AN EXPLORATION OF UNPARTNERED RURAL WOMEN'S PERCEPTIONS OF HOW THEIR SOCIAL RELATIONSHIPS INFLUENCE THEIR MENTAL AND EMOTIONAL HEALTH

by

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Table Of Contents

List of Tables

List of Figures

Abstract

Background: Humans are social beings, and it is essential for us to have positive social relationships in order to stay healthy mentally and emotionally. The literature on the social relationships of unpartnered women, and how these relationships may benefit and/or challenge their mental and/or emotional health is inconclusive. Some research finds that unpartnered women (e.g., never-married, divorced, separated, or widowed, and without a partner) are more likely than partnered women (e.g., married or common-law, and/or with a partner) to have few social relationships, which challenges their mental and/or emotional health, notably by creating increased stress, loneliness, and depression. However, other studies have found that unpartnered women have numerous supportive social relationships, and are not more likely than partnered women to experience mental and/or emotional health challenges. These different findings suggest that unpartnered women's social relationships may vary across place. This research adds to the current body of literature by focusing on the key social relationships of unpartnered, older women living in one place – rural Cape Breton.

Purpose: The purpose of this study was to explore the key interpersonal relationships (e.g., family, friends) and community relationships (e.g., shared interest groups) in the lives of rural, unpartnered women, and how these relationships may benefit and/or challenge their mental and emotional health.

Methods: Elements and principles of a grounded theory methodology were used in order to develop an interpretation of the lived experience of participants. Nine qualitative, face-to-face interviews were completed with unpartnered women, ages 50-65 living alone in rural Cape Breton.

Results: Three key themes emerged from the analysis of the interviews. The first theme speaks to the value of interpersonal and community relationships to the women's mental and emotional health. The second theme is about obstacles to developing and maintaining positive social relationships, which can be challenging to the women's mental and emotional health. The third key theme centres on the need for change in order to reduce the obstacles, and promote positive relationships to benefit unpartnered women's mental and emotional health.

Conclusions: Older, unpartnered women living alone in rural Cape Breton appear to have numerous positive social relationships, which was highly beneficial to their mental and/or emotional health. However, at the same time, the women also experience various obstacles to these social relationships, which could challenge their positive social relationships as well as their mental and/or emotional health. These findings point to the need to promote positive social relationships and reduce the obstacles to these positive relationships in order to promote the mental and emotional health of this population.

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Chapter One: Introduction

Social Relationships and Health

Humans are social beings, and it is essential for us to have positive social relationships in order to promote and maintain good overall health and well-being (Berkman, Glass, Brissette, & Seeman, 2000; Kawachi, & Berkman, 2001; Umberson & Montez, 2010). Social relationships can be defined as the different types of social integration or involvement, formally and informally, at both the interpersonal and community level (Berkman et al., 2000; Umberson et al., 2010). Social relationships are complex and can have a significant positive or negative impact on one's mental and emotional health, depending on the quality, quantity, and context of the relationships (Berkman et al., 2000; Hawe & Shiell, 2000; Kawachi et al., 2001; Umberson et al., 2010).

For this study, emotional health is generally defined as one's feelings and the ability to have appropriate emotional reactions, and mental health is generally defined as the ability to think clearly and analyze critically (Donatelle, Munroe, & Thompson, 2007). Mental and emotional health are closely related, and both contribute to an individual's overall health and well-being (Donatelle et al., 2007). For the purposes of this study, mental and emotional health are often used together in order to consider both aspects of an individuals' overall health and well-being.

The influence of social relationships on one's mental and emotional health has been shown to vary by gender. The research literature suggests that positive social relationships are especially important for the mental and/or emotional health of women, relative to men (Adams, Bowden, Humphrey, & McAdams, 2000; Denton, Prus, &

Walters, 2004; Hurdle, 2000; Saito, Sagawa, & Kanagawa, 2005). Therefore, it is important to study the social relationships, or lack thereof, in the lives of women, and how these relationships may benefit and/or challenge their mental and emotional health.

A key social relationship in many adults' lives comes from partnered relationships. For this research study, women who are married or cohabiting, and/or in a 'serious' partnered relationship (as defined by participants) are referred to as 'partnered', and women who have never been married, or are divorced, separated, or widowed, and without a partner are referred to as 'unpartnered'. The majority of women in Canada (including Nova Scotia) are partnered by the age of 35, and being in a partnered relationship continues to be the dominant relationship status for women throughout the rest of their life course (Milan, 2013; Nova Scotia Community Counts, 2011; Statistics Canada, 2011; Wu, 1998). Although partnered women represent the majority of women over the age of 35 in Canada, the proportion of unpartnered, older women has been steadily increasing over the past three decades (Milan, 2013; Nova Scotia Community Counts, 2011; Wu, 1998). As the unpartnered population of women in Canada continues to grow, it is essential to gain an understanding of this population in terms of their key interpersonal and community social relationships, and how these relationships, or lack thereof, benefit and/or challenge their mental and emotional health.

The Issue: Unpartnered Rural Women's Health

The research findings in the literature vary in terms of the social relationships in the lives of unpartnered women, and how these relationships, or lack thereof, may benefit and/or challenge their mental and/or emotional health. Much of the research literature has found that unpartnered women are more likely to have fewer positive social

relationships, in comparison to partnered women (Akhtar-Danesh & Landeen, 2007; Arber, 2004; Caron, 2010; Rohrer, Bernard, Zhang, Rasmussen, & Woroncom, 2000; Wade & Pevalin, 2004). It is suggested that unpartnered women may lack positive social relationships because, on average, they are economically disadvantaged, relative to partnered women, which can challenge their interpersonal and community relationships that require money to participate (e.g., member fees, transportation costs) (Cooney et al., 2001; Lichter et al., 2011; Waite, 1995). In addition, the stigmatization of unpartnered women may also challenge their ability to develop and/or maintain numerous positive social relationships (Sharp & Ganong, 2011). A lack of positive social relationships is one of the key explanations in the literature for why unpartnered women experience greater mental and/or emotional health challenges, notably stress and depression, in comparison to partnered women (Holt-Lundstad et al., 2008; Kobayashi et al., 2009; Lin et al., 2012; Rohrer et al., 2008; Ross, Mirowsky, & Goldsteen, 1990; Sherbourne & Hays, 1990; Umberson, 1987).

Although there is a body of literature which finds unpartnered women to have few positive social relationships, there is other research literature which finds that unpartnered women have numerous positive social relationships, and do not necessarily have fewer social relationships in comparison to partnered women (Arber, 2004; Cooney et al., 2001; Stull & Scarisbrick-Hauser, 1989). These studies suggest that unpartnered women develop healthy and supportive relationships with friends, family, and/or community organizations (Arber, 2004; Cooney et al., 2001; Stull et al., 1989). These studies also indicate that unpartnered women may not be at an increased risk for mental and/or emotional health issues, relative to partnered women, because they are not socially

isolated (Artazcoz, Cortes, Borrell, Escriba-Aguir, & Cascant, 2011; Cooney et al., 2010).

The varied findings in the literature suggest that the social relationships, or lack thereof, in the lives of unpartnered women may be influenced, in part, by different *places*. That is, the geographical location, physical environment, and socio-cultural context associated with living in a certain place may influence the positive social relationships, or lack thereof, in the lives of unpartnered women (Steadman, 2003: Sutherns, McPhedran, & Haworth-Brockman, 2004; Thurston et al., 2003). For example, the value and opportunities available to develop and maintain positive social relationships, as well as the relative income and stigma of unpartnered women, may vary across place. Therefore, the place in which the unpartnered women reside may influence their ability to develop and/or maintain positive social relationships, which may also influence their mental and emotional health outcomes, as a result.

This research study focused on the social relationships, or lack thereof, of unpartnered women living in a particular place – rural Cape Breton, Nova Scotia. For this research study, rural was defined as any place outside of a population centre, according to the updated Statistics Canada guidelines (From urban areas to population centres, 2011). Based on these guidelines, a rural place has 1,000 or less people within a population centre, a small population centre has 1,000 to 29,999 people, a medium population centre has 30,000 to 99,999 people, and a large population centre has 100,000 or more people.

A rural setting was chosen for this study because there is very little research that focuses specifically on unpartnered women living in a rural place. Health research

focusing on rural places is especially important in Canada, and Nova Scotia, where 19.9% and 44.7% of the population, respectively, live in a rural setting (Statistics Canada, 2009). In addition, there is a relative lack of health literature focused on rural populations in Canada, and especially rural women in Canada (Leipert & George, 2008; Sutherns et al., 2004; Romanow, 2002).

Research Purpose

Some research has investigated the social relationships of rural women on the one hand, and unpartnered women on the other, but there is a lack of research focusing specifically on the social relationships of unpartnered women living in a rural setting. Furthermore, there is little research examining the benefits and/or challenges of these social relationships for the women's mental and/or emotional health. The purpose of this study was to explore the key interpersonal and community social relationships of unpartnered, older women (ages 50-65) living alone in rural Cape Breton, Nova Scotia, and how these relationships may be beneficial and/or challenging to their mental and emotional health. The age range of 50 to 65 years old was selected because it is an increasing population group in rural Nova Scotia, and because there is very little research that looks at the social relationships and challenges for unpartnered women within this age category (Nova Scotia Community Counts, 2011). Participants living with others or supporting dependents were excluded from this study in order to explore the social relationships for unpartnered women living alone. This research also explored the potential program and policy changes that older, unpartnered women perceive as needed in order to reduce obstacles, and promote positive social relationships.

Research Questions

Based on a review of the current health research literature, the following research questions were developed:

1. What are the key interpersonal and community social relationships in the lives of older, unpartnered women living in rural Cape Breton, Nova Scotia?
2. How do unpartnered, older women living in rural Cape Breton, Nova Scotia perceive these social relationships as benefitting and/or challenging their mental and emotional health?
3. What types of changes, if any, do unpartnered, older women living in rural Cape Breton, Nova Scotia believe are necessary in order to improve their social relationships, as well as their mental and emotional health?

Significance of the Study

This exploratory research is important because a focus on the unique experiences of unpartnered older women living in a rural Canadian context is largely absent from the health literature. As the population of unpartnered, older women continues to grow, it is essential to develop a better understanding of the social relationships and the mental and emotional health needs of this group of women. An understanding of the key interpersonal and community social relationships in the lives of unpartnered, older women living in rural Cape Breton, and how these women perceive their relationships as challenging and/or benefitting their emotional and mental health will add to the existing body of literature. It will also help to inform programs and/or policies aimed at promoting the mental and emotional health of this population.

Health promotion strategies to improve the social relationships and social support of unpartnered, older women living in a rural setting are ultimately aimed at improving the mental and emotional health of these populations. Mental and emotional health issues pose significant health challenges for Canada. One in five Canadian will experience a mental and/or emotional health issue in any given year, and this costs the Canadian economy in excess of $150 billion per year (Smetanin, Stiff, Briante, Ahmed, & Khan, 2011). Therefore, mental and emotional health is clearly an important health and economic challenge for Canadians, in terms of effectively reducing mental and emotional health issues, and decreasing the large costs currently associated with mental and emotional healthcare.

Some of the research literature indicates that both rural populations and unpartnered population are at an increased risk for mental and/or emotional health issues, and have higher rates of mental illness relative to the general population (Caron, 2010; Kubik et al., 2003; Leipert et al., 2008; Painting the Landscape of Rural Nova Scotia, 2003; Willits et al., 2004). Strategies aimed at preventing mental and emotional health issues and promoting positive mental and emotional health among these populations may be effective methods for reducing the burden of mental healthcare costs on the Canadian healthcare system (Berkman, 1995). This is similar to the key suggestions by the Mental Health Commission of Canada (2012), which states that, among other areas, Canadians need to first promote mental health across the lifespan and prevent illness, and also reduce disparities to risk factors and provide access to the right combination of services. The correlation between positive interpersonal and community social relationships and benefits to mental and emotional health is well documented (Berkman et al., 2000; Hawe

et al., 2000; Kawachi et al., 2001). Thus, promoting positive social relationships among older, unpartnered women living alone in a rural setting may be a key strategy for addressing some of the mental and emotional health challenges, and promoting the overall health, of this population.

Research Approach

This qualitative research study was exploratory in nature and was informed by elements and principles of grounded theory methodology (Charmaz, 2006; Corbin & Strauss, 2008; Strauss & Corbin 1994). Prior to beginning the study, ethical approval was obtained from the Dalhousie University Research Ethics Board. All participants were provided with a consent form explaining the potential risks and benefits of participation, and informed written and/or verbal consent was obtained before beginning each interview. Nine face-to-face interviews, and five follow-up telephone interviews were completed with unpartnered women, ages 50-65, living alone in rural Cape Breton, Nova Scotia. These interviews were audio recorded and transcribed verbatim. Initial/open coding and focused/axial coding techniques, as well as memoing techniques were used to identify, analyze, and interpret key themes in the data and to develop an interpretive description of the lived experience for rural, unpartnered women in terms of their key social relationships, and their mental and emotional health. The methodology and methods used for this study are described in greater detail in Chapter Three.

Summary

In summary, positive social relationships play a key role in the mental and/or emotional health of all people, and research suggests these positive social relationships are especially important for women (Berkman et al., 2000; Denton et al., 2004; Kawachi

et al., 2001). Therefore, it is important to explore the key positive and negative social relationships in women's lives in order to develop a better understanding of how social relationships may benefit and/or challenge their mental and emotional health. This research study has specifically explored the key social relationships in the lives of older, unpartnered women living alone in rural Cape Breton. This research is important because there is currently very little qualitative research investigating the social relationships in the lives of older, unpartnered women living in a rural place. In addition, a better understanding of the social relationships in the lives of these women may help inform strategies to promote the mental and emotional health of this population.

Following an introduction to the research study, a review of the current literature relating to the research topic can be found in Chapter Two. Next, the methodology and methods used to design the research study are described in Chapter Three. This is followed by the study results in Chapter Four, and finally, the conclusions and relevant discussion and implications based on the research findings are presented in Chapter Five.

Chapter Two: Literature Review

This chapter will present a summary of the current research literature related to this research study. This includes an introduction to social relationships, and how social relationships can positively and/or negatively influence one's mental and emotional health. This is followed by an exploration of the literature regarding the social relationships in the lives of unpartnered women, and how these social relationships, or lack thereof, may benefit and/or challenge the mental and emotional health of unpartnered women. Next, the rural context, and how living in a rural place can impact social relationships, and mental and emotional health are explored. Finally, a summary of the relevant literature, as well as a description of how the literature has informed this research study, are included.

Defining social relationships.

Positive social relationships are essential to maintain good overall health and well-being (Berkman et al., 2000; Kawachi et al., 2001; Umberson et al., 2010). Social relationships can be defined as the different types of social integration or involvement, formally and informally (Almedom, 2005; Berkman et al., 2000; Umberson et al., 2010). Social relationships can consist of interpersonal-level social relationships or community-level social relationships. Social relationships at the interpersonal level include relationships on an individual level, such as those with family and close friends. Social relationships at the community level include relationships with a variety of people within a certain group or organization, such as shared interest groups. Informal social relationships include support volunteered by close friends and family, and community and religious organizations, while formal social relationships include those involving the

law, government, or a formal business or organization (Bushy, 2000; Clark & Leipert, 2007).

Social relationships are *diverse and complex*. They can vary based on size, density, boundedness, homogeneity, frequency of contact, duration, and reciprocity (Berkman et al., 2000; Umberson et al., 2010). Social relationships are also shaped by various social-structural conditions, notably culture, politics, socio-economic factors, and social change (Berkman et al., 2000; Hawe et al., 2000). Furthermore, social relationships are influenced by the various socio-demographic variables of the people involved in the relationship, including gender, income, health, place, and marital status (Belle, 1987; Hawe et al., 2000; Umberson et al., 2010). Therefore, individuals can experience a range of social relationships, at an interpersonal and community level, that are influenced by a variety of contextual factors.

Social relationships and health.

Social relationships have a significant impact on all aspects of health, including mental, social, emotional, and physical health (Berkman et al., 2000; Kawachi et al., 2001; Saito et al., 2005; Umberson et al., 2010). In the 1950s, the link between positive social relationships and positive health outcomes was first recorded when Durkheim found that positive social relationships correlated with decreased risk of suicide (Durkheim, 1951). Since then, this correlation has been well established in the research literature (Berkman et al., 1979; Kawachi et al., 2001; Umberson et al., 2010). Individuals with a variety of positive social relationships experience better physical, mental, and emotional health in comparison to those with few social relationships, or socially isolated individuals (Berkman et al., 2000; Kawachi et al., 2001). "Social

exclusion" and "social safety net" are even listed as two of the fourteen Canadian social determinants of health by Mikkonen and Raphael (2010), because of the significant influence of social relationships on health.

According to Donatelle and colleagues (2007), emotional health can be defined as one's feelings and the ability to have appropriate emotional reactions, and mental health encompasses the ability to think clearly and analyze critically. Mental and emotional health are closely related. For example good mental health is often related to good emotional health, and poor mental health is often related to poor emotional health. Mental and emotional health both contribute to an individual's overall health and well-being (Keyes, 2002; Donatelle et al., 2007). This definition of mental and emotional health was used for this research study because it defines mental and emotional health separately, and as they relate to an individuals' overall health and well-being.

Social relationships can impact mental and/or emotional health positively through at least two key mechanisms: first, by promoting positive mental and/or emotional health activities, behaviours, and services, and second, by influencing the way individuals cope, react and recuperate from various mental and/or emotional health issues (Denton et al., 2004; Kawachi, Kennedy, & Glass, 1999; Umberson et al., 2010). For example, a person with numerous positive social relationships is more likely to engage in healthy behaviours with others, such as exercising, communicating, and helping one another, which is beneficial for one's mental and emotional health (Adams et al., 2000; Denton et al., 2004). In addition, if an individual is suffering from mental and/or emotional health issues, they are more likely to be able to cope with the illness and recover more quickly if they have numerous positive and supportive social relationships, in comparison to an

individual with few or negative social relationships (Denton et al., 2004; Hinton & Earnest, 2010; Turner & Turner, 2005). Santorius (2003), describes that this relationship between positive social relationships and positive mental health outcomes is cyclical: increases in social relationships benefit mental health, and improvements in mental health leads to improvements in social relationships. Therefore, developing and maintaining positive social relationships is a key strategy for positive mental and emotional health outcomes.

Social relationships can also negatively impact one's mental and/or emotional health. Research indicates that people with few social relationships or with negative social relationships are more likely to have lower self-rated health, and poorer mental and/or emotional health outcomes, in comparison to those with numerous positive relationships (Almedom, 2005; House et al., 1988; Kawachi et al., 1999; Umberson et al., 2010). Research has also found that negative social relationships, such as abusive, untrustworthy, or unreliable relationships, are linked to a greater risk of mortality (Holt-Lundstad, Birmingham, & Jones, 2008). Berkman and Syme (1979), for example, found that people with very few social relationships had two times the risk of death in comparison to those with many social relationships, after accounting for socio-economic status and individual health behaviours. It appears that social relationships have the potential to be beneficial and/or challenging ("can be both an asset and a liability") for the mental and/or emotional health of individuals (Almedom, 2005, p. 943).

Social relationships are complex.

Research indicates that the quality and quantity of social relationships can influence one's mental and emotional health (Cohen, 2004; House, Landis, & Umberson,

1988). For example, having numerous positive social relationships (quantity) is important, however, simply having a high *quantity* of social relationships does not necessarily correlate with direct benefits to mental and/or emotional health. Rather, it is also the *quality* of these relationships that will shape how a relationship will benefit and/or challenge one's mental and emotional health. Therefore, both the quantity and the quality of the social relationships in an individual's life appear to be important in how a relationship may benefit and/or challenge one's mental and emotional health outcomes.

Perception of a social relationship has also been found to influence how a relationship will impact one's mental and/or emotional health (White, Philogene, Fine, & Sinna, 2009). White et al. (2009), found that older men and women report better health status when they are satisfied with the social and emotional supports available to them. Therefore, a variety of factors, including one's perception of their social relationships, as well as the quality and quantity of the relationships, will influence how one's social relationships will impact their health.

Several studies have found that the positive and/or negative health effects of social relationships can accumulate over the life course, and, as a result, can have a cumulative positive and/or negative impact on health (Brockman & Klein, 2004; Ferraro & Shippee, 2009; Hughes & Waite, 2009). That is, the positive health effects of positive social relationships can increase over time, and the negative health effects of few or negative social relationships can also increase over time.

Although the accumulated benefits and/or challenges associated with social relationships affect everyone, research indicates these benefits and/or challenges are not distributed equally in the population. Instead, social relationships impact the health of

different population groups to a different extent (Belle, 1987; House et al., 1988; Umberson et al., 2010). For example, Atchley (1994), found that social relationships became increasingly important later in life, when there are often fewer opportunities for social interaction, such as employment, child rearing, and marriage. Other studies have found that social relationships are especially important for the mental and/or emotional health of women, in comparison to men (Adams et al., 2000; Antonucci & Akiyama, 1987; Denton et al., 2004). In the next sections, the literature focusing specifically on social relationships and the health of women will be explored.

Social relationships and women's health.

Research indicates that males and females often perceive and experience their social relationships differently due to their gender (Kawachi et al., 2001; Umberson et al., 2010). As a result, the influence of their social relationships on their mental and emotional health may differ (Kawachi et al., 2001; Umberson et al., 2010). Various studies, for example, have found that social relationships play a more central role in the lives of women, and therefore, have a greater influence on the mental and/or emotional health of women, in comparison to men (Adams et al., 2000; Antonucci et al., 1987; Denton et al., 2004; Hurdle, 2001; Saito et al., 2005). That is, the positive aspects of social relationships have been found to have a greater benefit, and the negative aspects of too few or negative social relationships have been found to have a greater challenge, for the mental and/or emotional health of women, relative to men (Antonucci et al., 1987; Belle, 1987; Denton et al., 2004).

There are several explanations as to why social relationships appear to be especially important for the mental and/or emotional health of women, relative to men.

Denton et al. (2004), found that social relationships were especially important for women because social structural determinants of health (e.g., social support, marital status, age, and gender) are generally more important for women's health, while behavioural determinants (e.g., smoking, drinking, exercise, and diet) are generally more important for men's health. Other research has found that social relationships are especially important for women because, in general, women earn less money than men, which puts women at a disadvantage economically and, therefore, health-wise (Mikkonen et al., 2010). Women need positive social relationships in order to help mitigate the negative health effects associated with having a lower income (Hawe, 2000). Despite the various reasons for the gendered impact of social relationships on health, however, it is clear that positive social relationships are key in the lives of women, and can have a large beneficial impact on the mental and/or emotional health of women.

Social relationships are not always correlated with positive health outcomes in women, as negative social relationships may also be detrimental to the health of women. Social relationships with individuals or the community that are stressful, judgmental, exclusive, or costly may have a negative impact on the mental and/or emotional health of women (Belle, 1987; Jackson, Unruh, & Donahue, 2011). Belle (1987) found that being a part of some social relationships was more harmful than beneficial for women if the relationships were an additional source of stress. For example, women with few resources may experience stress from a social relationship because they may struggle to meet the needs of the relationship, such as costs for member fees or transportation to meet with the social relationship. When social relationships are stressful, they may create

mental and/or emotional health problems for women, as opposed to reduce them (Belle, 1987; Umberson et al., 2010).

Negative relationships can be especially challenging for women because the socio-structural determinants of health (e.g., social relationships) are generally more important for the mental and/or emotional health of women, relative to men (Denton et al., 2004). Therefore, negative social relationships may be disproportionally challenging for women, relative to men, as women may rely more on their relationships to meet their mental and/or emotional needs. Although positive social relationships can have positive impacts for the mental and/or emotional health of women, negative social relationships can also have a largely negative impact on the mental and/or emotional health for women.

Partnership Status and Health

Partnered/unpartnered definitions and trends.

A key social relationship in many adults' lives comes from partnered relationships. For this study, women who are married, cohabitating, and/or with a partner will be referred to as 'partnered', and women who are never-married, divorced, separated, or widowed and/or without a partner will be referred to as 'unpartnered'. Among women in Canada over the age of 16, 73% are partnered, and 27% are unpartnered (10% widowed, 10% divorced or separated, and 7% single) (Sutherns et al., 2004). The majority of women in Canada are partnered by the age of 35, and being in a partnered relationship continues to be the dominant relationship status for women throughout the rest of their life course (Milan, 2013; Statistics Canada, 2011; Wu, 1998). Unpartnered women over the age of 35 are a minority group in comparison to the partnered majority

(Nova Scotia Community Counts, 2011; Statistics Canada, 2011).

