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ARE SISTERS DOING IT (ALL) FOR THEMSELVES? ELDERLY  
BLACK WOMEN AND HEALTHCARE DECISION MAKING

by

Carlene Buchanan Turner

A dissertation submitted to the Graduate Faculty in  
Sociology in partial requirement  
for the degree of Doctor of Philosophy

The City University of New York

2009

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This manuscript has been read and accepted for the  
Graduate Faculty in Sociology in satisfaction of the  
dissertation requirement for the degree of Doctor of Philosophy.

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## ABSTRACT

ARE SISTERS DOING IT (ALL) FOR THEMSELVES? ELDERLY  
BLACK WOMEN AND HEALTHCARE DECISION MAKING

by

Carlene Buchanan Turner

Advisor: Professor Juan Battle

This dissertation examines the effects of health values on the decisions made by elderly Black women to use self-care methods and homecare services. The research is grounded in the healthicization or wellness promotion paradigm, which prescribes behavioral or lifestyle changes for previously biomedically defined events.

The dissertation consists of both quantitative and qualitative research. The quantitative component focuses on a sample of Black women over 70 years old (N= 642) from the 2000 NHI Second Longitudinal Study on Aging dataset. The qualitative component analyzes ten in-depth interviews with respondents from Southern Maryland used to supplement the quantitative findings.

Although the quantitative and qualitative analyses resulted in complementary findings, there were some important differences. First, the results from the Multiple Regression demonstrate that, for elderly Black women, health values explained a fair amount of the variance in equipment self-care ( $R^2$  of .199); equipment self-care also contributes more to the independence of elderly Black women than behavioral and environmental self-care (which accounted for 8.4 and 1.0 percent of the variance respectively).

Secondly, structural equation modeling (SEM) was used to establish causality among the three major constructs of the research in order to make inferences about the sample population. For example, the SEM findings revealed that elderly Black women with positive self-values are less likely to practice traditional self-care, while those who practiced self-care were more dependent on homecare services.

Finally, the interviews helped to illustrate the findings from the quantitative analysis. Specifically, elderly Black women choose to practice self-care to maintain their independence, and believe they are personally responsible for maintaining a healthy lifestyle.

Two major policy implications were derived from this study. First, while the personal responsibility crusade in healthcare is important, clients from marginalized populations should not be deprived of public healthcare programs if they choose not to participate in this trend. Second, greater flexibility should be allowed the elderly client in deciding how to spend homecare subsidies from local Respite programs.

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## CHAPTER 1: INTRODUCTION TO THE ETHICS OF SELF-CARE

### Introduction

This dissertation examines new trends in self-care – activities “performed by the individual or their families ... to achieve, maintain, or promote maximum health” (Bakken Henry and Holzemer, 1997, p. NS34) – and how elderly Black<sup>1</sup> women respond to these practices. Working from the premise that healthcare attitudes and trends are shaped by our health values (preference for certain health conditions), the current research explores the relationship between self-care and health values. It also examines the impact of self-care on the use of homecare services for elderly Black women. The dissertation analyzes self-care as it is defined and measured on three distinct points: (1) changing behaviors (e.g., exercising regularly and changing diet); (2) equipment use (e.g., use of walkers and canes); and modifying environment (e.g., installing bars in showers and ramps at entrances). This tripartite self-care definition was partially adopted from Kincade Norburn, Bernard, Konrad et al. (1995), the principal investigators for the National Survey of Self-care and Aging in 1994 and 1999.

Senior citizens<sup>2</sup> care is becoming an increasingly important social issue in the U.S. because of the rapidly graying population. The U.S. Census Bureau reports that the over 65 years old population increased eleven fold between 1900 and 2000, compared to a threefold increase in the non-elderly population (Hobbs, 2001). While three million

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<sup>1</sup> Throughout the dissertation, the term Black is used to refer to people of the African Diaspora, and to such populations that reside within the U.S. To some, African Americans are a sub-group within the larger Black community. Since the present discussion purposely includes those who may be first-generation immigrants or who, for what ever reason, do not identify as African American, the term "Black" is employed. Furthermore, it is capitalized to distinguish the color from the racial category and related identity. Similarly, the word "White" will be capitalized when referring to race.

<sup>2</sup> The U.S. Census Bureau's definition of seniors/senior citizens will be used in the dissertation. That is, members of the population who are over 65 years old (or the elderly).

people over 65 years old lived in the U.S. in 1900, in 2000 there were 35 million – or four percent and 12.6 percent of the entire population respectively (American Community Survey, 2006; Hobbs, 2001). The expanding numbers of senior citizens have resulted in a greater demand for post-retirement geriatric healthcare and social services from – and for – this significant segment of the population. Gerontologists believe that the “new-old demographic” – members of the population who will enter the older Americans cohort in the next few decades – will inject changing value-systems into healthcare decision-making (Binstock, Janigen and Post, 1994), and that these value systems have led to a focus on modifying lifestyle practices rather than relying only on medical solutions. Increasingly, these value-systems can be equated to a “new health morality” demanding that individuals take responsibility for their health (Conrad, 2005; Hacker, 2008).

Senior citizens’ healthcare is dominated by two approaches located on opposing ends of a continuum. At one end is what Binstock, Jahnigen and Post (1994) call an “apocalyptic demography,” a pessimistic discourse that locks us into an over-medicalized (exclusively biomedical) approach to understanding senior healthcare. This discourse concentrates on issues such as age-related diseases and their medical solutions. At the other end is healthicization (Conrad, 1994), an approach emphasizing lifestyle changes and environmental modification to achieve healthier bodies and minds. This dissertation contends that there is a neo-liberal trend that places a greater emphasis on healthicization – that is, asserting one’s independence by caring for oneself. Another contention is that most seniors and their healthcare providers choose options that are mid-way along the continuum.



Additionally, two critical structural phenomena of aging – the increasing dependence of the aged on the state for economic support and the transformation of retirement into a period of leisure – shape how seniors are now viewed by society (Uhlenberg, 1992). Over the last three decades, seniors’ concerns have come to the attention of the general public as the proportion of public funds expended on the elderly grows. (Cain, 1974). Increasingly, the public views senior citizens as a large and active voting bloc with political power, resulting in their advocacy being labeled “the third rail of politics” (Campbell, 2003 ). Interest in senior citizens’ healthcare has increased over the past 30 years as seniors-- not wanting to be seen as weak and feeble--continue to make their own healthcare decisions in order to manage their life choices away from the perception of debilitation, (Duncan and Smith, 1989).

One major aim of this research is to examine the tangible outcomes of self-care methodologies by examining their impacts on homecare services demanded by elderly Black women. Throughout the dissertation, homecare service refers to assistance with Activities of Daily Living (ADLs<sup>3</sup>) and Instrumental Activities of Daily Living (IADLs<sup>4</sup>) by paid non-medical caregivers (e.g. CNAs<sup>5</sup>, GNAs<sup>6</sup> and HHAs<sup>7</sup>). The advocates of self-care imply that there are beneficial outcomes for adopting these practices (Dill, Brown, Ciambrone, and Rakowski, 1995). Outcomes can include (but are not limited to) lower healthcare costs and healthier bodies. Positions such as these are supported by studies showing that simply communicating with the elderly and educating them about self-care

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<sup>3</sup> ADLs – “basic self-caring activities [e.g.] feeding, bathing, toileting, walking, and getting in and out of bed” (Etaugh and Bridges, 2004, p. 360).

<sup>4</sup> IADLs – “goes beyond personal care to include preparing meals, doing housework, shopping, doing laundry, ... taking medication and managing money” (Etaugh and Bridges, 2004, p. 360).

<sup>5</sup> CNA – Certified Nursing Assistants

<sup>6</sup> GNA – General Nursing Assistants

<sup>7</sup> HHA – Home Health Aides

results in greater monetary savings and fewer medical visits (Vickery, Golaszewski, Wright, and Kalmer, 1988). A universal indicator of health and well-being for senior citizens is their dependence on homecare services. The increasing dependence of the elderly community on homecare is recognized by the U.S. government (Wiener, Estes, Goldenson, and Goldberg, 2001). Members of the elderly population, their families, caregivers, and researchers in the field of aging agree that homecare is one of the most efficient methods of caring for the elderly (Aronson and Neysmith, 1996). Homecare works.

Individuals' healthcare decision-making processes require an understanding not only of their health conditions, but also of their social and economic circumstances, personal histories and health values. This dissertation suggests that elderly Black women's decisions to use self-care depends not so much on specific physiological conditions as on contemporary health values (or the new health morality), and the identity of the elderly Black woman.

*Theoretical Overview:*

The dissertation studies the social realities of elderly Black women, analyzing their healthcare choices within an intersectional framework derived from Black Feminist Theory (Hill Collins, 2000a). The study targets elderly Black women because they face triple discrimination based on age, gender and racial identity. An intersectional approach identifies what is distinct about elderly Black women's healthcare decision-making, and

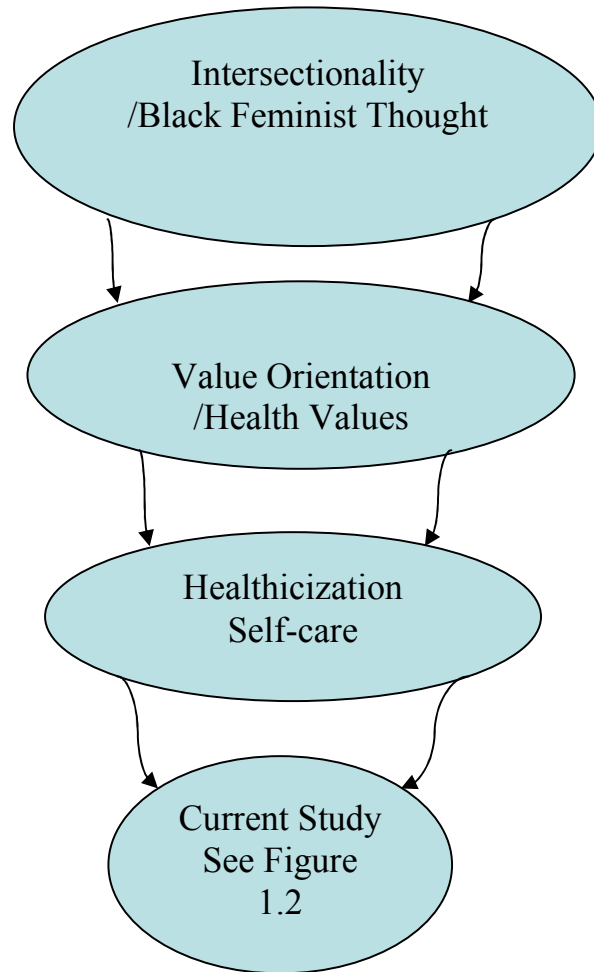
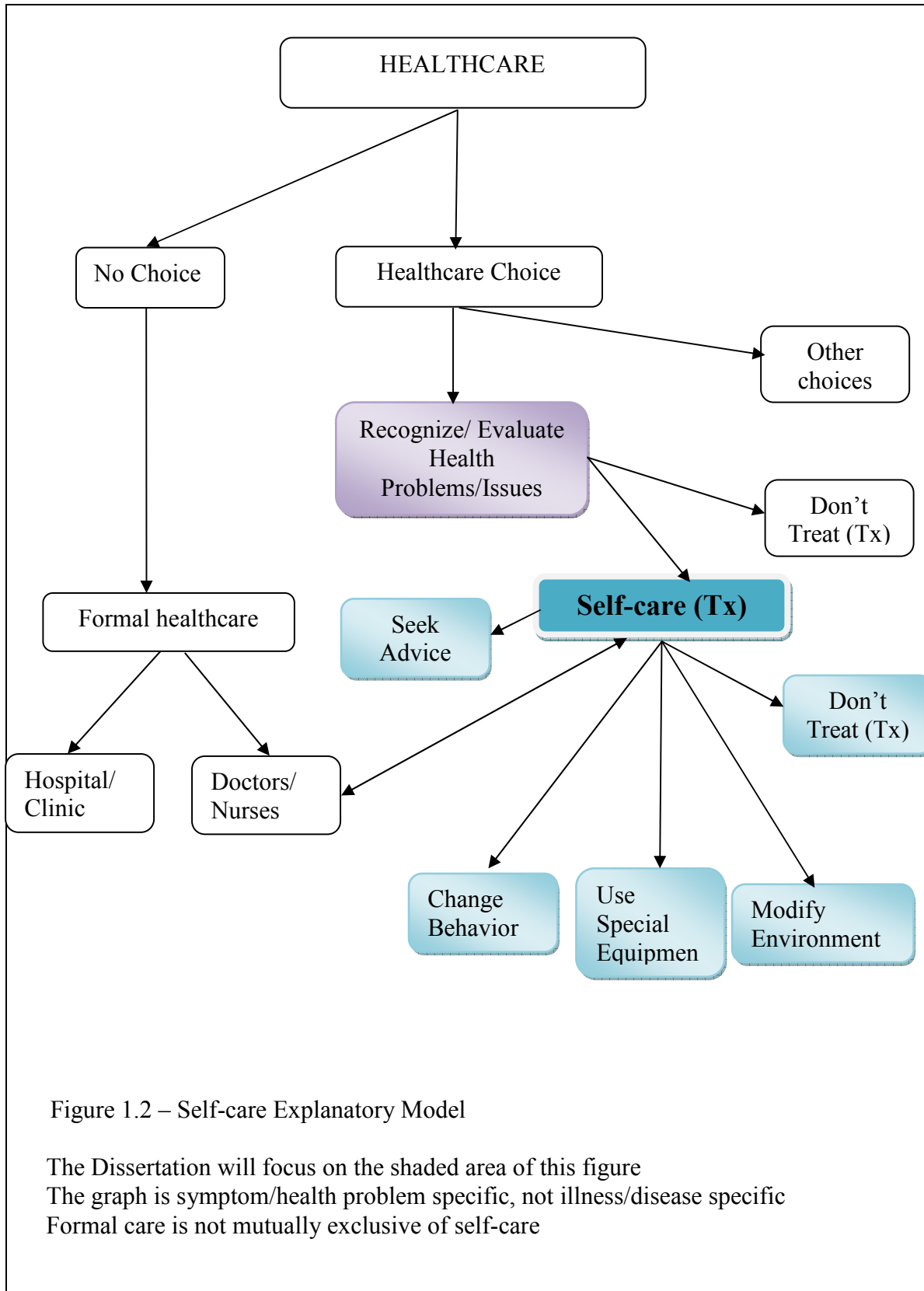


Figure 1.1: Theoretical Framework



discusses how this can inform social policy and contribute to their inclusion in the Sociology of Health and Medicine literature. The dissertation shows that the particular needs of this neglected social group shape their health values and approaches to healthcare. A systematic analysis of this social group, its values and its norms, and how they affect healthcare decisions, can impact contemporary political and economic debates about issues such as social security. The research does not capture a culturally homogenous group, as elderly Black women encounter different cultural and socioeconomic experiences that shape their everyday lives. Not only are these nuances ignored in the gerontology literature, but, overall little attention is paid to Black women's concerns in the field of Sociology of Health and Medicine.

The research is also grounded in the neo-liberal health paradigm of healthicization, which is predicated on value-driven practices. Healthicization has been tagged the “new health morality.” Healthicization or wellness promotion proposes behavioral or lifestyle prescriptives for previously biomedically defined events, such as age-related illnesses (Conrad, 1994; Westfall and Benoit, 2004). A part of this morality or value-system suggests that self-care methodologies should be a pivotal part of the life of every responsible adult. Dill et al. (1995) define self-care as the range of methodologies employed by the individual first to recognize and evaluate symptoms, and then either to treat those symptoms or seek advice about treatment. Self-care is also increasingly being used as a substitute for and/or a supplement to conventional healthcare and especially expensive healthcare (Dill et al., 1995).

The arguments outlined above justify the inclusion of the two theoretical paradigms – healthicization (modifying one's lifestyle for good health), and a Black

Feminist intersectionality – to explain elderly Black women’s healthcare issues. The proposed theories should also lend a dynamic framework within which one can examine not only the adoption of self-care practices by elderly Black women and their effect on the use of home healthcare services, but also most value driven healthcare practices (see Figure 1.1 and 1.2 above).

### *Statement of the Problems*

What is the association between the practice of self-care behaviors by elderly Black women and the eventual use of formal homecare (provided by paid, non-medical health workers)? How do health values (preference for certain health conditions) drive self-care activities among elderly Black women? How are these relationships mediated by demographic variables and interpersonal networks? Finally, are there any manifest outcomes for elderly Black women and society from practicing self-care methods: that is, are women who do not practice self-care in danger of being viewed as health deviants?

### *Research Questions*

This work advances the idea that healthcization trends (as evidenced by self-care methodologies) are not only present among Black women, but are also shaped by contemporary ideas that individuals are responsible for their own well-being. In light of this, the specific objectives of this dissertation are to ascertain:

- i. How do health values manifest themselves in the healthcare decisions (specifically, to use self-care methods and homecare services) of elderly Black women?

- ii. Are there differences among the three types of self-care methodologies that elderly Black women practice?
- iii. Is there an explicit relationship between self-care and homecare service demand (provided by paid, non-medical health workers e.g. CNAs, GNAs and HHAs)?
- iv. How is this relationship mediated by socioeconomic status, health, insurance status and the interpersonal networks of elderly Black women?

### *Methods*

The current research addresses some of the pressing demands in the contemporary senior citizen discourse. For example, gerontology researchers find it necessary to re-measure the trends, levels and differentials in seniors' functional limitations periodically, as these limitations can affect not only quality of life but also the need for such support services as homecare (Dawson and Hendershot (1987). In terms of impairment that disrupts normal life, Dawson and Hendershot (1987) point out that the National Center for Health Statistics has done several surveys on senior citizens' functional limitations.

While it may be taken for granted that national surveys will capture issues about senior citizens' personal care in their homes, before the 1980s this type of data was very limited. However, there was a deliberate movement by the National Center for Health Statistics in 1979 to broaden their surveys (particularly the National Health Interview) to elicit from older Americans such information as the kind of assistance they needed at home (Feller, 1983). Despite this change, a deficit of research on self-care remains, resulting in confusion about how to measure the concept. Additionally, such minority populations as elderly Black women have been traditionally omitted from health surveys and research. The dissertation responds to these limitations.

## Organization of Dissertation: Chapters

### *Chapter 1 - Introduction*

The first chapter introduces the area of senior healthcare, presents the rationale for concentrating on this topical area as a Sociological treatise, and reviews some general sentiments about seniors' healthcare. The chapter considers the idea that, while the emergent baby-boomer senior citizens want to be viewed as empowered, they still may want the security of old-fashioned healthcare. The Sociology of Health (e.g. Conrad, 2005) and Gerontology (e.g. DeFrieze and Kincade Norburn, 1999 and 2006) literature guides this phase of the dissertation.

### *Chapter 2 - Background*

The Background chapter reviews the literature and introduces the theoretical framework in which the research is grounded. The rationale for including these two sections together is that they complement each other. They are also placed early in the dissertation as the concepts and paradigms are used to ground the rest of the research.

First, the comprehensive literature based on a self-care and homecare nexus is presented, including some contemporary perspectives about self-care and homecare in Sociology of Health and Illness. The relationships that both self-care and homecare have with the following variables are also discussed: race, gender, age, values, educational level, annual income level, interpersonal network, health and insurance status.

Following the literature review is a comprehensive analysis of both healthcization and Black Feminist Thought as they pertain to the theoretical framework of the dissertation. The tenets of the neo-liberal trend known as healthcization are



presented, with an emphasis on the role of self-care. Finally, the use of intersectionality within Black Feminist Thought is addressed.

### *Chapter 3 - Research Methods*

This chapter outlines the research methods of past gerontology researchers, with a particular emphasis on self-care and homecare topics. This overview analyzes the strengths and weaknesses in these works. The chapter also includes a comprehensive discussion of the two major components of the research, which have the designation “Quantitative Component” and “Qualitative Component.”

The Quantitative Component of the research has three phases. The first phase examines the relationship between self-care and values using Multiple Regression; the second also uses Multiple Regression to investigate the relationship between homecare and health values; and the third analyzes the overall model that is the relationship between values, self-care and homecare using Structural Equation Modeling. The dissertation only concentrates on the sample of elderly Black women, so a statistical description of the group is outlined in this chapter.

Chapter Three closes with a description of the methodology that guided the face-to-face interviews of the Qualitative Component of this research, an explanation of how the respondents were recruited for the study, and a discussion of the interview questions.

### *Chapter 4 - Phases I and II Results: The Relevance of the Healthicization Ethics in Healthcare*

Chapter Four comprises two phases, and is the first of three results chapters. Phase I examines the effects of health values on elderly Black women’s decisions to use

self-care methods. The analysis is based on a sample of Black women over 70 years old (N= 642) from the 2000 National Health Interview Survey: Second Longitudinal Study on Aging dataset. Multiple Regression is used to analyze the sample's response to three types of self-care (behavioral, equipment and environment).

Phase II analyzes if seniors' decisions to receive homecare are value driven. The analysis is also based on the Longitudinal Study on Aging (LSOA) dataset. The aim is to identify any manifest motivation for elderly Black women's use of homecare services. Health values in the analysis capture the healthcization concept of striving to achieve healthier lifestyles through greater personal responsibility.

A comprehensive interpretation of the results is also presented for phases I and II respectively. These interpretations are juxtaposed against different perspectives from the literature. A sociological interpretation is incorporated in the analysis grounded in Black Feminist Theory and the concept of healthcization.

#### *Chapter 5 - Phase III Results: The Rationalization of Homecare Through Self-care*

Phase III is the focal point of the research effort as it presents the analysis of the overall model. The key variables are integrated (self-care, values and homecare) to assess their impact on each other. A causal model including the key variables, along with the relevant interacting variables, is analyzed using Structural Equation Modeling (SEM).

#### *Chapter 6 - The Interviews: The Ethics of Caring*

Here the dominant discourse in the women's conversations is presented. The women indicate whether or not they practiced self-care and/or used homecare services. The interviews are evaluated in order to get the women's view about healthcare issues

and the choices they make. The evaluations are then used to illustrate the findings from the quantitative results.

### *Chapter 7: Prescriptions and Conclusions*

This chapter revisits the role of values in shaping senior citizens' healthcare practices. It also proposes the significance of all the findings. Recommendations are made to address deficiencies in the existing literature. An interdisciplinary future direction suggests improving Medicare directed healthcare so that self-care is not forced upon marginalized groups, and recommends the incorporation of more systematic homecare needs analysis, sensitive to cultural norms

### Contribution

The contribution this dissertation makes can first be seen from a micro-sociological perspective, as behavioral changes can have an impact on many areas of the subjects' lives. Interpersonal bonds, particularly familial and friendship ties, are explored for their relationship to self-care and homecare use (Bass and Noelker, 1987). From a macro-sociological perspective, this research explores the impact of norms on the health practices of seniors and their quality of life (DeFriese, Konrad, Woomert, Kincade Norburn, Bernard, 1994). The aim is to analyze how overarching phenomena such as values are internalized by the population in question. Demographic factors such as race, sex, age and socioeconomic status are used to refine the analysis. These parameters are pivotal in grounding the analysis sociologically.

This research topic has many policy implications. The implications are sometimes

specific, such as expending substantial resources on person-directed homecare (Powers, Sower and Singer 2006), or encouraging seniors who receive state funding to participate in self-improvement classes (Dempsey, 2007). The research also have more overarching implications, such as suggesting the need for a legislated change in Medicare prescription benefits at the federal level (Bush, 2007).

## CHAPTER 2: BACKGROUND

### Introduction

This research aims to answer three questions: (1) How do health values manifest themselves in the healthcare decisions of elderly Black women (specifically, to use self-care methods and home care services)? (2) Are there differences among the three types of self-care methodologies elderly Black women practice? (3) And is there an explicit relationship between self-care and homecare service demand? The research intends to add to the limited literature on the relationship between health values and healthcare choice, and present a less medicalized understanding of self-care. It will also study the link between American seniors' self-care initiatives and the outcomes of such healthcare decisions from a sociological perspective, a perspective currently absent from the literature.

