation of attachment and meaning by older adults in qualitative studies of the lives experienced within older adult communities. Their studies revealed how older adults interacted in the creation of a meaningful sense of self and

surroundings through rituals and symbols, as well as through development of new social roles and structures. The meaning and importance that a sense of place, belonging, and community hold for older adults was illuminated by the research of these authors.

Social Cognitive Theory

Social cognitive theory is congruent with the perspective of symbolic interactionism which holds that what humans say and do is linked to how they cognitively interpret their social world (Berg, 1989). SCT presents a conceptualization of interaction based on triadic reciprocal determinism. Triadic reciprocal determinism exists when "three factors, behavioral, cognitive and other personal factors, as well as environmental influences all operate interactively as determinants of each other" (Bandura, 1986, p. 23). The term determinism must not be interpreted to mean causality (Bandura, 1986). In reciprocal determinism particular factors are associated with effects "probabilistically rather than inevitably" (Bandura, 1986, p. 24).

SCT proposes that much of human thought and behavior has social origins, and it acknowledges the importance of cognitive processes in motivating change (Bandura, 1986). The assumption that change is possible is an important aspect of the life span developmental process. SCT assumes

that older adults can change and thus control their own behaviors (Dzewaltowski, 1989).

Although SCT evolved from learning theories, unlike these theories, SCT recognizes the role of personal subjective hypotheses and expectations in shaping behavior (Rosenstock, Strecher, & Becker, 1988). SCT views antecedent determinants as predictive cues rather than controlling stimuli, and in so doing shifts the locus of regulation from the stimulus to the person. Concepts derived from SCT include self-efficacy which is created through four principle sources of interactional information. Three of these sources, mastery experiences, modeling and social persuasion, involve interaction with the social environment. The fourth contributor to self-efficacy, the individual's cognitive interpretation of somatic information, can be affected by information gained through interaction with the social environment (Bandura, 1991).

Self-Efficacy

An important concept in SCT is self-efficacy. Bandura (1986) defined self-efficacy as "people's judgments of their capabilities to organize and execute courses of action required to attain designated types of performances" (p. 391). Self-efficacy has four primary interactional sources, described below, which affect the likelihood of engaging in

exercise (Frank-Stromborg, Pender, Walker, & Sechrist, 1990).

Sources of self-efficacy. Self-efficacy is based on four major sources of information: (a) performance accomplishments based on personal mastery experiences (participant modeling); (b) vicarious experience (seeing respected others such as family members, friends or peers perform as role models); (c) verbal encouragement that the person can cope or achieve an action (this may be viewed as verbal encouragement provided by friends, respected others, and family members); and (d) self-monitoring of the state of physiological arousal (Perry, Baranowski, & Parcel, 1990).

Studies Employing Social Cognitive Theory

SCT has been linked in the literature to exercise activity in younger and middle aged adults (Dishman, 1989; McAuley, 1991). Some studies have also included older adults. Hovell et al. (1989) conducted a mail survey to identify variables associated with walking for exercise in a sample of 2,053 middle to upper class adult Caucasian residents of San Diego. The study variables were derived primarily from social learning theory. Independent variables included: (a) self-efficacy, (b) modeling, (c) friend support, (d) family support, (e) barriers, and (f) benefits.

The measure of walking for exercise was based on two items: "How many times in the past 2 weeks did you walk for

exercise?" and "About how many minutes did you do the activity each time?" (p. 858). Among the demographic variables related to walking, age was the most powerful and reliable. Adults over 50 reported more walking for exercise than did younger adults.

Self-efficacy and family support were found to be repeatedly associated with walking for exercise. These associations suggested that "the family is an important influence on walking habits and that self-confidence in one's general ability to perform exercise may increase the likelihood of walking" (p. 864). The authors noted that walking may be an especially acceptable form of exercise for women and older adults.

In a survey to identify correlates of exercise self-efficacy among 2,053 adults who participated in physical activity when young, Hofstatter, Hovell, and Sallis (1990) employed a path analysis to analyze data. Self-efficacy was found to be a strong correlate and predictor of current and future exercise behaviors. The variables accounting for the greatest explained variance were: (a) environmental variables, which included barriers, home equipment, and facilities; (b) cognitive factors, which included perceived benefits, normative beliefs, perceived barriers; and (c) social variables, which included models, and friend and family support.

In a two-part study to develop self-efficacy scales for eating and exercise behaviors, Sallis et al. (1988) found high eigenvalues for two exercise factors in their analysis of a sample of 171 young adults. Their findings indicated that the ability to resist relapse and to make time for exercise were the most important factors related to sustained exercise behavior. The moderate correlations in other areas revealed the difficulties frequently encountered in quantitative measurements of health habits. The authors noted that measurement error had reduced correlations.

The Role of Social Support

A life span developmental view may be considered to be broadly concerned with reciprocal interchanges over time between the individual and others in their social environment (Connell & D'Augelli, 1988). Social support describes the comfort, assistance and/or information that one can receive through contact with individuals or groups (Wallston, Alagna, DeVellis, & DeVellis, 1983). The provisions of social support are information, advice, aid or action offered by social intimates, or inferred by their presence, that are beneficial emotionally or behaviorally (Connell & D'Augelli, 1988).

A close social relationship is one in which the "action scripts of the people involved are interlinked" (Ewart, 1991, p. 933). Each person in the relationship has the

ability to facilitate or impede the other's act and thus affect the other's ability to attain goals related to work, self-care or other desired ends (Ewart, 1991). It is possible that social support and close social relationships may support the adaptation of health promoting activity (House, Landis, & Umberson, 1988).

Social support has been posited to affect health in several ways, including the promotion of adaptive behaviors which might include physical activity (House, Landis, & Umberson, 1988). Cassel (1976) argued that social relationships can affect health in a causal manner and reported that decreased social support renders the individual more susceptible to disease by reducing the body's defense mechanisms. However, Krause (1990) noted that findings from empirical studies of the stress-moderating functions of social support have been inconclusive and the research itself problematic. Krause (1990) argued that the use of global indices of stress and social support has led to a failure to recognize that social support is effective only if congruent with an individual's perception of his or her personal needs.

Minkler (1985) proposed two hypotheses related to the positive effects of social support. These are: (a) social support may mediate stress and thus create a buffer between the vicissitudes of undesired life changes and the older

adult, and (b) social support may increase the individual's sense of control. An increased sense of control has been shown to lead to positive health outcomes for older adults (Langer & Rodin, 1976).

Conceptual and methodological problems in current research on social support and health include, among others, a tendency to select measures of social support which pose the least measurement problems. This tendency results " . . . in a quantitative bias which undervalues the unique qualitative meaning of support as a process that changes over time and circumstances" (Connell & D'Augelli, 1988, p. 105). There has also been an " exclusion of investigations of social support as a naturally occurring process in the development of healthy individuals" (Connell & D'Augelli, 1988, p. 105).

Empirical Studies of Social Support and Health

The powerful influence of social support and close social relationships on life itself has been dramatically evidenced by research indicating that simply having a friend, or a support group, may be as important to a person's health as medical treatment (Williams, 1992). In a study of 1,386 patients who completed a battery of economic and social support questions prior to cardiac surgery, Williams (1992)

determined that factors other than cardiac status contributed to early death.

Whether patients' hearts were good or bad, if they didn't have a spouse or confidant they were 3 times as likely to die within 5 years after catheterization than a patient with a spouse or friend. The mere fact that someone was married -- whether or not it was a good marriage -- or that someone had a good friend was protective (Williams, 1992, p. 30).

Married patients among the sample of primarily white males, whose median age was 52, had a better survival rate than did unmarried patients. A significant interaction was found to exist between marital status and confidant availability, such that unmarried patients without a confidant had the lowest survival scores. In this study both economic and social effects remained significant in the final model, and there were no differences between men and woman in the effect of marital status and confidant availability on survival (Williams, 1992).

Empirical Studies of Social Support and Adult Physical Activity

Social influences on adult exercise behavior are an important area for research because aging is

responsive not only to biology but also to people's human relationships, to the roles they pursue and the ways they define themselves (Riley, 1981). Peer networks provide contacts with others who can suggest effective coping strategies, help with problems, or bolster self-esteem by urging more favorable self-evaluation (Thoits, 1986). Peer networks can also enhance self-efficacy by providing positive social models and supportive feedback (Ewart, 1991). Because health behaviors are to some extent malleable they are subject to these possible social and personal influences (Parron, Solomon, & Rodin, 1981).

Persons who have a high frequency of contact with persons other than kin are more likely to evidence health promoting behaviors that include regular exercise (Langlie, 1977). Muhlenkamp and Sayles (1986) found that 28% of the variance in positive health practices in their sample of older adults was explained by social support and self-esteem.

Reduced social support has been found to affect health behaviors in ways that may increase risk. However, positive support from a spouse, or high levels of perceived social support from others, has been reported to improve a person's ability to reduce risk behaviors (Williams, 1992). For these reasons the

meaning and influence social relationships have for and on older adults is salient to understanding the motivation these adults have for physical activity.

Research on Social Support and Physical Activity Among Adults

A survey by Berkman and Syme (1979) of 4,775 Alameda County residents, 30-69 years of age, employed a social network index consisting of marital status, number of close friends and kin, and membership in community organizations. This social network index anticipated all-cause mortality rates in a large study population over a 9 year period. It was found that the larger the individual's index the less that individual's chance of death. Schaefer, Coyne and Lazarus (1981) noted that while this research demonstrated the importance of number of social ties to health, it left unanswered the question of how social ties affect health.

House, Robbins and Metzner (1982) adjusted data from 2,754 adults, 35-69 years of age, who were subjects in the 1967-1969 Tecumseh Community Health Study, in order to control for age and a variety of risk factors. The subjects for this study were drawn from the residents of a small city in a rural area. Among the study findings were that men with a higher

number of social relationships and activities in that period were significantly less apt to die in the follow-up period. Trends for women were similar but not significant. These findings were invariant across age, occupational and health status groups. The researchers found that for an activity or relationship to have such beneficial results the activity had to involve active effort by an individual and some contact with other people.

Social support from an activity partner is a potent determinant of adherence to clinical exercise programs. Taylor, Bandura, Ewart, Miller, and DeBusk (1985) included a cardiac patient's spouse in an exercise stress-test protocol and had the wife actually participate in the required physical activity. This shared activity was found to increase the wife's perceived exercise self-efficacy and also her positive attitude towards her spouse's ability to exercise. There was also an increased couple agreement on the husband's physical abilities. The researchers found the resultant increase in the wife's spousal support to be crucial to adherence in clinical exercise programs and suggested that spousal attitude could be more important than that of the participant in the participant's exercise adherence. A wife's exercise

self-efficacy, gained through participation in treadmill walking, was linked to spousal encouragement, optimism and support during her husband's recovery from a myocardial infarction (Taylor et al., 1985).

Recently Elward and Larson (1992) conducted a study among 571 sedentary elderly persons over age 65 who belonged to a health maintenance organization (HMO) in Seattle, Washington. The authors analyzed factors influencing participation in a voluntary exercise program provided by the HMO. No significant differences were found between participants and nonparticipants on a baseline index of physical activity, or on specific types of self-reported medical conditions. Those elders who chose to participate actually rated their perceived health as slightly worse than did the nonparticipants. Because of this discrepancy the authors offered the suggestion that the activity participants may have perceived a greater need for self-improvement than the nonparticipants. Those who chose to participate in the activity were characterized by more social interactions and more close friends than those who did not participate. This social involvement may have contributed to their choice to participate in a group exercise activity. The barriers to activity most reported by these older HMO

members were bored with the exercise program, an unawareness of how to initiate an exercise program, transportation problems, concerns about proper preparation for exercise, exercising in poor weather, and medical concerns.

Emery and Blumenthal (1990) assessed the impact of aerobic exercise on self-perceptions of mood and other aspects of personal and social functioning in 101 healthy older adults over age 65. They found "outstanding" adherence to the program throughout the study (p. 520). The authors attributed this adherence to regular positive feedback from class instructors. This finding is congruent with the SCT tenet that verbal encouragement increases self-efficacy. Perhaps importantly, a high degree of group identity developed in the class, and the older adults began to have social activities independent of the study. These incidental findings were reportedly beyond the domains of psychological well being and cognitive functioning being investigated by these researchers who urged that further studies be conducted that included older adults' expectations and self-perceptions related to physical activity.

It is possible that social relationships affect health, either by creating a subjective sense of

meaning, or by facilitating health promoting behaviors. If so, then the possible negative aspects of social relationships need to be considered because they may be detrimental to health seeking behaviors (House, Landis, & Umberson, 1988). For instance, a change in schedule or activity by one family member may disturb other family members and lead to their reduced support and cooperation with the new behavior (Ewart, 1991). Therefore, sensitivity to the potential for both positive and negative aspects of social support is necessary for understanding the influence of social support on mall walking.

Situational Factors and Adult

Physical Activity

Dishman, Sallis and Orenstein (1985) noted that situational influences, such as convenience of exercise facilities and available time to exercise, influence adult exercise practice. The authors found that perceived barriers among both supervised and spontaneous exercisers were similar. These barriers were: (a) lack of time (43%); (b) lack of will power (16%), (c) ". . . just don't feel like it" (12%); (d) medical problems (9%); and (e) lack of energy (8%). No data exist that indicate whether removal of these

perceived barriers to activity would lead to increased exercise activity.

Dishman et al. (1985) summarized a review of the extant literature on determinants of exercise by noting that while active people anticipate and believe they will receive personal health benefits from exercise, positive feelings that arise from participation in the activity tend to be more important than beliefs about the health benefits of the activity. Why people decide to initiate activity and why a person's activity declines with age is unknown (Dishman et al., 1985). What might be changed to diminish this decline is also unknown.

There may be other situational factors that influence meaning and motivation for physical activity in older adults. These factors may include the potentially restrictive functions of the socially constructed categories of age and gender. In our society age and gender help define the appropriateness of physical activity at specific points in the life span (Ostrow, 1983).

Ostrow and Dzewaltowski (1986) conducted the first known study contrasting older adults' perceptions of the acceptability of participating in physical activity based on age-role versus sex-role appropriateness. The

authors reported findings from an investigation of 44 female and 18 male participants of Elder-hostel programs. These findings indicated that the subjects viewed participation in each of 12 physical activities as decreasingly appropriate as the age of the potential participant increased. The findings also indicated that, with the exception of ballet, all physical activity was considered more appropriate for males than females.

Summary

The overall influence of self-efficacy, social and familial support, and situational variables such as perceived barriers, age, and gender on the meaning and motivation for older adults' practice of mall walking remain essentially unknown. Extant research has focused on quantitative research methods in analyzing data obtained from younger adults. Quantitative research continues to document the physiological and psychological benefits of exercise. However, there is little qualitative research into the meaning and motivation underlying an older adult's decision to participate in a physical activity such as mall walking.

Based on this review, the following areas were identified as being relevant to development of the

guiding research questions: (a) what older adults' perceptions are involving the experience and meaning of mall walking in their life, (b) how older adults perceive the influence of family and friends on their mall walking activities, (c) how situational and environmental influences effect older adults mall walking, and (d) the possible relationship between motivation for mall walking activity in older adults and exercise self-efficacy. These identified areas served to guide the development of the guiding research questions and were implemented in the generative questions for interviews in Appendix A.

The concepts explicated in this review and employed in this study were intended to enhance the researcher's theoretical sensitivity as well as guide development of the qualitative study. This approach attempts to heed Spradley's caveat: "Before you impose your theories on the people you study, find out how those people define the world" (1979, p. 11).

CHAPTER III

Methodology

Overview

A qualitative study and analysis were employed in this investigation because the research intent and focus were exploratory and interpretive in nature. The study's goals were to discover and understand the meaning of and motivation for participation in mall walking activity among a group of community dwelling, rural older adults. To achieve these goals theoretically informed, grounded theory methods were employed (Strauss, 1987; Strauss & Corbin, 1990).

A major determining factor in the decision to conduct a qualitative study was my personal reaction to information obtained during a focus group exploration: Determinants of Exercise in a Group of Older Adult Walkers conducted on April 19, 1991 at Warm Hearth in Blacksburg, VA. The focus group was directed by Shirley Travis, Ph.D., had Institutional Review Board exemption, and was conducted as part of a research project under consideration by Dr. Travis.

The questions asked of the focus group were derived from the conceptual model being developed for the project, SCT, and with the aid of Thomas R. Prohaska, Ph.D. who was conducting a related research project, Analysis of Mall

Walking Exercise Programs for Older Adults at the School of Public Health, University of Illinois at Chicago at the time (T. R. Prohaska, personal communication, March 5, 1991). A copy of the Warm Hearth Focus Group Questionnaire is included in Appendix C.

Although the participants responded to the written questionnaire, their verbal responses and input during the focus group revealed dimensions of their experience of activity not permitted by the structure of the questionnaire. The participants' personal motivation and meaning for their walking experience were revealed, not in the content of their written responses to the questionnaire, but in their subjective expression of experience through spontaneous remarks made during the focus group.

These remarks made me aware of the importance of the expression of the personal and the meaningful in research. Therefore, I made the decision to stop work on the conceptual model in progress with Travis and Prohaska, deconstruct my quantitative orientation, and begin work on planning a phenomenological approach to the research question. This qualitative approach permitted tapes of the focus group discussion to be heard and interpreted in a new way and led to my decision to use grounded theory method in order to explore the experiences of a community of older adult mall walkers.

Grounded Theory

Grounded theory is a mode of qualitative analysis that employs "a systematic set of procedures to develop inductively grounded theory about a phenomenon" (Strauss & Corbin, 1990, p. 24). It is a transactional system of analysis that focuses on actions and interactions (Strauss & Corbin, 1990). The method includes non-mathematical analytic procedures for data gathered by a variety of means including observations and interview (Strauss & Corbin, 1990).

Credibility of a grounded theory. May (1986) suggested that the following two questions be asked when evaluating the credibility of a grounded theory: (a) are multiple slices of data from a variety of sources used as the basis of analysis, and (b) is it relevant to the real world of practice? To address the first question multiple sources of data from field notes, interviews, and personal notes were included in this study to capture as much variety and range as possible. To address the second question, the findings of this investigation are relevant to the real world of health education and practice because the findings come from a place where healthy people are interacting. The findings are derived from the experience of active, independently living, older adults, and not from data gathered from the infirm elderly in a clinic or laboratory setting.

Grounded theory method is transcending (Wilson, 1989). This means that substantive findings in one area of study have potential for transcending a particular setting and being extended to a wide variety of settings and circumstances (Wilson, 1989). Thus, any substantive findings from this case study setting have the potential for extension to other settings (Wilson, 1989).

Theoretical sensitivity. Theoretical sensitivity has been linked with grounded theory (Glaser, 1978; Strauss & Corbin, 1990). Theoretical sensitivity aids in building theory faithful to the phenomenon under examination (Glaser, 1978). Two main sources of theoretical sensitivity are the literature and the researcher's experience. Literature included in Chapter II informed theoretical sensitivity as did the researcher's professional experience.

My professional experience is that of a registered nurse whose professional qualifications include undergraduate and graduate degrees in nursing, an adult health practice in a rural health clinic in 1984-1985, and the development of an ongoing faculty health practice among older adult mall walkers. These experiences, along with my knowledge of health among older adult populations, enhanced theoretical sensitivity and were incorporated into the research situation.

Equity, reciprocity and understanding are important issues in qualitative research (Marshall & Rossman, 1989). To address these issues I conduct a faculty health practice, which includes monitoring blood pressures for mall walkers each Wednesday at the mall . During data collection, I participated in mall walking 3 days a week from April 6, 1992 until July 3, 1992 to share the experiences and interaction among the mall walkers, understand their use of space, and observe their social activities during and after mall walking.

Study Setting

The investigation was a single site case study conducted in an enclosed shopping mall located in southern West Virginia. A diagram of the mall is provided in Appendix D. The context of the study is developed further in Chapter IV.

Entry into the setting. Two of the most important steps in initiating a qualitative project are entry into the appropriate setting and introduction to the prospective informants. On February 11, 1992 I met the president of the Mercer Mall Walkers Club to explore the possibility of starting a faculty practice with the mall walkers consisting of blood pressure monitoring and other health related topics that the walkers might identify as relevant to their needs. At this time I did not have a specific research project in

mind, although I anticipated developing a project that would involve the Mall Walkers Club members. At a Mall Walkers Club dinner on February 18, 1992 I identified myself as a registered nurse and member of the health science faculty at Bluefield State College who had an interest in starting a free faculty health promotion practice for mall walkers.

I also advised them that I was a graduate student at Virginia Polytechnic Institute and State University and was interested in what they could tell me about why they seemed to be aging so well. I told them that I was also interested in talking to them about mall walking and other things they could relay about successful aging. The mall walkers' responses were favorable, and they seemed pleased that health services might be provided at the mall.

On February 17, 1992 I met with the marketing manager of the mall, and we agreed that health promoting activities could be beneficial to the health of mall walkers. The approval of the Chairperson of the Division of Health Sciences at Bluefield State College was obtained. The faculty practice was initiated on March 4, 1992, between 8:00 a.m. and 9:00 a.m., the time the club president indicated most mall walkers were at the mall. On March 4, 1992 I began to monitor blood pressures of the mall walkers, and I was interviewed on March 11, 1992 by a radio station located in the mall. At this time I described the health

promotion activities available for mall walkers and the hours I would be present at the mall.