Although partnered women represent the majority of women over the age of 35 in Canada, the proportion of unpartnered older women relative to partnered women has been steadily increasing over the past three decades (Milan, 2013; Nova Scotia Community Counts, 2011; Wu, 1998). In 1981, 60.9% of the Canadian population ages 15 and over was partnered, and only 39.1% was unpartnered (Milan, 2013). In 2011, partnership among Canadians ages 15 and over had decreased significantly, with 46.4% of the population in a partnered relationship, and 53.6% unpartnered (Milan, 2013). This trend is due, in part, to increased rates of divorce and separation, and later first-marriage ages among Canadians (Milan, 2013; Nova Scotia Community Counts, 2011; Wu, 1998). Increasing independence, and improvements to women's education, employment, and income have also been described as reasons for the increasing unpartnered population (Lin & Brown, 2011). As the proportion of unpartnered women in Canada grows, it is essential to gain an understanding of this population in terms of their key interpersonal and community relationships and how these relationships may benefit and/or challenge their mental and emotional health.

Although these statistics provide a picture of changes over time in partnership status, it is important to note some possible limitations of the statistics. A key limitation is that statistical analysis often require people to classify themselves into specific categories (e.g., married, single, separated, divorced, widowed, and/or common-law), while these categories may not accurately represent themselves. For example, someone might indicate that they are never-married, divorced, or widowed because this is their relationship status by law, but they may also have a partner at the same time.

Conversely, someone may be married by law, but they may have no involvement with their partner, and may therefore consider themselves unpartnered, regardless of their legal partnership status. Although statistics are useful for getting an overall idea of the proportion of partnered and unpartnered women in Canada, it is also important to recognize that these statistics may not capture the true 'partnership status' for all Canadians. Hence, in this study, the terms partnered and unpartnered were conceived more broadly to account for this limitation.

Challenges for the mental and emotional health of unpartnered women.

Not only does research indicate that positive social relationships can have health benefits, research focusing specifically on partnerships as social relationships often emphasizes the health benefits of partnership and finds that unpartnered women are less healthy than partnered women (Cheung, 2000; House et al., 1988; Johnson, Backlund, Sorlie, & Loveless, 2000; Kaplan & Kronick, 2006; Wilson & Oswald, 2005). Kaplan et al. (2006), for example, found that unpartnered women have a relative risk of mortality up to two times higher than that of partnered women. Other research studies have found that unpartnered women have lower self-rated mental and physical health in comparison to partnered women (Caron, 2010; Rohrer et al., 2008). Wilson & Oswald (2005) go so far as to state that "marriage is arguably the most fundamental of all social ties", and that "the size of the health gain from marriage is remarkable. It may be as large as the benefit from giving up smoking" (p.1).

In terms of mental and/or emotional health, much of the research literature has found that unpartnered women are more likely than partnered women to suffer from psychological distress, depression, and other mental and/or emotional health issues

(Akhtar-Danesh et al., 2007; Caron, 2010; Hope, Rodgers, & Power, 1999; Lieberman, Masocco, Pompili, Vichi, Vanacore, Lester, & Tatarelli, 2008; Massey, & Goodwin, 2010; Lorenz, Wickrama, Conger, & Elder, 2006; Prigerson, Maciejewski, & Rosenheck, 1999; Rohrer et al., 2008; Simon, 2002; Simon & Marcussen, 1999; Wade et al., 2004; Willits, Benzeval, & Stansfeld, 2004). The article by Willits et al. (2004), claims that "partnership is protective of mental health" (p. 53), and being unpartnered increases the risk of mental and/or emotional health challenges. The health benefits associated with being partnered, and conversely, the challenges associated with being unpartnered also seem to accumulate over the life course (Brockman et al., 2004; Ferraro et al.,, 2009; Hope et al., 1999; Hughes et al., 2009). This indicates that the mental and/or emotional health challenges associated with being unpartnered may increase with age, making older, unpartnered people at a greater risk of the mental and/or emotional health issues associated with being unpartnered (Ferraro et al., 2009).

Few positive social relationships.

Many have suggested that the reason why unpartnered women may experience poorer mental and/or emotional health outcomes (e.g., loneliness, depression, and isolation), relative to partnered women, is because unpartnered women have fewer positive social relationships, relative to partnered women (Holt-Lundstad et al., 2008; Kobayashi et al., 2009; Lin et al., 2012; Rohrer et al., 2008; Ross, Mirowsky, & Goldsteen, 1990; Sherbourne & Hays, 1990; Umberson, 1987). In other words, these studies have found that not only do partnered women have a key relationship with their partner, but partnered women also have more positive relationships in addition to their partner, relative to unpartnered women (Sherbourne et al., 1990). These studies indicate

that unpartnered women may be at risk for poorer mental and emotional health outcomes in comparison to partnered women, due to a lack of positive social relationships.

Several research studies provide explanations as to why unpartnered women may have fewer positive social relationships, relative to partnered women. For example, Lund, Doe, Modvig, Holstein, Damsgaard, and Andersen (2002), found that unpartnered people often live alone, which may contribute towards being less "socially integrated", relative to others not living alone. A study by Lindstrom (2009), found that unpartnered women have significantly lower trust in others, in comparison to partnered women, which may also challenge their ability to have positive social relationships. In addition, research has also found that the interpersonal and community social relationships in the lives of unpartnered people did not compensate for the health benefits associated with being in a partnered relationship (Holt-Lundstad et al., 2008).

Stigma.

Another possible explanation for the poorer mental and emotional health outcomes among unpartnered women, relative to partnered women, centers around the stigmatization of women who are not in a traditional (heterosexual) partnered relationship (Conley & Collins, 2002; DePaulo & Morris, 2005: Morris, Sinclair, & DePaulo, 2007; Sandfield & Percy, 2003; Sharp et al., 2011). Stigma can be defined as an attribute, behaviour, or reputation that is socially discrediting, and causes an individual with that attribute, behaviour, or reputation (the stigmatized) to be negatively judged or stereotyped by those who do not bear the stigma (the stigmatizer) (Goffman, 1963). DePaulo et al. (2006) found that partnered people are more likely to be described in positive terms, such as "mature", "loving", and "stable", while unpartnered people are

more likely to be described in negative terms, such as “immature”, “unhappy”, “ugly”, and “lonely”. A study by Morris et al., (2007), found that participants (landlords) in their study favoured partnered couples over unpartnered people (when selecting tenants), and did not recognize this preferential treatment as a form of stigmatization or discrimination. Furthermore, participants in this study justified their discrimination against people that are unpartnered, and felt that this discrimination towards unpartnered people was more legitimate than discrimination towards other sub-populations (e.g., discrimination based on race, sex, religion) (Morris et al., 2007). DePaulo et al. (2006), also found that this stigma against unpartnered people increased with age, making older, unpartnered women a highly stigmatized population.

This stigma and pressure to conform to a traditional partnered lifestyle appears to be especially prominent for women, as compared to men, and also appears to increase with age (DePaulo et al., 2005; DePaulo et al., 2006; Sandfield et al., 2003; Sharp et al., 2011). That is, older, unpartnered women may experience increased stigma related to being unpartnered, in comparison to unpartnered men and younger unpartnered women (DePaulo et al., 2006). Unpartnered, older women are often labeled with pejorative terms, such as ‘old maid’, ‘cat lady’, ‘peculiar’, or ‘spinster’, which reinforces negative stereotypes and promotes stigmatization among women that are unpartnered (Sandfield et al., 2003; Sharp et al., 2011). In addition, being unpartnered is often viewed as a ‘failure’ or ‘dysfunctional’, rather than as a choice among unpartnered women (Reynolds & Wetherell, 2003; Sandfield et al., 2003). Sharp et al. (2011), argue that women remain restricted (i.e., face stigma for being unpartnered) in a society that promotes marriage and motherhood as central to women’s identities. Bryne and Carr (2005), describe

unpartnered women as being in a "cultural lag" due to the slow changing cultural ideals that elevate marriage as ideal in combination with the faster changes encouraging singlehood and independence as desirable for women.

Stigmatized populations often experience mental and/or emotional health challenges related to being stigmatized. A challenge for stigmatized populations is that they may sometimes believe that their stigmatizing attributes are, in fact, negative, and this can cause internalized negative perceptions and self-shame (Goffman, 1963). For example, a study by Reynolds et al. (2003), found that being unpartnered had multiple meanings and identities for unpartnered women, including positive aspects (e.g., "independence and choice" and "self-actualization") as well as negative aspects ("personal deficit" and "social exclusion"). This may create unresolved and mixed feelings for the women around being unpartnered, which can lead to mental and/or emotional health challenges (Lewis & Moon, 1997; Reynolds et al., 2003). Unresolved positive and/or negative feelings around being unpartnered may also challenge the development and/or maintenance of positive social relationships for unpartnered women. Therefore, stigmatization around being an unpartnered woman is likely another factor contributing to the poorer mental and/or emotional health outcomes found among this population.

Economic factors.

Another key explanation for the negative mental and/or emotional health issues affecting unpartnered women centers around economic challenges (Blanchflower & Oswald, 2002; Lindstrom, 2009). Unpartnered women, on average, are economically disadvantaged, relative to partnered women (McKeever & Wolfinger, 2011; Waite, 1995;

Walderon, Hughes, & Brooks, 1996). This economic disadvantage appears to be especially challenging for divorced and widowed women, who often do not earn as much money as when they were in a partnership (Cooney et al., 2001; Lichter et al., 2003; Walderon, Weiss, & Hughes, 1997). In addition, Hoffman and Duncan (1988), found that economic recovery for divorced and widowed women was unlikely unless they remarried. Not only does the average unpartnered woman earn less money than the average partnered woman, but unpartnered women also lack the financial safety net (e.g., supplemental income) that is often provided by a partner (Walderon et al., 1996). Although the educational and employment rates for women have been steadily increasing over the past thirty years, there has not been a substantial increase in income for women to match these improvements (McKeever et al., 2011). Unpartnered women are also less likely to have additional health insurance, due to low income levels, fewer employment benefits, and the lack of a partner with family insurance (McKeever et al., 2011). Being partnered is extremely beneficial economically, as Blanchflower et al. (2002), state, "a lasting marriage is estimated to be worth approximately $100,000 per year in well-being" (p. 1359). Thus, it appears that having a low income challenges positive social relationships and supports, and having few positive social relationships and supports can also challenge one's income. Therefore, economic challenges may contribute, in part, to the poorer mental and/or emotional health outcomes found among unpartnered women, relative to partnered women, particularly if lower incomes affect their social relationships (i.e., ability to participation in community organizations) (Caron, 2010; Lindstrom, 2009).

Benefits for the mental and emotional health of unpartnered women.

Although much of the literature indicates that unpartnered women are at a disadvantage in terms of their mental and/or emotional health in comparison to partnered women, other research literature suggests that unpartnered women are *not* at an increased risk for mental and emotional health challenges, relative to partnered women (Artazcoz et al., 2011; Gove, 1972; Williams et al., 2004). This may be especially true for women that are unpartnered for a large portion of their adult lives and have established an unpartnered lifestyle with healthy positive social relationships outside of partnership (Arber, 2004; Walderon et al., 1997). There is also some research which has found that it may be healthier for women to be unpartnered than to be in a low-quality partnered relationship (Holt-Lunstad et al., 2008; Williams, 2003). That is, women in abusive partnered relationships are more likely to have poorer mental and/or emotional health outcomes relative to unpartnered women (Holt-Lunstad et al., 2008). As Williams et al. (2004), state, "researchers should begin to question the assumption that marriage is good for all individuals at all times".

Positive social relationships.

Though some research points to the social isolation of unpartnered women, other research has found that some unpartnered women have strong, supportive social relationships and are not socially isolated (Arber, 2004; Cooney et al., 2001; Stull et al., 1989). Studies by Arber (2004), and Cooney et al. (2001), found that unpartnered women (notably never-married women) tend to develop strong, meaningful, and extensive relationships outside of partnership, which can compensate for the lack of a partnered relationship by providing alternative forms of social support. Arber (2004), for example,

found that unpartnered women have higher involvement in community organizations, including religious groups, interest groups, community organizations, and social groups. These studies suggest that unpartnered women do not become socially isolated due to the lack of a partner, and instead maintain a variety of positive interpersonal and community social relationships. These positive relationships may mitigate the negative health outcomes often associated with being unpartnered, and may promote the mental and/or emotional health of unpartnered women (Hewitt et al., 2012; Turner et al., 2005).

Decreasing stigma.

Other research suggests that the mental and/or emotional health of unpartnered people may be improving as the stigma around being unpartnered decreases over time. Hertel, Schutz, DePaulo, Morris, & Stucke (2007), and Thornton (1989), argue that the status of unpartnered people may be less stigmatized as the proportion of unpartnered people increases due to increased divorce rates and later marriage ages. Additionally, Reynolds et al. (2003), found that some unpartnered women described themselves as "independent" and "self-actualized", and felt that being unpartnered was a source of "achievement" (p. 498). Therefore, the stigma associated with being an unpartnered woman may be decreasing, and this increased acceptance towards being unpartnered may be another factor explaining the positive mental and/or emotional health outcomes among some unpartnered women. This may also partially explain the contradictory research findings in terms of the mental and/or emotional health of unpartnered women over the years. The following section will review the literature of rural health, focusing specifically on social relationships in rural settings, and how rural place may benefit and/or challenge the mental and/or emotional health of unpartnered women.

Rural Place

Defining rural.

There are numerous definitions for what constitutes a "rural" and an "urban" setting, as these are socially defined concepts that can change over time (Puderer, 2009). That is, each individual may have a different perception of what constitutes a rural and/or urban location according to their personal history and experiences, and these perceptions may or may not change over time. For example, someone living in a large metropolis may feel that a small town or village is very 'rural' in nature, but someone living in a rural and isolated location may feel that the same small town is very 'urban' in nature.

For the purposes of this paper, the recommendations of Statistics Canada will be used to define rural and urban (From urban areas to population centres, 2011). This definition was used because it was designed specifically for the Canadian context. Using these guidelines, population centres (formerly referred to as urban areas), are places where there is a high population density, and this is the opposite of rural areas, where there is a low population density. Population centres can range from large population centres, with a population of 100,000 or more people, to medium population centres, with a population of 30,000 to 99,999 people, and lastly to small population centres, with 1,000 to 29,999 people. All other areas with less than 1000 people per town or village are defined as rural.

Despite these 'black-and-white' definitions, it is still recognized that "rural areas" and "population centres" cannot always broken down into such distinct categories given that rural and urban are about more than population size and density. In addition to the physical environment (low population density, geographical isolation), the social culture

(collective values, feelings of belonging, community) also plays a key role in what defines a place as rural for its residents (Steadman, 2003; Wiborg 2004).

Rural Cape Breton, Nova Scotia, Canada.

Cape Breton is an island (approximately 10,300km^2), connected by a causeway on the north eastern coast of mainland Nova Scotia (Statistics Canada, 2012). This area is a popular tourist destination, known for its natural beauty consisting of rocky shores, rolling farmland, glacial valleys, barren headlands, mountains, woods, and plateaus. Of the approximately 136,000 people living on Cape Breton Island, approximately 97,000 (~70%) live in the Cape Breton Regional Municipality (CRRM), the largest population centre on the Island (Statistic Canada, 2011). The remaining 39,000 people living outside of the CBRM live in small population centres or rural and remote areas (From urban areas to population centres, 2011). Thus, the majority of the landscape of Cape Breton would be defined as rural and small population centres, based on the Statistics Canada definition used for this study.

Cape Breton currently faces many economic and social challenges. The area has experienced an economic depression since the closure of its two major industries (coal and steel) in the 1990s. One of the consequences has been a high rate of youth out-migration from the area, creating a population decline of -10.3% between 1996 and 2006 (Statistics Canada, 2012). Cape Breton also has lower education levels, lower average incomes, and higher unemployment rates than Canadian averages (Statistics Canada, 2012). These economic and social challenges have partially contributed to the health challenges that also exist in the area.

The health of Cape Bretoners is also poorer, on average, than the health of the average Canadian. One study found that the life expectancy for populations in some municipalities of Cape Breton was up to five years less than the Canadian average (Veugelers et al., 1999). In terms of mental health, Cape Breton also has among the highest rates of depression in Nova Scotia, where depression affects an estimated ten percent of the population, significantly above the national average (Painting the Landscape of Rural Nova Scotia, 2003).

Although many studies point towards the poor health indicators and health challenges for Cape Breton, there are also some positive health indicators for the area. Cape Bretoners self-rate their overall health and their mental health higher than provincial averages (Nova Scotia Community Counts, 2011). In addition, 81.6% of people in Cape Breton have a strong sense of belonging, relative to the provincial average of 76.3% (Nova Scotia Community Counts, 2011). These statistics may indicate that the Cape Breton area is characterized by a strong sense of rural community and belonging, which may be beneficial for their health. However, there is currently very little research that explores the mental and/or emotional health benefits and/or challenges for Cape Bretoners, and especially rural Cape Breton.

Rural place and health.

There is increasing recognition of the need for health research focused specifically on rural populations, and especially on women living in rural Canada because there is currently very little research that specifically considers the health challenges and needs for women living in rural places (Leipert et al., 2008; Romanow, 2002; Sutherns et al., 2004). Rural women face different health challenges, relative to women living in

larger population centres, due to the rural context, and these differences need to be explored.

The existing literature clearly indicates that living in a rural setting is a powerful determinant of health, and some argue that it should even be included as a key social determinant of health (Cattell, 2001; Hartley, 2004; Leipert et al., 2008;Wanless et al., 2010). More specifically, rurality is a powerful determinant of health as a geographic and physical influence, and as a socio-cultural influence (Steadman, 2003; Sutherns et al., 2004). The geographic and physical influence refers to the low population density, isolation, and physical environment associated with living in a rural place. The socio-cultural influence refers to the unique "rural culture" associated with living in a rural place. This culture often involves a sense of community and belonging, rural pride, coping with adversity, and rural change (Gaston, 2001; Goins, Williams, Carter, Spencer, & Solovieva, 2005; Harvey, 2007; Leipert et al., 2008; Painting the Landscape of Rural Nova Scotia, 2003; Rolfe, 2006). These various aspects of living in a rural place will influence social relationships, and the mental and emotional health of a rural population.

Rural health challenges.

In general, rural populations in Canada experience poorer mental and emotional health outcomes, relative to population centres (Campbell, Manoff, & Caffery, 2006; Leipert et al., 2005; Romanow, 2002; Sutherns et al., 2003). Quantitative studies have found that women living in rural and northern regions of Canada rate their overall mental health lower in comparison to women living in a larger population centre (Statistics Canada 2009). Studies have also found that rural women experience increased rates of depression, chronic stress, as well as suicide, relative to women living in a larger

population centre (Campbell et al., 2006; Kubik & Moore, 2003; Leipert & Reutter, 2005; Leipert et al., 2008; Painting the Landscape of Rural Nova Scotia, 2003). Indeed, much of the literature assessing the health of rural women in Canada finds that this population experiences greater mental and/or emotional health challenges, and have lower mental and/or emotional health outcomes, relative to women living in population centres.

Geographic factors.

Many of the explanations as to why rural populations have poorer mental and/or emotional health outcomes, relative to population centres, are based on the geographic isolation of rural communities (Goins et al., 2005; Harvey, 2007; Pahlke, 2001; Winters, Cudney, Sullivan, & Thuesen, 2006). Many studies have found that difficulty accessing formal services and supports is one of the main challenges for the mental and/or emotional health of rural populations (Jackson et al., 2011; Letvak, 2002; Pahlke, 2001; Ryan, 2000; Ryan-Nicholls, 2004; Wang, 2004). Due to the small population density of rural places, rural communities, on average, have less formal services than larger population centres (Health Canada, 2003; Ryser & Halseth, 2012). In Canada, rural public sector services have been downsized, regionalized, or closed over the past 30 years to reduce national expenditures (Halseth & Ryser, 2006). This means that rural populations now have to travel further to access the services (such as schools, hospitals), and businesses (shopping centres) in order to meet their daily needs. This can be challenging and stressful for rural populations, especially when transportation to these formal services can be challenging.

Private transportation challenges and a lack of appropriate public transportation options may make formal services inaccessible for some people living in a rural setting (Health Canada, 2003; Ryser et al., 2012). Driving long distances to access services using private transportation can be challenging for rural populations due to costs, time, and difficult weather and road conditions (Johnson, 1998). The alternative, public transportation, is often unavailable, unaffordable, or inconvenient in many Canadian rural areas (Health Canada, 2003; Ryser et al., 2012). Therefore, difficulty accessing formal services is primarily caused by the challenges associated with rural transportation.

Due to the geographic isolation, and subsequent transportation challenges associated with living in a rural place, rural populations may also experience increased difficulties accessing appropriate mental and/or emotional healthcare services, relative to urban populations (Harrold & Jackson, 2011; Jackson et al., 2011; Sutherns et al., 2003; Wang, 2004; York & Horvarth, 2008). "Appropriate" healthcare services are those that are affordable, useful, and comfortable for a specific population group. York et al. (2008), identify two main barriers that rural women face when they need mental health services. First, accessing the services (i.e., transportation challenges), and second, the availability of appropriate healthcare services (York et al., 2008). For example, there may only be a male doctor in the rural community, and some women may feel uncomfortable discussing intimate health issues with the opposite sex. In this case, even if nearby services are available, women may have to travel further to access appropriate healthcare services where they are comfortable, or they may not access the needed healthcare services at all, due to transportation challenges (Ryan et al., 2000; York et al., 2008). In addition, rural populations may experience longer wait times for healthcare

services, in comparison to people living in larger population centres, which can place additional stress and financial burden on rural populations (Harrold et al., 2011; Ryan-Nicholls, 2004). Harrold et al. (2011), for example, found that the experience of waiting for specialized healthcare services was challenging to the health of rural women in Nova Scotia because they often had to make-do with "the next best thing", such as private healthcare and/or informal services (e.g., friends, family, and/or community organizations). Therefore, informal forms of social support may be especially important for rural populations due to the challenges associated with accessing formal mental and/or emotional healthcare services.

Rural culture and context.

Another explanation in the literature for the poorer mental and emotional health outcomes among rural populations centers around the rural culture. Although generalizations must be made cautiously, as every rural community has a different history, culture, and dynamic, some research has found that rural communities tend to be conservative in nature, and tend to center around traditional family and religious values (Gaston, 2001; Struthers, & Bokemeier, 2000). In such rural contexts, there may be judgement and stigma associated with varying from certain traditional norms and expectations (Gaston, 2001; Leipert et al., 2005; Raingruber, 2002; Struthers et al., 2000). This may be especially challenging for the mental and emotional health of women that do not always fit within their traditional expectations as 'rural housewife' (Little, 2003). For example, lesbians living in a rural setting may be hesitant to 'come out' as gay due to the stigma associated with varying from a traditional partnership and heterosexual lifestyle (Ryan, Brotman, & Brown, 2000). Women may also be reluctant to seek formal mental

and/or emotional health services in a rural setting if there is a stigma around mental illness and seeking mental illness services in a rural setting (York et al., 2008).

In addition, the challenges associated with varying from the 'norm' in a rural context, the associated gossip can also be especially challenging in a rural place. Gossip may be especially challenging in a rural setting, relative to a more populated setting, because of the small population size and lack of anonymity (Jackson et al., 2011; Leipert et al., 2005). This gossip can be challenging to the mental and/or emotional health of rural populations because it can challenge positive social relationships and lead to social exclusion (Jackson et al., 2011; Leipert et al., 2005; Pahlke et al., 2001).

Rural health benefits.

Similar to the literature on the health of unpartnered populations, there are also studies that have found positive mental and/or emotional health outcomes associated with living in a rural place or no difference between the mental and/or emotional health outcomes for people living in rural settings or population centers (Pampalon, Martinez, & Hamel, 2006; Romans, Cohen, & Forte, 2011; Thurston & Meadows, 2003; Wang, 2004; Ziersch, Baum, Darmawan, Kavanagh, & Bentley, 2009). For example, Wang (2004), found that major depressive episodes were less prevalent among rural Canadian populations, in comparison to population centres. Furthermore, Thurston et al. (2003), found that rural Canadian women did not feel that living in a rural place was a threat to their overall health. These studies challenge some of the assumptions about the detrimental relationship between rural place and health. The factors influencing the mental and emotional health of rural populations will be explored in the next section in

order to gain a better understanding about the factors that may positively influence the health of rural populations.