### Literature Review

#### *The Self-care and Homecare Nexus*

Bakken Henry, and Holzemer (1997) identify self-care as those activities “performed by the individual, or their families or communities, to achieve, maintain, or promote maximum health” (p. NS34). They outline five major components of self-care,, synthesizing most definitions of self-care in the literature. These are: (1) health promotion, (2) health maintenance, (3) disease prevention, (4) disease detection, and (5) disease management. One apparent limitation of these definitions is that they seem to stress a medical model of self-care. This biomedical approach ignores a plethora of care activities that may not be motivated by problematic symptoms.

Fleming and Andrade (1984) also refer to the biomedical/self-care dichotomy, arguing that self-care activities appear to be substitutes for health service utilization. Other researchers suggest that self-care and formal healthcare are actually connected. Dill et al. (1995), for example, have argued that self-care is not necessarily the antithesis of formal medical care; it can include the incorporation of advice from medical professionals, as well as other caregivers such as family members and paid health aides. They also point out that medical professionals often recommend self-care methods. This indicates that, while there is a recognition of the cultural authority of traditional medicine, the intervention of laypersons can be valuable at times.

Although the majority of elderly persons in the U.S. utilize some form of self-care (Kincade Norburn, Bernard, Konrad et al., 1995), this becomes an option primarily when several dimensions of the elderly person's normal realities are threatened. Self-care as a remedy seems to be an attempt to re-capture a sense of wholeness (Dill et al., 1995). The most popular form of self-care is changing the patterns of one's behavior (Norburn et al., 1995), as in altering one's diet or becoming more active. Notably, most support for self-care comes from the formal health sector, which may be problematic as healthcare institutions could be perceived as working to keep undesirable consumers out of their workshops. For example, the move by California employers to reduce outpatient visits through self-care workplace intervention could be viewed as an attempt to minimize health insurance costs (Lorig, Kraines, Brown Jr., and Richardson, 1985).

The impact of health values on self-care by seniors is not readily evident in the Sociology of Health literature. However, a prevailing sociological standpoint is that many healthcare practices are value-driven (Lee and Craft, 2000). A useful explanation of

health value is that it is a personal rating of one's health which ranges from perfect health to death (Tsevat, Keck, Homung, and McElroy, 2000). The term "health value" is distinct from "health status": health status refers to physical and mental functionalities and the impact they have on the quality of life. There is an explicit link between health value, level of mobility and perceived disability in the medical care literature. Mobility level is the strongest predictor of self-perceived disability, followed by general health status. However, based on Iezzoni, McCarthy, Davis et al.'s (2000) study, not all immobile people see themselves as disabled. Members of the respondents' social network (e.g., proxies) were more likely to assess them as disabled. Hence a measure of perceived disability is a strong indicator of one's health value. A second indicator of health value as noted in the sociological literature is the individual's attempt to self-manage his or her time of death, or the Will to Live (Riley Jr., 1983) The Will to Live is also called the 'death dip' concept, which proposes that the timing of death and life expectancy are regulated by the subject. This phenomenon is evident when the individual has something valuable to live for and therefore acts to postpone death.

While previous sociological analyses have explored the impact of values on the adoption of certain health practices (e.g. Katz Rothman's [1998] study of the use of prenatal diagnoses), there has been limited research on how the successful integration of these values manifests in different social groups. Additionally, a sociological perspective on the link between American seniors' self-care initiatives and their outcomes is virtually non-existent. Some studies also question whether self-care practices have any impact on improving quality of life and other health outcomes. For example, Smolen and Topp

(2001) found that among a sample of patients with inflammatory bowel disease, self-care agency was unrelated to indicator of quality of life.

Like self-care, homecare for the elderly (that is, assistance with ADLs<sup>8</sup> within the senior's dwelling) is an increasingly important topic, as homecare is one of the most efficient means of taking care of a rapidly graying population. Whether it is paid, formal homecare, or the informal homecare provided by family members or other support groups, homecare works (Aronson and Neysmith, 1996). The efficiency of homecare is demonstrated financially. It is much cheaper than hospitalization and long-term institutional stay (Aronson and Neysmith, 1996). Elderly persons as well as their family caregivers also have a strong preference for homecare over formal institutional care (Angus, Kontos, Dyck, McKeever, and Poland, 2005). Additionally, this type of care is usually tailor-made for the elderly client, so that ADLs can be performed to suit particular idiosyncrasies.

The literature provides few examples of value-driven homecare. Yamamoto and Wallhagen (1997) conclude that in societies where filial responsibility and attachment to senior relatives are highly valued, homecare occurs more naturally. These authors also say that such values are reinforced by encouragement, understanding and appreciation from family, friends and community services surrounding the caregiver. Examples of value-driven self-care by seniors were not readily evident in the Sociology of Health literature.

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<sup>8</sup> Activities of Daily Living



*Socio-Demographic Variables with Self-care and Homecare*

Researchers have analyzed the possible effects of a number of socio-economic variables, including race, gender, education and annual income, on the use of self-care methodologies and the demand for homecare services.

For self-care, the findings about race as a significant variable are mixed. For example, Kincade Norburn et al. (1995) found that race did not significantly alter the use of self-care methodologies. In contrast, Kart and Engler (1995) found that Black seniors are less likely than others to respond to health problems with self-care methodologies and less likely to recommend those methodologies to their peers. Significantly, though, Kart and Engler also point out that too little is known about the healthcare practices of racial minorities to make binding conclusions about their situations.

In terms of homecare services, Black elders are less likely than Whites to receive both formal and informal assistance with their daily needs (Norgard and Rogers, 1997; Smerglia, Deimling, and Barresi, 1988). The official figures from the National Home and Hospice Care Study revealed that of the 1.5 million elderly people reporting homecare use in 1996, 12.6 percent were Black (Haupt, 1998). The service gap between Blacks and Whites is partially refuted by Li and Fries who concluded in their 2005 study that Blacks receive more informal homecare, but this difference is primarily because more Blacks are disabled. Hence, the literature seems to reveal that while Black elders are underserved in terms of formal homecare, they nevertheless are the recipients of more homecare.

The research about the impact of gender on self-care activities is also mixed. On the one hand, Burnette, Mui and Zodikoff (2004) report that elderly men and women do use self-care methods differently. However, medical equipment use and behavioral

changes were statistically significant and greater for men (Burnette et al., 2004). Others have contradictory findings. For example, Kart and Engler (1995) and Fleming, Giachello, Andersen, and Andrade (1984) found that women were more predisposed than men to treat their health complaints and to use a greater number of self-care practices.

According to most sources, women are more dependent on homecare services than men. This may be driven by the popular maxim, “women get sicker but men die quicker,” as two-thirds of the homecare recipients in the U.S. are women (Haupt, 1998). Langa, Chernew, Kabeto et al. (2001) agree that elderly women account for most homecare services, but they go further and point out that these women have greater statistical odds of using paid homecare. These findings justify this dissertation’s research objective of investigating nuances in the female homecare population, because subpopulations such as Blacks may have different experiences from other women.

Regarding the role of age, a distinction is made in gerontology between an old population (65 to 74 years old) and an older population (75+ years old), because of noted differences in the needs of both groups (McAuley and Arling, 1984). Kincade Norburn et al. (1995) identify a “middle age” elderly population between 75 to 84 years of age. While Upchurch and Mueller (2005) detail that younger senior citizens are more likely to carry out self-care techniques, Kincade Norburn et al. (1995) point to the middle age or transitional group as having the greatest variety of self-care activities. If the elderly subjects’ symptoms are associated with aging, they are more likely to elicit a passive or minimal self-care response (Dill et al., 1995). Self-care as used in this dissertation includes: changing one’s behavior (e.g., adding more vegetable and fruit to one’s diet); deciding to use equipment to assist with ADLs and IADLs (such as a walker); and

modifying one's environment (e.g. installing bath rails). All this is primarily done to improve functional limitations.

Most previous research indicates a positive relationship between aging and homecare use or demand. For example, Feller (1983) deduced that one in ten elderly who were between 65 to 74 years old needed assistance at home, compared with four in ten who were 85 years of age or over. Findings from the Vital and Health Statistics (1996) reveal that gender has an impact on the positive relationship between aging and homecare. The results from that study show that among women, the older old -- over 85 years old -- accounted for 30.5 percent of the homecare use, while for men the proportion was 20.9 percent for the same age cohort (Dey, 1996). The natural decrease in the elderly population as they age means that the age-cohort with the smallest number of people is the over 85 age group; so while they may be more infirm, the 74 – 85 age group actually demand and use the most health homecare services (Dey, 1996).

#### *Other Relevant Variables with Self-care and Homecare*

Apart from socio-demographic factors, other relevant variables can explain self-care efficacy. The state of the elderly person's health is important in determining when self-care methods will be used (Haug and Namazi, 1989). When the elderly person perceives that the symptoms are less serious, he/she is more likely to practice self-care methods (Dill et al., 1995). Seriously impaired seniors are also more likely to be dependent on the use of equipment in their self-care (Kincade Norburn et al., 1995). Kart and Engler (1995) report that seniors with positive subjective health status have greater confidence about using self-care. However, these positions are contradicted by Kincade

Norburn et al. (1995), who argue that with increasing disability, more self-care methods are used but that the practices diminish when the disability is severe. It is critical, therefore, to include measures of health status in the current analysis of self-care.

The literature around Self-Rated Health status is also found in feminist discourse. Feminists argue that an understanding of women's agency in relation to their bodies is important as it explains some of the health decisions they make (Pitts, 2003). Self-care allows for such agency as it encourages the practitioners, particularly women, to claim jurisdiction and authority over their bodies. The literature seems to suggest that the authority that we have over our bodies results from a growing intimacy over time. This supports Katz Rothman's (1998) position that "our understanding, our folk wisdom, our lived experience, ideology and mythology of the body [have] changed" (p. 141).

According to the existing literature, health status is not a clear indicator of homecare use. In 1986, a Congressional information paper on aging claimed that 38.6 percent of all elderly homecare recipients did not have low health status. The recipients' health status was viewed as relatively strong – they reported that they only need assistance with IADLs<sup>9</sup> and not ADLs (United States Senate, 1986). McAuley and Arling (1984) support this position as they found that other measures of health status, including number of illnesses and impairments, do not have a significant relationship with homecare use. It is critical, therefore, to include measures of health status in the current analysis of self-care and homecare.

In their research on IADL, Kart and Engler (1995) note that seniors' incomes have no statistically significant effect on self-healthcare practices. Kincade Norburn et al. (1995) point out, however, that environmental self-care may require the modification

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<sup>9</sup> Instrumental Activities of Daily Living

of one's built environment, and therefore it is practiced the least because of the substantial expenditure it requires. Education has also been examined, albeit it to a lesser extent than other variables. Fleming et al. (1984) found that seniors with 13 years or more of education were more likely to use self-care than those with fewer years of education. In sum, a person's level of education is indicative of knowledge about various types of healthcare choices, as is a person's socioeconomic status, and this in turn influences acceptance of and ability to obtain formal care (McAuley and Arling, 1984; Newman, 2003).

A condition related to the doctor's role in the senior's healthcare choice is the impact of others in the senior's social network. Research shows that the type of self-care practiced is related to the assistance provided by other caregivers (Dill et al., 1995). Many senior citizens learn different preventive and maintenance techniques from doctors and in-home nursing assistants, among others. Social networks can be seen as interactive or mediating forces in electing to use self-care (Dill et al., 1995). In their 1995 study, Dill et al. show that senior citizens' past and present interpersonal relationships have an impact on the description of their symptoms and the care practices employed. In contrast, Powers et al. (2006) reported that self-care (or person-directed care) can be inhibited by the presence of family members. The elderly person may not be allowed to manage his or her own healthcare if an adult child is living with that person. This may especially be the case when elderly Black patients reside with their adult daughters. As Hill Collins (2000a) points out, many daughters are taught to be caregivers as little girls (a part of the ethics of caring and personal responsibility), and so they more readily take over the care of their elderly parent. Therefore, adult daughters (not sons) usually assume a special

obligation of caring for elderly parents, and this is not simply the ethics of care but the feminine ethics of care representing a contrasting gendered value system (Gilligan, 1995).

More pointedly, as it concerns the elderly Black woman, Sichel 1989 pointed out that the ethics of caring applies differently to the person being cared for versus the one caring. If the one being cared for is an elderly Black woman who sees herself as fully competent, she may feel intruded upon if her ability to make healthcare decision is being over-ridden.

The final but by no means least important variable in self-care is health insurance. Medicaid recipients seem to be more likely to subordinate self-care practices to formal health services. Kart and Engler (1995) attribute this to perceived “official” poverty status. Additionally, they note that elderly people who use Medicaid benefits usually have the most serious illness symptoms, which make them more dependent on the formal healthcare system (Kart and Engler, 1995). Here again, the results are mixed, since Kart and Engler (1995) found that the decision to practice self-care is hardly influenced by programmatic factors such as insurance, Medicare and Medicaid. For the most part, these authors claim, self-care is driven by individual-level predisposing factors; therefore, a premise of the current research is that health values is one of these driving forces.

While this overview of the relevant variables aids the analysis, not all of the stated variables were addressed adequately in the existing literature. The results from this research directly address the current gaps.

## Theoretical Overview

### *The Healthicization Paradigm and Self-care*

An emerging concept in which seniors' healthcare practices can be grounded is healthicization. The medical sociologist Conrad (2005) tagged healthicization as the new health morality. The phenomenon is also referred to as surveillance medicine (Armstrong, 1995) or the "healthist culture" (Hislop and Arber, 2003). Proponents of healthicization suggest that the health values and practices of the individual are judged by others and can determine moral worth. Surveillance medicine targets everyone (Armstrong, 1995). This emerging theoretical paradigm posits that there is no absolution from individual responsibility, accountability and moral judgment (Zola 1972). This is a part of the contemporary neoliberal "personal responsibility crusade" (Hacker, 2008) that emphasizes that citizens should empower themselves by moving towards control of their own healthcare, while moving away from government dependence. The contemporary personal responsibility crusade encourages the patient to be "actively enrolled in the government of health" (Rose and Miller, 1992). This means even the elderly patient should feel morally obligated to be educated about health issues, and keep up-to-date about the consequences of lifestyle choices such as diet and exercise.

Therefore, this dissertation analyzes whether failure to adopt certain health behaviors will lead to the labeling of some persons as health deviants. Conrad's (2005) healthicization paradigm also offers a radical way to structure the evaluation of seniors' healthcare. Conrad emphasizes that this new health morality runs through all groups in modern American society; the research also addresses these taken-for-granted positions.

In this research, Conrad's ideas are used to understand the presence of health value orientation among elderly Black women.

Self-care, therefore, is presented in the literature as a derivative of the healthicization phenomenon (Westfall and Benoi, 2004). More pointedly, these authors see the concept of healthicization as the de-medicalization (moving away from the medical professional to the lay individual) of natural events associated with the body (for example, aging, child birth, menopause and menstruation). The problematization of normality and everyday life events is evidenced by the creation of explicit relationships between signs, symptoms and illnesses and precipitating factors situated outside the corporal body (Armstrong, 1995). Therefore, practices such as being more active, dieting, exercising, de-stressing and not smoking are ways of working towards a healthier body. This individualistic value exonerates the medical profession from being responsible for the individual's well-being, and advances the idea that we can all change the future by reforming our health attitudes and behaviors (Hislop and Arbor, 2003). This junction represents the importance of healthcare decision-making today; the health consumer has to be an active participant in receiving care if remedies are to be effective (Rose and Miller, 1992).

*Black Feminist Intersectionality: Being Elderly, Black and Female*

The current research is operationalized within the intersectionality of being elderly, Black and female. The intersectionality matrix refers to a social location where multiple systems of oppression operate simultaneously to delineate "Otherness" (Few, 2007). Focusing on dimensions of age, race and gender separately does not offer the same



level of analysis as studying the intersection of ageism, sexism and racism (Crenshaw, 1991). The identity politics of the intersectionality paradigm not only concentrate on vestiges of domination but also on what is empowering about these identities, which is a positive corollary. In this light, a systematic analysis of elderly Black women's values and norms, and how these values and norms affect healthcare decisions can have an impact on contemporary political and economic debates, for example, about social security. This is possible by highlighting areas lacking research, but more importantly by shedding light on differences in cultural norms that have an impact on healthcare policies. The proposed intersectionality paradigm also lends a dynamic framework within which one can examine not only the adoption of self-care practices by Black female seniors, but also most value-driven healthcare practices.

Like W.E.B. Du Bois, Patricia Hill Collins (2000b) argues that intersections of identities such as gender, sexuality, race, class and nation, are social hierarchies, not personal identity categories. These social hierarchies are important in shaping not only access to social goods, but the individual's value systems. Black Feminist Thought recognizes that Black women in the U.S. are not simply a homogeneous group. It acknowledges that the women's varied lives are bound together by a common identity (identity politics), but also allows for a standpoint theory where the individual woman's experiences can be used as a point of analysis (Few, 2007).

This research places Black women, whose lives are poorly understood, at the center of its inquiry. In conjunction with the racial, class and gender oppression they experience, they are marginalized in mainstream academic discourses. When they do appear, too often they are pathologized or problematized (Hill Collins, 2000a). It is

therefore important to continue the tradition of researchers such as Hill Collins (2000a) and make Black women the center of analysis. In particular, this research intends to outline Black women's views of themselves and their beliefs and values, because the controlled image of Black women is an indelible part of their oppression.

The intersectionality paradigm presented in Black Feminist Thought challenges traditional views of self-care. For example, healthcization as it is now conceptualized omits or trivializes core values held by many Black women and what they believe is healthy. An example of these core values is the decision not to take medication for serious illness out of a need for a greater sense of control over their physical health (Newman, 2003). In terms of core values, Hill Collins (2000a) posits that "within their extended families and communities, individual Black women fashioned their own ideas about the meaning of Black womanhood" (p.10). Additionally, these ideas are not stagnant, as Black culture evolves temporally, and is fostered by Black women's worldviews.

A major theme in Black Feminist Thought that is particularly useful in a discussion of Black women's value systems is that of controlling their own images (Hill Collins, 2000a). Despite many prevailing views on issues such as how one should construct ideas about one's own health, Black women do not always accept these values as their own, because these values can be equated with the controlling hegemony of U.S. society. Hill Collins (2000) pointed out that some Black women, "despite the pervasiveness of controlling images, . . . have resisted these ideological justifications" (p.93) in the name of their independence. As part of the oppressive position of being both women and Black, derogatory images of Black womanhood have been applied to this

group. Therefore, the struggle to hold on to positive self-definition is an on-going battle for U.S. Black women. Elderly Black women, who are the center of this analysis, can also be compared to the renowned Sojourner Truth who challenged prevailing value systems created by the oppressing class. Hill Collins (2000a) advances the idea that Truth did not accept many contemporary values as natural or as a simple reflection of reality, rather she deconstructed even taken-for-granted words such as “woman.” Similarly, the Black Feminist intersectional paradigm allows us to explore issues around Black women’s healthcare decision-making and the relevance of self-care methodologies among this group today.

In terms of healthcare, Black Feminists argue that a common image of Black women is that of being strong and large (Beauboeuf-Lafontant, 2003), almost as if the women are not susceptible to fragility and ill-health. A sweeping generalization applied even to elderly Black women is that the intense stress of living in a low-income situation stimulates fortitude and resilience (Newman, 2003). Regarding mental health, it has been advanced that Black women’s historical struggle has fostered a psychological fortitude and resilience resulting in coping skills (Jones and Ford, 2008). The myth of the strong Black woman is seemingly affirming, as it is juxtaposed against the idea of Black woman being representative of “deviant womanhood,” both psychologically and physically (Beauboeuf-Lafontant, 2003). Unlike White women, Black women are also less likely to be seen as passive and weak. This research will explore if this ideology is reflected in Black women’s health values.

The strong Black woman image is also accompanied by the need for independence seen among that group. Apparently, this need is inculcated in Black

females very early in life by their mothers, as daughters learn to “anticipate carrying heavy responsibilities in their families and communities because these skills are essential to their own survival and for those for whom they would eventually be responsible” (Hill Collins, 2000a, p. 183). According to the literature, Black daughters learn to take care of their own health so that they can care for others.

### Conclusion

The theoretical framework and gaps in the literature justify the focus on the following research questions: (1) How do health values manifest themselves in the healthcare decisions (specifically, to use self-care methods and homecare use) of elderly Black women? (2) Is there a difference in the type of self-care methodology that elderly Black women are more likely to practice? (3) And are there any manifest outcomes for the elderly Black women, and for society, from practicing self-care methods?

The existing literature is not explicit about the role of values in healthcare decision-making. For example, the Dill et al. (1995) analysis of interviews with self-care users focused primarily on the respondents’ understanding of self-care rather than what drives them to such practices. This dissertation, however, directly addresses the limitation by focusing on the values associated with self-care use. While past research on self-care is very informative, research efforts such as Bakken Henry and Holzemer’s (1997) theoretical paper on the phenomenon did not attempt to include minority or disadvantaged populations. A deliberate effort to include the minority population is necessary in social research or the sample will largely include members of the mainstream population. The present research remedies this limitation, with a special

emphasis on the aged, Blacks and women. Another limitation noted in the literature is the absence of research on outcomes of practicing self-care. Even national surveys on self-care and aging (DeFriese et al., 1999 and 2006) did not ask respondents how their lives have changed because of the decision to use self-care. An important objective of this research, therefore, is to ascertain the manifest outcomes from practicing self-care.

## CHAPTER 3: RESEARCH METHODS

### Introduction

Several datasets are useful in an analysis of the most topical senior citizens' issues: the Longitudinal Study on Aging (LSOA); the National Survey of Self-Care and Aging; the National Long Term Care Survey; the Health and Retirement Study; the National Home and Hospice Care Study; etc. However, none of these datasets seems to bring the two major concerns (self-care and homecare) of this research together adequately.

The stated research questions were examined through both quantitative and qualitative analyses. The quantitative component utilized the 2000 National Health Interview Survey: Second Longitudinal Study on Aging (LSOA II), Wave 3 dataset. The dataset includes responses from three time points – 1994 (base year), 1997 (first follow-up) and 2000 (second follow-up). This dataset was selected because its contents referred directly to the important issues of seniors' lifestyle. Additionally, the most recent national dataset on the topic was sought in order to address the issues nationally and contemporarily. The quantitative analysis was done in three phases. Phase 1 entailed an analysis of the relationship between self-care and values using multiple regression. The second phase presents the analysis of the relationship between homecare services use and values using multiple regression. The final phase used Structural Equation Modeling (SEM) operations to analyze the overall model (that is, the relationship between self-care and homecare). The qualitative analysis entailed the interviewing of senior citizens; conversation analysis was then used to interpret the data.

### Social Science Approaches to Health and Illness Research

For many sociologists, the arena of health and illness is more than the biomedical approach. The field of Sociology of Health and Illness has moved beyond the medical institutions (the hospital, doctor's office or the asylum) and the analyses now include a political, economic and cultural framework. Brown (2000) believes this is a modern, critical approach offering a fresh and more structural perspective than does traditional research in the field of Health and Illness.

### Social Science Approaches to Aging Research

Researchers are increasingly attracted to the field of aging because of the dynamic demographic and epidemiological variables that are reshaping the discourse. Aging research is also a cross-disciplinary field as not only is it found in the social sciences (e.g., sociology and economics) but it is also located in biological studies. Abeles, Gift, and Ory (1994) contend that most aging research in the social sciences falls within four categories. The first category is concerned with the impact of quality of life on the elderly's lifestyle (Haan, Kaplan, and Syme, 1989). The second area is the most traditional, where there is a concentration on the effects of physical health on quality of life (Schulz and Williamson, 1991). The most sociological of all these concentrations is the impact of social structure on the elderly (Baltes and Reizenzein, 1986). The final area is social policy research in response to the discourse (Capitman, 1989). These areas are not exclusive of each other. Not only do they overlap, but much of the research is conducted in an interdisciplinary arena (Butler, 1994).

