Journal of Transcultural Nursing

http://tcn.sagepub.com/

Spirituality and Its Relationships With the Health and Illness of Appalachian People

Gina Diddle and Sharon A. Denham

J Transcult Nurs 2010 21: 175

DOI: 10.1177/1043659609357640

The online version of this article can be found at:

http://tcn.sagepub.com/content/21/2/175

Published by:

SAGE

http://www.sagepublications.com

On behalf of:

Transcultural Nursing Society

Additional services and information for *Journal of Transcultural Nursing* can be found at:

Email Alerts: http://tcn.sagepub.com/cgi/alerts

Subscriptions: http://tcn.sagepub.com/subscriptions

Reprints: http://www.sagepub.com/journalsReprints.nav

Permissions: http://www.sagepub.com/journalsPermissions.nav

Citations: http://tcn.sagepub.com/content/21/2/175.refs.html

>> Version of Record - Mar 10, 2010

What is This?

Downloaded from tcn.sagepub.com at UNIV N CAROLINA GREENSBORO on October 16, 2012

Spirituality and Its Relationships With the Health and Illness of Appalachian People

Journal of Transcultural Nursing
21(2) 175–182
© The Author(s) 2010
Reprints and permission: http://www.sagepub.com/journalsPermissions.nav
DOI: 10.1177/1043659609357640
http://tcn.sagepub.com
SAGE

Gina Diddle, MSN, RN, PNP-BC,[1] and Sharon A. Denham, DSN, RN[2]

Abstract

This article explores the ways spirituality intertwines with the health and culture of those living in the Appalachian region. Nursing has long considered the value of spirituality and faith, noting its complex connections with health and illness. Literature pertaining to spirituality, health, and the culture of those residing in the Appalachian region was reviewed. Although the review suggests that connections between spirituality and health exist, empirical evidence is limited, somewhat dated, and lacks viable conclusions relative to the diverse needs of the Appalachian population. Focused research that addresses strongly linked operationally defined variables is needed to strengthen the evidence for clarity about distinct applications to practice.

Keywords

Appalachia, spiritual, health, religion, illness

> Appalachia is a place, a people, an idea, a culture, and it exists as much in the mind and imagination as on the map.
>
> —Richard Straw (2006)

Spirituality

Health care has long been considered to have spiritual roots, and in recent years much research linking faith, spirituality, and religion with health and illness have occurred (Arcury, Quandt, McDonald, & Bell, 2000; Gesler, Arcury, & Koenig, 2000; Jesse & Reed, 2004; Koenig, 2001). Spirituality is highly individualized and multidimensional; it is likely to have important personal interpretations and meanings (Rodgers, 1989). Spirituality shares some commonalities with religion, but it can be ambiguous and may be difficult for some to describe without using religious terminology (Mills, 2002; Thoresen, 1999). Differences between spirituality and religion are not always clearly delineated, and well-controlled research about spirituality seems to be lacking (Thoresen & Harris, 2002). However, spirituality may surpass cultural and religious boundaries (Delgado, 2005) and have special relevance when health or illness is considered. Use of the *Family Health Model* (Denham, 2003) is a means to view spirituality as a contextual factor that saturates all aspects of an ecologically lived experience and suggests numerous attributes that influence individual and family health behaviors. This model can help us understand that spirituality, faith, and religion are not merely isolated personal traits but that their influence springs from the larger societal exchanges across multiple systems over time.

Spirituality, Nursing, and Health

Dating back to Florence Nightingale, spirituality has held great value in nursing, for clients and practitioners (Delgado, 2005; Lowry & Conco, 2002). Definitions for spirituality have been widely discussed by numerous nursing scholars (Burkhardt, 1989; Delgado, 2005), and many nurse theorists (e.g., Watson, Parse, Newman, Neuman, Patterson, and Zderad) have presented spirituality as a central concept in their theoretical frameworks (Martsolf & Mickley, 1998). Spirituality has been defined as "the unifying force that shapes and gives meaning to the pattern of one's self-becoming," a force expressed in one's being, knowing, and doing and linked with Self, Others, Nature, God, or a Higher Power (Burkhardt, 1994, p. 19). Spirituality has been described as "honoring a sense of presence that is higher or greater than the individual human being" (Jesse & Reed, 2004, p. 740). Another definition of spirituality is

> an innate trait of all persons that concerns connectedness to self, others, and a higher power; transcendence to places and energies beyond one's own being; and an essence of meaningfulness. It often includes religion, faith systems, sacred principles, worship, symbolic meanings, and ritual practices. (Denham, 2003, p. 280)

[1]Charleston Area Medical Center, Charleston, WV, USA
[2]Ohio University, Athens, OH, USA

Corresponding Author:
Sharon A. Denham, School of Nursing, Ohio University, Athens, OH 45701, USA
Email: denham@ohio.edu

Downloaded from tcn.sagepub.com at UNIV N CAROLINA GREENSBORO on October 16, 2012

Some would contend the tenuous qualities of spirituality are difficult to fully comprehend and challenging to measure. Thus, one must determine the reliability and validity of standardized spirituality measurement for evaluation Appalachian populations within the geographic region of interest.