Social relationships.

Some research studies have found that rural women also experience a variety of benefits from their positive social relationships in a rural setting, which likely correlates with a positive impact on mental and/or emotional health outcomes (Jackson et al., 2011; Leipert et al., 2005; Martin & Jackson, 2008; Sutherns et al., 2004; Ziersch et al., 2009). Social relationships play a significant role in the mental and emotional health of individuals living in rural settings, just as they do for large population centres (Rolfe, 2006; Wanless et al., 2010). Social relationships are often described as one of the primary reasons women choose to live in a rural place, despite the challenges (Ames, Brosi, & Damiano-Teixeira, 2006; Letvak, 2002; Letvak, 1997; Martin et al., 2008; Rolfe, 2006). Numerous studies have found that rural populations report higher levels of community belonging and more positive interpersonal and community social relationships, in comparison to large population centres (Painting the Landscape of Rural Nova Scotia, 2003; Shields, 2008; Turcotte, 2005).

The emphasis and value of social relationships reported in rural communities relative to large population centres seems to promote the mental and/or emotional health of the rural population, and may also help rural populations to overcome the adversities associated with living in a rural setting (Cattell, 2001; Shields, 2008; Sutherns et al., 2004; Turcotte, 2005; Wainer & Chesters, 2000). An Australian study found that the benefits of positive social relationships for women in rural communities "crossed barriers of disadvantage, gender, and class, and has the capacity to increase the well-being in all

sectors of the community" (Healthy women, healthy communities, 2005, p. 3). A study by Martin and Jackson (2008), found that rural women in coastal Newfoundland and Labrador described their family and friends within the community as central to maintaining happiness and a sense of well-being, despite the challenges associated with living in a rural place. Additionally, Rolfe (2006) reported that the coping capacities of rural individuals and communities increased with higher levels of social connectedness and sense of belonging to the community. Other studies have also found that rural residents had a lower risk of depression if they have a strong social support network and variety of positive relationships in the community (Romans et al., 2011).

Despite the geographic and socio-cultural challenges associated with living in a rural place, it appears that positive social relationships can also help rural communities overcome or partially overcome these challenges. Several studies have found that rural communities often use informal social supports (i.e., interpersonal and community social relationships) as a means to promote mental and/or emotional health, and as a means to cope with mental and/or emotional health challenges (Adams et al., 2000; Koopman et al., 2001; Wanless et al., 2010; Wathen & Harris, 2007). Even though rural communities may be geographically isolated and may lack formal mental and emotional health services, it appears that interpersonal and community relationships may sometimes help to cope with the lack of services informally. Bushy (2000), and Hayes (2006), found that rural populations tend to prefer informal support (e.g., local friends, family, and community), in comparison to formal support services. Therefore, positive interpersonal and community social relationships appear to be a central aspect of rural culture, and may

help rural communities in the face of adversity by providing informal forms of support, mentally and emotionally, for rural community members.

Health of Unpartnered Women Living in a Rural Place

Research has investigated the mental and emotional health of rural women on the one hand and unpartnered women on the other, but there is relatively little research focusing on how the combination of being an unpartnered woman living in a rural setting may influence one's mental and emotional health. More specifically, there is a lack of research focusing specifically on the social relationships of unpartnered women living in a rural setting and the benefits and/or challenges of these social relationships for their mental and/or emotional health. There is a need to explore unpartnered women's social relationships in rural places in order to understand how living in a rural context may positively and/or negatively influence such relationships.

On the one hand, unpartnered women living in a rural place may experience challenges in terms of their social relationships because of cultural norms and values centered on traditional, partnered relationships in rural communities and the stigma of being unpartnered (Little, 2002; Raingruber, 2002; Struthers et al., 2000). Some people in rural communities may be judgmental and tight-knit, and gossip can spread quickly (Jackson et al., 2011; Letvak 2002). If this is the case, 'outsiders', or other minority groups, such as unpartnered older women, may be socially excluded, creating obstacles to social relationships, as well as mental and/or emotional health challenges. This is demonstrated in the quantitative study by Shields (2008), which found that unpartnered women in rural communities report lower levels of community belonging, in comparison to partnered women living in the same rural communities. Similarly, Ziersch and

colleagues (2009), found that partnership in a rural community could partially predict access to other social relationships in the community. Therefore, the stigma around being unpartnered may act as a barrier for social relationships in the lives of unpartnered women living in a rural setting, which may challenge their mental and/or emotional health.

On the other hand, the strong emphasis on social relationships and 'sense of belonging' in rural communities may have a decidedly positive influence on the social relationships in the lives of unpartnered women living in a rural place, and may help to promote the mental and emotional health for these women (Romans et al., 2011; Turner et al., 2005). That is, the social relationships and sense of community belonging associated with living in a rural place may prevent unpartnered women from being socially isolated and lonely. This may mean that unpartnered women living in a rural place may experience less loneliness, stress, and isolation, relative to unpartnered women living in a larger population centre, which may be beneficial to their mental and emotional health.

Women's roles in rural communities are also changing, as formal employment opportunities for women are increasing (McLeod & Hovorka, 2008; Midgley, 2005). This may mean that the norms around partnership for women may also be changing in rural communities, as more women move away from traditional rural homesteading lifestyles and move into the formal workplace. Changes in gender expectations in rural communities may also decrease stigma among unpartnered women, which may be beneficial for their mental and emotional health.

It is important to note that rural women and unpartnered women are not homogenous groups, and each individual within these groups has different experiences and outcomes in terms of their social relationships and mental and/or emotional health outcomes (Sutherns et al., 2003; Wainer et al., 2000). Unpartnered women living in a rural setting may be unpartnered for a variety of reasons. For example, lesbian women living in rural communities are likely to face increased discrimination, oppression, and non-acceptance due to their sexual orientation (if known), and may opt to remain unpartnered due to the stigma associated with being a lesbian (Ryan, Brotman, & Brown, 2000). This will impact the social relationships of lesbians living in a rural setting, and may contribute to the poorer mental and/or emotional health outcomes found among unpartnered women, relative to partnered women. There is currently a lack of research on lesbians living in rural Canada, but it is important not to assume that all unpartnered women living in a rural setting are heterosexual. Another factor that may play a large role in the mental and/or emotional health of unpartnered women is whether the women are unpartnered because they have chosen that partnership status or because they are unable to find a partner. Furthermore, the positive social relationships and sense of belonging in a rural community may vary for the women depending on how long they have lived in their rural community and the size and availability of relationships in their rural area. Therefore, it is important to explore these complexities among certain population groups in order to gain a better understanding of various individual and contextual factors that may benefit and/or challenge the mental and emotional health of this population.

It is important to also state that the social relationships experienced by each unpartnered woman will be unique, and generalizations about all unpartnered women cannot be made in terms of a single positive and/or negative social experience. Notably, various types of unpartnered women (i.e. never-married, divorced, separated, and widowed) will likely have different experiences in terms of their social relationships and mental and emotional health outcomes (Cooney et al., 2001; Walderon et al., 1997). For example, some research has found that, in general, divorced and widowed women experience poorer mental and/or emotional health outcomes, relative to women that have never married, and this may be due to differences in their positive social relationships (Arber, 2004; Cheung, 2000; Liu & Umberson, 2008; Rosenberg & Wilson, 2000; Turner et al., 2005).

Furthermore, the context and social norms and expectations around being unpartnered are constantly changing as marriage trends and traditional attitudes about the importance of marriage develop and change over time (Cooney et al., 2001; Liu et al., 2008; Thornton, 1989). The experience and social relationships of unpartnered women change over time and are likely to vary based on a number of contextual factors. Therefore, in-depth, qualitative research is needed in order to explore the range of social relationships and experiences for unpartnered women, and how the rural context influences the social relationships, and mental and emotional health of this population.

The social relationships rural women have within their rural community may vary from being socially involved to being very socially isolated. Changes to promote social relationships among rural, unpartnered women may be a method for improving the adverse mental and emotional health issues commonly found among this population.

Most of the current research literature involving partnership status and health is quantitative in nature. A limitation of many of these quantitative studies is that they often fix people into distinct categories (i.e., socially isolated/socially embedded), and do not always consider the complexity and context of these categories (Reed, 2004). Therefore, what is needed is in-depth qualitative research that can consider gender, location, and social relationships, as they relate to an individual's mental and emotional health (Reed, 2004; Rosenburg et al., 2000). Furthermore, qualitative research, which includes the voices and perspectives of the women themselves, is needed in order to develop an accurate picture of the social relationships in their lives and the challenges and/or benefits associated with their social relationships (Midgley, 2005; Petrucka & Smith, 2008; Pini, 2002). This will also help to ensure that the policy and practice changes, if any, suggested by the qualitative studies are practical and appropriate for the specific population within a specific context (Griffiths, Horsfall, Moore, Lane, Kroon, & Langdon, 2006).

Summary

According to some research studies, unpartnered women are more likely than partnered women to suffer from psychological distress, depression, and other mental and/or emotional health issues (Akhtar-Danesh et al., 2007; Caron, 2010; Lieberman et al., 2010; Lorenz et al., 2006; Prigerson et al., 1999; Simon, 2002; Simon et al., 1999; Willits et al., 2004). It is suggested that this is due, in part, to higher rates of isolation, loneliness, and stigmatization among this population (Akhtar-Danesh et al., 2007; Caron, 2010; Rohrer et al., 2000). However, other research has found that unpartnered women are *not* isolated and/or lonely, and that they do not suffer significantly more than

partnered women from depression and other related mental and/or emotional health issues (Arber, 2004; Artazcoz et al., 2011; Cooney et al., 2010). These contradictory findings suggest that unpartnered women's social relationships may vary across place, and further research is needed to understand women's key social relationships in different places, notably rural places.

In general rural populations in Canada experience poorer mental and/or emotional health outcomes, relative to population centres (Health Canada, 2003; Romanow, 2002; Ryan-Nicholls, 2004; Sutherns et al., 2004). The literature suggests that this may be due, in part, to the geographic isolation and subsequent lack of services, as well as the rural culture (Clark et al., 2007; Goins, 2005; Pahlke, 2001; Winters et al., 2006). However, similar to the literature looking at the health of unpartnered populations, there are also contradictory studies that have found positive health outcomes associated with living in a rural place (Thurston et al., 2003; Wang, 2004). The literature suggests that these positive health outcomes may be caused, in part, by the strong value and emphasis on positive interpersonal and community relationships in rural settings (Rolfe, 2006; Shields, 2008; Wanless et al., 2010; Wainer et al., 2000).

While research has investigated the mental and/or emotional health of rural women on the one hand and unpartnered women on the other, there is relatively little research focusing specifically on the social relationships of unpartnered women living in a rural setting and the benefits and/or challenges of these social relationships for their mental and/or emotional health. Unpartnered, older women living in rural areas have been largely absent from health research, practices, programs, and policies, and their specific challenges need to first be identified and then addressed. A better understanding

of the key social relationships in the lives of unpartnered, older women living alone in rural Cape Breton will lead to a better understanding of how social relationships, or lack thereof, may benefit and/or challenge the mental and emotional health of this population within a specific place.

Many of the beneficial aspects of living in a rural place and of being unpartnered are related to having a variety of positive interpersonal and community social relationships (Jackson et al., 2011; Leipert, 2005; Rolfe et al., 2006; Wanless et al., 2010). Therefore, promoting positive social relationships among unpartnered women living in a rural place may present a key opportunity for improving the mental and emotional health of this population (Mechanic & Tanner, 2007; Mikkonen et al., 2010). As increasing numbers of older women spend a greater proportion of their adult life living alone and being unpartnered, actively developing and fostering positive social relationships among this population may be a sustainable option for mental and emotional health promotion in rural communities, where there is currently a lack of appropriate formal mental and/or emotional health services (York et al., 2008).

Qualitative approaches to understanding the social relationships and mental and emotional health of unpartnered women are needed in order to develop appropriate practices and policies for this population (Reed, 2004; Rosenberg et al., 2000). Qualitative approaches emphasize the lived experience and context of the study participants, which is useful for developing practical and appropriate solutions to health challenges that will work for a specific population within a specific context (Petrucka et al., 2008; Reed, 2004). Such qualitative research studies would add to the current body of literature because they could provide important information about the lived experience

for unpartnered women, and how certain contextual factors may influence their social relationships, as well as their mental and emotional health. The methodology and qualitative methods guiding this study of older, unpartnered women living alone in rural Cape Breton will be described in detail in the following chapter.

Chapter Three: Methodology and Study Design

The purpose of this research study was to explore the social relationships in the lives of older, unpartnered women living in rural Cape Breton. This chapter describes the methodology, as well as the methods used for this qualitative research study. The paradigmatic stance and strategy of inquiry are first outlined. Then, the ethical considerations are described, followed by an outline of the study population, recruitment methods, and data collection, analysis, and management techniques. Finally, the criteria for quality and rigor in qualitative research, as well as the limitations of the study, are discussed.

Paradigmatic Stance: Social Constructivism

A paradigm, or worldview, can be defined as the basic and core beliefs about the world that influence and guide action (Guba, 1990). That is, one's paradigmatic stance defines "the nature of the world, the individual's place in it, and the range of possible relationships to that world" (Denzin & Lincoln, 1994, p. 107). Therefore, it is essential to understand the paradigm(s) shaping a research study in order to understand the research questions, and how these questions will be answered and interpreted by the researcher.

This study was guided by a social constructivist paradigm. A social constructivist approach seeks to understand lived experiences or phenomenon, as perceived and described by those living the experience (Creswell, 2007; Guba & Lincoln, 1994). Under this paradigmatic stance, research questions are answered and explained based on the perceptions and realities of those who are living the particular experience (Creswell, 2007; Guba et al., 1994). For this research study, the approach to understanding the social relationships in the lives of rural, unpartnered women centers around

understanding the women's perceptions, experiences, and realities around this lived experience.

A key tenet of social constructivism is that reality is perceived subjectively and each individual develops his or her own subjective meaning around an experience (Creswell, 2007; Guba et al., 1994; Weaver & Olson, 2005). Social constructivists believe that there are multiple and varied truths (as opposed to one, universal truth), which are constructed by individuals based on their personal, cultural, and historical experiences (Guba et al., 1994; Weaver et al., 2005). In other words, the meaning an individual attaches to a lived experience will vary based on the individual and community context, and these varied experiences result in multiple truths around a lived experience. The value of this paradigm is that it acknowledges that there are *multiple truths*, which are important because it allows a research study to explore the complexity of a lived experience or phenomena, and to consider how contextual factors can shape the experience and reality for each individual. This fits with the goal of this research study, which was to gain a deeper understanding of the multiple and diverse experiences in terms of the social relationships in the lives of unpartnered women living in a rural setting. In addition, contextual factors, notably rural place, was considered in order to gain a better understanding of the lived experience for rural, unpartnered women.

Another key tenet of social constructivism is that the findings of a research study are influenced by both the researcher as well as the study participants (Guba et al., 1994; Weaver et al., 2005). The researcher brings his or her personal, cultural, and historical experiences and values to the research study, which shapes the development of the research questions and how the experiences of participants are interpreted. Participants

also bring their personal, historical, and cultural experiences and values to the research study, which shapes how they will answer semi-structured questions related to a lived experience. Social constructivist researchers recognize that they are positioned within their research study, and will play a role in how the study develops as well as the research findings (Guba et al., 1994; Weaver et al., 2005). This researcher involvement should be clearly acknowledged before and throughout the research study.

Position of the Researcher

I am a younger female (age 24) in the process of completing my M.A. degree in Health Promotion. I have a Bachelors of Health Science degree in Biomedical Science, and my previous research experience has included evaluating malaria diagnostic tools, using primarily quantitative techniques. I am relatively new to Atlantic Canada, and have no history or connection to the rural Cape Breton area where the research was conducted. I grew up in a single-mother household, and have also lived in various rural locations growing up, including the Northwest Territories, Vancouver Island, and California. These personal experiences have influenced why this research topic was studied. My personal experiences have also shaped my sensitivity as a researcher, and have played a role throughout the data collection, analysis, and dissemination processes. More specifically, my personal experience growing up in a rural, unpartnered parent home gave me a strong and positive personal connection with an unpartnered woman while growing up. My previous experiences have been largely positive, and I was often oblivious to the challenges facing rural, unpartnered women. These assumptions were challenged by much of the research literature, which indicates that rural women and unpartnered women

face many challenges, and this motivated me to gain a deeper understanding of this population.

Qualitative Method of Inquiry

Qualitative research is a method of inquiry that focuses on the socially constructed nature of reality (Denzin & Lincoln, 2005). Qualitative research "studies things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Denzin et al., 2005, p. 3). A qualitative approach is useful for exploring and explaining human behaviour in context. In order to *explore and develop a deeper understanding* of the social relationships in the lives of rural, unpartnered women, this study used a qualitative strategy of inquiry. There are various ways of doing qualitative research, and grounded theory is one approach to doing qualitative research.

Principles and elements of grounded theory.

This research study was informed by elements and principles of grounded theory. Grounded theory methodology can be defined as "a way of thinking about and conceptualizing data" (Strauss et al., 1994, p. 275). The key concepts of grounded theory, as well as the systematic guidelines for conducting grounded theory research were used to guide this study.

A defining principle of grounded theory methodology is that the explanations about a phenomena or lived experience must be developed from research that is *grounded* in the data (Corbin et al., 2008; Glaser & Strauss, 1967; Strauss et al., 1994). In other words, one begins with an area of study, and allows the relevant ideas and experiences to emerge based on the data collected and analyzed. Such a 'grounded' approach is

essential in order to ensure that the themes "fit" within the data, and that the explanations make sense within a certain context (Charmaz, 2006; Corbin et al., 2008). This approach, characteristic to a grounded theory methodology, is suitable for an exploratory research study, where relatively little information is available on the topic beforehand.

There are various levels of analysis when conducting grounded theory research, ranging from superficial description to conceptual ordering to theoretical interpretation (Corbin et al., 2008). These types of analyses are not distinct categories, but instead represent a continuum of levels that can mesh together. The purpose of this research study was not to develop a theory due to the limited data collected. Instead, the data analysis for this study was completed with the goal of *describing and interpreting* the lived experience of the participants. Interpretive description involves "well constructed themes/categories, development of context, and explanations of process or change over time" (Corbin et al., 2008, p. 51). This level of analysis is useful because it generates new knowledge and develops a deeper understanding of a lived experience, on a level that goes beyond general knowledge. An in-depth description of the methods of analysis used for this study will be presented later in this chapter.

Methods

Ethical considerations.

Prior to beginning this study, ethical approval was obtained from the Dalhousie University Health Sciences Research Ethics Board (See Appendix A for Ethical Approval Letter). As with all research involving human subjects, it is essential to identify any potential risks for participants and to make efforts to minimize these risks. It was recognized that given the small nature of this study, including the small, close-knit nature

of rural communities in Cape Breton, it was possible that information may be linked to an individual and that was a risk of this study. All participants were told that their confidentiality could not be guaranteed; however, several steps were taken to mitigate this risk for participants. Participants were provided with the option of choosing among several locations to complete the face-to-face interview. Personal identifying details, organizational names, and specific community names were not transcribed.

Another potential risk for participants was that they may have felt uncomfortable talking about their experiences living as an unpartnered, older woman, due to the possible stigma associated with being unpartnered. Recognizing this, participants were asked to only discuss information that they were comfortable speaking about to reduce risks. Participants were also given the option to not answer or to skip any of the questions in the interviews, and could withdraw from participating in the research study throughout the data collection process. After participating in an interview, participants had up to one week to contact the researcher if they wanted all of their data removed from the study. Participants were also given the option to participate or not participate in the follow-up telephone interview. None of the participants skipped questions, ended the interview early, or asked for their information to be withdrawn from the study.

Informed consent.

In order to reduce the risks of participating in this study, informed consent was obtained from each participant. This was done by verbally reviewing the consent form with each participant prior to beginning each interview. Written consent (first name only) for the face-to-face interviews, and verbal consent for the telephone interviews were obtained (consent forms can be found in Appendices B, C, and D). Written consent

was obtained when the researcher had face-to-face contact with participants, in order to have hard-copy proof of participant consent. Verbal consent was obtained for the follow-up telephone interviews in order to obtain consent without having to send any confidential information in the mail, and to reduce the risk of losing this information. Consent was also specifically obtained to digitally record and pull quotations from the face-to-face interviews. All participants gave consent to digitally record and to pull quotations from their face-to-face interviews.

Study population.

To take part in this study, participants had to be women, ages 50-65, unpartnered, and living in rural Cape Breton. This age range was selected because it is an increasing population group in rural Nova Scotia. Additionally, there is also very little research that looks specifically at the social relationships for unpartnered women within this age category. Unpartnered included women that were never-married, as well as women that were divorced, separated, or widowed and not in a partnered relationship (as defined by the participants). All participants were unpartnered for the previous five years preceding the interview, meaning that over the previous five years they had not been married, cohabiting, or in a partnered relationship (as defined by the participants). A minimum of five years unpartnered was selected for this study in order to ensure all participants had the 'lived experience' of being unpartnered at an older age.

This research study was completed in the Nova Scotia CBDHA (District Health Authority #8), along the North-Eastern coast of Nova Scotia, Canada. This region was chosen because it is a very isolated and rural area (outside of the CBRM), with several small population centres. For this study, rural Cape Breton included any area outside of

the CBRM. All participants had lived in rural Cape Breton for at least the past year preceding the interview. A time period of one year was selected in order to ensure that all participants had some time to develop and/or maintain social relationships within their rural community.

Participants living with others or supporting dependents were excluded from this study in order to explore the social relationships for unpartnered women living alone. Finally, all participants had to be able to understand and speak English in order to participate in the study. Participants of any sexual orientation were eligible to participate in this study.

Data collection strategies.

Participants were recruited and data were collected for this research project in three parts. First, a pilot interview was completed in order to test the interview guide. The second part of the research consisted of face-to-face qualitative interviews. The last part of the data collection process consisted of an optional follow-up telephone interview with the participants that had completed the face-to-face interview. The data collection methods and data analysis techniques used are described in the following sections.

Pilot interview.

A pilot interview was first conducted to ensure that the interview guide captured the intent of the research objectives and that all of the questions were appropriately worded with relevant probes. The pilot interview was completed with one unpartnered woman, ages 50-65, that was living in rural Nova Scotia at the time of the interview. This participant was recruited by word of mouth. The pilot interview was conducted in a private room that ensured confidentiality in a public facility. Informed consent was

obtained prior to the pilot interview through written consent (See Appendix B for Pilot Interview Consent Form). The pilot interview was not digitally recorded, and data from this interview were not used in any of the results. All data from the pilot interview were destroyed one week after the interview was completed.

Face-to-face interviews.

The second part of this study consisted of nine qualitative, face-to-face interviews designed to explore and develop an interpretive description of the social relationship in the lives of the participants. The purpose of the face-to-face interviews was to explore the research objectives in a conversational and open manner with women that fit within the inclusion/exclusion criteria.

Recruitment.

Participants were recruited using multiple techniques. Participants were recruited using recruitment posters with a brief summary of the research study, inclusion/exclusion criteria, and researcher contact information (The recruitment poster can be seen in Appendix E). These posters were placed in rural community spaces throughout the Northern part of Cape Breton, such as shopping centres, libraries, churches, post-offices, gas stations, and community centres.

Participants were also recruited by the researcher using word of mouth. Directors of various community agencies were asked to identify potential participants and distribute smaller versions of the recruitment poster to women that may be eligible and interested in participating. The researcher also provided brief presentations about the research study at various local events or organizations, such as bake sales or craft fairs. At these presentations, smaller versions of the recruitment poster were distributed to any

women that were interested in participating, or knew another woman that may be interested in participating.

Snowball sampling techniques were also used to recruit study participants. Initial participants in the study were asked to tell other eligible women about the study. These participants were also given smaller versions of the recruitment poster to distribute to any women they felt may be eligible and interested in participating in the study.

The majority of the participants were recruited for this study by talking to directors of community organizations and doing presentations at community events. After receiving a call or email from a potential research participant, the researcher checked that the participant fit within the inclusion/exclusion criteria, using the screening script (Appendix D). If the participant fit within these requirements, a convenient date, time, and location was scheduled to do the face-to-face interview.

Data collection.