Identification and Description of the Sample Population

Informed consent for the project was solicited and obtained from 14 older adult mall walkers 60 years of age and older starting on June 3, 1992. Volunteers were initially solicited at the blood pressure monitoring service I conduct at the mall and then through a snowball method of sampling as mall walkers suggested other walkers to interview. All study participants walked at the Mercer Mall in Bluefield, West Virginia for 30 minutes or more at least 3 times a week for over 3 months. During the initial interview, potential volunteers were asked to read and sign a consent form describing the purpose of the study, assurance of confidentiality, and the right to withdraw at any time. A copy of the Participant Consent Form may be found in Appendix E. Demographic data and self-rated health status were gathered on the "General Information Form". (Appendix F) A question about perceived health was also included to better understand each individual's evaluation of his/her total health compared to others. This type of self-rated health questioning is used frequently in studies of elderly populations (Lichtenstein & Thomas, 1987) and has been shown to be a reliable indicator of morbidity and

mortality, as well as a global indicator of mental and physical health (Hooker, 1992).

Presentation of Instruments

This study employed participant observation, personal conversations, and interviews between the researcher and respondents. These interactions were directed at understanding each participant's own words (Taylor & Bogdan, 1984). The information obtained in the observations, conversations and interviews led to the discovery of concepts and categories which could be organized according to the paradigm model suggested by Strauss and Corbin (1990). Conversations conducted during participant observation permitted theoretical sampling of incidents in order to obtain data that could "identify, develop and relate concepts" adequate and appropriate to grounded theory methods (Strauss & Corbin, 1990, p. 177). Theoretical sampling is defined as "sampling on the basis of concepts that have proven theoretical relevance to the evolving study" (Strauss & Corbin, 1990, p. 176). However, as in all qualitative research the researcher was the instrument.

Procedures for Collecting and Recording Data

Site for interviewing. All of the scheduled interviews were conducted at the Mercer Mall. The interview site chosen by all but one participant was a private booth in an isolated section of a fast food restaurant. This restaurant

was centrally located and frequented by walkers. Because one participant desired to be interviewed in the central corridor of the mall, his interview tended to be more public than those of the other walkers.

Data collection. Telephone interviews were conducted with informants as necessary to obtain historical data. Personal interviews with 14 respondents that lasted between one hour and one hour and fifteen minutes each, were audiotaped by the researcher, and transcribed by a typist. The investigator listened to the audiotapes immediately after the interviews in her car in the mall parking lot and on the drive to the transcriptionist's home to permit constant comparison and analysis during the interview data collection process (Strauss & Corbin, 1990). The transcriptions of the audiotapes were read as soon as they were received from the transcriptionist, usually within two days of the interview. This approach permitted concepts to be refined as the interviews continued and allowed theoretical sensitivity to develop that suggested the inclusion, expansion, or omission of guiding interview questions. The investigator personally recorded and transcribed participant observer field notes and kept a diary.

The diary recorded my "feelings, hunches, preconceptions and areas for further exploration" (Taylor & Bogdan, 1984, p.

60) as well as my concerns. This approach was intended to increase my ability to "take the role of the other" and be introspective (Wilson, 1989).

The combination of these three methods of data sources provided triangulation (Denzin, 1989a; Taylor & Bogdan, 1984) to guard against bias. The use of triangulation also permitted deeper insights and understanding of the situation and the participants. It should be remembered that, although many possible meanings are inherent in any situation (Denzin, 1989b), this study represents only the interpretations of its author.

Generative questions for interviews. The generative questions for interviews provided the beginning focus and guidelines for this study. The initial interview questions were derived from the researcher's personal and professional experience, the literature review, and the research questions (Strauss & Corbin, 1990).

Analysis of Data

Several coding procedures were employed in the analysis of the information. Open coding, the process of breaking data down and conceptualizing words into concepts, was based on words found in the data. Open coding was performed after listening to and reading and rereading the interviews and conducting a line-by-line word search utilizing WordPerfect

Software (1989) to identify recurrent words and themes in the interview data.

Selective coding was then initiated with the help of my committee co-chair Shirley Travis, Ph.D. during meetings in her office. The initial words and concepts discovered through careful, repeated, and detailed simultaneous reading of interview transcripts by Dr. Travis and myself, were labeled and placed into groups of categories congruent with the conditions of the paradigm model (Strauss & Corbin, 1990). Then the data were recoded, and each individual's transcript coded with the line number, gender, age, interview number, and appropriate paradigm model category for the theme identified. After an initial attempt to use a WordPerfect 5.1 program macro file to manage the coded data, I found it more satisfying to cut the coded data into slips and group them manually into categories and conditions. Field notes were reviewed to add the process of selective coding as a story line began to emerge from the data.

In order to create visual pictures of how the story emerged from the data, I also participated in creating AutoCAD diagrams (AutoCAD, 1992) computer assisted design (CAD), that show how the community of mall walkers occupied space and recreated the mall space for their own mall walking experiences. (Appendices, D, G, H, & I). The CAD drawing of the Conceptual Matrix containing the contexts

within which the phenomenon took place was also developed (Strauss & Corbin, 1990). (Appendix J) These visual diagrams enhanced my ability to interpret and form conclusions from the data and to discover the themes or the "story line" emergent from the phenomenon of the mall walking experience.

CHAPTER IV

Results

Overview

Chapter Four presents the story of a group of independently living older adults who mall walk in Mercer County, West Virginia. This modern phenomenon, mall walking by older adults, occurs within the public areas of an enclosed shopping mall. The actions of the individual participants and their interactions with others created the phenomenon.

The study results are supported by the respondents' words as well as by the investigator's field observations. Some of the relevant observations were obtained prior to the formal initiation of the study as part of a faculty health practice at the mall. Participant observations were conducted at random intervals of one hour each, between the hours of 7:30 a.m. and 10:00 a.m., three days a week, from April 27, 1992 through July 3, 1992.

In this chapter a conditional matrix is presented as a means to conceptualize the various contextual environments within which the phenomenon of mall walking by older adults occurs (Strauss & Corbin, 1990). This matrix presents the context, "the specific set of properties of the phenomenon--the conditions--in which actions are embedded" (Strauss & Corbin, 1990, p. 131). A diagram of the conditional matrix

is represented in Appendix J with interrupted lines between the contexts to suggest that the boundaries of the model are permeable. Each contextual layer of the matrix is proposed to have the potential to influence and be influenced by another.

The paradigm model proposed by the Strauss and Corbin (1990) grounded theory methodology is also developed in this chapter. This model was employed to systematically relate study concepts to the phenomenon of interest. The paradigm model includes five categories which will be examined. These are the: (a) context, (b) causal conditions, (c) intervening conditions, (d) actions/strategies, and (e) consequences (Strauss & Corbin, 1990). I obtained information through participant observations and 14 personal interviews with mall walking older adults, and organized this according to the paradigm model. The integration and synthesis of guiding questions with the paradigm model is also discussed.

Context

The Conditional Matrix

The conditional matrix in this study may be pictured as five concentric, interactive, layers or rings. Each level may interact to influence the others. The five conceptualized rings, from outermost to innermost include: (a) the culture and history of malls, (b) the community of

Mercer County and West Virginia, (c) the institution of the Mercer Mall, (d) a group named the Mercer Mall Walkers Club and the interaction of this group and subgroups of people doing things together, and (e) those individuals whose actions and interactions contributed to the creation of the phenomenon of mall walking. These rings may be thought to constitute a broad context within which the paradigm model develops.

Culture and History

Charles Kuralt stated on CBS Reports that:

"twenty-five years ago, they weren't here. Today they're everywhere. What used to be farms or woods or country crossroads have become malls If you want to find America today, this is where you have to look" (1982).

While Kuralt was referring to the proliferation of shopping malls throughout the United States in the past three decades, the origins of the word mall itself reach back into past centuries. Well into the eighteenth century people in Great Britain played a game on grassy fairways that resembled a combination of croquet and golf. This game was called Pall-Mall and the fairway upon which it was played came to be referred to as the "mall." The modern word mall is derived from this game.

After Pall-Mall faded into obscurity the word mall came to mean a place to walk or a grassy open area suitable for

walking. Although the word mall now has the architectural definition of a specially designed pedestrian environment, the word mall itself has links both to the past and to walking (Kowinski, 1985).

Community

State. West Virginia has a population of 1,793,477 of whom 360,519, or 20.10%, are 60 years of age or more, a figure somewhat higher than the comparable national statistic of 16.8% for people over 60 (Tom Dudley, Program Specialist Office on Aging, West Virginia Department Health & Human Services, personal communication, March 19, 1992). Mercer County has a total population of 64,980 of whom 14,250, or 21.93% are 60 years of age and older.

The state of West Virginia itself is predominantly rural. In 1990, 63.6% of the people 65 years of age and over in the state lived in a rural setting. The magnitude of this figure becomes evident when it is contrasted with figures indicating that in 1990 only 22.5% of the nation's adults age 65 and over lived in rural areas (Raetzman & Jensen, 1992).

County. The mall used for this case study, Mercer Mall, is located in Mercer County, West Virginia. Mercer County is a rural area located in the southernmost part of the state in the southern Appalachian Mountains. This is part of the region known as the Bible Belt. The land was

originally settled during the early 1800's by Scottish, Irish and English immigrants. It is now home to an aging, rural and preponderantly caucasian (96.2%) population (Raetzman & Jensen, 1992).

Institution

The modern enclosed shopping mall is one of the phenomena that characterize civilization in our century. The mall has replaced the town square and the old "downtown," as a center of social life. Kowinski offers his opinion that the mall has become the "new Main Street. It is cleaner and dryer, more comfortable, more convenient, better scaled and designed for walking, apparently safer and brighter ... than the small town Main Street life" (1985, p. 68). Field observations conducted on Saturday nights, Sunday afternoons and week-day mornings at Mercer Mall lead me to agree that for many, young and old alike, this mall is "where the action is."

Location. Mercer Mall is located on West Virginia State Route 25, within sight of U.S. Route 460. The mall is 3.7 miles to the northeast of Bluefield, West Virginia, a city with a population of 12,697 (S. Repass, Bluefield Chamber of Commerce, personal communication, January 15, 1993). The mall is also nine miles southwest of the other major population center in the county, Princeton, West Virginia, a city of 7,043 (G. Santon, Chamber of Commerce of

Princeton, personal communication, January 15, 1993). It is the only enclosed shopping mall within 60 miles.

Description of the study site. Mercer Mall opened for business in 1980. It is a single story structure, carved into the side of a mountain, with bare hillside serving as its backdrop. The off-white building spreads, low and long, at the center of flat asphalt parking lots and carefully landscaped greenery. The mall is encircled by a road 1.1 miles in circumference which provides enclosure of its private property.

The mall is typical of many malls. There are 18 public entrances, but no eye level windows that open into the central space. Within this enclosure are 700,000 square feet of a world with its own controlled climate, piped in music, and security systems. This controlled space is protected from outside distractions. In the morning, when first opened for walking, the light is dim because the stores are not yet illuminated; but taped music begins playing at 8:00 a.m. Mercer Mall provides public access to two restrooms, 16 public pay telephones and one water fountain. Many unpadded wooden benches and seating areas are placed throughout the mall among large planters which contain live greenery. One of these areas contains a mining car, loaded with coal, bearing a brass plaque honoring John L. Lewis. The mall's interior has cream terrazzo floors

with a two foot wide border of gold terrazzo around the edge. The main axis of the mall, a central corridor 28 feet wide, is oriented north to south.

Central space. At the very heart of the main corridor, its area defined by a two foot wide circle of dark brown glazed tiles, is the central circle. This is a sunken area reached by descending three stone steps. The space above it opens into a circular sky light. This central area has a wishing well, spanned by an arched stone foot bridge, and is accessed by three stone staircases. It contains two stages and built in benches around the perimeter. Although the mall marketing manager told me that older persons did not like to use this area, my observations belie her opinion. This area is a popular congregating space during the weekly blood pressure monitoring I conduct. It is also the location of the first election of mall walking club officers. Other activities such as hand-crafts and photography exhibits and band concerts are held in the area. Each year Mercer County elementary school classes compete for the privilege of having their class conducted there for one week in May. This class seems to delight both the children and the watching mall walkers. The central area is definitely important to the older folks.

Food service. Serving customers within the mall are two restaurants, a cafeteria, a cookie shop, a candy and nut

store, and five fast food service eating places, including Hardee's. Of all these establishments only Hardee's is opened at 8:30 a.m. to provide service to mall walkers and employees. (Appendices G & H)

Public transport. Bluefield Transit System offers public transportation from the cities of Princeton and Bluefield to the mall eight times a day, five days a week. The fares from the center of either city to the mall is \$2.25 one way. Most people come to the mall via private car.

Walking within the mall. Early in the history of Mercer Mall, its management allowed the main mall entrances to be opened by 7:30 a.m., six days a week, Monday through Saturday, to allow the public to walk within its enclosed corridors. Most mall walkers believe that if they follow the golden terrazzo border around the mall four times they have walked three miles. This is not an accurate assumption. After talking with the walkers I used a Rolatape Measuring Wheel, Model 400, to measure the perimeter of the mall along the counter-clockwise path almost invariably followed by all the mall walkers.

(Appendix G) One measured lap around the mall was found to be 3,615 feet, or only 0.68 miles. Thus, four times around the mall is only 2.74 miles, not three miles as most mall walkers believe. Perhaps the walkers think that "four laps

is three miles" because they round each lap up to three quarters of a mile.

There are rules that mall walkers understand should be followed in mall walking at Mercer Mall. These rules include following the golden terrazzo path around the edges of the mall in a counter-clockwise direction, and absolutely never "rounding off", or otherwise "cutting the corners." Walkers also know that they must not walk on any freshly washed, wet areas, or create extra work for the mall employees. In the past when mall walkers did create extra work by walking on wet floors, they found that the mall doors remained closed to them until 8:30 in the morning.

Groups

History of sponsored programs at the mall. Over the years several organizations have been associated with the mall walkers. In the mid 1980s Mercer Mall sponsored the Mall Walking Club (Bernard Wilkinson, personal communication, October 16, 1992). The first president of the Mall Walkers Club, Maureen Ratliff, reported that during the mid 1980s the mall management distributed door prizes provided by the stores in the mall. "They [the mall management] gave us tickets to drop in a box at the mall information desk [each time they walked] and then someone drew for a gift" (M. Ratliff, personal communication, September 4, 1992). The mall management no longer does

this. One 78 year old mall walker, displaying his walking shoes with pride during our interview, said he won them as a gift from the mall. He added "it's been about two years now since they did that. I wish they'd start it back." Within the last three years an anchor store and three large department stores have closed, and two large store spaces remain unrented and empty. Economic conditions at the mall have caused an end to this practice.

In 1988 Princeton Community Hospital began a wellness program at the mall (Donna Charles, R.N., Wellness Coordinator, Princeton Community Hospital, personal communication, February 3, 1993). The intent of this program was to provide an affordable resource for rehabilitation and exercise for older adults. The hospital staff considered the mall terrain safe for walking, and the mall's controlled environment desirable for recovering cardiac patients. The hospital provided programs and speakers, once a month at first and finally, as attendance diminished, only once every four months.

Bernard Wilkinson, the Mall Walkers Club's first vice-president, recalled that the hospital provided "specialists who talked about heart conditions, medication, how to conduct ourselves in exercise programs, and what kinds of food to eat." He recalled that hospital staff were regularly located in the central seating area where they

offered "blood sugar checks and blood pressure monitoring, and lectures by a dietician on diet and cholesterol". Various small gifts, such as magnets and coffee mugs were also given to mall walkers. At one time the Bluefield Police Department contributed change purses that could be tied to the mall walkers' shoe laces (B. Wilkinson, personal communication, September 16, 1992).

According to Donna Charles (personal communication, February 3, 1993), the walking program was initially very well received, with over 150 walkers taking advantage of a free cholesterol screening conducted by the hospital in 1988. However, as a result of what Ms. Charles described as the "growing independence of the mall walkers, and because of policies consistent with cost containment," the hospital stopped the program in 1990. During conversations, mall walkers related that, although they do not know why the hospital stopped coming to the mall, they suspected it was because the services had become too expensive.

Early years of the Mall Walking Club. It is not possible to establish the precise date on which the Mercer Mall Walkers Club was formed, because no minutes or other archival data exist. Also no officer, past or present, can recall when they were elected. The present club officers also stated that they do not know with certainty when the club began. Details about the group may be sketchy because

of an apparent conflict among mall walkers that resulted in an abrupt end to the terms of the first elected officers. Reportedly, without the knowledge of the elected club officers, certain other mall walkers met and elected a new president and vice-president. These officers currently hold office. While the first president and vice-president no longer mall walk, they responded to telephone inquiries about the history of the club (B. Wilkinson, personal communication, September 16, 1993).

The best estimate of informants is that sometime in 1984 a group of older adults who made a practice of mall walking decided to form a mall walking club. These older walkers met in the central area of the mall to elect two officers, a president and vice-president. A secretary or treasurer was not elected. The first president said that members "did not consider it an official club," and that "there were no dues. You could just sign up at the information desk" (M. Ratliff, personal communication, September 4, 1992). The mall management provided a form at the information desk on which the mall walkers could put their names and record how many miles they walked.

This founding group called themselves "The Mercer Mall Walker's Marathon Club" (B. Wilkinson, personal communication, September 16, 1992). Since then that name has been shortened to "The Mall Walkers". One walker I

observed wore a maroon and white cap which he said he had purchased at the mall in 1985. The cap had the logo: "Mercer Mall Walkers Club."

Membership. Although there has never been a membership or mailing list, almost every older adult I spoke with while conducting participant observation at the mall claimed membership in the mall walking club. Only two people did not mention the club. In an article published in November of 1990 in the local newspaper, "Walk on the mall side: Dozens amble in from the cold," the club president estimated the membership of the mall walking club to be 200 walkers. I never counted more than 52 mall walkers between the hours of 7:30 a.m. and 10:00 a.m.

Club activities. When it began, the club had a group of walkers who "got together by word of mouth, to meet for dinner three or four times a year during the winter to enjoy prayer, entertainment, singing and playing" (M. Ratliff, personal communication, September 4, 1992). There were as many as 75 in attendance at those early gatherings. Club activities continued to include dinners held at a local Western Sizzlin' Steak House on dates near Thanksgiving and Valentines's Day. Walkers also held a picnic at a local park around Labor Day, and at Christmas served breakfast at the mall for the mall employees. Recent attendance at these events varied from 14 walkers who

attended the Labor Day picnic, to 38 walkers who were present at the Valentine's Day dinner in 1992.

Information about these club activities is transmitted through the "grapevine" and by "word of mouth." Stuart, a long-time member of the mall walking club, generated computer printouts that advertised the club's planned events. The current club officers displayed these printout printouts on their car windshields for passers-by to see. It is known that the mall management does not permit the advertising of club events within the mall itself.

Study Informants

Seven caucasian women and seven caucasian men participated in the personal interviews conducted for this study. At the time they were interviewed their ages ranged from 61 to 81. Participants are introduced in the following profiles in the order in which they were interviewed. The participant's names have been replaced by nicknames to protect their privacy while acknowledging each respondent's unique individuality. There is no intent to diminish the character of the participants, who were generous and gracious in sharing their experiences, nor is any disrespect implied or intended by the choice of any nickname.

Table 1 presents information about the age, gender and marital status of the participants.

Table 1

Age, Gender, and Marital Status of Participants at Time of Interview

Name	Age at Time of Interview	Gender	Marital Status
Concerned	62	F	M
Slim	77	F	M
Nickname	61	M	M
Helpful	63	M	M
Pasha	78	M	M
Mr. Chips	73	M	M
Teacher	72	F	D
Hulk	62	M	M
Husband	73	M	M
Wife	73	F	M
Sarge	65	M	M
Chief	70	F	M
Witty	81	M	M
Brother	76	M	M

Introduction of Individuals Interviewed

Concerned was a happily married 62 year old female. She retired from a position as a bookkeeper when the business closed and had been mall walking five times a week since the fall of 1991. She walked between one and one and one half-hours each time and generally walked with Slim, if she was present. Concerned's self-reported health was good, although she said she had arthritis in her hands, feet, and ankles, as well as high blood pressure.

Slim was a married, 77 year old female, who retired from a position as a retail sales clerk. Slim had been coming to the mall since 1990, walking four days a week for at least one hour a day. She usually met Concerned so that they could walk and talk together. Slim described her health as good, while remarking that she had high cholesterol and high blood pressure. During the interview Slim asserted her conviction that: "... after you get older you have to start fighting for your health. You can't just sit down and pray that it'll just go on. You've got to work on it and work on it, and that keeps you in shape."

Nickname was a married, 61 year old male who was retired from a job as an underground coal miner. He had been walking at the mall for 6 months, four or five mornings a week for at least one hour each time. Nickname usually

walked around the mall a few times with his wife and occasionally with his 32 year old daughter. Nickname's wife then walked around the mall alone or shopped, while Nickname walked and visited. He described his health as good although he had filed for black lung benefits on April 29, 1991. Nickname reported that he had high blood pressure, diabetes and "black lung ... my hands turn black ... and my fingers."