### Feminist-oriented Methodological Tools

The methodologies selected in feminist-oriented research are usually chosen with the knowledge that the data will be gathered and analyzed from a traditionally disadvantaged group. Feminists believe that the research enterprise is controlled by elite White men, whose interests it reflects (Small, 1995). Feminist research, and especially Black Feminist research, demands greater creativity, so that the analyses can be increasingly for women of color rather than about them. Feminists and researchers focusing on subordinate groups use alternative methods to hear and interpret their subjects' voices.

Therefore, a major methodological tenet in Black Feminist Thought is epistemology. It is important to know how knowledge is created, built upon and transmitted within this group. In essence, epistemology is an assessment of “why we believe what we believe to be true” (Hill Collins, 2000a, p. 252). Qualitative techniques such as in-depth interviews and observations are sometimes more appropriate than the analysis of a large quantitative dataset. Alternatively, a comprehensive analysis of a large population sometimes requires a substantial sample (for example, a national dataset). Marrying the quantitative with the qualitative tools is very useful to articulate the women's voices while adhering to rigorous academic criteria.

### Methodological Choices for this Dissertation

A deliberate attempt was made in this research enterprise to concentrate on elderly Black women; hence the methodological tools were selected to achieve the most cogent analyses. First, a national dataset was selected because of an interest in a



comprehensive research about the lives of elderly Black women across the U.S. A respected dataset in the field of Health and Illness and Aging research was also selected to further reinforce the credibility of this research. Finally, elderly Black women were interviewed in response to the need for a nuanced understanding of the group's episteme. It is through this mixed methods approach that the distinctive elderly Black women's standpoint is presented.

### Quantitative Component

#### *Participants and Procedures*

The National Center for Health Statistics (NCHS) and the National Institute on Aging (NIA) are the agencies responsible for collecting the Longitudinal Study on Aging II. The baseline for this study yielded 9,447 participants who were over 70 years old by 1995. This research, however, concentrates on the subset of elderly Black women from the achieved working sample ( $N=642$ ). The sample contained non-institutionalized, civilian individuals. Data collection (personal interviews) was conducted by the U.S. Census Bureau. The questions for the Supplement on Aging (SOA) were included in one of the five National Health Interview Survey (NHIS) supplements (the National Health Interview Survey on Disability – NHIS-D). The NHIS sample size included 40,000 households – approximately 103,500 persons – in 1994. The investigators detail that the survey had a multistage complex sample design (U.S. Dept. of Health and Human Services, 2003).

From the baseline year (1994), the following characteristics were ascertained. Consistent with senior research, the age range of the respondents was 69 and over. This

was further broken down into 47 percent between 69 and 74 years of age; and 53 percent who were 75 to 98 – also called the older old. Only 23.1 percent of the respondents were married in 1994. In terms of educational attainment, 63.1 percent of these elderly Black women did not complete high school, and had less than 12 years of education. A further delineation of their social status is that 53.5 percent of the respondents had a mean income of under \$11,000, including nine percent of the senior citizens who were below the poverty line.

The baseline data amalgamated information from 1) the 1994 NHIS Core questionnaire, 2) the Family Resources Supplement to the 1994 NHIS, 3) Phase I of the NHIS-D, and 4) Phase II of NHIS-D. The compilation of the dataset from different questionnaires is indicative of the complex design of this project. Therefore, appropriate weights were employed.

#### Phase I: Multivariate Analysis of Respondents Practicing Self-care

The reviewed literature demonstrates that values which precipitate self-care practices by elderly Black women have not been given adequate attention. Therefore, the first step is to gather this information from the data. This sets the foundation for a more thorough understanding of our comprehensive model; that is, the relationship between self-care and homecare and the impact of a value system.

#### *Measures*

The dependent variable in this analysis is **Self-care**. There are no specific variables that can perfectly measure the three self-care concepts in the dataset. For “behavioral self-care”, eight variables from 1994, 1997 and 2000 measuring deliberate

physical activities were combined. The variables include items such as “routine exercise”, and “level of activity compared to a year ago.” “Equipment self-care” in 1994 was created from ten questions which sought to ascertain the respondents’ utilization of wheelchairs, walkers, canes, and so on. The third variable developed was “environment self-care” from ten 1994 variables. The ten variables included items such as whether the respondents’ residences had ramps, railings, accessible parking, etc.

The first and main independent variable is **Value**. The following items were selected to operationalize “health value”: (1) self-rated disability status and (2) if respondents think others view them as disabled. Scales such as the Osteoporosis Functional Disability Questionnaire (OFDQ) suggest that the perceived absence of disability is equivalent to positive assessment of quality of life (Helmes, 2000), which is indicative of the health values.

The second independent and mediating variable is **Health Status**. Dill et al. (1995) state that the respondent’s health status is an important variable to consider in a discussion of self-care. Self-care by the elderly is related to illness attribution. Self-care can involve “the interpretation of present and past illness experiences” (Dill et al., 1995, p. 309). The variable that was operationalized for this concept is “Self-Rated Health”, an ordinal variable with a ranking of poor, fair, good, very good and excellent, which was collected in 1994.

**Health Insurance** is another independent and mediating variable. The type of health insurance the senior had was also important to the NHIS investigators. In 1994 the relevant item inquired if the seniors were only dependent on public insurance, a mixture of public and private, or private insurance alone.

**Family network** is another mediating independent variable. The literature is explicit about the impact of seniors' social networks on self-care practices (Kincade, Rabiner, Bernard, and Woomert, 1996). Suitable social network concepts that were operationalized are whether one lives with his or her (1) spouse, (2) son or (3) daughter.

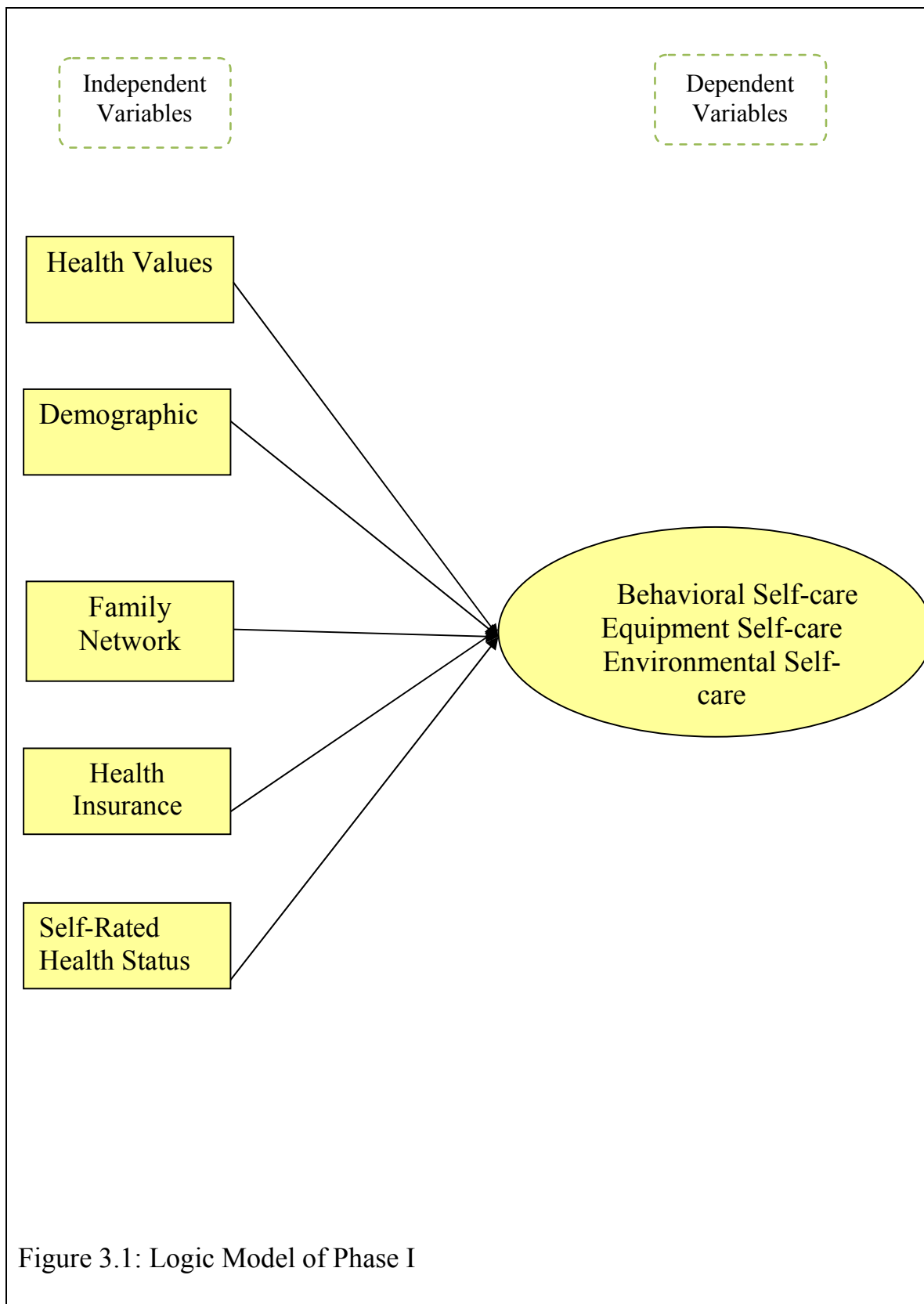
Finally, several **Demographic** variables are used in the analysis. Several items capture the respondent's demographic characteristics, including income, educational attainment, and marital status. They are also used as intervening variables in this analysis.

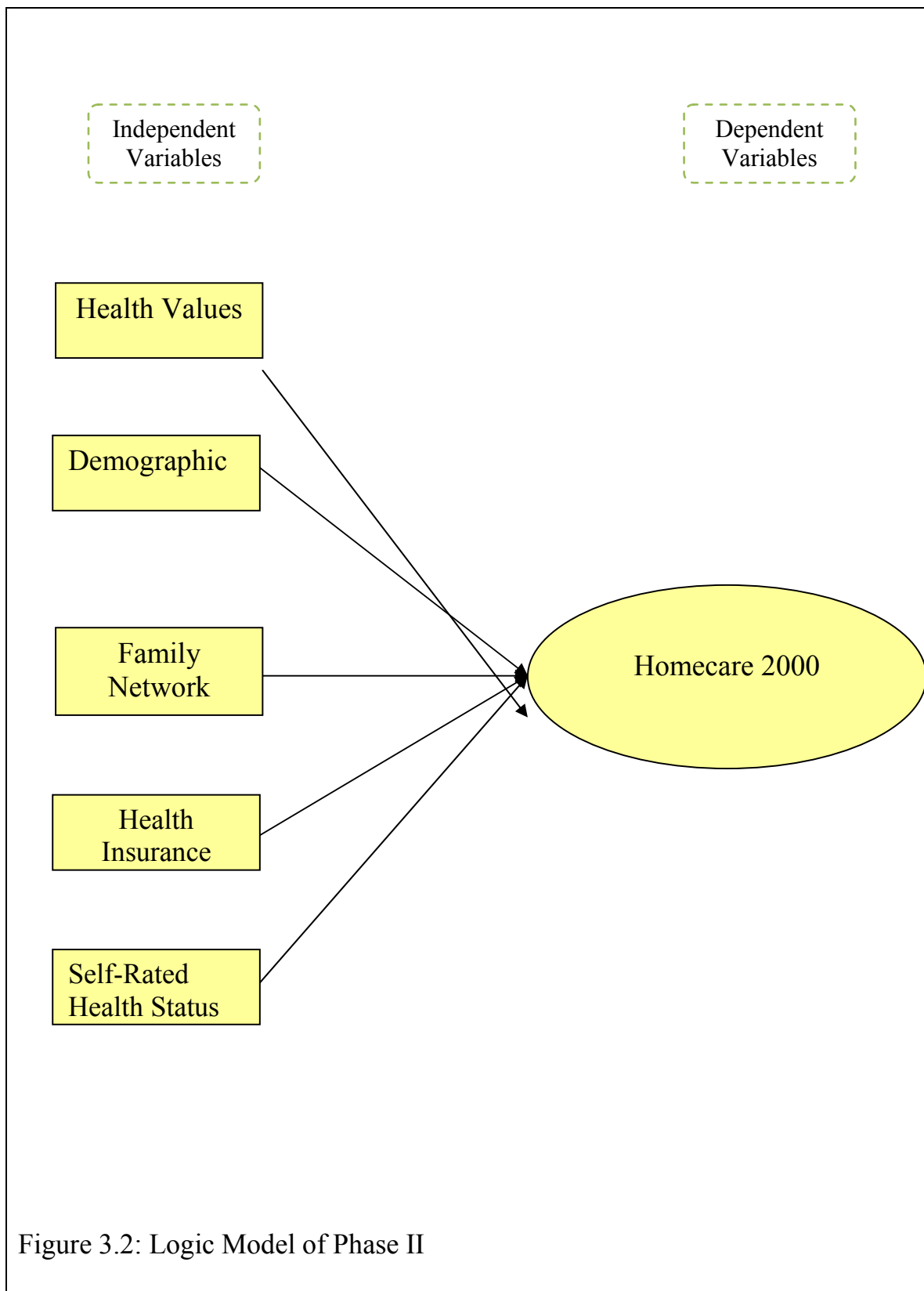
### *Analytic Plan*

To examine each type of self-care independently, the analysis was conducted separately for three distinct areas – behavioral, equipment, and environment. Elderly Black women's responses about self-care methods were analyzed in an effort to delineate both their value patterns and other sociological characteristics (see Figure 3.1 above). Specifically, healthcization factors such as valuing oneself as able-bodied, and believing that others view oneself similarly were analyzed and compared (between users of self-care and non-users). In addition, age, race, health status, insurance status, family network, etc. were analyzed in an effort to better understand the social norms of self-healthcare among senior citizens. Multiple regressions were used for the data analysis.

The essential questions that guide this phase are as follows:

- a. Do elderly Black women who practice self-care have differing health values?
- b. Do self-care methodologies predominate in particular age groups?
- c. Are there class (income and education) differences in the use of self-healthcare?
- d. Does family structure have an impact on self-care practices among elderly Black women?
- e. Can marital status account for the practice of self healthcare?





- f. What kinds of insurance schemes predominate among practitioners of self-care?
- g. Are elderly Black women who practice self-care healthier than those who do not?

### Phase II: Multivariate Analysis of Homecare with the Independent Variables

Phase II also used the Longitudinal Study on Aging II dataset. A Homecare item was created from the dataset and used with all the independent variables that were operationalized for Phase I. The dependent variable at this stage seeks to find out the usage of homecare by seniors and the values driving these practices. The measures for the additional variable used in this phase is outlined below.

#### *Measures*

The dependent variable in this phase is **Homecare**. Ten variables were used to capture the concept of homecare. The selected items ask whether the respondent received assistance with various ADLs<sup>10</sup> at home. The ADLs include bathing, dressing, getting out of bed, walking, meal prep, grocery shopping, money managing, light housework, using the telephone, and managing medication.

#### *Analytic Plan*

Similar to the proposed methodology in Phase I, Phase II demonstrates the relationship between homecare and the presence of particular healthcare values, and a number of independent variables. The independent variables were grouped in four categories: (1) demographics (2) health status (3) insurance status and (4) interpersonal network. The dissertation hypothesizes that examining senior homecare across these

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<sup>10</sup> Activities of Daily Living

different categories using this Longitudinal Study on Aging II should delineate some of the major barriers that plague seniors and their families in accessing important homecare services. This analysis is important because homecare is becoming an essential healthcare need for senior citizens (Aronson and Neysmith, 1996).

Phase II details the strength and the direction of the relationship between homecare and the independent variables (see Figure 3.2 above). The critical questions that guide Phase II are as follows:

- a. How are health values associated with the use of homecare services by elderly Black women?
- b. What is the relationship between homecare use and particular demographic groups (e.g. race, gender, age, income and education)?
- c. How do health and insurance status influence homecare use?
- d. How does the presence or absence of family members in the home affect the use of homecare services by elderly Black women?
- e. How does the presence or absence of family members in the home affect the health values of elderly Black women?

### Phase III: Quantitative Analysis of Self-care with Homecare, Structural Equation Modeling (SEM)

The final phase of the quantitative research first created three latent constructs that represent the major terms in this research. These terms are: Health Values, Self-Care and Homecare. The confirmatory SEM model was then used to explain the relationship among these three latent variables and several observed variables. An important objective was also to analyze the impact of the three latent variables on each other. As indicated in Figure 3.3, the path model also proposes that Health Values and Self-care cause Homecare (so that Health Values and Self-care are exogenous and Homecare is endogenous). Analysis such as that done by DeFries et al. (1994) is evidence that self-care can have a profound impact on the lives of the elderly.



### *Measures*

The SEM analysis incorporated eight observed, endogenous variables. The Latent variable Self-care was measured by three observed variables. These were: the behavioral changes in order to improve or maintain quality of life; reported Use of Special Equipment Self-care; and whether the elderly respondent had modified her residence to facilitate daily activities and functioning.

Three observed variables were used to measure Health Values. The first of the three was an expression of a Will to Live by these elderly Black women. This variable retained its original 10-point scale set for analyses. This variable is based on the “death dip” concept, which proposes that the timing of death and life expectancy are regulated by the subject. The Will to Live is therefore a fitting indicator of Health Value. The second was the elderly respondent’s perception of their physical and mental conditions, represented by self-rated health. The third and final observed variable associated with this construct was driving values, which represents the individual’s preferred health state.

Finally, the latent variable, Homecare Dependency, was measured by three observed variables. The first quantifies the number of close relatives (if any) living with the respondent who could assist with everyday needs. The second and the third respectively measures some popular Activities of Daily Living and Instrumental Activities of Daily Living for which the client needs or receives regular assistance.

### *Analytic Plan*

The hypotheses recognize that a number of factors can influence the relationship between self-care and homecare for seniors. Therefore a primary objective of this

research is to find out the role of health values in healthcare decision-making. In order to perform a rigorous quantitative analysis (Bryne, 2001), structural equation modeling (SEM) was employed to examine the relationships. SEM was used as the hypotheses contain multiple independent, dependent and latent variables whose relationships are estimated simultaneously (see Figure 3.3 in above). The Logic Model in Figure 3.3 also accounts for the expected error terms in the examination of the causal model. The critical questions that guide this phase are as follows:

- a. How do values impact the decision to practice self-care?
- b. What is the nature of the relationship between self-care use and the dependence on homecare services?

### Qualitative Component

In order to investigate the theoretical concerns laid out in this dissertation, a small sample was sought for further interviews. The sample reflects the intersection of interest in the dissertation. A convenient sample was selected from the state of Maryland. In 2006, Maryland accounted for the following breakdown of these demographic indicators versus the national percentage: 29.5 percent Blacks versus 12.8 percent nationally; 51.6 percent females versus 50.7 percent nationally; and 11.6 percent over 65 years old versus 12.4 percent nationally (American Community Survey, 2006). The significant Black population was chief reason for conducting the interviews in Maryland.

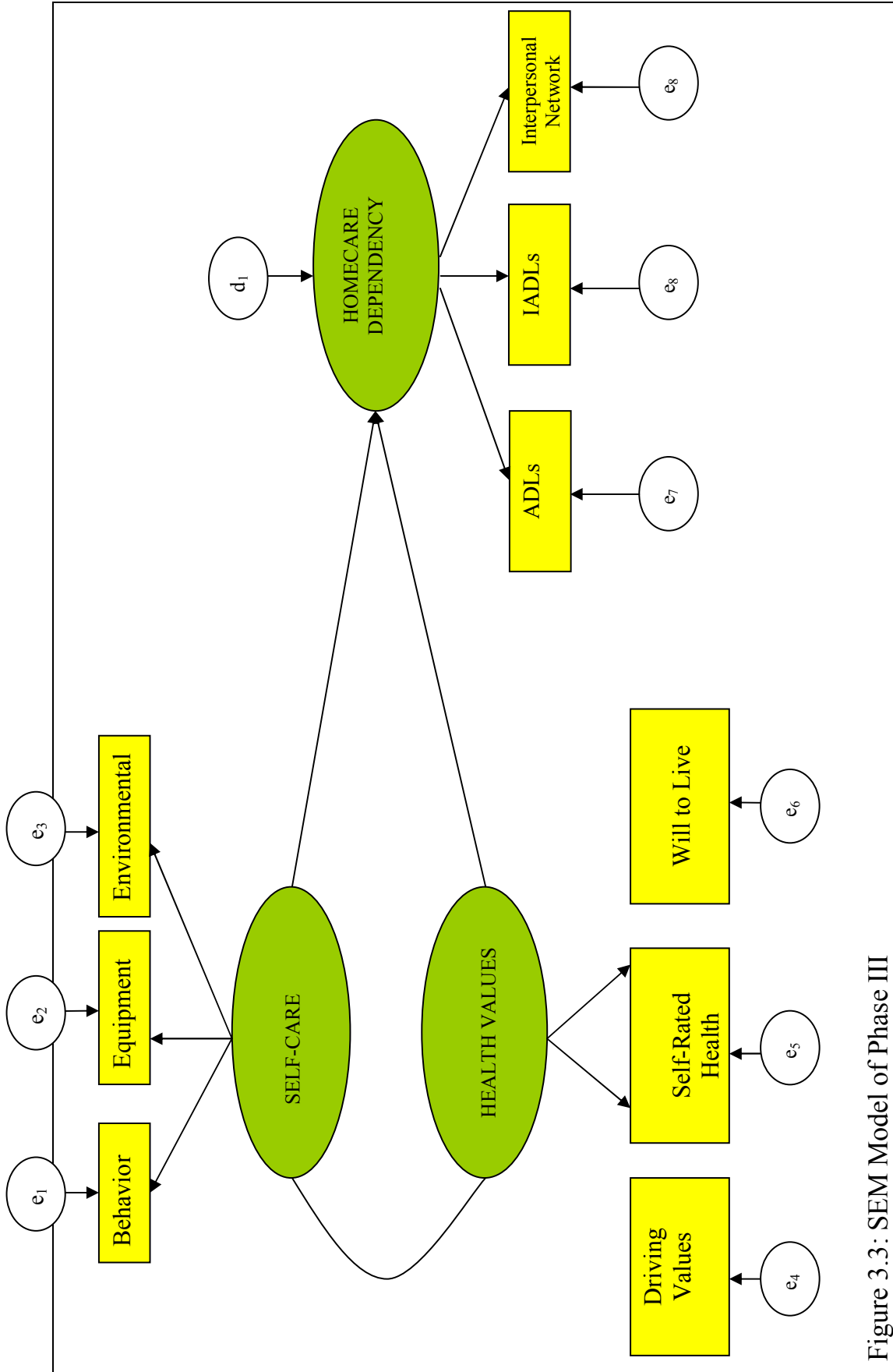


Figure 3.3: SEM Model of Phase III

### *Participants and Procedures*

The participants for the interview phase were selected through a combination of convenience and quota sampling technique. The aim was to gather the views and experiences of at least 10 elderly Black women through unstructured, taped interviews (see Interview Schedule in the Appendix). The quota sampling targeted respondents from two categories. Another aim was to explore the experiences of respondents who use homecare services and those who do not. Therefore, arrangements were made to access at least five respondents from a private senior homecare agency. The agency operates in Southern Maryland. The volunteers were recruited with the assistance of caseworkers.

The final set of respondents was recruited through convenience sampling. Through informants in Southern Maryland, five respondents who did not use home care were selected. Two of these respondents were members of a senior daycare program in the area. The non-homecare users were asked the same general questions as the homecare recipients.

