

AFRICAN-AMERICAN WOMEN AT MIDLIFE:
THE SOCIAL CONSTRUCTION OF HEALTH AND AGING

By

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A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

2004

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By

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ACKNOWLEDGMENTS

This work is dedicated to the memory of my foremothers. First, I thank my grandmother, Jessie, who taught the value of spirituality and fun. To my mother, Alberta, who always knew I could, I give thanks for the lessons of perseverance, belief in the indomitable spirit, and ballet lessons. To my othermothers, Frances Robinson-Combs, Elaine Frazier, Leslie Houts, Shannon Houvouras, and Sheila Roytman, I acknowledge their gifts of patience and kindness. To Sylvia Ansay and Renee Ruffin-Price for compassionate listening, I give thanks. I am grateful to the women of this study, who through the gift of their time shared my vision. Finally, I acknowledge and give thanks to my honorary othermothers, Joe Feagin, my academic advisor, and the other members of my dissertation committee, who helped put the pieces together and taught me to press on. I am grateful to my brothers, Gregory and Kenneth Combs, and to my spouse, Bobby Jones, for sharing and supporting my vision. I wish them peace and love.

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Abstract of Dissertation Presented to the Graduate School
of the University of Florida in Partial Fulfillment of the
Requirements for the Degree of Doctor of Philosophy

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August 2004

Chair: Joe R. Feagin

Major Department: Sociology

The intersections of race and gender clearly present a challenge in the study of health, aging and the life course among black women. Black women who experience the “double jeopardy” embedded in their status as black and female are dually penalized in a society that consistently discriminates on the basis of race and age. Moreover, the aging patterns of African-American women are issues made more complex by diversity due to social class. Inferences about the health and aging patterns of this group are frequently made using biomedical models and comparing black and white women. Such comparisons and models fail to account for the sociohistorical experiences through which the belief systems of black women are filtered. This study has two objectives. First, it seeks to disclose the social mechanisms that contribute to the health and aging beliefs of black women at midlife. In this respect the study is designed to examine the health beliefs and behaviors of black women as socially constructed within the context of family through intergenerational learning and a culturally bound collective memory. Second, this

study seeks to establish within-group patterns of normalcy, especially those that redefine midlife and aging within the context of the life course experiences of these black women. This research project is structured around four guiding questions. First, how do African-American women define their aging experience? Second, what roles do intergenerational learning and collective memories play in developing the beliefs of African-American women about aging and resultant changes in health? Third, is there a relationship between African-American women's perceptions of health care access and beliefs about their ability to "age successfully"? Fourth, what is the role of spirituality in the lives of these African-American women? In answering these questions I interview 26 midlife African-American women age 36 to 74 years of age. This study relies on the reported experiences of these participants to deepen the understanding of the interaction between individual and social constructs that affect health and aging across the life span of African-American women.

CHAPTER 1 INTRODUCTION AND LITERATURE REVIEW

At what age were you when you entered midlife?

I don't know if it was in my 40s, or my kids were grown and I didn't have to bother. I don't know. Kind of look to enjoy life for myself and not so much having someone dependent upon me. Not that I minded 'cause I enjoyed having them. But I was fortunate enough to look at them one day and started making sure that I enjoyed them. But after they were born it was a different stage of life. Maybe that was it, maybe it was the children that brought it on not necessarily an age.

The opening quote comes from a woman who declines to reveal her age until much later in the interview. "You really want to know my age?" she asks and wrinkles her nose. Rose is active with a part-time job related to her former career in education. Like many women in this study, she is well educated both formally and informally. Also like many of the women in this study, she is ambivalent as she searches for ways to define midlife and the experiences of health and aging. Rose's confusion, at age 71, is perhaps reflective of the research to date about African-American women and their health and aging experiences.

Black women as a group have rarely been studied in a systematic way. Yet there is evidence to suggest that early in the life course, and certainly by the time they reach midlife, African-American women have already experienced declines in health that are generally associated with older populations (Combs, 2001; LaVeist, 2000; Geronimus, 1996). In these studies, evidence suggests that being black is a major health disadvantage. In this sense, being black conditions the ways that African-Americans experience health,

illness and aging. This observation establishes the importance of conducting research that includes the social environment of the participants.

Purposes of the Study

This study has two purposes. The first is to disclose the social mechanisms that contribute to the health and aging beliefs of African-American women that manifest at midlife. To achieve this goal, twenty-six midlife black women are asked about life course events such as their earliest experiences with racism, the treatment they have received in the medical care system and the development of their spiritual beliefs.

Conceptually, the women's definitions and associated beliefs about midlife; their beliefs about health; and the roles of spirituality crystallize to form a cohesive Afrocentric and black feminist standpoint based heavily on their everyday experiences. A fourth concept relates solely to social structure and develops around the structural environments in which they operate. Their encounters with the social structures of the medical world serve to amplify beliefs about access to health care. These four concepts are more fully developed in separate chapters of this study.

The second, more complex purpose of this study is to establish within-group patterns of normalcy that define midlife and aging within the context of the life course experiences of black women. To the best of my knowledge, previous research has not attempted to define midlife and health related aging from the perspective of middle class black women. Typically studies of black women are conducted using models that compare black and white women and focus on the biomedical details of health. In this report, the data are generated by the participants. In this manner they themselves determine the cogent issues of midlife and health.

Approach

There are a number of reasons for choosing a within-group approach to the study of African-American women at midlife as opposed to one that compares black women to white women. I looked specifically at four of them in my study design.

The first basis for a within-group perspective for this study concerns the history of studies of black women. In general, black women are rarely studied from within the group or from outside of the biomedical models of health and aging. This causes most inferences about the aging and age-related patterns of health in African-American women to be made using biomedical models that compare black and white women. Moreover, the comparisons between black and white women tend toward labeling outcomes for black women as pathological (Whitfield & Baker-Thomas, 1999). In this respect, the research outcomes serve to bolster and increase the cultural capital of white women.

Cultural capital, according to Bourdieu and Wacquant (1992), is a commodity and a source of power for those who possess it; it is distributed when decisions are made about the source and the content of legitimate knowledge. This study regards the acknowledgment of the experiences of black women from their historical, political and structural positions in American society as cultural capital. The absence of these experiences from research robs black women of the cultural capital that legitimizes the knowledge produced by their experiences. In short, it produces a cultural assault that devalues their experiences and perspectives. The argument presented here is that it is far more significant to connect proven health disparity to individual and structural circumstances than it is to continue to compare rates of disease. The documented facts that African-American women have higher rates of diabetes, heart disease, stroke, and

cancer do little to bring research closer to explaining the cause for early onset of illness and higher mortality rates among black women.

A second reason to conduct within-group studies of black women stresses the importance of the sociohistorical experience. A sociohistorical experience considers the historical, political and social structures of C. Wright Mills' (1959) "sociological imagination," that impact individuals as they move through the life course. In the case of African-American women, this history includes slavery and the structures of institutional racism. Comparisons between black and white women fail to account for the sociohistorical experiences through which the belief systems of black women are filtered. In theory, as well as application, the experiences of racism and the ensuing discriminatory treatment filter the sociohistorical experiences of African-American women.

Third, comparisons between black and white women negate the intent of this research and violate one of the basic principles of feminist research methodology. The feminist standpoint seeks the creation of knowledge by those who reside in the borderlands of the dominant culture and not by those who are privileged by gender and race. In the traditions of feminist thinkers (Harding, 1998; Collins, 1998; Smith, 1987), this project addresses the issues of aging, health and wellness from the viewpoint of the women it studies. In this respect, this project argues that gaining an understanding of the daily lived realities of African-American women does not warrant a formalized comparison across racial lines. Informally, the women of this study make both implicit and explicit comparisons between themselves and white women that are consistent with the qualitative framework of the study.

The fourth and final argument regarding the strength of within-group study relates to the balance of power in the production of knowledge. This project, in using a within-group study approach, represents a resistance to power. It is this resistance to a power imbalance in the production of knowledge that so clearly distinguishes this study from those that are comparative in their approach. Thus the positioning of the black women represented in this study is not influenced by the ways in which they have previously been studied.

Background

This study of the health and aging beliefs among middle class African-American midlife women emerges from my earlier interest in the rates of age-related illness and early mortality among black women. That interest generated the question: Why are African-American women predisposed to higher rates of functional dependency than men and white women? The result of combining this information is that black women are assessed by health care practitioners as having more physical limitations or functional dependency as a result of aging than do white men and women or black men. However, there appears to be no literature that discusses physical limitation or functional dependency among black women. In short, this group of women is missing from the data.

In studies of aging, this functional dependency is gauged by the ability of the individual to perform specified tasks related to mobility and cognition. Traditionally this mobility and cognition have been measured by a count of activities of daily living (ADL, basic functions such as eating and bathing) and instrumental activities of daily living (IADL, cognitive functions such as taking medicine and keeping track of money). That model has since been adjusted, redefined, and renamed to include the consideration of conditions that demonstrate a conflict with the individual's environment. This has

brought into use the term physical limitation (Verbrugge & Jette, 1994). This expanded model takes into account environmental adaptations that make the categories of ADL and IADL too restrictive and allows a more accurate assessment of disablement. For example, certain environmental conditions, such as the close proximity of family member and fictive kin, may not consistently restrict aging black women. The historical strength of the social support networks among black families may operate to ameliorate those limitations. The simple reporting of numbers of ADL and IADL does not necessarily consider such factors as the support networks in black families and the cultural biases of self reporting. Studying the viewpoint of the participants ultimately encourages the discovery of the social structures within the community of black women that may contradict biomedical models of health and aging.

Research Questions

One of the primary purposes of this review is to situate the social construction of health and aging within the context of the African-American family unit. To do so, two key points need to be emphasized. First, the family as a social system is regarded to be the primary source for the development of values, beliefs and attitudes. It has been reported that, by and large, “families influence attitudes or beliefs [even] past childhood” (Glass, Bengston & Dunham, 1986, p. 696). Second, the real and mythical constructs of the American blacks’ family unit, like most social systems, develop and continue to evolve within a particular but fluid social environment. (Glenn, 2002; Gubrium, Holstein & Buckholdt, 1994; Elder, 1974). For example, Mullins (1997) reports that the mythical pathologies of the black family surfaced at a time “when African American women, men and children, along with some Euro-Americans were mobilizing against institutional racism and making significant gains in civil rights” (p. 79). In the era of the civil rights

movement, the strategy of devaluing the black family was used to diffuse movements against racism. Up to that point, African-American family structures were not considered a relevant social issue.

For African-Americans, there is a social environment that heavily influences their ability to participate equally in all aspects of American life. That environment includes a history of slavery and the legal segregation imposed through the Jim Crow laws of the last century. Furthermore, the social environment of blacks in the United States influences the roles of black women in the family, as well as conditions of unequal access to medical care. It is important to the arguments presented in this study to acknowledge and thereby begin to understand the historical biases that permit race and gender to act as barriers to blacks' access to health care.

The literature review associated with this project was a by-product of three guiding questions. In the progress of the fieldwork, however, a fourth question emerged and was incorporated into the study. These four research questions and the related literature are exemplified below.

How Do African-American Women Define Their Aging Experience?

This first research question derives from the literature that examines the social construction of health and aging. Although I could find no evidence that qualitative research has been conducted among midlife or aging middle class black women, literature does exist that develops the theory that health, illness and aging are social constructs external to the individual. As social constructs, beliefs about health, illness, and aging develop within the context of a specific social environment (Lorber & Moore, 2002; Lupton, 2000; Gubrium, Holstein & Buckholdt, 1994; Bordo, 1993; Andersen, 1988; Berger & Luckmann, 1967; Durkheim, 1979; Parsons, 1950). I apply the social

construction viewpoint to develop the position that the women of this study have constructed a view of health and aging specific to their sociohistorical experiences as black women in America. At the same time, these individual viewpoints are collective standpoints that reflect the everyday realities of their lives. The following comments by one of the study participants illustrate this phenomenon:

I don't know if this is factual, but I think black women age faster because of the stress and the pressures. Some may not agree. Although, white women *show* their age faster. We can be 75 and not look our age. White women may be able to hide it through cosmetic surgery, but black women don't because they can't afford it. Look at Tina Turner. She looks great.

In this woman's evaluation, the aging experience of black women is filled with the stress and pressures of being black. From the standpoint of a social context, this stress causes black women to age faster. Moreover, despite being middle class herself, she reasons that the financial resources of most black women restrict their ability to afford cosmetic surgery. However, she further reasons that because black women look younger than they are, cosmetic surgery is unnecessary. Thus in the social context of being a black woman, stress and unequal financial resources define aging black women.

The constructions of these women's points of view may be influenced by family systems. This family influence may be even more significant among southern blacks. As a result of continued segregated living, southern black family systems remain outside of the dominant culture's sphere of influence. Several participants describe their educational and general social interactions as being racially segregated. One woman expresses her separateness in this way: "I didn't really experience it [discrimination], or at least I didn't recognize it, because I lived in an all-black neighborhood." Her tone is both tentative and apologetic. This and similar comments about the experiences of a separate culture are more closely examined and further discussed in Chapter 4.

What Roles do Intergenerational Learning and Collective Memory Play in Developing the Beliefs of African-American Women about Aging and Health?

The examination of the second research question is informed by the literature on the transfer of knowledge and beliefs within the context of family and extended family. However, in order to develop a framework for understanding the roles of intergenerational learning and the collective memory in developing beliefs about aging, it is important to acknowledge the historical and stereotypical views of the black family. From a historical perspective, the African-American family was forged under conditions of slavery, splintered, and then following Reconstruction (1865–1877), reformed to meet the country's need for labor (Glenn, 2002; Dill, 1988). This relationship to production meant that black families, unlike Anglo family units of the pre-Reconstruction era, were not centered on patriarchal divisions of labor (Davis, 1983). Black women worked side by side with black men as field hands, often birthing children in cotton fields and returning to plant and plow shortly thereafter.

Despite egalitarian work relationships outside of the home, black men and women, and thus black families, maintained and even strengthened family ties. Following Emancipation, and within the framework of the Reconstruction era, black women left the work in the fields to manage their households and to supervise the activities of their children (Glenn, 2002). The stereotype of black women as matriarchs, the dominant figure in the household, continued to be a strong image in observations of the black family. In part, this stereotype evolved because black women who were working side-by-side with black men did not conform to Eurocentric ideologies of wife, mother and homemaker. Present day images of African-American family life continue to include these mythical images of black womanhood that overburden black women.

Questions about health and aging beliefs and experiences with health care systems support previous research efforts to disclose patterns in lifestyle, social environment and social structure that may influence how these participants construct midlife, health and aging. In 1984, The MacArthur Foundation brought together a group of scientists from divergent fields to conduct a 10-year study of successful aging. Their findings were published in over 100 scientific papers. The conclusion was that the process of normal aging, and the rate at which it occurs, is related to lifestyle, social environment and social structure and that genetics played a much smaller role than was thought (Rowe & Kahn, 1998; Elder, 1994; Riley, 1986; Featherman & Lerner, 1985). Additionally, in weighing the determinants of health, authors Porter and Gaston (2001) report that the most recent assessment by the national Centers for Disease Control and Prevention indicates that lifestyle governs 50 percent of the determinants of an individual's health. The remaining 50 percent is divided equally between heredity (20 percent) and environment (20 percent); medical care accounts for the remaining 10 percent of the determinants.

Both the MacArthur Foundation studies and the Centers for Disease Control and Prevention place an emphasis on socially constructed dimensions of health and aging. In a similar vein, this research project interviews thirty black women in an effort to expose those lifestyle patterns, social environments and social structures that may contribute to the early onset of illness and ultimately higher rates of mortality at earlier ages among black women.

Intergenerational relationships and collective memory

The research literature on aging addresses intergenerational relationships in terms of intergenerational solidarity. Under the rubric of aging studies, intergenerational solidarity concerns itself with measuring aspects of family dynamics. Among those

aspects is the “degree to which services are exchanged and the level of agreement about values and beliefs” (Quadagno, 1999, p. 404).

The existing literature addressing the social support or levels of exchange system among African-American families is primarily associated with the roles played by children in the care of aging parents. This study extrapolates from this traditional usage of intergenerational relationships to suggest that these relationships also provide the opportunity for the transfer of information, values, and beliefs. In particular, there is research to suggest that the intergenerational support system of the black family has not eroded and, in fact, may be stronger than that among white families (Laditka, 2000; Mutran, 1985). The existence of this support system implies that black families exhibit a cohesive characteristic that may foster a system for the transfer of knowledge and beliefs about health and aging. In this respect, this study will disclose evidence that among these black women, intergenerational knowledge is transferred through a collective memory of oppression. This collective memory is integral in forming their belief systems of health and aging.

At first glance, however, one study participant’s memory of family life failed to conclusively support this hypothesis about the intergenerational transfer of knowledge. When asked how she learned or came to know a particular aspect of her philosophy of life, she responds that she does not know, but thinks it comes from experience:

That is part of the black experience. Our families didn’t talk to us about life, of what to expect in life. We were all thrown out there. I never had a heart-to-heart with my mother or grandmother, even about our heritage or family tree. In elementary school, when doing show and tell about family, others would get up and talk about their different heritages. We can’t do that. Our parents didn’t talk about it. That is as far back as I can go, my grandparents. I can’t get people to talk about it. The slavery period, there’s a lot of shame. People did things just for survival. But because it’s not talked about, we don’t understand.

In these words, it is clear that this woman has no recollection of being told her history as a black woman in America. Judging by this account and the others examined in the succeeding chapters, it appears that the intergenerational transfer of beliefs is implicit rather than explicit and that the learning from the experiences of family members is more of a tacit experience among the women of this study.

The literature defines collective memory as “an extension of the past” into present time circumstances (St. Jean & Feagin, 1998, p. 33). An earlier examination of collective memory also suggests that the collective memory is cultural and always selective (Halbwachs, 1950). The hypothesis of a collective memory among African-American women asserts that the overt experience and traditions of discrimination, as well as the less concrete perceptions of discrimination, culturally bond African-American women. (St. Jean & Feagin, 1998; Feagin & McKinney, 2003). It is the position of this research project that this bonding and sisterhood often transcend

class, age, and regional differences. As shared experiences are the hallmark of cohorts, in this respect, black women are united as a cohort based on the discriminations imposed by race and sex. In turn, race and sex formulate a black, female consciousness or collective consciousness. The women of this study use this consciousness to define their health status, health beliefs, and health behaviors within a particular cultural environment and historic framework.

Afrocentricism and the collective memory

This study argues that within African-American families, and in particular among African-American women, there is an historical, cultural consciousness (Ani, 1994; Collins, 1991). This perspective, by design, is Afrocentric.

Afrocentrism is a method of social inquiry that has a strong and primarily academic concern for insertion of a cultural and intellectual African perspective into the social development of the American African Diaspora (Asante, 1987, 1988). At the center of this philosophy is the idea that the knowledge and preservation of African culture is essential to the survival of African-American cohesion. In addition, the Afrocentric literature maintains that exclusion of this perspective represents a racialized and inaccurate depiction of people of African descent. The Afrocentric philosophy is predicated on the belief that culture acts as a means to unify groups of persons. “Group identification” develops through shared values, attitudes, and beliefs (Ani, 1994). When group identification or cultural consciousness is lost, the way becomes clear for control of the group by a more dominant culture. For African-American women, this cultural consciousness, referred to in this study as the collective memory, has its genesis prior to Emancipation (Burgess, 2000).

Is there a Relationship between Perceptions of Access to Health Care and Beliefs about Black Women’s Ability to “Age Successfully?”

The third research question this study seeks to answer concerns access to health care. This question emerges from literature that discusses the structural inequalities of race and gender that form barriers to health care access. It is answered in part from literature related to the sociohistorical experiences of African-Americans.

A number of works briefly recount the sociohistorical basis for disparity in health care access among American Blacks (Feagin & McKinney, 2003; Burgess, 2000; Harris & Johnson, 2000; Byrd & Clayton, 2000). However, Byrd and Clayton (2000) provide one the most comprehensive works to date on the history of race, health and medicine in the United States. They outline seven “health system cultural” manifestations among

them is the “marginaliz[ation] of African-Americans at all levels of the health system” (p. xxiv). The following story, related by one study participant, presents a poignant illustration of the history of medical care for blacks in America.

Louise hesitates when asked her age. She is 67 and retired from a major retail chain. Louise has previously stated that she usually does not have an opinion about things, but after some extended prompting, recounts the birth, in 1957, of her twin sons in rural Mississippi. Louise quietly and evenly gives the following details of her birthing experience:

I went back to Mississippi during the pregnancy to stay with my family, and of course I went to the doctor there. From the time I was 4 months pregnant up until the babies were born, the doctor knew I was anemic. He didn't give me anything for it to build up my blood. So when my babies were born, he sent me to a hospital where they didn't take black women for childbirth. He sent me there. I don't know why. They put me in a room where they had only three other black people in the hospital. One of them was a diabetic, and I don't know what the others were in there for. So they put me in the room with these two women. We were in a little building that was outside of the hospital and it had three beds in there. They put me in the third bed. I think he was putting me in the hospital to keep me in there for a few days. I was in there and overnight I went into labor and the twins were born. After the twins were born, I went into convulsions and he had called my family and told them that I was dying and there was nothing he could do. And all I needed was blood, and he refused to give me a blood transfusion. And he had told them that blood in the hospital was for white people. So you can just imagine how many black people had died in Mississippi. It was 1957. So he says “she needs blood and we don't give transfusions to black people. The blood in the hospital is for white people, and we don't take blood from black people and we don't give blood to black people, to colored people.” So my brothers came down and said “we will donate the blood”. He said they don't take blood from black people and they don't give blood transfusions to black people.

This is one of the most detailed, candid, and moving accounts that the women of this study gave about disparate treatment in the American health care system. Although Louise's story is historical, it provides rich data about the lived experiences of black women.

What is the Role of Spirituality in Aging and Health?

The history of health care access among African-Americans is closely tied to the history of blacks as slaves in America, an historical relationship that is further examined in Chapter 5. This history of slavery also played a role in the development of a spiritual consciousness and practice among black women. As I began to closely examine the interview transcripts, one of the strongest and most consistent themes to evolve from the interviews was that of spirituality.

Early in the interview process, the participants repeatedly professed a belief and faith in a higher being they termed “God” or “the Lord.” These expressions of spirituality were connected to family values, intergenerational transfers of knowledge, and evidence of a collective memory of oppression. In this study, a closer examination of these spiritually based belief systems provides insight into the construction of participants’ professed beliefs about health and aging.