Definitions of spirituality tend to rely on personal assumptions as it is difficult to construct a definition that puts aside personal beliefs and values. Other commonly included ideas are the coexistence of a Supreme Being and spirituality as an inherent human quality (Delgado, 2005; Friedemann, 1995). Others suggest that one may enjoy vibrant spirituality without the confines of religion or religious practices (Kendrick & Robinson, 2000; Mueller, Plevak, & Rummans, 2001). Although spirituality might be studied scientifically, these scientific definitions of spirituality may not coincide with a believer's perceptions (Miller & Thoresen, 2003). *Faith* is another term often used interchangeably with religion and spirituality. A Biblical definition of faith is "being sure of what we hope for and certain of what we do not see" (New International Version, Hebrews 11:1). For believers, the Bible provides scriptures full of hope and comfort (Diggins, 2007). In Appalachia, this has been an enduring resource during times of trouble and hardship.

Many believe that acknowledging and encouraging client's spirituality has potential to enhance nursing care (Jesse, Schoneboom, & Blanchard, 2007). Nurses with any set of religious beliefs can provide spiritual care as it transcends religious ritual and can be tailored to clients' needs (Ford, 2007). Those with understandings about spirituality may even provide care recognized as superior (Delgado, 2005). Nurses that recognize spiritual distress can provide holistic care and assist clients to cope with, understand, and shape life meanings (Burkhardt & Nagai-Jacobson, 1985). Nurses who offer clients spiritual care may find mutually supportive and enriched dynamic client relationships (Kendrick & Robinson, 2000). It is possible that nurses can use spirituality to bridge gaps that might exist with usual nursing care and reduce clients' stress, enhance their emotional strength, and help them cope with suffering or illness (Narayanasamy & Owens, 2001).

Health care has historically failed to provide integrated holistic care for mind, body, and spirit (Treloar, 2000). On the other hand, spirituality has long been viewed as critical to a truly holistic integration of an individual's spirit, mind, environment, and body (Ruffing-Rahal, 1984) and has been shown to positively affect attitudes of those with declining health (Lowry & Conco, 2002). Some believe that spiritual needs may increase or become more important in the elderly, chronically ill, or those approaching death (Delgado, 2007; Denham, 1999b; Lowry & Conco, 2002; Mueller et al., 2001). Patients have long identified the importance of spiritual care. For example, 94% of hospital inpatients in one study reported that physical and spiritual health was equally important (King & Bushwick, 1994). Also, spirituality is viewed as an important aspect with critical impact for many on overall family health (Tanyi, 2006).

Appalachia

In the vast territory along the Eastern United States, bordering the northern, central, and southern Appalachian Mountain chain, is a 200,000 square-mile area recognized as Appalachia. The region includes 410 counties, located in portions of 12 states and the entire state of West Virginia. In the mid-1960s, the Appalachian region was identified by the Appalachian Regional Commission (ARC) as a geographic area that lagged behind the rest of the nation (ARC, n.d.-a, n.d.-b, n.d.-c). However, the region has not benefited equally from ARC funding and wide disparities still exist across some regional areas (Simpson & King, 1999).

Although major portions of the Appalachian region are rural (Behringer & Friedell, 2006), 60% of the 23 million residents live in metropolitan counties, 25% live in counties bordering metropolitan counties, and the remainder inhabit rural areas (Halverson, Ma, & Harner, 2004). However, a disproportionate population of disabled, retired, poor, unemployed, and underinsured or uninsured resides in Appalachia (Denham & Rathbun, 2005). Although many improvements have occurred, poverty continues to be a huge problem in Appalachia, and many health disparities exist for its underprivileged population (Behringer & Friedell, 2006). This geographic setting provides a place for understanding the ecological factors that affect the spirituality of its residents (Denham, 2003).

The People of Appalachia

Despite common stereotypical characteristics assigned to Appalachia, many agree that the region is a virtual melting pot of cultural heterogeneity (Brown & May, 2005; Jackson, 2006; Keefe, 2005; Straw, 2006). According to the last U.S. Census report, the population is primarily composed of non-Hispanic Whites, with African Americans constituting the largest minority group; however, a significant increase in the number of Hispanics is being seen in rural and urban areas (Jackson, 2006; Pollard, 2004). As early as the mid-1600s, early immigration of Presbyterian Scotch-Irish into the region now recognized as Appalachia began, they were largely drawn here because they were could purchase and own their land (Raine, 1924). Although differences in ideas about origin of original inhabitants vary, most describe the region by referring to the 18th-century Scots-Irish, Welsh, German, and English settlers (Keefe, 2005). However, Keefe notes that the mining of coal brought new waves of immigrants to this nation from Ireland, Eastern Europe, and Italy. The region was widely settled by European immigrants who came to work in coal mines, railroads, and other industries, but they joined groups

Downloaded from tcn.sagepub.com at UNIV N CAROLINA GREENSBORO on October 16, 2012

already there (i.e., Native Americans, African American slaves) who long predated their arrival (Jackson, 2006; Straw, 2006). African Americans have a rich history in Appalachia as slaves or freemen accompanying early French and Spanish explorers, slaves in the southern mountains, racial violence following the emancipation, and workers in industrial expansions that especially welcomed black coal miners (Wagner & Obermiller, 2004).