The signed consent of all participants was obtained, and they were guaranteed anonymity, the confidential handling of their sensitive information, as well as disclosure of final results if requested. The interview schedule was also pretested before the final data collection.

The main components of the interviews consisted of: (1) ascertaining the physiological condition of respondents, as the literature indicates that seniors' physical health can determine self-care efficacy; (2) cataloguing the seniors' care response (Kincade Norburn et al., 1995) details indicating that self-care is not only behavioral, but also includes caring with equipment and through environmental modification); (3)

determining whether the care of choice is self-care, based on some contemporary definitions (Bakken Henry, 1997; Dill et al., 1995; Kincade Norburn et al., 1995); (4) evaluating the values that drive self-care. Conrad (2005) posits that many healthcare choices today are grounded in the new health morality of healthcization; (5) assessing how long seniors using self-care have done so (retroactive history); (6) inquiring about the seniors' social network; (7) asking seniors if they received homecare for any ADLs (including their retroactive homecare history; 8) Collecting basic socio-demographic information.

### *Analytic Plan*

Transcript data from the interviews were analyzed to explore seniors' understanding of self-care. Interview data have been used by various researchers in the field of gerontology (Dill et al., 1995; Klinenberg, 2005; Unruh, 1983). The discourse was used to supplement the quantitative analysis. The basis of the analysis was identifying how many of the interview respondents use self-care methodologies, and their reasons for doing so.

### Quality Assurance

Durkheim (1982) emphasized systematically discarding preconceptions as a major tenet in sociological methodology. He reinforced this by saying that social facts should not be confused with their individual manifestations. In order to present a balanced analysis, I am aware that my individual script as a recent, Jamaican immigrant, coming out of a home with elderly grandparents, may have an impact on my interpretation of

caregiving by elderly Americans. Additionally, although my work at a senior home care agency in 2006 to 2007 propelled me towards this research, I am cognizant that the clients that I dealt with do not represent the totality of senior citizens' experiences. These encounters can only assist with a fuller understanding of the data to be analyzed. Hence, as reiterated by Durkheim (1982), special efforts were made in defining the phenomena of interest beforehand.

CHAPTER 4:  
PHASES I AND II RESULTS: THE RELEVANCE OF THE  
HEALTHICIZATION ETHICS IN HEALTHCARE

Phase I: Introduction

The analysis in Phase I aims to answer two questions: (1) How do values manifest themselves in the healthcare practices (specifically, self-care methods) of elderly, Black women? (2) Are there differences between and among the types of self-care methodologies elderly Black women are more likely to practice? This research intends to add to the limited literature on the relationship between health values and self-care, and presents a less medicalized understanding of self-care. Additionally, a sociological perspective on the link between American seniors' self-care initiatives and possible outcomes seems to be absent from the current literature. The bulk of the academic discourse on this matter are in the fields of gerontology, health-related disciplines, social welfare and social policy; hence this research addresses this lack.

*Descriptive Analysis*

In examining the descriptive statistics for the sample, Table 4.1 demonstrates that most elderly Black women did not practice behavioral self-care based on the mean score of 12.6 on the variable of the same name. Table 4.2 further lists the eight variables that make the composite behavioral self-care variable used in the regression analysis. Only the variable "Exercise 1994," indicates that on average respondents were exercising regularly and more often. Similarly, Table 4.1 demonstrates that most of the elderly Black women in the sample did not practice equipment and environmental self-care (mean scores of 26.95 and .000 respectively). The computation of both composite variables are also outlined in Table 4.2. It should be noted that the alphas for the

Table 4.1  
Descriptive Statistics  
Elderly Black women Sample  
(N=642)

Variable	Mean	SD	Range	Alpha
<b>Dependent Variables</b>				
<i>Behavioral Self-care</i>	12.60	2.08	9 - 17	.608
<i>Equipment Self-care</i>	26.95	1.35	26 – 34	.643
<i>Environmental Self-care</i>	.000	.810	-.748 – 3.791	.722
<b>Independent Variables</b>				
<i>Health Values</i>	3.578	.7916	2 – 4	.937
<i>Demographic</i>				
Age	76.59	6.084	69 – 98	
Married (1994)	.230	.422	0 – 1	
Annual Income (1994)	2.86	2.080	0 – 8	
Educational Attainment	9.4	4.66	0 – 18	
<i>Family Network</i>				
Live with Spouse (1994)	.190	.393	0 – 1	
Live with Daughter (1994)	.122	.327	0 – 1	
Live with Son (1994)	.148	.355	0 – 1	
<i>Health Insurance</i>	1.385	.536	0 – 3	
<i>Self-Rated Health Status</i>	2.822	1.093	1 – 5	

composite variables behavioral self-care and equipment self-care are not very strong. The decision was made to use these items nevertheless, as they were appropriate to validate the major tenets of the research questions. Additionally, the items that were used in the computation had relatively low numbers of missing cases, which made the tests more reliable. (Table 4.2 further details the make up of the three self-care concepts, with a list of all the items used to create the dependent variables). Furthermore, most of the sample reported positive health values. Health values resulted in a mean of 3.57, which indicates that the women prefer a positive health outlook.



Table 4.2  
Comprehensive Description of  
Regression Self-Care Variables

Variable	Mean	SD	Range	Label
<i>Dependent</i>				
<i>Behavioral Self-Care</i>				
Activity (1994)	1.72	.582	1 Less – 3More	Level Compared to 1 year
Activity (2000)	1.54	.653	1 Less – 3More	More/Less/Same
Exercise (1994)	2.24	.442	1 Less – 3More	Regular Routine
Exercise (1997)	1.37	.484	1 No – 2 Yes	Physical Activity
Exercise (2000)	1.40	.491	1 No – 2 Yes	Regular Routine
Alcoholic Drink (1994)	1.15	.360	1 No – 2 Yes	Had at Least 1 Drink
Weight (1997)	1.40	.491	1 No – 2 Yes	Lost 10lbs (1997)
Why health improved	1.19	.397	1 No – 2 Yes	Exercise (1994)
<i>Equipment Self-care</i>				
Diabetic equip	1.11	.319	1 Don't – 2 Use	Used during past 12 months
Inhaler	1.05	.222	1 Don't – 2 Use	Used during past 12 months
Nebulizer	1.01	.079	1 Don't – 2 Use	Used during past 12 months
Hearing aid	1.03	.161	1 Don't – 2 Use	Used during past 12 months
Crutches	1.01	.118	1 Don't – 2 Use	Used during past 12 months
Cane	1.26	.440	1 Don't – 2 Use	Used during past 12 months
Walker	1.15	.359	1 Don't – 2 Use	Used during past 12 months
Wheelchair during past	1.09	.288	1 Don't – 2 Use	Used during past 12 months
Scooter	1.00	.040	1 Don't – 2 Use	Used during past 12 months
Feeding tube	1.00	.056	1 Don't – 2 Use	Used during past 12 months
<i>Environmental Self-Care</i>				
Widened doorway/hall	2.05	.289	1 Need –3 Modified	Does residence have/need
Ramps or entrance	2.08	.372	1 Need –3 Modified	Does residence have/need
Railings	2.17	.534	1 Need –3 Modified	Does residence have/need
Automatic/easy doors	2.01	.238	1 Need –3 Modified	Does residence have/need
Accessible parking	2.16	.407	1 Need –3 Modified	Does residence have/need
Bathroom modification	2.07	.434	1 Need –3 Modified	Does residence have/need
Kitchen modification	1.98	.230	1 Need –3 Modified	Does residence have/need
Elevator or lift	2.05	.304	1 Need –3 Modified	Does residence have/need
Alerting devices	2.04	.301	1 Need –3 Modified	Does residence have/need
Other special features	1.99	.148	1 Need –3 Modified	Does residence have/need

Table 4.3  
Comprehensive Description of  
Regression Health Values Variables

Variable	Mean	SD	Range	Label
Dependent <i>Health Values</i>				
Perception of Self as	1.760	.428	1 Yes – 2 No	Disabled
Think other see you as	1.797	.406	1 Yes – 2 No	Disabled

Table 4.4  
Specification of Educational Attainment Variable  
(N=609)

Value	Label	Valid Percent
0	Never attended; kindergarten only	0
1	1 year	.7
2	2 years	2.5
3	3 years	3.9
4	4 years	4.9
5	5 years	4.4
6	6 years	6.7
7	7 years	9.7
8	8 years	10.5
9	9 years	6.1
10	10 years	7.7
11	11 years	7.2
12	12 years	23.6
13	1 year of college	2.5
14	2 years of college	3.1
15	3 years of college	1.1
16	4 years of college	2.1
17	5 years of college	1.3
18	6 years or more of college	1.8
Total	Total	100.0

Table 4.5  
Specification of Annual Income Variable  
(N=445)

Value	Label	Valid Percent
0	Under \$5,000	10.8
1	\$5,000-\$6,999	20.2
2	\$7,000-\$9,999	18.7
3	\$10,000-\$14,999	16.4
4	\$15,000-\$19,999	13.9
5	\$20,000-\$24,999	6.3
6	\$25,000-\$34,999	6.5
7	\$35,000-\$49,999	4.5
8	\$50,000 or more	2.7

Table 4.3 details that health values was computed from perception variables. The elderly respondent's perception of whether or not she perceived herself as disabled was positive evaluation, as an average of 1.76 meant that most do not label themselves as disabled.

Likewise, the elderly Black women from the sample did not believe that most people would call them disabled as indicated by an average of 1.797. Table 4.1 further highlights several demographic characteristics. The average age of the sample was 77 years old. Most of these elderly Black women were not married; however, 82 percent of the unmarried were widows. The sample had an average of 9.4 years of education. (The specific categories for the educational attainment variable are further outline in Table 4.4). The low annual income reported in Table 4.1 is further expounded in Table 4.5.

Table 4.5 details the categories of the annual income variable, and also demonstrates that most of the elderly Black women (20.2 percent) earn between \$5,000 and \$7,000. Finally, the sample's family network dynamics is pivotal to this paper. Table 4.1 indicates that only 19 percent of the sample reported living with their spouses in 1994; while 12 percent lived with their daughters and 15 percent lived with their sons.

### The Parameters of Self-care

Although there are clear definitions of self-care in the Sociology of Health and the Sociology of Medicine literature, it is still difficult to identify the components of this phenomenon because different individuals identify varying practices as self-care. A limitation of this research is that the Longitudinal Study on Aging 2000 does not employ specific variables to measure self-care. Therefore, the concepts that were employed in the data analysis, while informed by the literature, may not cover the breadth of the phenomenon defined as self-care. Tables 4.6, 4.7 and 4.8 respectively display the regression output of three types of self-care with several independent variables. The self-care concepts are examined independently, and this is reflected in the tripartite analysis which follows.

#### *Behavioral Self-care*

Table 4.6 presents the relationship between behavioral self-care methodologies – as practiced by elderly Black women – with several independent variables. Model 1 displays the simple regression between behavioral self-care and health value. The  $R^2$  statistics (.009) indicate that only a small proportion of the variance in the dependent variable can be explained by health value. The four subsequent models (2 to 5) allow for other variables to mediate the above-mentioned relationship between behavioral self-care and health value. Model 2 (which mediates health values effect by socio-demographic variables) explained 1.3 percent of the variance in behavioral self-care. The explanatory power was further increased with the addition of three interpersonal predictors in Model

Table 4.6  
 Unstandardized Regression Coefficients  
 for Behavioral Self-Care  
 Among Elderly Black Women  
 ( Standardized Coefficients in Parentheses)  
 Number of Cases=641

	<b>Models</b>				
	1	2	3	4	5
<i>Health Values</i>	.081* (.102)	.076* (.096)	.073* (.092)	.073* (.092)	.012 (.015)
<i>Demographic</i>					
Age (1994)		-.007 (-.074)	-.008* (-.011)	-.009* (-.091)	-.007 (-.090)
Married (1994)		-.015 (-.011)	-.125 (-.091)	-.124 (-.090)	-.106 (-.078)
Mean Income (1994)		-.011 (-.033)	-.007 (-.021)	-.006 (-.018)	-.008 (-.025)
Education (1994)		.009 (.066)	.009 (.064)	.009 (.066)	.007 (.051)
<i>Family Network</i>					
Live with Spouse (1994)			.134 (.091)	.137 (.093)	.136 (.092)
Live with Daughter (1994)			.005 (.003)	.002 (.001)	.031 (.019)
Live with Son (1994)			-.173* (.098)	-.174* (.099)	-.167* (.094)
<i>Health Insurance</i>				-.015 (-.014)	-.026 (-.024)
<i>Self-Rated Health Status</i>					.145* (.271)
<i>Constant</i>	1.434**	1.959**	2.228**	2.249**	1.889**
<i>Adjusted R<sup>2</sup></i>	.009	.013	.020	.019	.084
<i>R<sup>2</sup> Change</i>		.011	.012	.000	.066**

NOTES: \*p<.05; \*\*p<.01

3 (2 percent of the variation). The addition of the insurance and the respondent's Self-Rated Health status variables in Models 4 and 5 moved the models' explanatory power to 8.4 percent. A cross-model comparison indicates a significant R<sup>2</sup> change between Models

4 and 5; the addition of self-rated health status did in fact add to the prediction above and beyond the eight previous predictors.

In Model 2, an examination of the beta weights demonstrates that health value ( $\beta = .096$ ) was weakened as a predictor with the addition of the socio-demographic variables. With the addition of the three interpersonal variables in Model 3, living with one's son was significant ( $\beta = -.098$ ), while both health value ( $\beta = .092$ ) and age ( $\beta = -.011$ ) decreased in explanatory power. The incorporation of the respondents' Self-Rated Health status ( $\beta = .271$ ) in Model 5 decreased the predictive power of health values and negated its significance.

#### *Equipment Self-care*

The same predictors explained more of the variance for self-care with equipment (Table 4.7, Models 6 to 10) than they did for behavioral self-care. Starting with Model 6, the  $R^2$  statistics demonstrate that 15.3 percent of the variance in equipment self-care is explained by health values. In Model 7, the analysis produced an  $R^2$  which explained 18.1 percent of the variation in the dependent variable; this model only covered health values and four demographic variables. A significant  $R^2$  change in Model 7 over Model 6 reiterates that adding the demographic variables have an effect on the prediction. With the addition of three interpersonal variables, the explanatory power increased to 18.7 percent in Model 8; and 19 percent with addition of the insurance variable in Model 9. Model 10 produced the highest  $R^2$  of the four multivariate models,

Table 4.7  
 Unstandardized Regression Coefficients  
 for Equipment Self-Care  
 Among Elderly Black Women  
 ( Standardized Coefficients in Parentheses)  
 Number of Cases=613

	<b>Models</b>				
	6	7	8	9	10
<i>Health Values</i>	-.476*	-.460*	-.460*	-.462*	-.425*
	(-.393)	(-.379)	(-.379)	(-.381)	(-.350)
<i>Demographic</i>					
Age (1994)		.027*	.026*	.027*	.026*
		(.185)	(.183)	(.187)	(.178)
Married (1994)		.006	.098	.090	.080
		(.003)	(.047)	(.043)	(.038)
Mean Income (1994)		.004	-.011	-.017	-.016
		(.007)	(-.021)	(-.034)	(-.031)
Education (1994)		.000	.000	-.002	-.001
		(.001)	(.002)	(-.010)	(-.004)
<i>Family Network</i>					
Live with Spouse (1994)			-.078	-.095	-.095
			(-.035)	(-.042)	(-.042)
Live with Daughter (1994)			.244*	.269*	.251*
			(.099)	(.108)	(.101)
Live with Son (1994)			-.009	.006	.002
			(-.003)	(.002)	(.001)
<i>Health Insurance</i>				.114	.121
				(.069)	(.074)
<i>Self-Rated Health Status</i>					-.088*
					(-.108)
<i>Constant</i>	1.815	-.310	-.540	-.706	-.488
<i>Adjusted R<sup>2</sup></i>	.153	.181	.187	.190	.199
<i>R<sup>2</sup> Change</i>		.034*	.009	.004	.011*

NOTES: \*p<.05; \*\*p<.01

explaining almost 20 percent of the variation in equipment self-care. A significant R<sup>2</sup> change was also reflected in between Models 9 and 10.

Table 4.8  
 Unstandardized Regression Coefficients  
 for Environmental Self-Care  
 Among Elderly Black Women  
 ( Standardized Coefficients in Parentheses)  
 Number of Cases=613

	<b>Models</b>				
	11	12	13	14	15
<i>Health Values</i>	-.079* (-.092)	-.070* (-.081)	-.071* (-.082)	-.070* (-.082)	-.025 (-.064)
<i>Demographic</i>					
Age (1994)		.006 (.056)	.006 (.054)	.055 (.053)	.005 (.048)
Married (1994)		.026 (.017)	-.012 (-.008)	-.011 (-.008)	-.015 (-.010)
Mean Income (1994)		-.034* (-.095)	-.032* (-.088)	-.031 (-.087)	-.031 (-.085)
Education (1994)		-.002 (-.012)	-.002 (-.013)	-.002 (-.011)	-.001 (-.008)
<i>Family Network</i>					
Live with Spouse (1994)			.042 (.027)	.044 (.028)	.044 (.028)
Live with Daughter (1994)			-.010 (-.015)	-.028 (-.016)	-.035 (-.020)
Live with Son (1994)			-.028 (-.015)	-.029 (-.015)	-.031 (-.016)
<i>Health Insurance</i>				-.010 (-.009)	-.008 (-.007)
<i>Self-Rated Health Status</i>					-.036 (-.062)
<i>Constant</i>	.190	-.199	-.129	-.144	-.025
<i>Adjusted R<sup>2</sup></i>	.007	.014	.010	.008	.010
<i>R<sup>2</sup> Change</i>		.013	.001	.000	.003

NOTES: \*p<.05; \*\*p<.01

The beta coefficients in Model 7 show that the effect of health value ( $\beta = -.379$ ) on equipment self-care decreases compared to Model 6 ( $\beta = -.393$ ) when mediated by demographic variables. However, the only significant demographic predictor was age



( $\beta = .185$ ). The addition of the interpersonal variables did not have an impact on the effect of health value ( $\beta = -.379$ ) on equipment self-care. Living with a daughter ( $\beta = .099$ ) was the only significant interpersonal predictor in Model 8. The effect of health value ( $\beta = -.381$ ) decreased in Model 9 with the addition of the health insurance variable, which was not a significant predictor. Finally, in Model 10 the effect of health value ( $\beta = -.350$ ) is about four-fifths its original size when mediated by the respondent's Self-Rated Health status and the other independent variables. Self-Rated Health status ( $\beta = .108$ ) was also a significant predictor of equipment self-care.

#### *Environmental Self-care*

A series of regression were also conducted for environmental self-care on the dependent variables. No significant  $R^2$  change resulted through Models 11 through 15 in a cross model comparison.

The standardized regression coefficients for environmental self-care and the independent variables are presented in Table 4.8. The overall hypothesized model (15) manifested no significant predictors with the dependent variable. The preceding models had some significant relationships however. When health value was mediated by socio-demographic variables in Model 12, only health value ( $\beta = -.081$ ) and annual income ( $\beta = -.095$ ) were significant variables. The addition of the interpersonal mediating variables resulted in no further significant predictors in Model 13. Both health value ( $\beta = -.082$ ) and annual income ( $\beta = -.088$ ) remained negative and significant in this model. In model 14, only health value ( $\beta = -.082$ ) had a significant relationship with the dependent variable environmental self-care.

### Phase I: Discussion

Concentrating on elderly Black women in this analysis of self-care gives us new knowledge about the phenomenon of healthcization or surveillance medicine. Hill Collins (2000a: 44) believes that “centering on Black women's experiences produces not only new knowledge but new ways of thinking about such knowledge.” Using the Longitudinal Study on Aging II to examine the traditional concepts of self-care debunks the idea that elderly Black women practice self-care in the same ways as other groups. For example, the traditional behavioral self-care categories such as taking vitamins or trying to lose weight, which were pervasive throughout the Longitudinal Study on Aging, were not even viable as variables that could be used in the analysis of self-care among Black women. The Longitudinal Study on the Aging II 2000 dataset had several items that could measure self-care concepts, but the response rate on these items for Black women was very poor. Therefore, it can be concluded that many cultural norms around Black women’s healthcare were not captured by this dataset. Public policy can address this deficiency by funding research that seeks to address cultural differences among under-represented samples – e.g. Black women – versus the rest of the population.

The intersection of being elderly, Black and female was therefore useful in clarifying these results, because this highlights different conclusions from those outlined in the literature review. Healthcization trends are indeed present among elderly Black women, but these trends are manifested differently from those in the general population.

Of the three types of self-care that were analyzed, the equipment self-care segment (see Table 4.7) provided the strongest explanation (approximately 20 percent) of the impact of health values and the other independent variables. Health values remain a

strong, albeit negative predictor of equipment self-care across five models in Part 2. This provides some answers for the stated research questions.

Elderly Black women's health values seem particularly useful in explaining their use of equipment in self-care. When women believe that they are debilitated, they are less likely to either incorporate or desire things such as walkers, wheelchairs, and scooters to assist them with their ADLS and IADLs. Hence, elderly Black women who are more ambulatory make the decision to use equipment self-care, because it affords them greater individual accountability over their lives (i.e., fulfilling their personal responsibility crusade), and this indicates that they accept some aspects of healthcization as they value sound health.

Although health value is the concept in the literature with the least supporting evidence, the findings still refute the position in the literature that seniors with serious impairments are more likely to be dependent on the use of equipment in their self-care (Kincade Norburn et al., 1995). Rather, for elderly Black women, healthcization may propel them towards adopting this equipment so that they may not only remain ambulatory, but also independent. This surprising finding is also supported by the variable which measures the respondents' Self-Rated Health status. Self-Rated Health status also had a significant relationship with equipment self-care: when the women thought their health was excellent, they were more likely to incorporate or desire equipment in their self-care.

The healthcization theory can also explain these women's position. Obviously, equipment use is seen as essential in maintaining healthy lifestyles for many elderly Black women. Equipment self-care assists elderly Black women in taking care of many

of their regular daily activities – or, more succinctly, they can take ownership of their “Personal Responsibility Crusade”, that is, individual accountability instead of being dependency on existing social institutions (Hacker, 2008). Based on the findings in this research, an explicit relationship exists between equipment self-care and a type of health value which emphasizes the individual’s moral responsibility and accountability for the individual’s own healthcare (Zola, 1972). Therefore, the underlying values inherent within the surveillance medicine phenomenon (Armstrong, 1995) are evident within the elderly Black female community.

Hill Collins (2000a) posits that this characteristic of independence in the Black woman is a focal point of Black Feminist Thought. This is presented in the literature as a component of the emergent Black woman who struggled historically to form her own positive self-definition. Because Black women such as those in the sample, as well as their female kinfolk, struggled to overcome hardships, they became fiercely protective of their independence. This area of the research offers the most solid example of the intersectionality paradigm, as the need to be independent is quite pervasive within the female elderly Black demographic.

Based on the literature, another significant predictor of equipment self-care that was anticipated was the positive relationship with living with one’s daughter.

Traditionally, a hallmark of femininity within the Black community is women’s role as caregivers (Hill Collins, 2000a). What is revealing about this finding, however, is that even outside of giving of themselves as caregivers, Black daughters seem to have a positive impact on their elderly mothers’ use of equipment self-care for their ADLs and IADLs. It can be concluded that the ethics of caring is deeply ingrained in Black

daughters (Hill Collins, 2000a; Gilligan, 1995, Sichel 1989); so while the mother (if she has the capacity) chooses to practice self-care, she is also encouraged by her daughter.