It is important at this point to define spirituality, a concept that is often misconstrued as church affiliation. While church affiliation and activism through church work are traditions among black women, they do not come more from one church denomination than from another. Perhaps this loose association with church denomination speaks more of the significance of spirituality than it does of religiosity. In these words, Perkins (1995) suggests that her own spirituality is a means to connect with others:

I suspect now there are myriad paths to spiritual fulfillment. Of course, the assertion begs a definition of what it means to be spiritual; the concept evokes different meanings for different people. My own belief is that to be spiritual is to recognize and honor my inherent connection to other beings, to the earth, and to events in the world around me. It is to affirm life and to tap into the power—the life sustaining energies and forces that direct the motion of the universe. To be spiritual

. . . is to commune with, to nurture, and to celebrate that which is divine around and within us. (p.162)

Unlike “religion,” which Emile Durkheim (1979) defines as a social fact, “spirituality” is an individual and very personal experience not defined by the walls of a church. The approach of William James (1997), the early twentieth century American psychologist and philosopher, comes closest to defining the concept of spirituality referred to in this study. He relates “religious experience,” to religion, but only as the individual encounters it. In this sense, spirituality as a religious experience is not associated with any particular practice or physical symbol. In essence, James contrasts personal knowledge or experience with the inherited tradition of church attendance. In this respect he separates the church from the individualized religious experience. In some circles of sociological thought, spirituality appears as a subset of religion; therefore, to be religious implies that one is also spiritual.

The literature contains little regarding the concept of spirituality and its meaning in the world of religion. Again, the term is not clearly defined. Perhaps this is in part due to its relative youth. As a cultural marker, spirituality has been linked to the era of the baby boomers (1946–1964). Wade Clark Roof, in a 1993 work, surmises that “boomers,” in their rejection of organized religion, precipitated spirituality as a gesture of individuality. Admittedly, the era of the baby boomer produced major shifts in the economy, politics, and educational responses of the nation. These shifts may include the shift from religiosity to spirituality and the introduction of the term “spirituality” to the language of religious sociology.

This shift away from religiosity and to spirituality is clear in the words used by the study participants to explain how they connect to an essence that extends beyond their

own ability to control life circumstances. The women of this study define their spirituality outside the labels of a religious denomination employing its power to deliver them from worry and harm. Wilma, a study participant, illustrates this connection in talking about a difficult situation at work, or a time when she needs medical care. Of the work environment she says: “I pray about it. But it is still there.” She resorts to the same spiritual tool when she speaks about health care. “If I am going to the doctor, I [still] go. But I still pray for a healing. I pray before surgery. You want Him on your side.”

As with most discussions of religion and spirituality, there is much room for interpretation, and the debate goes far beyond the parameters of this study. However, the debate about the differences between spirituality and religiosity is less important than the fact that these women profess beliefs in a power outside of themselves that helps direct the activities of their daily lives.

As I will further demonstrate in Chapter 6, prayer is the symbol of spirituality among these women. Through prayer, the women of this study connect with one they call God. In their words there is the expressed belief that God has the ability to deliver them from worry and harm.

Theoretical Framework

The Life Course Perspective

The life course perspective is most often discussed in the context of aging. By definition, the life-course perspective primarily acknowledges and examines the circumstances of aging that are “socially created, socially recognized and shared” (Hagestad & Neugarten, 1985, p. 35). Other research (Riley & Bond, 1983; Featherman, 1983) includes the psychological contexts of human experience, as well as the biological dimensions of life, in studies of the life course. Across the life course of an individual,

the social environment, individual psychological frameworks, and individual biology, taken as a whole, determines how individuals experience aging. In discussing the social construction of realities that produce a black feminist perspective, Patricia Hill-Collins (1986) examines the work of Berger and Luckmann (1966). Collins suggests that, “it is impossible to separate the structure and thematic context of thought from the historical and material conditions shaping the lives of its producers” (p. S16). For the women of this study, the historical and material conditions that shape the life course are conditioned by experiences of discrimination and disparate treatment.

Additionally, the life course perspective is particularly useful in studies of aging when attempting to predict outcomes of later life based on earlier life events and circumstances (Henretta, 1995). In this respect, this study concerns itself with the correlation of sequential life course trajectories that have a cumulative impact and are therefore most likely to predict health outcomes in African-American women at midlife and beyond.

Much of the literature that governs studies of aging operates from the perspective of the life course continuum. The argument for this standpoint is that the life course perspective makes allowance for, and explains the cumulative impact of, experiences in the construction of patterns of aging. The multiple experiences and perspectives are due to the fact that history, social environment and social structure change over the course of individual lives (Bengston & Schaie, 1999; Riley, 1987). These changes are in turn reflected and affect the health, patterns of aging and morbidity of the population. In short, such a perspective suggests that disparities in health manifested in aging and older adults may be due in part to earlier life course events and their affect on successful aging

(Hayward & Hernon, 1999; Jackson, Chatters & Taylor, 1993; Moen, Dempster-McClain & Williams, 1992). For these reasons, it is argued that life course perspective is the most balanced way to study aging. A note must be made that for African-American women, early patterns of socialization as well as life course trajectories differ greatly from those of white women. Thus, the cumulative effects of life course events produce a different aging experience for African-American women. As one of the studies referenced in this research project notes, the early appearance of physical limitations in the lives of African-American women indicates that this group has the potential to experience longer periods of disability over the life course (Combs, 2001).

The examination of life course events has recently shifted to include events that occur in early childhood. Specifically, there is a growing body of literature that suggests early childhood and even fetal exposures to health risks have a cumulative impact on health (Barker, 1995; Dannefer, 1988, 1987). Some literature also considers the cumulative impact of racism on health outcomes in later life (Porter & Gaston, 2001). One complex analysis of cumulative disadvantage (Dannefer, 1987) turns to the work of Robert K. Merton and the “Matthew Effect.” Simply stated, the Matthew Effect is based on a passage from the gospel of Matthew. The passage intimates that those who have abundance and those who do not are equally required to give of their resources. Thus if one has less in the beginning and some is taken away, one still has less than others who began with more. So it is that blacks and women, who from the beginning of their life courses are disadvantaged by race and sex, continue to be disadvantaged across the life course. In Dannefer’s analysis, the Matthew Effect is specifically related to the social

processes that influence individual aging. The analysis also has implications for life course outcomes among blacks and women.

Emile Durkheim (1979) and Talcott Parsons (1950) provide additional insight. From the standpoint of the social construction of health, illness, and aging, both Durkheim and Parsons suggest that psychosocial factors external to individual responsibility may influence health and illness, and thus the conditions of aging. The literature further relates these factors to health disparity (Dess, 2001; House & Williams, 2000; Rogers, Huxley, Thomas, Robson, Evans, Stordy & Gately, 2001; Clark, Anderson, Clark & Williams, 1999; Marmot, 1998).

For African-Americans, discrimination and the perception of racism as psychosocial and sociohistorical factors have been demonstrated to elicit strong and consistent stress responses (Feagin & McKinney, 2003; Feagin, Early & McKinney, 2001; Williams & Wilson, 2001). This stress response is predicted to correlate over time to negative physical and psychological health outcomes (Clark & Anderson, 1999). However, no single psychosocial factor assumes responsibility for health outcomes; it is more likely that a combination of these factors, dictated by the specific and individual environment, contributes to overall illness or well being (Adler, Boyce, Chesney, Cohen, Folkman, Kahn & Syme, 1994). In light of this current research, lifestyle, socioeconomic status and racism as sources of stress are discussed in the lives of the women who participate in this study.

This research project takes the position that both illness and aging develop within the context of a specific social environment (Lorber & Moore, 2002; Gubrium, Holstein & Buckholdt, 1994). For women, the ways in which illnesses develop and are treated are

associated with gender inequality (Lorber & Moore, 2002). Thus, structural, as well as individual “agency,” form the ways in which the individual experiences aging and illness (Featherman & Lerner, 1985). In this respect, aging and health are both biological and social phenomena.

Deconstruction

Beyond the task of constructing the life course lays the task of deconstruction (Gubrium, Holstein & Buckholdt, 1994). Construction and deconstruction are different sides of the same coin. From a constructionist viewpoint, the task is to deconstruct, through careful examination of processes, information about the life course events of African American women. This occurs in two dimensions. The first is the dimension of myth; in examining the lives of these women, this study seeks to deconstruct myths about health and aging at midlife. The second dimension involves the deconstruction, or careful examination, of how the women assemble their life course events in order to place these events into a context and give them specific meanings. For example, how do these women assemble their spiritual beliefs to combat racism?

Organization

Chapter 1 contains the cogent issues presented by the accounts of the participants, and outlines the literatures related to the social constructions of health and aging and the social context of family and its role in transferring knowledge and beliefs of health and aging through the filter of the collective memory. This chapter also establishes the historical perspectives that ultimately form the sociohistorical contexts of health care access by black women. Similar historical information is also included in Chapter 5 in order to further illustrate the relationship between the cumulative nature of health disparity and the patterns of aging among black women.

Chapter 2 presents information about how both content and process form the structure for the methodology of this research project. Content includes the explanations and rationales for the methodologies used in this study, as well as a profile of the study participants. Process includes the strengths of the individual interviews as well as an examination of the roles of the researcher and strategies of the interview process. Finally, Chapter 2 provides an explanation of the data analysis methods.

In Chapters 3, 4, 5 and 6, the voices of the women are heard through their interviews and the interpretations of the interviews. Chapters 3 and 4 specifically reveal how the women of this study define midlife and aging. In Chapter 5, the participants suggest pathways and barriers to health care. In Chapter 6, the women formulate their understandings and applications of spirituality.

This study concludes with Chapter 7 which presents the interview findings. This chapter examines the interview texts to support the themes of the four research questions, summarizes the themes that emerge from the interviews, and presents those themes that extend beyond the scope of this project. Chapter 7 concludes by offering recommendations for the future study of health and aging among black women.

Summary

In summary, this first chapter lays the ground work for examining the construction of health and aging among midlife African-American women and frames the research questions within the context of the current research literature. These research questions take into account possible cultural nuances, such as body image, stress and experiences with racism that may be characteristic of black women. Should these nuances prove to be consistent, they may prove to describe culturally bound beliefs of health and aging. Additionally, this chapter points out that this study concerns itself only with within-group

comparisons. As a result, the patterns of thought that emerge from the interviews will ultimately define health and midlife within the context of the group's collective experiences.

CHAPTER 2 METHODOLOGY

This chapter explains the methodology used to capture the health and aging beliefs of a select group of 26 midlife African-American women. The explanation includes the application of Afrocentric and feminist methodological perspectives. These perspectives not only inform the project, but are viewed as elements that are already embedded into this social inquiry. The duality of being black and female requires that both culture and gender are considerations of the study. This chapter also includes a brief description and rationale for using both primary and secondary data sources to explore the everyday world of these black women and to develop a more comprehensive body of knowledge about the health and aging of African-American women. This chapter also addresses the significance of both content and processes in the effective use of the interview method. This is followed by an outline the characteristics of the participants and the procedures for collecting primary data. The chapter concludes with an explanation of the method used to analyze the content of the interviews.

Perspectives

As methods for sociological inquiry, both Afrocentrism and feminism inform this project. Both perspectives reflect the viewpoint that race and gender biases cause the perspectives and experiences of African-American women to stand fundamentally outside of proscribed norms. This study examines how these perspectives influence the participants as they construct their beliefs about health and aging.

Afrocentrism

Afrocentrism is a method of social inquiry that represents a strong, primarily academic concern for the insertion of a cultural and intellectual African perspective into the social development of the African population of America (Asante, 1987, 1988). At the center of this philosophy is the idea that the knowledge and preservation of African culture is essential to the survival of African-American cohesion. In addition, Afrocentric literature maintains that exclusion of this perspective represents an inaccurate, racialized depiction of people of African descent. This philosophy is predicated on the belief that culture acts as a means to unify groups of persons and that “group identification” develops through shared values, attitudes, and beliefs (Ani, 1994). When such group identification or cultural consciousness is lost, the way is clear for control by a more dominant culture. This study argues that within African-American families, and in particular among African-American women, there is an historical, cultural consciousness (Ani, 1994; Collins 1991) that is, by design, Afrocentric.

For African-American women, this cultural consciousness—or collective memory—has its genesis prior to Emancipation (Burgess, 2000). For these women, the experience of slavery and continued denigration nurtured an intense and pervasive will to survive both physical and psychological oppression. Simultaneously, the experience of slavery gave rise to a particular socially constructed standpoint or self-definition. It is this standpoint, or collective memory, that is the cultural consciousness whose “presence has been essential to black women’s survival” (Collins, 1990, p. 93).

In this respect, Afrocentrism is the belief system of black women whose history and biographies include not only enslavement but also continuous and calculated oppression from within the social structure that attempts to define their worth as African

American women. For C. Wright Mills (1959) and the “sociological imagination,” the consideration of history, politics and social structure is essential in determining the scope of the social issue. Still others such as Evelyn Nakano Glenn (2002) have effectively addressed the relationship of social structure to women’s role in the economic development of this country. Finally, Dorothy Smith has previously discussed the positioning of women within social structures as their relationship to the “ruling apparatus” (Smith, 1987, p.65)

Feminism

As a way of collecting and examining the data, a feminist methodological perspective informs this project. In general, the feminist perspective legitimates making observations about inequality from the perspective of the women who actually experience disparate treatment based on their gender. In this study, feminism requires that the viewpoints of the women being studied are central in the debate about the early erosion of psychological and biological health among African-American women. This position challenges the discipline of sociology in two important ways. First, it calls into question just who and what are the legitimate sources for the production of knowledge. As a source of power, knowledge and the production or construction of knowledge has historically been the domain of white men. In this light, women, and in particular black women, have been removed from discourses about their lives. Moreover, as mentioned in the introduction to the study, traditional ways of understanding the everyday experiences of midlife African-American women have centered on comparative models that fail to account for the different social experiences of this group. Second, a feminist methodology considers women the subjects of study rather than the objects. For black women, this is again a departure from how they have previously been studied. For them,

self-definition is critical to their psychological survival. Recent reports of race and health also suggest that discrimination that results in blacks being treated unequally also erodes their physical and mental health (Feagin & McKinney, 2003; Byrd & Clayton, 2002; Feagin, Early & McKinney, 2001; Williams & Wilson, 2001; Brown, Williams, Jackson, Neighbors, Torres, Sellers and Brown, 2000; Clark, Anderson, Clark & Williams, 1999).

Data Sources

The data for this study are derived from primary sources, that is, personal, semi-structured interviews with a group of 26 midlife, middle class African-American women. However, in designing this project, the initial points of departure were secondary data sources that used biomedical models of health and aging. In this light, a brief discussion of three of these secondary sources provides a contrasting way of studying black women. Chapter 3 mentions the findings from secondary data analyses in order to suggest two things. First, that there is a need for multi-dimensional approaches to studying black women; and second, that science needs to be reminded of its responsibility to correct the myths that may emerge from empirical studies that compare black and white women—or worse, where black women are missing from the analysis altogether. On the other hand, the processes of collecting and managing data were equally important and integral in the production of information about this diverse group of women. After extended deliberation, personal observation, and conversations with other black women, it became apparent that these models, as issues of content, were incomplete in their portrayal of life, health and aging among black women.

In this study, a distinction is made between method content and method process. Content refers to the data from the interviews and the interview instrument or scripts of the interviews. Process is used to indicate how the data are collected, the methods used to

recruit participants, the makeup of the interview environment, data management procedures, and interview strategies.

Because this study uses individual, semi-structured interviews as the primary source for data, the interviews were a factor in terms of both content and process; both proved to be critical considerations in collecting and organizing the data. However, at some point the process began to emerge as the more critical of the two. As the interviews proceeded, the process of engaging in conversation began to outdistance the content of the interview script and I found myself occupied in deriving ways to strengthen the bond between researcher and participant. Frequently I found that after the first few questions the participants entered freely into conversation with me and further questions became unnecessary. As this began to occur more frequently, I introduced the interview differently and asked the participants to consider this a conversation rather than an interview. I told them that the questions I planned to ask were merely a way to guide our efforts, but that we were not bound to follow any sequence. Changing the word “interview” to “conversation” appeared to relieve some of the participants’ anxiety. Several demonstrated their relief by adjusting their physical posture; their shoulders dropped in a gesture of relaxation and smiles appeared on previously expressionless faces.

Content

The interviews have both written and oral components. Participants were asked to complete a personal history questionnaire prior to taking part in a tape-recorded interview. The questionnaire asks for responses about age, education, occupation, family structure, health, and medical insurance coverage. This written component served two purposes. First, it eliminated the necessity to record and transcribe standard demographic

information, which reserved more time for taped discussion. Second, in most instances the participants were given the written component several days before the actual interview and instructed to complete it prior to the interview. Allowing the participants to complete the history according to their own schedules provided them with an opportunity to become somewhat familiar with the content of the interview beforehand and thus more comfortable with the process. The final question of this written component was: “What else about your personal background might be important to someone studying the lives of African-American women?” This question was purposefully open-ended and proved to be useful in preparing the participant for introspection.

The questions for the taped interview were constructed to provide information about the participants’ health and aging beliefs and their health status. The questions were divided into the following three subcategories that corresponded with the original research questions: 1) definitions of health and aging, 2) the role of intergenerational learning and collective memory in developing beliefs and behaviors of health and aging, and 3) health care access, race, and successful aging. Following a series of piloted interviews, I added an additional question regarding the role of spirituality, creating a fourth category for inquiry.

Data Coding and Analysis

The recorded interviews were professionally transcribed, and then reviewed and color-coded by sub-categories. Despite using the three research questions to organize the interview script, eighteen sub-categories emerged from the interviews at first glance. These sub-categories included relationships between black women and black men, the stress of being black, definitions of the self, the role of the family and expectations of children, generalities of being black, and generalities of being white. Some of these

sub-categories took the research agenda slightly outside of its original framework. As a result, I had to make decisions about which sub-categories contributed the most to discovering the social mechanisms for the development of health and aging beliefs among this group of black women. These were then re-coded into the original research themes. However, as I returned to the transcripts and again evaluated which categories to examine in support of the theses, it seemed that all of the ideas and the ways in which they were expressed, depicted how these women constructed their daily lives. I then began to consider that, although each woman had her own viewpoint, that viewpoint represented a small segment of a larger consciousness. Themes developed to suggest that although these women had autonomous personalities, they shared a common bond of race and gender. It was at this point that I gave each participant a pseudonym. For me, assigning fictitious names signaled the emergence of their individual perspectives.

The Interviews

In terms of content, the initial interview script inhibited the data gathering process. The script proved to be too detailed and extensive to generate the spontaneity that was later noted to produce the richest data. When the number of questions was reduced and the remaining questions posed in a more open-ended manner, the participants appeared more relaxed and less concerned with providing “the right answer.”

As a methodological tool, the interview served four purposes. First, it provided a means for these black women to disclose how they define themselves, thus making them the subjects rather than the objects of the research effort. Their responses—their “liberated voices” (hooks, 2000, p. 554)—create the research agenda. Historically, research agendas are set by the dominant culture, with the net result that research concerning black women tends to define black women from outside of the group and in

comparison to white women. Seldom do studies or social interventions consult the women themselves (Essed, 1990). In the interest of eliminating this bias, this project is informed by a feminist research perspective that relies on the women to define themselves. One participant underscored the importance of this approach in her comments:

I enjoyed the interview. It gave us the chance to rap. Why can't we be called just women? They don't say Asian women or Indian women. Why do they have to single out the race? Like in the newspaper they will always say a black person did this. If they don't say it, then you know they are white. . . . When I see people trying to heighten awareness in the medical field, I am glad." . . . You are interviewing common people. We are not dignitaries. [We are] every day women with real life situations.

A second purpose served by the interview process was the capture of more accurate data. Qualitative studies among black populations are reported to yield more accurate information when the participants are interviewed face-to-face rather than telephonically (Aneshensel, Fredrichs, Clark & Yokopenic, 1982). A preliminary telephone interview with one of the study participants supported this perspective. This particular participant provided more detailed information when she was interviewed face-to-face. Moreover, during the in person interview she also conveyed information with her facial expressions. As a result of this experience, the telephone interview was eliminated as a reliable means to collect data among these black women.

Third, one study further suggests that qualitative research might also contribute to an understanding of the construction of culturally-bound, self-rated health (Jylha, Guralink, Ferruci, Jokela & Heikkinen, 1998). In this respect, black women, because of their race and sex, represent a separate cultural orientation. Such cultural orientation is said to produce variance in self-reports of health status. David Newman, a proponent of Parsons' (1951) sick role theory, presents a perspective on the influence of culture on

self-reports of health. Newman (2000) suggests that, “cultural attitudes [about health and illness] also determine what it means to be sick. Each society has a sick role, a broad set of rules about how people are supposed to behave when sick” (p. 94). However, the sharing of a cultural orientation does not assume that all black women are alike in education or economic status. Both of these factors may also be determinants of health status in self-reported health.

Fourth and finally, qualitative methods that use information from focus group sessions and individual interviews have the potential to greatly enhance quantitative measurements. Just as important as how many persons fit particular categories is the discovery of how subjects of the study create or construct the environments in which they age and experience health and illness.

Volunteer recruitment

In recruiting participants for this study, I used social networks to solicit volunteer participants from among my neighbors, sororities, and other social networks. These volunteers in turn, identified to me other women who might be willing to give an interview. Using this snowball or network sampling (Bernard, 1995), I recruited 26 women for interviews. It was not uncommon that the person providing the name of an individual had already made my purpose known to their contact before I made the initial phone call. This introduction made interviews with women I did not know more comfortable for me and perhaps them as well.

The interview environment

The participants were allowed to choose the interview environment. I always offered to come to their location, but was careful and consistent in encouraging them to think about the best environment for them to be relaxed and comfortable as we talked. As

a result, only two of the interviews, the most difficult to schedule, were conducted at the workplace. The balance of the conversations took place in either my home or theirs. More often than not, we shared a beverage or some light snack. On one occasion I was invited for dinner.

The interviewer as participant

Interviews can take many forms, some of which are clearly governed by the environment, the purpose of the interview, and indeed by the participants themselves. The question that began to plague me early in the interviewing process was: “Who am I as researcher?” Sometimes I felt as though I were part of the data being generated. At other points, my role as the researcher, the leader of the effort, was more predominant. Much like the “shifting” described by Jones & Shorter-Gooden (2003) that occurs when black women want to fit in, usually with whites’ ideas of what is acceptable, I found myself moving from a political identity to a cultural identity and back again.

Code switching. Throughout the interview process, I found myself more inclined to enter the interview environment in a collaborative posture. One way that this was accomplished was through the use of code switching. Code switching is a term that sociolinguists typically use to refer to certain exchanges made in the context of bilingual speech. There was a language attached to the self as researcher, the political identity, and then there was a language associated with being a black woman, the cultural identity. This duality found its form in the cultural dialect and the terms of familiarity that we used to address one another. Most often these linguistic switches were spontaneous and often initiated by the participant rather than me. They were used to signal a change in the level of intimacy in the conversation or to emphasize a point that was being made. Code switching, as I later realized, became an effective method of building a bond between the

participant and me. At the core of the linguists' examination of code switching is "how language choice reflects power and inequality" (Auer, 1998, p. 3). Feagin and Sikes (1994) suggest that code switching to standard English may also be a way for blacks to avoid being treated poorly because of race. Clearly for me, and perhaps for some of the women of this study, code switching was a way to diminish the perceived differences between the political and the cultural. These linguistic shifts helped pull me deeper into their everyday world, where I became a peer.

