Health Care for Women International, 25:950–969, 2004

ISSN: 0739-9332 print/1096-4665 online
DOI: 10.1080/07399330490508730

Taylor&Francis
healthsciences

THE MEANING OF HEALTH: PERSPECTIVES OF ANGLO AND LATINO OLDER WOMEN

Marianne C. McCarthy, PhD, RN, Ester Ruiz, PhD, RN, Betty J. Gale, DNSc, RN, Cheryl Karam, MS, RN, and Nancy Moore, PhD
College of Nursing, Arizona State University, Tempe, Arizona, USA
Geriatric Solutions, Phoenix, Arizona, USA

This qualitative study, utilizing the dimensional analysis approach, was conducted to generate a substantive theory about the description and meaning of functional health from the perspectives of older Anglo and Latino women. Through focus group interviews with older Anglo and Latino women and data analysis, the investigators learned that the women's perceptions of functional health were vastly different. As planners and providers, we usually are trained in a health culture that is predominantly based on White, middle-class values. This ethnocentrism can act as a barrier leading us to disregard the notion that concepts such as health are not universally perceived. Findings from this study may enable us to achieve a closer approximation of the real experiences of our clients and to sensitize us to different world views.

This article presents the qualitative findings of a large two-part study conducted by Professor Betty Gale, who served as principal investigator (Gale, 1998). The study was designed to describe sociocultural influences

Received 31 October 2003; accepted 10 December 2003.
This study was funded by the National Institute of Nursing Research (Grant No. 1R15NR004239-01).
Address correspondence to Marianne C. McCarthy, PhD, RN, Associate Professor, College of Nursing, Arizona State University, Tempe, AZ 85287-2602, USA. E-mail: marianne.mccarthy@asu.edu

on functional health outcomes and to estimate relationships among variables influencing health in older Anglo and Latino women. The first part, the qualitative component whose findings are presented here, was conducted using the dimensional analysis approach (Schatzman, 1991) to elicit an understanding of the meaning of health from the perspectives of older Anglo and Latino women. Analysis of qualitative data yielded a grounded theory that informed the second part of the study. The dimensional analysis methodology was found to be particularly well suited for this qualitative study. The investigators will argue that a wider application of dimensional analysis will enrich studies of culturally focused research. To illustrate this claim, an in-depth discussion of the process of inquiry will be presented.

BACKGROUND

America's older population is increasing in numbers and becoming more diverse (Hetzel & Smith, 2001; Rowe & Kahn, 1998). The majority of older persons are women. Most live alone, and many are poor (Alliance for Aging Research, 1998). With changing demographics, new strategies for health care delivery that focus on preventing chronic disease and disability in older people and among minority populations are needed (Brogan, Haber, & Kutner, 2000; Wallace, 1997). Many researchers, clinicians, and older persons agree that disabilities or functional limitations associated with chronic diseases are a more important problem than the chronic diseases themselves (Evans, 1999; Fries, 1997). The potential for successful implementation of interventions that improve function is great, regardless of when limitations associated with diseases are found (Lee, 2000). Little emphasis, however, has been placed on assessing and correcting limitations of functioning in health care delivery arenas (Gale & Erickson, 1997).

Sociocultural influences, or the combination of gender, race, and class, have an impact on the occurrence of serious health needs among populations (Zambrana, 1987). Nevertheless, not enough is known about the sociocultural influences and descriptors of functional problems common across diagnostic categories (Geiger, 2001; National Institute of Nursing Research, 1994) and of problems that occur more frequently in women (Office of Research on Women's Health [ORWH], 1999).

Latino elderly are one of the fastest growing population groups in America (He, 2002; Liao et al., 1998). As a cohort, they are at risk for the development of many common health problems that plague older Americans. This concerns many health care planners and providers, especially those who are aware of data suggesting that functional limitations are disproportionately high in Latino groups and that they become

evident at younger ages (Aday, 1997). Further cause for alarm is raised when planners and practitioners consider that Latino women are reported to suffer higher rates of chronic, disabling conditions than many other groups (Gale, 1995; Gale & Erickson, 1997; Kass, Weinick, & Monheit, 1999). Moreover, it has been demonstrated that these women experience greater limitations in health care access (Mills & Bhandari, 2003; Moy, Bartman, Clancy, & Cornelius, 1998) and bear the brunt of cultural insensitivity demonstrated by many service providers (Campinha-Bacote, 1999; ORWH, 1999).