Finally, regarding equipment self-care, the results from the analysis seem to contradict the evidence from the literature. The results indicate that equipment self-care increases as Black women age; however, Upchurch and Mueller (2005) concluded that younger senior citizens were more likely to practice self-care, and Kincade Norburn et al. (1995) concluded that the middle age elderly population (between 75 to 84 years of age) were more likely to do so. This further points to another difference between the subset of elderly Black women and the entire elderly population in the U.S.

While the explanations which resulted from Part 1 (behavioral) of the self-care Logic Model were not as conclusive as those in Part 2 (equipment self-care), there were nevertheless some fair results. At its best, the overall model in Part 1 explained 8.4 percent of the variance in behavioral self-care. Behavioral self-care is easier to practice than equipment and environmental self-care because it is neither limited by cost factors, nor requires expertise necessary to operate equipment or modify the environment. This may be the explanation for the primary predictor (health value) not being significant, in that it is expected that everyone should practice some type of behavioral self-care, so it is not attached to any explicit value system. Hence, in this situation, elderly Black women's health values do not adequately explain their decision to use behavioral self-care.

Consistent with the findings from equipment self-care, Self-Rated Health status was also a significant predictor of behavioral self-care among elderly Black women. Again, this is an indication that Black women who think of themselves as having excellent health want to maintain that status, so they are the ones who will report that

they are more active than in the previous year. Kincaid Norburn et al. (1995) reported similar findings in their research which showed that the practice of self-care methodology is precipitated by some amount of impairment, but decreases drastically with severe impairment. Elderly Black women seem to have adapted some of the values inherent in behavioral self-care. The women seem to accept that they are responsible for maintaining their good health (if they believe they have it), thereby not allowing themselves to be perceived as disabled.

Surprisingly, the results indicate that elderly Black women are less likely to practice behavioral self-care if their sons live with them. This finding can be explained by evidence from the literature illustrating that the presence of some family members can inhibit self-care or person-directed care (Power et al., 2006). It can be concluded that the sons of these elderly Black women were not instilled with the same level of the ethics of caring as their sisters (Hill Collins, 2000a; Gilligan, 1995, Sichel 1989). Therefore, the sons may not support their mothers' need to be in charge of taking care of themselves. Hence, while it was more likely for Black daughters to approach the care of their mothers driven by their hearts (which is central to the ethics of caring), Hill Collins (2000a) says that this was not the same for Black men. It is not that daughters are more caring, but they care in different ways, empowering their mothers rather than doing things for them. Black Feminist Thought posits that Black men still have to “resolve the contradictions that confront them in redefining Black masculinity in the face of abstract, unemotional notions of masculinity imposed on them” (Hill Collins 2000a: 264), which may explain their difficulty with caring as much as Black women.

Based on the achieved results, the independent variables did not offer the same, or as powerful an explanation, for environmental self-care as the other two types of self-care. One of the primary reasons for the negligible relationship between health values and environmental self-care may be the prohibitive cost component. An earlier observation in the literature review was that of the three types of self-care, environmental self-care was practiced the least because of the substantial expenditure that it required (Kincade Norburn et al., 1995).

### Phase II: Introduction

Most elderly Americans need some assistance with their ADLs because of physical limitations associated with aging. For example, the discourse around homecare does not investigate the motivation behind the decision to use these services. This section of the dissertation analyzes the relationship between health value and the use of homecare services. Some women who do not have a choice of whether or not someone should come in and bathe them, etc. Therefore, at one end of a continuum are some women who actively advocate, plan, save and pay for their own homecare services, because they know that a CNA can help them keep track of their medication or be present if they fall getting out of the shower. At the other end of that continuum are women

Table 4.9  
Descriptive Statistics  
Elderly Black Women's Homecare Use  
(N=642)

Variable	Mean	SD	Range	Alpha
<b>Dependent Variables</b>				
<i>Homecare 2000</i>	18.142	2.721	10 - 20	.895

Table 4.10  
Comprehensive Description of  
the Homecare Variables

Variable	Mean	SD	Range	Label
<i>Dependent Homecare Use</i>				
Bathing	1.25	.435	1 No – 2 Yes	Receive Help with
Dressing	1.19	.395	1 No – 2 Yes	Receive Help with
In/Out Bed	1.14	.350	1 No – 2 Yes	Receive Help with Getting
Walking	1.16	.366	1 No – 2 Yes	Receive Help with
Meal Prep	1.21	.411	1 No – 2 Yes	Receive Help with
Shopping	1.43	.495	1 No – 2 Yes	Receive Help with Grocery
Money	1.22	.413	1 No – 2 Yes	Receive Help with Managing
Telephone	1.09	.288	1 No – 2 Yes	Receive Help with Using
Housework	1.23	.425	1 No – 2 Yes	Receive Help with Light
Medication	1.16	.367	1 No – 2 Yes	Receive Help with Managing

who believe that having someone assist them with basic daily activities compromises their independence. This section of the dissertation analyzes the relationship between homecare use and health values, to weigh whether recipients have specific motivations for someone coming into home to take care of them.

#### The Parameters of Homecare

Descriptive statistics for homecare use by elderly Black women are presented in Tables 4.9 and 4.10. Table 4.9, which details the sample's receipt of homecare services, indicates a relatively high mean usage (18 out of 20). Table 4.10 provides further details on the ten variables that were used to create the composite Homecare 2000 variable in Table 4.9. Homecare 2000 is used as the dependent variable for further analyses in Phase II.



Table 4.11  
 Unstandardized Regression Coefficients  
 for Homecare Use  
 Among Elderly Black Women  
 ( Standardized Coefficients in Parentheses)  
 Number of Cases=642

	<b>Models</b>				
	1	2	3	4	5
<i>Health Values</i>	-.446** (-.184)	-.423** (-.175)	-.419** (-.173)	-.420** (-.173)	-.348** (-.144)
<i>Demographic</i>					
Age (1994)		.033** (.115)	.035** (.120)	.035** (.120)	.032** (.112)
Married (1994)		.072 (.071)	-.056 (-.013)	-.057 (-.014)	-.077 (-.019)
Mean Income (1994)		.040 (.040)	.020 (.019)	.018 (.018)	.021 (.021)
Education (1994)		-.041* (-.083)	-.039* (-.079)	-.040* (-.081)	-.030 (-.071)
<i>Family Network</i>					
Live with Spouse (1994)			.202 (.045)	.199 (.611)	.200 (.045)
Live with Daughter (1994)			.192 (.039)	.196 (.040)	.162 (.033)
Live with Son (1994)			.321 (.060)	.323 (.060)	.314 (.059)
<i>Health Insurance</i>				.020 (.006)	.033 (.240)
<i>Self-Rated Health Status</i>					-.168* (-.104)
<i>Constant</i>	13.453**	10.924**	10.206**	10.177**	10.596**
<i>Adjusted R<sup>2</sup></i>	.032	.047	.048	.046	.054
<i>R<sup>2</sup> Change</i>		.020**	.005	.000	.010*

NOTES: \*p<.05; \*\*p<.01

Table 4.11 presents the relationship between homecare use and several independent variables. Model 1 displays the relationship between homecare use and health values. For Model 1, the R<sup>2</sup> statistics indicate that only 3.2 percent of the variance

in homecare services is explained by health values. In the second model, health value and four socio-demographic variables (age, marital status, annual income and education) were regressed on the dependent variable. This accounted for 4.7 percent of the variance in homecare. Model 2 also represents a significant R<sup>2</sup> Change (.020) over Model 1. In the third model, three interpersonal variables (living with spouse, son or daughter) were entered into the regression; this raised the explanatory power of the independent variables incrementally to 4.8 percent. In the fourth model, to better understand how the effect of values on homecare use by elderly Black women changed with insurance status, the variable public/private insurance was added as a predictor. This addition decreased the explanatory power to 4.6 percent. Finally, in model 5, the women's Self-Rated Health status was included, and this overall model resulted in 5.4 percent of the variance in homecare. A cross-model comparison also demonstrates a significant R<sup>2</sup> Change (.010) Between Models 4 and 5 with the addition of the Self-Rated Health status variable.

The standardized regression coefficients in Table 4.11, Models 1 through 5, demonstrate that the effect of health value on homecare remains significant across the models. Using the standardized beta scores for the ease of cross model and cross variable comparison, the simple regression between homecare use and health values resulted in  $\beta = -.184$ . Model 2, with the inclusion of the socio-demographic control variables, resulted in a decrease in the effect of health value ( $\beta = -.175$ ) on homecare use, over Model 1. Additionally, age ( $\beta = .115$ ) and educational attainment ( $\beta = -.083$ ) were the only significant socio-demographic predictor in Model 2. The addition of the interpersonal predictors in Model 3 decreased the effect of health value ( $\beta = -.173$ ) on homecare use. However, none of the interpersonal variables had a significant relationship

with homecare in the model, but age ( $\beta = .120$ ) and educational attainment ( $\beta = -.079$ ) continued to be significant. Model 4 did not result in any changes in the effect of health value. Finally, in Model 5, the effect of health value ( $\beta = -.144$ ) on homecare use also decreased with addition of the women's Self-Rated Health status. While Self-Rated Health status was significant in this regression ( $\beta = -.104$ ), age ( $\beta = .112$ ) was the only other significant variable in Model 5.

### Phase II: Discussion

The literature is silent on the motivations that drive elderly Black women's use of homecare services. Health values are indelibly linked to the motivation behind healthcare decision making, as they are an indication of the need to achieve a preferred health status. An important finding established by this research is the significant relationship between homecare use and health values. Although the health values explain only a small percentage of the variance in homecare use, it is possible to make two important conclusions from this result. First, it demonstrates that elderly Black women wanting to be seen as having good health are less likely to be receiving homecare services. As noted in the discussion of self-care and values in Phase I, the elderly Black women want to establish themselves as independent; therefore when they reject the label of feeble they are less likely to be homecare service recipients. Rose and Miller (1992) pointed out that such motivations are the hallmark of healthicization. Many elderly Black women are motivated to be active participants in their own healthcare in order to be healthier – this includes performing their own ADLs and IADLs. Additionally, the motivation behind

this individualistic value exonerates the medical establishment from being responsible for the individual's well-being (Hislop and Arbor, 2003).

The second conclusion from homecare use's significant relationship with health values is that elderly Black women who believe that others do not see them as disabled use homecare services less. In one of the few references to value-driven homecare in the literature, Yamamoto and Wallhagen (1997) pointed out that members of the elderly's social network can influence the use of homecare services. For elderly Black women the influence of members in their network manifests itself in shaping the women's health values. Black women seem to care how others perceive them, and they also use impressions of others to manage their own identity. An important vestige of Black Feminist Thought is the power Black women seek in forming their own identity (Crenshaw, 1991). The inference made from the results is that Black women do not want to be viewed as feeble. A surprising conclusion being presented here is that Black women may be giving up some of the power in shaping their own identities. Alternatively, the conclusion can be drawn that the healthicization trend is responsible for this value-orientation. The elderly Black women in this sample use both what they and others think about their well-being to monitor their own healthcare choices. This position evolves from the healthist culture (or healthicization), which implies that the health values and practices of the individual are judged by others and can determine moral worth (Hislop and Arber, 2003).

The healthist culture can therefore have positive and negative consequences for elderly Black women. Black women who are perceived by themselves and others as too feeble to take care of their own ADLs and IADLs may be viewed as deviant, and this

perception can actually influence their decision to use homecare service. This can be positive if the women assert their independence by taking care of their own daily needs; and it can be negative if women who need help are hesitant to seek it so they are not seen as feeble.

Another significant indicator of homecare use for elderly Black women is the natural process of aging. This is consistent with the evidence from the literature that the older old use more homecare services (Feller, 1983). Additionally, within the older old population cohort, women receive a greater proportion of the homecare services compared to men (Dey, 1996). This is consistent with the trend of homecare services being more important to aging women than to aging men. The assumption could therefore be made that motivation driving homecare use is more of an issue for older old women, compared to women less than 75 years old and elderly men.

The state of the women's health (Self-Rated Health status) is also a significant mediating variable in the homecare use and health values relationship. This speaks loudly to the motivation behind homecare use, in contrast to the position in the literature that low health status is not a predictor of homecare use (United States Senate, 1986). The negative significant relationship demonstrates that healthier elderly Black women are more likely to use homecare services, or make the decision to get in-home assistance. This reinforces that elderly Black women have bought into the concept of healthcization. Healthy elderly Black women acknowledge their personal responsibility for their own well-being (Hacker, 2008), so they are willing to get assistance in the home, and delay their reliance on the medical establishment.

CHAPTER 5  
PHASE III RESULTS: THE RATIONALIZATION OF HOMECARE  
THROUGH SELF-CARE

Introduction

In an effort to build on the findings produced by the regression analysis, a complementary method was used to examine how elderly Black women make healthcare decisions. Chapter 5 examines the premise that health values (preference for certain health conditions) influence attitudes towards the adoption of healthicization norms (the promotion of healthy lifestyles) in everyday life, which then have an impact on the practitioners' quality of life (such as reducing the dependence on homecare services). Another stipulation in this research is to investigate whether this is a rational premise for the sample of elderly Black women. Therefore, as previously stated in the Methodology chapter, the analysis in this chapter is driven by two research questions. The first asks whether health values have an impact on the decision to practice self-care. The second research question examines whether elderly Black women who practice self-care are more or less dependent on homecare use.

Black feminist thought is a credible anchor for an analysis of elderly Black women's involvement in healthcare. The theoretical assumption is that Black women's resilience, which has resulted from the many conflicts they have faced as they navigate their multiple roles and identities on a daily basis, shapes their attitudes towards healthcare (Jones and Ford, 2008). The perspective that Black women's psychological fortitude and resilience have been shaped by their historical struggles is therefore an underlying assumption of this Structural Equation Modeling (SEM) analysis.

The term Homecare Dependency in this chapter is not used in a negative manner. It is neither an indictment of the women who use the service because they cannot “help” themselves; nor is it recriminatory toward women who do not use such services (as being irresponsible guardians of their own health). Rather the term Homecare Dependency is primarily operationalized as a measurement concept that recognizes that some elderly people need – or choose – to use assistance at home, while others do not. It is standard to measure homecare need and use in this manner, as shown in Republic of Ireland’s Fair Deal (2008) for nursing homes and homecare. This government paper shows how nursing home and homecare need can be quantified as medium dependency, high dependency or maximum dependency. This measurement construct recognizes that factors that can lead to Homecare Dependency include (but are not limited to) increase in physical weakness and psychological stressors (Boggatz and Dassen, 2005).

Self-care practices by senior citizens have been advanced as enlightening activities that can improve practitioners’ lives. Various studies claim that self-care can be used to promote health and prevent disease but there is little research on tangible outcomes (Dill, et al, 1995; Conrad, 1994). Two contradictory studies indicate opposing findings about the impact of self-care on health practices and outcomes. The first study demonstrates that self-care *education* (not specifically self-care practices) has a statistically significant effect on decreasing medical visits and reducing medical payments (Vickery, Golaszewski, Wright, and Kalmer, 1988). However, the second study shows that among a sample of patients, self-care agency was unrelated to quality of life indicators (Smolen and Topp, 2001). This prior research helps to set the stage for further analysis which can help to clarify the discussion.

This chapter presents a causal model which explains a dimension of the healthcare decision process. The conscious decision to practice self-care (such as a regular exercise routine) can be seen as a component of the healthicization trend. As elucidated in the previous chapters, this type of self-care also imposes upon the individual the ideals of personal responsibility (Hacker, 2008). Healthicization is viewed as the approach that encourages lifestyle practices and environmental modification to enhance and maintain individual health.

Through SEM using AMOS version 17 the analysis in Chapter 5 investigates nuances in healthcare behavior variables by focusing on causal effects that occurred in the past. SEM is appropriate in this case, as the intention is to make inferences about the causality for self-care practices, and ultimately the use of homecare services. SEM researchers including Heise (1969) believe that when making predictions about past causality to future possibilities, it is appropriate to use SEM because it

...defines a set of equations which, in some sense corresponds to actual causal processes in the real world; that is, one seeks a set of equations which permit prediction of how change in any one variable in system affects the values of other variables in the system (Heise, 1969, p.41).

The hypothesis that drives the investigation in Chapter 5, therefore, is that the healthicization concepts can be measured by a three-factor model: Health Values; healthicization practice (e.g. Self-Care activities); and outcome (e.g. homecare dependence).

This builds on the previous results chapters, which focused on an analysis of the relationship among these three variables. The assumption is that what holds true for the sample, will most likely be reflected in the target population. Thus the causal relationship



is that health values influence self-care; and self-care in turn impacts homecare. This is first examined by determining the goodness-of-fit between the sample of elderly Black women and the population of elderly Black women in the United States. The formal hypothesis is expressed as:

$$H_o: \Sigma = \Sigma(\theta) \text{ }^{11}$$

This null hypothesis asks whether the overall model (including the factor loadings, factor variances, covariances and error variances) are indeed valid.

#### Homecare – A Measurable Outcome of Self-Care

The constructs of the preliminary model (see Figure 3.3. in Chapter 3) were operationalized using several scale interval measures from the National Health Interview, Longitudinal Study on Aging. Table 5.1 shows the descriptive statistics for the endogenous variables in the SEM analysis. The three latent constructs that were used to represent the healthcare decision-making process were Self-Care, Health Values and Homecare Dependency. With AMOS, the three latent constructs were then each measured by three observed, endogenous variables.

As it relates to the three variables that measured Self-Care, the average behavior change (3.22) indicates that the elderly Black women were less likely than White women to practice self-care by modifying their behavior. Secondly, an average of 10.71 also demonstrates that most of the sample did not incorporate equipment in their self-care regimen. Finally, just over half of the sample (with an average reported environmental

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<sup>11</sup>  $\Sigma$  - represents the population covariance matrix; set out by the hypothesized model (Bryne, 2001)

$\Sigma(\theta)$  – represents the restricted covariance matrix

Table 5.1  
Descriptive Statistics of  
Endogenous Variables  
Elderly Black Women Sample  
(N=642)

Variables	Mean	SD	Range	Alpha
<i>SELF-CARE</i>				
Behavior Change	3.22	1.079	2 Low – 5 High	.602
Equipment Use	10.71	1.034	10 Low – 15 High	.601
Environmental Modification	20.63	1.727	12 Low – 30 High	.724
<i>HEMOCARE DEPENDENCY</i>				
Interpersonal Network (Live with)	3.46	.606	3 Alone – 6 ≥3 people	.680
Activities of Daily Living (ADLs)	7.84	1.084	7 Low – 14 High	.836
Instrumental ADLs	7.75	1.106	6 Low – 12 High	.820
<i>HEALTH VALUES</i>				
Will to Live	9.57	.806	0 Low – 10 High	
Driving Values	3.58	.726	2 Low – 4 High	.937
Self-Rated Health	2.82	1.083	1 Low – 5 High	

modification of 20.63) had upgraded their residences to facilitate self-care coping methods.

As noted in Chapter 5, the alphas for the composite variables behavioral self-care and equipment self-care are not very strong (.602 and .601 respectively). The decision was made to use these items nevertheless, as they were appropriate to validate the major tenets of the research questions. Additionally, the items that were used in the computation had relatively low numbers of missing cases, which made the tests more reliable.

Table 5.2  
Comprehensive Description of  
SEM Self-Care Variables

Variable	Mean	SD	Range	Label
<i>Dependent Behavior Change</i>				
Level of Activity (1994)	1.72	.582	1 Less – 3 More	Compared to 1 year
Exercise (1994)	1.50	.442	1 No – 2 Yes	Regular Routine
<i>Equipment Use</i>				
Variable Computation outlined in Table 4.2				
<i>Environmental Modification</i>				
Variable Computation outlined in Table 4.2				

Another three endogenous variables were used to measure homecare dependence. The first variable, interpersonal network, examines who lived with these elderly women. An average of 3.46 indicates that the elderly Black women who made up our sample were more likely to live alone, than to live with someone. For both the Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) variables, it is seen that most of the sample believe that they needed assistance with most daily personal care task and regular chores. The average ADLs and IADLS scores were 7.84 and 7.75 respectively.

Three endogenous variables were also used to measure the Health Values construct. The variable Will to Live indicates that the women had a very high desire to stay alive, as the average was 9.57. The item Self-Rated Health supports the Will to Live variable, as most of the women had a positive view of their own health (average=2.82). Driving Values, which is another measure of the women's perceived health was also

strong. The score on that manifest variable was 3.58 out of 4, which is an indication of a positive regard for self.

As indicated by the alpha column in Table 5.1, most of the observed, endogenous variables that were used to test the hypothesized model are composite variables. Only the variables Will to Live and Self-rated Health were not computed from two or more variables. Additionally, the operationalization of at least three of these variables can be found in Chapter 4, as they were previously used in the regression analysis.

A further breakdown of the endogenous Self-Care measures is displayed in Table 5.2. Behavior change was computed from two items that indicated the respondents' deliberate incorporation of exercise in their daily lives. The output was mixed from these two variables. First a mean score of 1.72 level of activity compared to a year ago, meant that for most of the sample, deliberate attempts at calisthenics remained the same compared to a year ago. The second variable indicated that most of the sample did not have a regular exercise routine (mean score=1.50, SD=.442). The computation of the composite variables equipment use and environmental modification was previously outlined in Table 4.2 (as equipment and environmental self-care) to facilitate the regression analysis. Both endogenous constructs were computed from ten items each.

The endogenous variables that were used to measure the latent construct Homecare Dependency (Table 5.3), were all operationalized for the SEM analysis. The first variable, interpersonal networks, was computed from three items about whether the respondents lived with their spouse, son or daughter from the 1994 Survey on Aging. Table 5.3 indicates that the elderly Black women in the sample were more likely to be living alone. However, of those respondents who reported living with a specified relative

Table 5.3  
Comprehensive Description of  
SEM Homecare Dependency Variables

Variable	Mean	SD	Range	Label
<i>Dependent</i>				
<i>Interpersonal Network</i>				
Spouse	.190	.393	0 No – 1 Yes	Live with
Son	.122	.327	0 No – 1 Yes	Live with
Daughter	.148	.355	0 No – 1 Yes	Live with
<i>Activities of Daily Living (ADLs)</i>				
Bathing	1.252	.434	1 No – 2 Yes	Receive Help
Dressing	1.192	.395	1 No – 2 Yes	Receive Help
Eating	1.047	.213	1 No – 2 Yes	Receive Help
Getting in & out of Bed	1.142	.350	1 No – 2 Yes	Receive Help
Walking	1.159	.366	1 No – 2 Yes	Receive Help
Using the Toilet	1.086	.281	1 No – 2 Yes	Receive Help
Preparing Meals	1.214	.411	1 No – 2 Yes	Receive Help
<i>Instrumental ADLs</i>				
Grocery Shopping	1.426	.495	1 No – 2 Yes	Receive Help
Managing Money	1.217	.413	1 No – 2 Yes	Receive Help
Using the Phone	1.091	.288	1 No – 2 Yes	Receive Help
Doing Heavy Housework	1.536	.500	1 No – 2 Yes	Receive Help
Doing Light Housework	1.235	.425	1 No – 2 Yes	Receive Help
Managing Medication	1.160	.367	1 No – 2 Yes	Receive Help

they were more likely to: live with a spouse (mean=.190) and least likely to live with a son (mean =.122).

As detailed in table 5.3, the major distinction between the ADL and the IADL variables is that the first set of items are done *to* the elderly person to ensure that they can navigate their daily lives comfortably and with dignity; while the second set of items are done *for* the client to maintain structure in their lives. The mean scores for each item were all below 1.50 (except heavy housework, mean score = 1.536) which indicate that on average these elderly Black women were not assisted at home with their personal activities. The conclusion can therefore be drawn here these women did not express a

relatively high amount of Homecare Dependency. This situation could have resulted from limited access rather than a rejection of homecare assistance.

In measuring the latent construct Health Values, only one composite variable was used (Driving Values). The operationalization of this variable was previously outlined in Table 4.3, and in the earlier computation Driving Values was called Health Values, therefore the same statistical description applies, which indicates that most of these women see themselves as able-bodied. The other two observed, endogenous variables (Will to Live and Self-Rated Health) are original scaled items from the Longitudinal Study on Aging, 2000, and they were presented in Table 5.1.