Open-ended questioning. A second interview strategy was the use of the open-ended question. I relate this to Patricia Hill Collins' (1986) view of the "outsider-within," a concept that addresses yet another aspect of the duality in being a black woman who stands with a foot in each of two separate and even distant worlds. For Collins, the outsider within describes the tension between conducting social research as an academic "outsider" and continuing to view everyday life from a perspective within the group being studied.

In selected instances, as the outsider within, I entered the interview as a participant. This gave me entrance to spaces that might have otherwise been closed. This occurred in situations when a participant would ask my opinion, thereby inviting me into the interview as a participant; or when something the participant revealed resonated with my own experiences or when I wanted to encourage trust.

Many of the interview questions (Appendix A) are open-ended. In addition to moving me from outside of the group as an academic to inside of the group as a participant, the use of these open-ended questions provided three additional benefits. First, making a statement and then asking the participants to provide a response allowed

the participants to interpret and assign their own meanings to the various categories of responses, and, in some cases, to construct their own categories of concerns, such as male-female relationships at midlife. In this way, the information that they provided was less affected by my own biases (Reinharz, 1992).

Second, open-ended questioning permitted me to give the interview a less formal format, an approach that encouraged the sharing of information. In sharing information, I did not bear the burden of having to know the answers to their expressed concerns. In using the open-ended question as an interview tool, I was not placed in the position to be “the expert.” In many instances I found my role to be that of “the student.”

Mostly I attempted to follow the lead of the participant. When I judged that the woman was engaged with the topic it was frequently more fruitful not to break the flow of the conversation with questions, but to follow her lead. I would then return to the question or issue at hand and connect her response to the general framework of the project.

The third advantage gained from using open ended questioning as interview strategy was that it encouraged amplification and clarification. At the end of each interview I extended an invitation to the participant. I asked her if there was anything else that she would like to add to our discussion about African-American women. In a number of cases this invitation seemed to be particularly important to those women who appeared to be concerned about structure and tended to edit their responses during the more formal portions of the interview. In this light, I noted that some very rich comments resulted when using this closing as an interview technique. Therefore, the request for additional

information proved to be an effective way to end the interview and resulted in a number of rich, reflective comments.

The Women

Demographics

I invited twenty-six African-American women ages 36 to 71 to participate in this study. This age range was chosen to provide a broad range within which the women could define their ideas of midlife and approaches to aging. The participants represent a cross section of midlife women who are predominantly middle class by virtue of occupation, education, and income (Vanneman & Cannon, 1987; Blau & Duncan, 1967). Ninety-three percent (93%) of this group work full-time. Only two women reported that they had spent extended periods of time as homemakers, however, both had periods when the financial circumstances of the family required that they work part-time for pay; one worked as a cosmetologist in her home and the other found jobs outside the home. The occupations of the 26 women are varied; they include a domestic worker, several retired military personnel, nurses and a physician, a teacher, educational counselors, a juvenile probation officer, a part-time cosmetologist, retail sales clerks, and administrative assistants. Four of the women work as health care professionals; one is a medical doctor. Although only two were not currently employed, 25 of the 26 women in this study had at one time worked full time at jobs outside of the home. Only one of the participants, a second-generation medical doctor, could be described as upper middle class and standing outside of this mostly working or middle class group of women. She was the most educated of the group. The educational level of these women was clustered around those 42 percent (42 %) who held masters' or higher level degrees. Combining both those with masters' degrees only and those who held masters or higher level degrees, 76 percent

(76%) of these women had some formal education beyond the undergraduate level. Only one woman, the woman who performed domestic work, had not graduated from high school. Ninety-three percent (93%) of the women were either born in or had spent the majority of their life in the southern region of the United States. The average age of the group is 51.6 years. Ninety-three percent (93%) of the participants are, or have been, married. Of those who never married, 50 percent (50%) had given birth. The youngest grandmother is 43 and was unwed at the time of her daughter's birth. Among the grandmothers, one woman has sole custody for her two grandsons, both of whom are under 2 years of age; one other grandmother has been responsible for the rearing of a granddaughter, age 15, on and on-and-off basis. Despite the heterogeneity of this group, racial discrimination and spirituality (both are discussed in later chapters) were common denominators.

In terms of study design, I acknowledge that the participants are drawn from a select population of African-American women. This is a direct result of two factors. The first is that I use my own existing social networks to recruit the participants; most of whom have working and middle class backgrounds. The second factor that influenced the selection of participants reflects what is known about poverty rates among blacks. As will be noted again later in this chapter, in reality only about one-third of black Americans earn wages below the poverty level (Walcott-McQuigg, 1997). This makes accessibility outside of the working and middle-class network difficult, even for a researcher who shares the same racial identity.

However, regardless of socioeconomic status, blacks are still subject to discriminatory treatment from even the poorest of whites. In essence, while class may

influence interactions amongst blacks, when it comes to black-white relations, poor whites have a tendency to ignore class, believing that all blacks are poor, underprivileged, and deserving of overt discriminatory treatment. Hooks (2000) reflects that in her southern home town “black children learned to fear poor whites more than other whites simply because they were known to express their racism by cruel and brutal acts of violence” (p. 112). Thus, from the position of the dominant culture, issues of class among blacks tend to be invisible. This study argues that amongst these black women, class lines are equally blurred and often obliterated in their own eyes by the common experience of racial discrimination.

Distinguishing Characteristics

Class or socioeconomic status (SES) and midlife are two factors that identify this group as select among African-American women. These factors reflect a specific socially constructed framework and for this reason are set aside in this study. This “bracketing” requires some discussion of the construct of class that is embedded in SES.

Socioeconomic status

Class is frequently associated with education and income or SES (Fussell, 1983). One participant articulates the complexity of class among blacks in the following way, in response to my question about in what ways did she feel connected to other black women:

Sometimes I do. Sometimes I don't. In a lot of ways, most of my crew I like. The connection starts right there. I have other things on my agenda. Their stuff is important, but so is mine. I don't have a lot of black friends. A lot of them dislike me. You don't think you are smarter. You are scared to death. They think because you have a degree, you got it going on. The crew at church likes me because we walk [together]. That is our common goal.

Is there anyway that you feel connected?

Spiritually. We are in the same Bible groups together and at church. Outside that, I don't have any girlfriends that are friends. You have to have a commonality.

Rita is the first of her generation to attend and complete college. Throughout her educational experience she has struggled with dyslexia, a condition that I sense she does not mention to most people. In explaining how she feels disconnected from other black women, she easily cites education as the cause of the rift. In addition to pointing out the perceived difference that her education makes in her relationships with other black women, Rita also reveals two other details of her perspective. First, she switches her language from a more formalized dialect to one that is more colloquial or "black." This shift in language has previously been discussed as "code switching." For Rita, this occurs in her words, "They think you got it going on." Rita has previously mentioned that the way she speaks is still another cause for others to question her "blackness." Here she slips into a street-wise vernacular, returning herself to being black in a stereotypical way. Thus for Rita, education and a formal way of speaking serve to distinguish her class status among other blacks. Second, Rita's primary social interactions seem to center around the women of her church, her "crew," with whom she exercises on a regular basis. She views these women and the spirituality she shares with them as a common bond. It is the way that she describes her connectedness to other black women. The role of spirituality in the lives of black women is discussed in greater detail in Chapter 6.

Many earlier studies of health disparity view SES as the strongest social mechanism affecting health. From this viewpoint, SES enters the debate of health disparity by serving as proxy for access to health care. American blacks, especially at midlife, exhibit large differences in SES (Markides & Black, 1996), however, it is careless to assume that SES is a major factor for all blacks in gaining access to adequate

health care. In truth it has been assessed that less than one-third of all blacks in America have earned income below the poverty level. Yet according to one source, it is this one-third that is most frequently studied (Walcott-McQuigg, 1997). Given this broad spectrum of SES and class among blacks, it is more likely that among blacks other social factors outside of class or SES contribute to profound differences in rates of illness, disease, mortality and access to health care. Therefore, believing that “upward mobility does not overcome racial disadvantage,” this study controls for SES (Patillo-McCoy, 1999, p. 45).

Midlife

The second factor distinguishing this sampling of African-American women is most frequently referred to as “midlife.” By definition, midlife represents a chronological, often biological and psychological, period in the life course of individuals. Recent discussions of midlife present variations in identifying a chronological age for midlife and it has been suggested that it may be more accurate to define midlife not in terms of an absolute chronological age, but as the period between young adulthood and late adulthood (Staudinger & Bluck, 2001). Among black Americans, differing life trajectories such as higher rates of teenage pregnancy suggest that, for African-American women, the period between young adulthood and late adulthood begins earlier than it does for white women. This may result in early incidents of age-related health and illness. At the very least, differing life trajectories suggests variations in midlife and aging experiences.

From the standpoint of biology, midlife is traditionally calculated in one of two ways. The first calculation is based on the estimated life expectancy or survivorship rates. These rates tend to vary by country. However, from a global standpoint, 100 years is the

life expectancy. The midpoint of this calculation is of course 50 years. Thus, when an individual reaches age fifty, from a biological perspective, he or she has effectively reached midlife. For African American women, shorter life expectancies may also indicate that midlife occurs earlier for black women than it does for white women. The current life expectancy at birth for black women is 75 years compared to 79.4 years for white women. Calculating midlife as the midpoint between birth and death would then mean that black women typically enter midlife when they are age 37.5.

The second way midlife is calculated biologically is related to reproductive capabilities. Since many men have proven capable of fathering children long past age fifty, this calculation only applies to women. For women, that capability typically ends with the onset of menopause. As will later be noted in the accounts of these women, midlife may also be marked by life events, such as children leaving home. Rarely however, do these women describe midlife in relation to biological events.

While little is known and documented about the midlife health experiences of African-American women, women in general face a variety of health and psychological challenges at midlife (Porter & Gaston, 2001; Jacobson, 1995). It has also been suggested, from the perspective of life course studies, that midlife presents the opportunity to change behaviors that effect future longevity and disability (Spiro, 2000). For black women, the challenges of midlife include the cumulative impact of racial discrimination and perhaps early onset of aging. Nevertheless, five pilot interviews gave the first indication that, at the very least, the middle class women of this study do not necessarily see themselves as disadvantaged by age or race.

Summary

The research methods selected for this study were applied based on the belief that the most complete profile of African-American women could only be drawn by investigating the ways by which these women have constructed their identities as aging beings. In this light, the semi-structured interview seemed the best way to begin an investigation of health, aging, and illness among midlife black women. In the case of these women, the semi-structured interview provides the optimal opportunities to create bonds between the participant and the researcher establish trust and gather candid perspectives of everyday life. Afrocentric thought and experience filters the responses of the participants, while feminist methodology encourages and honors the dialogue. This chapter also begins to use the words of the women to illustrate the ways that class and spirituality are operationalized

In large measure, the women of this study present a view of what it means to be black, female, and aging and that view conflicts with common perceptions of their health and aging experiences. In contrast to the selected reports of the effects of cumulative disadvantage and despite documented reports of early declines in health, these women do not see themselves as disadvantaged. The findings from these reports are later and briefly discussed in Chapter 3. By and large, despite issues of weight, lack of exercise, smoking, high blood pressure, and age, they view themselves as healthy. This perhaps supports the report of Byrd and Clayton (2000) that for blacks, “poor health status and outcomes...are ‘normal’ and acceptable.” (p. xxiv).

In Chapters 3, 4, 5, and 6, the texts and ensuing discussions revolve around the viewpoints of the participants. The women of this study are gracious, talkative, candid, engaged with the topic, sometimes angry, sometimes tearful, and always encouraging.

Their comments give voice to the constructions of identity and aging that form the thesis of my argument.

CHAPTER 3
“AGE AIN’T NOTHIN’ BUT A NUMBER!”

... the ways in which we think about, treat, and live our bodies are always and inevitably socially and culturally shaped. . . we can only ever know, think about and experience these realities through our specific location in society and culture. (Lupton, 2000, p. 50)

As the opening quote suggests, the purpose of this chapter is to formulate the social and cultural context for the expressed beliefs about health and aging of the women in this report. Here the participants’ words build the contexts of their beliefs, and thus shape the meanings, for them, of health and aging. In this respect, this chapter begins the integration of the interview content into the development of the study’s theses. For example, among these women, a consistent approach to discussing the aging process was to contrast the differences between the way white women age and black women age.

Rather than asking the women of the study a specific question about the differences in aging among black and white women, they are asked to state their beliefs about the way white women age and the way black women age. In the following words, Ruth, a 42-year-old participant, makes an initial comparison that focuses on physical appearances:

I feel good and I feel great. I sometimes think that I don’t look forty-two. When I look at other people my age, forty-two is kind of unbelievable.

The other people you look at, are they black or are they white?

I have to admit that a lot of them are white. I mean people say, and I’ve heard white people say, that we age a little bit different. Might be the melanin. I guess as far as wrinkles and all. It makes me feel great. I feel younger.

That’s interesting because a part of what we’re talking about here is the way that black and white people age. You have any idea why that is?

I have no idea. The only think I can think of is the melanin in our skin. You think about it. A lot of the reason wrinkles come from the exposure to the sun. Because we were designed to be exposed to the sun, live in climates that were hotter, and that kind of thing. Also, we have oily skin as opposed to dry skin in our faces. That might have something to do with it also. We don't dry out as much.

The comment that black women age better than most white women was a consistent response from these women. This perspective suggests perhaps that, despite data to the contrary, this group of aging and older women does not see themselves as disadvantaged as a result of age. However, later in the interview, Ruth's response relates to the differences she has observed in dietary practices of blacks and whites. From her perspective, the dietary practices of blacks also influence the aging process. She says:

I feel like I've aged better. I don't know why exactly. It might have something to do with diet. I don't know if diet has a lot to do with it. I do know they [whites] tend to eat a lot more like boxed stuff and refrigerated stuff and canned stuff. We don't particularly like stuff like that. It's not our thing. But I think we eat maybe a lot more fresh stuff. I do know blacks are starting to use a lot of stuff now that is not good for them.

In the second part of her reply, Ruth demonstrates what qualitative researchers call typification (Gubrium, Holstein & Buckholdt, 1994). In making this comparison about dietary practices among blacks and whites, Ruth demonstrates how she orients to whites. It is the way that Ruth and other women of this study address what it means to be white in America and contrast it to what it means to be black in America. Similar typifications, as processes in the social construction of life course, are illustrated and discussed in greater detail in Chapter 4.

However, before further reading the words and hearing the voices of these women, it is important to provide a context for the contrasts between the traditional ways of viewing aging and that presented in the women's statements. This backdrop is created in three ways. First, through the discussion of two of the traditional ways that aging has

been viewed in the field of gerontology; second, by bringing the women to the center of the debate by outlining the two major challenges faced by aging women; and, third, by presenting evidence in favor of viewing aging as a socially constructed process that is largely and almost exclusively influenced by the psychosocial environments of the individual. I will demonstrate that for the black women of this study, their beliefs about health and aging are grounded in the traditions and experiences specifically related to participating in society as member of a double minority. Thus, as women and as blacks, their experiences of health and aging are filtered through lenses of cumulative, disparate treatment. Yet these women frequently describe the burdens of racism and sexism as inconsequential or nonexistent. Despite biomedical reports to the contrary, for these aging and older women, “Age ain’t nothin’ but a number.” The task here is to disclose and closely examine the psychosocial mechanisms that allow these women to minimize the experiences of racism and sexism and their potential to heavily influence the aging process.

Traditional Views of Aging

According to gerontologist Bernice Neugarten, true senescence, sometimes referred to as normal aging, begins between the ages of 50 and 55 (Rowe & Kahn, 1998). Specifically, this means that some individuals, in the process of normal aging, may begin during this time to experience “risky physiological changes.” While such maladies as high blood pressure, diabetes, and heart and lung disorders are not inevitable in all aging persons, the risks associated with changes in these physiological functions increase as a condition of normal aging (Kart, 1997).

In the last decade, the American Association of Retired Persons (AARP), an organization in the vanguard of advocates for aging persons, has considered persons

eligible for membership at age 50. Yet the official magazine of the AARP recently touted white, 60-year-old former super-model Lauren Hutton as the ideal aging citizen. In the general public, however, senior citizen privileges such as reduced auto insurance rates and shopping discounts are offered to persons age 55 and older. Gerontologists tend to begin studies of aging with persons 65 and older. This numbering is driven in part by the federal Social Security Administration's eligibility criteria for social security benefits.

The point here is that it appears that the older the baby boomers become (the eldest of the baby boomer birth cohort will turn 65 in the year 2005), the further the age that defines the beginning of midlife and old age is extended. Other contributing factors may include the increases in overall life expectancies, as well as the attempts by the market economy to reach the swell of aging consumers. In all these respects, the chronological parameters of old age are shifting.

As noted in the MacArthur Foundation's decade and a half long national study of well-being at midlife, the processes of senescence, or normal aging, and the rate at which they occur are not solely related to genetics; rather, lifestyle, social environment and social structure affect the process of normal aging (Rowe & Kahn 1998; Elder, 1974; Riley, 1987; Featherman & Lerner, 1985). Especially for racial and ethnic minorities, the aging process in general, and successful aging in particular, are adversely impacted not only by the biological process, but also by the structural inequalities of SES (O'Rand, 1996; Markides & Black, 1996; House et al., 1994).

Studies of aging frequently cite Rowe and Kahn's (1998) model for successful aging. This model uses three overlapping, concentric circles labeled "low risk of disease and disease-related disability," "high mental and physical function," and "active

engagement with life.” The words “successful aging” appears at the center of the model where the circles overlap. This model suggests that, ideally, aging members of society will maximize their opportunities to experience aging in a positive manner by achieving balance in these three areas. In essence, the model focuses on modifications of health behavior and overlooks structural barriers in the social environment (Feinstein, 1993) Acknowledgment of historical structural barriers such as institutional racism, are critical when examining health disparity in the life course of African-American women.

A report from the U.S. Department of Health and Human Services Task Force on Black and Minority Health (1985) suggests that minority health is influenced by specific social characteristics. In particular, the Task Force lists demographic profile, nutritional and dietary practices, environmental and occupational exposures, and stress and coping patterns as challenges to the physical well-being of blacks and other ethnic minorities (Edmonds, 1993). Despite the age of the study, the information retains its validity when consideration is given to the current poverty and health statistics of African-American women. It has been well documented that this group of women experiences higher rates of poverty and poorer health than do their white counterparts (Doress-Worters & Siegal, 1994).

As key concepts in the study of aging, the notions of normal aging and successful aging support the theory that aging is not only a managed experience, but one that is individually constructed as well (Gubrium, Holstein & Buckholdt, 1994). In this sense, individuals have the opportunity to modify their lifestyle over the life course and even into late life, and thus positively alter the impact of normal and usual aging. This alteration in lifestyle may develop a blueprint for successful aging, and will have special

significance for recommendations for health behavior interventions at midlife.

Unfortunately, this approach puts the onus for achieving positive health on individuals who experience differential and disparate health outcomes. Such an approach continues to ignore the importance of structural and material support in reducing the cumulative effect of disparities experienced over the life course. In short, studies of aging have not successfully isolated the behavioral inhibitors of successful aging from the social inhibitors associated with limited or inadequate access to resources (Feinstein, 1993).

Women and Aging

Colette Browne (1998) suggests that economics and body or social images are the primary influences on the aging experiences of women. However, despite outnumbering men, older and aging women have yet to develop the political presence required to alter their economic status and social image as older citizens. This economic disparity, coupled with living in a youth-oriented society, creates patterns of successful aging that differ based on gender. What the literature on the subject of poverty and aging teaches is that, in essence, aging does not cause poverty; rather poverty is related to a series of financial conditions that occur in early adulthood (Social Security Administration, 1997). For women, this has traditionally meant that late, sporadic, unequal and sometimes non-existent participation in the labor market has retarded their ability to acquire the capital necessary to enjoy late life. Among minority women, the rates of poverty are even higher than among minority men and white women.

Social images of women are oriented to having and maintaining a youthful appearance. The media bombards the senses with clothes, cosmetics, and activities that are suited to women under the ages of 40. By and large, these images portray the subjects of attention as white. This presents aging black women with few, if any, public role

models of aging. The question that this poses for black women is: What should I expect as I enter this stage or period of my life? For the most part, this question is answered by current health and aging research that uses biomedical models to address the potential health issues related to aging. These models tend to overlay historical medical conditions and outcomes based on that one-third of the African-American population that is so frequently studied. This causes African-Americans who earn wages below the poverty level to represent the greater African-American population.

Before entering the discussion of age as a social construct, it is important to note the difference between Browne's perspective regarding the challenges of aging women in general and those perspectives of aging found in the words of the women of this study. First and foremost, Browne's position speaks to the circumstances of women in general. In this respect, the concerns of economics and body image may be more reflective of a larger population of primarily white women. In subtle ways, the women of this study tended not to appear overly concerned with either economics or body image. Thus their accounts contradict Browne's thesis. This is not an unexpected outcome considering that age and health are both products of individualized social, historical and political environments. The social, historical, and political environments of this study reflect a middle class, black experience.

Age as a Social Construct

To say that an individual act, an idea, or even an historical event is socially constructed is to suggest that the environment and the interactions that occur in that environment determine its meaning. In this respect, individuals may make choices from a variety of options available within their social environments (Elder, 1994). These choices

in turn determine the experiences they will have over the life course (Gubrium, Holstein & Buckholdt, 1994).

Defining Midlife

As presented earlier, midlife is most accurately associated with a period in the life course between young adulthood and late adulthood (Staudinger & Bluck, 2001), and there are many variations in identifying a chronological age for midlife. The women of this study now voice those variations.

Sunday afternoon finds two participants and me on the patio of Lisa's home. I have driven an hour and a half to attend church with these two new acquaintances. Both women were raised in South Carolina, and at age 49, both are grandmothers. We have talked while sharing a meal at a local restaurant. Now, after a short drive to the house, we are contemplating dessert choices. Mindy comments:

I haven't even thought about mid life. I know each year that I get older I like to think age is just a number. What does it mean though? When you are a child no one asks you what it is like. What exactly is midlife? I would have to think of it as the point you are realizing that you are almost there. You went through your youth. You come to the realization that you are embarking upon the latter stages of life. Uh-oh, it is around the corner. There is no specific age. It depends on the person.

As Mindy continues, she alludes to the reproductive factor as a marker of aging.