Helpful was a married, 63 year old male who was retired from managing an ABC store. Helpful had been walking with his wife and nephew since 1989. He walked six times a week for 45 minutes each time. Helpful was eager to provide information about participating in mall walking, writing down the reasons he thought people mall walk. He reported that his health was good despite the fact that he had undergone coronary bypass surgery four years ago.

Pasha was a married, 78 year old male. Prior to his retirement he worked at a local manufacturing company. Pasha was disabled in a mining accident which injured his right leg and hip and resulted in a noticeable limp. The disability necessitated his use of a cane. He had a heart attack, but described his health as being average for his age. Pasha had been mall walking for six years, four or five times a week for at least an hour at a time. He was observed resting and talking frequently during those hours.

Pasha refused to be interviewed in a private, quiet place, insisting instead that we conduct the interview in one of the circular seating areas in the center corridor. During the interview he paused to nod, conducted conversations with passers-by and hailed passing mall walkers. He appeared to be thoroughly enjoying the attention.

Mr. Chips was a married, 73 year old male who taught English literature before his retirement. He and his wife drove one-half hour each way, six times a week to and from the mall. Although his wife accompanied him on these trips to the mall, she rarely walked because of her arthritis. She did her crafts or read in Hardee's while he walked alone. Mr. Chips walked "three miles in one hour" and had done this for seven years. His self-reported health was good although he stated that he had "brittle" diabetes since the age of 22 and had hypertension which was controlled by medication.

Teacher was a divorced, 72 year old female who was a retired high school teacher. Her self-reported health was excellent although she related multiple chronic physical disorders that included osteoporosis, hypertension, bunions, back problems, high blood cholesterol, and thyroid problems. She said she generally walked with the same two women for one hour every day except Sunday and Wednesday. She began walking in 1987 and once walked while wearing a cast on her

fractured leg. Teacher was frightened by the fact that her mother "ended up becoming senile ... and I'm determined that's not going to happen to me. I'm determined that my brain is not going to go, and I feel like this [mall walking] will keep that ... from happening." Divorced, she had not attended the social activities of the Mall Walkers Club, because "When you're single, when you're alone, you don't run around with married people. See these people outside? No. They're married."

Hulk was a 62 year old married retired male who formerly operated a coal hauling truck 15 or 18 hours a day. He began walking in June 1991 and mall walked for one hour six times a week, completing four and one-half laps. Hulk said that occasionally his wife accompanied him, but she was unable to mall walk because of "crippling arthritis." His self-reported health was good except for his breathing. Hulk had hypertension and "breathing problems" which he related to black lung from hauling coal, not to his past history of smoking three packs of cigarettes a day for 45 years. He stopped this habit two years ago when he "gave up cigarette smoking cold turkey."

Husband was a 73 year old married male, who was retired from a nearby manufacturing plant. He reported his health was fair, although he had a few "minor problems." He wondered aloud how he had escaped more serious health

problems because, "I worked in all kinds of chemicals. They've outlawed this benzene I worked in ... and I used to be in it all the time. Got it all over me." Husband has walked at the mall five times a week since 1983 and is usually accompanied by his wife.

Wife was a 73 year old married female who had never been employed outside the home. She reported her dedication to a career as a hospital volunteer and said she enjoyed her work with staff and patients. She had been mall walking with Husband for four years. Her self-reported health was excellent. She had had a bilateral mastectomy for breast cancer, and her last surgery for cancer was eight years ago. She also reported that she had arthritis, hypertension and a profound hearing deficit in both ears.

In spite of her past medical history, Wife had anticipated the possibility of widowhood and made plans should that occur. She shared that she had several mall walking friends whom she would consider asking to include her in their walking activities if Husband were to die. Wife said she believed "You have to think about these things," and she had.

Sarge was a 65 year old male who retired both from the military and from coal mining. Sarge walked at the mall five days a week, three or four miles each time. At the time of the interview he had been mall walking for five

months. His self-reported health was good. He also reported that he had been hospitalized for a "heart attack" five months ago and that he had high blood pressure and cholesterol. He stated that: "My legs draw up from [poor] circulation, but I just go on." He was exposed to Agent Orange in Viet Nam and felt that Agent Orange was responsible for multiple skin lesions and growths present on his head, axilla, and chest. He had married for the second time two weeks before being interviewed, and his bride walked with him.

Chief was a 70 year old white female who had been married for 52 years. Having retired from caring for older adults, she remained active in volunteer efforts such as Help-Line and her church. She was the president of the mall walking club and had held this position for two years. Chief reported mall walking three miles, three times a week for three years. She cherished the three computer printed banners given to her over these years by the mall walkers that wish her "Happy Birthday," displaying them in her home, a 35 minute drive away. Her self-reported health was good, although she had a history of both diabetes and asthma.

Witty was an 81 year old, married male who retired at age 71 from the construction business he owned with his brother. Witty had been mall walking with his brother about three years, five days a week for 45 minutes each time.

Although he mischievously said he had to get out of the house to avoid "all those honey-do jobs," he was obviously pleased to tell me that in February, 1993, he would have been married for 60 years. His self-reported health was good; and he joked that, although he had diabetes and high cholesterol, his only concern was that "most women can out-walk me."

Brother was a 76 year old married white male who, like his brother Witty, retired from the construction business. He reported that he often mall walked twice a day, both in the early morning and in the late afternoon. He said he walked "two rounds" with Witty in the mornings and walked with his wife in the later part of the day. His self-reported health was good. He stated that he had diabetes and high cholesterol and that he had been hospitalized six years ago for endocarditis, a condition which forced him to use a walker that he hated.

Paradigm Model Categories

The paradigm model described in Chapter Three was employed after interviews and participant observation generated data for the open coding that provided the initial provisional concepts. Those provisional concepts were then analyzed, reconstructed, and related as selected model categories and subcategories. The paradigm model consisted of the: (a) context, (b) phenomenon, (c) causal conditions,

(d) intervening conditions, (e) action/interaction strategies, and (f) consequences (Strauss & Corbin, 1990).

Synthesis of the paradigm model categories and guiding questions. In this case study five questions guided the research and served to ease the investigator's entry into the contextual milieu. All or part of these guiding questions were synthesized into the study's paradigm model during the process of interpretation, analysis and evaluation of the data as demonstrated below. This paradigm model is not intended to be considered either linear or causal. It is simply conceptual.

A. The **context** of this study was framed within the conditional matrix which described the history, culture, demographics, institution, and groups all of which were conceptualized to have interacted with the study participants in the creation of the mall walking experience.

B. The phenomenon under investigation was that of the mall walking experience created by a group of older adults. The parts the of paradigm model labeled phenomenon and consequences were derived from participants' responses to the question: "How do older adults situate the experience of mall walking within the broader context of their personal life?"

C. Many of the **causal conditions** of the paradigm model were conceptually related to the responses to questions

which asked: "What are the meanings and motivations attributed by older adults mall walkers for their participation in mall walking" and "what are the motivations and meanings that older adult mall walkers relate for their adoption of ... mall walking?"

D. Intervening conditions were most often mentioned in response to questions that probed for: (a) the perceived influence of family and friends on participants' mall walking experience; and (b) descriptions of the physiological, situational, and environmental factors that influenced their participation in mall walking; and (c) that portion of guiding question number two which asked, the reasons older adult mall walkers related for their continued participation in mall walking.

Causal Conditions

Incidents or events attributed by the older adult participants as their primary reasons for initiation of mall walking, were grouped under the model label of causal conditions. Two categories related directly to the initiation of walking by the individuals: (a) a need to comply with a physician's advice (expert-directed) or to manage a medical condition and (b) perceived health needs or health goals (self-directed). The initiation of mall walking was directly influenced by one other factor: the direct invitation of a spouse, family or friend.

Expert directed causal conditions. Not surprisingly, most of the 14 older adult interviewees said that they initially started to walk on the advice of their physicians. This expert-directed advice was either explicit as to the time and frequency of the activity or a more general suggestion to exercise and lose weight. Most of the time the advice was directed at the walker. On at least one occasion, however, the physician elicited the support of the walker's spouse.

All of the mall walkers agreed that "walking was good for you," and beneficial to one's health. Three female walkers attributed their initial walking activity solely to their physicians' recommendations that they walk, exercise and reduce their weight. There was also a clear understanding of the relationship of walking to the management of medical conditions among all of the individuals who walked on the expert advice of their physicians. They believed in the value of exercise for reducing problems that were associated with their respective medical diagnoses, including arthritis, hypertension, osteoporosis and elevated cholesterol levels. At least two participants had purchased blood pressure equipment to assist them in monitoring their progress, and I instructed them in the use of these instruments.

The advice of a physician was sometimes relayed in a comical way. For example, Hulk laughed and said his doctor told him to walk, but cautioned him to "Walk normally." The physician said "If you go to the mall and walk, I don't want you out there flopping your arms like you're getting ready to fly like a lot of them do."

Some walkers felt more pressure than others from their physicians. Witty, at 81 the oldest man interviewed, thought that his walking was probably prompted by his physician who repeatedly inquired whether he was walking. However, Witty specifically denied that anyone told him to begin walking. He felt that his walking did help to manage two medical conditions, diabetes, and a high serum cholesterol level.

Some walkers followed expert advice while having their own self-directed health goals. These walkers related a need to control a medical condition in conjunction with a strong desire to avoid taking medications. Nickname proudly said that "if I really need it, I believe in medicine and doctors. But I don't take it [medicine] unless I need it. I can prevent taking a lot of medicine [by walking]. I don't take no medicine for sugar or blood pressure or nothing."

Self-determined causal conditions. In synthesizing information provided to me by the study participants it

became evident that a small group of mall walkers had constructed a definition of health as a condition for walking that was different from that of the other walkers I interviewed. These individuals were motivated to mall walk primarily to retain their health and independence. They walked to achieve self-set goals, rather than to correct a medical condition or illness.

A belief among this minority group was that, with increasing age, one must act purposefully to avoid inactivity. Helpful initially began walking because of his concern that "as you get a little bit older you just sit down ... and don't get the right amount of exercise." Helpful felt that he promoted his health by engaging specifically in mall walking. Others who felt they helped control their own health by mall walking included Husband who asserted that "I decided to do it on my own. I knew if I wanted to increase my life span I'd better get in shape," and Brother, who denied that an expert advised him to mall walk, but said instead that he was motivated to mall walk by a great desire to maintain his current health status and never again have to use a walker.

The importance attributed to remaining in or retaining good health was very evident among the members of this smaller group. They established self-activity programs simply to stay healthy. Mr. Chips stated that his reason

for walking was to "keep in good health." This professor had independently gathered information about appropriate activity and aging by reading "a lot about exercise for retirees ... and I came to the conclusion that walking was it." When asked if he felt mall walking allowed him to better manage his diabetes, a condition he has had for fifty years, Mr. Chips replied that he wasn't sure. Apparently, being healthy meant more to him than managing a chronic illness that wasn't making him look or feel bad.

Wife equated being healthy with being independent. Her self-directed health goals included the "independence and the maintenance of my body." She desired "to stay on my feet and take care of at least my own body until I die," saying that, "while I don't aspire to be long lived, I do aspire to stay on my feet for as long as I live ... " She believed that mall walking would help promote the attainment of health and independence.

The heterogeneity of the causal conditions among the entire group of older adult mall walkers was reflected by Mr. Chips when he volunteered:

I didn't come for the socialization. Many people do, I think. But we're not all out here for the same thing. People are out here because they're diabetic. There are a lot of people that have been coming over the time that I've been here who

have started with a crutch or a cane, who now walk without. There are some who have been to Weight Watchers ... and there are some who do it to maintain. Like this (Chief) who's president of the thing (mall walking club) now. She's diabetic, and she also has emphysema, and there's a tall thin man ... he has had part of his colon removed from cancer and he's out here trying to do.

The professor's synopsis of the causal factors that influenced mall walking among his peers was apt. However, it appeared to me that Mr. Chips exhibited a depth of knowledge about his fellow mall walkers' medical conditions beyond what I might have expected of someone "who did not come here to socialize."

Invitation by significant others. Those adults who participated in the interviews indicated that their initial decision to mall walk was strongly influenced by family and friends. Spousal influence on initial mall walking activity was evidenced by statements such as those of Husband who extended an invitation to his wife to join him mall walking when, "Really, I would prefer walking outside in the fresh air. I walk (at the mall) so she can walk in here."

Further spousal influence and encouragement in the initial decision making process regarding mall walking

activity was evidenced by Brother's remark that he decided to begin mall walking only after a discussion with his wife who walked with him, and by Nickname who told me, "My old lady was wanting to walk for herself, and I just joined her." Expert directed advice that urged Sarge to walk was given to his wife, who related that she considered it her responsibility to take good care of Sarge by seeing that he mall walked.

Influence by family members other than a spouse was evident in the comments made by several mall walkers. Nickname also walked with his oldest daughter "a lot if she ain't working," and understood this daughter's deep concern about his health saying, "She's got to know everything about me. She was wanting to find out about giving me one of her lungs, and I had done told her that wouldn't work. I wouldn't take it." During participant observation I spoke with his daughter who confirmed those remarks.

The influence of invitations from other family members also existed. Witty decided to walk in the mall only "because my brother does," while Helpful invited his nephew to join him in mall walking.

The importance of a friend's invitation in initiating an older adult's mall walking activities was related by only a few older adults and did not seem as profound as that exerted by family invitations. Among those who attributed

the initiation of mall walking to friends were the members of a group of three couples who had known each other for many years prior to mall walking. They encouraged and motivated each other initially to come to the mall and engage in mall walking activities.

Review of Causal Conditions

The majority of the walkers interviewed initially began mall walking because of a physician's direction and a perceived need to manage chronic medical conditions. A smaller group of walkers had self-directed goals that placed value on the maintenance and retention of health, as well as continued physical independence. These older adults believed they could achieve their self-directed goals through mall walking.

Invitations from family and, much less frequently, from a friend, were among other causal conditions related by older adults for their initial participation in mall walking. The influence of spousal support was strongest and the most frequently mentioned.

Intervening Conditions and Action/Interaction Strategies

Strauss and Corbin describe intervening conditions as "the broad and general conditions bearing upon action/interactional strategies" (1990, p. 103). These conditions "act to facilitate or constrain the

action/interaction strategies taken within a specific context" (Strauss & Corbin, 1990, p. 103). Intervening conditions and strategies influence and are influenced by the more global contextual conditions within which they occur. This global context has been described in the conditional matrix.

Grounded theory is a transactional system at the heart of which lie action/interaction strategies (Strauss & Corbin, 1990). The paradigm model's intervening conditions were linked to the action and interaction strategies undertaken by the study's participants. The participants undertook these strategies to create, manage, carry out, or respond to the phenomenon under investigation (Strauss & Corbin, 1990). In order to give immediacy to the integration and linkages between intervening conditions and action/interaction strategies, both were interwoven in the text that follows and situated within the contextual conditions described previously as the conditional matrix.

Specific intervening conditions. Four major categories were identified as intervening conditions. These included: (a) work issues, (b) fear and perception of vulnerability, (c) social supports, and (d) development of community and belonging.

Work Issues

The most frequently related intervening condition experienced by mall walkers were work issues. These were issues of life with paid employment contrasted to life without paid employment. Although several married men agreed that their wives had never retired, both women and men with employment histories outside the home stressed the importance that changes in employment status had on their lives and their activity choices.

Work history. One influential contextual issue was the work ethic embedded in the character of many of these older retired adults. Their personal biographies included tales of childhood work carried out within large, rural families with agricultural lifestyles. Their biographies illuminate why the issue of work loomed so large in their lives. Many of the respondents spoke compellingly about childhood experiences that formed their earliest memories. Typically, they recalled hard physical labor on the family farm as part of large families in which family members learned at an early age the contributions each member, no matter how young, was expected to make to ensure the survival of the family group.

"Oh, we did work hard," said Husband, reminiscing about his boyhood. "There was eight of us in the family, and we had a six hundred acre farm. We milked twenty, twenty-five

head of cows. ... Get to go to school? ... that was a vacation going to school!"

Brother also came from a family of eight. He recalled, "We always had to get out and hoe. We had to do things. I told people that's all I ever knowed was work. And we had the good life, I'm not talking bad about it."

Chief came from a large family and remembered, "There was ten of us children, and I went to work in the cornfield at six in the morning when I was six years old, with a hoe bigger than I was. You had to hoe your corn then, now you have a tractor. We always were taught to work."

Retiring. All of the respondents, with the exception of one housewife, had a life history that included paid employment outside the home. None of the participants wanted to retire, and they expressed regret at the loss of a paid work role and subsequent reduction in social contacts. None of these women or men described any plans or goals that they had made for retirement.

The first two years of retirement were described as especially difficult by several male walkers. What to do with themselves was a problem. Unaccustomed leisure and inactivity were boring and difficult. Husband "turned into a couch potato" after his retirement and reported, "I didn't do anything. I didn't know what to do with myself for the first two years." Even though he was 71 when he

retired, Witty told his wife, "retirement is a dull thing, and I guess I would have stayed in business 'til I was broke if I'd have knowed it would have been so dull."

The respondents found that depression and loneliness were not uncommon following retirement. In their minds the reduction in social contacts following retirement led to loneliness and depression. Helpful found, "You do get a little depressed at times. Oh, I missed all the people just all the time." Concerned discovered, "When you're out working you meet a lot of people. When you stay at home all of the time you get kind of depressed."

These expressions of loneliness and depression by mall walkers drew the investigator's attention to the model developed by Kuypers and Bengtson (1973), Social Breakdown and Competence: A Model of Normal Aging. This model proposes that social reorganizations such as retirement create vulnerability and problems for the older adult. The congruence of this model and the study findings will be discussed in Chapter V.

One exception to the general experience of a reduction in social contacts upon retirement was that of the retired coal hauler Hulk. Hulk "never did have time to make friends. I drove a truck and was on the road about all the time and had no exercise." In his experience, retirement increased rather than diminished his social contacts.

Creating new work. These older adults initiated action and interaction strategies to replace the paid employment they no longer had. They created another type of quasi-work role: that of mall walking. All the retired respondents related that they began their mall walking activities only after leaving the paid work force.

Mall walking became a substitute or replacement for the older adults' former employment and their other pre-retirement routines. They incorporated established pre-retirement routines into their mall walking habits. Most retired mall walkers rose at the same time every day, five days a week, dressed and came to the mall where they greeted their peers who were similarly "employed". Instead of going to work they went to walk.

Work related social contacts were replaced by mall walking social contacts. The respondents' words demonstrated the links they established between work and mall walking, as well as their patterns of mall walking activity that mimicked pre-retirement routines. Several males stated a direct link between paid employment and mall walking. "I started walking as soon as I retired," said Hulk. "I enjoy it [retirement] now. I get up at the same time, like I did every morning when I was working, ... and I come out here. That's the first thing I do in the mornings. It's just like a job for me." Helpful found that, "It's

just an everyday thing now for us. We get up at a certain time, get ready, and go to the mall. It's just like going to work."

Continuing their previous work related patterns, mall walkers arrived at the mall between seven-thirty and eight-thirty in the morning, and frequently established an unvarying schedule. Chief explained, "Well, we come in at seven-thirty and speak to everyone and wish everyone a good day. Then we go off into groups." For some the routine is so well established that one walker could remark, "I set my watch up by this every day." Husband's mall walking routine was well established. He said, "I get here at seven-thirty when the doors open. I'm here waiting for the doors to open." At least twenty other mall walkers begin their day the same way, chatting and joking together outside the mall entrance, while they wait for the doors to be opened.

The majority of these older adults confined their mall walking activity to the working week, Monday through Friday. Concerned explained, "On Sundays you go to church, and you meet people." Only one male reported ever walking outside on Sunday. Sunday remained a day of rest for most mall walkers.

In summary, changes in employment status apparently motivated the respondents to initiate actions and strategies to fill the void in their lives experienced upon leaving the

paid work force. These older adults filled this void by creating the quasi-work routine for mall walking.

Perceived Fear and Vulnerability

Although A National Crime Victimization Survey Report: Criminal Victimization 1991 (Bastian, 1992) data indicate that, of all age groups, those over 65 are the least apt to experience criminal victimization, many of the older adults reported a real sense of fear and vulnerability. Consequently they come to the mall seeking the protection of a safe place.

Fear and concerns about physical vulnerability were expressed freely during our casual conversations and formal interviews. Concerned recollected that, "Last summer I walked down at the Bluefield City Park. But I don't like to walk down there unless someone's with me It's safer out here at the mall." Slim was frightened when she "walked alone, out at the cemetery, ... that's the reason I got afraid." She became fearful walking alone because, "If you're out ... walking by yourself you're pretty vulnerable." Chief mall walked only during the daylight hours because she felt "safe in the daytime, but at night I wouldn't walk to the car by myself at all," and Helpful found "it became too dangerous" to continue walking on the road near his home.