#### A Causal Explanation of Homecare Dependency

To evaluate the overall fit of the model a  $\chi$ -square statistics, degrees of freedom (DF), Goodness-of-fit Index (GFI), Root Mean Square Error Approximate (RMSEA), and the  $p$  value for the Test of Close Fit were calculated and reported. Satisfactory results would require the  $\chi$ -square to be approximately twice its degree of freedom or smaller, the GFI to be above .900, the RMSEA to be below .05, and the Test of Close Fit to be above .05 (Bryne, 2001). The notes for the hypothesized model produced by AMOS suggest that this is an over-identified model; hence the output is valid for the analysis. The various model fit statistics did not unanimously indicate that the model was a good fit for the data. However, there were sufficient significant model fit statistics to indicate that the sample explained causal relationships in the population.

The test of healthcization, comprised of three-factor structure as depicted in Figure 5.1 yielded a Chi-square ( $\chi^2$ ) of 106.21, with 26 degrees of freedom, and a

Table 5.4  
 Maximum Likelihood Estimates of Self-care  
 and Homecare Dependency by Elderly Black Women  
 with Associated Error Terms in Recursive Model  
 (N=642)

	Y <sub>1</sub>	Y <sub>2</sub>	Y <sub>3</sub>	res <sub>b</sub>	err <sub>i</sub>
Health Values (Y <sub>1</sub> )	---	-.414*** (.048)	---	---	1.000
Self-Care (Y <sub>2</sub> )	---	---	.653*** (.122)	.128** (.048)	---
Homecare Dependency (Y <sub>3</sub> )	---	---	---	.674*** (.110)	---
Driving Values	.309*** (.034)	---	---	---	.441*** (.027)
Self-Rated Health	1.000	---	---	---	.367*** (.070)
Will to Live	.019 (.036)	---	---	---	.649*** (.036)
Behavior Change	---	-.724*** (.124)	---	---	1.015*** (.064)
Equipment Use	---	1.000	---	---	.788*** (.065)
Environmental Modification	---	-.199 (.164)	---	---	2.967*** (.166)
Interpersonal Network	---	---	.039 (.030)	---	.366*** (.020)
ADLs	---	---	.963*** (.133)	---	.438*** (.102)
IADLs	---	---	1.000	---	.429*** (.109)

\*p<.05; \*\*p<.01; \*\*\*p<.001

Notes: Numbers are unstandardized slope coefficients with standard errors in parenthesis.

probability of less than .001 ( $p=.000$ ), thereby suggesting that the fit of the data to the hypothesized model is not entirely adequate. That is, the chances of Health Values causing self-care practices, which would then cause Homecare Dependency, is an unlikely event, (less than one time in a thousand under the null hypothesis) and is then rejected.

On the other hand, both the goodness-of-fit index (GFI) and the adjusted GFI (.962 and .935 respectively) are indicative that the model is a good-fit to the sample data. The parsimonious GFI offers an even more realistic evaluation of the hypothesized model by taking into account the complexity of the model (the number of parameters being estimated). The parsimonious fit index of .566 along with GFI of over .90, compensates for the non-significant  $\chi^2$  reported earlier.

The Root Mean Square Error of Approximation (RMSEA) of .069 indicates that the sample is representative of reasonable errors of approximation in the population. That is, the RMSEA helps to answer how well this model with optimally chosen parameter values, would fit the population. Byrne (2001) indicates that a model whose RMSEA is .10 or more has a poor fit (ideally it should be less than or equal to .05). It is therefore appropriate to make valid inferences from the achieved RMSEA of .069 for this causal health care model. This means that there is a 90 percent chance that the true RMSEA will fall within the bounds of .056 and .083, which is a fair degree of precision. However, the Test of Closeness of Fit (.010) is smaller than .05 and so it does not support the RMSEA; the data does not fit the hypothesized model well.

The next stage of the analysis tests the measurement model. The SEM analysis is appropriate for this causal analysis, as it produces maximum likelihood estimates, which



increases the chance that the obtained values (those in ellipse in Figure 5.1) will be correctly predicted. From the methodology chapter, Figure 3.3 outlined a preliminary hypothetical model of how the variables should be tested. When run as hypothesized, the covariate relationship between Self-Care and Health Values produced an inadmissible model; hence the model was readjusted to a more linear format (see Figure 5.1) which is the basis of the analysis in Chapter 5.

Table 5.4 and Figure 5.1 present the path coefficients for all the paths in the complete model. Notably, while Table 5.4 displays both the unstandardized path coefficients and their associated standard errors; only the unstandardized parameters are displayed in Figure 5.1. The model contained eleven paths; however only five were significant. Three of the five significant parameter estimates were positive. The path coefficient associated with the unexplained error for each variable is reported in the right column across from the corresponding variable. A similar listing appears in the table for the two residuals and their corresponding unobserved, endogenous variables. All the parameter estimates are correlations  $<1.00$ , and the variances for the error terms are positive, hence these are reasonable measures.

The regression weights displayed in Table 5.4 demonstrate that only one out three observed variables had a significant relationship with each of the latent variables. For the Self-Care construct, the regression weight was fixed for equipment use at 1.00, and therefore was not estimated. However, behavior change had a significant relationship with Self-Care. The model demonstrates that when Self-Care goes down by one, behavior change goes up by .724. This is significantly different from zero at 0.000 (two-tailed).

Health Values was also tested with one of its observed, endogenous variables

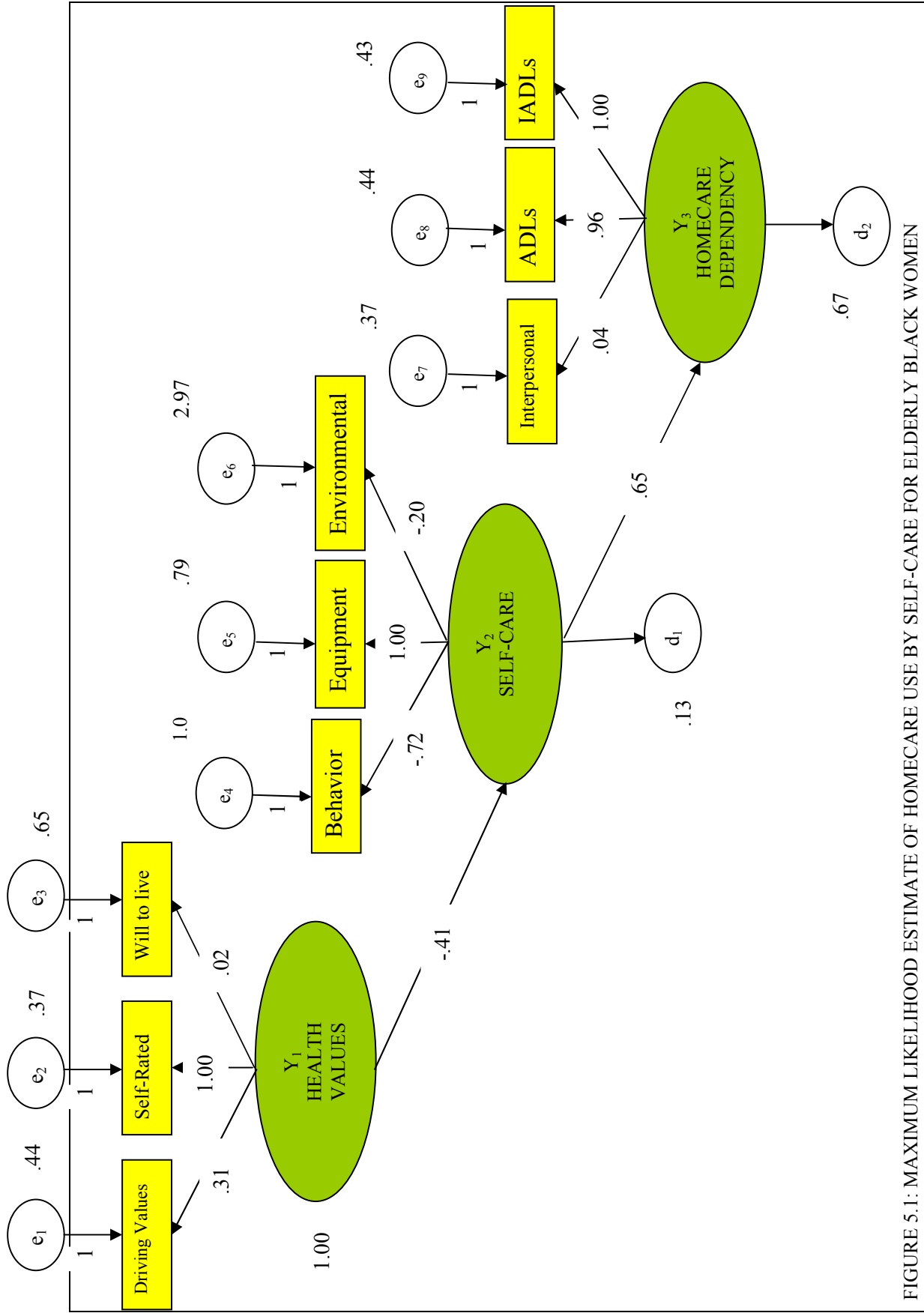


FIGURE 5.1: MAXIMUM LIKELIHOOD ESTIMATE OF HOMECARE USE BY SELF-CARE FOR ELDERLY BLACK WOMEN

(Self-Rated Health) fixed at 1.00. Driving Values had a significant and positive impact on Health Values: when this latent construct increases by one, Driving Values goes up by .309.

The path model between Homecare Dependency and the three observed, endogenous variables (ADLs, IADLs and interpersonal network) also resulted in one significant path. While IADLs regression weight was fixed at 1.000 and therefore not estimated; the model revealed that when the value of Homecare Dependency changed by one, ADLs increases by .963.

The major findings in the model (in terms of parameter estimates) are two-fold. The first finding is that Health Values have a significant relationship with Homecare Dependency, that is, it is significantly different from zero at the 0.001 level (two-tailed). When Health Values goes up by 1, Self-Care decreases by 0.414. The second finding between Self-Care and Homecare Dependency goes in the opposite direction. Therefore, when the Self-Care construct changes by one, Homecare Dependency goes up by .653.

The decision was made not to perform a post-hoc analysis, as this three-factor model was the point of interest for the SEM analysis. Of course, the hypothesized model was driven by the theory that the individual's responsibility to adopt a healthy lifestyle (healthicization) can have a significant effect on other health factors in her life. Past research on the subject suggests that the model was theoretically sound, as there has been evidence of statistically significant relationship between variables such as Self-Care education and decreased medical visits (Vickery, Golaszewski, Wright et al., 1988). Additionally, it is possible to make generalizations about the model because the AMOS output also established that there were minimal misspecifications in the model. This

Table 5.5  
 Standardized Residual Covariances  
 Self-Care by Homecare Dependency for Elderly Black Women  
 (Group number 1 - Default model)

	Self-Rated Health	Interpersonal Network	IADLs	ADLs	Environmental	Equipment	Behavioral	Driving Health	Will to Live
Self-Rated Health	-2.565								
Interpersonal Network	-.383	-.001							
IADLs	1.567	.388	-.120						
ADLs	1.332	-.457	-.140	-.116					
Environmental	.076	-2.369	.614	-1.020	-.005				
Equipment	2.323	-.672	.497	.920	.228	-.319			
Behavioral	-.121	-.387	.676	1.669	-.438	.697	-.155		
Driving Health	-2.136	.983	-1.870	-1.948	-.419	<b>-4.918</b>	-.984	-.359	
Will to Live	-.562	.825	-2.362	<b>-3.911</b>	.186	-.727	-.505	.986	-.001

summary information from the SEM analysis not only helps affirm that the three-factor model of health-care fits the data, but also that there were few areas of misfit in the model based on the model misspecification test.

The observation drawn from Table 5.5 is that only two of the standardized residuals exceed the critical cut-off point of being  $>2.58$ . Therefore the covariances between first, ADLS and Will to Live; and secondly, Equipment Use and Driving Values fit this criterion. Ultimately, these are the only two statistically significant discrepancies which resulted in the entire model. It is therefore appropriate to move on to further generalizations about our SEM results, and the causality among Health Values, Self-Care and Homecare Dependency.

### Discussion

Based on the evidence from the confirmatory factor analysis, we cannot unequivocally reject the hypothesized model. There are some appropriate model fit statistics, strong parameter estimates, as well as support from the model misspecification test, that indicate that areas of the model are valid. However, it is not possible to explicitly accept the hypothesis that this model based on the sample data is predictive of the population of elderly Black women in the United States.

In interpreting the results of the SEM analysis, it is once again noted that the validity of the proposed structural model is based on the underlying healthcization paradigm, and the preceding regression analysis (Chapter 4), which established linkages between the three major constructs.

The path analysis demonstrated empirical support for the exogenous effect of health values on self-care practices, which is a major premise of the healthcization

concept. However, the results do not follow the general rule that positive health values are associated with wellness promotion practices. That is, elderly Black women may be incorporating other forms of self-care in their lives; or they may not have accepted the variables earlier defined as typical self-care as being suitable for them. The SEM analysis therefore supports the premise that health values (or preference for positive health states or conditions) are related to low levels of self-care practices among elderly Black women. This could be an indication that this population has not accepted the rhetoric from self-care advocates that to be personally responsible for one's health is not only rational, but it is an indication of higher morals (Lorig, Kraines, Brown Jr., and Richardson, 1985; Conrad, 2005). As it now stands, the theoretical premise that healthicization is integral to elderly Black women in the United States seems invalid.

The negative relationship between positive Health Values and Self-Care is further supported by the descriptive statistics from Table 5.2 which indicate that not all Black women are active participants in what is considered traditional behavioral self-care. There is an underlying current that many of these women are not adopting these healthcare norms even though society disapproves. Implicit in the healthist culture critique is that these elderly Black women's actions will be judged by others (Armstrong, 1995). Some of the adherence to practices that are linked to healthicization may be attempts to eliminate the possible label of health deviant. This is a crucial issue for Black women, because a major feature of Black Feminist Thought is the struggle these women have had over controlling their own images (Hill Collins, 2000a). This may be the Black woman's way of saying she can do things differently. Hill Collins (2000a) points out that

resistance to controlling images such as these, is indicative of the Black woman's effort to reclaim and hold on to her independence.

The significant impact of Health Values on Self-Care can be seen as problematic, as it implies that these elderly Black women have not accepted greater individual responsibility, which would exonerate the medical profession from its role as chief guardians of health (Hislop and Arber, 2003). Based on the results from Table 5.4, Health Values' (inclusive of Will to Live, Self-Rated Health etc.) negative relationship with self-care (behavioral, equipment, etc.) may cast elderly Black women as health deviants. The counter-argument being presented in this dissertation is that the deviant designation cannot be made unless these women's practices have been elucidated (this is explored in the Chapter 6 interviews), and compared with those in the majority population.

Another important finding that results from the SEM analysis is the positive relationship between the latent constructs Self-Care and Homecare Dependency. Supporting the Health Values – Self-Care relationship, the positive relationship between Self-Care and Homecare Dependency seems to indicate that there are few manifest benefits for adopting healthcization norms. This seems to suggest that the elderly Black women who practiced self-care were also more likely to be dependent on homecare services. Again, this finding may seem puzzling (as we expected that individuals who practice self-care should be less dependent on homecare services) because it is assumed that elderly Black women's healthcare practices should be consistent with that of the general population. Such an assumption allows us to continue to trivialize these women's core values. However, elderly Black women appear to be using other information and resources to finalize their healthcare decisions. Newman (2003) observed a practice

among the elderly Black women that she studied, where they made the decision not to take medication for serious illnesses out of a need for a sense of greater control over their physical health; and perhaps there are many other similar examples. An item such as ‘not taking medication’ was not an item of care listed in the Longitudinal Study on Aging. This demonstrates that it would be inappropriate to conclude that this segment population is less likely to practice self-care.

The evidence from the literature review clearly pointed out that elderly American women are more dependent on homecare services than elderly men (Haupt, 1998; Langa, Chernew, Kabeto, and Katz, 2001). The SEM and descriptive statistics show that this was not the case for elderly Black women who had a relatively low rate of Homecare Dependency. This is evidenced by the significant, positive relationship between the observed endogenous variable ADLs and the latent construct Homecare Dependency. The descriptive statistics that preceded the SEM analysis show that most of the sample did not receive assistance with their ADLs. Therefore, the low dependency rate is based on the sample choosing not to use, or not having access to homecare services. The findings also support a prevailing (but not unanimous) view in gerontology that elderly Black people are less likely to use (and be dependent on) formal and informal homecare services than other racial groups – particularly Whites (Norgard and Rogers, 1997; Smerglia, Deimling, and Barresi, 1988).

One of the manifest variables that was used to measure Homecare Dependency was the role of close family members – that is, interpersonal network -- who could provide assistance at home (informal homecare). This relationship was predicated on the view held by many gerontologists that Blacks receive more informal homecare services



than other groups (Li and Fries, 2005). The analysis did not support this position, as the descriptive statistics clearly demonstrated that most of the elderly Black women of the sample lived alone. The conclusion can therefore be made, that these women were taking care of their own health at home as their significant others were not present in their homes.

The low dependency on homecare services can be explained by the idea that Black women have a need for independence. Hill Collins (2000a) said that this is a value passed on matrilineally because personal responsibility (as well as caring for the family and community) is essential for the Black woman's survival. It may be argued further that this kind of self-reliance is contrasted against the traditional ideals of the cult of true womanhood, where caring, assertive women take charge of their everyday lives.

Finally, the relationship between self-care and homecare is not explained very well by the common image of the strong and large Black woman who is not susceptible to fragility and ill-health (Beauboeuf-Lafontant, 2003). Such a stereotypical generalization of Black women can distort the fact that these women do care about being healthy. Evidence of this is seen from the observed endogenous variables in Table 5.4. The sample, and hence the population, preferred health conditions that are positive. This is further demonstrated by those (although limited) who have taken on healthcization norms such as behavioral self-care. Hence, since our population of interest are not making traditional health-care decisions, then it is very likely that they have other means of maintaining their health and thus their independence. This will be further illustrated by the interviews done with a sample of elderly Black women, which are presented in Chapter 6.

## CHAPTER 6 INTERVIEW RESULTS: THE ETHICS OF CARING

### Introduction

This chapter reports findings from ten in-home interviews with elderly Black women who reside in Southern Maryland. In these interviews, they explained their healthcare decision-making process. The first major aim of this research is to ascertain if the elderly Black women identified self-care methodologies as a healthcare choice, therefore the women were asked about the types of health care practices that they used. The second major aim is to identify any health values (ethics) which precipitated these practices. The final aim of this study is to examine a tangible outcome of self-care, by examining its impacts on homecare services demand by elderly Black women.

The objective of the qualitative component is first to present the narratives of these ten Black women; and secondly, to use their experiences to illustrate some of the results from the quantitative chapters. This is where the Black Feminist paradigm operates as a methodology and not simply as a theoretical framework. The ten women interviewed contributes to the evaluation of their experiences, which is a deliberate move to empower a sample that is from a traditionally marginalized group.

As indicated in the earlier chapters, self-care is defined as activities performed by the individual to maintain and promote good health. Subsequent definition of self-care in this research has also classified it as a tripartite concept inclusive of: (1) changing behavior (e.g., exercising regularly and changing one's diet); (2) equipment use (e.g., use of walkers and canes); and modifying one's environment (e.g., installing bars in the shower and ramps at the entrance). The analysis in this chapter will also incorporate a

more flexible definition of self-care, as the interviewers' opinion of self-care along with the tripartite model will be integral to the evaluation.

For this research, "homecare service" refers to assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) by paid non-medical caregivers (e.g. CNAs<sup>12</sup>, GNAs<sup>13</sup> and HHAs<sup>14</sup>). Additionally, homecare service is juxtaposed against self-care, because it is classified as a part of the formal healthcare system (Dey, 1996). The advocates of healthcization practices such as self-care imply that there are beneficial outcomes for adopting these practices (Conrad, 2005). Outcomes can include reduction in healthcare costs, maintaining healthier bodies, etc. A universal indicator for senior citizens of health and well-being is their use of homecare services.

The increasing dependence of the elderly community on homecare has been recognized by the United States government; for example, this was demonstrated when the Clinton Administration included the issue of long-term care in the in 1993-1994 Health Reform Debate (Wiener, Estes, Goldenson, and Goldberg, 2001). The importance of homecare is also manifested at the state level, for example, in New York where the elderly poor receive Medicaid-funded home health care services (De-Ortiz, 1993).

From first-hand knowledge gained while working at a private seniors' homecare agency in Maryland between June 2006 and March 2007, I became aware of the local Respite program. The program provides relief for family caregivers by providing several hours of paid homecare for their elderly relatives. In general, members of the elderly population, their families, caregivers, and also researchers in the field of aging assert that as a method of caring for the elderly, homecare works (Aronson and Neysmith, 1996).

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<sup>12</sup> Certified Nursing Assistant

<sup>13</sup> General Nursing Assistant

<sup>14</sup> Home Health Aides

A misconception that some may have about older Americans is that they are not able to manage their own healthcare. While working at the senior homecare agency, I realized that this was not entirely true. Many of the company's elderly clients called in to make their own arrangements for homecare services. These elderly clients also regularly submitted the checks for payment. Furthermore, when the elderly called to arrange their services, they were more specific than if another person made the arrangements about the caregiver they wanted (or the kind of caregiver), as well as the specific ADLs and IADLs they needed with which assistance. When the elderly client called they were apt to stay on the line longer than other members of their interpersonal network. As a result, they were more likely to engage us in conversations about their everyday lives. Additionally, since I was pregnant during the latter part of my tenure at the agency, several of the elderly women kept up-to-date on my progress. These interactions demonstrate that there are elderly clients who are very engaged with the decision to use homecare services.

An objective of this chapter is therefore to analyze if the use of homecare services by the elderly is increasingly being viewed through the neoliberal lens of healthcization. The healthcization paradigm questions whether the individual emphasizes lifestyle changes to improve their health rather than being totally dependent on the formal medical system (Conrad 2005). The proposition is that the use of paid homecare services is a prescriptive from the formal medical system. Therefore, if these ten elderly Black women are doing for themselves, that is practicing self-care, will the decision to use homecare services be contradictory? A stigmatizing effect of the healthcization paradigm casts homecare recipients as passive patients who should be transformed, and become "actively

engaged in the administration of [their] health if the treatment is to be effective and prevention assured (Rose and Miller 1992).

The ethics of caring is presented in the results of this chapter as it is a thread that runs through the healthcization paradigm. Home-care recipients such as the elderly Black women in this study are not simply agents being ministered to, but are active participants in the caring relationship. The ethics of caring cautions against intruding on and overriding the elderly person's prerogative to make healthcare decisions.

Furthermore, proponents of self-care believe that it is the individual's responsibility to be fully in-charge of their own wellness. The way that these elderly Black women manage all aspects of their health, including their use of homecare services, can be debated using the ideals of the self-governing of health (Rose and Miller 1992).

The findings presented in this chapter focus first on the identities of these women and the social context of healthcare decision making. Secondly, there is an evaluation of what elderly Black women identify as self-care, and the ethics of (or values driving) self-care. Finally, there is an examination of the relationship between self-care and homecare.

#### Description of Interview Respondents

The interviews were conducted between February and June 2008. Table 6.1 provides the names of the ten respondents along with a synopsis of some common characteristics. Throughout this chapter the women who participated in the interviews will be identified by pseudonyms in order to guarantee their anonymity. The sample of elderly Black women was made up of five homecare clients and five who did not get assistance with their ADLs, as the intention was to see how different segments of the

target population respond to self-care. In terms of demographic characteristics, the average age of all the women interviewed was 77.6 years, ranging from 65 to 97 years old.