Making reference to the Bible, she discounts the importance of chronological age:

Even in the Bible, Moses was 80 before the Lord fully used him. 'Now you are prepared. Now I have a job for you.' Abraham was 100 when he impregnated Sarah. So what is midlife? Where is your thought process? If you think you are going through midlife, then you keep thinking about it. What is a crisis for midlife? You have younger men who like to date older women. Does that mean you cannot be a woman? You cannot be sexy? You cannot be fulfilling your role as a woman? I went to a doctor for a check-up. The doctor asked if I was in menopause. I didn't know. I don't think about it. I choose not to participate in menopause. I choose not to participate in any midlife crisis.

I don't hear the term used other than midlife crisis. You get people at different ages saying they are going through a midlife crisis just because they are a certain age.

Being a woman who is 49, I never even thought about it. You don't know when your end will be. How do you determine your age?

Mindy forms her responses as rhetorical questions, suggesting that she is now in the role of interrogator. There is an edge to her voice that further suggests her impatience in attempting to wrestle with defining midlife. However, once she settles on her position, she is not ambivalent. She defines the concept of midlife largely in terms of biology. Using menopause as her marker for aging, she says: "I don't think about it. I choose not to participate in menopause. I choose not to participate in any midlife crisis." She simply rejects the concept of menopause altogether. For Mindy, the socially constructed and largely chronological ideology of age prevalent in the United States (Gubrium, Hosltein & Buckholdt, 1994) does not govern her ideologies. What Mindy is saying is that as long as she does not allow her mind to accept unwanted images of aging, then aging is of no concern. It has been suggested (Gullette, 1997) that reliance on this mind-body connection provides an approach to aging that may prove the difference between aging successfully and early declines in health and early mortality.

Lisa, Mindy's friend of 15 years and the other member of our trio, relates another way of looking at what it means to be at or in midlife. Lisa's comments throughout the joint interview are not as detailed or extensive as those of Mindy. In some instances, the fact that Mindy was Lisa's mentor in the workplace may contribute to their informal hierarchy. Whatever the reason, I am pleased to at last hear Lisa's comments.

Although not the youngest grandmother in this group, Lisa, 49, has full responsibility for rearing two young grandsons, both under the ages of two. Lisa's husband, a truck driver, is often away from home and Lisa manages the care of the children, runs the household, and travels in her own line of work as a notary. When

asked, “What was the greatest challenge you faced in midlife?,” Lisa replied in these words:

Finding a good balance. I come from a small family. Maybe there are ten people that I call my family. Adjustments with my children [gone from the house] and the empty nest syndrome. What do you do when the kids are gone? Even though we have grandchildren, what do you do? You have to readjust to a new stage in life. And teetering on whether I should let them go. The void in the house. Less activity. No PTA meetings or parent-teacher conferences. That is the biggest challenge. When I left home, I lived in the same town as my parents. I would call just to say hello. Now I am in whole other world. I don't have my parents. My children are gone. I remember Job. When he lost his children, the Lord replaced them with more children. I thought about throwing myself into work and grandchildren. They are a whole different sex from my children. I had girls. The grandchildren are boys.

What is it like to have grandkids in the house?

I almost forgot what to do. But that was what I needed. They needed a home. So it was two-fold. It filled a void. Family was back in my life. Whatever Job lost, like him, what was taken from my life was added back to it. I went from not knowing what I was going to do, to back in the nurturing role.

The subject of family, children and grandchildren form the challenge, and ultimately the meaning, of midlife for Lisa. She considers her immediate family to be small and admits that she misses the activities that accompanied having her two daughters in the home. With those daughters no longer under the same roof, there was “a void in the house” and in Lisa’s life. She was not certain how to fill her time.

Lisa goes to the Bible and the story of Job to explain how having the grandchildren with her fills the void of her midlife challenge. Like Job of the Bible, the “loss” of her children is replaced by her grandchildren, for whom she now has full and legal custody. Later Lisa explains that the state of Florida has special programs to assist grandparents who are raising grandchildren. She seems comfortable and happy with this new role of grandparent-caregiver. Lisa has found a “good balance” in the period she considers as midlife, unlike the next participant.

The text of Mildred's interview is difficult to transcribe. Her thoughts contain mixed metaphors and frequently seem disjointed. In searching for themes of her discourse, I come to understand that the presentation, including the mixed metaphors, is the theme. Mildred seems on the cusp of making a lifestyle change. Several times during the interview she seeks my advice and even approval about her plans for the future. The future plans and ensuing transition that she discusses with me seem to be the genesis of her confusion. After nearly three hours, her interview is the longest. The interview takes place in her second floor office.

In response to being asked to define midlife, Mildred says:

Since I am there now, midlife is being born again. It is like starting all over at ground zero with this knowledge. I find it fascinating. I woke up at 2:30 (a.m.) and, for a fleeting minute, I started thinking about people who were gone. As I started thinking about them, I thought I am now at that point. I felt a little sad. There was this show called "Sarah Plain and Tall." I loved that show. They referred to the aunt as a treasure. For some reason I started thinking about all those who passed on. At that time I wondered, "Did anyone think of me as a treasure?" So midlife to me is that point in time. It is very hard because I think of what old folks say. 'Be careful what you do when you are young because you will pay for it.' My mother would say, 'Get off your knees, they will hurt you.' Health wise, some things are true. Now I want to mop my floors on my knees. I don't want to use a mop. So it is very hard for me. I don't picture myself as 20, but I realize that the things I have are not [in] the container that I carry around. My container does not go along with me. Midlife is taking a [different] container and mentally we have a different spiritual body. Spiritually I can see myself somewhere else. I don't see myself there. That's why some people focus in on your heart. I wish I knew things then that I know now. I don't regret anything.

There are some things that living in my culture has taught me now. Going to a doctor you had to be almost dead before momma would take you to a doctor. They had no money. And they knew everything. Put a cold press on your nose. Put matches behind your ears. Rub keys down your back. I think about it now, what in the world would that do? How would that stop my nosebleed? But in that point in time, that is what they did. What were the matches and keys for? Kerosene and a little sugar—[that] would blow you up! But they said that would cure worms. All kinds of stuff I remember now. Midlife to me is a number, a passing. For me as a woman, it's hot flashes. They are killing me. As you are talking to me I am having hot flashes. If I could find Eve, I would slap her.

I find it difficult, if not impossible, to interrupt Mildred's comments. The words pour out and spill over themselves as she moves her thoughts from past to present events and back again to the home remedies used in her childhood. Mildred's patterns of thought and thus speech are not linear, but rather circular. She defines midlife as "being born again," "a different point in time," taking a "different container," a "number" and a "passing," and "hot flashes." For Mildred, midlife is marked in two different ways. As a specific point in the life course, it is a time when she is "born again" and would like to be considered a "treasure." Midlife is also marked by a biological change. For Mildred, this biology is not her personal appearance but the physiology of "hot flashes." Mildred's idea of what it means to be midlife is not single faceted. Her definition contains a number of subjective signals of midlife and Mildred seems comfortable with the mix.

This interview with Mildred presented the first evidence that it might be difficult to formulate present ideas of health and aging without references to the past. These historical references provide an indication that intergenerational experiences influence social constructions of the present day self.

Iris, the only physician in this study, does not make reference to any particular source, but had this to say about a chronological age for midlife:

I used to think it was between 40 and 60. But the older I get, the older I make it. I say 50 and above is midlife. Typically that is the definition.

Iris' numerical pinpointing of midlife and aging presents a conflict between her personal experiences and what she, as a medical doctor, has been taught is the "typical" way to identify the beginning of the aging process. For her, the process "used" to be defined by where she was on the aging continuum. This internal conflict between what

these women sense and believe about themselves and what traditional science teaches is discussed later in this chapter under the rubric of aging as a social construct.

The next comments, by Ester, present yet another example of combining time-ordered and event-ordered markers of midlife. At 50, Ester is recently retired. Empty-nesters, she and her husband have recently moved to Florida. I ask her to define midlife; she responds by saying:

If you die at 80, then it [midlife] starts at 40. Mine started in my early 40s. It was rough in the beginning. I had a hard time when I turned 30. You are coming out of the young group. It was a learning process. Our children were out of high school. We were just learning to relearn ourselves.

In these words, Ester describes midlife from two standpoints. First, she does a mathematical calculation in which she reasons that midlife depends on the number of years a person lives. What is interesting about this calculation is the absence of any assumptions or preconceived idea about longevity. From this viewpoint, it is only possible to calculate midlife after the person is dead! Second, Ester sees midlife as marked by an event. In her situation, that event is her children leaving high school. The absence of children in the home seems to signal midlife to a number of women of this study. Mildred and Ester reveal this dual nature of midlife. However one of the participants provides a definition that is neither time nor event ordered.

Jewel is the mother of one of the other participants. At 70, she is reestablishing her household and has moved to Florida from New York City to be closer to her daughter, Ruth, and Ruth's two teenaged children. She has decided to move to Florida without her husband, from whom she is separated. He later moved to Florida, however they do not share the same household. She talks easily about her separation from him. For now, our

conversation focuses on her definition of midlife. Jewel, who describes herself as a fatalist, defines midlife in the following way:

It is inevitable. Like being between two fires. You don't have as much incentive as [a] younger person. Yet you are [not] willing to withdraw completely from things. Midlife is easing out of younger life and easing into old age.

Jewel's response is both poetic and profound. Although she refers to midlife as "being between two fires," she does not identify any specific event that marks the beginning or the end of the phase. For her, midlife is an unnamed but inevitable midpoint between a "younger life" and "old age."

When the Number and the Mirror Disagree

The women of the study believe that their functional age—how they look and move about—belies their chronological age. In this respect, these women construct a subjective age identity of themselves as looking younger than white women of the same ages. Their comments on midlife as time ordered and marked by appearance were typically a result of asking the participants to tell me about the way white women age and the way black women age. The first of these comments comes from Iris' observations not only as a medical physician but as a black woman. Iris makes the following observations without hesitation:

It is pretty clear, even in terms of being a physician. We [black women] age more graciously. Our physical appearance is that it is difficult to tell how old we are. They [whites] can't distinguish between a 40-year-old or 50-year-old black woman. When we get in our 60s, 70s, 80s, it is hard to tell how old we are. You may tell from other ailments, but not just by skin and appearance.

Iris does not talk about her own appearance at this point. Instead, she focuses on what she observes as a physician. However, in the use of "our" and "we" she numbers herself among those black women whose "skin and appearance" fail to reveal their chronological ages. In her view, to "age graciously" is to appear younger than your years.

Betty, 58, is also a health practitioner. She describes the appearance factor of aging in this way:

A lot of females that come in here [a Veteran's Administration health clinic] look older than I am. They look like they have had a harder life, like things weren't easy for them. It wasn't [easy] for me either. I don't know if it is heredity for me or what.

Betty has a bird's eye view of many women in her work as a nurse. Although she doesn't specify whether or not the women she primarily observes are black or white, her perception is that she looks younger than they do. Again, there is an air of self confidence about looks at midlife.

Juanita, age 52, presents a final example of how these black women view the physical self at midlife. Again, I ask her to compare the way black women age and the way white women age.

I think we age beautifully, especially at this age. When I was overseas and came back, the black women looked so great. We are gorgeous women. I think the whites are out in the sun. They want their skin dark. [Whites are] being very weight-conscious. They are always dieting. I hardly ever hear of blacks doing Botox. It doesn't seem to improve their [whites] looks when they age. You can tell when you look at their necks. When I first moved here, I would say look at all the old people. Now I am one of them. But you see these beautiful black women, big and plump, their skin looking great. Although, I always complain about my arms and the skin hangs down a little. You have to pick up the rolls. Some people don't think anything about it. I think all women do this. I am 52, but in my mind I am 30. I can dress the same way. Even when you are 70, 80 or 90, you probably are the same way. To wear a short skirt or put on heels, that is something white women will do. I may be stuck in time, but I don't dress that way.

Juanita admires the way she believes black women age. She highlights "big and plump" and "skin looking great" as positive signs of black women's beauty. Moreover, Juanita continues to think of herself as younger than 52, admitting that "in my mind I am 30." Certainly, in a youth-oriented society, Juanita's interest in keeping young is not

unusual. However, she seems to draw the line between feeling mentally young and dressing appropriately for her age.

There were many more examples, similar in tone to the ones discussed above. These examples serve to demonstrate that the women of this study believe their physical appearances at midlife are acceptable and indeed exceptional.

The Importance of Primary Data Sources

Findings from historical reports of health disparity among black men and women (Combs, 2001; LaVeist, 2000; Geronimus, 1996; Barker, 1995) suggest that African-American women generally manifest age-related declines in health early in the life course. This decline is coupled with a deterioration of access to adequate health care services. Unfortunately, with the exception of my own aforementioned work, it has been presupposed that the information from these studies can be extrapolated to include middle class black women. This raises the troubling point that cumulative disadvantage, especially among poorer black populations, fails to explain why these same results exist among black women whose income and education do not expose them to the same risks. In essence, this would indicate that other social factors contribute to early signs of decline in health related aging.

I anticipated that there would be a difference between what has previously been reported and what the women of this study believed about themselves as examples of successful aging. The first such report is derived from an analysis completed using the National Survey of Midlife Development in the United States (MIDUS) (Combs, 2001). This analysis, like many of its kind, compared black and white women in order to identify variables that contribute to the continuing dilemma of health disparity among African-Americans. It noted that compared to white women of the same ages, black

women reported experiencing physical limitations, a sign of aging, as early as age 25. This same condition was reported nearly ten years later in white women. The same age difference existed in queries about whether or not these same women were receiving prescriptions for medical conditions. Also, the black women of this data set had less health insurance at an earlier age than did their white counterparts. However, because physical limitation was self reported, I was reluctant to make a strong link between self-reports of physical limitation and socioeconomic status (SES); I believed that self-reported physical limitations were influenced by factors other than SES. These findings inspired further study and search beyond the biomedical and socioeconomic models for the causes of early life course health disparity.

Three other studies (LaVeist, 2000; Geronimus, 1996; Barker, 1995) also provide evidence that declines in health and markers of aging appear early in the life course among African-Americans. These studies suggests that reports of early signs of aging may not be consistent or even reliable predictors of health and aging in later life among middle class black women.

My interest in the subject of black women's aging processes stemmed from two separate and seemingly unrelated pieces of information. Namely, that information was that blacks reported more functional limitations than whites and that women reported more functional limitation than men. I later began to note that despite The National Institute of Health's increased general interest in health disparity among African-Americans, there was little if any specific or in-depth information about issues of health and aging among black women.

Given my serendipitous discovery that black women were reporting and demonstrating signs of aging as early as age 25, I became reluctant to accept information about this population that did not address the following three concerns.

The first concern relates to culture. Again, I argue that the social construction of health and aging occurs within a cultural environment. This environment presents internal normative realities such as dietary practices, community structures, community SES, family dynamics and geographic location. Arguments for early and cumulative disadvantage must be balanced by cultural realities. For example, in this study I discuss that among black women, concepts of “normal” body weight are influenced by the cultural and historical notion that more weight is a sign of prosperity and therefore being “overweight” may be relative and certainly acceptable.

Second, as I have previously noted, only one-third of the black American population earns wages below the poverty level, yet it is this one third that is routinely studied and used as the model for intervention. This is not to suggest that this one-third is unimportant, rather that this group represents only a narrow view of life within the population of black Americans.

The third concern is related to the exclusive use of comparative, biomedical models to investigate health disparities. Although these models may introduce the scope of the issue, they are less effective than interviewing populations to determine possible structural causes such as institutional racism for health disparities. As LaVeist notes in his analyses of scientific journal articles, “the majority of articles published in these journals failed to offer insights into the causes of health disparities among racial and ethnic groups” (LaVeist, 1998, p. 18). Moreover, because such studies do not have the

benefit of input from the target audience, they have the potential to produce interventions that fail to address the subject group's perceived needs for health care services. Input from the target population is instrumental in planning interventions. For example, research into breast cancer among African-American women has begun to examine culturally-bound health beliefs that may affect choices in treatment (Edwards, McClave & Combs, 2000; Lannin, 1998). Finally, in all likelihood, these models use the dominant culture as the norm. This has the potential to render reports of health outcomes among minority groups as pathological when in some instances of disease and illness, whites actually fair worse than blacks.

In examining the early and cumulative nature of illness among blacks, early life course events have been identified as a major contributor to health disparity (Hayward & Hernon, 1999; Jackson, Chatters & Taylor, 1993; Moen, Dempster-McClain & Williams, 1992). I closely scrutinized two reports to determine how they applied to American black women.

The first report was an analysis conducted among economically disadvantaged black women (Geronimus, 1996). The study produces what is most commonly referenced as the "weathering hypothesis," the view that, much like the gradual erosion of land by environmental elements, human bodies "weather" or erode in response to environmental assaults. In this case, the assault is racial discrimination. Thus the report concludes that among black women of lower socioeconomic statuses, the risk of undesirable low birth rates increases with age. In essence, this hypothesis captures the notion that despite efforts to alter individual health behaviors among disadvantaged black populations, the net effect of structural racism is a cumulative impact on the infant birth weights among

this group. The question that I pose and attempt to examine with the women of this study is: Does higher SES protect middle class blacks from the same health disadvantages?

The second report that I scrutinized (Barker, 2002) analyzes statistics collected on a population outside of the United States. In this report, reviewed in *Discover(2002)*, David Barker, MD presents an argument frequently referred to as the “Barker hypothesis.” The argument is that:

...conditions of the womb and in early infancy ‘program’ the way our kidneys, liver, pancreas, heart, and brain develop, and they function later in life. When a fetus must adapt to a poor environment in the womb, or when infants are exposed to malnutrition or infection shortly after birth, permanent and even lethal damage is done” (p.1).

This hypothesis seems obvious in its conclusions that early exposures to health risks have life course consequences. However, as straightforward as these conclusions might be, they do not address the confounding effects of race and class.

Both the weathering hypothesis and the Barker hypothesis have been cited hundreds of times in studies of health disparity that focus on the one-third of blacks who earn wages below poverty level or come from disadvantaged childhoods. Neither hypothesis, however, addresses the issues of race and class. In large measure, the women in this study present views that conflict with both of these hypotheses. In contrast to these selected reports of the effects of cumulative disadvantage, and despite documented reports of early declines in health among black women, these women do not see themselves as disadvantaged. By-and-large, despite issues of weight, lack of exercise, smoking, high blood pressure and age, they view themselves as healthy. This perhaps supports the report of Byrd and Clayton (2000) that, for blacks, “poor health status and outcomes...are ‘normal’ and acceptable.” (p. xxiv).

Summary

This chapter provides a general discussion of the existing framework for the study of aging, and how the experiences of aging women in general, and black women in particular, fit this framework. Against the theoretical framework of aging studies, the participants begin to link their social, political and historical perspectives to their beliefs about aging. From their words, the reader learns that these black women calculate midlife in two ways. First, “midlife” may be a numbered or time-ordered event. However, the chronological age is less meaningful when making within-group comparisons. For these women, lack of the physical signs of aging, usually the condition of the skin, make aging a fluid and pleasant experience. Second, the period of midlife may also be signaled by life course events, such as children leaving home. A few women, primarily those without children, assigned menopause the task of announcing midlife.

The following chapter again uses the words of the women to explain their perspectives of health, and race is introduced as a significant factor in the construction of health and aging beliefs among the women of this study.

CHAPTER 4 "PEANUT BUTTER AND JELLY AIN'T A BLACK THING!"

This chapter has two objectives. The first is to introduce one of the ways that the women of this study organize their everyday thoughts about whites. This is a typification process, one of several processes in the construction of the life course (Gubrium, Holstein & Buckholdt, 1994). For the women of this study typification takes the form of making observations that contrast the traits or beliefs of black women to those of white women. Generally these address physical signs of aging among white women. Selected portions of interviews and the biographical data of the participants provide examples of typification.

The second objective of this chapter is to examine how the women of this study view themselves as a part of the greater whole or consciousness of black women. In this respect, the project seeks to gain insight into construction of an individual, yet collective black female consciousness. In large measure, this consciousness develops as a result of shared psychosocial experiences, particularly racism. The words of the women are used to examine the influence of racism on health.

Typifications of the Life Course

In the previous chapter, Ruth's comments about the dietary practices of whites and aging provide one of the first examples of the typification process. To typify what whites do and to demonstrate how she sees herself in contrast to whites, Ruth says: "I do know they tend to eat a lot more boxed stuff and refrigerated stuff and canned stuff and we don't particularly like stuff like that. It's not our thing." As a characteristic of social

constructions during changes in the life course, the process of typification serves the purpose of “organiz[ing] events and courses of action, to give them meaning” (Gubrium, Holstein & Buckholdt 1994). Typification adds slices of information to form the entire pie of black-white relationships. As Gubrium, Holstein and Buckholdt point out, “Recollected anecdotes may suggest that someone is ‘obviously’ this or that type of person. On the other side, once typifications are formed, they in turn are used to warrant and elaborate the meaning of the available information” (p. 62). In this way and in the circumstances of these black women, they are now constructing a “whiteness” of aging and health as well as a “blackness” of aging and health.

By using typification as a way to contrast themselves to white women, the women of this study determine who they are not rather than explicitly stating who they are. Expressed another way, these women construct and define their selves not only explicitly but implicitly through the use of typification. If white women are described as ‘thus and such’ then the obvious description for black women is the implied opposite. As a process embedded in the conversational patterns of these women, typification is the most complex theme that appears in these interviews. It develops as the women use their personal observations and experiences with whites to form belief systems about whites in general.

Body Image and Dietary Practices

Comments about the physical appearance of aging whites and dietary practices of whites serve as examples of this belief system. I was especially struck by Rose’s comment regarding dietary practices and the source of her knowledge about eating foods for good health.

Rose, age 71, is recalling her life in Philadelphia and her mother's work environment as a domestic worker. She recalls that some of what she knows about nutrition came from the whites who employed her mother. She smiles and confesses an encounter with peanut butter and jelly sandwiches. At this point she remarks that eating peanut butter and jelly is clearly not what blacks do. As Rita does in the previous chapter, Rose makes use of code-switching to emphasize her point and her connectedness to being African-American.

Rose, like Rita, is a retired educator and has acquired patterns of speech that not only reflect the region of the country where she was reared, but also her formal education. Towards the end of the interview, Rose repeats in a code-switch that, "Peanut butter and jelly ain't a black thing!" Subtlety and implicitly, the comment frames the way this particular black woman thinks about what she considers are the unusual eating habits of whites. This and similar comments may serve to reveal how responses to black-white differences and resultant conflict also serve to form beliefs about equal access to health care. These beliefs are not myths nor are they immediately obvious. They do however arise from processing ordinary, consistent and everyday observations about the white world in order to understand everyday racism (Essed, 1991).

Chapter 3 presented the women's comments about the contrasts between the physical appearances of aging black and white women. These comments, coupled with ways of viewing the body and dietary practices, suggest a patterned viewpoint among these women. One issue of body image for black women is weight and obesity. Among black women, obesity has been reported to be a health threat of epidemic proportions. However, the following comments from the participants will indicate that issues of

weight may be of less concern to the women of this study than biomedical models would suggest.