Mr. Chips related his crime fears to changes in society. "The safety factor is ... an item anymore. We don't like to get out in places where we're isolated. We used to walk all day in the Smokies and never meet a single soul. But if we did, we had no fear I would not feel that way about it now. Deplorable, but that's the way it is."

A pervasive sense of fear and vulnerability resulted in many older adults devising strategies intended to promote their safety. In some cases, safety was purchased at the cost of their freedom to continue an outside activity the older adult preferred. Husband's fear of his physical vulnerability explained why, although he preferred to walk outside, he no longer did so. He said:

I used to walk uptown, but the east end of [home town] got pretty rough. Those winos would be sitting right in the doorways of those apartments drinking wine ... and they'd bug me for a cigarette or ... a dollar. I got a little bit scared, you know. They're liable to drag me in. I quit walking up there, and that's the reason. Then I heard about [mall walking].

For these older adults there was a sense that the mall, unlike their local community, provided a safe and sheltered environment for their morning walk.

Social Supports

As most people who have begun any structured program can attest, it is one thing to start and quite another to continue on a regular basis. As might be expected from the literature previously cited, social supports played a critical role in promoting regular mall walking practice.

Many mall walkers believed that spousal support helped motivate them not only to initiate, but even more importantly, to continue mall walking. Some felt their spouses encouraged them to continue mall walking, even when the spouse did not share their activity. Encouragement by spouses and other family members, particularly daughters, reinforced the actions and strategies of the older adult mall walkers.

Instrumental support, the "provision of advice, information or practical assistance" (Dykstra, 1990, p. 8) was expected from husbands by several wives who relied on husbands to take them to the mall if the weather was bad. Affective support, "which includes expressions of affection, admiration, respect or affirmation," (Dykstra, 1990, p. 8) was important to other walkers, particularly to one male who had made significant lifestyle modifications.

Husband and Wife always supported and encouraged each other in their mall walking activity. Although the couple considered mall walking to be "boring," they always walked

around the mall together. On days Wife was unable to mall walk, Husband was observed continuing to make the requisite four rounds of the mall alone. Wife never came mall walking without him.

Several other walkers reported that verbal encouragement or prodding from a spouse helped to promote their walking activity. Concerned said she knew she could rely on her husband to urge her on by saying, "You'd better get up, if you're going to walk today." Even though "there are some times that I should stay home and do things, my husband encourages me to come out and walk first." Witty acknowledged his wife "tells me to go, or advises me." But after a moment he reflected, laughed and added, "Why did I say that, she orders me to do it! Every morning she says 'time for you to go'."

Daughters also provided support that helped motivate continued parental mall walking. Although Slim regarded her husband as "a couch potato who doesn't get out," and who provided her little encouragement, she relied on her two daughters to: "keep saying to keep walking ... and ask if I'm still walking at the mall. They push me a lot." Nickname's daughter encouraged her parents' participation in mall walking by joining them whenever her work schedule permitted and otherwise taking great interest in their reported activities.

The importance of affective support from family was particularly poignant during an interview in which Hulk discussed his past drinking problems and current health behaviors. He stopped both drinking and smoking and stated that he knew, "Some of them said I quit drinking on account of my mother or my wife, but I was the one that was a drunk. I was the one with the problem, and I had to do it for myself." At the end of our interview, he explained the importance his family's support and encouragement played in motivating his changed behavior with great emotion, saying: "Oh, they're [his wife and mother] all so proud of me. I guess it keeps me going."

Family support, both affective and instrumental, clearly played an important part in encouraging and promoting continued mall walking. There were no reports of a son's encouragement or support for a parent's mall walking activity, even when the son was living in the parental home.

Companionship. As adults age, their opportunities to make new friends and enjoy social interaction may be fewer than those of younger people, although friendship formation can continue throughout life (Blieszner, 1989; Dykstra, 1990). Reduced opportunities to meet others can be problematic when older adults depend on "the immediate social context--the potential friends that live, or don't live next door" (Hochschild, 1973, p. ix). For the

participants in this study, although potential friends may no longer live next door, they may still be found at the mall.

There was a shared consciousness among older walkers that aging led to decreased contacts with other adults and a subsequent potential for social isolation. Wife believed "that elderly people are actually lonely. If you let yourself, you can become very lonely." Concerned said her pace partner "came out here because, if she didn't, she wouldn't see people or anything," and Concerned had just seen her neighbors for the first time in several years while mall walking.

Both male and female mall walkers frequently mentioned that they met a social need for companionship by coming to the mall to walk. Coming to the mall apparently served as an effective strategy for increasing social contacts that otherwise would have been diminished by retirement and other losses which accumulated with advancing age. Husband indicated his need for companionship when asked if he would mall walk alone, "No, no! I'd need a little company you know. Of course, you know I've got a lot of friends here. I could go sit with them or talk with them." Witty thought, "It's great to stay active and get out and meet your friends on a daily ... or even a weekly basis."

Strategies in the Process of Creating Companionship

Just coming to the mall did not guarantee the older adult companionship or assure making friends. Older adults reported that initiating friendships required effort and time. Teacher said, "You've got to put out effort on your own. I mean you can't sit back and wait for people to come to you, ... a lot of people who don't have friends, they just don't put out effort."

Acquaintances were made while walking, but a period of time was required to establish companions. Many older adults said that when they first came to the mall they walked alone for several weeks until people began to speak to them. One woman described the process, "First you walk alone, then you speak as you pass a walker, and then you begin a little conversation." Many relationships developed during the miles shared together with a pace partner.

Keeping pace with partners. Typically, mall walkers formed into small groups for walking. Most married couples arrived at the mall together, separated into same sex pace partnerships and rejoined at the completion of the requisite number of miles. Same sex couples were by far the most popular grouping with stable groups of three mall walkers rarely seen. Only two triads were observed, each composed of related family members. Three individuals said they preferred to walk alone.

Although mall walking partners usually walked at the same natural pace as their partner or partners, a few married couples and family members modified their pace so that they could walk together. Husband found that "sometimes it's a little awkward. Everyone has their different pace, and we had to learn to walk together ... sometimes she'd have to trot to keep up." Two brothers who mall walked together also had different natural paces, but one said, although he "could walk a little faster, ... I'm not training for any Olympic records," so he slowed his pace to permit him to share the companionship of his slower paced brother. A triad of sisters all modified their paces so they could share mall walking together.

The key to formation of the other mall walking dyads was consistently referred to as pace. Pace was defined by mall walkers as one's speed of walking. Many mall walking relationships were initiated when a mall walker identified another available walker who shared the same pace. One woman identified three groups of walkers based on pace, "the fast group, the medium group, and the slow group." She laughingly placed herself in the slow group.

Slim believed that pace, "depends on what's wrong with you." A few, like Pasha, always walked alone because a disability resulted in a pace too slow for the other walkers to share. Some, like Hulk, began to mall walk alone because

their slow pace caused them embarrassment. As their physical conditioning improved so did their pace and the chance to meet more pace partners. Even though a walker might have begun walking alone or with one individual, he/she eventually gravitated to someone who walked at his/her pace. It appeared that first a partner with compatible pace was found, then walking together began, and at last stable companionships ensued.

Three walkers apparently preferred to walk alone. One of these lone walkers was Mr. Chips who chose to "use the walking time to think and solve problems, personal and otherwise." He also had an extremely rapid pace which was difficult for an average walker to match. Another exception to most of the commonly accepted mall walking norms was a man I called "Wrong Way Corrigan." He walked alone, and of all the mall walkers I observed during three months of field observation, was the only person to walk clockwise, not counter-clockwise around the mall. His behavior was considered odd by most walkers. I was told that Teacher once asked Wrong Way why he walked the wrong way, only to be firmly informed that "it was none of her business." Obviously he could see and be seen by all the mall walkers as he passed by. Unfortunately, Wrong Way was not interviewed for this study because he did not participate in

blood pressure monitoring and frequently walked later than the hours during which the study was conducted.

Other walkers were adamant in their desire to walk alone. This fact was evident in a rebuff given to Chief when she attempted to initiate a new acquaintanceship. Her potential partner said, in response to Chief's overtures that they walk together, "I just like to walk by myself and look in the windows and meditate." Chief found other pace partners to walk and share time with, and her potential companion continued to mall walk alone.

Pace partners became important parts of the mall walking experience. They were considered reliable and valued companions although most pace partners had not known each prior to the time they began mall walking together.

Belonging and Creation of Community

A community may be broadly defined as a "collection of people who share some important feature of their lives" (Spradley, 1979, p. 5). The older adults of the Mercer Mall Walkers Club have created a community with one defining interest, mall walking activities. Mall walking served as the mechanism that brought these otherwise dissimilar and geographically diverse older adults together.

Whether or not they acknowledged membership in the Mercer Mall Walkers Club, the mall walkers considered themselves as being part of a special group. They all

belonged to the community of mall walkers. The actions and strategies undertaken by these older adults served to support the creation and continuation of their mall walking community. The members of this community shared customs, roles, rituals and beliefs. However, as is described below, this sense of community is highly constrained, and in most cases, it exists only within the mall walking environment. Furthermore, the experienced community differs among different sub-groups.

Knowing names. A popular television show begins with lyrics that assert, "You wanna go where ev'rybody knows your name" (Portnoy & Angelo, 1982). This belief did not hold true for most of this group of mall walkers. As long as they were at the mall, knowing each other's names didn't seem to be what mattered. For example, when a male mall walker fell and broke his arm while leaving home to go to the mall, distressed mall walkers, who heard of the accident through the grapevine less than an hour after it occurred, told me of the incident. They described the accident victim and his many medical problems in detail, but did not know his name. His plight mattered to them, however; and they all knew he had been taken to the emergency room of the regional medical center for treatment.

This peculiar feature of mall acquaintanceships was identified by Teacher, "You know these people and you speak

to them, but you don't know the names." Witty concurred when he observed, "I don't know anybody's last name, but everybody says Hi." Not knowing each other's names has occasionally created a problem. For instance when Wife attempted to send a get well card to an ill mall walker, she was hindered in her attempt by the fact that she did not know the other woman's last name or address.

Speaking. Speaking was important to the walkers. The sense of worth and recognition created by mutual exchange of greetings between fellow walkers was an important part of the walking experience. Although in most cases the mall walkers did not know each others' last names, they nevertheless exchanged greetings and evidenced concern about each other. These practices contributed to the mall walkers' belief that the mall "was a friendly place" and actually created the friendly atmosphere at the mall they all reported enjoying.

Almost everyone said good morning, or inquired about health, when they passed other walkers. Sarge recognized the limitations of these signs of friendliness when he observed, "Most of them speak back ... they think they know who I am, but they don't know me. But they'll speak to me anyway."

Shared customs. The activities of mall walking went beyond physically striding around the mall. An important

part of the day was visiting after the mall walking was completed. All but a few mall walkers shared the custom of having coffee after their mall walking. Many belonged to a particular group of walkers with whom they shared this custom. This interaction helped reinforce a sense of belonging. Within the larger group, the Mercer Mall Walkers Club, were three main groups, several smaller groups, and couples who observed this custom of breakfasting together.

The Breakfast Club. The largest of these groups was the Breakfast Club. This group appeared to take the lead in creating and maintaining the caring gestures and social routines that reinforced the mall walking community. Between 8:30 a.m. and 9:15 a.m., five mornings a week, members of the Breakfast Club met at their table in Hardee's.

The attending members sat in one long double line around tables that accommodated 16 persons. No nonmember was observed attempting to occupy these seats even if a chair was vacant. When a member of the Breakfast Club was not present, his or her place remained unfilled. Wife said, "It's the funniest thing, they [the Breakfast Club members] have their special places. It's like a pecking order. If I say anything [her husband] says 'don't be critical,' ... I'm not being critical, I'm amused. There's a little quirk about this seating arrangement, you know." Attendance at

this table varied from 8 to 15 adults. All but two of the Breakfast Club members were married couples and the other two were sisters-in-law who walked together. Membership in this club is by invitation only.

The president and vice-president of the Mercer Mall Walkers Club were members of the Breakfast Club. According to Chief, members of the Breakfast Club met to share complaints, and ailments, and personal problems. "They discuss their marital problems and their children's divorces and all that."

In an extraordinary recent event, the club celebrated the five year post mastectomy survival of one of its members with prayer and cake. Chief explained her reason for engaging in these activities by saying, "I think I have problems, and then I'll come out here and maybe make a new friend and she'll start telling me all about her problems and I'll think 'Oh, how lucky I am'."

Breakfast Club rituals. The Breakfast Club members participated in two other rituals. One was a group prayer experience that closed the breakfast they shared in Hardee's. The members held hands, or put their arms about each others' shoulders, leaned together and bowed their heads in prayer. They prayed for each other and for afflicted members.

The other custom the Breakfast Club members shared was the celebration of each member's birthday. All the older adults in Hardee's joined in singing "Happy Birthday" to the celebrants. These special celebrations were held once a month and honored all the members born in that month with cake, a card, and a computer printout with balloons on it that read Happy Birthday ...[person's name].

Caring roles. Sending cards was an important caring gesture among the mall walkers. During conversations almost every walker related that they had signed a card to send to a sick walker. This gesture served to reinforce community bonds. Members of The Breakfast Club "chipped in five dollars" to buy get well cards for ill or hospitalized mall walkers. Other members of the Mall Walkers Club contributed to the purchase of these cards, but only one woman in the Breakfast Club "does birthday and sick cards." Her tasks are to buy cards and keep track of who is ill. News of a walker's illness spread when "Someone hollers out, did you know so and so is in the hospital?" Cards are then purchased and circulated, to be signed by as many mall walkers as possible. If the ill mall walker's last name and address are unknown, the card is held and given to the person upon recovery and return to mall walking.

No one I talked with acknowledged knowing of any deaths that have occurred among the members of the mall walking

club. When a person in a member of the Breakfast Club member's immediate family dies, members attend the funeral services, and flowers are sent in the club's name. If services are held in a funeral home, "lots of people ... go," but if "services are held in a church, only members of that church go. For example, Lutherans go to Lutheran church services." Chief explained that, because of the expense, Breakfast Club members sent flowers only to members who were hospitalized or upon the death of one of their immediate family.

Only once, when an African-American woman mall walker was ill and hospitalized, did the Breakfast Club send flowers. This event entered mall mythology. More than ten respondents volunteered the tale of when "Lillybeth" was hospitalized, and all the mall walkers sent flowers and gave her a card. This gesture from the essentially caucasian walking group in rural West Virginia to an African-American was remarkable and somewhat out of character. Perhaps this is why it entered into mall mythology and helped to reinforce the mall walkers' self-image of themselves as "good people."

Grapevining. The members of the Breakfast Club played an important role in keeping mall walkers up to date on what was happening among the mall walking community. Their altruism was sometimes regarded with suspicion by other

walkers. The role of grapevining in the exertion of social control was obvious to Wife who pointedly observed that one woman "seems to know a lot about everybody ... although I'm sure it's because she has got such a good heart and is concerned." Her observation was substantiated when Helpful explained, "Nosey, a little bit, you might call it. You know a lot of people's got a tendency to kind of want to know about other people's things. People ask questions 'was that so-and-so's wife walking with so-and-so, or was that her husband?'" Community gossip as well as community concern was spread through the grapevine.

Other groups. Another group that met at Hardee's after mall walking was composed of Helpful and five other walkers. This group-of-six were all married couples who sat in the nonsmoking area after they completed mall walking. This group was unusual in that its members had known each other for many years prior to mall walking, being the only group who had previously socialized together outside the mall. The men all belonged to the same fraternal organization, and the couples traveled together to attend fraternal events. Members of this group were acknowledged by, and interacted with, the Breakfast Club and participated in a Breakfast Club prayer service. This group-of-six signed cards for ill walkers and paid occasional condolence calls as well.

However, they never sat at the Breakfast Club table and had no special name for themselves.

The Old Boy's Club. There was another social group whose members never bought coffee or sat in Hardee's. It seemed quite different from the other groups at the mall which shared coffee and conversation. This Old Boy's Club, as I came to call them, varied in size and composition, but usually consisted of eight to ten members, five of whom were almost always present and constituted the core of the group. These men gathered every morning beside the Orange Julius concession and surrounded the first two tables in the food court service area. The member that I considered as leader of the Old Boy's Club was always present. He drew the attention of the other walkers once when he set off a firecracker while he was mall walking.

Members of this group were more vocal and physical in their greetings than members of other groups. Although Hulk sat with this group every morning, he was quick to add "not for long, just to cool down." I was unable to interview other members of this group. During the three months of participant observations conducted at the mall, I never observed a woman seated among this group of men. Women who appeared to be the partners of men who paused to chat with members of the Old Boy's Club always stayed on the

outskirts. The women usually sat at separate tables, so that the men actually had their backs turned to them.

The Old Boy's Club members walked and then purchased coffee from restaurant employees before the shops opened. They sat joking, talking, laughing, greeting walkers and, according to Husband, "telling some splendiferous tales," from 8:15 a.m. until almost 10 a.m., leaving just before the stores opened.

Small groups and couples. Husband and Wife always sat in the same booth in Hardee's. He invariably ordered a biscuit and coffee, but sometimes expanded his menu to include a sausage biscuit, especially if his wife wasn't there. Wife said Husband always urged her to, "hurry up so we can get our seat" when they were mall walking. Husband had never been invited to join the Breakfast Club table when his wife was absent, although he had been mall walking for over five years. Husband sat at their table alone if Wife wasn't there with him.

Sarge and his new bride also ate in a booth at Hardee's and ordered "one coffee, which we share, and then we get a free refill ... that way we save money." Although members of the Breakfast Club were aware that Sarge "had been looking for a wife," there were no celebrations or acknowledgement of his marriage by any of the mall walkers. This couple was not asked to sign the cards sent to ill mall

walkers, and they did not receive a card of congratulations when they married. This curious omission was partially explained by grapevine gossip among the walkers concerning the living arrangements of the couple prior to their marriage, as well as the 25 year difference between the ages of the newlywed pair.

Another mall walking family always sat at a front table, separated from the others by a half wall. Composed of a sister, brother, and his wife, this triad was the only one I observed that consistently mall walked together and ate in Hardee's. They had conversational exchanges with members of the Breakfast Club, but never moved from their special table at the front of the restaurant.

Many other older people were often seated at the tables at Hardee's between the hours of 8:30 and 9:15 in the morning, and filled the atmosphere with laughter, conversation, and, occasionally, the strains of "Happy Birthday to You." Younger mall employees and visitors were observed purchasing their breakfasts at Hardee's and consuming them outside the restaurant in the main corridor of the mall, leaving the older adult walkers in control of their space and community. Occasionally a mall employee would enter and eat, but employees usually waited until after the older adults had departed before ordering breakfast. (The floor plan of Hardee's as well as the

seating areas occupied by various groups are shown in Appendices G and H)

Shared beliefs. A sense of community is reinforced by shared beliefs. There was a collective consciousness among the mall walkers about the role of the community of mall walkers, as well as the proper use of the mall itself, during the time the mall doors were opened for their special group. Community beliefs included their sense of responsibility for events that occurred at the mall during morning mall walking hours, a mindset about the walkers' special qualities, the dire consequences of inactivity, and religious faith. Walkers had strategies that served to construct and reinforce the shared beliefs of the community.

Our turf, our responsibility. Members of the mall walking club related that they tried to "take care of a woman" who came to the mall every day to use the pay phone. They observed that "she wasn't clean and came up and used the pay phones all morning. She put her baby on the floor, and it would put everything in its mouth. Well, one morning we just offered her money for breakfast, but she didn't take it." Failing in that strategy to solve what they had come to feel was their problem, they took other action. They gave the mother money to buy a sweater and brought clean, used baby clothing for the child. One Breakfast Club member bought shoes for the child because "winter was coming and it

was barefoot." Now they wonder "what happened," and "where she went?," because the woman no longer comes to the mall. They expressed the hope "that social services helped her."

Mall walkers also took action to exert social control over the conduct of others in the mall area during early morning walking club hours. Chief told of the time a non-mall walking couple became a problem. "They'd do everything except the final act right out in public. Well, the mall maintenance man said to do something, and I did! I told them they would just have to wait until after dark, and he said 'yes ma'am' and we were never bothered again. They weren't mall walkers they were mall lovers." Her direct intervention might have been less successful if attempted on Saturday night at the mall. On Saturday night the turf is controlled by a much different and younger age group. On Saturday nights at the mall older adults are practically nonexistent.

Mindset. The mall walker's sense of community is reinforced by other shared beliefs. One of these is that those who mall walk possess a certain mindset, a special attitude, or "discipline." In the minds of the walkers this special attitude helped set them apart from other, inactive, older adults. Their shared mindset helps walkers forge a special bond as fellow members of the mall walking community. They are among a special group, doing something

that wasn't easy, and they knew it. Wife said, "Everybody ... when they're finished ... says to each other, 'Boy it doesn't get any easier, does it?' and it doesn't, ever!"

All the older adults agreed that mall walking, while perhaps hard, boring or dull, was good for you. They hold dire expectations for those older adults who do not exert the willpower and discipline to engage in what the walkers believed was a preventive and beneficial activity.