Also residing in the Appalachian region are the Melungeons, a racially mixed group with several theories about their mixed-race ancestry origins (Jackson, 2006), but many agree their descendents were likely from Spain, Portugal, and Middle Eastern origins and predate the European immigrants (Winkler, 2007). Tri-racial groups or WIN (White, Indian, Negro) continue to have links back to early Appalachian settlement. Amish and Mennonite communities are located primarily in northern Appalachia, with large populations in rural Ohio and Pennsylvania (Jackson, 2006; Meyers, 1990); however, migration into rural southeast Ohio has been continuous over several decades. Many of these early immigrants originated from Switzerland in the 17th century. The region is home to a rich blend of other immigrant populations, including a recent influx of thousands of immigrant workers from Mexico and many of Asian origin (Barcus, 2007; Jackson, 2006; Straw, 2006). Thus, stereotypical views of a monolithic ancestry continue to be clarified as less ambiguous understandings of the land and its people are uncovered (Billings, Norman, & Ledford, 2001). Whenever scholars refer to Appalachian cultural aspects, both positive and negative associations surface (O'Brien, 2001). As diverse settlers in the region became more integrated over time, cultures blended and new practices and belief systems were forged, adding regional or geographical uniqueness that must be considered with any cultural assessment (Jackson, 2006; Keefe, 2005).

A distinctive pride exists with regard to cultural heritage and homeplace; however, many negative stereotypes also riddle perceptions of residents (Keefe, 2005). Geographical isolation has been a factor in the ways Appalachian people have assimilated and acculturated common beliefs and values (Denham & Rathbun, 2005; Williams, 2002). However, even in the past, it is likely a mistake to consider Appalachian people as totally isolated, as they have always been connected to the outside world through industry, trains, newspapers, and workers that traversed the region (Billings et al., 2001). Many say that Appalachians share a common distrust of outsiders (Brown & May, 2005; Lohri-Posey, 2006; Owens, Richerson, Murphy, Jageleweski, & Rossi, 2007), but once trust is established Appalachian people tend to be viewed as friendly, polite, and welcoming. The family is a key element of Appalachian rural society, and a high priority continues to be placed on family-centered activities (Gross, 2005). Things such as distinctive dialects, kinship, community ties, and the importance of place are other underlying factors for cultural behaviors (Keefe, 2005). This fits with the *Family Health Model* ideas about suggested relationships between individuals' intrinsic valuing of spirituality, their identity, behaviors, and health (Denham, 2003).

Appalachians, Religion, and Faith

Appalachians tend to place great value in faith, God, family, community, honesty, independence and self-reliance, and traditions (Coyne, Demian-Popescu, & Friend, 2006; Hayes, 2006), and although other religions abound, many are still linked with their Protestant heritage (Keefe, 2005). Religious roots of early settlers in the region are also linked with those with Calvinistic views, some Quakers, Mennonites, and Moravian Brethren, many of whom experienced persecution prior to relocating to America (Raine, 1924). Many early settlers wound up in areas where no pastor existed and often organized themselves into local congregations where one of them assumed responsibility for leading lessons and scripture discussions (Campbell, 1921). The lack of availability for a classical education and beliefs that a ministerial vocation should be taken seriously limited the numbers of Presbyterian ministers for the region (Raine, 1924). Thus, the way was paved for welcoming uneducated ministers that claimed a calling or anointment from God that empowered them to guide others in spiritual beliefs.

Over time and for many reasons, earlier settlers pulled away from organized religious ideas belonging to denominational organizational structures. Instead, independent and Separatist Mountain churches were established where largely unguided religious freedom presided. Raine (1924) suggested that "Mountain People" were interested in the mysterious or magnificent, which lead to much attention to death, judgment, and the promises of heaven. Raine described early religion in terms of a unique religious pageantry that allowed for infrequent meetings, long-winded preachers, a homey or unplanned atmosphere, and a religion more personal than public. Campbell (1921) saw the Mountain church as an agency to promote spiritual growth among the people of rural places.

The rural heritage aligned with the Mountain church and its ways give roots to the faith of many that currently reside in Appalachia. Along with these rural places of worship are well-established denominational churches that adhere to beliefs and practices similar to much of mainstream America. Regardless of church attendance, religion and faith still permeate the lives of many Appalachian people (McCauley, 1995) in the form of conservative moral codes derived from Biblical interpretations (Keefe & Greene, 2005). Additional values linked with regional residents that are likely associated with religious or faith are things such as egalitarianism, independence, individualism, personalism, familism, religious world view, neighborliness, love of the land, and conflict avoidance (Caldwell, 2007; Jackson, 2006; Keefe, 2005). *Fatalism* is a term often used to describe beliefs that what happens is largely outside their purview and may be the hand of God

Downloaded from tcn.sagepub.com at UNIV N CAROLINA GREENSBORO on October 16, 2012

(Huttlinger & Purnell, 2008). In fact, it is not uncommon to hear an expression such as, "Hit must be God's will, I reckon." Although there seems to be an underlying willingness to accept whatever comes without resistance, the term is often mistakenly used to describe Appalachians' dislikes of change and misunderstanding common beliefs that hasty decisions can carry negative consequences (Denham, 1996; Gross, 2005). Nevertheless, for many in the Appalachian region, faith transcends religious ideas, permeates many of their daily actions, and serves as a foundation for many of their societal values and perspectives.