Several years ago, Mary, now 57, underwent surgery to reduce the size of her stomach. At the time of the surgery she considered herself overweight and was experiencing multiple chronic illnesses. Her physician agreed to perform the procedure in hopes of reducing Mary's future health risks. Mary's approach to weight, health and body image is the most divergent among the women in the study. In response to my inquiry about her satisfaction with her looks Mary had this to say:

I think I am [pleased]. I am [pleased]. The only thing I would change is the surgery on my eyes. I don't like wearing glasses. I am only 57. I think I look well. I don't want to get heavy again. I would like to lose another pound. I have allergies. But I am otherwise okay. Weight is very important in anyone's life. It can hurt you. It means an early death if you are overweight.

There are a lot of black women who are overweight

Way overweight. I was at a birthday party with over 200 people. There were some very heavy black women. Maybe it is something in the genes. Or we are not eating properly. They are young women too.

Some say we eat to compensate.

I heard that, too. Maybe, I don't know. But there are an awful lot of younger women overweight, very overweight. Weight will take you down. It may be in the genes. Or it may be because of frustration. I am sure a lot of black women are upset over things in their life. You have a lot of single parents among the blacks. There is some among the whites, but more among the blacks.

Mary has expressed three reasons for excess weight among black women: genetics, inappropriate dietary practices and being frustrated "over things in their life." In her everyday observations she suggests that the high rate of single-parent households among blacks is one of things in their lives that cause frustration. Mary says "their" lives, indicating that she is not part of collective. She has left the ranks of the overweight and now concerns herself with the loss of a single pound. Although she is less decided about

the causes for overweight among black women, Mary's overall message is that "weight will take you down. . . . It means an early death if you are overweight." Mary's viewpoint diverges from several of the women in this study who express a higher tolerance for weight.

Like Mary, military retiree Ann connects overweight or obesity to issues of health and illness. Ann has recently had a hysterectomy. She is still recovering as she prepares to move her household. Her furniture is gone so we sit on the floor of her near vacant duplex to discuss issues of health and aging. Near the end of our time together I ask Ann to tell me what she thinks is the most important thing for African-American women to know about health care.

A lot of us [black women] are gaining a lot of weight and we are not taking care of our bodies. We think that is okay. You start getting hypertension, diabetes, heart disease. A lot of us are overweight. We don't know how to control that weight.

Why do you think there is an overweight issue among black women?

Diet. What we eat. It is difficult to change.

Ann sees weight as a pervasive issue among black women and one that is associated with several illnesses. Her list of chronic health conditions begins with hypertension, which is undisputedly the number one health concern of African-Americans. She sees diet—"what we eat"—as the reason for overweight. Like other women of this study, Ann sees a particular pattern of eating among blacks and questions the wisdom of these practices. Finally, Ann determines that these eating patterns, perhaps because of being culturally embedded, "are difficult to change."

Despite the warnings of Mary and Ann, research into the cultural views of weight among black women point to one strong cultural reason for acceptance of high body mass indices among blacks. Researcher Estelle Disch (2000) states that "In African-American

communities, a certain level of obesity [are] considered attractive. Historically, African-Americans have associated degrees of obesity with well-being. To be thin is to be poor” (p. 449). It is suggested here that a few extra pounds of body fat signifies that the family has the money to afford large quantities of food. One participant’s testimony supports this idea. Wilma, one of two girls and three boys in her family, has this to say about eating practices in the southern household of her youth:

I wouldn’t let the boys out eat me. So maybe that is why I am overweight. I have always been overweight. The doctor never told me about my weight until this last visit. I was always active. I never let weight stop me.

At 55, Wilma sees herself as having always been overweight. However, the first time weight became an issue of health was during a recent doctor’s visit. Wilma’s previous acceptance of weight appears to conflict with some current medical guidance. For Wilma, who says she was “always active” and that she “never let weight stop [her],” weight only becomes an issue for concern as she transitions to another phase in the life course. What is interesting about this situation is that Wilma appears to only recently begun to consider herself overweight, and then only in light of a medical standard that may not accurately portray the cultural realities of black womanhood. The question remains, who and what sets the norm for weight among black women?

In the following two interviews I attempt to unveil the meaning of weight among these women. The first attempt is with Ruth. I ask her if she considers herself overweight.

Just slightly. Not enough to stress over.

What is “slightly” to you?

I probably could lose about 10 lbs.

Is that what you think or because you have read a chart.

No, I look at my tummy and my butt and neck and it's sticking up a little bit. Slim it down and it'll look great. No saddle bags.

Ruth's tolerance for overweight is ten pounds, while Mary, whom we know has undergone stomach reduction surgery, is interested in losing one pound.

Juanita provides the second set of comments regarding weight tolerances. Juanita, who considers weight management the greatest challenge of her midlife experience, and her mother have agreed to come to my house for the interview. We are sharing some light refreshments. This is the first of two dyads among the interviews. Juanita comments:

Weight [is the greatest challenge at midlife].

What is your concept of weight?

Maybe not weight. It is just stuff that happens to you. I have this tire now. I will lose weight, but this tire stays. I think that comes from mom's side of the family. You get this pouch that develops. Some women can be nice and flat. But some black women have this thing going on here. I inherited the big shoulders and arms.

What is the basis for this comparison?

[I compare myself] to other black women.

Juanita reconsiders her initial reply to suggest that body composition may be genetic. Her bases for comparison are the black women of her family, as opposed to media images in which white women are the standard.

For these women, weight is both an issue of body image as well as one of health. Lee wants to get her weight under control so that it does not develop into "a serious problem later on." Mary says that weight "can take you down." Ann produces a chronology of illnesses related to being overweight. Juanita believes that weight is her greatest challenge at midlife. Yet despite concerns about weight, none of these women

appears to have any obsession about the subject. In fact, they indicate satisfaction with the appearances of their bodies despite what may be considered as extra poundage.

Food and Diet

In discussing weight and diet, typification is again employed to contrast how these women see themselves in relation to white women. The first of these comparisons is made by Lee who has invited me to have dinner at her home as part of the interview process. The meal, a ritual among African-Americans, serves as a spring board for our discussion of health and aging. At 48, Lee has recently completed her master's degree and received a job promotion. She is extremely proud of these accomplishments.

In defining midlife in the early part of the interview, Lee stated that she wanted to make changes in her lifestyle. Among those changes, she believed that she “needed to get serious” about her weight. These are the words she uses to demonstrate how she constructs her standard of appearance:

I tried to put on something and it doesn't fit. But it is not because I look at other people. It is a personal thing. And I realize if I don't take care of my weight now, there will be a serious problem later on.

Like Juanita and Ruth, Lee sets her own standard of appearance. She does not gauge being overweight by any standardized body shape but by the way her clothes fit and the way she feels about herself. We also hear Lee connecting weight to health and taking responsibility for improving her health through weight management.

As our conversation continues, we turn to the subject of eating, specifically the meaning of eating among some black women and how this differs for white women. Lee expresses and contrasts the cultural meanings and purposes of food in the following:

When I look at black women, including myself, we eat because it makes us feel good. We like the food. But when I talk to white women, they want to keep a healthy body. They don't care what it costs. If they have to eat a yogurt every day,

they will. We look at our bodies differently. I don't want to eat beans and rice. They will eat nothing and it won't bother them. They will talk about going out and partying. Most don't talk about food.

Why to you think this is so?

Culture. The way you are brought up. To us [blacks], food would make you happy. When I am around my siblings we will say, 'wasn't Laura's baking the best...?' I don't think white women talk about the food at Thanksgiving. We will sit around and talk about food all the time. [For example], when you said you were coming I said I would make something. White women don't care about it.

From Lee's typification of white women's attitudes about food we learn that Lee believes there is a marked difference between the way black women and white women view food. In two respects Lee alludes to eating as a ritual among blacks. Phrases such as, "We sit around and talk about food all the time" and "when you said you were coming [for the interview], I said I would make something [to eat]," point to sharing food and eating as ritual.

In the preceding discussion and interview analysis, the reader comes into contact with examples of the perceived differences in the dietary practices of blacks and white. These differences are part of the ongoing dialogue of health and aging among black women at midlife. These expressed differences demonstrate how the women of this study construct their beliefs of health around issues of weight and dietary practice.

Stress

The Stress of Being Black

The discussion now moves to another pervasive health issue among black women: stress. Most often, stress is associated with being black, and occasionally the participants make links to the impact of stress on overall health.

The stress of being black in America is a frequent topic of research. This study adds to that body of knowledge by disclosing how some women link stress of being black

to health outcomes. The indicators of intergenerational learning and collective memory are most visible in the following section that discusses the intersections of health, racism and stress. For the women of this study, their explicit recounts of experiences with racism, as well as their implicit ideas of the impact of racism, crystallize around early childhood, racial encounters. What occurs in the texts of these interviews demonstrates the filtering of everyday life through the experiences of race.

Racism expressed as discrimination has been identified as a major cause of stress among African-Americans. Overtime, the stress of being black in America has been associated with producing higher risks of illness (Feagin & McKinney, 2003; Feagin, Early & McKinney, 2001; Williams & Wilson, 2001; Clark, Anderson, Clark & Williams, 1999). However, for the women of this study, most of who were educated and raised in the southern regions of the United States, their exposure to racial discrimination was controlled by their environment and did not appear until later in the life course. For them, their parents and segregated environments in which they lived prevented interaction with whites. It was not until the woman entered young adulthood and left their hometowns that they became fully aware of racial discrimination. Juanita described her childhood experiences with racism in this way:

I didn't know it was racist at the time, but I went uptown with my siblings in Knoxville. They said we don't serve you here. We had no clue what that meant. We just thought we couldn't go to that store. Later on I found out what it meant. I was about 10 or 12.

What kept you unaware of it?

My environment. I just knew I couldn't go in there. But it didn't bother me. When you are in controlled neighborhood, you don't know. If no one is talking about it, you don't worry about it.

Wilma's experiences were similar to Juanita's. She had this to say about early her childhood memories of discrimination.

My earliest memory wasn't pertaining to me. But in our hometown, my mother was especially protective. There was a store that had different bathrooms. I asked my mother why. If I was going to one, she would redirect me. She wouldn't let us go to the movies. We went upstairs, and they [whites] would be downstairs. At the bus station, we would sit on one side of the bus. I would ask why we were doing that. I was about six or seven. I never paid attention to it. We went to church. I had a good life. My mother would explain it in a way like we are not Catholic; we are Baptist. My life was so good that I never really thought about it. My first encounter was in Greenville, South Carolina. My brothers were involved in that. Even in school, I never really paid attention to it. It wasn't until I got older. The clerks in stores would wait on the whites before they waited on you.

Mildred also offered an observation about childhood experience with racism:

I can remember hearing my momma and the older ones talking about white folks. I grew up in an all-black community. Everyone looked like me. I didn't really know what racism was until I was somewhere else. I was in the north. Racism was the pecking order in the community. The only things I can remember was when I went south with my grandmother and went into town; going and buying something. We couldn't buy it. Those were subtle things. We were from the north. That didn't happen. But that community shielded you away from it. It was schizophrenic.

There was a whole new world out there. Teachers, doctors, everyone that took care of me, looked like me. We were a black community. I didn't know anything until I moved away. When I went to college I went to a whole new universe. My roommate was from Mobile, Alabama. I [would say to her], 'hey, how are you doing?' There was no [answer]. When I left my community, everything kicked in. I went to Indiana University. There are teachers that prepared me with the best they could, but they couldn't prepare me for the standards that were out there. That is the mental pain that is caused. Those are the things we drag. That is what causes us pain. But I am at a point that I am over my mental trauma. Racism has made us a strong people. It makes you strong.

We learn several things about racial discrimination and childhood from these statements. The first is that prior to the civil rights movement, segregated living—especially for children—was the order of the day and that the realities of discrimination were learned outside of the community. Second, parents did not necessarily discuss their own experiences of racial discrimination with young children. Third, we begin to

understand just how pervasive racial discrimination is in the life course of these women and how early that appears.

Stress and Health

Explicit references to stress and health surfaced frequently during these interviews. These included references to conditions, especially while at work that were stress producing. As a general rule, those stressful incidents at work were not explicitly connected to health. They were however, always related implicitly to the stress of operating as black women in white worlds. Mildred talked about this duality in this way:

We live in the world of being black. When you walk out the door, you take on the world of whiteness. You have to learn the survival skills of the white world. Education is important. It is like going in the battlefield—you need to strategize. Some days you walk in [to work] beat up. We live in two worlds. From the time you grow up, you learn that. The person you are at home is not the person that is at the air force base. [For example], my hair. I couldn't wait to get out of the military. [Now] I can do it as I please. We are the only group that lives in two worlds.

Mildred's pattern of speech slowed as she used her hands to describe the "shifting" that takes place as she moves from the world of blackness to the world of whiteness and back again. Researchers Charisse Jones and Kumea Shorter-Gooden (2003) describe this adaptive behavior as one in which black women are "relentlessly pushed to serve and satisfy others and made to hide their true selves to placate" (p. 7).

Leading double lives implicitly exposes black women to consistent stress. As mentioned earlier, this stress has been reported to have a negative and cumulative impact on health. Two participants address the cumulative nature of stress over the life course due to racial bias. For Ruth, exposure to the stress of being black was an everyday lesson of "growing up." She says of her childhood in New York City:

Growing up, I was always taught to do everything twice as good to be considered half as good. That is a lot of stress to deal with every day, especially if you are an

achiever. You see your white counterparts and they do not have this, and that's a tough thing to deal with everyday.

Jean, who grew up in rural Mississippi, does not specifically mention the day-to-day dimension of stress, but she does imply that the process of surviving as a black in America is an on-going one. Jean phrases it like this:

We've overcome a lot, but we still have a long way to go, and those of us that have the knowledge need to try to continue to tell our brothers and sisters what we know works [and what] helped to make us better physically and mentally.

Both Ruth and Jean have effectively captured the continuous nature of racial biases.

Two situations or opportunities in the interview elicited responses about racism, stress and health. The first occurred when I asked the woman to tell me one good thing about being a black woman in America, and one bad thing about being a black woman in America. Depending on the point in the interview, this question was also sometimes phrased as, "What is it like to be a black woman in America?" The second occurrence came when I asked, "If you had proof that black women became ill and died before white women, what would you say was the cause for this?"

I posed the question about being a black woman in America to Rita earlier in the interview than I did for some of the other participants. Rita, age 40, is employed as a juvenile probation officer. She has invited me to her office for the interview. It has been difficult to schedule the interview during her work day, and because she has already cancelled one appointment to meet for coffee outside of the office environment, I am skeptical about the success of this second attempt. My sense of the current situation is that she is busy, stressed and easily distracted. I want to get her attention and interest quickly. Almost immediately after entering her office I ask to "Tell me about being a black woman in America." Just as immediately she fires back:

Not fun. It is a lot of pressure, but the pressure comes from [us]. We are pushing ourselves to be the best professionally with appearance. We want to be the perfect parent, perfect Christian, the perfect everything. . . although that is unrealistic.

I found this response so strong that I was compelled to ask a second question to learn if there was a positive side to her observations of being a black woman in America.

“Are there times when you are happy to be a black woman? Again, a quick response comes forth. Rita says:

All the time. But there is so much pressure to succeed in all that you do. That is from my generation more than the women today. That’s from the 60s. Your parents want you to achieve all the things that they didn’t achieve. My mother looks to me because my sisters didn’t get it, so I am the only one who is achieving. You have to be a big sister to all those black women coming up. Being a black sister is a great thing. Being part of organizations is a great thing. Being out there and knowing what you are talking about is a big thing. . . Being in the mix. Having a learning disability, it wasn’t always the way, But [after] identifying that [my learning disability], I am now in the mix.

Although it is not fun, Rita is always happy to be a black woman. However, her caveat is that as a black woman who is now “in the mix” there is, “so much pressure to succeed in all that you do.” Thus, for Rita, the work world presents a major challenge to her as a black woman. Earlier she has stated that the pressure to succeed is self-imposed, but as the interview progresses we begin to see that the pressure may have begun within the family environment. “Your parents want you to achieve all the things that they didn’t achieve,” she says. Whether self-imposed or reflective of family values, Rita attributes stress to being a black woman.

One final illustration of the stress imposed by being a black woman is presented in the words of Mildred, who has generously and previously commented on the subject of being a black woman. I ask Mildred to tell me one bad thing about being a black woman in America. She says:

We don’t think of each other as girls. When you say ‘girlfriend,’ that is an endearment. We were raised to be women. We were never girls. You were adult

all your life. I don't remember playing. You were always raised to work. It wasn't about a party. You were constantly prepared to be a woman. You don't know anything else. Even our young girls today; it is the same way. When you leave your environment, you realize it. Black women were raised differently and that can be a hindrance.

Mildred suggests that black women do not enjoy a traditional childhood. For Mildred, the responsibilities of adulthood or being a black woman do not allow a time to play. Mildred equates this adulthood and being a woman to working when she says: "You [black women] were always raised to work." This sense of responsibility and obligation to work, echo the thoughts of bell hooks, author and scholar, regarding the meaning of work for black women. In hooks' (1984), estimation work represents another difference between the socialization of black and white women: "Historically, black woman have identified work in the context of the family as humanizing labor, work that affirms their identity as women, as human beings showing love and care" (p. 133). Although hooks is specifically addressing the early feminist issue of work inside of the home, what might be concluded from the collective remarks of Mildred, an organic intellectual, and bell hooks, the author and scholar, is that for black women working is a part of their everyday lives. However, as noted earlier, because of pressures to excel, workplaces outside of the home are also sources of stress among black women. Thus, for many black women, complex tensions exist between contributing to the maintenance of the family through paid or unpaid labor and developing a sense of self that is unrelated to the world of work. For Mildred, this tension may well be construed as a source of stress related to being a black woman.

As I conducted more interviews, I noted that the source of the stress changes with the age of the women, however, being black continued to be the catalyst. Wilma, age 55, sees race as a stressor in another light.

Wilma is retired. Although she and I have never met, she greets me at her front door with a hug. The interview takes place in her front room where there is a piano that she admits she cannot play. Early in the interview, Wilma talks about the transition she is making from working to not working and her move to Florida. Although born and raised in North Carolina, she has spent most of her adult working life in Queens, New York City. At the moment, her chief concern as a new retiree is being able to afford adequate health care because her retirement package did not include a health care component. Wilma and her husband are too young and too “wealthy” for Medicaid.

I have asked Wilma to comment about possible reasons that black women became ill and die earlier than white women. Wilma had this to say about the illness and mortality differentials:

I would think not eating properly and stress. Black women have more stress than white women. The women have to raise children by themselves. There is more friction in the household. The black families don't have enough finances. Now it is in white families, too. If you don't have the money [to raise] children by yourself, that causes stress. That will trickle down. You work double shifts. You are not home to prepare food. So then you are not eating proper foods. You don't have the money to buy the proper foods. You don't have time, money or energy to care for your family. That will stress you out.

Wilma's response about stress and the relationship to finances and medical care appear to reflect her present day concerns. However, she does not fail to underscore that in her opinion, regardless of the reason, black women have more stress than white women.

The interviews contain additional comments about stress and race that provide insight into constructions of race as a stressor for blacks. Summarizing these comments, I noted that sources of stress among this group of women are varied. That is to be expected, given the heterogeneity of the group, however what is most telling is that regardless of the nature of the stressor, in the minds of these women the circumstances of the stress are directly attributable to being a black woman. The women also reveal a variety of reactions and coping strategies for dealing with this stress, including the development of the 'strong woman' archetype and overeating and obesity. A rather significant proportion of these women turn to spirituality to cope with racial discrimination. Spirituality as a coping mechanism is discussed separately in Chapter 6.

Summary

This chapter has identified how the women of this study use typification to organize their beliefs about whites. Here I have especially emphasized that the differing beliefs about body image, weight and food are integral to the construction of the patterns of aging among these women at midlife. Moreover, these typifications are universally assigned among the women of this study. In this respect, typifications serve as a unifying strategy of these women to organize thoughts about everyday life as it contrasts to that of white women. The value in exploring these typifications comes from the belief that the implicit and explicit comparisons between blacks and whites are ultimately the cornerstone of beliefs about a number of interactions with whites. With respect to aging and health care these systems of beliefs have the potential to influence whether blacks enter the predominantly white operated medical system as well as whether or not they comply with medical directives.

In the following chapter, the issues of access to medical care and compliance with medical directives are woven into the background and subsequent historical experiences of blacks in the health care system. In concert with, and sometimes in contrast to this collective history of receiving disparate medical treatment, the women expound on their own experiences, expectations and beliefs about medical care.

CHAPTER 5
“BUT I DON'T KNOW WHERE YOUR
EVERYDAY BLACK FEMALES ARE SEEKING CARE”

This chapter examines possible pathways to health care for the middle class African-American women of this study. The discussion looks at the categories of age, gender, race and class in an effort to illustrate how these designators potentially influence access to health care in America, especially among black women.

As the chapter title suggests, everyday women are the focus of the discussion as I draw a contrast between them and the participants of the study.

The chapter opens with a brief historical background of medical care among blacks in America. Following this history, the discussion turns to the words of the women for insight into how medical care is accessed. The challenge in organizing their words is to draw the lines of demarcation between instances of disparate treatment that are related solely to age, gender, race or class. In many cases, these stratification devices are interconnected and cannot clearly be separated. The overarching task of this chapter is to begin to provide a framework for the study of aging middle class black women within the context of their life course experiences.

Historical Perspective on Health Care

The history of medical care for black Americans begins primarily with Reconstruction (1865–1877). Prior to that time, medical care for blacks was the responsibility of slave owners, many of whom provided minimal medical attention to their slaves. Thus, much of the responsibility for the health of enslaved blacks fell to the

individual and his or her kinship network. In this respect, community based folk medicine was an integral part of black health care.

Many changes occurred in the social structure during the Reconstruction period that followed the Civil War and. Among them was the transfer of the responsibility for medical care for blacks to the state and federal governments.

The primary purpose of Reconstruction was to provide infrastructure and thus support for the South. However, because President Rutherford B. Hayes' administration never gave its full support to Reconstruction as an intervention into the affairs of the region, programs failed to produce the expected results. With the withdrawal of Union troops from the South, the new-found rights of former slaves were unenforceable. For African-Americans, the era "based on the slaves' material role in the U.S. political economy, was over" (Byrd & Clayton, 2000, p. 329). Many former slaves could neither read nor write. No longer a valuable commodity, American blacks were left with few marketable skills that could be parlayed into a means for subsistence. Moreover, even if medical care had been affordable, the stigma of having been enslaved continued to exist. Blacks were discriminated against in both private and public sectors because of this former status.