The consent form for the face-to-face interview was thoroughly reviewed with each participant prior to beginning the interview. This was done by verbally reviewing each section of the consent form and allowing the participant to ask any questions before providing consent. Written consent (first name only) was obtained before conducting each interview. For the face-to-face interview, consent was also specifically obtained to digitally record and to use direct quotations from the interview. All participants received a $20.00 honorarium for participating in the face-to-face interviews to compensate them for their time and travel costs. This honorarium was given to the participants prior to beginning the face-to-face interview.

Face-to-face interviews were conducted using a semi-structured interview guide (The interview guide for the face-to-face interviews can be found in Appendix G). The interview guide was developed based on an in-depth review of the literature and the pilot interview, and was completed in collaboration with the research supervisor and thesis committee. The definition of mental and emotional health, as described in the literature review, was clearly defined for all participants prior to beginning the face-to-face interview in order to ensure all participants used these terms consistently. All of the face-to-face interviews were completed in private spaces that ensured participant confidentiality within public facilities, such as community centres, fire halls, libraries, and workspaces. The interviews ranged from thirty minutes to an hour and thirty minutes in length, depending on the length of participant answers to the open-ended questions.

All participants provided consent to be audio recorded and all interviews were recorded using a digital recorder. All participants also completed a demographic questionnaire (Appendix H) in order to collect general information about the participants' education, occupation, income, rural background, and relationship status and background. Following the face-to-face interview, an information sheet containing phone numbers for local and provincial mental health services was made available to participants in order to provide professional health resources in case any mental, emotional, or psychological issues came up during or after the interview. (A copy of this handout can be found in Appendix I).

Follow-up telephone interviews.

Following the face-to-face interview and preliminary data analysis, five follow-up telephone interviews were completed with some of the participants that took part in the

face-to-face interview. The purpose of the follow-up interview was to receive feedback about the emerging themes from preliminary data analysis of all of the face-to-face interviews, and to further discuss potential policy and/or program changes that might be needed, if any, to address challenges to social relationships for older unpartnered women living in a rural setting.

At the end of the consent form for the face-to-face interviews, participants were asked if they would like to be contacted to participate in a follow-up telephone interview. They were told the purpose of the follow-up interview and that participation in this interview was optional. If the participant indicated that they would like to take part in the follow-up telephone interview, they were given a hard copy of the consent form for the follow-up interview. The participants were asked to provide a contact telephone number and preferred calling time for the follow-up telephone interview.

Prior to beginning the follow-up telephone interview, the researcher verbally reviewed the consent form over the phone, and obtained verbal consent from each participant. The interview guide for the follow-up telephone interview was developed following preliminary analysis of the face-to-face interviews (Appendix J). The follow-up telephone interviews lasted approximately 20-30 minutes and were recorded using written notes only.

Fieldnotes.

Fieldnotes were also written throughout the research process. The purpose of these fieldnotes was to record any observations throughout the data collection process, such as the mood of the participant or the general atmosphere of the interview (Corbin et

al., 2008). These fieldnotes were useful to supplement the face-to-face interviews in order to have a written record of the context for each interview.

Data analysis.

All data collected from the face-to-face interviews were transcribed verbatim by the researcher. All data collected from the follow-up telephone interviews were recorded by the researcher using written notes. A qualitative data software program (Atlas.ti) was used to assist in the storage and management of the data from the face-to-face interviews and the follow-up telephone interviews. Following transcription of the data, transcripts were first read and re-read multiple times in order to get comfortable with the data and to develop an overall idea of the main story and content of each interview. This step is essential in order to ensure the researcher has a clear and foundational understanding of all of the data before the coding process begins (Corbin et al., 2008).

Coding and memoing.

Following the reading and re-reading of the data, coding and memoing began. Coding is the process of "attaching labels to segments of data that depict what each segment is about" (Charmaz, 2006, p.3). The purpose of coding is to separate, sort, and synthesize the data into meaningful and reoccurring ideas (Charmaz, 2006; Corbin et al., 2008). The initial/open coding and focused/axial coding techniques used for this study are described below.

Open/initial coding is the process of "taking data and segmenting them into categories of information" (Creswell, 2007). During this process, recurring ideas and categories of information were labeled in the transcripts, with descriptive codes. For example, some initial codes included "safety", "sense of belonging", "transportation",

and “loneliness”. These labels/codes were initially quite large in number, and were reorganized and regrouped in order to reduce the number of codes into similar categories and ideas. Throughout the open coding process, a handwritten ‘conceptual map’ of the codes, and how they relate to one another, was developed and modified in order to lead into the axial coding process.

Following the open coding of the data, focused/axial coding techniques were used to pull out significant statements and group them into meaningful units, or themes, for interpretation (Corbin et al., 2008; Creswell, 2007). That is, the descriptive codes developed from the initial/open coding process were restructured and reorganized in order to group related ideas into higher-level concepts. For example, some focused codes included “benefits/challenges mental and/or emotional health”, “rural benefits/challenges”, and “unpartnered benefits/challenges”. Throughout the focused/axial coding process, constant comparison methods were used in order to compare, contrast, and relate themes (Corbin et al., 2008). Using these methods, codes were analyzed for their similarities and differences in order to ensure that the emerging themes fit all of the data. Finally, the key themes were generated to describe something significant about the data in relation to the research questions that represents a similar or shared experience among all of the participants.

In addition to coding the data, grounded theory also emphasizes the importance of using memos, or “preliminary analytic notes” about the codes as they are developed and modified in the data analysis process (Charmaz, 2006; Corbin et al., 2008). Memos were used throughout the coding process in order to track the initial concepts and changes over time. These memos are also important because they served as an audit trail to explain

how and why various codes were established and modified throughout the data analysis process.

Data management.

All computer files (audio files, transcripts, coded data, and aggregate demographic information) were stored on two password-protected, encrypted flash drives, which were stored in a locked desk in the graduate student office throughout the data analysis period. Hard copies of interview consent forms, demographic information forms, and fieldnotes were also stored in this locked cabinet during the data analysis phase. All audio files were deleted following the transcription of the data. After the data were analyzed, all paper and computer files related to this research study were stored in a locked filing cabinet in the office of the research supervisor. The computer files were also backed up on a password-protected, encrypted external hard drive for storage. Data will be securely maintained for five years post-publication, consistent with the Dalhousie University Policy on Scholarly Integrity. At the end of the five years, all digital files, transcripts, coded data, and consent forms will be deleted and/or destroyed.

Dissemination of results.

The results of this study will be available for the academic population, the research participants, and the rural Cape Breton communities involved in the study. The final thesis results will be presented in a thesis defense presentation, as well as a written thesis, which will be available at the School of Health and Human Performance at Dalhousie University and online on the Dalhousie library website. The research findings have also been presented and discussed at a rural health conference in Sydney, Nova Scotia and at an interdisciplinary health conference in Halifax, Nova Scotia. A short one-

to two-page executive summary of the study results will also be mailed to the rural community centres that were involved in the recruitment and/or research process.

Quality and Rigor

The four criteria for quality and rigor in qualitative research, as established by Lincoln and Guba, (1985), include credibility, transferability, dependability, and confirmability. Each criterion was identified within this research context, and the methods used for obtaining each criterion are discussed.

First, credibility refers to the actual truth of the findings (Lincoln et al., 1985), and ensures that the experience and realities of the participants are accurately reflected in the final research findings. There are a variety of methods to ensure the credibility of a qualitative research study, including member checking, triangulation, prolonged engagement in the field, peer-review, and reflecting on researcher bias. In this study, *member checking* was completed by collecting data multiple times from the participants. For example, the questions asked in the follow-up telephone interview were informed by the data collected and analyzed from the first face-to-face interview. This gave participants a chance to reflect on the preliminary finding of the face-to-face interviews, in order to provide feedback about the initial ideas and emerging themes. Multiple data sources were used to inform this research study in order to *triangulate* the data. This included an in-depth review of the existing literature, a face-to-face interview with each participant, and a follow-up telephone interview with some of the participants. The researcher lived in rural Cape Breton while recruiting participants and completing the face-to-face interviews (approximately one month) to ensure *prolonged engagement* in the field. *Peer debriefing* was also completed through intensive and critical discussion of

the research process with multiple experts in the field, notably the supervisor and the thesis committee. These debriefings and discussions were completed weekly with the research supervisor and bi-annually with the thesis committee. Finally, the *researcher's biases and motivations* were directly recognized at the beginning of and throughout the research process in order to acknowledge how they played a role throughout the research process.

The second criteria, transferability, ensures that the results of the study are applicable to other research contexts and useful in a practical settings (Lincoln et al., 1985). The primary method used for establishing transferability in this study was through a *thick description* of the data. This means that a clear and detailed account of the relational, social, and cultural influences throughout the research process were accounted for, as opposed to making generalizations about the findings. This was done by taking in-depth *fieldnotes* throughout the data collection process, and by keeping memos throughout the data analysis process. This helps to ensure that other researchers can identify the similarities and differences between research projects, and potentially transfer methods or results to other project. A thick description of the data has also been established by using *direct quotations* from the interviews in the final dissemination, to accurately describe and communicate the lived experiences of the participants.

The final two methods of ensuring quality and rigor in a qualitative research study are dependability and confirmability. The dependability of the research is the extent to which the research process and findings can be repeated in similar social contexts (Lincoln et al., 1985). Confirmability determines the extent to which the final findings are the representation of the research participants (Lincoln et al., 1985). This means that

the researcher did not drastically alter the findings based on her or her biases, motivations or interests. An *audit trail* will be kept (via fieldnotes and memos) in order to ensure the research process is logical and can be repeated by external sources. This audit trail has been critically reviewed by the research supervisor to examine the process and ensure the participant's experience is accurately represented in the final results. In addition, *reflexivity* was continually applied throughout the research process. That is, the researcher was conscious of her biases, values, motivations, and experiences, and how these play a role in the qualitative research study (Creswell, 2007). This was done by keeping a detailed account of the research process in a reflective journal kept by the researcher. The purpose of the reflective journal is not to separate the position of the researcher from the research study, but rather to recognize any researcher biases, values, and motivations, and how they will inevitably shape the research study.

Limitations

The face-to-face interviews were completed in November/December, as the fall tourist season was ending and the winter season was quickly approaching. The key social relationships described by participants, therefore, may have been biased towards interpersonal and community relationships that are available in the winter season, and may have overlooked relationships that are only available during the warmer, summer months. If the interviews were conducted in the spring, summer, or fall, when more facilities and businesses are open for the tourist season, the types of social relationships described by the participants may have varied.

A key recruitment technique for this study involved talking about the research study at rural community organizations and through snowball sampling/word-or-mouth.

Thus, there was a recruitment bias towards women that were already involved in the community and had a variety of relationships within the rural area. Unpartnered women that are socially isolated may not have been as well-represented as the women with a variety of relationships, and these isolated women may have a different experience in terms of their social relationships and benefits and/or challenges to their mental and emotional health.

Finally, the interview guide for this study asked participants about the interpersonal and community relationships that they thought were "key" in their lives. This may have biased responses towards positive social relationships, as people tend to disengage from their negative social relationships, and generally do not classify negative relationships as "key" in their lives. Thus, participant responses may have varied if the interview guide also included questions specifically about negative social relationships.

Chapter Four: Results

Introduction

This chapter presents the results from nine face-to-face interviews and five follow-up telephone interviews that were completed with unpartnered women, ages 50-65 living in rural Cape Breton. The context of the research location, rural Cape Breton is first described. The socio-demographic background of the participants, as well as their rural background and relationship background and status are then presented. The types and characteristics of the key social relationships in the lives of the participants are also described. Three key themes related to these social relationships, and how the participants perceive them as benefiting and/or challenging their mental and/or emotional health, are explained. This includes the changes suggested by participants to reduce obstacles and promote positive social relationships and their mental and emotional health.

Quotations from the interviews are used throughout this section to demonstrate some of the key points illustrated by the participants. All quotations are identified by interview number in order to protect the confidentiality of the participants. It is important to note that participants did not all have the same experience in terms of their social relationships; what was beneficial to the mental and/or emotional health of one participant was sometimes challenging to the mental and/or emotional health of another participant. These differences will be described throughout this section.

Research Context: Rural Cape Breton

This research study was conducted in Northern Cape Breton, Nova Scotia, in five rural communities situated along the Cabot Trail Highway, as shown in Figure 1. The populations of these communities ranged from approximately 250 to 1,000 people. All

communities had basic services, such as a general store and a post office, and only some of the communities had additional services, such as health centres, libraries, gas stations, and/or community centres.

The rural communities were fairly isolated, ranging from 100-200km away from the nearest medium population centre (CBRM), and 400-500 km away from the nearest large population centre (Halifax). The rural communities were only accessible by personal vehicle, as public transportation options (e.g., bus, train) were not available at the time of the interviews. These distances can be especially difficult to travel by personal vehicle in the winter, due to poor weather and road conditions, making the rural communities even more isolated from population centres during these times.

Figure 1. Map of Cape Breton Island

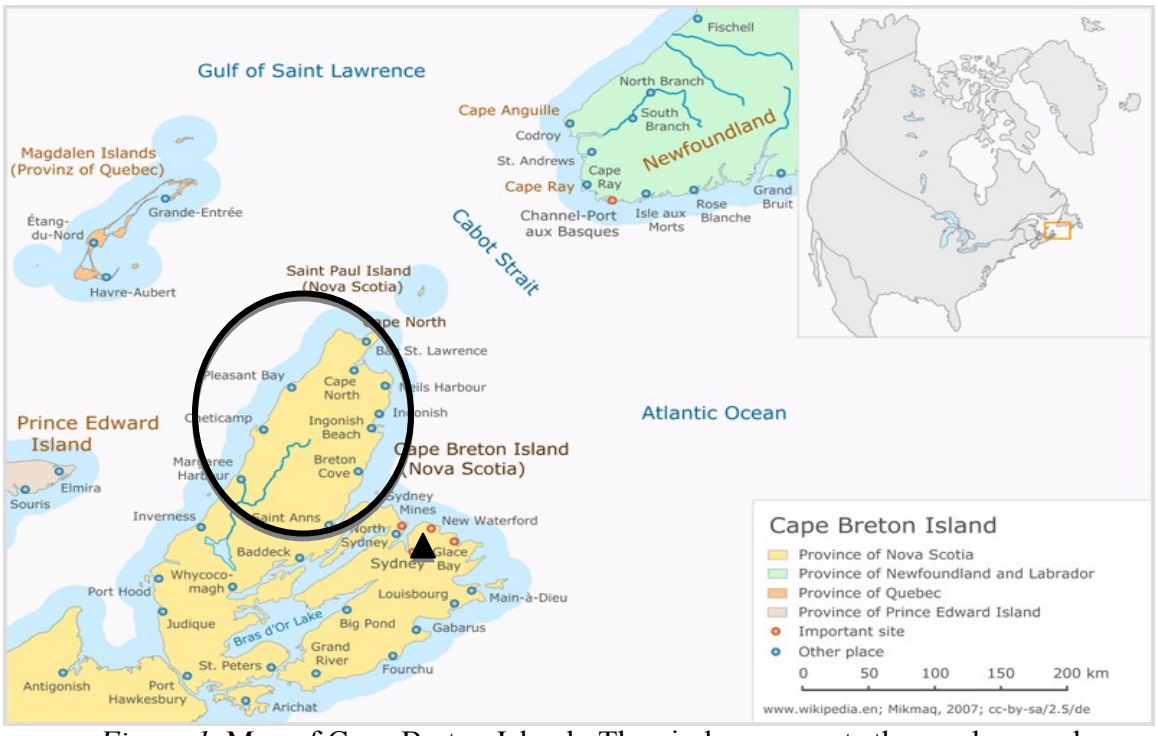

Figure 1. Map of Cape Breton Island. The circle represents the rural area where interviews were conducted; the triangle represents the nearest medium population centre (CBRM). Adapted from Cape Breton Island. (n.d.). In *Wikipedia.* Retrieved August 28, 2013 from http://en.wikipedia.org/wiki/Cape_Breton_Island

Socio-Demographic Background of Participants

A summary of the socio-demographic background of participants in terms of their age, highest level of educational attainment, current occupation, and income can be found in Table 1. This information will also be described and compared to the general population in the following section.

Age, education, occupation, and income.

Participants ranged in age from 52 to 63 years, with an average age of 58.8 years. All of the participants had at least completed high school. Five participants had some or all of a community college and/or undergraduate degree. Two participants had completed some or all of a postgraduate university degree. This indicates that the participants were an educated group of women, relative to the average education levels among adults in this rural Cape Breton area, where 35.5% of the total population and 37.8% of the female population (15 years and older) has not completed high school (Nova Scotia Community Counts, 2011).

In terms of employment, six participants were employed full-time and three participants were retired at the time of the interviews. Of the six employed participants, the majority of the women were working in the service sector, notably in the health sector. Four participants earned less than $29,999 annually, four participants earned between $30,000 and $59,999 annually, and one participant earned between $60,000 and $89,999 annually. In 2011, the average individual income among adults in this rural Cape Breton area was $25,713, with men earning an average of $30,575 annually, and women earning an average of $20,866 annually (Nova Scotia Community Counts, 2011).

Many participants, therefore, had higher income levels than the average income in this rural area of Cape Breton.

Table 1: Socio-Demographic Information of Participants (n=9)

Age	
50-55 years	2
56-60 years	4
61-65 years	3
	[Average = 58.8 years]
Highest Level of Educational Attainment	
Completed High School	1
Completed Community College	3
Some or Completed Undergraduate University	3
Some or Completed Postgraduate University	2
Current Occupation	
Services Sector	5
Retired	3
Self-Employed	1
Annual Income	
Under $29,999	4
$30,000 - $59,999	4
$60,000 - $89,999	1

Rural background of participants.

The participants had lived in rural Cape Breton from two to 59 years. On average, participants had resided in a rural Cape Breton community for 31.1 years preceding the interview. Five participants were born and raised in rural Cape Breton, and four participants had moved to rural Cape Breton from another location. The participants that had moved to their rural Cape Breton communities commonly referred to themselves as "*come from aways*" (CFAs), regardless of how much time they had been living in rural Cape Breton. A summary of the rural background of participants can be found in Table 2.

Relationship status and background of participants.

At the time of the interview, four participants had never been married, three participants were divorced, one participant was separated, and one participant was widowed. Some of the participants indicated that they were unpartnered by choice, while others indicated that they were open to being in a partnered relationship or actively looking for a partner. The average length of time that the participants had spent continuously unpartnered preceding the interview was 18.6 years. The majority of the participants had been unpartnered for 20 years or less. In rural Cape Breton, similar to the rest of Nova Scotia and Canada, the majority of the population over the age of 35 is in a partnered relationship. Therefore, being unpartnered was not the norm among women ages 50-65 in their rural communities.

All of the participants were living alone in their own rural households. This is also uncommon in the rural Cape Breton area, where only 12.4% of the population lives alone (Nova Scotia Community Counts, 2011). A summary of the relationship status and background of participants can be found in Table 2.

Table 2: Rural and Relationship Background of Participants (n=9)

Time in Rural Community	
1-20 years	3
21-40 years	3
41 + years	3
	[Average = 31.1 years]
Relationship Status	
Never-married	4
Divorced	3
Separated	1
Widowed	1
Time Unpartnered	
5-10 years	4
11-20 years	3
20 + years	2
	[Average = 18.6 years]

Types and Characteristics of Key Social Relationships

All participants indicated that they had a variety of key interpersonal relationships. Key interpersonal relationships consisted of close friends and/or family members. Family relationships included those with children (sons and daughters), mothers, siblings (brothers and sisters), and cousins. Interpersonal relationships with friends included neighbours, coworkers, community members, as well as people outside of the community.

Participants also had relationships with a variety of different community groups or organizations or work groups. Key community relationships consisted primarily of religious organizations, shared interest groups, and work groups. Some participants also described their neighbourhood or rural community as a whole as a key 'community' relationship. For example, one participant described a key community relationship as the people living in several houses around her house; "*So they're [neighbourhood] my community as well, albeit as tiny as that seems*" (A1). Lastly, although they were not described by participants as social relationships, pets (cats and dogs) were mentioned by some participants as important companions in their lives.

Participants ranged in the number of interpersonal and community relationships they described as key in their lives. All participants described multiple interpersonal relationships as key in their lives, ranging from three to seven key interpersonal relationships. In contrast, one participant indicated that she did not have any key community relationships, while others described as many as five community relationships that were key in their lives. Participants also ranged in the amount of time they preferred to spend alone versus the amount of time they preferred to spend with their

social relationships. Some participants chose to be very involved in a variety of interpersonal and community relationships, while others preferred to have more time alone, describing themselves as "*hermits",* "*homebodies*", and as "*much happier and saner alone*" (A1).

Some participants indicated that in their rural communities, there were a variety of community relationships available for older women. These relationships were often in a context of church groups, craft groups, shared interest groups, exercise, and health groups, which were primarily organized and attended by older women in the community. As one participant commented, "*For our age group [50 years and over], it's [availability of community relationships] pretty good"* (A9).

Most of the key interpersonal and community relationships were with other women, including female family members, female friends, and/or groups or events attended primarily by females. These relationships were often very close and were described by some participants as "*sisters*" or "*life-lines*". Some participants indicated that they felt "*safer*" and more "*comfortable*" in relationships with females, in comparison to relationships with males, on both an interpersonal and community level. They indicated that this was because they felt that they could "*connect*" better with other women, in comparison to men. Some women, however, did describe key relationships with men. For example, some women described male family members, such as brothers and sons, as well as males within community relationships, as key relationships in their lives.

Some of the interpersonal and community relationships that the women spoke about were within their rural community, and were accessible by vehicle. However,

some participants also described key relationships with people quite a distance outside of their rural communities. These long-distance relationships were commented on in particular by the women that had "*come from away*". Key long-distance relationships were often maintained by phone, email, Skype, or Facebook. For example, one "*come from away*" participant described her key long-distance interpersonal relationships as "*only a phone call or Skype away*" (A9). Some participants found that living in a rural setting did not necessarily mean that you had to be isolated or "*cut-off*" from the rest of the world. Rather, some participants indicated that they were able to use technology to maintain their key social relationships at a distance.

> *I've got a large circle of friends living elsewhere that are at the other end of the phone and it's not like it was when I was a kid, you know, you can email people, you can phone people, you can even Skype with them if you've got the camera. And there's not the isolationism that I grew up with, so to me this [rural Cape Breton] is not isolated* (A9).

Key Themes

Three key themes emerged from the analysis of the interviews. The first theme speaks to the value of interpersonal and community relationships to the women's mental and emotional health. The second theme is about obstacles to developing and maintaining positive relationships, which can be challenging to the women's mental and emotional health. The third key theme centers on the need for change in order to reduce the obstacles and promote positive relationships to benefit unpartnered women's mental and emotional health.

Theme one: The value of positive interpersonal and community relationships.

All participants indicated that they valued their key interpersonal and community relationships, and perceived them as "*highly*" beneficial to their mental and emotional health. Participants indicated that they were thankful for these relationships because they helped to fill a variety of needs, on both a practical and emotional level. As one woman explained: "*So I am very grateful, just extraordinarily grateful that [social relationships] give me so much in that regard [practical and emotional needs]"* (A1).

Filling practical and emotional needs.

Although participants typically described themselves as "*independent*", "*resourceful*", and capable of meeting their practical and emotional needs, some also recognized that their social relationships were sometimes essential to help them meet their practical and emotional needs. The participants spoke of sometimes needing help with such practical needs, or day-to-day responsibilities, as daily chores, house maintenance, transportation, and finances. Emotional needs in the lives of the women centered around connecting with someone who is "*understanding*", "*supportive*", and "*fun to talk to*" on a "*reliable*" basis. In addition, emotional needs for the women included having community relationships, which gave many participants a sense of "*community*", "*belonging*", and "*safety*". Meeting these practical and emotional needs prevented and reduced loneliness, isolation, stress, and worry for participants.

Especially important when living alone.

Participants indicated that they valued their relationships to help them meet their practical needs because they sometimes struggled with doing the physical work alone,

notably manual labor, chores, and house maintenance. These tasks could be "*physically demanding*", "*tiring*", and "*boring*". Some participants indicated that if they were partnered, they would have a "*man around*" to help with the physical labor required to meet their practical needs; however, because they were unpartnered, they had to rely on themselves and their key relationships outside of their homes to help them meet these needs. One participant described how she had just re-painted her house with the help of a family member. Although she was capable of painting the house on her own, she indicated that this practical task was easier and more enjoyable to complete with another person. Another participant described how these types of physical tasks were much easier to do with another person, as opposed to doing them alone.