Health and Illness in Appalachia

Appalachia has more than its share of illness and disease with differences in the incidence, prevalence, mortality, and types prevailing across population groups to be known as place-based disparities (Behringer & Friedell, 2006). An aging population, risky health behaviors, and poor health practices result in increased numbers of chronic health problems and numerous health disparities (Lengerich et al., 2006; Wewers, Katz, Fickle, & Paskett, 2006). Health disparities are substantiated by high mortality rates and hospitalizations that exist throughout Appalachia for heart disease, certain types of cancer, stroke, chronic obstructive pulmonary disease, accidents, diabetes, suicide, and infant death (Halverson, Ma, & Harner, 2004). Diets high in fat content, cigarette smoking, poor genetics, low socioeconomic status, and drug and alcohol addiction have increased some risks for those living in the region (Caldwell, 2007).

Rural Appalachian populations tend to have higher poverty incidence, health disparities, less education and literacy, less nutritional diets, and riskier health behaviors than their urban counterparts (Brown & May, 2005; Hartley, 2002; Wewers et al., 2006). Strong correlations between low health literacy and poor health have also been found (Denham & Rathbun, 2010; Foulk, Carroll, & Wood, 2001). Evidence suggests that higher disease and mortality rates are because of social, cultural, and economic influences (Coyne, Demian-Popescu, & Friend, 2006). In addition to common concerns faced by the majority of Americans regarding health care, such as rising health care costs, Appalachians share additional concerns. Issues include accessibility to services, education of health care workers, and culturally sensitive health care services (Blakeney, 2005, 2006). Blakeney suggests that these problems stem from chronic poverty, lack of insurance, lack of health care providers, and culturally incompetent health care professionals in the region.

The majority of Appalachia is located in an area known as the *Bible Belt*, and Appalachians are largely of Christian ideology with melded ideas about spirituality and religion (Coyne et al., 2006; Jesse & Reed, 2004). Although diverse, the largest religious groups in Appalachia, in order, are Baptist, Catholic, and Methodist (Wagner, 2006). The diversity raises questions as to whether churches within the region are concerned with the individual soul or primarily concerned with social reform (Wagner, 2006). Scholars have labeled the Appalachian culture as collective, and many believe that these attributes supersede any indications of individualism within the prevailing religions (Wagner, 2006). One such Appalachian collective attribute is social equality or egalitarianism (Beaver, 1986).

Spirituality is not merely defined by one's religious beliefs but also by culture (Keefe, 2005; Lowry & Conco, 2002). In the Appalachian culture, patient's religion has been found to have a profound influence in determining the course of decisions regarding health care actions (Caldwell, 2007). One study found that the majority of Appalachian elders believe that health is directly related to the will of God (Simpson & King, 1999), but this would not be true of all elders or people in the region. Use of prayer as an alternative to health care was cited by 78% of those identifying as Appalachians, compared with 48% identifying as non-Appalachians, in a study that examined and challenged Appalachian stereotypes and preconceptions (Keefe & Parsons, 2005). When the meaning of spirituality was explored, four themes were identified: (a) God exists and participates in the lives of believers, (b) God summons believers to act on his direction, (c) stronger connections to God occur in times of need, and (d) patients have an expectation for health care providers to meet spiritual needs (Lowry & Conco, 2002).

Scholars commonly question the evidence in other studies, and because spirituality is so closely related to religion, it becomes debatable. Thus, skepticism is called for when findings from studies with mixed results occur. Accordingly, a literature review about the positive effects of spirituality or religion on health identified a moderately strong and consistent relationship, but limited research methods and limited empirical evidence demand methodological pluralism, experimental research design, and more comprehensive assessments (Thoresen, 1999). Several findings from the review warrant skepticism and further investigation (Table 1).

Health Perceptions in Appalachia

When conceptualizing health and its meaning, it is essential to consider the vast differences that might exist between objective (client defined) and subjective (professionally assessed) health (Hartley, 2002). Studies about health in Appalachian people have defined it as "an adaptive state that persons experience as they seek opportunities and wrested with liabilities found within themselves and their families, households, and diverse contexts throughout the course of their lives" (Denham, 2003, p. 3). In a different study about Appalachians, health was defined as the absence of illness and the ability to meet their own basic needs (Denham, 1999a).

When family health is the concern in the Appalachian culture, mothers are "the primary health care resource as well as

Downloaded from tcn.sagepub.com at UNIV N CAROLINA GREENSBORO on October 16, 2012

Table 1. Findings That Warrant Skepticism and Further Investigation

- Cognitive processes boost the immune system
- Social environment and culture influence health and disease
- Some religious groups experience less chronic disease and longer lives than nonreligious groups
- Some religious groups have healthier habits and stronger family support systems
- Religious factors are associated with reduced coronary heart disease, hypertension, stroke, cancer, and other indicators of health status
- Reduced morbidity and mortality in all causes
- Positive findings for the following races: Hispanics, Whites, and African Americans
- Positive findings for the following cultures: European, American, and Asian
- Higher life satisfaction and overall well-being
- Divorce rates lower and marital satisfaction higher
- Less drug and alcohol abuse

Source: Adapted from Thoresen (1999).

gatekeepers, stewards, sentinels and care tenders" (Denham, 1999d, p. 216). Even when family members dwell outside the household, extended kin relationships are affected by other member's illnesses (Denham, 2003). Appalachian families share in medical decision making, and women made most of the food choices within the household (Coyne et al., 2006). Often, within the region, family and church members are perceived in similar ways (Gross, 2005), thus care providers may extend to a church family. When dealing with health problems, Appalachians tend to rely heavily on support from faith, family, and friends (Denham, Meyer, Toborg, & Mande, 2004; Hunsucker, Flannery, & Frank, 2000).