In response to the need for programs that addressed the medical needs and increasing health disparities faced by blacks, the black medical community established the National Medical Association (NMA) in 1895. The establishment of this organization was necessary because the all-white American Medical Association (founded in 1847), was unwilling to include black physicians or the concerns of blacks on its agendas. The role of the NMA was to "upgrade the quality of medical life several notches in the Black

community . . . and provide the medical leadership and organization required to address the black health crisis of the future” (Byrd & Clayton, 2000, p. 357). The extensive work of Byrd and Clayton reflects current, conflicting views and interests of the National Medical Association and the American Medical Association. As the authors state:

They (the NMA and the AMA) are diametrically opposed ideologically and philosophically, regarding health needs and health care services, and the health rights of minority and disadvantaged populations. Failure to address, and eventually resolve these race-and class-based health policy, structural, medical-social and cultural problems plaguing the American health system could potentially undermine any possibility of a level playing field in health and health care for African Americans and other poor populations... (p. 572)

In short, the establishment and maintenance of these separate health care structures continues to marginalize the health interests of African-Americans.

For aging African-American women, this marginalization is compounded by the intersections of age, gender, race and class. A primary concern of this study is to examine the ways that black women manage their health and health care access through these barriers. This study now turns to the women for further comment about the barriers they face in gaining access to health care access.

Barriers to Health Care Access

Voices of Ageism

For women, both ageism and sexism present challenges over the life course. Although studies of aging rarely consider how these conditions intersect (Calasanti & Slevin, 2001), the challenges become more profound in a society in which youth and youthful appearances are highly prized. As was noted in Chapter 2, aging women are disadvantaged not only by the socially constructed images of aging, but also by occupying positions outside of the power structures because of gender. This position limits income, which in turn limits access to goods and services. Lack of access to goods

and services in part explain the high rates of poverty among older women. Furthermore, research reports that for American blacks, differentials in income become more pronounced at midlife. It follows that African-American women at midlife would be greatly disadvantaged by both age and gender.

Nevertheless, the women of this study do not specifically link their aging experiences to disparate treatment. This may, in part, reflect two thought processes that occur in their assessments of aging. First, they tend not to view themselves as disadvantaged by age. As one woman puts it, “I think black women . . . just accept life and move on.” This position was strongly voiced in Chapter 3, “Age Ain’t Nothin’ But a Number.” The women’s comments told of positive approaches to aging and general satisfaction with body images. Second, the biases inherent in the intersections of race and gender and may override considerations of age.

Voices of Sexism, Voices of Racism

Mildred has found a way to address the intersection of racism and sexism. These are the words she uses to combine these elements of black womanhood:

There are too many [black] women who are walking around with something [illnesses] because nobody will take the time to see that this is a different body. Not just a woman’s body. You first have to fight the sexism, and then you have to fight the racism. Even some of our black women doctors haven’t been educated to the differences [of incidences in] diabetes, heart [attack], and stroke. If you are weaned on tofu, things will be different. But fast food will kill you. You have to understand that. We talk about our bodies, but our [bodies are] different. There are things that go with these hips, these eyes.

Mildred’s words illustrate the subtle way that race and sex combine in the medical world to disadvantage black women. In her mind, differences in medical pathologies, medical incidences, and diets require different medical protocols. She also suggests that

differing physiology, which she describes as “these hips, these eyes,” is cause for different medical considerations.

Iris, the physician in this group of women, underscores the belief that black women’s bodies are different:

There are different responses in African-American women to medicine. Physicians as a group are beginning to recognize that. There are definite genetic markers that will make you respond differently to certain medicines. Even in terms of the disease process, there are certain diseases that are white people diseases and certain ones that are black people’s diseases.

Mildred provides a similar, though less clinical, response:

For years and years I remember watching television and the only people that got put in the hospital were white. How long does it take to know if this drug is okay for my system? My fear is [going] to the hospital and not being able to talk for myself. They see me as this poor little black woman. You have no voice there. [pause] Even the medical resources aren’t shared. There is racism in the sharing of resources.

Mildred’s observation of who is hospitalized reveals two facets of how she views health care. First, she bases her conclusions on observations that span a period of time (“For years and years”). She also draws out her words to further emphasize that her opinion is formulated not by any early or brief example, but over an extended time period. I have the impression from the inflection in her voice that she has given the matter a good deal of thought. Second, Mildred’s answer is a critique of the media and its portrayal of blacks. Mildred uses the absence of a black presence in the fictitious world of television to draw conclusions about the medical needs of African-Americans. She also uses her observation to draw conclusions about her own safety in the predominantly white medical world. Mildred is an educated woman with a responsible position in a government agency. As a researcher and trainer in the field of equal opportunity, she is intimately familiar with the questions of race. Yet, she turns to the media to acknowledge her fear,

especially as she ages, of the white world. Mildred believes she not only has “no voice” in the medical system, but that the system is flawed because of the lack of shared resources. This lack of shared resources is reminiscent of the “separate but equal” ideology present in the Jim Crow laws, the systematic practice of discriminating against and segregating black people, particularly in the American South from the end of Reconstruction to the mid-20th century. Mildred shares with Louise, whose story is told in Chapter 1, a fear and mistrust of the medical system. For Mildred, going to the hospital and being mistreated because she is old, black, and poor reflects the lack of black images she sees on the television. In this way, she expresses an underlying fear that since she sees no blacks in hospital scenes on the television, perhaps real life is the same. That is, the medial systems have no experience in treating illnesses that may require different procedures when the patients are black women.

Louise also mistrusts and perhaps fears the medical system; however her emotions are grounded in her personal experience, rather than in media representations. In Chapter 1, Louise told the story of her near-death from childbirth as a result of medical mistreatment in rural Mississippi in 1957. This experience continues today to influence her perspectives of the medical system. Louise says, “Since that happened to me in Mississippi, I haven’t trusted doctors that much anymore.” For Mildred and Louise, both fabricated and actual experiences of the medical system form mistrust and fear.

Iris, the physician, adds additional information about what she has observed from within the medical system about the treatment of blacks and whites:

My experiences observing the treatment of blacks to the treatment of whites [is that] the people that had an unkempt demeanor were treated more horribly than the people who had a better appearance. There was less an effort to explain things

to people of color. They [healthcare providers] assumed they didn't have the education.

Iris addresses appearance and race in the same breath. In unpacking her statement, it appears that Iris may be associating an “unkempt demeanor” with people of color. The lesson here, of course, is that appearance, along with “color,” may also weigh heavily in determining the treatment received in the medical system. Finally, Iris intimates that race and appearance lead to assumptions about levels of education. Education as a marker of class is discussed later under the rubric of classism. For now, the discussion continues to focus on race-related medical care experiences.

Although it is not a first hand account of disparate medical treatment, Beth, a practicing registered nurse, provides some additional information regarding the experiences of blacks in the medical system. Below, she relays the observations of a black doctor with whom she currently works:

I work with a black doctor now. The first thing that he has noticed is the white person is receiving much better medical care, and the black patients are not. I must admit he said if a white client came in and needed a test done, that the physician would order it without question. But if a black person came in, he didn't get as many tests or the more sophisticated tests as needed as the white counterpart.

Can you speculate why that was?

It's simply related to the fact that the person is black. I don't know. I've never seen it, but...

Before turning to a discussion of how classism buffers racial discrimination, I will present one final example of a secondary account that surfaced from inside the healthcare system. It further strengthens the argument that many women of this study, because of their class privilege, do not have first-hand experience with racism in the medical system. The observer, Pam, is 36 years old. She commutes several times a week to complete her

certification as a nurse practitioner. She also works at night as a full time registered nurse. Pam mentions that because of her light complexion and facial features, she is frequently mistaken as being other than black, a source of sadness and frustration for her. However, when interacting with doctors and patients, this mistaken identity gives her lenses to view the racial nuances of patient care. Pam has this to say from her vantage point:

You don't know how many patients will request they not have a black nurse. Not me, because they don't know I am black. They [whites] think they [blacks] are not as smart. That is how narrow minded they [whites] are.

No. [I don't see patients treated poorly because of race]. We are nurses and we care about people. People are people. We have empathy. I don't see that at all. I have never heard another nurse make any reference to anything racial towards patients. I have seen black patients come in there that don't trust what the white nurse or what the white doctor says. Maybe because of the prejudice they [blacks] experienced in their life.

Pam finds several occasions during the interview to defend her profession. In this instance, while she notes that race calls to question professional ability, she is firm in her conviction that race is not a factor for nurses in providing patient care. She also seeks to advocate for the patient as she explains the source of mistrust for blacks who enter the hospital's patient care system. Pam's ability to empathize leads her to conclude that perhaps black patients mistrust white nurses and doctors because of past experiences with racial discrimination.

Pam continues to weave the threads of racial interplay by explaining the patients' perceptions of black nurses and the issue of trust from the perspective of the physician. Here and in the following quote, she links the patients' mistrust back to remembered discriminatory treatment.

Then you get a black nurse who tells them the same thing and they believe it. I had white doctors tell me the same thing. [The doctors] think the patients think

they are not telling them the truth. The patients don't trust them because of what happened to them [the patients] throughout their lives. In their past, there was so much prejudice that when they [blacks] come to hospital they think they won't get the same care. You have to explain they have ethical values that they have to maintain—to care for every patient the same, regardless of race.

As always, Pam presents a loyalty to her profession with an explanation of the “ethical values they have to maintain.” That ethical value to which she refers is to demonstrate color blindness in order “to care for every patient the same, regardless of race.”

Finally, Pam returns to the issue of trust. This time she establishes the explanation from the standpoint of the physician. She says:

The doctors know it is a trust thing. And they understand a lot of times, even if you are not black, if you are smart, you can understand. You know what racism is about. You would be surprised by how many doctors would say race is a barrier because of trust. I have only seen it between black patients and white doctors. That is the only race I have seen it in. [It is] because of discrimination. [Patients think that] ‘Outside [of the hospital] I am discriminated against, but in here you are supposed to be looking out for my best interest?’ It is a fear.

From inside of the medical system, the perspective is the same. The perspectives and thus beliefs are that blacks are treated differently and sometimes inequitably when they enter the medical care system.

Voices of Classism

Bell hooks asserts that “the evils of racism, and later sexism were easier to identify and challenge than the evils of classism” (hooks, 2000, p. 16). This designation of classism as “evil” does not concern this study, however, what did stand out as important about class identification through these women’s comments was that it made a subtle distinction between how these women viewed their own experiences with the healthcare system versus the experiences of other black women in the same system. In this respect, class appeared to set these women apart from other black women who had fewer

resources. As the analysis of the interviews took form and were organized around certain common themes, I began to note frequent mentions of education, occupation and income. The meanings of these status markers, as well as their importance in obtaining adequate medical care, were expressed frequently enough for me to consider class to be a significant factor in the lives of these women.

My original hypothesis was that racism serves as a barrier to blacks' receiving medical care on par with that received by whites. While this may be true for certain blacks, the remarks of the study participants reveal a variation on the theme. In short, while looking for evidence of current racial discrimination in the interview texts, I found that the texts failed to support the original hypothesis. I began to search for a commonality among these women, in hopes of identifying the cause for a lack of evidence about racism in the medical care system. One of the variables that seemed to be consistent was that of class as defined by education, occupation and income. The question that surfaced from this observation was, "Does middle class status among blacks affect views of racism?" Moreover, the search for a plausible answer, in part allows the study participants to explain racism within the context of a constructed social class. At this point in the discussion, it is important to examine the parameters and meanings of class among blacks in America. The following brief examination of middle class status among blacks sheds new light on why it is that the women of this study generally fail to identify and experience a more personalized racism in the health care delivery system. By- and- large, on the basis of race and gender, they do not perceive access to medical care and treatment to be problems for them. I now argue that this is so because, as middle class women, they are privileged by education, occupation and income.

The Black Middle Class

In America, social class differences are frequently designated on the basis of education, occupation, and income. Among African-Americans, the expansion of a middle class began with the civil rights movement of the 1960s. Following this large scale social movement for racial equality, increased numbers of blacks entered institutes of higher learning. Similarly, there was an influx of blacks into trades and occupations that provided better wages. Numerically speaking, Feagin and Sikes estimate that “from one quarter to one third of the black population is more or less securely middle class (Feagin & Sikes, 1994, p. 28).

One of the historical roles of the black middle class has been to provide leadership within black communities. This leadership was designed to direct collective efforts towards advancement (Banner-Haley, 1994; Feagin & Sikes, 1994). At the forefront of this effort, “black middle class women . . . came forth loud and strong on issues of pressing concern in the black community” (Banner-Haley, 1994, p. 13). This tradition of leadership and thus speaking about the concerns of others may occur in practice more frequently when lines of class are drawn between the haves and the have-nots.

In general, the women of this study are middle class. Every woman has some formal education beyond high school. Some are working on, or have completed, master’s degrees. Fewer have done doctoral work, one is a physician, and four are nurses. Their educational involvement has led to full employment. Thus, in this study, 96 percent of the participants were currently working and had health care plans that adequately addressed their health care needs. Therefore, their comments about lack of health care access tended to arise not from personal experience, but from observations of others whose educational and financial circumstances were different. They resort to secondary accounts to describe

racialized experiences in the medical system. In this respect, the participant's comments are related to what they hear others say about treatment in the health care system. These "others" are those who may not have jobs that provide health benefits, or who have educational levels that may limit their ability to seek professional medical advice. In essence, these women displayed empathy for black women who did not have the financial resources to support adequate health care. It is also apparent that, although their information comes secondhand, they treat it as factual. There also appears to be a clear distinction of class based on income, which serves as a proxy for occupation, health insurance, and education. These women who have the education and income to enter the health care delivery systems do not consider themselves to be "everyday women." Instead, they use their positions as successful, middle class black women to speak about and for others with lesser means as well as the "everyday black female."

Speaking for and about the "Everyday" Black Female

The words of Louise present one example of the use of secondary accounts. Louise is retired as a sales clerk from a major retail sales chain store. As a result of her and her spouse's retirement and eligibility for Medicare, she believes her medical coverage is adequate to meet her needs. She has concerns, however, for others who do not have the same circumstances; these are her words:

I run across white women, some of them have better health than I have. I run across some of them that have worse health than mine. But I think they go to the doctor more than I do. I can't really say if their health is worse or better than mine. I do feel that I run across a lot of black women who have worse health than mine.

Why do you think that their health is worse?

I just sit around talking with them. They don't visit doctors and they don't go to the doctor's office when they have a problem. They let it just go away or go to the drug store and get something. A lot of black women do that. Usually, they say all

the doctors want is money and they don't have the money to give them. So they take care of their own health for but just about everything that ails them. They don't have the confidence in the doctor.

Why don't they have the confidence in the doctor?

[Usually] it's about something that they have heard from somebody or a friend or somebody. I've never run across a black woman that has any personal experiences (of discrimination) with the doctor. Women that are my age, well I sit down and talk and a couple of them are from really low-income areas. I don't think that they had medical insurance like most women my age would have. There are a couple of them that do have good insurance. One [woman] in particular hasn't had personal medical experiences with the doctor, but she doesn't go to doctors unless she feels like she really needs it.

Louise begins by talking about what she views as the health and health care of white women; she continues and concludes several things about black women and health care. She acknowledges that she has no recent, first-hand experience with discrimination in the health care system and refrains from again mentioning her own trauma while giving birth in Mississippi in 1957. However, she is willing to share reports from others who are her age and have less income. Louise tells us of women who medically treat themselves because they don't have the money to go to the doctor. She speaks also of women who do not trust doctors, even though money to pay for medical care may not be a concern. One especially telling phrase in Louise's secondhand account is, "I don't think that they had medical insurance like most women my age would have." Louise is 67, an age at which she believes most women have medical insurance. Yet, she is discovering through the conversations of her everyday life encounters that this is not the case, especially for women living in "low-income areas."

Education

I now ask Beth to switch from her former role as a health care practitioner to that of an everyday patient so that she might discuss any racial or sexual biases she has faced as

a patient. I ask if she has experienced any discrimination because of race or sex while in the medical care system. Her response is an immediate “No.” She follows with this assessment:

I think that is because of my medical knowledge. When I go in to see them [doctors], they immediately pick up on that I’m a nurse and I know what they should be doing. So I’m not like any other lay person. I [am] in a whole different category. So no, I have not experienced it.

Despite attempting to separate herself from her role as practitioner even for this brief time, Beth’s identity as an insider to the medical system cannot be extricated. She always sees herself as a nurse with the ability to communicate on a level with the physicians who provide care and as someone who is aware of what they “should” be doing. In this way, Beth’s role as a patient is privileged by her education as a nurse.

As a health care provider, Iris’s response regarding disparate racial or sexual treatment is similar in nature to Beth’s. I ask if she has ever faced mistreatment in the medical field as a patient because of race or sex. As noted in Chapter 3, Iris’s experiences while training to become a physician were riddled with racial incidents. For the moment we are addressing what she sees from her perspective as a health care practitioner, turned patient:

I don’t think I can talk about it. I have always been given the best of healthcare because I am in the medical field. Once they know you are in the medical field, they take care of you better. You also receive better treatment if you ask a lot of questions and seem better educated. They know you are the type of person who demands it.

Again, Iris presents a clear example of the benefit of the patient’s education in obtaining adequate health care. She now switches from her perspective as an educated patient to that of a physician. As a physician entering the medical care system, Iris is privileged by her education. Again, the issue of education is central to her assessment of

compliance among her black patients. In the following lines, Iris talks about blacks who are educated about health issues and those who are not. In her view, those who are more educated tend to take health issues more seriously. Iris has this to say about her black patients:

Those not educated well don't take their illness seriously. [There is] diabetes, and hypertension. I see who takes their medicine and who doesn't. It has a lot to do with the level of education.

Historically, education has played a key role in the upward mobility of blacks. Both Booker T. Washington and W.E.B. DuBois, though different in their philosophical approaches to the nature of education, shared the view that education was the best means for blacks to acquire parity with whites. As a marker of class status, education is one way that the black middle class women of this study ameliorate the impacts of racism in the medical care systems. In the preceding accounts of the women of this study, education continues to be a tool to combat disparate treatment.

Occupation and Income

The final markers of middle class status under discussion in this chapter are occupation and income. In the minds of many upwardly mobile blacks, higher education and training are the antecedents of good jobs and competitive incomes. Incomes that allow them to purchase health insurance are the subject of much discussion among the middle class women of this study. As noted in the following statement, outside of having adequate income and subsequently adequate health care plans, these women do not know where the women without these benefits seek health. One of the nurses in the study puts it this way:

Well, first, of all black women, I would say income down in Florida hampers a lot of people in seeking out health care. I have my private doctor and I go to him. When I go to him I may be the only black one in the office. I don't know where

the black female population [goes]. [I don't know] whether it is through clinic or several organizations. I know where I go and I have three other friends, they're all black, and they go to the same doctor so I know these women are taken care of. But I don't know where the others go. I don't know where your everyday black females are seeking care. We [four] all have insurance [and] it's not our husbands' insurance that we have access to.

Betty has a master's degree in nursing and access to medical advice, medical research findings, and money for medical services. In her status as a nurse and a woman who provides her own health insurance, Betty places herself outside the ranks of the "everyday black female." In Betty's next response, she links the importance of financial resources to aging and longevity.

Again, it's a matter of economics. I mean if you have the money you can age beautifully, and then again sometimes money doesn't make a difference. It's the way you treat your body. Money can do anything for you and that has been shown. Rose Kennedy had been kept alive for years. Money can keep you alive for years. Other people with money have been kept alive for so many years. But if you had money that you could afford certain doctors and staff that were professionals. You could most likely live through an incurable disease. Black women don't have those types of financial resources.

As a practicing nurse and one of a handful of black nurses in a local Veteran's Administration clinic, Betty expresses some very clear views regarding the nature of health care. Although she transitions from the topic of money to how you "treat your body," Betty almost instantaneously, returns to the importance of money in aging. For her, there is a clear connection between financial assets, health and longevity. Her response is not uncommon among these women who express concerns for those other than themselves who have circumstances that limit their access to adequate medical care. She further comments about the importance of financial resources and education, as markers of class, in the following ways:

If you have the financial resources, then you can do certain things and I think that is where black women are lacking. We are finding out more that we are making strides and moving forward, but we can still go much further.

With respect to education Betty determines that education is an important carry over for success at midlife. Of the challenges faced at midlife, Betty says:

Because if you do not have the right position or the right training, I would say you would have a difficult time in terms of jobs. If you don't have that education and that certain way of attaining, you're going to have problems. I was lucky because I am a nurse and I do have certain degrees and so I'm very fortunate because I can move from one place to another place. From the time I graduated from the school as an RN, and at every step, they take my education [into consideration]. So every step I made, they gave me a promotion... I had a masters' degree and here I was working with a person who had no more than a bachelor's [degree]. You have to have certain things in order in your life in order to achieve certain things. Without the right education, you're not going to make it. You have your goals and your goals should be attained. Some people think they don't need goals until much later in life.

In this portion of her interview Betty repeats the importance of education as she links education to the advantages she now has at midlife. One of those advantages is a good job. As was already stated, education is a proxy for the full employment that provides affordable medical care. Like other women of this study, Betty is proud of her accomplishments, especially that of being a nurse.

Another nurse, Beth, is retired from the military and now works at the same Veteran's Administration clinic as Betty. Having also spent time working in the public health care field, Beth has this to say about what she observed while there: "I'm seeing more indigent white women. I've seen more white [people] than I did black [people] when I worked there." Together Beth and I make some estimates about the percentage of the county population that is black. Registering at nine percent, we conclude that the black population, while not large, is clearly underrepresented in the public health care system of her experience. Beth says, "You would think there would be more blacks there." These calculations and observations would seem to suggest that a larger than expected proportion of blacks has the ability to use other health care systems. In the worst

case, it could also mean that poorer blacks are not using any health care system at all. More likely, is that Beth, like many others, has accepted the stereotype of the indigent black when, in reality, research tells us that “many more white citizens were welfare recipients than black folks” (hooks, 2000, p. 124).

Another woman of the study expressed the link between health care, finances and racism in the medical care system in this way: “Talking about medical care, if you don’t have any money you aren’t getting any medical [care]. Medical care is racism.” Here the participant apparently assumes that race is connected to financial resources and that having money makes access to medical care easier.

From this perspective, the financial resources of all non-white racial groups are categorized as sub-standard. However, as noted earlier in this chapter, medical professionals, as well as those outside of the profession, express the belief that education is also a way to combat the potential for disparate treatments in the medical system. Thus, it becomes clear that for these women at least, education and income are the two factors most likely to ameliorate disparate treatment on the basis of race.

Summary

This chapter provides a brief history of black healthcare in America to provide a means a context for the anticipated reports of racial discrimination in healthcare delivery system, and then turns to the women of this study for their comments on healthcare access for blacks. The participants’ accounts of racialized experiences in the health care systems were not as personal as I had anticipated. In the analysis of their stories, it becomes clear that they speak about events not in a personal, experiential manner but rather base their information of what they hear and understand from the reports of others. In this way, these middle class black women distance themselves from other black

women as they use secondary accounts to assess the delivery of healthcare. The question that I then seek to answer relates to the mechanisms used by these women to prevent racism, and, less frequently, sexism, from denying them equal access to medical care.