> *"I find there's the work where it's like, this would be a lot easier to share this burden of work with somebody else, both physically and psychologically. Like, there's a lot of routine, you know, stacking wood, it's like, it goes, it takes so much time, it's a lot more fun when you have someone that you're joking with or carrying on with as you're stacking wood"* (A2).

Participants also indicated that they valued their interpersonal and community relationships to help them meet their emotional needs. Key interpersonal relationships outside of the home were important to the women on an emotional level because they often provided "*support*", "*advice*", and "*fun*". As one participant described, "*Well, she's [friend] just very understanding and supportive and she's always there to help you if you need anything ever, ya. She's got good common sense, a good head on her shoulders I guess, gives good advice*" (A3).

Key community relationships outside of the home were also emotionally important because they gave the women a sense of "*community*" and "*belonging*" in their rural community. Some participants indicated that they had relationships with a variety of people in their community, and saw these people within a variety of contexts, which gave them a sense of "*interconnectedness*" and "*belonging*" within their rural area. As one participant commented, "*When I came here [rural Cape Breton], by chance, what I found pretty quickly was community. You know, there was something that made this different, there was like-minded people, but there was a mix, which was also healthy*" (A2).

Another emotional need described by some participants centered around feeling "*safe*". This was especially important to some of the participants because they were unpartnered and living alone in a rural, and often isolated, setting. Some participants indicated that they felt safe because they had a variety of "*strong*" and "*reliable*" interpersonal and community relationships. One participant said she felt safe in her rural community because she knew her "*neighbours*", her "*neighbour's neighbours*", and had interpersonal and community relationships with a variety of people living in her rural community; "*I always feel safe here in [rural community], I feel that if, if for some reason I needed help with anything I know I can go to a neighbour, or friend, or friend of whatever, and someone's going to help me*" (A4).

Some participants indicated that feeling safe and having a "*sense of community*" also facilitated the development of new relationships and the maintenance of established relationships, which was another key emotional need for many. Some participants indicated that the small and interconnected populations associated with living in a rural

setting made it easier to develop and maintain relationships within the community. This was because participants often knew many of the people living in the community, and could easily be introduced to new people or groups through their existing relationships. One participant argued that, "*Well, I would just think that, again, because I am fairly shy, if I weren't in an area [rural] where I knew everybody, I probably wouldn't get involved, you know*" (A4). Another participant described that living in a rural setting with a small population helped her to maintain her relationships in the community because she could make a trip to the grocery store and "*bump into*" several people she knew. Therefore, for this participant, a trip to the grocery store was not only an errand that had to be done, but also a chance to socialize with people outside of her home, and develop and/or maintain her relationships in the rural community, which helped her to meet her emotional needs; "*I see them [key relationships] out and around. You run into somebody in the store or whatever, you might chat for a bit, so it's kind of a community feeling I guess*" (A3).

Especially important in rural context.

Participants indicated that their key social relationships were especially valuable in a rural context, because formal services to help them meet their practical and emotional needs are often unavailable. That is, formal services to help meet practical needs, such as house maintenance services, cleaning services, and snow-shoveling services are often "*unaffordable*" or "*inaccessible*" in rural communities. In addition, formal services to help meet emotional needs, such as formal mental and/or emotional health services, are also often inaccessible or do not allow for confidentiality because "*everyone knows everyone*". Some participants indicated that their key relationships sometimes helped to fill these gaps in formal rural services by providing informal support, on both a practical and/or emotional level. One participant had a key

relationship with a friend that helped her meet her practical needs because she could rely on her to watch her pet when she was away; "*So she [friend] helps me with that [pet-sitting] because I couldn't leave [cat] and go to [town] if I didn't think someone was going to come in and look after her*" (A1). Without this key relationship, this participant indicated that she would not be able to travel to town because there were no formal services available in her rural community to watch over her pet while she was away. Participants also described how their key interpersonal relationships provided informal emotional support by providing "*advice*", "*teaching*", and "*love*".

Especially important during illness, injury, or crisis.

Some participants recognized that their key social relationships were especially important to help them meet their practical and emotional needs during a time of illness, injury, or crisis, when they were not always capable of meeting all of their needs on their own. For example, when one participant fell ill, she had to travel daily to the nearest medium population centre (over two hours one way) to receive medical treatments. The additional resources (time and money) associated with traveling to treatment were difficult for this participant to meet on her own, and people in the community "*came together*" to help her to meet her practical needs, notably by helping her financially.

Some of the divorced, separated, or widowed participants also described their key relationships as "*essential*" and "*instrumental*" for getting through a divorce, separation, or death of a spouse, and for moving on with their lives, mentally and emotionally. One participant found this emotional support especially important after she separated from her partner: "*I'll say, when I was going to fall down, when my marriage broke down, they [key relationships] just lifted me up and carried me on*" (A7). Although some

participants indicated that they were usually able to meet their basic practical and emotional needs on their own, they recognized how important and valuable these relationships were to have as a safety net during a time of illness, injury, or crisis.

Theme two: Challenges to developing and maintaining positive interpersonal and community relationships.

Although participants described having and valuing positive key relationships in their lives, they also indicated that they experienced various obstacles to developing and/or maintaining these relationships at both the interpersonal and community level. The major obstacles centered on not having enough resources (e.g., money, time) and the stigma of being unpartnered. These obstacles were often described as causing "*stress*", "*anxiety*", "*worry*", and "*frustration*" because they could hinder the development and maintenance of the positive relationships that were highly valuable to the participants. Participants indicated that not having positive relationships could lead to mental and/or emotional health challenges, including "*loneliness*", and feelings of "*isolation*" and "*exclusion*".

Not having enough resources.

Some participants noted that not having enough resources was a primary obstacle to developing and maintaining their positive interpersonal and community relationships. They described not having enough personal resources at the individual level and not having enough community resources at the community level, and sometimes attributed this lack of resources to living in a rural setting and/or being unpartnered and living alone.

Not having enough resources at the individual level.

At the individual level, not having enough resources was primarily described in terms of time and/or money. Participants indicated that a personal investment of both time and money is often required to develop and maintain relationships. That is, money for transportation and participant costs (e.g., church donations, membership fees, costs related to doing certain activities with a group), and time to participate in the relationship, is often needed to develop and maintain relationships.

> *And you're not making any money doing it [participating in community relationships], it's costing you money to do it, and it's costing you your energy. So, you know, that's the downside of some of these involvements. So you have to make sure that what you're getting from it is balancing out what it's taking from you* (A2).

Some participants indicated that because they were unpartnered and had to "*carry the load*" alone in terms of earning an income, carrying out household tasks, and other duties, this often limited the amount of time and money available for relationships. These tasks (e.g., household chores and maintenance) were often described as an obstacle to relationships because it took a large amount of resources, notably time, to do all of this work alone.

> *And disadvantages, well, realizing that it's, so often it just comes down to you. It's like no one's cooking your supper, no one's picking up the milk, no one's doing the laundry, no one's bringing in the wood, no one's, no one's… it could be a lot easier to be doing it with someone else, you know, sharing the load* (A2).

The practical needs of participants, such as the need to earn an income, manage a house, and engage in daily chores would often come ahead of social relationships. That is, because the women had to meet their practical needs on their own, the personal resources (time and money) they could commit to their key relationships were sometimes limited.

Some participants also indicated that doing these household tasks was becoming more difficult, physically and mentally, as they aged.

> *The chores. The house maintenance, you know, mowing, shoveling. As I get older I'm minding it more, like I really mind, like you know, I find it really frustrating when you have something that you have to get done … I really mind that part of it, that can be really stressful* (A5).

Some participants worried that as they aged, the household chores were becoming more difficult and were taking longer to complete, which was taking away from the time they could be spending with their friends, family, and/or community groups. Some participants also worried that they may not be able to maintain their rural properties on their own as they aged, and that they would have to leave their rural community, and social network, if the household chores and labor became too difficult to manage alone.

In addition to not having adequate time, some participants indicated that they had inadequate financial resources to participate in their relationships. Some of the participants indicated that they had a large enough income to meet their basic needs, but had limited supplemental funds and resources remaining for the costs associated with being part of a relationship. Unlike partnered relationships, where two people are usually living together off of one or two incomes and sharing the household work, some unpartnered women did not have this financial safety net, should they lose a source of

income. Therefore, some of the women felt that being unpartnered put them at a disadvantage financially because they had to cover all of their expenses on their own.

> *The downside of living alone is, it's all your expenses. You're not sharing expenses, the phone bill is my phone bill, I'm not dividing that, I don't have two incomes coming in here, we have one income…So it costs more, you know, to have a car, you know, one person paying insurance, one person paying all the gas, one person, you know. So economically, it's more of a strain to be one person* (A2).

Some of the women explained that if they became financially unstable, their only option was to work longer hours and/or cutback on costs, and that they were less likely to be involved in relationships that cost money if they were unable to meet their basic financial needs on their own.

The rural context also seemed to create additional obstacles to developing and/or maintaining relationships for some participants because of the geographic distance required to travel to be part of various relationships. Spending time with family, friends, and community groups usually meant leaving one's house, getting into a car, and driving a long distance. Therefore, even "*free*" activities associated with living in a rural place, such as hiking, swimming, and camping, require an input of both time and money for transportation. This added to the individual resources, notably time and money, that was needed to be part of a relationship in a rural setting. For example, one participant described how she could not just "*drop-in*" on a community event. Instead, she had to drive, often over an hour, to the location. Then, once she got there, she felt that she had to stay for the entire time of the event because she had invested so much time and effort in getting there.

Sometimes, you spend two-and-a-half hours in a round trip for a one-and-a-half hour event. You know, and you have to, and once again it's a cost, you know, and a cost in just, you know, gas, but also a cost of your time. It's not like, 'oh, I'll just pop in there and hang out for a while, and then I'll get home and I'll do my thing', you know. It's a commitment (A2).

Discussions with the women suggest that if the time and money associated with transportation in rural areas was not a factor, they may be more involved in their interpersonal and community relationships. However, not having enough time and money for transportation meant that participants had to weigh the value of being involved with the social relationship with the cost of transportation.

Not having enough resources at the community level.

Some participants indicated that inadequate and unsustainable funding for rural community organizations was another key obstacle to their rural community relationships. Some women indicated that their rural communities did not have adequate funds for community organizations, and this was challenging because they were constantly struggling to acquire community grants to keep their rural organizations operating on "*shoe-string*" budgets. Not having enough funds for community organizations was often described as "*worrying*" and "*stressful*" for some participants because they were uncertain as to whether or not their rural community relationships would be able to continue.

The only thing I dislike is the fact that they're [community] still always scrambling for grants to keep it [community group] going. And my greatest fear

is that it will fold … so that's a real concern for me. Because what if they don't - winter will be very long if there isn't anything to do outside (A7).

Some participants spoke specifically about how there were relatively few rural facilities (e.g. restaurants, theaters, or shopping centres) that could be used to meet with other people, either individually or as a group due, to a lack of community funds for rural community organizations, and that this was a major obstacle to developing and maintaining their relationships. For example, one participant commented, *"Just sometimes you're lonely. Like the evenings are long, especially when it gets dark early and ya… Like when you're rural, you can't, the stores are closed, there's no restaurants open, like just to go somewhere* (A3). This was especially problematic in the winter when the majority of the "*tourist-season*" restaurants, cafés, and centres were closed for the season. For example, one participant commented, "*Well, there's not really anything to do here in the winter. Like a place to go and meet and have a meal or have coffee, the sidewalks roll up along about after [fall festival]*" (A8).

Participant's experiences with the availability of rural facilities varied depending on their rural community. In some rural communities there were no local facilities open year-round, while other communities had facilities that were open on occasion. Although some rural communities had local facilities available year-round, they often did not have the financial resources to adequately heat or maintain these facilities throughout the year. One participant explained that she was involved in a community group, but was less likely to participate in the group throughout the winter months because the facility in which they met was not adequately heated: "*And I also find the cold here [rural facility]*

gets to me and I don't like to come here [rural facility], but I try and come to maybe once a month instead of every Wednesday" (A9).

Some of the rural community organizations described by the participants relied heavily on volunteers because they had inadequate funding. Participants often had to contribute their own resources, notably time and/or money, to keep community organizations operating in their rural communities. This additional financial strain and time commitment required to maintain certain community relationships was challenging for some participants, and even prevented some participants from being involved in these organizations because they did not have adequate personal resources. For example, one participant remarked that it is sometimes better "*not to join*" a community organization, rather than to join and then experience the stress and worry of not being able to contribute to the organization.

> *Well sometimes, it's easier not to belong to a group [organization] because financially sometimes you can't afford it. Because when you want to belong to a group, that includes gas for going to meetings and going to functions and supporting it and or cooking and stuff, and not always could I afford to do that. So, rather than say I can't afford to cook, you just don't join, you just don't join* (A6).

Although some participants indicated that they were "*happy*" to do fundraisers and donate their time and money to rural community organizations, they also recognized that this approach was not sustainable and also could create additional stress and worry.

Some participants indicated that once they joined and were committed to a community relationship, they sometimes felt pressured to continue to be actively

involved in the relationship. Again, participants indicated that this was because many rural community organizations often struggled for funding, and had to rely on volunteers in order to remain viable and "*afloat*". Participants described these sometimes "*forced*" or "*pressured*" relationships as "*challenging*" and "*difficult*" because they often created additional stress and worry. One participant was involved in a community organization that required a considerable amount of volunteer work, and she described this work as stressful and challenging because of the amount of time she had to give to the organization. However, she chose not to leave this community organization, even though it was "*challenging*" at times, because she felt that if she left, the group might fall apart, and the event they were organizing might not happen.

> *And it's like 'ohhhh', and once you become part of something [community relationship] then it's like you almost have to find your replacement to get out of it [community relationship] because it's like this [community relationship] will only continue as long as we all keep doing our thing. And you're not making any money doing it, it's costing you money to do it, and it's costing you your time and it's costing you your energy* (A2).

This participant also indicated that it could be difficult to find a "*replacement"* volunteer to ensure community organizations have the volunteer base they need to remain functional. This was related to the small population associated with living in a rural place, and could cause additional stress for participants in challenging community relationships

Stigma and being unpartnered in a rural community.

Another obstacle to developing and maintaining positive relationships centered around the stigma of being unpartnered. Some participants noted that the majority of people living in their rural communities were partnered, and consequently, many of their social relationships were with partnered people. Being unpartnered was described by some participants as a "*stigmatizing*" life choice or status. Most of the stigma related to being unpartnered was described as being very "*subtle*" or "*joking*" in manner. None of the participants described being actively discriminated against because they were unpartnered. However, this subtle stigma was present and had an impact on relationships for many of the participants. For example, one woman described jokes that were made about her at a dance by her partnered friends, which subtly highlighted that she was unpartnered and should be trying to find a partner because this is the norm in the rural community.

> *And so if the music isn't going to start till 10:30 I leave. And so the joke was the first couple of times I did it, 'well, you're never gonna get a man if you leave before the dancing starts'* (A9).

Some women indicated that this stigma related to being unpartnered could be socially excluding and challenging to their mental and emotional health, while others said that they *"don't mind it"* (A9).

Some participants described the stigma around being unpartnered as especially challenging due to the rural context. In a rural setting, some participants felt they were not able to "*blend-in*" because the majority of the population is in a traditional, partnered relationship. Some participants felt that they would be able to "*blend-in*" more in a larger

population centre because they could be more anonymous within a larger population and because there would likely be "*more single people*". The inability to blend-in due to being unpartnered could sometimes be an obstacle to developing and/or maintaining relationships (especially friendly male relationships) in the community because some women felt that any relationships they developed would be open for discussion and "*gossip*" among the community members. For example, some participants indicated that they would be hesitant to develop a friendly interpersonal relationship with a male because members of the community would notice and may begin to "*pair you up*". Participants indicated that this was less likely to occur in a larger population centre because you could go out with someone and would be less likely to see people you know. Therefore, in a rural context, some participants were "*very aware*" of the subtle stigma about being unpartnered, and were "*cautious*" and "*leery*" about developing certain social relationships in order to prevent and reduce the gossip, stigma, and potential judgment from community members.

Some participants also described partner-focused events or groups as subtly stigmatizing, and as an obstacle to being involved in certain community relationships. Participants indicated that they sometimes felt uncomfortable and excluded at these events because they were unpartnered or "*the odd one out*". These partner-focused events included, but were not limited to, dinners, dances, and couples-orientated groups, where there is more of an emphasis on doing the event or activity with a partner. For example, one participant described how she felt awkward at group dinners, where a group would meet, primarily as couples, and she would be the "*odd one out*" because she did not have a partner.

Well, you know, sometimes even going to a dinner, you're, they're [community relationship] not sure what to do with you cause you're number three or number five, you know, it's not six, it's not an even number. So sometimes that sort of thing is a problem (A8).

Participants indicated they would sometimes not attend these partnered-focused events or groups alone because they did not want to experience being left out, or to be highlighted as different from the majority of the group.

In this area, I find it, like if I want to go to the dance, unless I have a girlfriend going, like I wouldn't go right. Not by myself. That kind of thing. I don't mind going to other social events by myself most of the time, but it would be nicer with somebody. (A3).

These partner-focused events or groups were described as especially challenging in the rural context because it is less likely that there will be other unpartnered people to meet or 'blend-in' with when there is a smaller population.

Self-protection around being unpartnered.

Some participants indicated that they did not want to appear "*needy*" or "*reliant*" on their key relationships because they were unpartnered. Therefore, they sometimes protected themselves from being perceived as "*needy*", and potentially reinforcing negative stereotypes, by not interfering in partnered relationships. For example, one participant described a key interpersonal relationship in which she would receive telephone calls from a partnered friend, but she was hesitant to make spontaneous telephone calls *to her* because she did not want to appear to be "*needy*" and she wanted to give her friend and her friend's partner, time alone.

I don't ever call her [friend] on the weekend, I very rarely call her [friend] because she has [husband], so I'll actually let her [friend] call me for the most part, unless she's left me a message I'll always call [friend] (A1).

Theme three: The need for change.

All participants indicated that there is a need for change to reduce the obstacles and promote positive relationships, at both the interpersonal and community level. Their suggestions for change focused on meeting their practical and emotional needs, and on reducing the stigma around being unpartnered. Participants argued that changes would be beneficial to unpartnered women's mental and emotional health because they would promote the feelings of "*fun*", "*safety*", "*support*", "*belonging*", and "*community*" associated with positive relationships, and reduce the "*stress*", "*worry*", "*anxiety*", and "*loneliness*", associated with the obstacles to developing and maintaining positive relationships.

Changes to help meet practical needs.

Some participants pointed to changes to help them meet their practical needs, notably in terms of household chores and maintenance. One participant suggested, for example, having a hired hand or "*handy-man*" that a group of women living alone could "*co-op*" or hire and pay for together. She argued that help that was readily available and affordable to a group of unpartnered women living in a rural place would be important in helping to meeting their practical needs.

Another suggestion by some participants was to have a rural housing option somewhere "*in between managing an entire property on your own and living in a senior's home*". Some participants indicated that their rural communities lacked a variety

of housing options, such as apartments, assisted-living, or group homes. Participants indicated that they did not feel ready to move into a senior's home, but were finding that doing house maintenance and daily chores alone was increasingly challenging as they aged. Some participants also said that they "*feared*" that if they were no longer able to manage a property alone, they would have to move to a larger population centre, and leave behind their "*social network*". Therefore, changes to provide alternative housing options in rural communities for unpartnered women was considered a priority for many of the women. One participant suggested having several small cottages and one common area within the same property. She maintained that this would allow a group of unpartnered women to still live "*independently*" in a rural setting, but would also reduce the stress and worry associated with managing a property alone.

> *I always say if I was a millionaire I would build, buy some land and build little cottages. Self-contained with support staff to kind of help you with shoveling snow or transportation or repairs, or… separate, but together, assisted living kind of stuff. There's certainly no apartments here [rural community] if that's the kind of living you want to do* (A7).

Another participant suggested having a home remodeled so that several unpartnered women could live together and manage the house together.

Some participants also indicated that change was needed in terms of rural transportation options. At the time of the interviews, all of the participants owned and were able to drive their own vehicle, which was key to being involved in their interpersonal and community relationships in a rural setting. Having to meet these transportation needs alone was, however, costly, and sometimes stressful, and at times,

could hinder the development and/or maintenance of social relationships. In addition, many participants feared that they could become very isolated and lonely if they were no longer able to own and drive a vehicle. Some participants suggested that there should be some form of shared or public transportation available for rural communities, such as a weekly bus or carpool into a nearby town, *"Well, there's times when it would be nice to be able to pick up the phone and say 'why don't we take off and go to [city] and watch a movie', rather than doing the drive alone"* (A9). Some participants felt that having public transportation options in their rural communities would reduce the cost of traveling to community events, and would also reduce the stress and worry of having to drive alone. Some participants also indicated that this would be especially helpful during the difficult weather and risky travel conditions, notably snow and icy roads, that often occur throughout the Cape Breton winter.

Some women indicated these changes to help them meet practical needs, notably in terms of house maintenance and transportation, would be beneficial because it would give them an alternative form of support. For example, one participant explained that she knew she could ask for help when she needed it, but that she "*disliked*" having to rely on these relationships because they would often help out as a favor and not accept payment in return.

> *That's [asking for help with practical needs] a tough one, because even though I know people, it's hard to pick up the phone and call somebody and say, you know… but then, like I said, you hate to call somebody because you know they're not going to take your money (laughs). Like I said, if it was a business, you'd just*

call and say 'okay, I need work done' and they come and do it and you pay them. But it doesn't work here like that (A4).

This bothered the women because they wanted to remain "*independent"* and self-sufficient, and not appear "*needy*" among their interpersonal and community relationships.

Changes to help meet emotional needs.

Other changes suggested by the participants focused on helping them to meet their emotional needs. In particular, participants focused on the need to develop "*supportive*", "*safe*", and "*understanding*" relationships. One of the main changes suggested by some participants focused on the need to sustainably fund and facilitate rural community organizations. This was important to some of the participants because they relied on these key relationships to meet their practical and emotional needs, especially during times of illness or crisis. Often, just knowing that a rural community group or organization may be cancelled due to a lack of funding was stressful and challenging to the mental and/or emotional health of some of the participants.

I've been here [rural community] long enough now to see this happen, you know, it's like, 'okay, weren't we lucky we had that [community organization] for eight years, now we don't have that anymore'. And you know, that happens, once again, because it's all shoestring budgets, volunteer driven, and when someone's, a key players life changes, well there isn't necessarily the next key player to continue making that happen (A2).

Having adequate community funding for rural community organizations would also reduce the stress and worry associated with having to constantly volunteer and contribute

individual resources (i.e., time and money) to these organizations, and the discomfort associated with having to "*make-do*" with meeting in inadequately maintained facilities (i.e., "*non-heated*" buildings during the winter months).

Another suggestion to help unpartnered women meet their emotional needs and promote positive relationships centered on having more "*women's-only*" or "*sisterhood"*"-type events. The majority of relationships described by participants were with women, and some participants indicated that they felt more "*comfortable*", "*safe*", and "*connected*" in female-only groups. For example, some participants described an international women's day celebration in their rural community, which consisted of a women's-only dinner and party. However, this event only happened once a year, and some women indicated that they would benefit from more of these "*women-only*" events.

> *We [rural community] should have more girls' nights. I know the women in [nearby community] are great. There's a groups of them that get together quite often. Then they have, once a year, they have a get together, women's international day or whatever, I forget what day it is* (A3).

In addition, some participants suggested having a telephone "*support line*" or "*check-in*" system, in which a group of unpartnered women living alone in a rural community could call each other on a daily basis in order to help them meet their emotional needs, notably feeling safe. Some participants indicated that having a telephone support system would be a very practical and efficient method to reduce loneliness and feelings of isolation for unpartnered women living alone in a rural place.

> *And I've often thought, wouldn't it be wonderful if we [rural community] had a system set up so that, okay, like I'd love to see something set up so that we could,*

you could depend, somebody would call you at some point during the day to see if you're okay (A5).

Some participants indicated that such a telephone support system would be especially beneficial during a time of illness, injury or crisis, when they may not be able to access help and the support they need. A telephone support system would reduce feelings of isolation and loneliness because it would provide the women with a supportive relationship on a daily basis to ensure they were safe, healthy, and "*doing okay*".