Appalachians tend to view mental health negatively and are more likely to seek informal help outside the medical realm (Hauenstein, 2003; Keefe, 1988; Mulder et al., 1994). When mental health is the problem, Appalachians often present emotional problems as physical symptoms, seeking medical treatment as opposed to verbal therapy (Keefe & Greene, 2005). "In a society where personal worth and family are the basis for reputation, Appalachian people are often reticent to talk about personal or family problems" (Keefe & Greene, 2005, p. 305). Cultural taboos regarding mental health and treatment are pervasive in rural Appalachia, and residents are reluctant to discuss problems or seek professional services (Hauenstein, 2003). Mothers play a larger role than fathers in meeting the emotional care needs of Appalachian families; however, family cooperation was viewed as an important support tactic in mental and spiritual health (Denham, 1999c, 2003). Mothers were also found to be primarily responsible for adherence to religious rituals.

In a study of pregnant Appalachian women, spirituality and religion were identified as the basis for a reduction in cigarette smoking, a decrease in risky health behaviors, and an increase in other positive health behaviors (Jesse & Reed, 2004). Lowry and Conco (2002) found a correlation between spirituality and higher levels of self-esteem and social support as those with lower levels of spirituality having poorer health behaviors and elevated stress levels. Those participating in this study unanimously agreed that "God is a source of physical healing." Spirituality and religion were viewed as positive influences on health and wellness, as well as a major coping strategy and source for a positive attitude.

Conclusions

The literature supports a limited but encouraging relationship between spirituality or religion and health. Several conclusions can be drawn regarding links between spirituality, health, and the Appalachian culture; however, empirical evidence is limited to fully support distinct ideas about relationships. Many people in the Appalachian region might believe that their illness or disease are direct results of God's will (Keefe & Greene, 2005), and when these beliefs exist, they may hinder health care–seeking behaviors. Perceptions about health are undoubtedly rooted in cultural values among some Appalachians (Hartley, 2002). Appalachians are a proud people who value independence, taking care of self and family, and may delay getting care for medical problems until they are debilitating. This delay may occur as a result of distrust of medical professionals, lack of insurance, limited access to care, or simply waiting for God's will or an answer to prayer. Nurses that lack understandings about spiritual assessment or care may be challenged when caring for those long rooted to the Appalachian region (Lowry & Conco, 2002). Spiritual assessments must be comprehensive and include much more than religious preferences and affiliations (Stuart & Sundeen, 1991).

Koenig (2001) notes that religious patients use religious beliefs and practices to better cope with illness. He asserts that factors associated with religiosity including optimism, supportive friends, clear purpose and meaning in life, and healthier lifestyles correlate with mental and physical wellness. Some scholars resolutely believe that these components lead to less stress, lower blood pressure, better recovery rates, and higher immune systems (Koenig et al., 1998; Matthews, McCullough, Larson, Koenig, & Swyers, 1998). Thoresen (1999) discussed a rising interest in spirituality related to health because "people may feel more socially disconnected, more fragmented in their personal lives, with little sense of connectedness or community" (p. 293). In the Appalachian region, kinship and community are vital elements, and connectedness is a key factor of spirituality. A recent literature review about links between physical health and spirituality or religion eliminated studies with confounding and bias factor and stringently reviewed studies to eliminate those where findings seemed inconclusive (Powell, Shahabi, & Thoresen, 2003). Nine categories were identified for the

Downloaded from tcn.sagepub.com at UNIV N CAROLINA GREENSBORO on October 16, 2012

Table 2. Categories Indicating Religion/Spirituality Protects Against Mortality

- Church/Service attendance protects against death.
- Religion or spirituality protects against cardiovascular disease.
- Religion or spirituality protects against cancer mortality.
- Deeply religious people are protected against death.
- Religion or spirituality protects against disability.
- Religion or spirituality slows the progression of cancer.
- People who use religion to cope with difficulties live longer.
- Religion or spirituality improves recovery from acute illness.
- Being prayed for improves physical recovery from acute illness.

Source: Adapted from Powell et al. (2003).

review, and new findings indicated that religion or spirituality has a protective effect against mortality for those that are healthy (Table 2).

The insufficient Appalachian-specific studies regarding roles spirituality plays in health and illness make it difficult to deduct clear conclusions about the many variables that might be in play. Qualitative studies may be helpful in clarifying the mutually subjective and objective perceptions of illness and wellness. Sound experimental research using clearly operationalized variables and tightly developed research designs are needed to provide empirical evidence. Concise definitions of the concepts and constructs that comprise spirituality and religion are needed for testing with culturally distinct groups. Valid instruments to measure spirituality and religion over time in groups such as Appalachians who have a shared cultural ancestral heritage might be useful.