Crime and punishment. The older adult mall walkers share a belief that those who do not engage in activity will suffer the sad consequences that an inactive, sedentary lifestyle had for people they knew or had heard of. As was noted earlier Teacher attributed her mother's senility to an inactive lifestyle, while Brother told of a retired policeman who just, " ... sat down there at the house. He never would get out, never would go. Now he's over at a nursing home." Others related their belief that, if you didn't get up and out, you'd eventually get to the place where you couldn't walk at all.

Excuses found little sympathy among mall walkers. Slim said, "You have to be [determined] because you can always find an excuse if you want to." The consensus among mall walkers was that there were mental and physical penalties to be paid by those who make excuses and choose not to exercise. Mall walkers viewed sedentary older adults as

lacking the discipline and willpower necessary to push themselves to engage in mall walking.

Shared faith. Religion has a powerful affect on the elderly in Appalachia. It is frequently described as fundamentalist in that many believe that lives must be lived in accordance with very clear rules (Lewis, Messner & McDowell, 1985). Many members of the mall community profess faith in Christianity and identify themselves in conversation as being a Christian. They are concerned with the proper ways for a Christian to act and hold definite opinions about what some of these ways are.

Sarge related that he married because he was a Christian and "didn't want to do anything that looked wrong." However, before he married his young housekeeper, many opinions were expressed through the grapevine about their relationship. Rules for forgiveness were followed by the former vice-president of the Mall Walkers Club, who explained carefully that, while he had no desire to ever see a particular group of mall walkers again, "I'm a Christian and so therefore I have to forgive them."

While it is not necessary to attend a church to consider oneself a Christian, most walkers belong to what Concerned called "a church family." Nickname professed his need to "get right with Jesus" when he explained why he stopped smoking. Although he belonged to no church, he felt

that while "smoking ain't all that bad, it's a dirty habit, and I think Jesus wants you clean." The culture of Appalachian Christianity prevails at the mall, and most mall walkers are keenly aware of the denomination of the church attended by their fellow walkers as well as the need to do "the Christian thing" in their dealings with others.

Consequences

Strauss and Corbin (1990, p. 97) define consequences as "the outcomes or results of action and interaction." These results were influenced by the intervening conditions that created the need for action and interaction strategies. Two major consequences occurred among the older adults who participated in this study. These consequences included a perceived increase in health, both physical and psychological, and creation of new social contacts and sense of belonging within the borders of a mall community.

Health

Physical. There was an expressed consensus among the walkers with whom I spoke that mall walking, although boring, is "great physically," and that the benefits accrued were enough to motivate older adult walkers to continue the practice. These results were usually measurable to the respondents, although walkers were not unduly concerned with monitoring physiological parameters during their mall walking activities.

Weight reduction. The primary physical benefit reported by walkers was weight reduction. Several walkers reported losing a considerable amount of weight. Husband lost 19 pounds and Sarge, who once weighed 300 pounds, reduced his weight to below 200 pounds. Women frequently attributed less success to mall walking in weight reduction, although Slim lost 10 pounds and felt mall walking had helped her to maintain a lowered weight. However, for most women, walking did not lead to a large reduction in weight. One dedicated walker had not "lost a pound", while another said that it "wasn't walking, it was what you didn't put in your mouth" that led to weight reduction.

Other physical benefits. Several walkers attributed a reduction in serum cholesterol levels to mall walking. Four women with arthritis found that they were less stiff after they walked, and one walker noted that she felt less arthritic pain after mall walking.

All the older adult mall walkers with a medical diagnosis of hypertension said that they considered that mall walking played an important part in helping control their high blood pressure. These mall walkers participated in the blood pressure screenings offered by the investigator at the mall and thus were able to measure any progress they made in reducing hypertension. Reduction in blood pressure measurements may well be related to the reduction of stress

reported by walkers upon completion of mall walking activity.

Psychological. Mall walkers invariably attributed positive psychological outcomes to walking. They all said they felt better and had more energy after mall walking. For some, benefits occurred even before the mall walking activity began, because of pleasurable anticipation associated with the event. One man found, "It gives me something to look forward to as long as I'm able to do it."

Mall walking activity was described as leading to mental stimulation and a lift in mood, as well as being good for "nerves." In Appalachia, emotional problems are frequently referred to as "bad nerves" (Lewis, Messner & McDowell, 1985). One mall walker related that mall walking activity sharpened her mind, because walkers were "always asking you things that you probably would have forgotten or never thought about ... maybe about your family or something that happened back in your childhood." This positive effect on mentation was also reflected in the remarks of another walker who said that "it takes the cobwebs out of your mind" and "it helps you up here [indicating the head] a whole lot too. It kind of clears your mind."

Elevation of mood was reflected by Mr. Chips who said, "If I'm in a bad mood in the morning and I walk, I feel

better." Sarge agreed that mall walking activity "puts me on a high."

Stress reduction. Stress reduction and relaxation were among other major benefits attributed to mall walking by study respondents. One woman with whom I spoke during participant observation shared her past psychiatric problems, as well as her belief that she had been able to overcome addiction to Valium through the reduction in stress and anxiety she experienced by mall walking. She related that mall walking was relaxing and good "for her nerves." Slim said, "You work off that stress by walking; your nerves are calmer; you're more relaxed."

Emotional support. The emotional support of their fellow female mall walkers was important to female community members. Concerned experienced great despair and grief last year when her brother died at age 59 from a brain tumor, and she turned to mall walkers for help. She knew, "... when I came out here I could talk to people. I used to [talk] a lot more than I do now, about that [the death], and they sure were a lot of help. These friends [mall walkers] seem like they're close to you. Everybody knows you and comes up and talks to you." The support and concern of her confidants at the mall aided Concerned in her process of grief and recovery. She felt that her mall walking companions helped her cope with depression, loss, and grief.

Emotional support was also offered by women mall walkers to two other members of their mall walking community who have had concerns about serious illnesses. Mall walkers visited one woman in her home following her surgery for breast cancer and provided emotional support to another walker when she discovered a suspicious mass which would require a biopsy. Female mall walkers gave many hugs and much hand-holding to these two women.

Social Contact and Companionship Within the Mall Community

Older adult mall walkers expressed satisfaction with their opportunity to see people and be greeted during mall walking activities. Walkers also appreciated the increased sense of belonging and possibilities for friendship formation inherent in the mall walking activity. Slim said when she came to the mall in the morning she got "a real good feeling because everyone else is walking. They have a purpose and you feel like you just fit right in."

The potential for social isolation was reduced by mall walking activities. Two female mall walkers, who participated without their spouses, said they thought that if they did not mall walk, the only persons they might see for days would be their husbands. Contact with their husbands evidently did not satisfy their need for social contacts. Both of these women met their needs for social contact and companionship through mall walking activities.

Boundaries of relationships. The older adult walkers at Mercer Mall created a unique community within the context of the mall environment. These relations occurred in different group memberships. Aside from an occasional casual contact at the grocery store, most mall walkers rarely saw each other outside the mall. Little desire was expressed to extend their mall walking contacts to social contacts outside the mall. Concerned had invited Slim and Slim's husband to her home several times, but her invitations have never been accepted. Their close companionship existed only within the confines of the mall.

There were few exceptions to the widely accepted limits on socialization within the mall. Twice over the years some couples in the Breakfast Club had taken a trip together, the latest a Sunset Tour to Nashville. The group-of-six had attended fraternal events together before they initiated mall walking activities. Their most recent trip together was to Gatlinburg, Tennessee, where the men had a fraternal convention. However, except for the three annual social events scheduled outside the mall, which seem to be attended by the widowed and married couples, I found no evidence of intentional social contact outside the mall between most members of the mall walking community.

Summary

Mall walking was more than a physical activity to the older adult Mercer Mall Walkers. The phenomenon of mall walking they created was composed of a process of events, routines and actions that were incorporated into the lives of those who participated. Those events included opportunities for work, friendship making, companionship, creation of social roles, rituals, support in times of illness and bereavement, as well as the creation of a sense of community and fellowship. This phenomenon, according to the stories told by the participating older adult mall walkers, with rare exceptions, began and ended at the mall entrance.

CHAPTER V

Discussion and Implications

Overview

The purpose of Chapter V is to discuss the research findings presented in Chapter IV and the study's implications for practice and further research. Study findings about how older adults construct the meaning of and motivation for mall walking are integrated with extant theory and the limitations of the study are discussed.

Theoretical Relevance

Symbolic Interactionism, Health Constructs and Grounded Theory

The perspective of symbolic interactionism influenced the my broad view and informed the study's direction and focus. Symbolic interactionism emphasizes the meaningful and ongoing processes emergent from social interaction (Passuth & Bengtson, 1988). Thus the interactions of older adults in this study have created "a constructed and enacted entity," the phenomenon of the mall walking experience (Lincoln, 1992, p. 389).

Wellness, health, and lifestyle are constructs made up in large measure by human behaviors (Lincoln, 1992). These everyday social constructs are enacted by people in the places they live, work, and play, not in clinics or laboratories. Environments where human beings engage in

creating meaning and motivation for wellness and health are ordinary places such as the shopping mall, the beauty salon, and the grocery store.

Information gained by this study, conducted in the setting of a rural shopping mall, was intended to contribute to the development of theory grounded in the actual life experiences of aging adults. This use of grounded theory methodology also allowed exploration of questions of human behavior, interactivity, and attribution of meaning among older adults (Lincoln, 1992).

Discussion of the Findings in Relation to the Guiding Questions

The study employed theoretically informed questions to guide the interviews and observations. This portion of the chapter discusses the findings presented in Chapter IV in relation to the questions that guided the research. Each question is restated and is then followed by a discussion of relevant findings.

1. What are the meanings and motivations attributed by older adult mall walkers for their participation in mall walking?

Although older adults attributed a variety of reasons for their initial participation in mall walking, the responses fell into three major categories: (a) the advice of a physician or a perceived need to manage chronic medical conditions (expert-directed); (b) the desire to meet self-

perceived health goals (self-directed); and (c) the response to two sources of social invitation: most typically by a spouse, or other family members.

Expert-directed participation. Response to expert-directed advice was the primary reason given by study respondents for initiation of mall walking. Expert-directed advice was generally offered directly to a patient, but on at least one occasion advice was given to the female spouse who then assumed responsibility for the mall walking activity of her husband. It would be necessary to conduct a longer study in order to assess the effectiveness of this indirect intervention strategy in promoting compliance with expert-directed advice. However, this couple was absent frequently during the times participant observation was conducted for this study, suggesting that indirect advice is less effective than direct advice for the continuation of mall walking.

Many older adults began walking in response to a physician's directive to exercise, usually in an attempt to control a medical condition such as hypertension or a heart problem. Although the majority of walkers began to walk to comply with a physician's expert-direction, most walkers did not concern themselves with frequent monitoring of pulse or breathing rates during their walking activities. In fact,

these traditional medical monitoring activities were grossly absent among the walkers.

Self-directed participation. A smaller group of walkers set self-directed health goals which they pursued through mall walking. These older adults valued health and considered it possible to be healthy even if they had chronic medical disorders. Their major motivation was not the management of medical problems or disorders. They did not concern themselves with whether or not mall walking allowed them to control their medical problems. This group of mall walkers was initially motivated to mall walk by a desire to maintain or retain health and functional independence. They did not wait for expert-directed advice to initiate mall walking and were self-motivated in achieving their own health goals. Members of the self-directed group were much less likely than the expert-directed group to mall walk for socialization purposes, and they often walked alone or with a spouse or sibling.

Invited participation. The invitation to mall walk was usually extended by a spouse, although other family members, including siblings, were mentioned as extending invitations. Invitations from friends were the least likely primary reason older adults began mall walking. Lack of invitations from friends may reflect the diminished social contacts and friendship opportunities of these aging adults or a lack of

normative role expectations for mall walking among older adults in the community.

2. What are the motivations and meanings that older adult mall walkers relate for their adoption of, and continued participation in, mall walking?

Older adult mall walkers demonstrated many motivations and meanings for their adoption of mall walking. The three causal conditions related to the initial adoption of walking have been discussed in relation to the first guiding question. This part of the discussion focuses on the primary motivations for continuation of mall walking.

Motivation and work issues. Older adults with a history of paid employment outside the home continued to participate in mall walking in order to create meaningful roles after retirement. Those who had retired from paid employment created quasi-work roles related to mall walking.

Walkers established patterns and routines related to mall walking similar to those that gave meaning and structure to their lives prior to retirement. For example, most mall walkers arrived at the mall Monday through Saturday, during times employed persons are usually scheduled to arrive at work, and no one mall walked on Sunday. Equating mall walking with work permitted the activity to have positive meaning for the older adults.

This is an important issue because health promoting programs targeted for older adults might gain increased participation if they incorporated aspects of participants' previous work related routines.

Socialization as motivation. Socialization with their peers allowed older adults, particularly females, to meet social needs. Many feared loneliness and walked for a social activity that would prevent the loneliness they feared. Mall walkers invariably reported the mall to be a friendly place, commenting that they made friends during mall walking activities. Respondents indicated that they had made more friendships mall walking than would be expected to be made by adults their age. Retired study participants apparently substituted social contacts made during mall walking for those reduced through age and retirement. They promoted and retained their sense of social connectedness through mall walking companionships.

Motivation and exercise. During the first interviews and conversations conducted for this study it became apparent that few study respondents referred to mall walking as exercise. Unless I used the term first, older adults did not generally say they began mall walking for exercise. Few mall walkers spontaneously referred to mall walking as exercise, although they used the term when describing the advice given to them by a physician. Several walkers

referred to mall walking as entertainment. After that insight I avoided using the term exercise in talking with the walkers unless they employed the term first. Perhaps respondents avoided the term exercise because exercise was not a normative social expectation for this age group, or because the word held unpleasant, or medical connotations.

3. How do older adult mall walkers perceive the influence of family and friends on their mall walking?

The influence of spouse and siblings contributed to both initiation and continuation of mall walking activities. Female spouses provided affective support and encouragement, while males provided both affective and instrumental support. Gender was a factor in determining support from offspring for parental mall walking. Daughters supported parental mall walking while sons did not, even when the son resided in the parental home. Proximity was not an issue but gender issues exist both in the support provided, and support desired.

Friends were mentioned only twice by respondents as having influencing the initiation of mall walking activity. However, companionship and community became salient issues in continued motivation for mall walking activities.

4. How do older adult mall walkers describe physiological, situational and environmental factors that influence their participation in mall walking?

Physiological factors. No differences were evidenced in responses from expert-directed walkers versus self-directed walkers in regard to the influence of physiological factors on their participation in mall walking. Neither group reported concern for or self-monitoring of physiological factors, such as pulse and respiratory rate, during mall walking activity. Probing questions about body monitoring (such as noting one's heart rate on exertion) were included in the initial interview questions. None of the older adults responded to questioning probes concerning their reactions to an increase in heart rate when walking.

This finding may indicate that those who complied with expert-direction later created their own motivation and meaning for the mall walking experience other than a medical basis for exercise. It may also be the case that walkers who walk for medical reasons chose not to participate in this study, or do not maintain the activity and drop out early, or develop denial patterns about walking.

Although no physiological factors were currently important to their continued participation in mall walking activities, some walkers expected to be "too old to continue someday". Such responses apparently reflect internalization of age normative social expectations that activity should decline with advancing age.

Situational and environmental factors. A safe environment for walking activity was important to the older adults who lived in the study's mountainous area. Walkers preferred the mall environment to other outside paths because of its flat and level terrain, controlled climate, and presence of security guards.

Security was an important issue for the older adult walkers who were concerned for their physical safety. Although none had been victims of crime, many reported concern about their potential physical vulnerability. Fear motivated some to walk within the protected environment of the mall during daylight hours. After dark, for a variety of reasons, the mall was regarded as less safe. Walking alone in the community was regarded by many as unsafe and dangerous.

Summary. Both expert-directed and self-directed participants were remarkably similar in their recollections of what motivated them to continue mall walking activities. There is reason to suspect that there may be different attrition rates between the groups over time. This is because of the finding that, although many walkers reported initiating mall walking on the advice of their physicians to exercise, no walkers reported that they continued to mall walk for these reasons. Further study is necessary to determine if there are differences between these groups in

adherence or social patterns. Self-directed walkers reported less interest in socialization than those who were expert-directed. Over time, attrition rates may differ between the two groups.

Interestingly, despite medical problems, expert-directed walkers did not monitor symptoms of their medical disorders while walking. Although some walkers developed strategies for coping with physiological effects of walking, they denied being troubled if they occurred.

Fear was the situational factor most described as motivating older adults to walk within the mall environment. They felt vulnerable in the world outside the mall, and this vulnerability caused some to limit outside activities they might otherwise enjoy. The mall environment offered safe terrain, companionship and community as well as physical safety in compensation for this loss.

5. How do older adult mall walkers situate the experience of mall walking within the broader context of their personal life. (What are older adult mall walkers' expectations and self-perceptions involving the experience and meaning of mall walking in their life?)

Older adult mall walkers situated themselves for a few hours a day, four or five days a week, in a pleasant community that they had created. This community of older adults within a modern enclosed shopping mall shared expectations, rules, customs, rituals, beliefs and a sense of territoriality. Membership in the mall walking community

diminished the possibility of social isolation, and allowed older adults to experience a sense of belonging.

The roles, rules, and rituals established by interaction among the older adults at the mall created meaning and definitions of reality, as well as self-affirmation. Walkers received support from their peers during significant life events. When mall walkers confronted situations, such as appropriate health seeking, or social and retirement behaviors, for which there are yet no clearly evolved social norms (Blieszner, 1989), interaction within this community helped them define age and situation appropriate norms.

For at least an hour most mornings mall walkers placed themselves amidst an environment of active, cheerful, healthy older adults who reinforced a positive image of themselves as engaged in socially appropriate and desirable behaviors. The experience of mall walking became an integral part of the lives of these older adults. They looked forward to coming to the mall with anticipation and enjoyed the company of companions during the variety of activities that comprised the experience of mall walking. Companionship and social contacts vital to the well being of older adults were initiated and maintained within the mall community. These companionships required effort and servicing. Dykstra has noted that "it is by doing things

together and talking about things together that ties between the individuals are created and cemented" (1990, p. 177). The older adults mall walk together and while doing so create ties of companionship and community.

The ties of mall companionship and community were generally place and time specific, with little or no planned contact between mall walking companions outside of the mall. Nevertheless this mall walking community has importance and meaning for the older adults. Although initially coming together from various areas and backgrounds simply to walk, the adults generated meaningful ties among themselves. Their sense of community is considered sincere by mall walkers, who give and receive support during significant life events such as illness, bereavement, and celebrations.

The practices established by older adult mall walkers may be related to their past employment socialization patterns. Is there a relationship between the observed lack of socialization among mall walkers outside the mall and the limited contacts generally seen among co-workers outside the work place? Further study would be necessary to explore the similarities or differences between the socialization patterns of the respondents at the mall and those of their pre-retirement period. This research could lead to support of this study's findings that mall walking resembles a work experience.

Integration of Study Findings and Extant Theories

Theoretical Perspectives

Two interactionist models, social breakdown and competence, (Kuypers & Bengtson, 1973) and social cognitive theory (Bandura, 1986) have constructs congruent with the study findings.

Social cognitive theory. As noted in the literature review, there is a dearth of research findings involving social cognitive theory and self-efficacy in adults over 60. The results of this investigation suggest contributions to the knowledge of self-efficacy, one of the major tenets of SCT, in older adults.

Self-efficacy, (the degree of confidence an individual has in his/her ability to perform a given behavior), is composed of four sources; **personal mastery, vicarious modeling, verbal encouragement, and physiological self-monitoring** (Bandura, 1977). The study indicated the importance of three of these factors, personal mastery (based on past work experiences), vicarious modeling (family and peer exercise behaviors), and verbal encouragement (positive statements from family), as well as qualitative aspects of a fourth, physiological self-monitoring.

Personal mastery. With only one exception, a woman who had never been employed outside the home, all the respondents had a life history what included paid

employment. The mall walkers' past work history and behaviors were major contributors to personal mastery. Past work behaviors and experiences contributed to both the structuring of mall walking as a work activity as the confidence of the mall walkers in their ability to perform the quasi-work routines and behaviors that comprised the activities of mall walking.

Vicarious modeling. There was agreement among most study respondents that mall walking activity by members of their family exerted a positive influence on both their initiation and maintenance of mall walking activity. This positive influence was exerted by spouses and siblings. Some older adults began walking on the invitation of family or kin who were already mall walking. Others, once they began mall walking, were motivated to emulate the accomplishments valued by their peers and continued mall walking activities.

Verbal encouragement. All the older adult mall walkers related that they received verbal encouragement from their spouses, or other kin, as well as their fellow mall walkers. As discussed in Chapter Four, some walkers could depend on the prodding and encouragement of a non-mall walking spouse. Walkers related that this informal verbal support was important to their maintenance of mall walking.