Recognizing that there is a lack of formal mental and emotional health services in rural settings, some participants argued for an increase in these formal services. Some participants indicated that having formal mental and emotional support services available in rural communities was important to reduce the barriers, notably time and money, associated with traveling to larger population centres for such services. These formal services were described as especially important to have after a difficult event or crisis, such as after a divorce, separation, or death.

As far as resources, we [rural communities] could definitely use more resources. Like for mental and emotional support. Like when it comes to, it's a big thing if you become separated or divorced. There should be a [formal] support group, or somebody that you can talk to. If you have a death, there should be a support group or somebody that you can talk to (A6).

Although some participants noted that it is important to have these formal mental and emotional health services available in rural communities, others indicated that it is also just as important to provide rural community members with the option of accessing formal mental and emotional services in larger population centres, in order to allow for

some anonymity when seeking mental and/or emotional help. Therefore, change is needed to provide rural community members with the option of accessing formal mental and emotional health services either in their rural communities, where travel distances and costs would be reduced, or in larger population centres, where anonymity would be more protected.

Changes to reduce stigma of being unpartnered.

Other changes suggested by participants focused on raising awareness and reducing the stigma associated with being an unpartnered woman in a rural community. Participants felt that they were sometimes subtly stigmatized or excluded because they were unpartnered; however, some participants also indicated that their partnered friends might not even realize they were stigmatizing or excluding them based on their partnership status. Some participants felt that increasing awareness about the needs of unpartnered women may help to raise attention about the stigma, and promote stronger and more supportive interpersonal and community relationships for unpartnered women in rural communities. More specifically, some participants indicated that changes are needed to increase awareness and understanding about the "*choices*", "*living situations*", and some of the additional challenges rural, unpartnered women face.

> *Ya, but anyways, I don't know that a program, but you know, it's about awareness, and you are drawing awareness to it. So the more people will have awareness about solitary women and…how much support needs to come into place, emotional, physical, or, ya* (A1).

Chapter Five: Conclusions and Discussion

This chapter will first present a brief summary of the results. This will be followed by a discussion of the research findings, and how they are similar and/or different to the current body of literature. Next, the health promotion implications of these findings will be discussed, along with strategies to promote positive social relationships, and mental and emotional health outcomes for rural, unpartnered women. Finally, suggestions for future research are described.

Summary of Results

The purpose of this study was to explore the key social relationships in the lives of older, unpartnered women living alone in rural Cape Breton. Findings indicate that participants have a variety of key interpersonal and community relationships. The number of interpersonal and community relationships described by the women as "key" in their lives varied among participants. Many and seemingly in some cases almost all of these relationships were with women, including female family members, female friends, and/or groups or events attended primarily by females. Key relationships included those within the rural community as well as long-distance relationships outside of the community.

All participants indicated that they valued their positive interpersonal and community relationships, and perceived them as highly *beneficial* to their mental and emotional health because they helped them to meet their practical and/or emotional needs. This was especially important to the women for multiple reasons. First, because the women were unpartnered and living alone, they recognized that they needed relationships outside of their home in order to help with practical needs (e.g., day-to-day

chores) and emotional needs (e.g., having someone to talk to). Also, because the women were living in a rural community, where there are few formal services (e.g., mental health services, house-maintenance services, shopping centres, and restaurants), their relationships helped to fill this gap by providing informal forms of support. In addition, the women recognized that their relationships were especially valuable during a time of illness, injury, or crisis, when they were not always capable of meeting all of their needs on their own.

Participants also experienced various *obstacles* to developing and/or maintaining their key social relationships at both the interpersonal and community level. Participants described obstacles related to two areas. The first obstacle centered on not having enough personal and/or community resources to participate in interpersonal and community relationships. The second obstacle centered on the subtle stigma associated with being an unpartnered woman in a rural community. Both of these obstacles hindered the development and/or the maintenance of positive relationships. This could also cause mental and emotional health challenges for the participants, notably stress and loneliness, because they challenged their ability to develop and/or maintain positive social relationships.

Participants indicated that change is needed in order to reduce the obstacles and promote positive relationships in the lives of rural, unpartnered women. Suggestions for changes focused on strategies to help meet their current practical and emotional needs as they age, and on reducing the stigma linked to being unpartnered. Participants indicated that these changes would help to promote positive social relationships in their lives, and would also improve their mental and emotional health.

Unpartnered rural women as socially integrated.

Much of the literature suggests that partnership is beneficial for women in and of itself, and for developing and/or maintaining positive social relationships outside of the partnership (Holt-Lunstad et al., 2008; Lin et al., 2012; Rohrer et al., 2008; Sherbourne et al., 1990; Umberson, 1987). These studies also suggests that unpartnered women are more likely to be socially isolated or have few positive social relationships, in comparison to partnered women (Holt-Lunstad et al., 2008; Lin et al., 2012; Rohrer et al., 2008). For example, Holt-Lunstad et al. (2008), found that the social relationships in the lives of unpartnered women, notably those relationships with family and friends, were not as beneficial as partnership, and did not compensate for the negative health effects associated with being unpartnered. On the other hand, some research studies have found that unpartnered women are *not* socially isolated because of their partnership status, and that unpartnered women do have a variety of positive and valuable social relationships (Arber, 2004; Cooney et al., 2001; Stull et al., 1989). For example, studies by Arber (2004), and Cooney et al. (2001), found that unpartnered women tend to develop strong, meaningful, and extensive interpersonal and community social relationships, which may compensate for the lack of a partner by providing alternative forms of social support.

The present study found that unpartnered women have a *variety* of *positive* interpersonal and community relationships. All participants described relationships with close friends, family, and/or community organizations, and highly valued their relationships because they were beneficial to their mental and emotional health. In addition, these positive relationships were sometimes described by participants as preventing mental and emotional health issues, including stress, worry, loneliness, and

depression. These findings, therefore, support the body of literature that finds unpartnered women to have positive social relationships.

Rural context.

In this study, the rural context may have positively influenced the role and value of social relationships in the lives of the unpartnered women. The finding that the women have a variety of positive and valuable relationships is similar to many rural studies, which have also found that rural populations tend to have a variety of positive interpersonal and community social relationships (Jackson et al., 2011; Martin et al., 2008; Painting the Landscape in Rural Nova Scotia, 2003; Shields, 2008). Numerous studies have also found that rural populations report higher levels of community belonging and more positive interpersonal and community social relationships, in comparison to larger population centres (Rolfe, 2006; Shields, 2008). Rural populations appear to especially value their positive relationships because formal services are often not as readily available in a rural setting as they may be in a larger population centre, and informal positive relationships may help to provide supports and/or services (Adams et al., 2000; Bushy, 2000; Cairney et al., 2003; Hayes, 2006; Wanless et al., 2010; Wathen et al., 2007). The results in the present study which found unpartnered women to have a variety of social relationships may be due to the fact that they live in a rural place, where social relationships and informal social supports are highly valued and central to the rural culture (Leipert et al., 2005; Sutherns et al., 2004). Living in a rural place may reduce social isolation, and may benefit the mental and emotional health of unpartnered women because of the rural culture which values and facilitates positive social relationships and a sense of belonging.

Socio-economic status and education.

Another possible explanation for why the women in this study had many beneficial relationships may center on the socio-economic status of the women, which was slightly higher, on average, than that of the rural community. One of the main explanations in the literature for the social isolation of unpartnered women is that unpartnered women, on average, earn less money than partnered women (Cooney et al., 2001; Lichter et al., 2003; McKeever et al., 2011; Walderon et al., 1996). The literature indicates that those with a lower socio-economic status are more likely than those with a higher socio-economic status to disengage or 'disinvest' in their social relationships (Hawe et al., 2000). This is because relationships often cost money, and therefore, those with less money are less likely to be able to 'afford' the costs associated with having a variety of positive relationships. It is suggested that because unpartnered women, on average, earn less income than partnered women, they are also more likely, on average, to have fewer positive social relationships, in comparison to partnered women (Lindstrom, 2009). Therefore, this literature suggests that economic factors may partially explain why unpartnered women tend to have few positive social relationships or be socially isolated.

The annual incomes reported by the unpartnered women in this study were higher, on average, than the annual incomes reported for the rural Cape Breton communities in the area (Nova Scotia Community Counts, 2011). Therefore, the unpartnered women living in this rural place did not appear to have a lower income, on average, relative to the general (partnered) population. This may partially explain why the participants had a variety of positive interpersonal and community relationships and did not indicate that they were socially isolated.

In addition to earning a higher income than the average person in rural Cape Breton, the unpartnered women in this study also had a higher education level, on average, relative to the average education levels in rural Cape Breton (Nova Scotia Community Counts, 2011). These higher levels of education may partially explain why this group of women had a higher average income, as higher levels of education are often associated with higher income (Mikkonen et al., 2010). This suggests that higher levels of education and/or income may play a role in the promotion of positive social relationships for unpartnered women.

Unpartnered women experience obstacles to positive social relationships.

Another key finding of this research study centered around the obstacles the unpartnered rural women experienced in terms of developing and maintaining their key social relationships. These obstacles often hindered the development and/or maintenance of positive social relationships, and could contribute to feelings of social isolation and loneliness. This is similar to the research literature, which finds that unpartnered women experience challenges to having positive social relationships, and this can lead to mental and/or emotional health challenges (Holt-Lundstad et al., 2008; Kobayashi et al., 2009; Lin et al., 2012; Rohrer et al., 2008; Sherbourne et al., 1990). The key obstacles described by the women (not having enough individual and/or community resources and the stigma of being unpartnered) are well documented in the research literature for rural and/or unpartnered populations. Although much of the population living in rural Cape Breton experiences these obstacles to positive social relationships (e.g., not enough individual and/or community resources), these obstacles to positive social relationships are especially problematic for unpartnered women because they are living alone, and

their only social relationships are their interpersonal and community relationships outside of their home.

Not enough individual resources.

The women in this study indicated that not having enough personal resources (time and money) was a key obstacle for developing and/or maintaining their positive social relationships. This is similar to the research literature, which suggests that unpartnered women may be more socially isolated than partnered women, because unpartnered women, on average, earn less money than partnered women (Cooney et al., 2001; Lindstrom, 2009; McKeever et al., 2011).

Although not having enough time and money was described by participants as an obstacle, the women in the present study had a higher average income relative to the general population living in the rural Cape Breton area (Nova Scotia Community Counts, 2011). A lack of money was described by participants as an obstacle to their positive social relationships, however, it is important to recognize that this obstacle likely affects the rural population in general, where the average rural Cape Bretoner earns less than the average participant in the study. Therefore, a key obstacle specific to unpartnered women living in a rural place may center around not having enough *time* to develop and/or maintain positive social relationships. Not having enough money may act as an obstacle to social relationships for many people living in a rural place; however, a lack of time for social relationships may disproportionately challenge unpartnered women.

The unpartnered women indicated that they were challenged by a lack of time for social relationships because they were living alone and had to meet all of their practical and emotional needs (earning an income, maintaining a property) on their own (without

the help of a partner), which took up the majority of their resources in terms of time. For example, some women indicated that after they spent their day earning an income, maintaining a property, and meeting their daily needs, they did not always have the time or energy to be as involved with their interpersonal and community relationships as they may have liked. Thus, a key finding of this research study is that unpartnered women living in a rural place do not always have enough time to develop and maintain their positive interpersonal and community relationships.

Not enough rural community resources.

Participants also indicated that their rural communities did not have enough resources, in terms of formal facilities (e.g., community centres, restaurants, theaters, sport facilities, government services, and shopping centres), and funding for rural community organizations. This was another obstacle to developing and/or maintaining relationships in a rural setting, and is similar to the existing literature, which finds that rural communities, in general, have fewer resources, in terms of community facilities and social and support services, relative to larger population centres with a higher population density (Health Canada, 2003; Ryser et al., 2012). Halseth et al. (2006), highlight that rural public sector services in Canada have been downsized, regionalized, and cut over the past 30 years in order to reduce national expenditures. Similarly, businesses, such as shopping centres, restaurants, and theaters, have also been decreasing in some rural Canadian communities (Romanow, 2002). Therefore, not having enough rural community resources to develop and maintain positive relationships is not a new finding. However, this obstacle to positive social relationships may be especially challenging for the unpartnered women because they rely on these community relationships outside of

their home to help them meet at least some of their practical and emotional needs (e.g., counseling services to meet their emotional needs and house maintenance businesses to meet their practical needs).

A key challenge for some participants centered around rural transportation, and a lack of community resources for public transportation options. Participants indicated that driving alone could be challenging and public transportation options were not available in their rural communities, and, at times, this presented an additional obstacle to developing and/or maintaining their social relationships. The challenges associated with driving in a rural setting included cost, time, and difficult road and weather conditions, and this is well documented in the literature (Johnson, 1998; Ryser et al., 2012). A lack of resources for public transportation in rural communities is also documented in the health literature as an obstacle for the social relationships and the health of rural populations (Health Canada, 2003; Ryser et al., 2012). Therefore, it appears that the unpartnered women in this study experience some of the same obstacles, notably transportation challenges, to social relationships as general rural populations.

Stigma of being unpartnered.

Another key obstacle to positive social relationships centered on the stigma associated with being an older, unpartnered woman. The general body of literature has found that there is stigma, judgment, and negative stereotypes associated with being an unpartnered woman (Byrne et al., 2005; DePaulo et al., 2005; DePaulo et al., 2006; Morris et al., 2007; Sharp et al., 2011). The stigma of being unpartnered has also been found to increase as women age (i.e., older, unpartnered women face more stigma than younger, unpartnered women) (DePaulo et al., 2006). Similar to these studies, some of

the women in the present study indicated that they sometimes felt that they were stigmatized and judged as "peculiar" or "different" because they were unpartnered.

By definition, a stigmatizing attribute is socially discrediting, and creates a divide between the stigmatizers and the stigmatized (Goffman, 1963). Therefore, stigmatized populations are often socially excluded, to various degrees, by the stigmatizing population. Research has found that the stigmatization of unpartnered women can be especially challenging to their mental and/or emotional health when it challenges the development and/or maintenance of their positive social relationships (Byrne et al., 2005; DePaulo et al., 2005; Morris et al., 2007; Sharp et al., 2011). Similar to research by DePaulo et al. (2005), and Morris et al. (2007), the participants in the present study felt that the subtle stigma related to being unpartnered could be challenging to their social relationships, and could also challenge their mental and emotional health. Therefore, the stigma described by the unpartnered women in the present study mirrors the stigma of unpartnered women described in the literature, and the subsequent mental and/or emotional health challenges experienced as a result of this stigma.

It appears that unpartnered women living in a rural place may experience stigma differently than women living in a larger population centre due to their rural context, where the norm, and sometimes the expectation, for older women is to be in a partnered relationship. This is similar to the research literature, which often finds rural cultures to be conservative in nature, centering around traditional nuclear family- and religious-values (Gaston, 2001; Little, 2003). Participants indicated that varying from certain norms and expectations (i.e., being unpartnered) could foster negative gossip and judgment from the rural community, which could be challenging for their interpersonal

and community relationships. This negative gossip can be especially challenging for social relationships in a rural context, where "everyone knows everyone" and it is difficult to remain anonymous (Jackson et al., 2011; Leipert et al., 2005).

Heterosexual language and tones.

In addition to the stigma related to being unpartnered, participants sometimes used language which could be characterized as heterosexual, in terms of language, tones, and assumptions. This may further perpetuate stigma associated with varying from the heterosexual norms and traditional gender roles in a rural community (e.g., unpartnered men and women or people that identify as gay, lesbian, bisexual, transgender, or queer (GLBTQ)), and may create additional obstacles to positive social relationships for these stigmatized populations. Although the unpartnered women in this study did not fit the role as "traditional farmer's wife", and did not necessarily perpetuate traditional feminine roles in rural communities, they did use language with heterosexual tones and assumptions, which reinforced the women's role in the house and the man's role doing physical labor. For example, participants used language such as "it would be nice to have a man around" and "I need a wife to do the cooking and cleaning", which assume traditional, heterosexual relationships, as well as traditional gender roles. This indicates that the unpartnered women themselves may play a role in the stigmatization of men and/or women that do not fit within traditional gender and/or partnership roles. This assumption about heterosexuality is similar to the study by Little (2003), which found that the "ubiquitous, uncontested nature of heterosexuality [in rural settings] means that it is rarely acknowledged as a sexual identity in it's own right" (p. 406). That is, heterosexuality, and traditional masculine and feminine gender roles, are often *assumed*

in rural cultures. These assumptions can lead towards the stigmatization of people that do not fit within these norms, notably people that are GLBTQ, as well as unpartnered men and women, which can challenge their positive social relationships, as well as their mental and emotional health, as a result.

The challenge of maintaining positive social relationships

The findings in this study indicate that older, unpartnered women living alone in rural Cape Breton have numerous positive social relationships. However, *at the same time*, these women also experience various obstacles to developing and/or maintaining these positive social relationships. This study suggests that there are both favorable and unfavorable consequences in terms of the social relationships for older, unpartnered women living alone in rural Cape Breton. That is, on the one hand, they have numerous positive social relationships, which are valuable and beneficial for their mental and emotional health. However, on the other hand, they experience various obstacles to these social relationships, which challenges their ability to develop and/or maintain positive social relationships, as well as their mental and emotional health. The women appear to experience both the beneficial and the challenging aspects of their social relationships at the same time, and experience the positive aspects (i.e., benefits of positive social relationships), with the negative aspects (i.e., stress associated with making time/money for relationships and stigma).

The benefits and challenges of social relationships for the unpartnered women were closely related to the rural context. The rural context was beneficial because of the value on positive social relationships and sense of belonging, but, at the same time, the rural context was challenging because of the geographical isolation, and associated

transportation and resource challenges. Therefore, it appears that the rural context concurrently benefits and challenges the social relationships in the lives of unpartnered women, as well as their mental and emotional health.

These findings are similar to a variety of research studies, which have found the rural context to be both beneficial and challenging for the health of rural populations (Health Canada, 2003; Jackson et al., 2011; Thomlinson, McDonagh, Crooks, & Lees, 2004; Watkins & Jacoby, 2007; Wenger, 2001). For example, Jackson et al. (2003), found that younger women living in rural Nova Scotia perceived their rural context as both "good" and "not so good" for their mental and emotional health. In a review on rural aging and health, Wenger (2001), also found that living in a rural place presented both advantages and disadvantages for rural populations, and that generalizations about living in a rural place as positive or negative must be made cautiously. These studies demonstrate that rural residents may experience a "co-occurrence of characteristics of rural living", which can enhance health and create obstacles to health at the same time. This study adds to these findings by demonstrating that this is also the experience in terms of social relationships for unpartnered women living in a rural place. That is, the social relationships in the lives of the women were both beneficial and challenging at the same time. This presents many opportunities, as well as many challenges, to promoting the social relationships and mental and emotional health of older, unpartnered women living in a rural place.

Healthy aging.

Some participants indicated that the challenges associated with aging might challenge their ability to live independently in a rural setting. This was described as

being potentially detrimental to their social relationships, as well as their mental and emotional health. For example, at the time of the research, there were no forms of public transportation available for the rural communities involved in the study, and participants worried that they would not be able to maintain their positive social relationships if they should lose the ability or confidence to drive. Participants also indicated that a lack of affordable rural housing options was another key issue that was going to be especially challenging as they aged. Discussions with participants indicate that if they are no longer capable of driving or managing their rural properties on their own, they may have to relocate to a more populated setting in order to meet their practical and emotional needs. These challenges associated with aging would also challenge the social relationships of the women because if they had to leave their rural community, they would also have to leave their valuable and often long-established interpersonal and community relationships.

Thus, a key challenge for the unpartnered women living in a rural place was to maintain independence and continue to live in a rural setting while overcoming the challenges associated with aging (Hayes, 2006). This is similar to a variety of studies evaluating the challenges of aging in a rural setting (Arbuthnot, Dawson, & Hansen-Ketchum, 2007; Rygh et al., 2007). More housing options, public transportation, shopping facilities, and other day-to-day services are required by populations as they age (Arbuthnot et al., 2007; Federal/Provincial/Territorial Ministers Responsible for Seniors, 2007). Federal/Provincial/Territorial Ministers Responsible for Seniors (2007), also found that key issues and services for aging adults included affordable housing options,

outdoor spaces that promote a healthy lifestyle, general services, activities, and keeping seniors engaged in the community.

Implications

The research findings have some implications for promoting health of rural, unpartnered women, which center on promoting positive social relationships and reducing the obstacles to these positive relationships. There are several approaches, or strategies that can be implemented to promote positive social relationships for rural, unpartnered women. A potential strategy would involve increasing education and awareness about the stigma of being unpartnered. A second potential strategy would involve reducing some of the burdens related to being alone for unpartnered women living in a rural setting. A third potential strategy would involve promoting aging-friendly communities in rural settings. These strategies involve complex human issues, and must consider the various contextual factors of the population, notably being unpartnered and living in a rural place.

Strategies to help reduce stigma of being unpartnered.

The stigma associated with being an older, unpartnered woman was sometimes an obstacle to positive social relationships. Increasing programs and policies to reduce this stigma was also discussed by participants as important. In the health literature, most of the research on stigma and stigma reduction centers on the stigma associated with certain mental health issues and certain physical health issues (e.g., HIV/AIDS) (Graham et al., 2003; Heijnders & Van Der Meij, 2006; Rusch, Angermeyer, & Corrigan, 2005). However, the strategies used to reduce these forms of stigma can also be applied towards reducing the stigma around being unpartnered, because the goal of all anti-stigma

strategies is the same: to increase awareness and education about a stigmatizing attribute in order to decrease negative stereotypes about a certain stigmatizing attribute.

In a review of the literature, Rusch et al. (2005), found three primary methods for reducing stigma: contact, education, and protest. Contact methods involve personal contact between the stigmatized population and the stigmatizing population, in order to increase understanding and increase the normalcy of the stigmatized (Rusch et al., 2005). This approach will likely not be useful for reducing stigma among unpartnered rural women, as the women were already very involved in their rural communities and have contact with a variety of interpersonal and community social relationships. This constant contact between the unpartnered women and the general rural population (through a variety of positive interpersonal and community relationships), may partially explain why the stigma of being unpartnered is described as 'subtle' in nature. Contact between the stigmatized population and the stigmatizing population may help increase the 'normalcy' of unpartnered women living alone, and has helped the women to be socially integrated in their rural communities. However, it seems that this approach alone is inadequate, as a subtle stigma around being unpartnered still exists, despite this constant contact.

The second approach, education, reduces stigma by providing information about the stigmatized population that is contradictory to the negative stereotypes about the population (Rusch et al., 2005). Educational methods may be an effective approach for reducing the stigma around being unpartnered, as many people are often not even aware that they may be subtly stigmatizing older, unpartnered women (Morris et al., 2007). Lastly, protest methods are a third method for reducing stigma. This method reduces stigma by addressing stigmatizing public statements, media reports, and/or

advertisements (Rusch et al., 2005). For example, protest methods to reduce the stigma of being unpartnered may focus on raising awareness about and removing public statements, media reports (e.g., television shows, news reports), and advertisements that reinforce the negative stereotypes and stigma against unpartnered women. This method may be effective for reducing the stigma associated with being unpartnered as it may stop promoting the traditional ideology that partnership is central to the happiness of women, and that being unpartnered is 'dysfunctional'. Thus, it appears that education and protest methods for reducing stigma may be effective strategies for decreasing stigma around being unpartnered.

Stigma reduction strategies using educational or protest methods need to first focus on increasing *awareness* that stigma against unpartnered women exists, and then work to *decrease* negative attitudes and common stereotypes about this population (Graham et al., 2003; Heijnders et al., 2006; Raingruber, 2002). These strategies must be multi-pronged in order to address the stigma at a variety of levels. Two key areas to address include language and actions. First, the language assumptions around partnership, sexuality, and gender roles need to be addressed. Many people currently appear to be unaware that certain language (e.g., "cat-lady", "old maid", "never going to find a man") can reinforce negative stereotypes and stigmatizing attitudes about a certain population or attribute (Sandfield et al., 2003; Sharp et al., 2011). Thus, bringing attention to this language is a key factor for increasing the awareness about the stigmatization of older, unpartnered women. For example, educational shows, information pamphlets, and/or theatre and art shows could provide useful information and bring attention to the stigma of unpartnered women to the larger rural population.