In the accounts of these women, the lines between discrimination based on age, gender, race and class are often blurred. Rather, the single and unifying element of these discourses seemed to be that of class status. In some cases, such as those explained by Iris, the disparate treatment they receive may in actuality be based on the perception that race and class go hand-in-hand. Thus, if a patient is black then he or she is naturally less educated and therefore less likely to understand and follow medical protocols.

Class status as marked by education, occupation and income, presents itself as a major element in determining access to health care. Many of the accounts of these women mention the importance of education in seeking medical help and understanding medical protocols. This is closely linked to the ability to afford adequate health care insurance. When education and income are aligned, issues of racism and sexism are minimized. For middle class black women, the privilege of class that is embedded in levels of education and income may ameliorate age, race, and sex discrimination in the health care system.

In the following chapter, the goal is to examine the role of spirituality in the lives of these participants. Spirituality is treated not only as a unifying principle to connect black women, but also as a strategy for coping with the oppression of racism and sexism. In this respect, spirituality is linked to good health and successful aging. As with class status, spirituality inserts itself into the accounts of these women and thus, their lives.

Spirituality acts as a buffer between them and their everyday experiences as black women in America.

CHAPTER 6 “YOU HAVE TO COUNT YOUR BLESSINGS”

My development as an intellectual and as a critical thinker is tied to spirituality because growing up as a working-class black woman, the only arena of my life that gave me the sense that I had the right to a space of contemplation was religiosity and spirituality. (bell hooks, p.112).

In this opening quote, noted black feminist thinker bell hooks describes the role of religiosity and spirituality in her own life. For hooks, the religiosity and spirituality of being a black woman is tied to the ability to control an element of her life. In this sense, these qualities give her the “right” to move into a space for managing her own thoughts. Although the women of this study do not articulate religiosity or spirituality as explicitly as hooks, spirituality surfaces as a strong force in their lives. References to “God” and the “Lord” enter the interviews in tandem with a number of topics.

I did not include questions about faith, religious practices such as church attendance, or ideas about spirituality in the original design of the study and the pilot interviews. As the fieldwork progressed, the frequency of the references to spiritual beliefs encouraged further investigation. This created the need to develop a strategy for incorporating this strong and recurring topic into the research. This was accomplished through two methods. The first was to demonstrate how the women of this study construct spirituality in order to manage the events of their lives, with special emphasis on the spiritual approaches that promote good physical and mental health and, ultimately, successful aging. The second method was to examine, from an Afrocentric perspective, both the family and the collective memory as the sources of spirituality. These two

strategies helped form a response to one of the original research questions: “What are the roles of intergenerational learning and the collective memory in developing beliefs about aging and the resultant changes in health?”

This chapter begins by clarifying the terms religiosity, church, and spirituality, and by providing information about the historical importance of the church community in the lives of African-Americans. Next, the participants’ voices reveal how spirituality operates in their everyday lives as black women. Finally, the parameters used to define spirituality from an Afrocentric view are outlined.

Defining Spirituality

In studies of religion, the terms “religiosity” and “spirituality” have been used interchangeably. For the sake of clarity in this discussion, the term “spirituality” is used exclusively. The intent is to avoid confusion with the other meanings conveyed by the words “church,” “religion,” or “religiosity.” It is understood that these labels are considered only as symbols of spirituality. More importantly, the words “church,” “religion” and “religiosity are not considered reliable markers of spirituality. That is, these words and the behaviors associated with them (such as ceremonies, weekly services and other rituals) do not convey the inner essence of the individual. In this study, the concern is in revealing the inner lives of the women and identifying spirituality as one of the unifying principles of black womanhood. In the following discussions of spirituality, the women do not use the word “church” to describe the place where their spiritual beliefs reside, yet a number of them belong to church communities and attend church services on a regular basis.

Historical Roles of the Church

As a symbol, the black church is the focal point in many black communities. For many of its members, the church represents solidarity and safety.

Historically, churches not only embody the history of its members, they also foster leadership. A number of national leaders have emerged from the church community, for example the Reverend Dr. Martin Luther King, Jr. and the Reverend Jesse Jackson. Especially in the South, black churches continue to symbolize home, close family relationships, political activism, and solidarity not often experienced in other organizations. In addition to providing a sense of solidarity, continuity and leadership among American blacks, black church communities also have a history of responding to issues of health affecting the black community. Moreover, the church has always espoused a connection between faith and good health (Taylor, 2001).

Voices: Constructing Spirituality

The voices of the women in this study harmonize and organize around three central themes with respect to spirituality: 1) mental and physical health, 2) stress and coping, and 3) a category I designate as “everyday life challenges.” This third category addresses issues that are outside the rubric of health and the stress of racism; but are integral to understanding the role of spirituality in the lives of these women.

Mental and Physical Health

As noted in Chapter 4, stress is a significant health concern among African-Americans. Recent research has clearly demonstrated that the stresses of racial discrimination and its consequences add to the already high incidences of physical illnesses among American blacks (Feagin & McKinney, 2003; Williams & Neighbors, 2001; Brown et al, 2000; Williams & Williams-Norris, 2000; Clark, Anderson, Clark &

Williams, 1999; Smith, 1998; Landrine & Klonoff, 1996). Unresolved and persistent stress has been related to risky health behaviors such as cigarette smoking, excessive consumption of alcohol, and drug abuse. In addition, reactions to racism have been identified as “the single most common problem presented by African Americans in psychotherapy” (Landrine & Klonoff, 1996, p. 145).

In the interview process, I introduced the topic of spirituality in several ways. One of the ways was to ask the participants about their beliefs concerning mental health. I also asked participants if they had any spiritual beliefs that impacted their beliefs about health and aging.

Pam, the nurse introduced in Chapter 5, was perhaps the most verbal about her spiritual beliefs. References to God spilled into every corner of the interview texts. Pam also has strong bonds with her family. At age 36, she is the youngest of the participants. For a number of years she has shared a home with an older sister. Together, she and her sister attend weekly bible study and church services. Both were teenage mothers who never married the fathers of their children, and until recently, her sister was unmarried. At present, Pam is not in a committed relationship. Despite the challenges of being a single parent, student, and fulltime nurse—or perhaps because of them—religiosity and spirituality are evident in her everyday life. Pam sums up her spiritual perspective about mental health in this way:

I know how to keep it [my mental health], and other people lose it. My foundation is belief in God and my relationship with family. It is very simple.

We read Mildred’s comments about the image of blacks on television in Chapter 5. She is equally as committed as Pam to spiritual involvement. In response to my questions about the most important thing for a black woman in America to know about aging and

about her beliefs about mental health, Mildred states that aging black women need to know the following:

The body will age but the mind won't. The spiritual part never ages. The container ages. . . . I think it is part of that badge of courage. For the world to see you as strong, that means they can't see what is going on in your head. What have relieved me are spiritual things. I pray every day. I pray less for me and more on the spiritual things. This is a very big step for me. It is important to heal. That is where mental health comes in.

In Mildred's words, the spiritual transcends the physical appearances of aging. As I read the words "badge of courage" and "strong," I think of Mildred as a warrior against racism. She has found relief from this struggle in her spiritual practice of praying. She also sees prayer as a way to make her strong and to keep others from knowing "what is going on in [her] head." This effort to shield her thoughts from others is a strategy for maintaining her mental health. Mildred's responses were, in many instances, a complex network of thoughts regarding her racial experiences and philosophies.

This last statement by Mildred is again one of those instances when the complexity of interviewing with her comes to the surface. While discussing her early memories of racism or discriminatory treatment, Mildred talks about the "mental pain" caused by racism after she left the shelter of her all-black community. She has this to say about the mental anguish of leaving a protected environment and later, the environment of college, to enter the world of work:

There are teachers that prepared me with the best they could, but they couldn't prepare me for the standards that were out there. That is the mental pain that is caused. Those are the things we drag [around]. That is what causes us pain. But I am at a point that I am over my mental trauma. It is my spiritualness that has allowed me to make it a tool. [It is] a coping mechanism to deal with the good and bad.

In Mildred's words, racism, mental health, and spirituality are linked. Her spirituality ("spiritualness") is a tool for coping with the "good and bad" of life course

experiences. In using “I” and “me” and then switching to “we” and “us,” Mildred switches from her personal issues to the concerns of a collective. This switch suggests that in Mildred’s world view, other black women share her “mental pain” and “mental trauma.”

In the following example, Pat also connects good health and spirituality. Racism is not a part of this dialogue, although she continues the discovery of how spirituality provides relief from personal challenges:

I believe that you keep the faith and trust in God. I pray for good health. I have a strong spiritual belief in God. I try not to feel old.

Do your spiritual beliefs affect how you feel?

Yes. If I feel bad, it affects me. When I go and see other people with the same problems as me, I consider myself blessed. I am not in a wheel chair. I can take care of myself. I am not on insulin for the diabetes. You have to count your blessings.

In the last five years, Pat has been diagnosed with multiple sclerosis. Since our first meeting to arrange the interview, Pat has also been diagnosed with non-insulin dependent diabetes. Yet, in comparing herself to those less fortunate, those who may be in wheelchairs, she considers herself “blessed.” In the language of spiritual discourse, being “blessed” is a euphemism used to convey that an individual is grateful for receiving special favor or generosity. In this light, Pat considers that, despite her multiple illnesses, her situation could always be worse. In this example, her spirituality gives her the ability to see the positive side of her physical circumstances.

Iris, the physician in this group, humbly acknowledges that there are outside forces at work in her world of medical miracles. Iris is of Haitian descent and still speaks a version of French with her parents. I originally believed that her Haitian heritage might make her experiences with race very different from those of the other participants, and

was at first hesitant to include her responses in the data. I learned, however, that Iris considers herself to be more African-American than Haitian, and that even in medical school she faced a series of racially motivated incidents, one of which was related and discussed in Chapter 4. I decided to use her interview as an opportunity to explore, and perhaps to contrast, her experiences with discrimination to that of the other women in the study. I was also very interested in learning the perspective on health and aging of a black woman who is a trained medical professional.

In our first attempt to complete the interview, Iris' parents met her at my home where we shared tea. In addition to having her parents present, Iris was on-call this particular weekend. We chatted awhile and agreed to reschedule. In the second meeting, I found Iris to be more relaxed and less anxious about time.

The question I put to her is: "Does your spiritual belief affect the way you see aging and health?"

When you are in the sciences, you are so used to separating those two out. You automatically separate health and spiritual aspects. Let me explain. As a physician, you know that a lot of healing has to do with the power of the mind and what you believe spiritually. I know the patients that I have who are positive heal better than those who are negative and do not have a good spiritual base. From that aspect, I try to nurture their healing. If they are spiritual, then that is a good thing. But if you look at what is in the Bible and what is taught from the scientific point of view, they are different. What I know as a physician is opposed to what I know as a spiritual person. After surgery, I know that a person heals better because of their spiritual base.

Is that difficult for you?

Yes. Whatever happens you have to see them through it somehow. It is not always a positive outcome, but sometimes it is. A lot of times you did all you can do. There is nothing left but prayer. I know I have been put in places that had to be an act of God. One time this little Haitian woman who was blinded because she was hit up against a wall and it ruptured her eye, they called me. I helped her through her problem. I went ahead and scheduled surgery. Later, I helped get her rehabilitation. The doctor didn't respond until five hours later. [By then] his services weren't needed. It was interesting. I have been placed in places to help. I

know I am there for a reason. In that sense I know I am needed. It helps me to be better at what I do. That keeps me grounded. It has very little to do with me. I am an instrument.

Iris' reply is a blend of the scientific and the spiritual. Although she never uses the words, "God," "Jesus," or "the Lord," she conveys a belief in a power outside of herself. Iris admits that there is an intellectual conflict between what is spiritual, as in what is written in the Bible, and what is secular, as in what she knows of scientific practice. However she conveys that she feels a partnership with a spiritual essence. She sees that partnership as one that helps her do her work better, gives her a purpose, and keeps her grounded. When she says, "It has very little to do with me" and intimates that she is "an instrument," Iris places the onus for healing outside of her technical skills. Iris' spirituality is both private and public. It guides the work of her everyday world.

Coping with Stress

In Chapter 4, I note that the stress associated with racism is clearly present in the lives of the women I interviewed. This section employs the voices of the women to show the role of spirituality in coping with this stress.

Spirituality has long been an element in the lives of African-American women. As slaves, American blacks were introduced to the symbols and philosophies of Eurocentric spiritual practices. This included a racial hierarchy that featured blacks as savages and unthinking children who needed rescue from evil. Over time, blacks' reinterpretations of the Bible transformed the role of God into that of a liberator. Moreover, women were viewed as active, long suffering and largely spiritual forces within African-American communities (Williams, 1993). In light of the transformations of Eurocentric spirituality, it follows that African-American women have developed a spirituality that continues to

provide ways to organize and manage the racialized events of their everyday lives. Lee views spirituality and God as sources of relief from stress:

We put too much emphasis on others, but I had to realize that, too. I couldn't do it [all]. That's why a lot of black women are spiritual. God is the only one to help with stress. I give it all to God and have him help me. I am the type of person whose faith is in God. I am like a child when it comes to his Word. It says he will take care of me. I believe it, and it is true. That's how it works for me. He will do what he says.

For Lee, black women need to be less concerned with the opinions of others, and more concerned with receiving help from God. She sees that the reason black women are spiritual is because, like her, they realize that they can not "do it all" without help. In seeking this help, Lee trusts in the ability of God to "take care of me." The theme of Lee's discourse reflects the historical development of spirituality in the lives of black women, that is, that spirituality will provide relief from the effects of oppression.

A final example the ways in which spirituality helps the women of this study to cope with stress comes from the woman whose near-death birthing experience was related in Chapter 1. I now return to that story from the perspective of how she uses her spirituality to explain survival from this incident. While this example of coping with racism through spirituality is less obvious than in the situations just described, what is intriguing about the following response is that it has a history that begins in 1957. For me, this story demonstrates just how long the trauma from racial discrimination can linger in the minds of those who experience it.

This is a brief summary of the incident. Following the birth of twin boys, Louise suffered from severe anemia and required a blood transfusion. Citing policies that prohibited transfusions for blacks, the hospital refused to perform the procedure. In retrospect, at age 68, Louise explains her survival in the following way:

He [the lieutenant] made a lot of threats. So they gave me blood transfusions. I had been out for almost forty-eight hours. I really think that I died and came back because when I went into convulsions I was out for like 48 hours. And as I came back, Harvey [her husband] was sitting on the foot of the bed. I could feel somebody touching my hand and pulling me back. I was lying there waiting for somebody to come and get me. Then they started the blood transfusion and I felt like somebody had taken my hand and pulled me out of this hole that I had gone into. When I went out I felt like somebody had me by the hand, pulling me down into this cone. When they started the blood transfusion, it was like somebody had grabbed me by the hand and was pulling me back out of there. When I woke up, Harvey was sitting on the foot of the bed. I thought I had just come out of the labor and delivery room. I [thought] ‘how did you get here this fast and the babies were just born?’ Then Harvey told me what had happened. So I really think I was right at the edge of death. That guy from the recruiting base [the lieutenant] came up from the station and told them to give me blood. [If he had not] been a white man [I would not have been given the blood transfusion]. The lieutenant was there at that station for some reason I think.

Out of curiosity, did you ever see that lieutenant again?

No, but I thought of him a lot, always. I don’t even think we ever got his name. If I’m not mistaken, he was stationed down in [another part of Mississippi] but he was up here at the recruiting station for some reason on that particular day. I really think God had a hand in it. He knew that we needed him. Other than that, I don’t think I would be alive today. Nobody else could have made that hospital give me blood. I think it was a time [when...] Well, there is a saying ‘If God’s not ready for you, he is not going to take you. I really think that is what happened to me. It wasn’t my time.

Louise’s recall and interpretation of these events describes a nearly paranormal experience. Unidentified hands pull her down into a cone and a lieutenant whose name she never knew mysteriously appears and disappears after interceding on her behalf. Yet, in the final analysis and 40-plus years later, Louise attributes her survival from this experience to the hand of God. Louise is not an especially “religious” or demonstratively spiritual woman and this is the only spiritual reference in her interview. Still, she places a value on being assisted by a spiritual force in a time of personal challenge.

Everyday Life Challenges

Not all of the women's comments related to spirituality were connected to health or with coping with racism. Many of them were connected to encounters with life course events, a global view of spirituality that is indicative of the pervasive role it plays in these participants' lives. For example, at least three women of this group cited relationships with men as the focus of spiritual interventions. I asked Juanita under what circumstances would she use a mental health counselor. In answering this question, she describes her relationship with a man and the role spirituality played in helping her decide to end the relationship. The interview includes comments from her mother.

Would you ever use a mental health counselor?

Yes. That comes from being in the military. Because it may impact their career, they [military personnel] won't typically go. When I went through my bad marriage, I did. I don't think we [blacks] typically do because of our spiritual faith. If I need counseling, it will come from my higher power. I pray about things. It will be God's will. I came from an abusive relationship. You wouldn't dare go outside the home. It was the way I was raised. You tend to get labeled outside your family. I needed to get out, but didn't know how. So one night I got down on my knees and ask the Lord to show me how to get out of the marriage if I wasn't supposed to be in it. That is when my life began. I got out, joined the military and got on with things. But it was my faith that gave me the strength. In my new life, I would go to counseling. But I do rely on my faith. I pray and ask for guidance. It is a two-fold [effort].

Juanita sought help from a counseling service during a difficult marital relationship; but she acknowledges that this was not typical of persons in her situation. First, as military member she feared that seeking counseling might adversely impact her in the military environment. Second, Juanita does not think that counseling is a typical resource for African-Americans. For her, "spiritual faith" is the best source for counseling. Her two-fold approach is to combine secular counseling with the spiritual ritual of prayer. She does not attribute her ability to leave an abusive relationship to the

counseling she received, but rather to the fact that she prayed for guidance. She believes her life began following this time of contemplation.

As a follow-up to Juanita's response about mental health, I turn to Juanita's mother, Martha, and posed the following question:

What do you think about mental health?

I have always believed that if you pray, God will change things for you. Don't expect it to be done tomorrow because you pray today. He [God] does things in his own time, [at] the time when the change should be made. All you have to do is trust and believe in the Lord. He will heal you.

Martha's response suggests that mental health counseling is not a choice for her; she goes directly to her spiritual resources. For her, the combinations that will "heal you" is prayer, God, and patience. As a woman of 74 years, Martha's subtle dismissal of mental health counseling as a source to resolve problems may reflect a cohort effect. Unlike her daughter, Martha was not a member of the baby boom birth cohort. It has been observed that the spiritual practices of baby boomers may reflect a "mixing of traditions" (Roof, 1993, p. 247). Such a mix may explain Juanita's comfort with both mental health counseling and prayer.

In the next example, Ann also takes a spiritual approach to the issue of being a single woman in search of a partner. Ann has retired from a very successful career in the military having reached the most advanced non-commissioned officer rank and retired before she was 50. Ann has never been married and is now returning to her small home town. I ask her: "What is the greatest challenge at midlife?"

As a single woman, for me it would be companionship. Will I grow old by myself? I don't dwell on it. I have a strong belief in God. I believe he has plans for me.

Although the question was posed to address global issues of concern at midlife, Ann personalizes her response. The use of the words “for me” signals that she is may not be able to talk in general terms about the challenges of midlife, but can narrow her response to what it means for her. Concerned about growing old alone, Ann believes that because of her belief in God this issue is not a cause for worry. Ann’s relocation to the small town of her upbringing gives further testimony to her belief that there is a plan for her. She has mentioned earlier that she does not know why she is returning home and that this move was not one that she had anticipated. However, she is going, trusting that it will be the best choice for her in the long run.

Pam presents the final example of the role of spirituality in resolving male-female relationships. In contrast to the preceding comments, the following response came early in the interview as the result of a probe into Pam’s list of beliefs about health and aging. Pam referred to her 85-year-old grandmother to describe how to live a long life and listed several things to describe her grandmother. The last item on the list is, “Connect with God.” At that point, I probed further and asked her to tell me more about spirituality. She responded:

That [spirituality] is everything to me. [I am] looking for a partner. I have never been married. He [my partner] has to have a strong bond with God. If he doesn’t, he is out immediately. Other things I can live with—that, no. I talk to God more and more every day in prayer. I can’t do anything without him.

Pam immediately lets it be known that spirituality is the driving force in her life. So much so that in looking for a partner spiritual involvement (“a strong bond with God”) is one of the criteria she uses to evaluate potential partners. Pam’s conviction about the importance of God in her future relationships with men is so pervasive that she is willing to overlook other shortfalls that they may have.

For Ann, spirituality is also pervasive in areas outside of intimate relationships. Ann, who formerly commented about trusting in God's plan to resolve growing old alone, and attributes the successes of her military career to prayer and listening to the guidance she receives while in prayer. In describing how she arrived at a decision to relocate, she says:

I put it in God's hands. I went where the Air Force said I should go. I prayed every day. I said 'Lord it is up to you. If I shouldn't go there, you can fix it.' He didn't fix it. I ended up in Fresno, California. He has plans. He had one more square for me to fill.

Again, the theme of God's grand plan surfaces in her words. Later, Ann reveals that her location assignment placed her in a position to excel and make a significant promotion. Thus, her belief system is reinforced by the successes she encounters. Ann believes these successes are a result of vigilance in prayer and belief in God's ability to guide and care for her needs.

Finally, Pam's comments summarize this prevailing theme of spirituality among the women of this study and sheds light on the accepted source of that spirituality with these words:

A lot of black women are pretty strong. They have strong ties to family. I think that is common. Definitely midlife black women have a stronger connection with God. That's what I found in observations in the medical world.

Pam perhaps describes best the nature of spirituality among the majority of the women of this study. From her viewpoint, women have a strong, if not "stronger connection with God" at midlife than before. For Pam, this may be in part because her experiences in the medical field center on the sick and dying. In these cases, spirituality, as one woman noted, becomes a focal point. However, Pam's inclusion of the descriptor "black" indicates that under certain circumstances many African-American women are

connected to some spiritual belief and perhaps a spiritual practice as well. In Pam's statement, concepts such as "strong black women" and "strong family ties" are connected to her construction of African-American women at midlife. Families, as meaningful sources of spiritual constructs, are discussed in Chapter 7.

Summary

This chapter has provided a definition of spirituality as a force outside of individual control. Spirituality serves as a unifying principle for the women of this study in managing the events of the life course. In the text of their interviews, the participants use spirituality to explain events of their lives as well as to assuage concerns about the future. Further, spirituality is connected with religiosity. In this connection, religiosity and the church community serve as the physical symbols of spirituality. Typically, the historical role of the church in the African-American community has been to serve as the focal point for leadership, solidarity and safety.