All the respondents reported being married at some point. Only two of the ten women indicated they were still married and living with their husbands at the time of the interview (Ms. Francis and Ms. Boston). It was evident from Ms. Francis slurred speech that she was a recovering stroke patient. She advised that she was the one who managed their household however, as her husband had dementia. The interview was conducted in the Francis' living room. The couple sat in matching armchairs with a coffee table between them; their live-in caregiver was never far away. Several times during the interview, Mr. Francis would re-introduce himself to me, his wife told me to ignore him however. Despite her husband's senility, it was quiet obvious that Mrs. Francis treated her husband with dignified respect.

When the marital status question was asked, Ms. Milton pointed out that although she was a widow, she and her husband separated while she was still young, so she basically raised her babies by herself. Ms. Milton said that her divorce made more independent and caused her to refocus on herself. She said that she lived fabulously: going to the hairdresser weekly; having her nails done regularly; and wearing the latest styles. She reminisced about the past, saying that she was not motivated to do all of that anymore, as she comfortable with the way she was presently, and even with the weight she had gained.

A third demographic characteristic that was gathered from the women was how much education they had completed. Most the sample (six out of ten) said that they were

Table 6.1 -Getting to Know the Women						
Recipients	Age	Marital Status	Educational Attainment	Interpersonal Network (Live with?)	Insurance Status	Income
<b>Non-Homework</b>						
Ms. Milton/Nana	70	Widow	Some University (4 years Part time)	Alone	Kaiser Permanente	Retirement & babysitting
Ms. Vincent	69	Widow	High School	Alone	Blue Cross, Blue Shield	Retirement & selling Avon
Ms. Conners	67	Widow (28 years)	GED, achieved 15 years ago	Alone	Kaiser Permanente	Husband. Retirement & babysitting
Ms. Alexander	65	Widow	High School	Alone - boarder	Medicaid	Social Security
Ms. Davis	70	Widow	High School	Daughter & Granddaughter	Medicaid & Carefirst	Social Security
<b>Homework</b>						
Ms. Ranger	91	Widow	University – Teaching degree	Son	Private insurance	Retirement
Ms. Francis	87	Married (Live with Senile Husband)	University – Teaching degree	Senile Husband	Medicare	Retirement
Ms. Thomas	72	Widow (Took care of husband before he died)	High School	2 Daughters	Medicare	Social Security
Ms. Jackson	97	Widow	High School	Daughter	Medicare	Husband.
Ms. Boston	88	Married	University – Teaching degree	Husband & Daughter	Blue Cross Blue Shield	Husband. Only worked 3 years

high school graduates. This included Ms. Conners who informed us that she received her diploma later in her life. Ms. Conners said her kids urged her to go back to high school - for the GED certificate, especially since she had seen all of them through to a college level education.

Four of the ten respondents said that they had attended university. Ms. Ranger, Ms. Francis and Ms. Boston achieved teacher education degrees. Although she had a teaching degree, Ms. Boston explained that she has never taught a day. She said that she got married immediately out of college and she became a homemaker. The women's past careers seemed to have allowed them to lead typical middle-class lifestyles. Ms. Ranger and Ms. Francis both used the same private homecare agency because they knew each other from their days in teaching. After telling each about my research focus they both directed me to seek out the other woman for an interview.

The fourth respondent, Ms. Milton, reported that she started but did not complete her university program. Ms. Milton took secretary of science and social work courses at a city college in the Washington D.C. area, part-time for about four years. However, she had to stop because she was raising her children alone after separating from her husband.

The interpersonal network, specifically the family relations of these elderly Black women, appeared to be extensive and strong. Even when the women lived alone, they reported that their children were very involved in their daily lives. (Later in the analysis there is an examination of the role families plays in women's healthcare decisions). Six of the ten respondents lived with one or more relatives. The first of these women is Ms. Jackson who lived with a daughter only. Her daughter was present at the time of the interview to assist her mother with answering the questions. The others were: Ms.



Thomas who lived with two daughters; Ms. Boston, lived with a daughter and her husband; Ms. Francis lived with her senile husband; Ms. Ranger, lived with a son; and finally Ms. Davis lived with her daughter and granddaughter. Ms. Davis' daughter and granddaughter were very supportive of her, and the decision she made to live a healthier life. In particular she pointed out that they would get the food she wanted from the store so that she could stick with her diet.

The other four women lived alone. This included Ms. Alexander who reported a unique living arrangement. Although she lived independently, it was as a boarder with another family. She was emphatic to point out that she was independent however. Ms. Alexander said that because she was a widow, she did not need to take on the expense of renting a full apartment, hence she did the most prudent and rented a room as a boarder.

Another interesting source of interpersonal attachment that several of the women brought up was their connections to their church community as well as their local daycare center. For example, Ms. Ranger is a Roman Catholic indicated that her church was a significant part of her support system. The pastor and members of the church visited her regularly and brought her communion which she said made her feel so good. She pointed out that she hardly got the chance to attend church anymore because of her blindness. Another respondent, Ms. Davis is a member of a very vibrant church community which she said she could not do without. Interestingly, she highlighted the fact that her church had many empowered older women in the congregation. Additionally, Ms. Davis along with Ms. Alexander were the two respondents that I met at the senior daycare center. They also indicated that the center was a great way for them to continue to feel connected to their peers. The center basically gave them a purpose and a reason to get out of their

homes. On my first visit to the center, some of the attendees were being guided in planning the annual Fall dance. They were excited about the event, especially since the AARP magazine covered several dances across the nation each year. From cursory observations, the daycare center seems to be located in an older residential, working class community in Prince Georges County, which is indicative of the target population it would serve.

Another descriptive variable that helps to explain who these women are is their health insurance status. All the women interviewed said that they had health insurance. Three of the respondents (Ms. Francis, Ms. Thomas and Ms. Jackson) said that they had Medicaid only. The youngest interviewee (Ms. Alexander) also had public health insurance as she reported having Medicaid only. Another five respondents reported that they had private health insurance, such as Blue Cross/ Blue Shield and Kaiser Permanente. One of the five women with private insurance included the 91 year old Ms. Ranger, who was not sure about the name of her health insurance program which her late husband bought for them. Her evaluation of her health plan was that it was very good because it took care of everything (including the payments for homecare services). This was a relatively good plan, as most insurance plans do not pay for home care services. Finally, Ms. Davis was the only respondent with a mixture of private (Carefirst) and public (Medicaid) insurance. Hence, the sample seemed to have the security of having their healthcare needs covered.

The type of income that the women had also helps us to see who they are. Although these women were all from the same county in Southern Maryland, they had varied sources of income. The two former teachers in the homecare recipient group (Ms.

Ranger and Ms. Francis) said they received retirement packages from their years of service. Ms. Thomas said she was a cook in the school system in North Carolina for 25 years, so although it's not much, she receives social security payments as a result of that job. Finally, Ms. Jackson and Ms. Boston from the homecare users group said that they got income from their husband's retirement packages. Ms. Boston was a university-trained teacher but she said she only worked for three years before she became a full-time homemaker.

Likewise the non-homecare recipients had various sources of income. Ms. Alexander and Ms. Davis said that they got social security only. Three of the non-homecare users (Ms. Milton, Ms. Conners and Ms. Vincent) also pointed out that they supplemented their incomes with post-retirement work. Ms. Milton was receiving her retirement package from her former federal job and supplementing that with off-the-books babysitting. Ms. Vincent said her income include annuity along with proceeds from selling Avon's products. Ms. Vincent said her Avon's sale, along with her retirement package made her very independent. She was happy about this, because she did not want to burden her children unnecessarily.

The final non-homecare recipient, Ms. Conners, described receiving money from several sources. She explained that she worked with the federal government for 26 years and after retirement she operated a licensed daycare out of her home for another 14 years until 2006. As a result she is now reaping her social security benefits (about \$200 monthly), in addition to her retirement package. Additionally, she reported that she was receiving a handsome package from her husband's (who was a tractor-trailer driver)

workman compensation benefit as he was killed on the job. She jokingly said that is one of the reasons she never re-married.

Current source of income is a great starting point in assessing the women's socioeconomic status, and a second indicator is home ownership status. Almost all of the women interviewed owned their homes, which indicates some level of financial security. Ms. Milton and Ms. Vincent (non-homecare users) both lived in the same modern-looking condominium community. Ms. Milton was still paying a small mortgage. However she was thinking about doing a senior citizen's reverse mortgage program because "it would make no sense for her to die and not benefit from paying for so many years of mortgage." Ms. Milton also indicated that she lived in a larger home previously but decided to move to the condo community when her children were all grown and her husband had died. Ms. Conners (non-homecare user) along with Ms. Ranger, Ms. Francis and Ms. Boston all lived in older homes, which have been their residences for many years and where they raised their families.

Ms. Francis, who lived in a ranch-style house on top of a hill, also pointed out that she and her husband were significant land owners. Her husband inherited the land from his family. She said they owned the land around their house, "as far as the eyes can see." In fact, they had recently sold some of the land, which was the development I passed as I was coming down the country road.

The other four respondents were not currently homeowners. Three of these women lived with their children, more specifically their daughters and granddaughter. Ms. Thomas lived with two daughters in a modern-looking town house. The interview was conducted in the room which was equipped with several assistive devices (including

a hospital bed) because she suffered from severe arthritis. The oldest woman interviewed, Ms. Jackson, lived in typically middle-class community, in an older home with a large yard. The final interviewee was a boarder in a private home. The home ownership status information indicates that most of the interviewees' socioeconomic status did not correspond with that of the sample from the Longitudinal Study on Aging, where nine percent of the cohort was below the poverty line (see page 36 of the Methodology Chapter).

### How Sisters Do It for Themselves

#### *The Women's Health Condition*

The findings from the regression analyses demonstrated that there is a relationship between the respondent's Self-Rated Health status and the three types of self-care; as well as the relationship between Self-Rated Health status and homecare use. The views of the ten women can be further used to illustrate a more nuanced understanding of the quantitative findings.

Each interview with the ten respondents began with a self-evaluation of their current health condition or Self-Rated Health status. This set the foundation for asking about self-care practices that could be related to these conditions, and for getting information about homecare use. Four of the ten respondents indicated that they were not satisfied with their current health condition. One of the four, Ms. Ranger, was a 91 year old breast cancer survivor, who also had diabetes and was blind. However, she said she was not hindered by her lack of sight because she has been blind for so long. The women reporting poor health also included Ms. Jackson, the oldest woman interviewed (97 years

old). She said she was also blind, she could “hear but so good,” and she was not ambulatory. Ms. Francis was also among the four. She was a recovering stroke patient (she could not recall when she had the stroke). She also said that she had an infection in her bladder, “at least that’s what everyone tells me they think it is.” The fourth and most debilitated of the women, Ms. Thomas, was the youngest homecare recipient (72 years old). She was bed-bound during the interview due to severe arthritis; she also reported problematic blood pressure and a cholesterol problem.

On the other hand, six of the ten respondents reported more positive health status. Three of the five women (Ms. Milton, Ms. Davis and Ms. Alexander) said their health was good; while two reported average health. Of the three women reporting good health status, Ms. Milton had borderline diabetes, Ms. Davis diabetes, and Ms. Alexander high blood pressure. The two who said they had average health, had the following to say about their condition. Ms. Vincent said:

Well with all the medication I’m great. I have high blood pressure, thyroid, and I take some medication for seizure, I had two head surgery and I’m on medication for the seizures. I haven’t had one for a while.

Ms. Connors said:

Well right now I have a problem with my ankle. I have tendonitis in my foot. And by me not being able to walk on it, it made my ankles weak, and it seems like this has been going on for about three to four months, so it seems like now it takes longer for me to heal, than it did say ten years ago. And I don’t know, but I am 67 and I feel since I have turned into my 60s that my health has kinda been going down.

Finally, among the women reporting a positive health or a normal health status was Ms. Boston, a homecare recipient. She offered the following evaluation of her health status:

Normal. I feel o.k. [about my health] I can't complain. I don't have too many health problems when I have them, but I don't have severe health problems.

These elderly Black women were experiencing the normal course of aging as evidenced by their health status. They did not all respond to their condition using self-care, or the same type of self-care however.

### *Behavioral Self-care*

The interviews helped to illuminate some of the issues around elderly Black women's approach to healthcare decision making as both the multiple regressions and SEM analyses indicated that health values are not conclusive in explaining traditional self-care practices. Based on the descriptive statistics generated from the Longitudinal Study on Aging, when the respondents practiced self-care, it was more likely to be behavioral self-care rather than equipment or environmental. Six of the ten women that were interviewed deliberately practiced behavioral self-care. The only bed-ridden respondent (Ms. Thomas) said she watched what she ate because of her high blood pressure, but she was not strict about her diet. Another respondent Ms. Boston described her routine below:

I just eat a lot of vegetable, that's most of what I do and it seems to agree with me. And I walk sometime my husband ask me to walk with him but I don't like to walk.

The type of self-care practiced by the interviewees seemed to have little to do with their homecare use. The non- homecare users identified walking as a popular type of behavioral self-care. Three of the women said that regular exercise routines such as walking was an integral part of their lives. Norburn et al. (1995) cited regular exercise as a hallmark of behavioral self-care techniques. Ms. Vincent a 69 year old woman, who

had head surgery for a tumor, walked two to three miles daily, and she cited this as an example of behavioral self-care. She also pointed out that she changed her eating habits:

I changed my diet too. I stopped eating a belly full I still eat breakfast but after that I would eat very light fruits and vegetables for the rest of the day.

One of these respondents who walked regularly said she also drank at least a gallon of water daily to keep her health balanced.

Ms. Alexander, the sixth and youngest (65 years old) respondent also changed her diet and specifically stopped eating pork. Hence, walking for exercise and changing one's diet seem to be popular forms of self-care for women in this convenience sample. These examples show instances where Black women went against the trend manifested by the quantitative analysis, which identified low-levels of self-care among the national elderly Black sample. The responses demonstrate that self-care practices were not foreign to these respondents.

Along with the women who practiced behavioral self-care, there was Ms. Ranger, who did not deliberately set out to improve her well-being through self-care. However she inadvertently performed behavioral self-care that impacted her life course. The following interview excerpt demonstrates how this 91 year old, blind woman realized she had breast cancer:

I was taking a bath and I felt something, and I pulled my clothes down, and the first nipple had gone inside and I pulled it out. I didn't do nothing else. My daughter had gone on a boat cruise so I waited on until she came back. And she said Mama if you need to go for a mammogram I'll be glad to take you.

The final two respondents, Ms. Francis and Ms. Jackson, (who were also homecare recipients) said they were totally dependent on their doctor for guiding their healthcare.

Ms. Jackson (97 years old and the oldest woman in the sample) pointed out "I can't do



anything.” Despite the decision to use self-care by at least two of the homecare recipients, all five had high level of engagement with the formal system. Hence for them self-care neither substituted for the medical authority, nor was it a significant part of their healthcare regime, rather it complemented whatever their doctor did.

### *Equipment Self-care*

While several of the women indicated that they had walkers, wheelchairs and canes most were not deliberately chosen by the women. That is, it was not self-care. This was unlike the emphatic findings from the regression analysis, where there was significant relationship between health values and equipment self-care in order to address functional limitations. From the regression analysis it was further concluded that equipment not only made the women ambulatory, but it also strengthened their sense of independence.

Only Ms. Conners from the interviews indicated that she practiced equipment self-care. This respondent was a 67 year old woman who did not use homecare service. She detailed how she evaluated her health condition (problematic ankle) and then chose an appropriate treatment:

My doctor told me to wrap it but I went out and bought me one of those maximum ankle brace and wrapped my ankle with it, and I sleep with it on and that kinda give me a little bit of stability. But the only difference is I can't get a shoe on, so I am getting ready to go buy myself one of those shoes, because I am wearing a slippers and the slippers is not giving me the arch support that I need. And I think that why, the ankle is weak because I have not been using it, so I am trying to build up the muscles and the strength in that ankle. So it seems like if I could just put something with a little bit of support on it you know that would help... Well they had a medium but I decided that I'd go one and get the maximum one. Cause I said that would help. And come to find out that the maximum was what I really, really needed.

Ms. Conners had a well-thought-out process behind her use of the ankle brace. She took the initiative to buy the brace to alleviate her own discomfort. The addition of this respondent to the affirmative list for practicing self-care indicates that all the non-homecare users incorporated some sort of self healthcare in their everyday lives. This affirms the findings from the structural equation modeling analysis that as self-care increases homecare dependency goes up.

#### *Environmental Self-care*

Consistent with the results from the quantitative analyses, the respondents all indicated that they did not make any attempts to convert their living space. Hence, environmental self-care as defined by Kincade Norburn et al. (1995) was not evident in the daily lives of the interviewees. Notably, Ms. Milton, a non-homecare recipient lived in a condo that was modified to accommodate someone with functional disabilities. She offered the following information:

The unit is handicap accessible so certain parts of the house was built with handicap access. It was for my late father. He lived with me until he died four months ago. We have handicap parking, we are on the ground floor and the patio entrance has a ramp.

Ms. Milton did not need the environmental modified environment, however she said she would keep it the changes as she was getting older.

#### The Ethics – Why Women Do It (All) for Themselves

An important goal of the interviews was to hear from the women how and why they make certain healthcare decisions. The women were therefore asked about the

motivation driving the practice of self-care. The reasons that the women offered for practicing self-care ranged from it makes them feel better to it is empowering.

The homecare users for the most part, did not identify with self-care practices. They did not value it as a feasible healthcare option. When asked how she took care of herself, Ms. Jackson the oldest woman in the sample (97 years old) who was blind and not ambulatory, said she cannot do anything. This was also reiterated by Ms. Thomas a bed-ridden 72 year old homecare user, who actually watched what she ate to control her high blood pressure; she said:

I can't help myself. Not really. It's late now. I can't even get around. I can't even walk.

This position sums up the attitude that homecare users had towards self-care. It was simply not a feasible option for them or they were not capable of practicing self-care at this point in their lives. This position that was evident among the homecare users can also be explained by the fact that they were much older than the non-homecare users.

The non-homecare recipients were more likely to identify reasons for practicing self-care than the homecare users. Two of the women believed that there was a strong connection between practicing self-care and improving their physical health. Ms. Milton A 70 year old offered the following opinion to show the physical results of practicing self-care:

Oh yes! very very important, water and walking. Well, I've suffered from kidney stone from all kind of fake diets 23 years ago and my mother used to say that it is important to get in a gallon of water each day to keep gall stones flushed. So for this reason I drink a lot of water and I know that I feel much better because my body is flushed out. And I feel a lot better when I walk, I can feel the fatigue right after I get that walking in, guess it then brings that second wind and give me that positive outlook.

However, her statement shows that self-care contributes to more than physical wellness. She used the beliefs and norms passed on from her mother (who was still alive and living in a nursing home), to address her gall stone issues; and her self-care action ultimately gave her a positive outlook on her health situation. This speaks to the ethics driving self-care as such activities can be uplifting and give the practitioner a positive outlook on life.

Along with gaining a positive outlook, the self-care practitioners also have an opportunity to assert their independence by adopting these methodologies. Ms. Connors, the only woman in the group of ten that practiced equipment self-care asserted that she did not have full confidence in the formal medical care system; hence equipment self-care became an option. To ascertain whether she proactively addressed her own health issues, or if she relied only on interventions from the formal health system she was asked: “Did your doctor tell you to put weight on [your ankle], or did you find out that yourself? This 67 year old woman declared:

No.... I did that myself, cause I got tired of running back and forth over there, and they just saying to elevate, and do this and do that, and try to stay off of it, and I am just saying – this has been a long time and it makes no sense to keep running back and forth to the doctor and they keep telling you to do the same thing. And so I just decided, that’s it, I have to grin and bear and build some strength up into this ankle. Well I think you know your body better than your doctor know your body, and you know your limitations better than your doctor know your limitations. And I am not going to do anything that will harm me. And then too I try to stay mobile because for a year I was immobile, and I know how it is to lay around and wait for someone to even bring you a glass of water, and I am not trying to get myself back in that position again.

Also, Ms. Connors expressed an intimate knowledge of her body which allowed her to subvert medical authority with self-care practices. She explicitly said she knew her body better than her doctor, hence that allowed her to take ownership of her body and to make healthcare decisions.

Ms. Davis, another of the non-homecare user reiterated the primacy of independence when asked why she had a regular exercise routine to help with her diabetes. The 70 year old woman said:

I like being independent. I want to be healthy. When I go to church and see those over 80 year old women in their high heels going about their business, that's how I want to be. I want to live long and healthy.

Hence, there was a moral or a value driving self-care practices for these women – as defined by the healthcization paradigm. The respondents seem to have accepted the responsibility for assisting medical professionals with their healthcare. Self-care appeared in these women's lives in varying degrees however, but it was all aimed at achieving or maintaining wellness and a sense of independence. That in essence is what Conrad (2005), Armstrong (1995) and Zola (1972) called healthcization.

### Role of Family

The role family members play in elderly Black women's healthcare decision making was highlighted by the regression analysis in Chapter 4. For example Table 4.7 shows that living with a daughter had a significant and positive relationship with equipment self-care. This means that daughters were more likely to support their elderly mothers in the practice of equipment self-care. The interviews did not reveal that family members explicitly encouraged or discouraged self-care practices.

The information from the interviews also indicate that some elderly Black women's interpersonal network was not limited to blood relatives. When asked how members of her family assisted her, Ms. Boston an 88 year old homecare user pointed first to a non-family member:

My companion comes in everyday and stays half a day sometimes more than half. I have a daughter here, she works and I have a son he lives in Virginia.

Even with a very supportive family network Ms. Boston still had the option of a daily home caregiver. This respondent also indicated that her son supported her by taking her to the doctor, if her husband could not do it. She said she could also count on her daughter who lived with her. The position of the paid caregiver, who was pointed to as part of the close interpersonal network, was also affirmed by Ms. Francis a 87 year old woman recovering from a stroke. When asked if she got help from her family she replied, “that’s my companion.” Ms. Francis and her husband did not have biological children, therefore their nephew and a lawyer handled their estate which included a significant amount of land.

Although most of the elderly Black women interviewed received support from their children and husband, the relationship was sometimes reversed. Ms. Milton, a 70 year old non-homecare user is an example this reality. She was the family member upon whom her kids depended for support. Because Ms. Milton was the matriarch of the family, her children, grandchildren and great grandchildren depended on her for advice and money. Her 18 year old granddaughter even lived with her for a short time when the grandchild became rebellious.

Unlike the obvious trend from the quantitative analysis that indicated Black daughters seem to help their elderly mothers more, the situation was not as obvious for all of the women interviewed. A non-homecare user Ms. Vincent (who had head surgery) said she got help from all her children. She did not specify that her sons helped more or less than her daughters. She also pointed out that she got their help when it was convenient. This was not because they did not love her but because she preferred doing

for herself, hence she pointed out that: "...first when I start taking the bus they didn't like it but now they get use to it."

There seems to be a theme among at least four of the five non-homecare users that because they could take care of themselves, they did not want to inconvenience their children. The children did not seem to value their mothers' needs for independence however, as Ms. Conners a 67-year-old non-homecare user reported:

...even though my kids busted me and say "Mom why didn't you call someone for so and so." I just like to do for myself because I have been in my house for ten years by myself and I am just like my independence.