Second, the actions reinforcing stigmatizing attitudes about partnership, sexuality, and gender roles also need to be addressed. Social relationships that exclude a stigmatized population (e.g., partnered dances) could be modified to be more inclusive for all rural residents, including older, unpartnered women (e.g., encourage unpartnered women to come with their interpersonal relationships or having more group dances).

Stigma reduction and elimination is not an overnight process, and instead, requires time. The rural context needs to be considered when developing stigma reduction strategies for a rural population (Crawford & Brown, 2002; Raingruber, 2002). For example, changes in stigmatizing attitudes may be especially slow in a rural setting, where traditional norms (i.e., partnership) are highly valued, and varying from this norm often fosters gossip (Gaston, 2001; Leipert et al., 2005; Raingruber, 2002). Nevertheless, stigma reduction strategies aimed at reducing the subtle stigma associated with being unpartnered in a rural community are an important health promotion strategy to promote the development and maintenance of positive social relationships that include unpartnered women, and act to benefit their mental and emotional health.

Strategies to reduce the burden of being alone.

Another potential strategy to help unpartnered women develop and/or maintain their positive social relationships centers around reducing the burden of being alone. Participants indicated that they sometimes struggled to meet their practical and emotional needs on their own, while maintaining their independence and not asking for too much help from their social relationships. When participants struggled to meet their practical and emotional needs, their social relationships could be challenged due to a lack of time.

Key methods for reducing the burden of being alone include developing and improving formal and informal supports and services for unpartnered women living in a rural place.

Formal supports and services.

The research literature, as well as the present study, finds that many rural Canadian communities do not have adequate formal services (e.g., shopping centres, government services, restaurants, and/or theaters) that are accessible and appropriate for rural populations (Pahlke, 2001; Ryan, 2000; Ryan-Nicholls, 2004; Wang, 2004). This is due, in part, to the low population density, and large distances between communities, making the cost of formal services in rural areas much more expensive, per person, than those in larger population centres (Health Canada, 2003; Ryser et al., 2012). It is often not realistic for the Canadian government or businesses, financially, to develop formal services in each rural community. However, modified formal services, adapted to serve rural communities, may be effective for accessing rural populations in a cost-effective manner. Two primary methods for making formal services (and notably healthcare services) accessible for rural communities include outreach programs, and telehealth programs.

It may be practical for rural communities to develop outreach social services and supports that can travel to different rural communities and offer the much-needed formal services and supports in isolated and remote locations. For example, the Cape Breton Regional Library currently operates a 'bookmobile', where a van full of library books travels monthly to various rural communities that do not have permanent library facilities due to the small size of their community. This program provides library services to the rural populations of Cape Breton that would likely not be able to access the libraries as

often in the larger population centres. Thus, the bookmobile outreach library service is able to access rural populations in a cost-effective and 'community-size-appropriate' manner.

Such an outreach model may also be useful for making other formal services, such as government services (e.g., healthcare services) and businesses (e.g., shopping facilities, theaters, restaurants) more accessible for rural populations. A Cochrane review by Gruen, Weeramanthri, Knight, & Bailie (2009), of outreach programs in rural settings and population centres found that specialist outreach clinics (from simple consultations to complex multi-faceted interventions) were very beneficial for rural populations because they improved access to care, quality of care, health outcomes, patient satisfaction, and use of hospital services. Thus, increasing outreach services and supports for rural areas of Cape Breton may make formal services more accessible for rural populations, notably unpartnered women living alone.

Another method for increasing formal services and supports available for rural populations is telehealth. Telehealth, or telemedicine, is health practiced at a distance, using technology such as the Internet and videoconferencing. A review of telehealth methods found that its primary benefits were "increased access to health services, cost-effectiveness, enhanced educational opportunities, improved health outcomes, better quality of care, better quality of life, and enhanced social support" (Jennett et al., 2003, p. 311). More specifically, telehealth methods have also been useful for addressing mental healthcare challenges for rural populations by making mental healthcare more accessible and anonymous for rural populations (Hunkeler et al., 2000; Jennett et al., 2003).

Therefore, telehealth methods of healthcare may also help to make formal healthcare services and supports available for unpartnered women living in rural locations.

Informal supports and services.

While providing accessible and appropriate formal services for rural communities is important, the value and significance of informal social support and services must also be considered. Informal social supports are especially appropriate to consider in a rural setting because many rural residents tend to prefer informal supports over formal supports and because they are also less costly, relative to formal support services (Bushy, 2000). The present study found that unpartnered women living in a rural place had a tendency to rely on their social relationships as an informal support system. At the same time, however, some of the women struggled to meet their practical and emotional needs because they did not want to be 'needy' or reliant on their social relationships. Although participants indicated they received informal support from their positive social relationships, some rural unpartnered women may need more support than they are currently receiving in order to help them to meet their practical and emotional needs.

Therefore, perhaps what is needed is an increase in co-operative approaches to addressing challenges in rural communities. For example, the women may call on one of their key social relationships to help them meet a practical need, such as stacking firewood or painting the house. This informal support could be partially formalized and stabilized by creating a co-operative, where rural community members can sign up to receive and/or volunteer help in their community.

Co-operatives have long been documented as informal community support systems for rural locations (Johnston, 1950; Zeuli, Freshwater, Markley, & Barkley,

2009). They are important for rural communities because they involve local rural residents in collectively overcoming challenges specific for their rural community (Zeuli et al., 2009). Co-operatives can be developed to address a variety of rural challenges, from economic challenges (e.g., farming co-operatives that share seeds and farming equipment) to social challenges (e.g., transportation/carpool co-operatives to share vehicles and the cost of transportation). Promoting co-operatives may be especially beneficial for unpartnered women in rural communities because they also promote positive interpersonal and community social relationships among members. Thus, developing rural co-operatives may be a potential strategy for reducing the burden of being alone for unpartnered women.

Although co-operatives in rural communities may reduce the burden of being alone for unpartnered women, it is also important to not over-burden the informal supports, notably close friends, family, and community organizations. As formal services are regionalized and/or cut for rural areas of Canada, many rural residents are increasingly relying on informal forms of support to meet their practical and emotional needs, which may be stressing for the informal support systems in rural communities (Nocon & Pearson, 2000; Ryser & Halseth, 2011; Skinner, 2008). For example, the rural women in this study indicated that their community social relationships could sometimes be challenging and stressful when they demanded too much from the women, notably in terms of time and money. Therefore, it is also important to "care for the caregiver", and "provide adequate training for [rural] residents that equips them with the knowledge, tools, and networks to provide a greater level and breadth of support" (Ryser et al., 2011, p. 198).

Increasing both the formal and the informal supports available for unpartnered women living in a rural setting will likely reduce some of the obstacles to positive social relationships by helping the women to meet their practical and emotional needs and reducing the burden of being alone. When developing such supports and services, it is essential to ensure that they are not stigmatizing for the unpartnered women. That is, formal and informal supports and services need to respect the dignity of unpartnered women living in a rural place by helping them to remain independent and prevent the feeling of being 'needy' and reliant on such services. Support and services that are helpful and respectful for rural, unpartnered women will be the most successful at promoting positive social relationships, and mental and/or emotional health, for the women.

Strategies to promote aging-friendly rural communities.

This research found that the obstacles to social relationships, and to good mental and emotional health, might become especially challenging for rural, unpartnered women as they age. This mirrors current Canadian health trends, where "age-friendliness" is increasingly promoted as a population health strategy among the aging population of Canada (Health Canada, 2005; Lui, Everingham, Warburton, Cuthill, & Bartlett, 2009; Spine & Menec, 2013). These results demonstrate the importance of understanding rural populations as they age in order to promote age-friendly environments that are viable for the aging rural population to function and thrive in.

Promoting age-friendly environments is especially important in rural communities, where there is often a higher proportion of older and aging adults, caused, in part, by youth out-migration and senior in-migration (Dandy & Bollman, 2008;

Federal/Provincial/Territorial Ministers Responsible for Seniors, 2007). Rural communities pose unique challenges for older adults, and these rural factors need to be considered when developing age-friendly programs and/or policies. For example, a lack of services (social services, health services), a lack of affordable public transportation or housing options, and social isolation are some of the key challenges for rural adults as they age (Arbuthnot et al., 2007; Federal/Provincial/Territorial Ministers Responsible for Seniors, 2007; Health Canada, 2005; McDonald & Conde, 2009; Spina et al., 2013). These challenges are very similar to the obstacles to social relationships described by the unpartnered women living in a rural place. Developing healthy aging initiatives to promote the health of the aging population in rural Canada will play a key role in the health of rural Canadians, and especially rural unpartnered women living alone as they age.

Future Research

Many directions for future research emerged from this exploratory study. Currently, the literature on the social relationships and/or mental and/or emotional health of rural and unpartnered populations is primarily quantitative in nature. Statistics correlating various population groups with specific mental and emotional health challenges have been documented in the literature; however there is little research that takes these questions a step further and asks *why* certain health outcome differences are occurring among different population groups. This requires qualitative approaches in order to include the experiences and perspectives of different sub-populations and to also consider the contextual factors influencing the health of certain population groups. This type of health research is essential to develop an understanding of the qualitative data and

to develop effective and realistic solutions to promote health among specific population groups.

Due to the small scope of this study, comparisons between different types of unpartnered women (i.e., never-married, divorced, separated, and widowed) could not be completed. However, differences may exist among the different types of unpartnered women. Much of the literature indicates that widowed and divorced women, in general, have greater mental and emotional health challenges in comparison to never-married women (Cooney et al., 2001; Lin et al., 2012; Rohrer et al., 2008). A study using similar methods and a larger sample size would allow for inter-group comparisons among unpartnered women, and for a better understanding of how one's relationship history impacts one's current social relationships and mental and emotional health.

In addition to exploring the similarities and/or differences among various types of unpartnered women, further research is also needed to explore the social relationships of unpartnered women in a variety of rural settings. The present study was confined to a very rural and isolated area, with a long distance to the nearest medium and large population centres. Research studying a variety of settings would provide useful information as to how the geographical location, the physical environment, and the social characteristics of a rural setting may shape the social relationships and mental and emotional health of unpartnered women. In addition, the number of formal social supports or services available, and the reliance on informal social support or services will vary in each rural community, and this may impact the importance and value of positive social relationships in each setting.

Future studies exploring the social relationships of rural unpartnered women over a variety of age ranges will also be important contributions to the existing health literature. Participants in this study indicated that their social relationships may be especially challenging as they age. Further research is needed to explore the challenges associated with aging for rural unpartnered women as well as methods for reducing these challenges and promoting age-friendly initiatives in rural places (Spina et al., 2013).

Further studies are also needed to explore the role of certain key social relationships that were discussed by participants. Some participants spoke about their community relationship with a religious organization as a central aspect of their social life and of the rural culture. Studies exploring the role of religious organizations and community relationships within these religious organizations would be useful for exploring the role these organizations have for members and non-members in the rural community. Another key relationship discussed by some participants centered on their interpersonal or community relationships through work. The participants that were still working will likely be looking to retire within the next five to fifteen years. This may mean that the women will lose one of their key interpersonal or community relationships when they retire, which may challenge their mental and emotional health. Studies exploring how unpartnered women transition from a working lifestyle to a retired lifestyle, and how this transition impacts their social relationships are also needed. Lastly, some participants mentioned their pets throughout the interviews. Although this was not brought up as a key social relationship by any of the participants, future studies exploring the role of pets as positive companions in the lives of unpartnered women

living alone would provide useful information about alternative forms of social support and companionship.

There is also a need for similar research focusing on the social relationships for unpartnered men living in a rural setting, and how these relationships, or lack thereof, may impact their mental and emotional health. Rural men that are unpartnered may have poorer social relationships and supports relative to rural women because men tend to rely more heavily on their partners than women, and may also find it harder to ask for help (Clark et al., 2007; Krout, McCullough, & Kivett, 1997). Therefore, the social relationships, or lack of social relationships, in the lives of older, unpartnered men living in a rural setting may vary from those of unpartnered women due to gender roles, norms, and expectation in rural culture.

Throughout the interviews, traditional views about heterosexual partnerships and gender roles were common. While there is some literature regarding gender roles in rural communities, and how these gender roles are changing over time, there is very little research exploring people that identify as GLBTQ, and their social relationships in rural communities. Due to the emphasis on traditional partnerships, as well as the stigma, gossip, and/or social exclusion associated with varying from the norm in rural communities, lesbians likely experience unique obstacles to developing and maintaining key relationships in a rural setting. Further research exploring the social relationships in the lives of rural, lesbians would provide valuable information about the unique social relationships and mental and emotional health of these women.

Further research is needed on these various population groups in order to understand potential differences in mental and emotional health challenges among these

groups, and to establish context-specific solutions that address the specific challenges and needs of each population group. Research and evaluation studies are needed to follow-up with some of the suggestions for change in terms of programs and policies. Such evaluation studies are especially important to ensure that the programs and/or policies are effectively implemented, and that they are also effective at reducing the obstacles and promoting social relationships in the lives of older, unpartnered women living in a rural place. Evaluation studies could also be completed in a variety of settings to determine if the changes suggested by the women in the present study (rural Cape Breton) are also compatible with the needs of older, unpartnered women living in other rural areas. Such studies would be valuable additions to the current literature, as they would provide useful information about ways to improve the mental and emotional health of a population commonly absent among the literature.

Final Thoughts

In conclusion, unpartnered women living alone in a rural place value their positive interpersonal and community relationships, and recognize that these relationships are essential for them to maintain their mental and emotional health. At the same time, the women also experience certain obstacles to developing and/or maintaining these relationships, which can present challenges to their mental and emotional health. Many of the obstacles to positive social relationships described by the older, unpartnered women living alone in rural Cape Breton were similar to those described in the literature for rural populations in general and unpartnered women in general. However, it is especially important to address these obstacles for rural unpartnered women because they are living alone and need positive social relationships outside of their home, and because

they live in a rural place, where there is often a lack of formal social services. Therefore, it is essential to reduce the obstacles and promote positive social relationships in the lives of rural, unpartnered women throughout their life-course in order to promote their mental and emotional health and well-being.

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Appendix A: Ethical Approval Letter from Dalhousie Ethics Review Board

Health Sciences Research Ethics Board
Letter of Approval

October 17, 2012

Ms Jennifer Pasiciel
Health Professions\Health & Human Performance

Dear Jennifer,

REB #: 2012-2786
Project Title: An Exploration of Unpartnered Rural Women's Perceptions of How Their Social Relationships Influence Their Mental and Emotional Health

Effective Date: October 17, 2012
Expiry Date: October 17, 2013

The Health Sciences Research Ethics Board has reviewed your application for research involving humans and found the proposed research to be in accordance with the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans.* This approval will be in effect for 12 months as indicated above. This approval is subject to the conditions listed below which constitute your on-going responsibilities with respect to the ethical conduct of this research.

Sincerely,

Dr. Brenda Beagan, Chair

Appendix B: Consent Form for Pilot Face-to-face Interview

DALHOUSIE UNIVERSITY
Inspiring Minds

Faculty of Health Professions

Consent Form for Pilot Face-to-face Interview

Title of Study: An Exploration of Unpartnered Rural Women's Perceptions of How Their Social Relationships Influence Their Mental and Emotional Health

Researcher: Jennifer Pasiciel, MA Candidate, Dalhousie University

Thesis Committee:
Lois Jackson, Dalhousie University (Supervisor)
Debbie Martin, Dalhousie University
Madine VanderPlaat, Saint Mary's University
Tanya Brann-Barrett, Cape Breton University

Introduction

This is an invitation for you to take part in a pilot test of a research study exploring the relationships of unpartnered women living in rural Nova Scotia. This research study is being completed as part of a Master's of Arts student's thesis. It is important for you to read this consent form. It will help you to understand the study and what you need to do to participate. It will also explain any possible risks or benefits of participating. You have the option to not participate or withdraw from the pilot test throughout the data collection process. ***Your participation is your choice***. Informed consent begins at the first point of contact and continues until the end of the study. This package should help you to understand the details of participation. I (Jennifer Pasiciel) will be available to answer any questions you may have during the research process.

Description of the Research

This pilot test is being completed to ensure that the interview questions for the study are worded correctly and are capturing the intent of the research study. Only one (1) participant will be required for this part of the study. The purpose of the overall study is to explore the relationships of unpartnered women. This study will also explore how these relationships may challenge and/or benefit the mental and emotional health of unpartnered women. This research will also ask unpartnered women about the types of changes needed (if any), to their relationships to improve their mental and emotional health. This study is being done because there is a gap in the research that studies the relationships of unpartnered women in rural places.

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Debbie

What will you be asked to do?

If you are an unpartnered woman, 50-65 years of age, that has lived or is living in rural Nova Scotia, you will be asked to take part in this pilot face-to-face interview with me [Jennifer Pasiciel]. The interview will take place at a location that is convenient and safe. This may include a public library, college or university, or a community centre in rural Nova Scotia. The pilot test will be recorded using written notes only. You will be asked questions about your experience as an unpartnered woman living in rural Nova Scotia. This will include questions about your key social relationships and how you feel these relationships challenge and/or benefit your mental and emotional health. You will also be asked to recommend any changes that you feel may help to promote your health through improving social relationships. Lastly, you will be asked to provide feedback on the structure of the interview guide and the wording of the questions. Throughout the interview process, you can choose *not* to answer any question, leave the interview, or withdraw from the study without being questioned.

Data Storage and Management

Any personally identifying information will not be recorded. All computer files will be stored on a password-protected laptop during the research process. Your contact information will be destroyed one week following the pilot interview. All records from the interview will be destroyed after the thesis has been written. The principal investigator and thesis committee will have access to the written notes. They are required to sign an oath of confidentiality before seeing any data.

What are the possible risks?

You may not be comfortable talking about certain relationships, particularly if you have not had a positive experience. As such, it is suggested that you only discuss the information you feel comfortable sharing. The face-to-face pilot interview will be completed in a private space at a safe and public location. However, others may know you have participated. *Please do not discuss anything you do not wish to.*

There are mandatory reporting duties under the law if data in this study was ever necessary. This means that if information about child abuse or the abuse of an adult in need of protection is revealed, the law requires that this information be reported to the appropriate authorities.

What are the possible benefits?

Taking part in this study does not offer any significant direct benefits. However, participants may benefit from having the opportunity to discuss their relationships and health in a face-to-face interview. The results of this study may include suggestions to improve the social relationships of unpartnered women. The results will also add to the existing literature on the health of unpartnered women. This may lead to further research on this topic in the future.

Can I withdraw from the study?

You can withdraw from the study at any time throughout the interview. You can also choose not to answer specific questions if you do not want to. If you choose to not answer a question, the data from other responses may still be used for research purposes. There is no risk involved with withdrawing from the study.

Will the study cost me anything, and if so, how will I be reimbursed?

The study will not cost you anything other than the time and effort of participating in the interview. You will receive $20.00 (cash) prior to the pilot test to help cover your time and travel expenses related to participating in the research study.

Are there any conflicts of interest?

The principal investigator, research supervisor, and thesis committee have no conflicts of interest to declare.

What about possible profit from study results being used for business?

There is no planned profit associated with the study results.

How will I be informed of study results?

When the study is complete, a one- to two- page summary of the results will be prepared. This summary will be available at the various community organizations that were involved in this research study.

What if I have study questions or problems?

You can ask questions about the study at any time. If you have any questions about the research study, please contact: Jennifer Pasiciel: (902) 818-8781 or jpasiciel@dal.ca. If you have any ethical concerns about your participation in this research study, please contact Catherine Connors (Director of Research Ethics at Dalhousie University), at (902) 494-1462 or catherine.connors@dal.ca.

What are my Research Rights?

Your signature on the participant signature page indicates that you understand the information about this research. Your signature means you understand what will be needed from you. This does not waive your legal rights or release the researchers, sponsors, or involved associates from their legal and professional responsibilities. You are free to withdraw from the study at any point throughout the interview with no questions or consequences.

Signature Page: Participant

Title of Study: An Exploration of Unpartnered Rural Women's Perceptions of Their Social Relationships and How These Influence Their Mental and Emotional Health

Informed Consent

I have read or had read to me this consent form for the pilot face-to-face interview. I have had the chance to ask questions and they have been answered to my approval before signing my name. I understand that the nature of this study and I understand the possible risks. I understand that I have the right to withdraw from the study at any time throughout the interview process. I have received a copy of the consent form for future reference. *I freely agree to my participation in this research study.*

_____ (Initial) I have received $20.00 cash for participating in this study

Participant First Name

(Printed):_____

Participant First Name (Signature):_____Date:_____

Witness:_____

Witness Signature:_____Date:_____

Appendix C: Consent Form for Face-to-face Interview

DALHOUSIE UNIVERSITY
Inspiring Minds
Faculty of Health Professions

Consent Form for Face-to-face Interview

Title of Study: An Exploration of Unpartnered Rural Women's Perceptions of How Their Social Relationships Influence Their Mental and Emotional Health

Researcher: Jennifer Pasiciel, MA Candidate, Dalhousie University

Thesis Committee:
Lois Jackson, Dalhousie University (Supervisor)
Debbie Martin, Dalhousie University
Madine Vanderplaat, Saint Mary's University
Tanya Brann-Barrett, Cape Breton University

Introduction

This is an invitation for you to take part in a research study exploring the relationships of unpartnered women living in rural Nova Scotia. This research study is being done as part of a Master's of Arts student's thesis. It is important for you to read this consent form. It will help you to understand the study and what you need to do to participate. It will also explain any possible risks or benefits of participating. You have the option to not participate or withdraw from the study throughout the data collection process. ***Your participation is your choice***. Informed consent begins at the first point of contact and continues until the end of the study. This package should help you to understand the details of participation. I (Jennifer Pasiciel) will be available to answer any questions you may have during the research process.

Description of the Research

The purpose of this study is to explore the relationships of unpartnered women. This study will also explore how these relationships may challenge and/or benefit the mental and emotional health of unpartnered women. This research will also ask unpartnered women about the types of changes needed (if any), to their relationships to improve their mental and emotional health. This study is being done because there is a gap in the research that studies the relationships of unpartnered women in rural places.

How will the researchers do this study?

This research study consists of two parts. The first part will be a face-to-face interview with me (Jennifer Pasiciel). It will last approximately one (1) to one and a half (1 ½) hours. This component will involve eight to ten study participants. The second part of the study will be an optional follow-up telephone interview with individuals who have participated in the face-to-face interview. This part of the study is expected to last approximately 30 minutes. *You may, or may not choose to participate in this second interview.*

What will you be asked to do?

If you are an unpartnered woman, 50-65 years of age, living in rural Cape Breton without any dependents, you will be asked to take part in a face-to-face interview with me [Jennifer Pasiciel]. These interviews will be done in a place that is convenient and safe. This may include a public library, college or university, or a community centre in Cape Breton. Interviews will be digitally recorded. However, if you do not wish to be digitally recorded, the interview will be documented using written notes only. If you choose to have the interview digitally recorded, the tape will be transcribed word-for-word by either myself (Jennifer Pasiciel) or a hired professional transcriber. You will be asked questions about your experience as an unpartnered woman living in rural Nova Scotia. This will include questions about your key social relationships. It will also include questions about how these relationships may challenge and/or benefit your mental and emotional health. You will also be asked to suggest any changes that you feel may help to promote healthy social relationships among unpartnered women. You can at any point choose *not* to answer any question, leave the interview, or withdraw from the study without being questioned.

The second part of the study will consist of an *optional* follow-up telephone interview. You may or may not choose to participate in this part of the study. The follow-up telephone interviews are being completed in order to discuss the general results from the face-to-face interviews. This interview is also being done to discuss any program/policy changes that may promote healthy relationships for rural unpartnered women. The follow-up telephone interview will be recorded using written notes only. This means that direct quotations will not be used from this part of the research study. Again, you can choose *not* to answer any question, leave the interview, or withdraw from the study without being questioned.

Data Storage and Management

Any personally identifying information will be removed from all data as soon as possible after the interview. All computer files will be stored on a password-protected laptop during the research process. Any contact information will be destroyed one week following the final interview (either the face-to-face interview or optional follow-up telephone interview). All paper and digital records will be stored in a locked cabinet in an office at Dalhousie University. All records will be destroyed after five years. Only the principal investigator and research supervisor will have access to the digital tapes.

The thesis committee will have access to the full interviews after any identifying information has been removed from the data. All researchers and the professional transcriber (if hired) are required to sign an oath of confidentiality before taking part in this study.