Unfortunately, this literature review has left more questions than answers. Largely unknown are what types of specific spiritual or religious practices influence health, and which ones contribute positively or negatively? How does culture affect spirituality and health? Are there better ways to measure depth of religiousness or spirituality? How do researchers factor in personal perceptions of health and wellness? Means of adequate control for an endless array of variables must be considered. These factors are not fixed and require longitudinal studies to allow for changes such as beliefs, practices, and medications (Thoresen, 1999).

Finally, care providers should not assume that relationships between spirituality and health are always positive (Gesler, Arcury, & Koenig, 2000). Those who believe that sin causes illness may not seek care. Decades of high chronic illness rates throughout the Appalachian region signal the importance of addressing those that harbor direct causational thinking between sin and illness and will likely need to resolve personal values before seeking care. Thus, if people believe, "the Lord will take care of things," they may sense chastisement if they do not allow time to test their faith. Clinicians are challenged to not only be familiar with specific religious views and faith practices of those in the Appalachian region but to also find ways to address primary prevention and health risks that too often result in long delays in seeking medical care.

Declaration of Conflicting Interests

The authors declared no conflicts of interest with respect to the authorship and/or publication of this.

Funding

The authors received no financial support for the research and/or authorship of this article.

References

Appalachian Regional Commission. (n.d.-a). *Appalachian regional commission.* Retrieved November 2, 2007, from http://www.epa.gov/reg3hscd/bf-lr/fed_prog_guide/arc.htm

Appalachian Regional Commission. (n.d.-b). *The Appalachian region.* Retrieved October 15, 2007, from http://www.arc.gov/index.do?nodeId=2

Appalachian Regional Commission. (n.d.-c). *The ARC distressed counties program.* Retrieved January 10, 2008, from http://www.arc.gov/index.do?nodeId=955

Arcury, T. A., Quandt, S. A., McDonald, J. A., & Bell, R. A. (2000). Faith and health self-management of rural older adults. *Journal of Cross-Cultural Gerontology, 15*, 55-74.

Barcus, H. R. (2007). The emergence of new Hispanic settlement patterns in Appalachia. *The Professional Geographer, 59*, 298-315.

Beaver, P. D. (1986). *Rural community in the Appalachian South.* Lexington: University Press of Kentucky.

Behringer, B., & Friedell, G. H. (2006). *Appalachia: Where place matters in health.* Retrieved September 21, 2007, from http://www.cdc.gov/Pcd/issues/2006/oct/06_0067.htm

Billings, D. B., Norman, G., & Ledford, K. (2001). *Back talk from Appalachia: Confronting stereotypes.* Lexington: University Press of Kentucky.

Blakeney, A. B. (2005). Educating culturally sensitive health professionals in Appalachia. In S. E. Keefe (Ed.), *Appalachian cultural competency*. (pp. 161-178) Knoxville: University of Tennessee Press.

Blakeney, A. B. (2006). Health care in Appalachia. In G. T. Edwards, J. A. Asubury, & R. L. Cox (Eds.), *A handbook to Appalachia* (pp. 101-118). Knoxville: University of Tennessee Press.

Brown, J. W., & May, B. A. (2005). Rural older Appalachian women's formal patterns of care. *Southern Online Journal of Nursing Research.* Retrieved January 13, 2010, from http://www.snrs.org/publications/SOJNR_articles/iss02vol06.pdf

Burkhardt, M. A. (1989). Spirituality: An analysis of the concept. *Holistic Nursing Practice, 3*, 69-77.

Burkhardt, M. A. (1994). Becoming and connecting: Elements of spirituality for women. *Holistic Nursing Practice, 8*, 12-21.

Burkhardt, M. A., & Nagai-Jacobson, G. (1985). Dealing with spiritual concerns of clients in the community. *Journal of Community Health Nursing, 2*, 191-198.

Caldwell, D. R. (2007). Bloodroot: Life stories of nurse practitioners in rural Appalachia. *Journal of Holistic Nursing, 25*, 73-79.

Campbell, J. C. (1921). *The Southern Highlander & his homeland.* New York: Russell Sage Foundation.

Coyne, C. A., Demian-Popescu, C., & Friend, D. (2006). *Social and cultural factors influencing health in Southern West Virginia: A*

Downloaded from tcn.sagepub.com at UNIV N CAROLINA GREENSBORO on October 16, 2012

qualitative study. Retrieved October 17, 2007, from http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1779288

Delgado, C. (2005). A discussion of the concept of spirituality. *Nursing Science Quarterly, 18*, 157-162.

Delgado, C. (2007). Sense of coherence, spirituality, stress and quality of life in chronic illness. *Journal of Nursing Scholarship, 39*, 229-234.

Denham, S. A. (1996). Family health in a rural Appalachian Ohio county. *Journal of Appalachian Studies, 2*, 1-12.

Denham, S. A. (1999a). The definition and practice of family health. *Journal of Family Nursing, 5*, 133-159.

Denham, S. A. (1999b). Family health: During and after death of a family member. *Journal of Family Nursing, 5*, 160-183.

Denham, S. A. (1999c). Family health in an economically disadvantaged population. *Journal of Family Nursing, 5*, 184-213.

Denham, S. A. (1999d). Epilogue: Summary of three studies on family health with Appalachian families. *Journal of Family Nursing, 5*, 214-217.

Denham, S. A. (2003). *Family health: A framework for nursing.* Philadelphia: F. A. Davis.