Physiological self-monitoring. The concept of physiological self-monitoring is expanded by the study findings from the usual medical model, evidenced in the quantitative counting of pulse and respirations, to recognize the qualitative personal experience of physiological response. Without using quantitative traditional medical monitoring, many study respondents interpreted and used the informative function of physiological arousal to inform adaptive coping strategies. For example, some walkers devised strategies to cope with physiological problems. Among them was one male who, when he experienced chest discomfort, rested until the pain diminished, and then resumed mall walking. Several other walkers who experienced shortness of breath adapted self-pacing strategies that permitted them to achieve success within their perceived physical limitations. Many walkers with respiratory problems initially attempted small distances and then gradually increased their self-set goals until they could walk longer distances around the mall. These walkers' subjective assessments of physiological responses allowed them to judge their own capacity for walking.

In summary, four tenets of self-efficacy were reported by the respondents in this study. These were: (a) personal mastery based on past work activity, (b) vicarious modeling

of mall walking activity by similarly aged related kin, (c) verbal encouragement by family and peers, and (d) subjective aspects of physiological self-monitoring. These four factors are included in suggestions for practice interventions discussed later in this chapter.

Social breakdown and competence. Estes (1991) located the "micro in the macro", (p. 28) in recognition of the fact that society represents the background against which any theory of aging must be enacted. Therefore, the findings of this study were first examined in the micro-environmental context of self-efficacy, (Bandura, 1977) and are now situated in the macro-environmental context of the social breakdown and competence model of normal aging (Kuypers & Bengtson, 1973). The interactionist social breakdown and competence model of normal aging is introduced and discussed now because of the emergence from the data of the important themes of work roles and quasi-work activities. Introducing this construct also permits the findings of this study to be located in the social context where the life experiences of active older adults take place. At the end of this discussion suggestions will be offered for a synthesis of constructs from the macro and micro models to add to theory-based practice.

The social breakdown syndrome suggested by Kuypers and Bengtson (1973) is a means to conceptualize how

vulnerability in older adults is created by the unique social reorganizations required in later life. Among factors that cause social reorganizations are the role losses experienced with retirement from employment. The significance of work-related role losses was revealed in the statements of the older adult respondents in this study. Therefore, inclusion of this model, the appropriateness of which was grounded in the study data, helps to clarify the study findings.

Kuypers and Bengtson (1973) described the potential negative impact of social conditions such as role loss, sudden change without preparation, and lack of normative information, reference groups and clues to appropriate behaviors on older adults. These were all conditions experienced by respondents in this study.

Kuypers' and Bengtson's model proposed that older adults become vulnerable to problems upon retirement from the work force because of the loss of status and personal devaluing that occur when work roles are lost. These losses occur frequently in societies such as the United States where great value is placed on productivity and productive people. According to the model, these role losses result in interactions with society that create a negative self-concept and a downward, spiraling process of increasing vulnerability in the aging adult. This downward spiral

results in older adults adapting the roles of physical and social inadequacy and incompetency (Passuth & Bengtson, 1988).

The authors' suggested that such an unfortunate descent may be reversed through interventions proposed in the social reconstruction syndrome (Hendricks & Hendricks, 1986). This reversal is accomplished by increasing support for older adults through interactions with a positive environment. Such interactions are postulated to increase older adults' sense of personal competence. Personal competence may also be enhanced by: (a) successful social role performance, (b) adaptive capacity to environmental change and, (c) personal feelings of mastery and control (Kuypers & Bengtson, 1973).

Successful interactions were apparent among study respondents who found new social companions and created new roles and rituals within the positive environment of an enclosed shopping mall. The study participants created and adapted the mall walking environment for their own use. Respondents also exhibited control over their continuation of voluntary mall walking activities.

Integration of model and findings. Most older adult mall walkers were ill prepared to experience retirement from the paid work force and subsequent loss of roles. According to the social breakdown syndrome, such role losses should have resulted in older adults who felt inadequate and

incompetent. However, the group of mall walkers in this study resisted being labeled as incompetent, sick, or dependent, and instead defined themselves as healthy.

Older adult mall walkers in this study resisted internalizing negative social stereotypes, in part because of the supportive environment created within the mall by interaction with their peers. These older adult mall walkers exerted effort to build new, adaptive, quasi-work roles and interactions with their peers that empowered them to accomplish this. Their mall walking experience included creation of new roles that helped to replace those work roles lost upon retirement.

Implications for Practice

Appropriate paradigms. One of the incidents revealed in this study was the demise of a wellness program offered by a local hospital. Although initially very successful, the program ended after only two years. One reason attributed for the failure was the "growing independence" of the mall walkers and their diminished attendance at programs. The hospital out-reach program was marketed to promote the rehabilitation and management of medical problems and illness among patients of physicians in the community.

However, the adult mall walkers in this study considered themselves healthy, despite evidence of

significant medical pathology, and were not involved in formal programs of rehabilitation or recovery. To the distress of the program director, they went to Hardee's to eat sausage biscuits after hearing a lecture about cholesterol and diet. Evidently programs based on a medical paradigm of illness cure and management did not meet the needs of these older adults with self-reported "good health". Although grateful to the hospital for free testing, they stopped attending programs that had no meaning for them.

Health care providers must develop a new paradigm that recognizes the self-concept of a growing number of older adults who see themselves as healthy and independent. The medical paradigm, appropriate to laboratory, clinic and hospital, is not appropriate to these active, independently living, older adults. The failure of the medical model was evidenced by the rejection and subsequent demise of the hospital out-reach program.

Programs enhancing the supportive environment of the older adult, as suggested in the social reconstruction model, could be a basis for health promoting programs for older adults. These programs should respond to the self-definition and self-defined needs of the older adult, and not the health care providers' perceptions of their needs. As has been illustrated in this study, if older adults who

mall walk for socialization are offered programs whose content focuses on their unperceived medical needs, the adults may well not attend. Wellness programs that incorporate constructs of self-efficacy may be more effective in reaching older adults. The study findings of the effectiveness of spouse and family members in role modeling for, and verbal encouragement of older adults should be considered by program planners.

Work programs. As discussed in Chapter Four, many respondents related that they experienced loneliness and lack of purpose upon retirement from paid employment. They "missed all the people" at work, and "needed something to occupy ... mind and time". None of these mall walkers had any plans or goals upon retirement. These older adults might well have benefitted from health oriented social programs for workers and their families conducted in the work place prior to retirement. Such programs could help prepare older adults and their family members for the new roles they will need to create upon retirement.

Work issues. Future programs intended to encourage activities such as mall walking among older adults might attend to two findings of this study. The first is that, upon loss of a work role, older adults undertake other activities and roles that become "work". Mall walking was identified as "work" by most respondents in this study. The

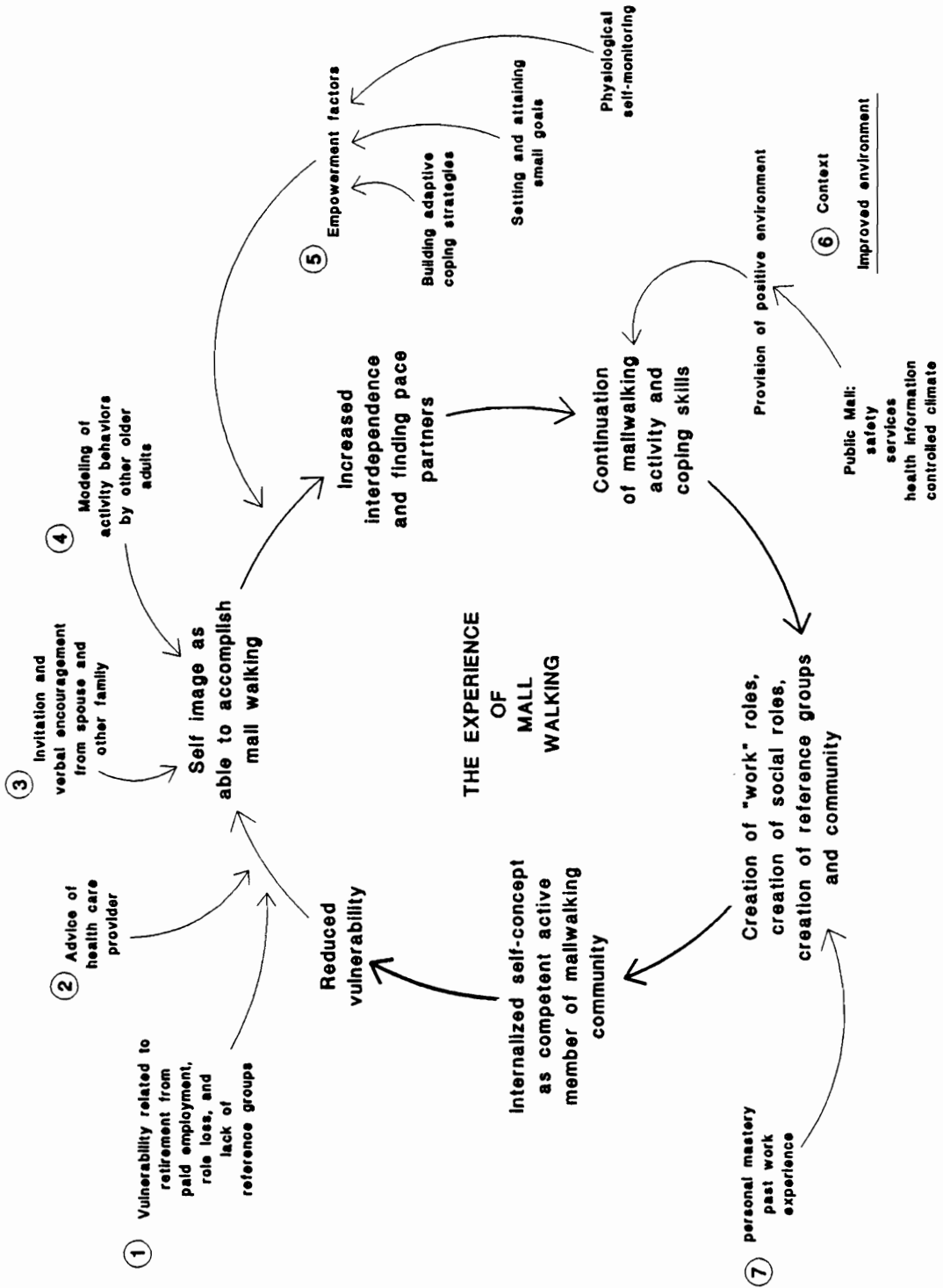
second finding was that older adults in this study did not view their activities as "exercise." Perhaps health promotion programs and activities should consider marketing health promotion among older adults as a work activity, not exercise, and model the programs after the work place with attendance requirements, set schedules for participation, and occasional tangible rewards for excellence.

Proposals for Practice

Synthesis of self-efficacy and social reconstruction.

Kuypers and Bengtson (1973) have suggested that positive social inputs may ameliorate the vicious cycle of social breakdown by enhancing the older adult's: (a) competency, (b) positive self-image, (c) maintenance of coping skills and problem solving strengths, and (d) appropriate interdependence. The results of this study suggest a synthesis of self-efficacy, and social reconstruction that might guide practice interventions designed to promote health promoting activities such as mall walking among older adults.

Figure 1, Intervention Model for Practice, offers a synthesis of aspects of social reconstruction and self-efficacy that are grounded in the findings of this study. The figure is intended only to suggest possible practice interventions that might be explored in programs intended to promote mall walking activities among older adults.



Intervention Model for Practice

Figure 1.

The inner circle represents concepts derived from the social reconstruction syndrome. The themes of self-efficacy identified in this study are indicated by arrows representing positive social inputs into the circle.

Entry into the model occurs in response to social events and role losses suggested at point 1. These are among factors requiring social reconstruction on the part of the older adult. After entry into mall walking, inputs based on self-efficacy are suggested to promote the continued experience of mall walking.

Advice from health care providers, including health educators, nurses and physicians (Input 2), **invitation and verbal encouragement from a spouse and other family members (Input 3)** and **modeling of mall walking behaviors by other older adults (Input 4)** initially promote the older adults' self-confidence and belief that they can accomplish mall walking. The effectiveness of expert-directed advice and spousal and family participation and encouragement have been found in this study to contribute to the initiation of walking activity.

Empowerment factors (Input 5) increase the older adult mall walkers' interdependence and coping skills, as well as enabling them to find appropriate pace partners. These inputs also help promote a positive sense of self through the accomplishment of self-set goals.

At this point in the circle continuation of mall walking activity and coping skills are seen as being reinforced within the context of a **positive social environment (Input 6)**. In the case of this study, the social environment was an enclosed shopping mall where safety, food services, health information and controlled climate were provided to enhance the older adults' opportunity to interact with their peers in creation of companionship and community. Positive environments, such as a mall opened for older walkers at a special time in the morning, should be considered as locations for health promoting activities. Locations shared by active individuals of all ages, rather than those for the infirm or socially isolated elderly, offer active, independently living, older adults a positive environment.

Positive environments enhance the older adults' social competency by providing a place in which new social roles and appropriate interconnectedness may be established. Rather than offering health programs and activities in a hospital setting, health programs in environments such as a mall could increase an older adult's social integration as well as program participation. While illness rehabilitation and medical related instruction is generally best provided in environments appropriate to illness, such as hospital sponsored clinics and rehabilitation centers, a social

paradigm of health seems best enacted in a positive social environment shared by healthy people.

Personal mastery, (the older adults' history of past work activities) is indicated in **Input 7**. Within the context of a positive environment the walkers' past **personal mastery** of work roles enhances their ability to create "work roles", age appropriate reference groups, other related social roles, and community. These factors promote the older adult's self-concept as a competent, active member of the mall walking community and result in **reduced vulnerability**.

The sequencing of inputs into the circle was suggested by the findings of this study. Although each of these inputs contributed to the meaning and motivation for mall walking among study respondents, the most effective sequencing of social inputs must be determined by future research and practice.

Limitations of the Study and Suggestions for Future Research

This study was intended to explore the meanings and motivations for mall walking among rural, independently living, active older adults. This intent was both a strength of the study and a limitation. The transferability of the study to other non-rural groups of older adult mall walkers is problematic. However, all the limitations of the

study are viewed as containing seeds for the growth of future research.

The first limitation of the study is that it was conducted over only four months. This abbreviated time frame prohibited comparisons between expert-directed mall walkers and self-directed mall walkers on such issues as long term commitment to mall walking and changes in the intensity and duration of the activity over time.

The second limitation is that because the investigation was limited to current mall walkers it could not provide information about the meaning of and motivation for mall walking among those who discontinued mall walking. Future investigation into motivations for discontinuation of mall walking activity could provide valuable insights about those who were not available to this study, as well as differences between older adults who continue to mall walk and those who do not.

A third limitation of the study is that all of the respondents, with the exception of one woman, had been employed outside the home. An important finding of the study was that mall walking was a quasi-work activity. Unfortunately, it is not possible to know if this would be the case among walkers who had not worked outside the home and thus had not experienced the loss of roles that accompany retirement. Older adults who had never been

employed outside the home may assign different meanings to and motivations for mall walking, or for not mall walking, than those included in this investigation. Future studies employing interviews with this population could identify these themes.

The fourth limitation of the study was the unavailability of unmarried respondents. With the exception of one divorced female, all the respondents interviewed were married. This bias may have limited the development of such findings as the role of companionship and social support in the sustaining of mall walking activity.

The fifth limitation of the study is lack of information about the socio-economic-status (SES) of the mall walkers. This study made no attempt to look for subtle indicators of SES. Although all the adult mall walkers came to the mall by car this mode of transportation did not necessarily indicate higher SES because public transportation is expensive, inconvenient and infrequent in this rural area. In other words, owning a car is a necessity even among the poor. Knowledge of respondents' SES might allow deeper understanding of the process of group formation within the mall walking community.

The final limitation in the study was the difficulty in establishing research rapport with older male mall walkers. This problem resulted in a qualitative difference between

the information obtained from male and female participants. As would be expected, females shared intimate experiences more freely than did males. Using a male co-investigator to relate to male participants might have helped to increase male openness and reduce the gender barrier. A male co-investigator might also have gained access to The Old Boy's Club which was as closed to this middle class, female investigator as a male working class bar.

Conclusions

The findings of this study provide the genesis of a grounded theory of health promoting activities among active, independently living, older adults. The implications of this study derive from data obtained through the use of qualitative methodology employed in an exploration of the real world of older adults. Most extant data have previously been obtained from infirm elders seen in contexts such as the hospital, clinic or laboratory.

The study found that mall walking was not viewed as exercise by the older adult mall walkers. It had become a kind of "work" that replaced work roles lost through retirement. The work of mall walking was carried out among a community of similarly "employed" older adults within the walls of an enclosed shopping mall. Roles, rituals, and meanings were created during the experience of mall walking

that created a sense of community and belonging that were important in the lives of the older adult mall walkers.

Other study findings indicated the importance of personal mastery based on past work experience, advice from physicians, invitation from family members, role modeling by peers (vicarious experience), and the verbal encouragement of a spouse, and other family members to the initiation and continued participation in mall walking activities.

An interesting finding was the relative unimportance of medical direction and concern about physical disorders to the continuation of mall walking activities. This finding strongly suggests that the medical paradigm may not be the best model on which to base health promotion programs targeted for active, independently living, older adults. Further studies that explore social paradigms of health are indicated by the findings of this study.

References

- Abdellah, F. H., & Moore, R. S. (Eds.). (1988). Proceedings of the surgeon general's workshop: Health promotion and aging. Department of Health and Human Services, Public Health Service. Washington, DC: U.S. Government Printing Office.
- AutoCAD Release 12 (1992). Autodesk, Inc. Sausalito, CA.
- Bandura, A. (1977). Social learning theory. Englewood Cliffs, NJ: Prentice-Hall.
- Bandura, A. (1986). Social foundations of thought & action: A social cognitive theory. Englewood Cliffs, NJ: Prentice-Hall.
- Bandura, A. (1991). Self-efficacy mechanism in physiological activation and health-promoting behavior. In J. Madden IV (Ed.), Neurobiology of learning, emotion and affect, (pp. 229-269). NY: Raven.
- Bastian, L. D. (1992). A national crime victimization report: Criminal victimization 1991. Bureau of Justice Statistics Bulletin. Washington: U.S. Department of Justice.
- Berg, B. L. (1989). Qualitative research methods for the social scientist. Needham Heights, MA: Allyn & Bacon.
- Berger, B., & Hecht, L. (1989). Exercise, aging, and psychological well-being: The mind-body question. In A. Ostrow (Ed.), Aging and motor behavior (pp. 117-158). Indianapolis: Benchmark.
- Berkman, L., & Breslow, L. (1983). Health and ways of living. NY: Oxford University Press.
- Berkman, L. F. & Syme, S. L. (1979). Social networks, host resistance and mortality: A nine year follow-up study of Alameda County residents. American Journal of Epidemiology, 109, 186-204.

- Blieszner, R. (1989). Developmental processes of friendship. In R. G. Adams & R. Blieszner (Eds.), Older adult friendship: Structure and process (pp 108-126). Newbury Park, CA: Sage.
- Blumer, H. (1969). Symbolic interactionism. Englewood Cliffs, NJ: Prentice-Hall.
- Buchner, D. M., Wagner, E. H., (1992). Preventing frail health. In G. S. Omenn (Ed.), Clinics in geriatric medicine (pp. 1-17). Philadelphia, PA: Saunders.
- Cassel, J. (1976). The contribution of the social environment to host resistance. American Journal of Epidemiology, 104, 107-123.
- Connell, C. M., & D'Augelli, A., R. (1988). Social support and human development: Issues in theory research and practice. Journal of Community Health, 13(2), 104-114.
- Denzin, N. K., (1989a). The research act: A theoretical introduction to sociological methods (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.
- Denzin, N. K. (1989b). Interpretive interactionism. Newbury Park, CA: Sage.
- Dishman, R. K. (1982). Compliance/Adherence in health related exercise. Health Psychology, 3, 237-267.
- Dishman, R. K. (1989). Determinants of physical activity and exercise for persons 65 years of age and older. In W. W. Spirduso & H. M. Eckert (Eds.), The academy papers: Physical activity and aging (pp. 140-142), Champaign, IL: Human Kinetics.
- Dishman R., Sallis, J., & Orenstein, D. (1985). The determinants of physical activity and exercise. Public Health Reports, 100, 158-171.
- Duda, J. L., & Tappe M. K. (1989). Personal investment in exercise among middleaged and older adults. In A. C. Ostrow (Ed.), Aging and Motor Behavior (pp. 219-238). Indianapolis: Benchmark.
- Dykstra, P. A. (1990). Next of (non)kin: The importance of primary relationships for older adults' well-being. Amsterdam: Swets & Zeitlinger.