All direct quotations, if you agree to being directly quoted, will be identified by participant number and partnership status (e.g. never-married, divorced, separated, or widowed). Quotations will be used in publications or presentations in order to show the key themes from the data. Demographic information will be presented for all participants together.

What are the possible risks?

You may not be comfortable talking about certain relationships, particularly if you have not had a positive experience. As such, it is suggested that you only discuss the information you feel comfortable sharing. This is a small-scale research study being completed in tight-knit rural Cape Breton communities. As a result, there is a risk that the information you discuss may be linked to you personally. The face-to-face interviews will be completed in a private space at a safe and public location. However, others may know you have participated. *Please do not discuss anything you do not wish to.*

There are mandatory reporting duties under the law if data in this study was ever necessary. This means that if information about child abuse or the abuse of an adult in need of protection is revealed, the law requires that this information be reported to the appropriate authorities.

What are the possible benefits?

Taking part in this study does not offer any significant direct benefits. However, participants may benefit from having the opportunity to discuss their relationships and health in a face-to-face interview. The results of this study may include suggestions to improve the social relationships of unpartnered women. The results will also add to the existing literature on the health of unpartnered women. This may lead to further research on this topic in the future.

Can I withdraw from the study?

You can withdraw from the study at any time up to one week following the face-to-face interview or follow-up telephone interview. You can also choose not to answer specific questions if you do not want to. Withdrawing or not responding will not affect you in any way. If you choose to not answer a question, the data from other responses may still be used for research purposes. There is no risk involved with withdrawing from the study.

After participating in the face-to-face or the follow-up telephone interview, you will have up to one week to contact me (Jennifer Pasiciel) if you would like to remove your data from the study. Again, there is no risk or negative consequence from withdrawing from the study.

Will the study cost me anything, and if so, how will I be reimbursed?

The study will not cost you anything other than the time and effort of participating in the face-to-face interview (and the telephone follow-up interview if you choose to take part in this part of the study). You will receive $20.00 (cash) prior to the face-to-face interview to help cover your time and travel expenses related to participating in the research study. You will *not* receive any additional compensation for participating in the telephone follow-up interview. The principal investigator will initiate the follow-up interview telephone call, however you may have to cover telephone charges for this incoming call.

Are there any conflicts of interest?

The principal investigator, research supervisor, and thesis committee have no conflicts of interest to declare.

What about possible profit from study results being used for business?

There is no planned profit associated with the study results.

How will I be informed of study results?

When the study is complete, a one- to two- page summary of the results will be prepared. This summary will be available at the various community organizations that were involved in this research study.

What if I have study questions or problems?

You can ask questions about the study at any time. If you have any questions about the research study, please contact: Jennifer Pasiciel: (902) 818-8781 or jpasiciel@dal.ca. If you have any ethical concerns about your participation in this research study, please contact Catherine Connors (Director of Research Ethics at Dalhousie University), at (902) 494-1462 or catherine.connors@dal.ca.

What are my Research Rights?

Your signature on the participant signature page indicates that you understand the information about this research. Your signature means you understand what will be needed from you. This does not waive your legal rights or release the researchers, sponsors, or involved associates from their legal and professional responsibilities. You are free to withdraw from the study throughout, and up to one week following your participation with no questions or consequences.

Signature Page: Participant

Title of Study: An Exploration of Unpartnered Rural Women's Perceptions of Their Social Relationships and How These Influence Their Mental and Emotional Health

Informed Consent

I have read or had read to me this consent form for the face-to-face interview. I have had the chance to ask questions and they have been answered to my approval before signing my name. I understand that the nature of this study and I understand the possible risks. I understand that I have the right to withdraw from the study at any point throughout the data collection process and up to one week following the interview. I have received a copy of the consent form for future reference. *I freely agree to my participation in this research study.*

Please circle YES or NO for the following questions:

1. I agree to have this interview recorded using a digital recorder. Direct quotations from my interview may also be used be used in any publications/presentations/reports.

   YES NO

2. I would like to participate in the follow-up telephone interview.

   YES * NO

If you wish to participate in the follow-up telephone interview, please provide your contact information:

Preferred Phone Number: _____ Contact Times:_____

Alternative Phone Number:_____ Contact Times:_____

_____ (Initial) I have received $20.00 cash for participating in this study

Participant First Name (Printed):_____

Participant First Name (Signature):_____Date:_____

Witness:_____

Witness Signature:_____Date:_____

Appendix D: Consent Form for Follow-up Telephone Interview

DALHOUSIE UNIVERSITY
Inspiring Minds

Faculty of Health Professions

Consent Form for Follow-up Telephone Interview

Title of Study: An Exploration of Unpartnered Rural Women's Perceptions of How Their Social Relationships Influence Their Mental and Emotional Health

Researcher: Jennifer Pasiciel, MA Candidate, Dalhousie University

Thesis Committee:
Lois Jackson, Dalhousie University (Supervisor)
Debbie Martin, Dalhousie University
Madine Vanderplaat, Saint Mary's University
Tanya Brann-Barrett, Cape Breton University

Introduction

This is an invitation for you to take part in the second part of a research study exploring the relationships of unpartnered women living in rural Nova Scotia. If you are reading this, you have completed the face-to-face interview and shown that you would also like to take part in the follow-up interview. This research study is being completed as part of a Master's of Arts student's thesis. It is important for you to read this consent form. It will help you to understand the study and what you need to do to participate. It will also explain any possible risks or benefits of participating. You have the option to not participate or withdraw from the study throughout the data collection process. ***Your participation is your choice***. Informed consent begins at the first point of contact and continues until the end of the study. This package should help you to understand the details of participation. I (Jennifer Pasiciel) will be available to answer any questions you may have throughout the research process.

Description of the Research

The purpose of this study is to explore the relationships of unpartnered women. This study will also explore how these relationships may challenge and/or benefit the mental and emotional health of unpartnered women. This research will also ask unpartnered women about the types of changes needed (if any), to their relationships to improve their mental and emotional health. This study is being done because there is a gap in the research that studies the relationships of unpartnered women in rural places.

The follow-up telephone interview is being completed in order to discuss the general results from the face-to-face interviews. This interview is also being done to discuss any program/policy changes that may promote healthy relationships for rural unpartnered women. The follow-up telephone interview will be recorded using written notes only. This means that direct quotations will not be used from this part of the research study. Again, you can choose *not* to answer any question, leave the interview, or withdraw from the study without being questioned.

Data Storage and Management

Any personally identifying information will be removed from all data as soon as possible after the interview. All computer files will be stored on a password-protected laptop during the research process. Any contact information will be destroyed one week following the final interview. All paper and digital records will be stored in a locked cabinet in an office at Dalhousie University. All records will be destroyed after five years. The principal investigator and thesis committee will have access to the written notes. They are required to sign an oath of confidentiality before seeing any data.

What are the possible risks?

You may not be comfortable talking about certain relationships, particularly if you have not had a positive experience. As such, it is suggested that you only discuss the information you feel comfortable sharing. This is a small-scale research study being completed in tight-knit rural Cape Breton communities. As a result, there is a risk that the information you discuss may be linked to you personally. *Please do not discuss anything you do not wish to.*

There are mandatory reporting duties under the law if data in this study was ever necessary. This means that if information about child abuse or the abuse of an adult in need of protection is revealed, the law requires that this information be reported to the appropriate authorities.

What are the possible benefits?

Taking part in this study does not offer any significant direct benefits. The results of this study may include suggestions to improve the social relationships of unpartnered women. The results will also contribute to the existing literature on the health of unpartnered women. This may lead to further research on this topic in the future.

Can I withdraw from the study?

You can withdraw from the study at any time up to one week following the follow-up telephone interview. You can also choose not to answer specific questions if you do not want to. Withdrawing or not responding will not affect you in any way. If you choose to not answer a question, the data from other responses may still be used for research purposes. There is no risk involved with withdrawing from the study.

After participating in the follow-up telephone interview, you will have up to one week to contact me (Jennifer Pasiciel) if you would like to remove your data from the study. Again, there is no risk or negative consequence from withdrawing from the study.

Will the study cost me anything, and if so, how will I be reimbursed?

The study will not cost you anything other than the time and effort of participating in the telephone follow-up interview if you choose to take part in this part of the study. You will *not* receive any additional compensation for participating in the telephone follow-up interview. The principal investigator will initiate the follow-up interview telephone call, and you may have to cover telephone charges for this incoming call.

Are there any conflicts of interest?

The principal investigator, research supervisor, and thesis committee have no conflicts of interest to declare.

What about possible profit from study results being used for business?

There is no planned profit associated with the study results.

How will I be informed of study results?

When the study is complete, a one- to two- page summary of the results will be prepared. This summary will be available at the various community organizations that were involved in this research study.

What if I have study questions or problems?

You can ask questions about the study at any time. If you have any questions about the research study, please contact: Jennifer Pasiciel: (902) 818-8781 or jpasiciel@dal.ca. If you have any ethical concerns about your participation in this research study, please contact Catherine Connors (Director of Research Ethics at Dalhousie University), at (902) 494-1462 or catherine.connors@dal.ca.

What are my Research Rights?

Your signature on the participant signature page indicates that you understand the information about this research. Your signature means you understand what will be needed from you. This does not waive your legal rights or release the researchers, sponsors, or involved associates from their legal and professional responsibilities. You are free to withdraw from the study throughout and up to one week following your participation with no questions or consequences.

Signature Page: Participant

Title of Study: An Exploration of Unpartnered Rural Women's Perceptions of Their Social Relationships and How These Influence Their Mental and Emotional Health

Informed Consent

I have read or had read to me this consent form for the follow-up telephone interview. I have had the chance to ask questions and they have been answered to my approval before verbally providing consent. I understand that the nature of this study and I understand the possible risks. I understand that I have the right to withdraw from the study at any point throughout the data collection process and up to one week following the interview. I have received a copy of the consent form for future reference. *I freely agree to my participation in this research study.*

For Interviewer to fill out only:

_____(First name only) has read or been read the informed consent form for the follow-up telephone interview and verbally agrees to take part in this research study.

PI Signature:_____

Date:_____

Appendix E: Sample Recruitment Poster

DALHOUSIE UNIVERSITY
Inspiring Minds

Faculty of Health Professions

PARTICIPANTS NEEDED FOR RESEARCH ON RURAL WOMEN'S HEALTH

Are you a **female** between the ages of **50-65**?
Have you been **unpartnered*** for the past 5 years?
Have you lived in **rural** Cape Breton for at least one year?

*Unpartnered means you have not been married, cohabiting, or in a serious relationship in the past five years, and do not currently have any dependents living with you.

We are looking for volunteers to take part in a research study exploring unpartnered women's social relationships and how they perceive these relationships as affecting their mental/emotional health. The research consists of one (~1 hour) interview in your rural community and you will be provided a $20.00 honorarium for your participation.

You may also choose, if you wish, to participate in a follow-up telephone interview. There will be no additional compensation for this participation.

If you would like to participate in the one-on-one, face to face interview, or for more information please contact:

Jennifer Pasiciel
MA Health Promotion (Candidate)
Dalhousie University
(902) 818-8781
jpasiciel@dal.ca

This study has been reviewed by, and received ethics clearance from, the Dalhousie Health Science Research Ethics Board at Dalhousie University.

Appendix F: Screening Questionnaire

Inclusion/Exclusion Criteria Screening Script

Use this script when screening potential study participants via telephone or email:
Hello, thank you for your interest in participating in this research study. My name is Jennifer Pasiciel and I am the principal investigator in this research study. I would just like to ask you several screening questions to make sure you fit within the inclusion and exclusion criteria for this study. If you do, and you still want to participate we can then set a date, time, and location for the interview.

1. First, are you female?

☐Yes: Continue to next question

☐No: Cannot participate in study

2. Are you currently between the ages of 50 and 65 years old?

☐Yes: Continue to next question

☐No: Cannot participate in study

3. Do you understand and feel comfortable speaking basic English?

☐Yes: Continue to next question

☐No: Cannot participate in study

4. Have you been unpartnered* for the past 5 years?
*unpartnered means that you have not been married, cohabiting, or in a serious or long-term relationship over the past five years.

☐Yes: Continue to next question

☐No: Cannot participate in study

5. Have you lived in a rural region of Cape Breton for at least the past year?
*rural includes any area outside of the medium population centre, CBRM.

☐Yes: Continue to next question

☐No: Cannot participate in study

6. Do you have any dependents living with you currently, such as your children or parents?

☐Yes: Cannot participate in study

☐No: Participant fits within all inclusion/exclusion criteria→ **schedule interview**

INTERVIEW:
First Name Only:_____

Date: _____ Time: _____

Location:_____

Contact Information:_____

Appendix G: Interview Guide for Face-to-face Interview

1st INTERVIEW GUIDE: UNPARTNERED RURAL WOMEN

BEFORE THE INTERVIEW

1) Thanks the participant for agreeing to volunteer for the research study

2) Provide the participant with a copy of the consent form to review

3) Verbally review the Consent Form with the participant and complete signatures

4) Give honorarium to participant, and have them sign the Informed Consent Form

5) Re-emphasize that participation is completely voluntary and that they may stop the interview at any time, or refuse to answer any questions that they do not want to answer

6) Ask the participant if they have any questions before the interview begins

7) Thank the participant for taking part in the interview

8) Fill out the Socio-Demographic Form with the participant

9) Check the two digital recorders (if participant has consented to being recorded)

10) Start the interview!

THE FACE-TO-FACE ONE-ON-ONE INTERVIEW

This interview is composed of three sections. The first section will ask questions about your experiences as being an unpartnered woman living in rural Cape Breton. In the second part, I will ask some questions about your social relationships. I will also ask how you feel these relationships may be challenging or benefiting your mental and emotional health. The third and final section of this interview will focus on changes you may recommend to improve the social relationships of unpartnered women, and their mental and emotional health as a result.

SECTION A: RURAL, UNPARTNERED EXPERIENCE

First, I would like to ask you some questions about your experiences as being an unpartnered woman in a rural setting.

---

1. Could you tell me about your experience living unpartnered in a rural setting?

    Probes: What do you like about being unpartnered and living in a rural setting? What are the benefits? (Do you feel that these benefits are due to age/ gender/ your rural location/ your partnership status?)
    Probe: What do you dislike about being unpartnered and living in a rural setting? What are the challenges? (Do you feel that these challenges are due to age/ gender/ your rural location/ your partnership status?)
    Probe: Have you ever experienced stigmatization or discrimination because you are unpartnered? If yes, can you please explain with examples? Does this happen often?
    Probe: Do you feel like you 'belong' in your community, given your status as unpartnered? Do you ever feel that you do not belong?

SECTION B: INTERPERSONAL & COMMUNITY SOCIAL RELATIONSHIPS AND MENTAL/EMOTIONAL HEALTH

In this next section, I will be asking you about your key social relationships. I will also be asking about how you feel these relationships may be beneficial or challenging to your mental and emotional health. So for example, emotional health focuses on your feelings and the ability to have appropriate emotional reactions (such as anger and/or happiness). Mental health, on the other hand, focuses on the ability to think clearly and analyze critically. Emotional health and mental health are closely related, and good mental health often goes along with good emotional health. Both contribute to an individual's overall health and general well-being.

1. First, I would like to focus on your key relationships at the interpersonal level. By interpersonal relationships, I mean any relationships that you have on an individual or one-on-one level, such as those with family or close friends. Could you tell me about one of your key interpersonal social relationships?

   Probe: What do you like about this relationship? How does this relationship benefit your mental and emotional health, if at all? (Do you feel that these benefits are due to age/ gender/ your rural location/ your partnership status?)
   Probe: What do you dislike about this relationship? How does this relationship challenge your mental and emotional health, if at all? (Do you feel that these challenges are due to age/ gender/ your rural location/ your partnership status?)
   Probe: Do you ever feel left out of this relationship? How so?
   Probe: Do you ever experience stress, anxiety, worry, or difficulty communicating in this relationship?

   Do you have any other key interpersonal relationships? (Repeat probes as necessary)

2. Now, I'd like to focus on your key relationships at the community level. By community relationships, I mean broader relationships with a variety of people within a certain group or organization. Could you tell me about one of your key community social relationships?

   Probe: What do you like about this relationship? How does this relationship benefit your mental and emotional health, if at all? (Do you feel that these benefits are due to age/ gender/ your rural location/ your partnership status?)
   Probe: What do you dislike about this relationship? How does this relationship challenge your mental and emotional health, if at all? What are the challenges (if any) in terms of your mental/emotional health? (Do you feel that these challenges are due to age/ gender/ your rural location/ your partnership status?)
   Probe: Do you ever feel left out of this relationship? How so?

Probe: Do you ever experience stress, anxiety, worry, or difficulty communicating in this group or organization?

Do you have any other key community relationships? (Repeat probes as necessary)

3. Could you tell me about your experience in terms of any social relationships that you are not apart of, if any?

Probe: Do you feel excluded from any interpersonal or individual relationships? Do you feel excluded from any community social relationships?
Probe: If yes, do you think this affects your emotional/mental health? If so, how?
Probe: Does living in a rural place make it difficult to form or maintain relationships with individuals or the community? Can you give me any examples?
Probe: Does being unpartnered make it difficult to form or maintain relationships with individuals or the community? Can you give me any examples?

SECTION C: SUGGESTIONS FOR POLICY/PROGRAM CHANGES, IF ANY

In this final section I will be asking you about the changes, if any, you feel may be useful to improve the social relationships in the lives of unpartnered women living in rural Nova Scotia.

---

1. Do you have any suggestions for future policy or program changes to improve the key social relationships in the lives of unpartnered women living in rural Nova Scotia?

Probe: Can you think of any methods to overcome barriers to social relationships (i.e. stigma, isolation, financial issues)?
Probe: Individual or community approaches?
Probe: What do you think needs to be done to create these policy and/or program changes?

2. Is there anything you would like to add that you feel was not addressed in terms of your mental and emotional health?

Thank you again for volunteering to participate in this research study on unpartnered women's health in rural Nova Scotia!

Appendix H: Demographic Questionnaire

To be filled out by or answered verbally by participant.

Age:_____

Occupation:_____

Highest Level of Education: (check the box that applies)

- ❒ Primary School
- ❒ Some Secondary School
- ❒ Completed High School
- ❒ Some Community College
- ❒ Completed Community College
- ❒ Some Undergraduate University
- ❒ Completed Undergraduate University
- ❒ Some Postgraduate University
- ❒ Completed Postgraduate University
- ❒ Other:_____

Your Annual Income Range:

- ❒ Under $29,999
- ❒ $30,000 to $59,999
- ❒ $60,000 to $89,999
- ❒ $90,000 to $119,000
- ❒ Over $120,000

What is your Relationships Status?

- ❒ Never-married
- ❒ Divorced
- ❒ Separated
- ❒ Widowed
- ❒ Other:_____

For how long have you been unpartnered?_____ (years)

How long have you lived continuously in this rural community? _____ (years)

_____

Appendix I: Local and Provincial Mental and Emotional Health Services

Provincial Mental and Emotional Health Services:

Canadian Mental Health Association:
Provincial Toll-Free Number: 1-(877) 466-6606
Cape Breton Branch: (902) 567-7735

Local Mental and Emotional Health Services:

Baddeck:
Victoria County Memorial Hospital – (902) 295-2212

Cheticamp:
Sacred Health Community Health Centre – (902) 224-4016

Evanston:
Strait Richmond Hospital – (902) 625-3100

Glace Bay:
Glace Bay Mental Health Clinic – (902) 849-4413

Ingonish:
Buchanan Memorial Community Health Centre – (902) 336-2200

Inverness:
Inverness Consolidated Memorial Hospital – (902) 258-1911

Sydney:
Sydney Mental Health Clinic – (902) 567-7730

Appendix J: Interview Guide for Follow-up Telephone Interview

FOLLOW-UP TELEPHONE INTERVIEW GUIDE:

BEFORE THE INTERVIEW

1. Thank the participant for agreeing to volunteer for the research study

2. Ensure the participant is in a quiet and confidential space and is able to talk for approximately 30 minutes

3. Verbally review the consent form for the follow-up telephone interview with the participant. Ensure participant has hard-copy, which was given to them during the face-to-face interview. If not, ask if they would like an electronic copy emailed to them.

4. Get verbal consent from participant and sign the consent form

5. Re-emphasize that participation is completely voluntary and that they may stop the interview at any time, or refuse to answer any questions that they do not want to answer

6. Ask the participant if they have any questions before the interview begins

7. Thank the participant for taking part in the interview

8. Have paper and writing utensil ready to take written notes

9. Start the interview!

THE FOLLOW-UP TELEPHONE INTERVIEW

This interview is composed of two sections. The first section will ask you to provide feedback about the emerging preliminary themes from all of the face-to-face interviews completed in November, 2012. The second part will focus on any additional changes you may recommend, if any, in order to improve the social relationships of unpartnered women, and as a result, help their mental and emotional health.

SECTION A: FEEDBACK ON PRELIMINARY ANALYSIS

First, I am going to share some of the preliminary findings from the analysis of all of the face-to-face interviews. After I have discussed the results, you will have the opportunity to provide feedback about the preliminary findings.

- Unpartnered women living in rural Cape Breton who I interviewed have a *variety of social relationships*
    - Individual level: family and close friends
    - Group level: religious organizations, shared interest groups, and work groups

- Participants indicated that they had *positive social relationships*: reliable, supportive, respectful, understanding, and provide a sense of belonging
    - Prevent mental and/or emotional health challenges (loneliness and depression)
    - Beneficial to their mental and/or emotional health
    - *Rural context:* can promote positive social relationships
        - People know who you are because of the smaller, close-knit communities
        - Variety of community organizations available for older women in their communities
    - *Unpartnered context:* can promote positive social relationships
        - More time and freedom

- Participants indicated that they also had *negative social relationships: can* create exclusion, isolation, stress, worry, and sometimes forced relationships
    - Can create challenges for mental and/or emotional health
    - *Rural context:* can create challenges and negative social relationships
        - Group gossip or rumors
        - You can become too involved → are pressured to stay involved in what can be a costly (time and money-wise)
    - *Unpartnered context:* can create challenges and negative social relationships
        - All relationships have to be organized outside of the home
    - *Awareness of being partnered and/or unpartnered*
        - Partnered activities or events, such as dinners or dances

        - Lack of understanding from partnered people about being unpartnered
        - Gossip and people 'trying to pair you up'
    - *Reliance on self:* work around the house, transportation, income, and to develop individual and community social relationships
        - Rural context: hard to find help with work
        - Challenges mental and/or emotional health by increasing stress, worry, isolation, and vulnerability

Follow-up questions for discussion:

- Do these results make sense to you? Can you explain why?
- Do any of the results not make sense to you? Can you explain why?
- Is there anything you would like to add?

SECTION B: SUGGESTIONS FOR POLICY/PROGRAM CHANGES, IF ANY

In this section I will be asking you about any additional changes (beyond what you said in the face-to-face interview), if any, you feel may be useful to improve the social relationships, and therefore the mental and/or emotional health of unpartnered women living in rural Cape Breton. Again, I will briefly present the overall results in terms of the suggestions provided in the first set of interviews, and the give you the opportunity to discuss the findings afterwards.

- Changes to promote the development and maintenance of positive social relationships
    - Year-round facilities within the community to meet (e.g.: restaurants or cafés)
    - Sustainable funding for rural community groups or organizations
    - More women's-only, "sisterhood"-type events
- Changes focused on reducing the reliance on self for rural unpartnered women
    - Assisted-type living options in a rural setting
    - Improved transportation options
    - Mental and emotional help groups, especially for times of crisis
    - Financial help options
    - A telephone support system
    - Affordable help with physical and manual labor
- Changes to reduce the subtle misunderstandings or barriers between partnered and unpartnered women
    - Increased awareness about the situation and challenges for rural, unpartnered women.

Follow-up questions for discussion:

- Do these results make sense to you? Can you explain why?
- Do any of the results not make sense to you? Can you explain why?
- Is there anything you would like to add?

2. In terms of what we have discussed, do you have any other suggestions for future policy or programs in order to develop or maintain key social relationships in the lives of unpartnered women living in rural Nova Scotia?

Probe: Can you think of any relevant methods to overcome barriers to social relationships (i.e. reliance on self, relationships outside of the home)?
Probe: Individual or community approaches?
Probe: What do you think needs to be done to create these policy and/or program changes?

3. Is there anything you would like to add that you feel was not addressed in terms of your mental and emotional health?

Thank you again for volunteering to participate in this research study on unpartnered women's health in rural Nova Scotia!