In the original design of this study, however, I did not develop a hypothesis about the role of spirituality in the lives of the women I intended to interview. However, as the field work progressed it became apparent that issues of faith and spirituality were linked to the life philosophies that the women apply when confronted with a number of life course challenges. Using their words, I have suggested some of the ways that spirituality inserts itself into their constructions of health and illness, coping with the stress of racism, and other circumstances of daily life. In many ways, spirituality unifies them as black women through its ability to buffer them from their everyday experiences as black women in America.

For the women quoted in this chapter, prayer is the primary symbol of their spirituality. Through prayer they receive guidance and reassurance that, in time, God will

resolve the challenges they face. Finally, they view God as healer, counselor, and protector. The following and final chapter evaluates the comments made in this chapter to determine the link of spirituality to family and the dynamics of intergenerational learning and the collective memory. In addition to discussing the foundations of spirituality, the last chapter provides a synthesis of the study's findings, evaluates the merits of the study, and makes recommendations for future research.

CHAPTER 7 CONCLUSIONS

The purpose of this study has been to examine the social constructions of health and aging among midlife African-American women. In this final chapter I synthesize the voices of the participants and provide evidence that being black and being female condition definitions of health and aging. The synthesis of this evidence is first organized around key points presented in the interviews. Throughout the examination of the findings, I consider the processes that the women employ to draw conclusions about the meanings of life course events. In essence, I describe the mechanics, or how these participants construct the meanings of midlife and aging, health, access to health care and spirituality. Among these processes I observe that these participants use mechanisms such as typification, historical experience, and secondary accounts to construct evidence of their standpoints.

Beginning with Chapter 3, and continuing through Chapters 4, 5 and 6, I review the key points, linking them to the four research questions. Where appropriate, I delineate where and how the findings support or fail to support the original research questions and suppositions of the argument. In this chapter I also point to the limitations of the study, making recommendations for future research methods. Finally, I suggest how this project: contributes to the effort of building theory and continues the tradition of health activism among black women.

Defining Midlife and Aging

In Chapter 3, the effort was directed to defining midlife and aging from the perspective of the middle class African American women who participate in this study. The argument here is that social, political and historical experiences of the life course form aging identities. The key points from Chapter 3 are that: (1) functional and subjective images of aging permit a fluid and non-threatening transition to old age—in essence, the adage, “you are as young as you feel,” is a recurring viewpoint; and (2), midlife is both time-ordered (chronology and biology) and event-ordered (e.g., retirements, children leaving home). The women make the first key point most frequently by using typification.

As a method of defining themselves in contrast to white women, the women of this study routinely practice typification. In the language of social construction, typification is the suggestion that someone or something is “‘obviously’ this or that type of person” (Gubrium, Holstein & Buckholdt, 1994, p. 62). As a way of organizing events of the life course, typification first occurs in the narratives of the participants when they contrast the differences between the way white women age and the way black women age. In using these contrasts, the women of this study imply who they *are* by demonstrating who they *are not*. As a result of these typifications or comparisons, the African-American women of this study see themselves as aging better than their white counterparts. Functional age, the way they look and how they feel, is the barometer for their beliefs about successful aging. Primarily, they use their personal appearances (usually fewer facial wrinkles) to make this assessment. Typification further expands into the language of the women in Chapter 4 as a strategy in managing the events of the life course.

The second key point made in Chapter 3 concerns descriptions of midlife. As a point in the individual life course, the women of this study sorted the meanings of midlife into one of two distinct categories. The first category acknowledges the biological changes associated with the process of aging. Several circumstances marked midlife as a biological and, subsequently, chronological event. The women either identified the onset of menopause or used a number, usually age 50 to signal midlife. The use of biological descriptors such as age and menopause were most often used among women who had no children and or were trained health care practitioners.

For those women with children, the second category, 'children leaving home' was the event that identified the beginning of midlife. The point at which the children moved out of their parent(s)' home was the point at which these women concluded that their lives were in transition. The women who had been teenage mothers made no exception to identifying midlife as beginning when the children left home. Using the absence of children in the home as the criteria for the onset of midlife means that the younger the woman is at the time of this particular event, the earlier in the life course midlife occurs. Thus, for the woman who gave birth at age 19, midlife began 18 years later, at age 37, when her child left home.

For all women of the study, whether they identified midlife as being time ordered or event ordered, the overriding consideration at midlife was the belief that midlife was an opportunity and time for change.

Images of the Self

Chapter 4 concerns itself with how the women of this study use the process of typification to organize their beliefs about whites. In organizing these beliefs they contrast themselves to what they observe about white women. Ultimately, these contrasts

or typification formulate their self-images as black women who share a collective, black female consciousness. Typification is first introduced as a process in constructing the life course in Chapter 3. In that chapter, typification begins to draw the lines between black and white women regarding the physical manifestations of aging. In Chapter 4, the explicit and implicit comparisons between themselves and white women continue to form the bases for their beliefs about themselves. These beliefs are related to body image (weight), eating practices and the stress of being black.

The key points of Chapter 4 are: (1) Body image represents one of the ways by which the women participate in a culture that is identifiably African American. Among these African American women, standards for body weight are more flexible and perhaps culturally bound; however, overweight is considered a major health risk. (2) Eating practices as well as specific foods are a part of cultural dialogues. (3) As black women, they are overburdened by stress associated with being black; in turn, this stress is a significant health hazard.

Body Image

As discussed in Chapter 4, body image is conceptualized as an issue of body weight. Obesity among black women has been reported as a major health concern (Taylor, 2001). However, the women of this study demonstrate a tolerance for overweight. Medically speaking, appropriate weight is measured by body mass indices (BMI). The women of this study appear to disregard this system of measurement. They determine appropriate body weight by the way they see themselves, not as others see them. In this respect, they set their own standards for weight and clearly manage weight around self image. This tolerance supports cultural notions of weight among African-

Americans. From a historical perspective, “African-Americans have associated degrees of obesity with well-being” (Disch, 2000, p. 449).

Eating and Diet

Eating and diet are similarly connected to cultural practice. This is the second key point of Chapter 4. Not only do these women contrast the types of food that black and white women eat, but also the smaller quantities of food consumed by white women who are concerned about weight management. One woman in particular notes that food plays a central role in the social lives of African-Americans. As such, eating and sharing “good” food are the foci when family members meet and spend time together. Eating becomes a ritual in this context. Finally, a number of these women connect the issue of overweight and eating to the stressful conditions of their everyday lives. The stress of racism is the condition on which they focus. These women suggest that over time; stress coupled with over eating or eating poorly, contributes to chronic illnesses such as high blood pressure and diabetes.

Stress

Although their personal experiences with racism and racial discrimination begin after leaving the shelter of segregated neighborhoods, a number of these women have vivid recollections of early childhood exposure to racism. They examine this exposure by relating instances when they accompanied their parents or another adult to places outside of the segregated communities of their youth. The experience typically involved situations in which they were denied a service, a commodity, or access to public restrooms. The adults, whom they questioned about these behaviors, minimized the importance of the incident, explaining it as a matter of course and no cause for alarm. From their testimonies it is clear that: (1) parents did not discuss or overburden these

children with the meanings of racialized experiences; (2) the realities of racism were learned outside of home communities; and (3) racism and, ultimately, the health-related effects of continued exposure to racism, begin early in the life course.

As adults, these participants now link the stress of being black to stressful incidents in the workplace, the stress of attempting, as one woman stated, “to do everything twice as good to be considered half as good,” and living in two worlds, one black and one white. The sources of stress are varied. However, regardless of the source of the stressor, for these women it is directly attributable to being a black woman attempting to operate, survive, and thrive as subjects of continuous racial discrimination.

Chapters 3 and 4 were tied to addressing the question of how the women of this study define midlife and aging. What is most significant about the various explanations they produce is the consistent pattern of defining themselves within a racialized framework. The contrasts made between how they experience and define midlife and aging and how white women experience the same life course events, suggest that experiences with racism filter their perspectives and define who they are as black women. In Chapter 5, these same racial discourses play a prominent role in the discussions of possible barriers to health care access.

Barriers to Health Care Access

Chapter 5 provides a brief history of black healthcare in America. This history points to persistent disparate treatment of blacks at both the practitioner and user levels of the health care delivery system. The history also provides a way to contrast and compare current accounts of medical treatment and access. Against this historical backdrop, the participants share their views about gaining access to medical care and how this access affects successful aging.

This study initially considered age, race and gender as possible barriers to gaining equal access to medical care services. However, during the course of analyzing the interview content for Chapter 5, issues of class unexpectedly began to appear. For the purposes of this study, class was based on education, occupation and income. The women of this study frequently mention education as the single most important factor in determining adequate medical care as well as a significant factor in gaining access to medical information. Education is a valued commodity in the black community and it is considered to provide the best opportunity for better jobs and increased income. I noted that 96 percent of the women of this study were currently working. In this respect, education acts as a proxy for both occupation and income. This perhaps accounts for the following key points made in their observations of health care delivery: (1) their health care plans were adequate in meeting their medical needs; (2) their experiences with racial discrimination in the medical care system are not personal but based on the secondary accounts from others who experience disparate treatment; and (3) the privileges of middle class status (as defined by education, occupation and income) may minimize age, race, and gender discrimination in the health care system.

Chapter 5 addressed the question of health care access in determining age-related health outcomes. From the interview texts and the implied importance of class, the women of this study determine that education, as a marker of class, serves dual purposes. First, it gives access to jobs and income that give them ability to afford medical health insurance. Second, education is important in seeking proper medical care and following medical protocols. In short, class does matter.

Spirituality

In Chapter 6, the subject of spirituality among the participants emerged during the analyses of the interview texts of the study, in much the same fashion as did the observations about class. The texts of the interviews demanded that spirituality as well as class be integrated into the explanations of how these black women construct and subsequently explain the events of everyday life. Spirituality was not an original key point or research question in the design of the study. However, references to “God,” “the Lord,” prayer, and a power that extends beyond the individual’s ability to influence outcomes appeared with some frequency. The comments of the participants provided compelling evidence that, like class, spirituality was a force at work in their lives.

In Chapter 6, spirituality surfaces as an important way in which many of the women in this study respond to the events of their daily lives. I define spirituality as it differs from religiosity; that is, spirituality represents a system of beliefs in which individual lives are guided or assisted by an outside force. Spirituality, unlike religiosity, does not concern itself with symbols of a belief system and does not rely on organizations such as churches or church rituals to define its meaning. However, churches and church communities may act as the physical symbols of spirituality.

For the women of this study, spirituality guides their beliefs about mental and physical health, the stress of racism, and other concerns of daily living. The key points made in Chapter 6 are: (1) spirituality plays a role in the constructions of health and illness; (2) the women of this study use spirituality as a mechanism to cope with the stress of racism and other circumstances of daily life; (3) prayer is the symbol of their spirituality and is used to seek guidance and reassurance that God as healer, counselor and protector will resolve the dilemmas of life course events; and (4) spiritual beliefs and

practices, particularly prayer, unite the women of this study., Spirituality acts as a buffer against their everyday experiences as black women in America and unifies the women who give testimony to its value.

This final key point suggests that the nature of spirituality as a unifying force may be related to cultural tradition. For African-Americans that cultural tradition is Afrocentric. The basis for such an argument is that the cultural dimensions of spirituality and religiosity of blacks in America emerged in response to physical and psychological oppression. In the face of continued racial discrimination, spirituality and its symbols remain as the core of black consciousness and cultural tradition. As one Afrocentric scholars notes, “This consciousness expresses our shared commitments, fraternal reactions to assaults on our humanity, collective awareness of our destiny, and respect for our ancestors” (Asante, 1988, p. 26). Asante’s expressed parameters of Afrocentric thinking contribute to establishing spirituality as a cultural marker among these African-American women.

Answering the Research Questions

Chapter 1 outlined the four research questions. (1) How do African-American women define their aging experiences? (2) What roles do intergenerational learning and the collective memory play in developing the beliefs of African-American women about aging and resultant changes in health? (3) Is there a relationship between perceptions of access to health care and beliefs about black women’s ability to age successfully? (4) What is the role of spirituality in the lives of these black women? The purpose of each of these questions was to determine the issues that the women of this study consider important in constructing their approaches and beliefs about health, illness and aging, and how they construct, interpret and manage the events of their life courses. With the

exception of the last question—*What is the role of spirituality in the lives of these black women?*—the research questions were developed based on pre-interview assumptions. The question concerning spirituality, as mentioned earlier, developed following several pilot interviews in which spirituality was mentioned with great frequency. At that point, spirituality seemed a topic worth exploring.

Earlier in this chapter I mention that Chapters 3 and 4 provide the responses to the first research question—*How do African-American women (of this study) define their aging experiences?* Chapters 4 and 6 address the roles of intergenerational learning and collective memory in the second research question and provide some insight into how these constructs impact the participants' beliefs systems. However, the connection between intergenerational learning, collective memory, and beliefs of health and aging was less concrete than I had anticipated. The discussion of early childhood racial incidents may connect to intergenerational learning and the collective memory about racism, however it does not necessarily indicate a connection to beliefs about health and aging. Even when I probed for further information about what the woman might have learned from an older person concerning health and aging, no clear memories of learning from the previous generation surfaced. The same loose connection may also be observed in discussing spirituality (Chapter 6). Thus I offer that spirituality among African-Americans is a residual of historical experiences as members of an oppressed group. As such, spiritual beliefs that buffer the effects of racism are beliefs learned from each racial incident. These lessons are subsequently passed to the next generation as a means to cope with disparate treatment and the stress of racism.

Two circumstances may account for this failure to link intergenerational learning and collective memory to beliefs about health and aging. First, as Halbwachs (1950) points out, the collective memory is always selective. The women may have filtered out unpleasant memories of illness and elderly persons. Second, the learning may be tacit in its nature, more implied than spoken. This may be so much so that the women are not consciously aware of the sources of their belief systems. Not unlike peripheral vision, intergenerational learning and collective memory operate as quick, temporary shifts in viewing the panorama of life events.

The third research question—*Is there a relationship between perceptions of access to health care and beliefs about black women's ability to age successfully?*— is answered in Chapter 5. As I have previously mentioned, the issue of class subtlety enters the dialogues of the participants and becomes the strongest predictor of successful access to health care. In cases where adequate health care and information is available through financial security or positions, such as nurse or physician, successful aging becomes a strong possibility.

Chapter 6 presents evidence in response to the fourth research question that spirituality plays a prominent role in the lives of these black women. Using prayer as its symbol, spirituality links the women not only to one another but also to a source of power to help them during times of illness.

During the interview process, the participants did not address the implied concerns of each research question with the same degree of detail. This may be an indication that the questions from the interview script were too general to produce the intended responses. Whatever the case, at the least, the research questions and the responses to

them provide evidence that these African-American women have perspectives on health and aging that reflect their social, political, and historical experiences in the United States. Including these perspectives in studies of health and aging aids the ability of health policy makers to make strategic interventions in health care delivery.

Limitations of the Study

In planning future projects that investigate the lives of African-American women, I recommend two adjustments in methodology. These recommendations relate to both the content and process. As an issue of content, the use of longitudinal data has the potential to provide greater depth in making within-group comparisons. The ability to plot change over time and over life courses enhances the ability to formulate theories of health and aging among black women. This may be a particularly important approach to use when examining intergenerational relationships and the transfer of knowledge.

Focus groups have been cited as useful for a number of reasons in conducting qualitative research (Pena, 2002; Madriz, 2000; Morgan, 1997). At the completion of this study, I examined the functions of focus groups and consider how their use might enhance the data of future and similar studies. In my view, given additional resources, further studies of African American women will benefit from using the focus group as an instrument of inquiry. A shortcoming of the individual interview method used in this study may be that the responses of the participants formulate in a vacuum. The ability of the participants to interact with one another creates a variety of observable dynamics, adding another layer to the data. For example, in a focus group setting it would be possible to examine issues of class conflict or clarify the nature of within-group relationships that affect cohesion. Also, focus groups provide the researcher an opportunity to step away from the interview in order to more closely observe and

evaluate both content and process in real time rather than in retrospect. Finally, using the focus group may greatly increase the ability to gather a greater amount of data in a relatively brief period of time.

**Building Theory: Towards a New Model
of Health and Aging from the “Borderlands”**

“Borderlands” are areas of everyday life and experiential knowledge that are contested by more conventional ways of knowing. It is from these vantage points, the borderlands, that this project assembles assumptions of midlife, health, and aging. One of the implied tasks of this study has been to clarify, demystify and deconstruct patterns of thought about African-American women. In accomplishing this task, this study relieves some of the tension in the power relations associated with the production of knowledge. In Afrocentric thought, the tension between the knower, whose experiences are from the borderlands and the conventional producers of knowledge is often perceived as an issue of power and control. Afrocentric scholars such as Molefi Kete Asante (1988) address the issue of the power relationship between the knower and what is known as he explains that Afrocentrism is “not a black version of Eurocentricity” in that “it does not condone ethnocentric valorization at the expense of degrading other groups’ perspective” (p. 172). In this light, the effort of this study has been to enhance a body of knowledge about the world of black women without discounting the way that white women understand and act on their life course experiences.

In short, this project emphasizes building theories of midlife, health and aging that are specific to African-American women. In this respect, this study does not claim to be conclusive in its representation of black women at midlife. However, what this project does attempt to accomplish is the advancement of a body of knowledge about black

women in America. In this study, new data influences theories of aging among African American women by questioning the reported signs of early aging. Additionally, through examination of the participants' reported experiences with racism and the stress caused by racism, their beliefs about black and white differences and their beliefs about aging, this study introduces patterns of thought among a select group of African American women at midlife. Their ways of defining themselves is not measured against any standard, but left to speak for itself.

In the development of a framework to examine the lives of black women, this study presents two perspectives that, as far I can determine, have not been applied in the study of black women. First, I presented arguments to support defining midlife in the context of the social, political and historical experiences of the African American women who participate in the study. As a result of life course experiences and observations of the white world, these African American women enter midlife with a set of expectations that discount comparative biomedical models of health and aging. Namely, they do not necessarily see themselves as disadvantaged by race or gender. This may be attributable in part to the fact that they enjoy the advantages of being educated, middle class women with the means to access adequate health care.

Second, I use little if any comparative data. With the exception of the explicit and implicit comparisons made by the women themselves, this study is relatively free of black-white comparisons. The effort here has been to avoid comparisons for several reasons. Typically, comparisons between dominant group culture and minority group result in the conclusion that minority group outcomes are pathological. This has been witnessed in studies of the African-American family. The second reason to avoid

comparison is to suggest alternative views of what is normal or standard. This is consistent with other research agendas that suggest social interventions can better be targeted when the issues are pinpointed within the range of the minority group's pattern of normality (Whitfield & Baker-Thomas, 1999).

Continued Health Activism

African American women have played a vital and continuous role in the promotion of good health through grassroots health reform initiatives. As a result of changes to the social structures that gave greater responsibility for health care programs to the state, the interests of American blacks, especially the poor and indigent, have not been adequately represented (Smith, 1995). Serving both as formal and informal spokespersons for health care reform, black women have traditionally spearheaded initiatives to improve the delivery of health care in African-American communities. This project continues that tradition.

The informal nature of the interview format was used to raise awareness of health and aging issues facing black women in America. I conclude this study with the words used by one participant at the conclusion of her interview with me. At age 70, this woman is a senior participant in this study. Her response encapsulates two of the key points made in this study. She makes these points as an informal advocate for continued vigilance and health activism among African- American women.

Is there anything else you like to add to our discussion of black women's health and aging?

My hope is that black women will take charge of their health. They will work toward having healthier aging. You will live as long as you will live, but you can live well or not well depending on your health. As a group in this country, they [black

women] work so hard they deserve an easier time when they get older. When they are in the aging process they still have quality in *their life*. *That they can reap some reward for what they put into it*

APPENDIX A
WRITTEN QUESTIONNAIRE

Personal History

Please answer the following questions. You may use the reverse side of this paper if necessary.

1. What is your age?
2. What is your highest level of education? or How many years of schooling/training do you have?
3. What is your job or occupation?
4. How many children do you have? _____
How many grandchildren do you have? _____
5. How old were you when your first child was born?
6. Are you married, single (never married), divorced, widowed or separated?
7. What is or was the occupation or job of your father?
8. What is or was the occupation or job of your mother?
9. In which area or state of the United States have you spent most of your life?
10. Do you have medical insurance?
11. How would you rate your current health?
12. What else about your personal background might be important to someone studying the lives of African American women?

Thank you. Please initial and date this form.

Initials only: _____

Date: _____

We will proceed with the discussion portion of the interview. This should take about 90 minutes.

APPENDIX B
INTERVIEW GUIDE

Research question #1 How do African American women of this study define aging and health?

1. How would you define midlife? (For example: How did you know that you had entered midlife? At what age does midlife occur? What was different at this point in your life?)
2. Tell me about what you believe about health and aging?
3. Tell me about what you believe about the way black women age and the way white women age. (For example: Do you believe that you are aging faster, at about the same rate, or slower than white women?)
4. What do you believe are the greatest challenges for a woman at midlife?
5. What are your beliefs about mental health? (For example: Tell me if you have or would ever seek mental health counseling)
6. How do your spiritual beliefs or practices effect your beliefs about health, illness and aging?

Research question #2 What is the role of intergenerational learning and collective memory in developing beliefs and behaviors of health and aging?

1. Tell me what your mother (grandmother) taught you about maintaining good health.
2. In what ways are your current beliefs about health and aging influenced by what you saw or heard that your parents or even grandparents did?
3. What events or circumstances of your early childhood do you believe are responsible for your present state of health?
4. What are your earliest memories of racist behavior or discriminatory treatment?
5. In what ways are your current beliefs and behaviors affected by this early memory of racism?

6. In what ways do you feel connected (disconnected) from other black women?
7. What is good (bad) thing about being a black woman in America?

Research questions #3 What is the relationship between health care access and beliefs about successful aging?

1. If you had proof that black women became ill at younger ages than white women did what would you say was the reason for the difference?
2. What do you believe would be the most important thing for African-American women to know about health care services?
3. Tell me about a time when you faced any mistreatment because of your race in any aspect of health care in the last 3 years. Please give an example.
4. What so you believe is the most important circumstance for aging well?

FINAL COMMENT: Now that we have completed the list of questions, is there any thing else that you would like to add to our discussion of black women, health and aging?

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BIOGRAPHICAL SKETCH

Yvonne Combs-Jones received her undergraduate and graduate degrees from Pacific Lutheran University in Tacoma, Washington. Following her undergraduate work, she was commissioned a second lieutenant in the United States Army and completed her master's degree while on active duty. Following retirement from military service she received her Doctor of Philosophy in sociology from the University of Florida. Yvonne's research interests include the study of African-American women, aging and health. She has recently entered the academic job market where expects to teach and continue research in these areas.