Regarding the role of her children in aiding her to continue to care for herself, Ms. Conners, who is fiercely independent said that her sons were very helpful with setting up a home environment for self-care. Although she had a very supportive daughter who lived nearby, she said the following of her sons:

My son and my grandson went with me and for my visit to the AnAn clinic. We interviewed and then we discussed the procedure and then the doctor left out and then we made a joint decision there because its like they wanted to operate on both of my knees at the same time. And so once we decided we were going to have the surgery and what date then we came home, and my son – you know the list of things I needed for the hospital, because I was going to rehab after, the list of things I needed for rehab. Then my son went and purchased the stuff for me so they got everything together and then they had everything ready for me at home. So when I came home, cause I am in a two-story house, I went upstairs to the bedroom, but one of my sons cooked my meals and put them in the freezer and another son when he came in from work would just put them in the microwave and heat them up. So someone would be in the house when I took my showers and stuff so in case I had a fall or something like that. And then between the boys they all took me to my doctor's visit. And I did power of attorney before I went into the hospital and I appointed two of my sons and my grandson to have power of attorney to handle my finances and stuff. And you know they went to bank, deposited my money and made sure my bills were paid on time and stuff like that.

Ms. Conners's sons helped her to set up everything, from shopping for basic items to being her power of attorney.

Evidence that sons were active in their elderly mothers' lives was also seen for homecare recipients. On the day of the interview with Ms. Thomas, a 78 year old respondent, she was being assisted in the home by her son. As soon as I wrapped up the interview, which took place in her bedroom, she called for her son. She then pointed out that she was in intense pain and she wanted her son to prop her up in bed.

Arthritis had left Ms. Thomas bed-ridden and hence she was not left alone for more than an hour. This started eight months prior to the interview when one of her two daughters who lived with her was preparing her lunch; she tried to use the potty chair by herself. The result was a very bad fall. Thereafter, if both daughters were at work, her caregiver would be relieved by her son, who did not live with her.

Although the daughters of these elderly Black women were very active in their mothers' lives, they did not seem to encourage their mothers to practice self-care. Three of the elderly women (Ms. Thomas, Ms. Jackson and Ms. Boston) for example had daughters who lived with them and were very supportive, but they did not want their mothers to over-extend themselves. Therefore, they took care of their mothers' ADLs personally or ensured a home caregiver was available. This was evident in the interview with the oldest woman in the sample, 97 year old Ms. Jackson. Her daughter sat in on the interview and helped with answering many of the questions. The daughter stated in the interview that her mother had done enough throughout her life, and she did not think she should be doing anything that was not totally necessary at this time.



### The Link Between Homecare and Self-care

The objective of this section of Chapter six is to illustrate some of the trends manifested by the quantitative analyses. It was concluded based on SEM analysis that the adoption (or practice) of self-care practices by elderly Black women meant that they were more likely to be dependent on homecare services. From the interviews it was illustrated that the non-homecare users exhibited little need for assistance with their ADLs and IADLs. The women seemed to dismiss the need for homecare services as if it were something negative. Ms. Conners, a 67 year old respondent who had knee surgery a year earlier and was the only person practicing equipment self-care said the following when asked if she needed homecare services:

Oh, no! I wash, I drive. Even though it's my right foot, I get up in my truck and I drive. I just be aware of my surroundings because you know elderly people can get jacked up out here.

While the women declared they did not need assistance with daily activities, they seemed only to be talking about paid homecare services. The interview respondents made a demarcation between paid and unpaid (or family) homecare services. The women's evaluation was that they were not dependent on homecare. However, evidence from the interviews indicates that physical limitations sometimes made homecare services a necessity even for these women. Two of the non-homecare users (Ms. Vincent and Ms. Conners) had family members assisting them after their surgeries. Ms. Vincent was also careful to point out that she did not use homecare services, but was assisted by her children after her head surgery. Ms. Conners who emphatically said she did not need and has never used homecare services said her son and grandson came in and assisted her with her ADLs and IADLs while she was recovering from her knee surgery.

An obvious departure from the trend of respondents choosing deliberately to use homecare services because of functional limitations is the case of Ms. Boston, an 88 year old respondent. Besides pointing out that that she is healthy (“I can’t complain”), she also emphasized that she did not really need homecare services. She was further asked about the presence of the Certified Nursing Assistant in her home, she said:

I just need somebody in the house with me to keep my company and to keep me from harm...My companion comes in everyday and stays half a day sometimes more than half.

Ms. Boston seemed to have a close relationship with the caregiver who she deferred to several times in the conversation. For example she confirmed with her caregiver that the insurance provider was actually Blue Cross Blue Shield and that the name of her vitamin was Centrum Silver. Additionally, when the respondent was hesitant to tell her age, saying: “Now that’s just the wrong question to ask!” The caregiver over-rode her hesitation and offered up her age. Similarly, Ms. Ranger, a 91 year old respondent also checked with her live-in caregiver during the interview to verify information about herself.

### Discussion

Reinforcing the results from the quantitative analyses, the interviews with these ten elderly Black women indicate that there is a consensus that healthcization is a good thing (eight out of ten women agree). The women seem to have internalized the value that health practices can determine their moral worth (Conrad, 2005). All of the women who were healthy enough to practice self-care did so. This could be an indication that the tenets of healthcization are pervasive among elderly Black women. Like Hacker (2008)

posits, this community seems to have accepted the “personal responsibility crusade” as it is related to healthcare decision making.

An understanding of the results juxtaposed against the healthicization theory also indicates that there are elderly Black women who do not want to be perceived as health deviants (Conrad, 2005). Therefore elderly Black women may choose to diet and exercise because they want to be seen as healthy as the fabulous 80 year old women in church, or they do not want to be labeled debilitated. Women who are seen as active participants of healthicization are viewed positively, even by the interviewees.

The interviews prompt further questions about the relationship between the body and healthicization. This is so, as the couple of women who declared they understood their bodies intimately (more than their doctors) were the more ardent practitioners of self-care. This intimacy with one’s body seems to temper the exclusive reliance on information from the medical authority (Westfall and Benoit, 2004; Pitts, 2003; Katz Rothman, 1998). It is not that elderly Black women completely substitute the medical directives with self-care, but if the doctor does not fully address a discomfort, then the individual may be pushed to “go out and buy an ankle brace.”

Consistent with the findings from the Longitudinal Study on Aging, the elderly Black women interviewed were more likely to report that they had been married. Two assumptions can be drawn from this trend. First, many of these women had spousal support, either emotional or financial, that they could count on as they got older. Secondly, elderly Black women are out-living their husbands – this means that they will need to assert even greater independence in late adulthood in taking care of their health.

At this point in their lives elderly Black women may therefore exhibit more features of the ethics of caring and personal responsibility (Hill Collins, 2000a).

The interviews with the women also show that even in health matters, elderly Black women wish to carve out an identity for themselves (Crenshaw, 1991). This is usually an identity that is separate from their children, husbands and others in their interpersonal networks. This may be linked to the finding that so many older women (both homecare and non-homecare recipients) are outliving their husbands, and are also choosing to live alone. The women seem determined to remain: active (going to church and/or the senior center frequently); independent (living in their own place); and healthy. Anecdotes such as these illustrate that the intersection of being elderly, Black and female is a vibrant area of identity politics that warrants further investigation.

The position from Black Feminist Thought that mothers raised their daughters and not their sons to be caregivers was not fully supported by the findings from the interviews. Additionally, the presence of Black sons did not hinder the interviewees from making the decision to practice self-care. On the other hand, the presence of the daughters in the home seems to discourage elderly Black women from practicing self-care (Powers, Sower, and Singer, 2006). This may be the result of daughters being raised with the feminine ethics of caring and personal responsibility by their mothers (Hill Collins, 2000a; Gilligan, 1995). Black daughters are willing to anticipate their mothers' needs and fill them.

Self-care is not always a first choice or even an option for elderly Black women because of their health conditions. This finding disputes the position of Kincade Norburn et al. (1995) that with increasing disability more self-care methods are used. Instead, the

opposite seem to be true where women admit with frustration, that because of ill health they cannot do for themselves. The propagation of the healthicization paradigm in society can become problematic therefore because of the demands it places on the elderly and other marginalized populations. The standards of healthicization – being your own minister of health (Rose and Miller, 1992) – are sometimes unachievable. For example, the bed-ridden senior may be able to monitor her diet, but another woman with dementia cannot be expected to research and source alternative vitamin supplements.

The foregoing discussion illuminates the possible links between self-care and homecare use. There seem to be a disdain by most self-care practitioners for the possibility of using homecare services. Consistent with the tenets of healthicization, these women did not believe that they could effectively promote and achieve maximum health if a paid caregiver was assisting them with their ADLs. Although the homecare services focused on in this research were provided by non-medical personnel (for example CNAs), this was not viewed by the women as part of healthist component of healthicization. Rather homecare was associated with the bio-medical rather than the healthist component of the dichotomy (Fleming and Andrade, 1984). The women who had more health complaints not only depended on their doctors but they also saw homecare as essential.

Once again this is problematic as it is generally accepted that homecare works as a method of caring for the growing elderly population in the U.S. (Aronson and Neysmith, 1996). If these women are rejecting the possibility of homecare use, they could diminish their quality of life. Women in the interview sample explicitly declared they did not want to compromise their independence. Sometimes it is necessary to ask for help as

is evident with the older women in the interview sample. In the final analysis, homecare use should not be seen as antithetical to self-care and the concepts of healthcization.

Even more worrisome, is that elderly Black women may be rejecting homecare services more so than other groups in the population (Kart and Engler, 1995). This position may perpetuate perception of elderly Black women as being large and strong (Beauboeuf-Lafontant, 2003; Newman, 2003). According to Black Feminist this is a problematic identity shaped by others, which can dismiss the needs inherent within that population. These women should be empowered and aware that they can both be strong, independent women who are taking care of themselves through self-care, and still willing to accept assistance at home.

## CHAPTER 7 CONCLUSIONS AND PRESCRIPTIONS

### Summary

This dissertation examined the relationship between the practice of self-care behaviors by elderly Black women and the eventual use of formal homecare. Two theoretical paradigms were used to examine the research problem. First, a Black Feminist Thought intersectionality framework identified what is distinct about elderly Black women's healthcare decision-making. Secondly, the healthicization paradigm was used to examine whether certain health values result in greater responsibility for one's health.

A mixed methods approach was used to analyze the research problem. First, multiple regression was used to explain how much of the variance in three types of self-care (behavioral, equipment and environmental) is explained by health values; as well as to what extent health values explain homecare decisions. Secondly, structural equation modeling (SEM) was used to establish causality among the three major constructs of the research (health values, self-care and homecare), in order to make inferences about the population of elderly Black women from the sample. Finally, a sample of elderly Black women from Southern Maryland was interviewed. The interviews helped to solidify the findings from the quantitative analysis, as the women's own words were used for further illustration. The interviews offered a more intimate portrayal of members of the target population than the quantitative analysis which gave a more overarching evaluation of healthcare practices.

For the most part, complementary findings resulted from all three areas of the dissertation. First, the analysis of health values and the three types of self-care with multiple regression revealed that equipment self-care had the strongest relationship with

health values (compared to behavioral and environmental self-care). From this it was concluded that elderly Black women chose to practice equipment self-care because it contributes to their sense of independence. Another finding from the regression analysis demonstrates that elderly Black women who had positive health values (for example, they do not think others see them as incapacitated) are less likely to use homecare services. A symbiosis of Black Feminist Thought and the healthist culture is helpful in understanding this finding, as many elderly Black women are motivated to be active participants in their own healthcare, so that they can be healthier – this includes performing their own Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

The findings that health values and self-care had a positive relationship were reversed for the SEM analysis. The negative relationship between health values and self-care which was demonstrated in the results could place elderly Black women at a disadvantage because they could be cast as health deviants. That is, health practitioners may conclude that these women have not accepted healthicization norms such as wellness promotion. However, further investigation into the norms of this segment of the population is necessary, as elderly Black women may have other means of expressing wellness.

Consistent with the multiple regression results, the findings from the SEM analysis demonstrated that self-care practices are related to high Homecare Dependency. The conclusion that was drawn from this result is that traditional self-care practices (such as modifying one's environment or using assistive equipment) do not always have positive outcomes for elderly Black women.



The final important piece of information for this dissertation was discovered in the face-to-face interviews conducted with ten elderly Black women in Southern Maryland. The women all seem to accept that healthcization norms were important, hence most practiced some sort of self-care, as long as they were physically capable. The most popular type of self-care routine for these women was walking. However, they also did things such as eliminating pork from diet; drinking lots of water, and keeping in contact with their extended communities through the daycare center and church. However, the greatest symbiosis between the quantitative data and the interviews came from the fact that most of the decisions these women made expressed or protected their independence. The women choose to take care of themselves, in order that they would not have to burden anyone else – especially their children.

### Conclusion

The public's as well as seniors' conception of the aging process is transforming rapidly. Increasingly there is a rejection of the over-medicalized view of aging, because for the contemporary cohort of seniors (the new-old; or baby-boomers) aging is not synonymous with sickness. This new paradigm can be both empowering as well as harmful to seniors. Duncan and Smith (1989) speak of a more empowered senior population that can choose to reject debilitation, and live a more leisurely life (Uhlenberg, 1992). Paradoxically, the same demands may thrust upon seniors the phenomenon Hacker (2008) calls the "Personal Responsibility Crusade." The basic premise of this crusade is that like every other segment of the population, seniors should be responsible for keeping themselves healthy. This not only includes having adequate

health insurance, but also adopting a healthy life style, etc. This is why the theoretical premise of this dissertation that there is a new health morality – healthicization, was indeed appropriate in examining self-care among elderly Black women. One of the concluding arguments of this study questions the assumption that responsible members of the citizenry will incorporate such practices in their lives (simply because it is not possible for everyone to do so).

The elderly Black woman’s view towards healthicization should not be exploited. Yes, it is true that their identity predisposes them to value their independence. This could force some measure of guilt upon members of this group, if they are not practicing self-care. While existing health institutions and seniors’ service institutions can encourage the practice of self-care – never should this become mandatory. This is especially so, because the elderly should not be penalized for not choosing, or for not being able to practice self-care. As elucidated in Chapter 5, the natural process of aging can rob the individual of the capacity of practicing even the most basic ADLs.

### Future Research

Based on the findings of this research, several areas merit future research. First, several instances were cited in the preceding chapters of limitations with the dataset (National Health Interview: Supplement on Aging Wave II - Longitudinal Study on Aging, 2000) in adequately measuring healthcare decision norms for elderly Black women. Therefore, future research could more adequately explore the healthcare norms within the Black community (particularly among elderly women), in order to make more definitive assertions about this segment of the population. As shown in Chapter 6,

exploratory interviews could be conducted with a larger sample of elderly Black women to see if a pattern of healthcare practice emerges. Such work could contribute to more ambitious research ventures such as creating new items for the next wave of the Longitudinal Study on Aging.

The challenge presented by the theoretical discourse of healthcization as well as the contemporary debate about doing for oneself, especially in the Black community, must be explored further. There is the belief that many in the Black community (especially considering the stereotyped image of the strong Black woman who takes care of community and self) have neglected this responsibility. In an address to the NAACP during the 2008 U.S. presidential campaign, Barack Obama said “We got to demand more responsibility from Washington ... and we got to demand more responsibility from Wall Street, but you know what? We also have to demand more from ourselves...” (Page, 2008). Future research could explore within the field of Sociology of Health and Illness, what it means for members of the Black community to be responsible citizens; and if there has indeed been neglect how can that be explained.

The rich data collected from the interviews is indicative that this work can form the basis of future study, especially regarding the role sons play in lives of aging Black mothers. One of the Black feminist ideals on which this dissertation was grounded, was the premise that mothers taught their daughters the ethic of caring and responsibility. However, a recurring response from the women who were interviewed was that their sons (even when daughters were present) were an integral part of their healthcare decision making. Hence, studying the connection between mother and son may bring a more

complete understanding about the phenomenon of personal responsibility in the Black community.

Future research efforts could also incorporate other types of qualitative methods. The healthcization concepts could be further explored in focus groups with women from several different communities. The fact that the research was based in Southern Maryland (Prince Georges county to be precise) predisposed the sample to a middle-class make-up. Many sociologists agree that this county has one of the most significant Black middle-class communities in the United States (Landry, 1988; Gregg, 1998). It would be remiss to advocate a Black Feminist intersectionality paradigm that is oblivious to class or socioeconomic status. Therefore, a follow-up to this research would gather data from other Black women from other social classes in focus group sessions as well as through personal interviews. Additionally, for comparative purposes elderly women from other racial and ethnic groups should be incorporated. The eventual aim is to be able to compare the healthcare decision making process of women from several racial and ethnic groups across the United States.

As a Jamaican researcher I can also envision that extending this study to a sample of elderly women outside the U.S. would be exciting and informative. While the racial composition of a Jamaican cohort (the country is approximately 90 percent Black) would compliment a Black American sample, there would be differences in terms of socio-cultural and economic realities. Future research which compares a Black Jamaican and a Black American sample would help with an exploration of whether the Black Feminist paradigm is only applicable to the United States or a North American situation, or if this theoretical framework could have applicability for the entire African Diaspora.

### Prescriptions

The recommendations that emerge from these studies are influenced primarily by the insightful interviews with the Southern Maryland sample, the results from the quantitative analysis, and the researcher knowledge based on work done in the elderly-care industry.

The elderly Black woman's sense of autonomy is very important to her. Even with children living around or close to her, she seems happiest when her independence is assured. One way of assessing her independence is her being able to care for herself in her home. Hence, it is being recommended that current Respite programs (which are operated by states to relieve family caregivers by subsidizing homecare services) not only subsidize family-care givers, but that the elderly should be able to apply for such funding and use it to pay for their own ADLs and IADLs. For example, the Respite funding (or similar programs) could be extended to the elderly care-recipient to apply to a one-time equipment or environmental modification expense. This is especially recommended because the research shows that elderly Black women are more likely to use equipment self-care to maintain their independence. While the elderly Black woman may not want a care-giver at her home, Respite funding could be applied to a ramp at an entrance way, for example. Hence, a restructuring of homecare subsidy programs could facilitate elderly people with alternative healthcare norms.

Secondly, the literature indicates that health education can be used to introduce the elderly to healthcization norms such as self-care. While this can be practical and may have positive outcomes for some individuals, at no time should acceptance of health education be mandatory for participation in critical programs or clinics. Therefore, the

second recommendation being offered is that supporting networks and community based organizations be used to introduce healthcization norms and emerging knowledge in senior care to populations such as elderly Black women. In giving information to elderly Black women, health educators should also be willing to learn from them. Health education campaigns can be hosted by community organizations frequented by elderly Black women. Supporting institutions such as churches and senior care centers are important in empowering elderly Black women, and through discussion at these venues, the women can not only find out about existing resources to take care of themselves, but they can learn best practices from each other.

Additionally, there should be safeguards and protection for older Americans who manage their own healthcare. The recommendation is that older Americans can be supported by advocacy groups – may be at the senior daycare center – and the aim is to make sure the seniors are not exploited and conned, especially out of money. The community organizations mentioned above, allied with more powerful groups such as the AARP, can help to safeguard the elderly. Already, clinics in Maryland, such as the one at located at the daycare attended by two of the interviewees, are doing such advocacy work.

Finally, there should be an objective measure to ascertain the needs of some of our elderly, especially those who live alone, in terms of need for care. The aim is not to be intrusive. However, results from the Longitudinal Study on Aging indicate that there were many elderly Black women who indicated that they either were not receiving care, or they did not need care. It is critical to ensure that the situation is not that they do not have access to assistance, but instead they can truly take care of themselves. Programs

like this exist in many other developed countries (such as Ireland) with the goal being inclusive and dignified home or nursing care for all senior citizens. Voluntary assessment could therefore determine the elderly person's need, and provide or recommend any necessary support.

### Policy Implications

This study shows that the ideals of the personal responsibility crusade are becoming a focal point of the healthcare discourse. Therefore, it is important that policy makers take note, in order that traditionally marginalized groups are not ostracized for not going along with this general trends. While government programs and clinics should be encouraged to disseminate self-care messages to elderly clients, safeguards should exist against a one-size-fits-all approach. Practitioners should ensure that the elderly client is capable of doing (and willing to do) for herself, before the practice of self-care is encouraged, or even enforced.

This policy recommendation is aimed specifically at the Medicare Health Support program for beneficiaries in Maryland and Washington D.C (MHS, 2008). This is because many Blacks and particularly low-income seniors, are dependent on these federal programs. The specific policy recommendation is that critical healthcare benefits should never be tied to self-care practice requirements. At present the program has an extensive follow-up and referral for clients enrolled in the self-care education initiative; these services should also be extended to non-self-care practitioners.

Another policy implication arising out of the dissertation is that states' program which support or subsidize long-term homecare services should direct their case workers

to be sensitive to some of the cultural norms of individuals from marginalized communities. The research suggests that more ore targeted needs analysis would not only be beneficial in identifying functional limitations, but should also take into account the woman's evaluation of her own situation. For example, the assumption should not be made that elderly Black woman with limited financial resources will simply be satisfied with a companion in their homes for four-hours each day. They may be more appreciative of a walk-in shower modification. Placing a homecare provider in the elderly Black woman's home may threaten her independence. More targeted needs especially by local Respite Care programs to adequately indentify specific ADLs and IADLs needs. These two policy implications therefore tie the research findings to more practical applications which occur in the elder-care healthcare dynamics.



## APPENDIX INTERVIEW SCHEDULE

### Introduction

*Questions will be asked of the elderly persons or a proxy (family member, friend or caregiver):*

*The greeting and the introduction to the interview will detail the following to the respondent:*

1. *Who I am*
2. *How I got their contact information*
3. *Participation is voluntary, and their signed consent will be requested. The respondents' anonymity will be guaranteed, and participants will be told that their sensitive information will be kept confidential.*
4. *That this interview aims to catalogue some of the health conditions that senior citizens have, and how they respond to them. The seniors' use of homecare will also be ascertained.*

### SELF-CARE

#### Stage 1: Health Problems/ Health Issues

How would you rate your current health condition?

Do you have any health problems/issues?

#### Stage 2: Care response

How do you respond to those health problems?

How did you respond to health problems/ issues in the past?

#### Stage 3: Determining Self-care

Describe the range of self-care behavior

Have you changed your behavior in response to your health condition?

Who told you to make these changes?

Do you use special equipment in response to your health condition?

Who told you to get this equipment?

Have you modified your living space in response to your health condition?

Who told you to do this modification?

#### Stage 4: Values driving self-care

Why do you use self-care?

Is it important to practice self-care?

What do you think can result from practicing self-care?

Do self-care practices make you healthier?

Do self-care practices help with detecting diseases?

Do self-care practices keep you disease free?

Can other people learn from your self healthcare practices?

Do self-care practices give you greater control over your health?

#### Stage 5: Time Frame

How long have you been practicing self-care?

#### Stage 6: Social context in which self-care occur

Do you have a regular physician / clinic?

Do your family members/ social network supports your healthcare decisions?

## HEMECARE

### Stage 1: Activities of Daily Living (ADLs)

Do you need assistance with any regular activities?

Do you currently get assistance through homecare?

How long have you been using homecare?

## SOCIO-DEMOGRAPHIC CHARACTERISTICS

Age    Marital Status    Income    Education    Which family member lives with you

Do you have health insurance?    What kind of health insurance do you have?

What is your current source of income?

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## AUTOBIOGRAPHICAL STATEMENT

Carlene Buchanan Turner is a Jamaican, Sociologist, and she studied at the Graduate Center, City University (CUNY) from August 2004 to May 2009. She is also a graduate of the University of the West Indies (UWI), Mona. At UWI she completed a BA (History) and a MSc (Sociology). Her Jamaican working-experience revolved around social research initiatives. Most of these activities were based on quantitative research techniques.

Her current research interests include: quantitative methodology; health and illness; aging; race and ethnicity; gender; remittances as a transnational development tool; the social integration of Caribbean immigrants in New York; and Caribbean identity. Additionally, investigating Motivation in Cricket teams is another of her on going research interests.

Carlene is an Adjunct Professor at University of Maryland, College Park, where she teaches: Sociology of Gender; and Social Problems.

Her non-academic interests include: youth empowerment (through youth organizations and service groups), Caribbean cultural issues, and of course – cricket, lovely cricket.

Carlene is married and she has a daughter, Amara.

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