- Dzewaltowski, D. A. (1989). A social cognitive theory of older adult exercise motivation. In A. C. Ostrow (Ed.), Aging and Motor Behavior (pp. 257-282). Indianapolis: Benchmark.
- Elward, K., & Larson, E. B. (1992). Benefits of exercise for older adults: A review of existing evidence and current recommendations for the general population. Clinics in Geriatric Medicine, 8, 35-50.
- Emery, C. F., & Blumenthal, J. A. (1990). Perceived change among participants in an exercise program for older adults. The Gerontologist, 30(4), 516-521.
- Estes, C. (1991). The new political economy of aging: Introduction and critique. In M. Minkler & C. Estes (Eds.). Critical perspectives on aging: The political and moral economy of growing old (pp. 19-36). Amilyville, NY: Baywood.
- Ewart, C. K. (1991). Social action theory for a public health psychology. American Psychologist, 46, 931-946.
- Frank-Stromborg, M., Pender, N. J., Walker, S. N., & Sechrist, K. R. (1990). Determinants of health-promoting lifestyle in ambulatory cancer patients. Social Science & Medicine, 31(10), 1159-1168.
- Fries, J. (1980). Aging, natural death, and the compression of morbidity. New England Journal of Medicine, 303, 130-135.
- Garfein, A., & Herzog, A. R. (1990). Paper presented in A. R. Herzog (Chair). Social and behavioral factors promoting health and well being in older age: Data from the American's changing lives study. Symposium conducted at the 43rd annual meeting of the Gerontological Society of America, Boston, MA.
- Glaser, B. G. (1978). Theoretical sensitivity. Mill Valley, CA: The Sociology Press.
- Gubrium, J. F. (1975). Living and dying at Murray Manor. NY: St. Martin's.
- Guralnik, J. M. (1985). Determinants of functional health status in the elderly. Unpublished doctoral dissertation. University of California at Berkeley: Berkeley.

- Hendricks, J., & Hendricks, C. D. (1986). Aging in mass society: Myths and realities. Boston: Little, Brown.
- Hird, J. S., & Williams, J. M. (1989). The psychological effects of chronic exercise in the elderly. In A. C. Ostrow (Ed.), Aging and motor behavior (pp. 257-282). Indianapolis: Benchmark.
- Hochschild, A. R. (1973). The unexpected community: Portrait of an old age subculture. University of California at Berkeley: University of California.
- Hofstetter, C. R., Hovell, M. F., & Sallis, J. F. (1990). Social learning correlates of exercise self-efficacy: Early experiences with physical activity. Social Science and Medicine, 31(10), 1169-1176.
- Hofstetter, C. R., Sallis, J. F., & Hovell, M. F. (1990). Some health dimensions of self-efficacy: Analysis of theoretical specificity. Social Science and Medicine, 31(9), 1051-1056.
- House, J. S., Landis, K., & Umberson, D. (1988). Social relationships and health. Science, 241, 540-545.
- House, J. S., Robbins, C., & Metzner, H. L. (1982). The association of social relationships and activities with mortality: Prospective evidence from the Tecumseh Community Health Study. American Journal of Epidemiology, 116, (1), 123-240.
- Hovell, M. F., Sallis, J. F., Hofstetter, C. R., Spry, V. M., Faucher, P., & Caspersen, C. J. (1989). Identifying correlates of walking for exercise: An epidemiologic prerequisite for physical activity promotion. Preventive Medicine, 18, 856-866.
- Howze, E. H., Smith, M. & D. A. DiGilio (1989). Factors affecting the adoption of exercise behavior among sedentary older adults. Health Education Research: Theory and Practice, 4(2), 173-180.
- Kaplan, R. M., Atkins, C. J., & Reinsch, S. (1984). Specific efficacy expectations mediate exercise compliance in patients with COPD. Health Psychology, 3, 223-242.

- Kimiecik, J. C., Jackson, S. A., & Giannini, J. M (1990). Striving for exercise goals: An examination of the motivational orientations of exercise behavior of unsupervised joggers, swimmers, and cyclists. In L. V. Velden & J. H. Humphrey (Eds.), Psychology and sociology of sport: Current selected research (pp.120-134). NY: AMS.
- Kowinski, W. S. (1985). The malling of America: An inside look at the great consumer paradise. NY: William Morrow.
- Krause, N. (1990). Perceived health problems, formal/informal support and life satisfaction among older adults. Journal of Gerontology: Social Science, 45(5), S193-205.
- Kuralt, Charles (1982). CBS Reports: After the dream comes true. NY: Columbia Broadcast System.
- Kuypers, J. A. & Bengtson, V. L. (1973). Social breakdown and competence: A model of normal aging. Human Development, 16, 181-201.
- Langer, E., & Rodin, J. (1976). The effects of choice and enhanced personal responsibility for the aged: A field experiment in an institutional setting. Journal of Personal and Social Psychology, 34, 191-198.
- Langlie, J. K. (1977). Social networks, health beliefs, and preventive health behavior. Journal of Health & Social Behavior, 18, 244-260.
- Lewis, S., Messner, R. & McDowell, W. A. (1985). An unchanging culture. Journal of Gerontological Nursing, 11(8), 20-26.
- Lichtenstein, R. L., & Thomas, J. W. (1987). A comparison of self-reported measures of perceived health and functional health in an elderly population. Journal of Community Health, 12(4), 213-230.
- Lincoln, Y. S. (1992). Sympathetic connections between qualitative methods and health research. Qualitative Health Research, 2(4), 375-391.

- Manen, M. van. (1990). Researching the lived experience: Human science for an action sensitive pedagogy. NY: State University of New York.
- Marshall, C., & Rossman, G. (1989). Designing qualitative research. Newbury Park, CA: Sage.
- May, K. A. (1986). Writing the grounded theory study. In W. C. Chenitz & J. Swanson (Eds.). Qualitative research in nursing: From practice to grounded theory. Menlo Park, CA: Addison-Wesley.
- McAuley, E. (1991, November). Efficacy, attributions, and affective responses to exercise participation. Paper presented at 44th Annual Scientific Meeting of the Gerontological Society of America, San Francisco, CA.
- McAuley, E., & Jacobson, E. (1991). Self-efficacy and exercise participation in sedentary adult females. American Journal of Health Promotion, 5(3), 185-191.
- Minkler, M. (1985). Building supportive ties and sense of community among the inner-city elderly: The tenderloin senior outreach project. Health Education Quarterly, 12, 303-314.
- Morgan, K., Dallosso, H., Basse, J., Ebrahim, S., Fentem, P. H., & Arie, T. H. (1991). Customary physical activity, psychological well-being and successful ageing. Ageing and Society, 11, 399-415.
- O'Brien S. J. & Vertinsky, P. A. (1991). Unfit survivors: Exercise as a resource for aging women. The Gerontologist, 31(3), 347-351.
- O'Leary, A. (1985). Self-efficacy and health. Behavioral Research and Therapy, 23, 437-451.
- Ostrow, A. C. (1983). Age-role stereotyping: Implications for physical activity participation. Ageing and milieu: Environmental perspectives on growing old. NY: Academic Press.

- Ostrow, A. C., & Dzewaltowski, D. A. (1986). Older adults' perceptions of physical activity participation based on age-role and sex-role appropriateness. Research Quarterly for Exercise and Sport, 52, 216-227.
- Parron, D., Solomon, F., & Rodin, J. (1981). Health, behavior and aging: Summary of a conference. In D. Parron, F. Solomon, & J. Rodin, (Eds.), Health and behavior: A research agenda. (Interim Report No. 5, pp. 1-13) Washington: National Academy.
- Passuth, P. M., & Bengston, V. L. (1988). Sociological theories of aging: Current perspectives and future directions. In J. R. Birren & V. L. Bengston (Eds.), Emergent theories of aging (pp. 333-355). NY: Springer.
- Perry, C., Baranowski, T., Parcel, G. (1990). How individuals environments, and health behavior interact: Social learning theory. In K. Glanz, F. Lewis, & B. Rimer (Eds.). Health behavior and health education: Theory research and practice (pp. 161- 186). San Francisco: Jossey-Bass.
- Piscopo, J., (1985). Fitness and aging. NY: Wiley.
- Portnoy, G., & Angelo, J. H. (1982). Theme from Cheers (Where everybody knows your name). NY: Addax Music.
- Powell, K., Thompson, P., Caspersen, C., & Kendrick, J. (1987). Physical activity and the incidence of coronary heart disease. Annual Review of Public Health, 8, 253-287.
- Prohaska, T. R., Leventhal, E. A, Leventhal, H., & Keller, M. (1985). Health practices and illness cognition in young, middle aged and elderly adults. The Gerontologist, 40(5), 569-578.
- Public Health Service (1990). Healthy people 2000: National health promotion and disease prevention objectives (DHHS Publication No. (PHS) 91-50212). Washington, DC: U.S. Government Printing Office.
- Raetzman, S. O. & Jenson, D. A. (1992). Reforming the health care system: State profiles. Washington, D.C: AARP Public Policy Institute.

- Riley, M. (1981). Paper presented at Conference on Health Behavior and Aging. In Health and behavior: A research agenda, Interim report 5. Institute of Medicine, Division of Mental health and Behavioral Medicine, Washington, DC: National Academy.
- Ross, C. E., Mirowsky, J., & Goldsteen, K. (1991). The impact of the family on health: The decade review. In A. Booth (Ed.), Contemporary families: Looking forward, looking back (pp. 341-355). Minneapolis MN: National Council on Family Relations.
- Rowe, J., & Kahn, R. (1987). Human aging: Usual and successful. Science, 237, 143-149.
- Rosenstock, T., Strecher, V. & Becker, M. (1988). Social learning theory and the health belief model. Health behavior and health education: Theory research and practice (pp. 161-186. San Francisco: Jossey-Bass.
- Sallis, J. F., Pinski, R. B., Grossman, R. M., Patterson, T. L., & Nader, P. R. (1988). The development of self-efficacy scales for health-related diet and exercise behaviors. Health Education Research, 3(3), 283-292.
- Schaefer, C., Coyne, J. C. & Lazarus, R. S. (1981). The health-related functions of social support.
- Sloan, M. R. (1989). Aesthetics and meaningfulness of movement in the older adult. In W. W. Spirduso & H. M. Eckert (Eds.), Physical Activity and Aging: American Academy of Physical Education Paper, No. 22 (pp. 59-61). Champaign, IL: Human Kinetics.
- Spradley, J. P. (1979). The ethnographic interview. NY: Holt, Rinehart & Winston.
- Staff, National Commission on Aging (1991, November). National sporting goods association survey. Perspectives on Aging, pp. 2.
- Strauss, A. (1987). Qualitative analysis for social scientists. NY: Cambridge University.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Taylor, S. J., & Bogdan, R. (1984). Introduction to qualitative research methods: The search for meaning (2nd ed.). NY: John Wiley & Sons.

Taylor, C. B., Bandura, A., Ewart, C. K., Miller, N.H., & DeBusk, R. F. (1985). Exercise testing to enhance wife's confidence in their husband's cardiac capability soon after clinically uncomplicated acute myocardial infarction. American Journal of Cardiology, 55, 635-638.

Taylor, C., Sallis, J., & Needle, R. (1985). The relation of physical activity and exercise to mental health. Public Health Reports, 100, 195-202.

Thoits, P. A., (1986). Social support as coping assistance. Journal of Consulting and Clinical Psychology, 54, 416-423.

Wallston, B., Alagna, S., DeVellis, B. & DeVellis, R. (1983). Social support and physical health. Health Psychology, 2(4), 367-391.

Williams, R. (1992, May). Duke University Medical Center. Duke study finds friends, money affect mortality. Perspectives, 12(3), pp. 29-30.

Wilson, H. S. (1989). Research in nursing (2nd ed.). Redwood City, CA: Addison-Wesley.

WordPerfect Software (1989). WordPerfect Version 5.1. Orem, UT: WordPerfect Corporation.

APPENDIX A

Institutional Review Board Exemption

APPENDIX B

Generative Questions for Interviews

Generative Questions for Interviews

The content of these generative questions will be theoretical sampling. The interview questions that follow are related to the research questions which appear in bold at the head of the appropriate topic grouping.

What are the meanings and motivations attributed by older adult mall walkers for their participation in the mall walking community?

1. Describe for me the main reason you decided to start mall walking.
2. What about this made you decide to start?
3. What else can you think of that prompted you to begin when you did?

What are the motivations and meanings that older adult mall walkers relate for their adoption of, and continued participation in, mall walking?

1. Tell me some of the reasons you think cause you to continue to mall walk.
2. Describe your typical morning at the mall.
3. In what ways do you think mall walking helps you?
4. Tell me some of the ways you find mall walking make you feel.
5. How do you feel mall walking affects your body? Your heart rate? How do you feel about that? Does that concern you?

6. Are you ever feeling stressed? If so, how do you manage to mall walk even if you are stressed or have lots of family obligations?
7. What can you imagine that would make you stop mall walking?

How do older adult mall walkers describe physiological, situational and environmental factors that influence their participation in mall walking?

1. Do you always walk at the mall?
2. Why? Why not?
3. (if not) Where and when else do you walk?
4. Could you describe any problems you have had mall walking? (i.e. getting here, problems with walking).
5. How do you cope with these problems?
6. Do you think any of these problems are related to your age?

How do older adult mall walkers indicate they feel family and friends motivate their mall walking activities? What meanings do family and friends have for older adult mall walkers in the context of this physical activity?

1. Who else in your family mall walks? Do they offer to mall walk with you? When?
2. Who do you walk with? How long have you been mall walking with this person(s)?
3. How does having company when you mall walk make you feel?
4. In what ways would you say family and friends encourage you to mall walk?
5. What do you usually do when you finish mall walking? Do you enjoy doing this with certain special people?
6. Can you tell me about other things do you do with these people? Describe these things for me.
7. How do you feel about mall walking alone?
8. How do you think it would affect your mall walking if you had to walk alone?
9. Overall, how do you feel your family and friends affect your mall walking?
10. Tell me about the most interesting thing that has happened to you while you've been mall walking?

How do older adult mall walkers situate the experience of mall walking within the broader context of their personal lives?

1. Tell me in what ways you think mall walking has affected you.
2. If you could reach lots of older people what would you advise those who are thinking about mall walking?
3. What else can you share with me that is interesting or important to you about mall walking?
4. What other questions can you think of that you might ask if you were talking to people about mall walking?

Additional Questions

1. What question(s) haven't I asked you that you'd like me to ask?
2. Is there any thing else you want to add?
3. Have you any advice that you would like to share?

APPENDIX C

Questionnaire for Warm Health Focus Group

QUESTIONNAIRE

DEMOGRAPHICS

Before we get started with our discussion we need to ask a few basic questions about you, and what you think about walking for exercise.

1. What is your age? _____ years.
2. Are you _____ male, _____ female.
3. Are you currently
 1. married
 2. widowed
 3. divorced
 4. separated
 5. never married
4. At this time do you consider yourself
 1. completely retired
 2. partially retired
 3. not retired
 4. have never been employed outside the home
5. About how much do you weigh without shoes?
_____ lbs.
6. About how tall are you without shoes?
_____ feet, _____ inches
7. How many years of schooling do you have?
_____ years

HEALTH STATUS

1. Do you currently have any chronic illnesses?
 0. no (if no, skip next question)
 1. yes
2. Please list all illnesses or chronic conditions you currently have.

3. Is there any health problem that keeps you from participating in a program of walking for exercise?
 0. no
 1. yes
4. Compared to other people your age and sex, would you say your health is:
 1. excellent
 2. very good
 3. good
 4. fair
 5. poor
5. Compared with (1) one year ago, how would you say your health is now? Is it:
 1. better
 2. worse
 3. about the same

6. How often do you have the energy to do the things you need to do?
1. hardly ever
 2. some of the time
 3. most of the time
 4. all of the time
7. During the last twelve (12) months how many times did you visit a doctor? _____ times

WALKING ACTIVITIES

1. How many times in the last (2) two weeks did you walk for exercise?
0. none
 1. less than once
 2. one to three times
 3. four or more times
2. About how many minutes did you walk each time?
_____ minutes
3. Was this the usual amount of walking that you do in two weeks?
1. yes
 2. no
 3. If no, how much do you usually exercise per week
_____ number of times, _____ number of minutes

4. Would you describe your rate of walking as
 1. strolling
 2. slightly brisk
 3. brisk
 4. very brisk
5. How long have you been walking for exercise?
_____ months, _____ years
6. Do you participate in the exercise program here at Warm
Hearth?
 0. no
 1. yes
7. If yes, do you participate
 0. on an irregular basis
 1. once a week
 2. twice a week

BELIEFS ABOUT HEALTH AND WALKING FOR EXERCISE

1. How many days a week do you think a person should walk
to realize any physical and/or mental benefits?
 0. don't know
 1. less than three days
 2. three or four days
 3. five or more days

2. For how many minutes do you think a person should walk to strengthen the heart and lungs?
 0. don't know
 1. less than fifteen minutes
 2. fifteen to twenty-five minutes
 3. more than twenty-five minutes
3. Do you feel you walk: much more than, somewhat more than, the same as, somewhat less than, or much less than other persons your own age and sex?
 1. much more than
 2. somewhat more than
 3. about the same as
 4. somewhat less than
 5. much less than
4. How many of your friends walk regularly (at least twice a week)?
 0. none/almost none
 1. some
 2. about half
 3. most of them
 4. all/most all
5. Does anyone in your family encourage you to walk?
 0. no
 1. yes
 2. If yes, who in particular encourages you?

(specify) _____

6. Do you walk with anyone in your family?
 0. no
 1. yes
 2. If yes, with whom do you walk? _____
7. Do any of your friends encourage you to walk?
 0. no
 1. yes
8. Do you walk with your friends?
 0. no
 1. yes
9. Did your doctor encourage you to walk?
 0. no
 1. yes
10. Has anyone encouraged you not to walk?
 0. no
 1. yes (specify) _____

HEALTH LOCUS OF CONTROL: SELF EFFICACY

1. Overall, how do you feel you are doing in taking care of your health? Would you say
 1. excellent
 2. very good
 3. good
 4. fair
 5. poor

2. How confident are you in your ability to set aside time to walk even when family and social demands are great?
 1. I am sure I cannot set aside time
 2. I probably cannot set aside time
 3. I can set aside time
 4. I probably can set aside time
 5. I am sure I can set aside time

3. Do you feel confident in your ability to set aside time to walk even if you are feeling sad or under stress?
 1. I am sure I cannot set aside time
 2. I probably cannot set aside time
 3. I can set aside time
 4. I probably can set aside time
 5. I am sure I can set aside time

4. To what extent do you agree or disagree with the following statements?

Circle 1 if you DISAGREE STRONGLY

Circle 2 if you DISAGREE SOMEWHAT

Circle 3 if you NEITHER AGREE NOR DISAGREE

Circle 4 if you AGREE SOMEWHAT

Circle 5 if you AGREE STRONGLY

DISAGREE

AGREE

STRONGLY

STRONGLY

5. There is not much a person
can do to avoid poor health

1 2 3 4 5

6. Exercise is important
to being healthy

1 2 3 4 5

7. I am directly responsible
for my health

1 2 3 4 5

8. If the waking club was
not here I would walk
anyway

1 2 3 4 5

9. No matter what, I set
aside time for walking

1 2 3 4 5

DISAGREE
STRONGLY

AGREE
STRONGLY

10. I often read articles or
buy literature specifically
in order to learn more about
ways to protect my health
or stay healthy

1 2 3 4 5

11. Exercise is important to
improving poor health ...

1 2 3 4 5

FOCUS GROUP DISCUSSION

DETERMINANTS OR TRIGGERS TO EXERCISE

1. Can you tell me the (1) one particular event or situation that was the major factor in your decision to participate in walking for exercise?

(if no response prompt: for example did your doctor advise you, did a friend invite you?)

1A. When did this event occur?

1B. How soon after this did you begin walking?

1C. After this event, on a scale of (1) one to (10) ten in intensity, how strong was your feeling that you needed to walk?