In delivering health care services, most planners and practitioners depend upon models that have been developed to serve non-Latino White populations (National Coalition of Hispanic Health and Human Services Organizations, 1995). Although Latino populations are as diverse as White populations, their cultural values and similarities in language allow them to self-identify as members of the same ethnic group (Marin & Marin, 1991). Dissimilarities among the various Latino cultures are nevertheless becoming ever more apparent and include dissimilarities in education, socioeconomic status, physical and mental health, and access to health care (Aponte, Rivers, & Wohl, 1995; Mays, Cochran, & Sullivan, 2000; Molina & Aguirre-Molina, 1994).

Trends observed in investigations of successful aging and functioning (Minkler, Schauffler, & Clements-Nolle, 2000; Rowe & Kahn, 1998) and findings suggested by rigorous assessment of the contribution of psychosocial factors related to functioning are paving the way for development of culturally sensitive health services (Glass, 1998). These services reflect a broader and richer conceptual approach that considers the social and cultural context of people's lives. A grasp of the description of health, of the meaning attributed to health, and of how people from different cultures function is necessary before we can fully understand the effect of culture on health care. The authors agree with others that more studies that explore discrepancies among different cultural groups, genders, and age cohorts are needed (Glass, 1998).

METHOD

This qualitative study was conducted as the initial part of Gale's larger investigation, which examined the processes of stratification and acculturation and their relationships to and influences on health perceptions, stress and coping, physical health, psychosocial health, and independence of older Anglo and Latino women (Gale, 1998). During this qualitative phase, differences and similarities between these two groups were sought and revealed. The theoretical orientation of Gale's larger study (Gale, 1998) followed an established schema of aging, health, and behavior

linkages that included sociocultural influences on health outcomes (Ory, Abeles, & Lipman, 1992). In Gail's larger study, both inductive and deductive techniques were utilized in an attempt to triangulate data collection and analysis to achieve results that were as scientifically sound and contextually rich as possible (Duffy, 1987; Hinds & Young, 1987). Strauss and Corbin (1990) suggested that inductive and deductive techniques incorporate multiple procedures that are independent yet complementary. The current qualitative study accepts the premise by examining the data from multiple perspectives.

An original intent of this qualitative portion of the larger study was to discover factors about the meaning of health and description of health practices from two culturally diverse perspectives. The investigators believed that such knowledge might sensitize them to issues that would be pertinent to subsequent data collection and analysis. In other words, the qualitative investigation study was conducted to enable investigators to gain conceptual entré into an area about which little was previously known: the relationship between culture and functional health.

Dimensional Analysis Approach

The grounded dimensional analysis (DA) approach provided a conceptual and methodological framework for the interpretation of those data. Professor Lenny Schatzman (1980, 1986, 1991), who had been a colleague of Glaser and Strauss at the University of California, San Francisco, first developed and described this approach. Although originally conceived for the purpose of improving the articulation and communication of the discovery process in qualitative research, later authors (Kools, McCarthy, Durham, & Robrecht, 1996; McCarthy, 2003a, 2003b) presented the DA approach as an alternative to the constant comparative method of grounding theory (Glaser & Strauss, 1967).

Dimensional analysis is consistent with the constant comparative grounded theory method in its directive to work analytically with one's own experiences. Dimensional analysis extends and elaborates on the original method, however, by providing an epistemological foundation for analysis (Schatzman, 1991). DA seeks to answer the question "What is involved here?" rather than to establish a hierarchy of factors that answers the question "What is most important?" By creating a research environment in which study participants are not guided by questions from the researcher but rather set the direction of the inquiry themselves, this conceptual shift allows the researcher to incorporate data that are atypical or unexpected (McCarthy, 1991). Although DA as a method is generally informed by grounded theory, it nonetheless has its own procedures, assumptions, and logic, as will be illustrated here

(Kools et al., 1996; McCarthy, 1991, 2003a, 2003b; Robrecht, 1995; Schatzman, 1986, 1991).

The product of DA inquiry is the construction or novel reconstruction of a story or theory that depicts a complex social phenomenon. From the standpoint of health research, one of the most elusive questions has been how to capture the nuances and richness of complex cultural influences on an individual's perception of personal health. Dimensional analysis generates a theory by arranging multiple layers of related dimensions observed in the data, which are then organized and interpreted according to some key perspective. Organization and interpretation of data are facilitated by utilization of an explanatory matrix, an analytical template unique to the DA method (Kools et al., 1996). In this study, DA was well suited to study the descriptions and meaning of functional health as perceived and reported by two culturally diverse groups of women.