Denham, S. A., Meyer, M. G., Toborg, M. A., & Mande, M. J. (2004). Providing health education to Appalachia populations. *Holistic Nursing Practice, 18*, 293-301.

Denham, S. A., & Rathbun, A. (2005). *Appalachia: An overview of health concerns and health literacy.* Retrieved October 29, 2007, from http://www.oucom.ohiou.edu/arhi/research.htm

Denham, S. A., & Rathbun, A. (2010). *Evaluating health literacy and information seeking behaviors in Appalachia*. Manuscript submitted for publication.

Diggins, K. (2007). Generating hope. *Journal of Christian Nursing, 24*, 30-31.

Ford, G. S. (2007). Hospitalized kids: Spiritual care at their level. *Journal of Christian Nursing, 24*, 135-140.

Foulk, D., Carrol, P., & Wood, S. (2001). Addressing health literacy: A description of the intersection of functional literacy and healthcare. *American Journal of Health Studies.* Retrieved October 29, 2007, from http://ajhs.tamu.edu/17-1/2.pdf

Friedemann, M. (1995). *The framework of systemic organization: A conceptual approach to families and nursing.* Thousand Oaks, CA: Sage.

Gesler, W., Arcury, T. A., & Koenig, H. G. (2000). An introduction to three studies of rural elderly people: Effects of religion and culture on health. *Journal of Cross-Cultural Gerontology, 15*, 1-12.

Gross, C. (2005). To listen is to learn: The social worker in rural Appalachia. In S. E. Keefe (Ed.), *Appalachian cultural competency* (pp. 75-88). Knoxville: University of Tennessee Press.

Halverson, J. A., Ma, L., & Harner, E. J. (2004). *An analysis of disparities in health status and access to health care in the Appalachian region.* Retrieved September 21, 2007, from http://www.arc.gov/index.do?nodeId=2467&print=yes%20*

Hartley, L. A. (2002). Health perceptions and health status measurement among rural Appalachian elders. *Journal of Appalachian Studies, 8*, 284-298.

Hauenstein, E. J. (2003). No comfort in the rural south; Women living depressed. *Archives of Psychiatric Nursing, 17*, 3-11.

Hayes, P. A. (2006). Home is where their health is: Rethinking perspectives of informal and formal care by older rural Appalachian women who live alone. *Qualitative Health Research, 16*, 282-297.

Hunsucker, S., Flannery, J., & Frank, D. (2000). Coping strategies of rural families of critically ill patients. *Journal of the American Academy of Nurse Practitioners, 12*, 123-127.

Huttlinger, K., & Purnell, L. (2008). People of Appalachian heritage. In L. D. Purnell & B. J. Paulanka (Eds.), *Transcultural health care* (pp. 95-120). Philadelphia: F. A. Davis.

Jackson, S. R. (2006). Peoples of Appalachia: Cultural diversity within the mountain region. In G. T. Edwards, J. A. Asubury, & R. L. Cox (Eds.), *A handbook to Appalachia* (pp. 27-50). Knoxville: University of Tennessee Press.

Jesse, D. E., & Reed, P. G. (2004). Effects of spirituality and psychosocial well-being on health risk behaviors in Appalachian pregnant women. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 33*, 739-747.

Jesse, D. E., Schoneboom, C., & Blanchard, A. (2007). The effect of faith or spirituality in pregnancy. *Journal of Holistic Nursing, 25*, 151-158.

Keefe, S. E. (Ed.). (1988). *Appalachian mental health.* Lexington: University Press of Kentucky.

Keefe, S. E. (Ed.). (2005). *Appalachian cultural competency: A guide for medical, mental health, and social service professionals.* Knoxville: University of Tennessee Press.

Keefe, S. E., & Greene, S. (2005). Mental health therapy for Appalachian clients. In S. E. Keefe (Ed.), *Appalachian cultural competency* (pp. 301-314). Knoxville: University of Tennessee Press.

Keefe, S. E., & Parsons, P. (2005). Health and lifestyle indicators in a rural Appalachian county: Implications for health care practice. In S. E. Keefe (Ed.), *Appalachian cultural competency* (pp.183-195). Knoxville: University of Tennessee Press.

Kendrick, K. D., & Robinson, S. (2000). Spirituality: Its relevance and purpose for clinical nursing in a new millennium. *Journal of Clinical Nursing, 9*, 701-705.

King, D. E., & Bushwick, B. (1994). Beliefs and attitudes of hospital inpatients about faith, healing, and prayer. *Journal of Family Practice, 39*, 349-352.

Koenig, H. G. (2001). Religion, spirituality, and medicine: How are they related and what does it mean? *Mayo Clinic Proceedings, 76*, 1189-1191.

Koenig H. G., George L. K., Hays J. C., Larson D. B., Cohen H. J., & Blazer D. G. (1998). The relationship between religious activities and blood pressure in older adults. *International Journal of Psychiatry in Medicine, 28*, 189-213.

Lengerich, E. J., Bohland, J. R., Brown, P. K., Dignan, M. B., Paskett, E. D., Schoenberg, N. E., et al. (2006). *Images of Appalachia.* Retrieved October 17, 2007, from http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1779276

Lohri-Posey, B. (2006). Middle-aged Appalachians living with diabetes mellitus. *Family & Community Health, 29*, 214-220.