(circle number)

NOT

VERY

STRONG

STRONG

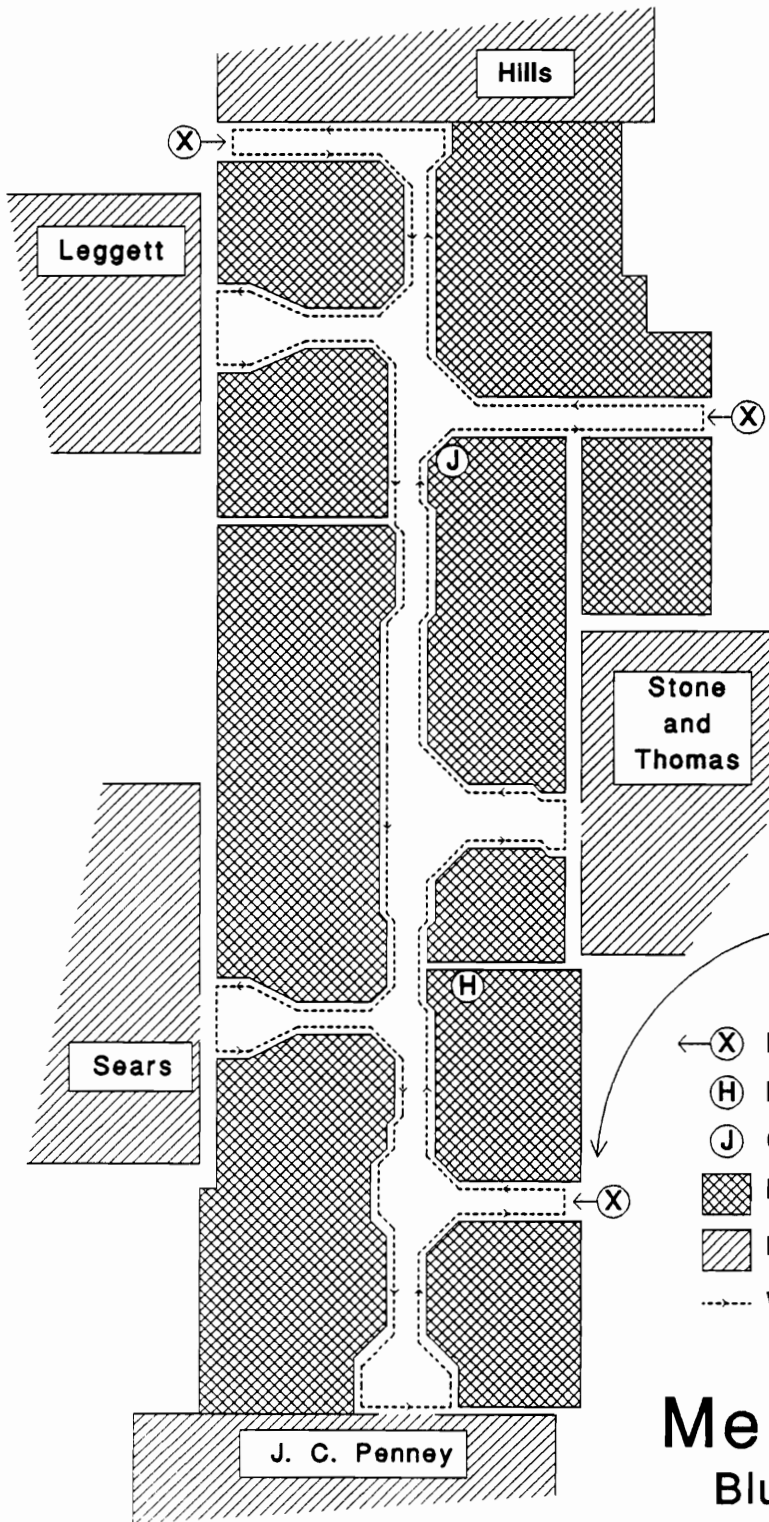
1 2 3 4 5 6 7 8 9 10

2. Had you ever considered, or even thought about, walking before this event, but didn't?

a. if not, why not?

APPENDIX D

Diagram of Mall with Walking Path



DATA

Walking lap
3615 feet
0.86 miles

four lap walk
14,460 feet
2.74 miles

First entrance
opened in AM
for mallwalkers

- ← (X) Mall Entrance / Exit
- (H) Hardee's restaurant
- (J) Orange Julius snackbar
- (Cross-hatched box) Retail stores
- (Diagonal lines box) Department stores
- (Dashed line) Walking path

Mercer Mall
Bluefield, WV

APPENDIX E

Participant Consent Form

Participant Consent Form

This is an invitation for you to participate in a study of people who mall walk. I am a graduate student at Virginia Polytechnic Institute and State University (VPI). The purpose of the study is to develop a better understanding of why older adults use mall walking for exercise.

If you are willing to share your thoughts and experiences regarding mall walking, I am requesting an individual conversation with you. Our interviews will be audiotaped and transcribed by a typist so that I may examine them in detail. Only first names will be used in these transcriptions.

Your name will not be included in any book, article or lecture based on interview material. You will not be quoted by name.

I hope and expect that you will find participating in a research study an enjoyable experience. However, if at any time you feel uncomfortable and want to change your mind about continuing an interview you should feel free to pause, postpone, or even end the interview.

My name, address and phone number is listed on the attached sheet which you should keep just in case you need to get in touch with me. Information on my faculty advisor is also listed for your convenience. Please feel free to contact either of us if you have any questions about the study.

Thank you for your willingness to participate in this study.

Your signature

Researcher's signature

Date

STUDY ON MALL WALKING

IF THERE ARE ANY QUESTIONS YOU WOULD LIKE TO ASK ABOUT
THIS STUDY PLEASE CALL:

Shirley Travis, Ph. D.
317 Wallace Hall
Virginia Polytechnic Institute & State University
Blacksburg, VA 24061
(703) 231-7657

or

Harriet H. Duncan, MSN, RN
430 Dickason Hall
Bluefield State College
Bluefield, West Virginia 24701
(304) 327-4217

APPENDIX F

General Information Form

GENERAL INFORMATION FORM

NAME _____ DATE _____

GENDER _____

BIRTHDATE _____ ETHNICITY _____

NUMBER OF TIMES A WEEK YOU MALL WALK? _____

HOW LONG DO YOU USUALLY WALK EACH TIME? _____

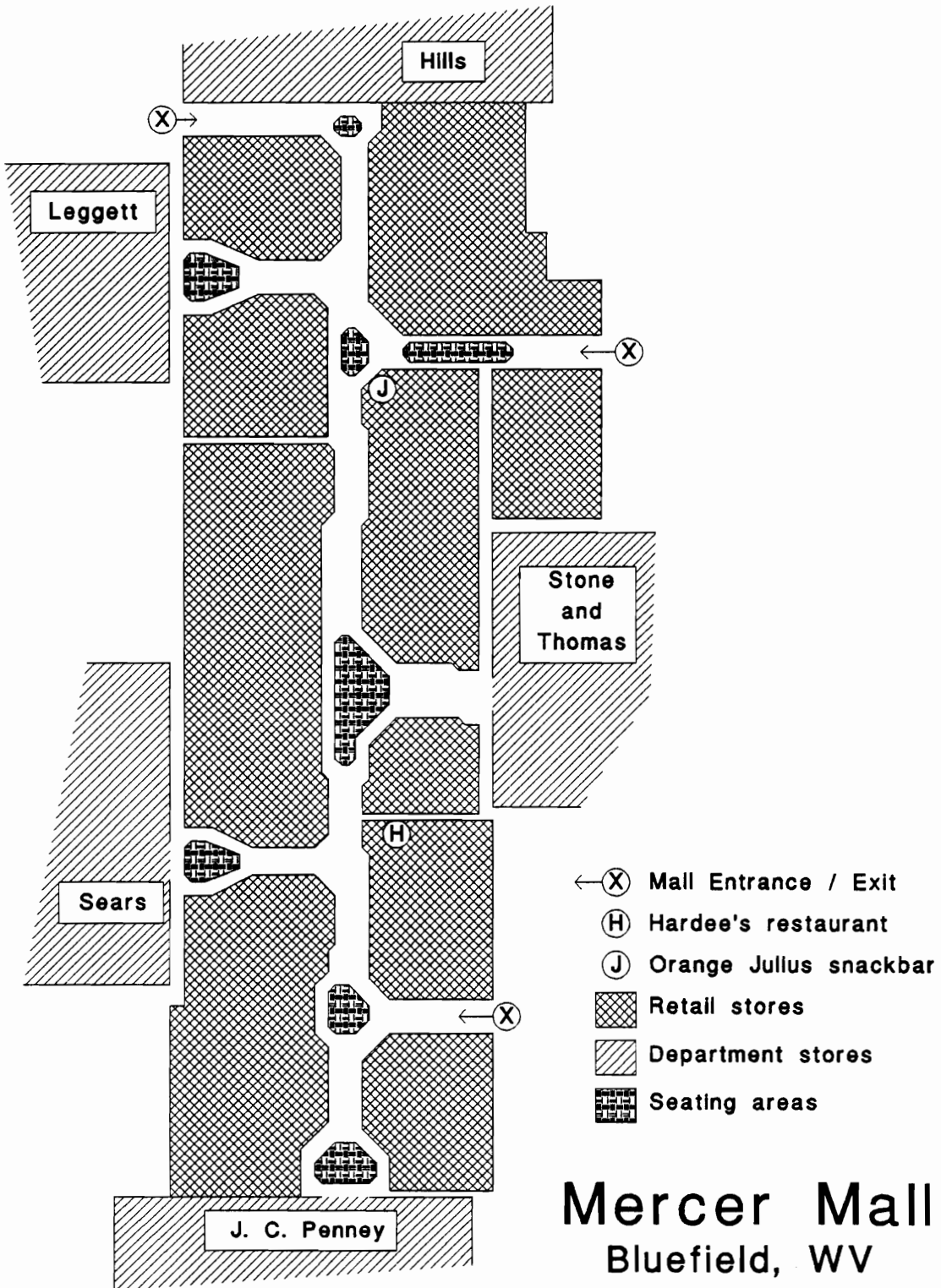
WHEN DID YOU START MALL WALKING? _____

COMPARED WITH OTHER PERSONS YOUR AGE, HOW WOULD YOU
DESCRIBE YOUR CURRENT HEALTH? (CHECK ONE)

EXCELLENT _____ GOOD _____ FAIR _____ POOR _____

APPENDIX G

Floor Plan of Mall With Seating Areas

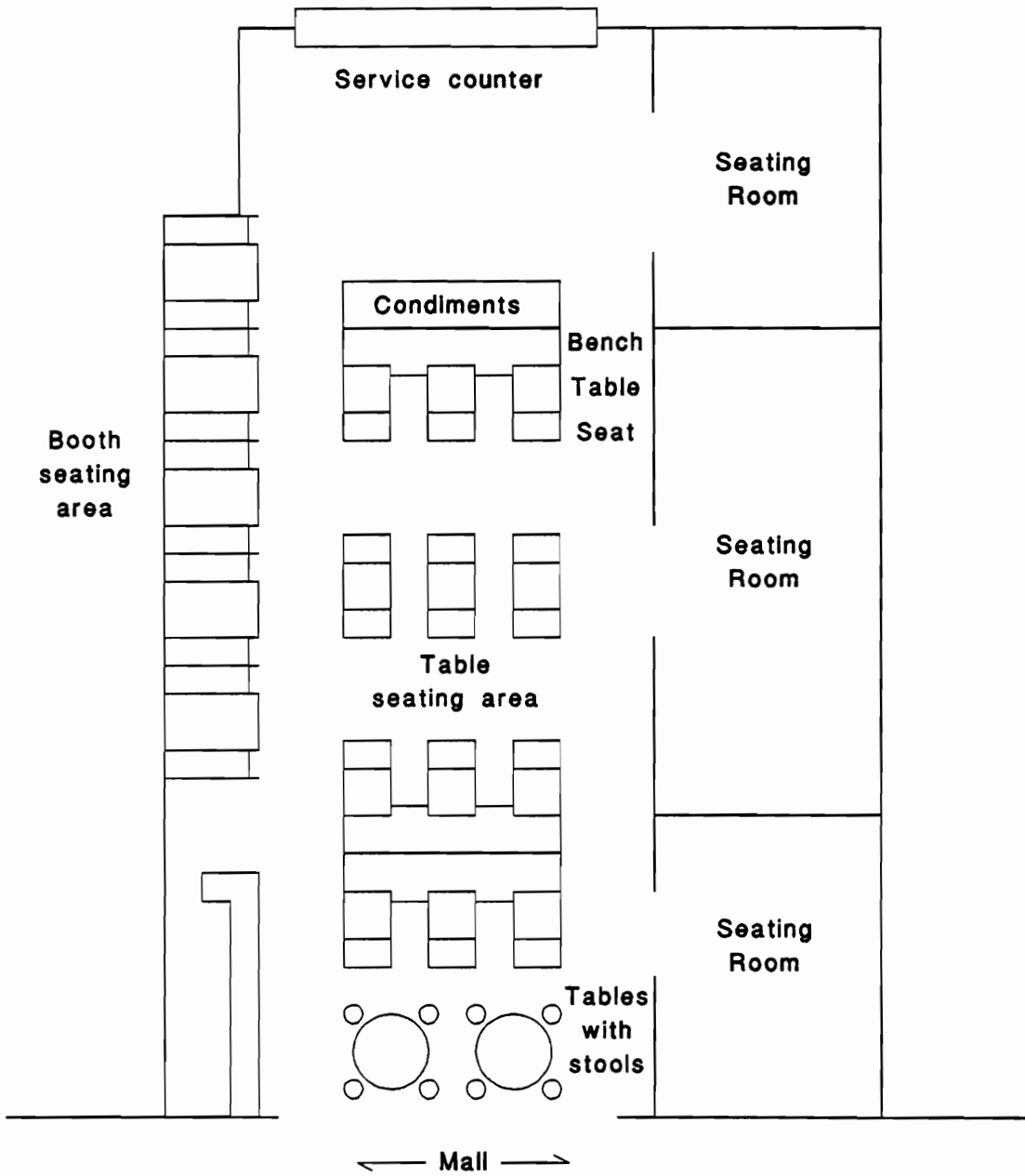


Mercer Mall

Bluefield, WV

APPENDIX H

Floor Plan of Hardee's

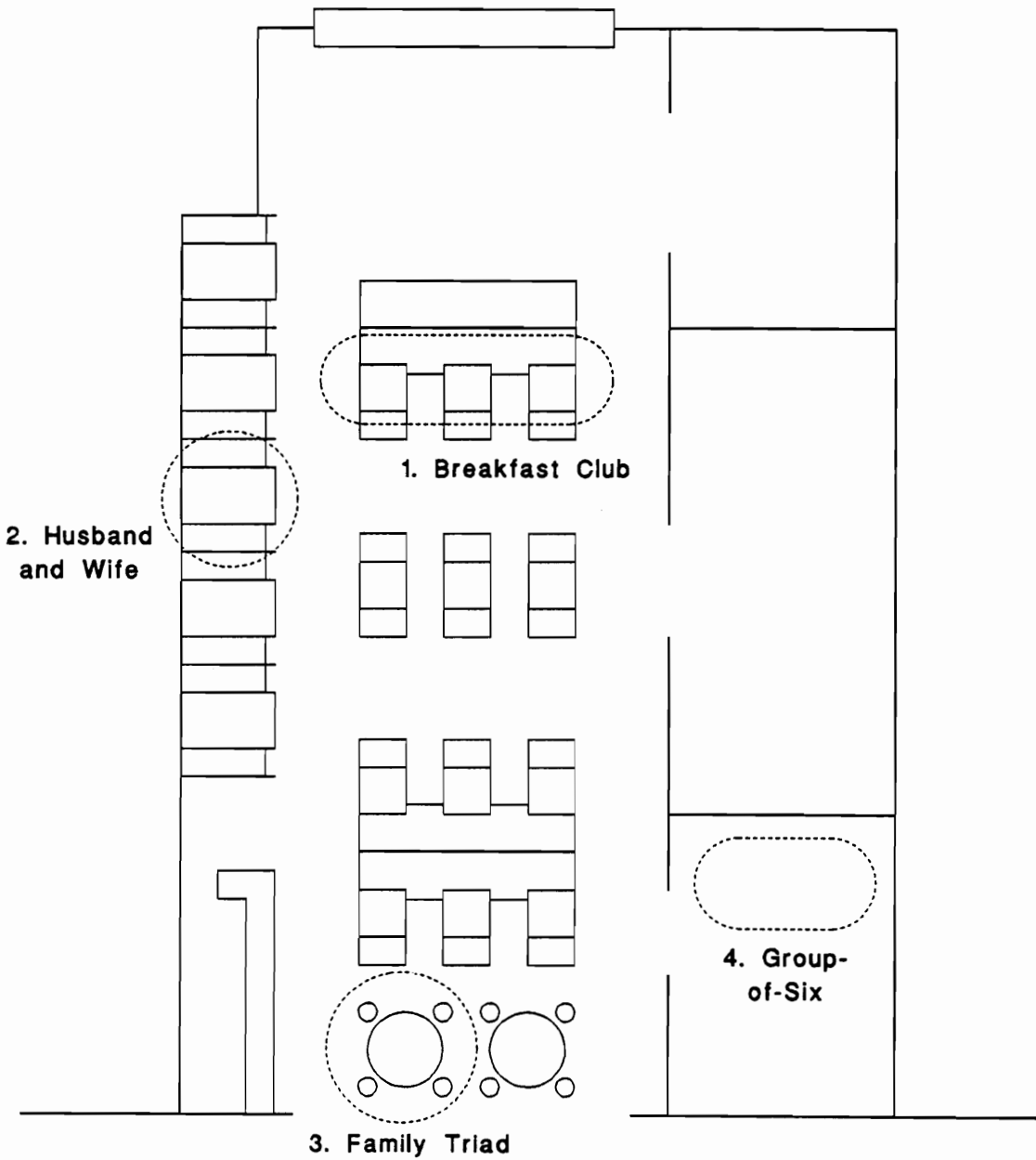


Hardee's Restaurant

Mercer Mall
Bluefield, WV

APPENDIX I

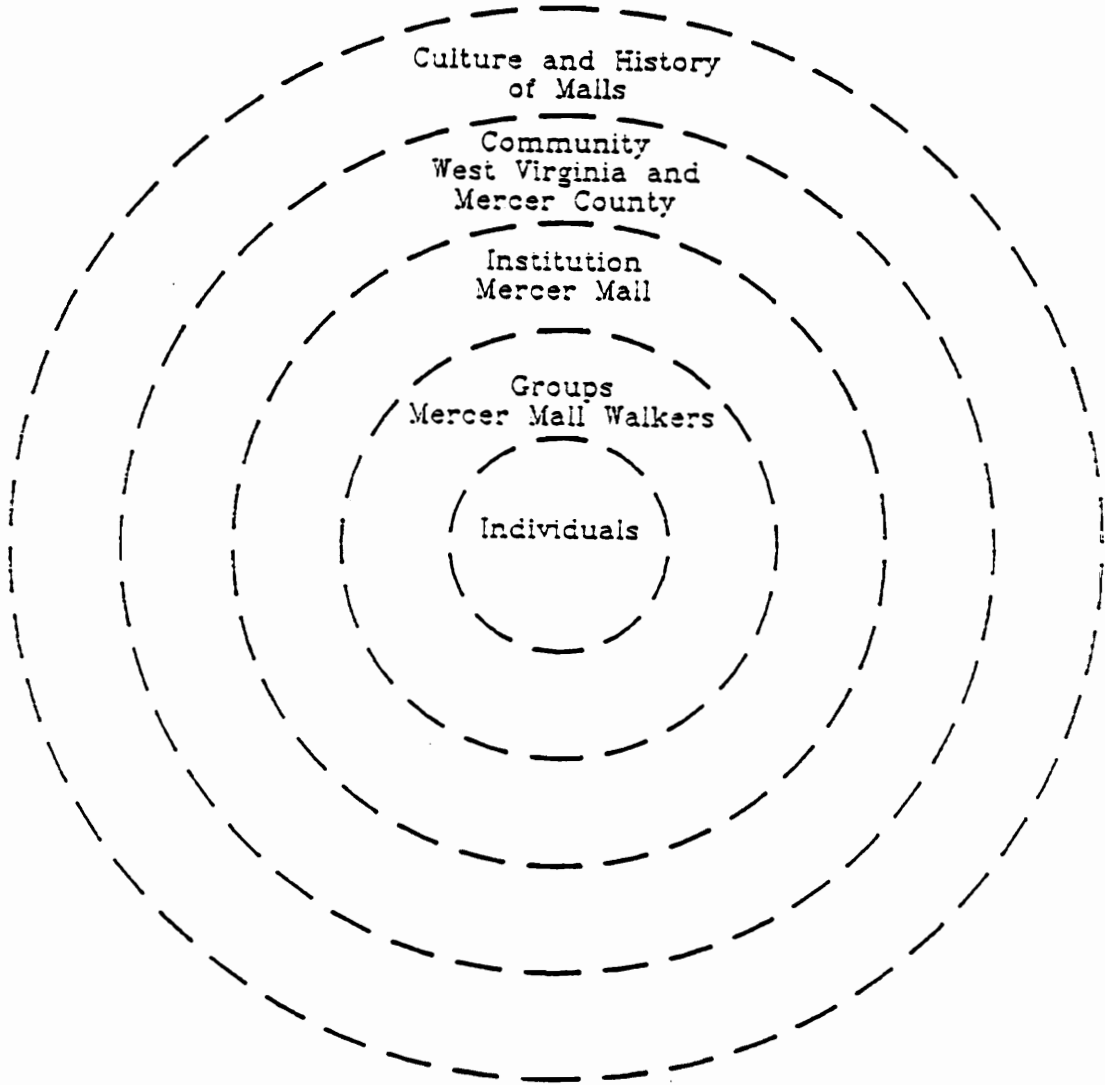
Seating Areas of Groups at Hardee's



Group seating areas
 Hardee's Restaurant
 Mercer Mall
 Bluefield, WV

APPENDIX J
Conditional Matrix

Global Environment



Conditional Matrix

APPENDIX K

Vita

VITA

Name: Harriet Hindinger Duncan

Place of Birth: New Haven, Connecticut

Education:

Doctoral Candidate, Virginia Polytechnic Institute and State University, College of Human Resources, Department of Family and Child Development. Area of Concentration: Adult Development and Aging.

Master of Science in Nursing, College of Nursing, West Virginia University, Morgantown, WV. Area of Concentration: Adult Health, 1985.

Bachelor of Science in Nursing, University of Connecticut, College of Nursing, Storrs, CT.

Professional Experience:

1990 to present: Associate Professor of Nursing, Baccalaureate level, Bluefield State College, Bluefield, West Virginia.

President, Bluefield State College Faculty Senate, 1989-1990.

Service:

West Virginia Health Care Commission Special Task Force, 1992-1993.

Founding Board Member, Hospice Care of Mercer County, 1987.

Harriet H. Duncan