PROCESS OF INQUIRY

Data Collection

Data were obtained by conducting a series of focus group interviews with two groups of older Anglo and two groups of older Latino women. The primary theme of all interviews was the description and meaning of functional health in their everyday lives. The qualitative investigators took this as their direction of inquiry because of Gale's preliminary conclusions, which suggested that Latino and Anglo cultures perceive functional health differently (Gale, 1998).

The 29 group participants for all four focus group interviews were volunteers recruited from among the White and Latino attendees of a neighborhood senior center. The senior center is part of a multigenerational community center located in a low-income, predominantly Latino neighborhood in a city in central Arizona. Each participant received $10 and a bag of fresh fruit for her contributed time. Each group session lasted approximately 2 hours, and all were conducted in private conference rooms. Conference rooms were comfortably furnished, and refreshments were available for participants throughout the group sessions. Round-trip transportation was provided for those participants who required it.

The first and second Anglo groups were composed of 6 and 10 participants respectively. They ranged in age from 57 to 81 years, with a mean age of 69.5 years. All the Anglo women had been born in the United States. Most of the women were Protestant, and they listed their religious affiliations as Methodist, Lutheran, Baptist, Church of Latter Day Saints, or nondenominational. Their years of formal education ranged from 12 to 17 years, with a mean of 13.7 years. Fifty percent (8) of the Anglo

women were married and lived with spouses; 2 were divorced and lived alone; and 6 were widowed, with 3 living alone and 3 residing with family. All the women reported that they had a regular health care provider and had seen their physician anywhere from 1 week to 8 months prior to participating in the group sessions. Personal health conditions that led them to seek health care included stroke, hypertension, diabetes, and high cholesterol.

The first and second Latino groups were composed of 5 and 8 participants respectively. They ranged in age from 51 to 85 years, with a mean age of 64.5 years. Half of the Latino women were born in Mexico or Central America, and the others were native to the United States. All the Latino women stated that they were Christian. Religious affiliations were Roman Catholic, Evangelical, or other Protestant sects. Their years of formal education ranged from 2 to 16 years, with a mean of 9.6 years. Eight of the women were married and lived with spouses; 4 were widowed and lived with families; only 1 woman was divorced and lived alone. Six women reported that they did not have a regular health care provider, although they had seen a physician at least once during the previous year. The remaining 7 Latino women reported that they did have regular health care providers, and most had seen a provider within the previous year. They sought medical attention for the same health conditions as the Anglo women; in addition, 1 Latino woman had a seizure disorder.

Procedures

Focus group interviews were conducted on four different occasions. Each of the four groups met individually. The first two focus groups were conducted several months before the last two focus groups. Originally, the investigators planned to conduct only two interviews, one with older Anglo women and the other with older Latino women. As focus group data were being collected and analyzed during the early part of the qualitative study, the need for additional information became apparent. At that point, the investigators assembled and interviewed two more focus groups, similarly composed of older Anglo and Latino women.

Based upon findings from previous studies on functional health (Gale, 1994; Gale & Erickson, 1997), and following a review of literature, interview themes and related questions were developed for the first two focus group interviews. At the beginning of each session, questions were posed at a level of generality in order not to restrict discussion (Morgan, 1988).

The same investigator conducted all focus group interviews of the Anglo and Latino women. She is a bilingual Latino woman with a professional background in psychiatric nursing and counseling psychology.

She conducted the interviews with the two Anglo groups in English, and interviews with the two Latino groups primarily in Spanish. All interviews were audiotaped with the permission of participants. Audiotapes subsequently were transcribed into written texts for future review. The English versions were prepared in typical fashion, but the audiotapes of the two sessions conducted in Spanish were handled differently. Initially, these tapes were transcribed in their original form by bilingual clerical assistants. These transcriptions were then translated into English and then back translated. The same investigator/focus group leader further evaluated the English versions for accuracy of content and intent, and she made necessary text adjustments.

Data Analysis

All data primarily were reviewed by the second investigator, an analyst skilled in DA methodology and geriatrics/gerontology. As analysis progressed, the analyst enlisted the other investigators to act as a "judge and jury" for her constructs, accepting or refuting elements of the theory that was emerging about how these cultures viewed functional health. Raw data were composed of field notes, transcriptions of taped interviews, and theoretical memos. All data were analyzed according to the techniques of DA. For the purpose of reporting the process of inquiry, the components of analysis are used here as an organizing scheme. These components are viewed as stages of analysis and include (1) designation, (2) differentiation, and (3) integration. Although deliberately presented here as a linear process for the purpose of illustration, it must be stressed that analysis using the DA approach occurs simultaneously and interactively (Kools et al., 1996; McCarthy, 1991, 2003a, 2003b; Robrecht, 1995).