Downloaded from tcn.sagepub.com at UNIV N CAROLINA GREENSBORO on October 16, 2012

Lowry, L. W., & Conco, D. (2002). Exploring the meaning of spirituality with aging adults in Appalachia. *Journal of Holistic Nursing, 20*, 388-402.

Martsolf, D. S., & Mickley, J. R. (1998). The concept of spirituality in nursing theories: Differing worldviews and extent of focus. *Journal of Advanced Nursing, 27*, 294-303.

Matthews, D. A., McCullough, M. E., Larson, D. B., Koenig, H. G., & Swyers, J. P. (1998). Religious commitment and health status. *Archives of Family Medicine, 7*, 118-124.

McCauley, D. V. (1995). *Appalachian Mountain religion: A history.* Urbana: University of Illinois Press.

Meyers, T. J. (1990). Amish. *Global Anabaptist Mennonite encyclopedia online.* Retrieved March 8, 2008, from http://www.gameo.org/encyclopedia/contents/A4574ME.html

Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion, and health: An emerging research field. *American Psychologist, 58*, 24-35.

Mills, P. J. (2002). Spirituality, religiousness, and health: From research to clinical practice. *Annals of Behavioral Medicine, 24*, 1-2.

Mulder, P. L., Daugherty, A., Teel, W., Midkiff, J., Murray, K., & Smith, L. (1994). Rural West Virginia: A cross-cultural perspective with implications for clinical intervention. *The West Virginia Journal of Psychological Research and Practice, 3*, 9-25.

Mueller, P. S., Plevak, D. J., & Rummans, T. A. (2001). Religious involvement, spirituality, and medicine: Implications for clinical practice. *Mayo Clinic Proceedings, 76*, 1225-1235.

Narayanasamy, A., & Owens, J. (2001). A critical incident study of nurses' responses to the spiritual needs of their patients. *Journal of Advanced Nursing, 33*, 446-455.

O'Brien, J. (2001). *At home in the heart of Appalachia.* New York: Alfred A. Knopf.

Owens, J. S., Richerson, L., Murphy, C. E., Jageleweski, A., & Rossi, L. (2007). The parent perspective: Informing the cultural sensitivity of parenting programs in rural communities. *Child and Youth Care Forum, 36*, 179-194.

Pollard, K. M. (2004). *A new diversity: Race and ethnicity in the Appalachian region.* Retrieved October 24, 2007, from http://www.arc.gov/images/reports/raceethnic/diversity.pdf

Powell, L. H., Shahabi, L., & Thoresen, C. (2003). Religion and spirituality: Linkages to physical health. *American Psychologist, 58*, 36-52.

Raine, J. W. (1924). *The land of saddle-bags: A study of the Mountain people of Appalachia.* New York: Council on Women for Home Missions & Missionary Education Movement.

Rodgers, B. L. (1989). Concepts, analysis, and the development of nursing knowledge: The evolutionary cycle. *Journal of Advanced Nursing, 14*, 330-335.

Ruffing-Rahal, M. A. (1984). The spiritual dimension of well-being: Implications for the elderly. *Home Healthcare Nurse, 2*, 12-17.

Simpson, M. R., & King, M. G. (1999). "God brought all these churches together": Issues in developing religion-health partnerships in an Appalachian community. *Public Health Nursing, 16*, 41-49.

Straw, R. (2006). Appalachian history. In G. T. Edwards, J. A. Asubury, & R. L. Cox (Eds.), *A handbook to Appalachia.* Knoxville: University of Tennessee Press.

Stuart, G., & Sundeen, S. (1991). *Principals and practice of psychiatric nursing.* St. Louis, MO: C. V. Mosby.

Tanyi, R. A. (2006). Spirituality and family nursing: Spiritual assessment and interventions for families. *Journal of Advanced Nursing, 53*, 287-294.

Thoresen, C. E. (1999). Spirituality and health: Is there a relationship? *Journal of Health Psychology, 4*, 291-300.

Thoresen, C. E., & Harris, A. H. S. (2002). Spirituality and health: What's the evidence and what's needed? *Annals of Behavioral Medicine, 24*, 3-13.

Treloar, L. (2000). Integration of spirituality into health care practice by nurse practitioners. *Journal of the American Academy of Nurse Practitioners, 12*, 280-285.

Wagner, M. B. (2006). Religion in Appalachia. In G. T. Edwards, J. A. Asbury, & R. L. Cox (Eds.), *A handbook to Appalachia.* Knoxville: University of Tennessee Press.

Wagner, T. E., & Obermiller, P. J. (2004). *African American miners and migrants: The Eastern Kentucky Social Club.* Urbana: University of Illinois Press.

Wewers, M. E., Katz, M., Fickle, D., & Paskett, E. D. (2006). *Risky behaviors among Ohio Appalachian adults.* Retrieved October 23, 2007, from http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1779290&blobtype=pdf

Williams, J. A. (2002). *Appalachia: A history.* Chapel Hill: University of North Carolina Press.

Winkler, W. (2007). *A brief overview of the Melungeons.* Retrieved March 8, 2008, from http://www.melungeons.com/articles/jan2003.htm

Downloaded from tcn.sagepub.com at UNIV N CAROLINA GREENSBORO on October 16, 2012