Designation

Designation, the process of denoting things and events in the data regardless of salience, began early in the analysis, following the conclusion of the first focus group interviews. During the designation stage, the analyst developed a vocabulary that could be used to perform the cognitive work of analysis. Dimensions or codes were generated during this phase of analysis and then were subdimensionalized or characterized in a general way to expand data by asking the methodological question "What is involved here?" In this way, the analyst was able to explore the density of the older Anglo and Latino women's experiences in an attempt to reveal the complexity of the phenomena, namely, cultural perceptions and descriptions of functional health.

By dimensionalizing data, a number of provisional concepts about the description and meaning of functional health were revealed and

designated by the analyst. (Some of these were in vivo terms used by the participants; others were conjured by the analyst to fit the data.) A partial list of these early dimensions included the good life, states of being, being healthy, states of unhealth, consequences of unhealth, life review, social exchange, inevitability of depression, conditions for acceptance of disability, enabling conditions for good health, impediments to good health, and states of doing.

Initially, the direction this qualitative study needed to take to identify the dimensions and subdimensions that would elucidate cultural differences came from an earlier study by Gale (1995). In it, she discovered that older Latino women consistently referred to the term *the good life* when discussing the construct of *being healthy*. Because of this finding, in the first session with the Latino women the focus group leader used the term in provisional questions to elicit conversations regarding the meaning of health. This same term was not used during the first focus groups of older Anglo women. Instead, the open-ended question "What does being healthy mean to you?" was substituted in the Anglo group for the question, "What does it mean to live the good life?" posed with the older Latino women.

The dimension "good life" was described in terms of typical and repetitive responses made by the Latino women; it was subdimensionalized to break down the elements of the good life that the Latino women felt came together to create their picture of functional health. In this study, the Latino women used the "good life" as the in vivo term to denote good health. Properties of the good life as revealed by the participants were categorized by the analyst as primarily either states of being or states of doing. "States of being" itself then became a dimension that the investigator recorded in a theoretical memo and conceptually defined as a collection of personal attributes offered by the participants to describe, explain, or articulate what they meant when they said that they were healthy or that someone was healthy. The analyst designated data perceived to denote actions or processes performed by the participants that demonstrated good health as "states of doing." The analyst further conceptualized these two dimensions as either positive or negative because some of the women might be considered healthier than others, when viewed from a standpoint of traditional Western medicine. These decisions were based largely upon interpretations of both the content and the intent of the responses made by the Latino women.

The analyst wrote theoretical memos during this phase of analysis to expand upon any set of dimensions observed in the first focus groups and possible relationships among dimensions. Continuing to follow methodological strategies of DA, these memos were then themselves regarded as data that the analyst needed to further abstract and analyze. The following

excerpt exemplifies the type of memo that the analyst wrote during early stages of data analysis:

> The interviewer [group facilitator] uses the in vivo term the "good life" with the Latino women to qualify or modify the term "being healthy." This same terminology was not used with the Anglo group. I have concerns with this, insofar as it represents a departure from what was originally discussed during the Anglo focus group. The responses of the two groups are distinctly different. I am not surprised that the responses are different, indeed, had hoped they would be, but now [I] must wonder if the differences are related to the ethnic makeup of the two groups or if they are related to the fact that the women were responding to two different directives from the interviewer? [We must] consider whether or not this is a *condition* that sets the responses of the two groups apart. Perhaps a second set of focus groups should be conducted to tease this out.

The extensiveness of the contrasts between the two groups required the investigators to ask new theoretical questions to ascertain whether differences were related to cultural dissimilarities or whether something besides ethnicity had come into play during group interactions. To allay their concerns, they convened the second focus groups of Anglo and Latino women, regarding this as a way to eliminate the potential effect of culture and language on the choice of words, introduced by the leader, used to describe health.

At this stage, the dimensions, together with assigned properties, helped to direct inquiry by prompting investigators to organize questions for the second focus groups around newly derived concepts as well those reinforced concepts identified in the early phase of the investigation. Interviewing during the second groups near the close of the designation stage became focused on the exploration of the range and depth of the identified dimensions and corresponding subdimensions and relationships.

Differentiation

Following the expansion of data done during the designation phase, the analyst began to limit data during the second phase of analysis, referred to as differentiation. By limiting data, interpretation now became more directed and focused. The analyst accomplished this data reduction by selecting a perspective or key dimension from among all dimensions that had been identified in the data and conceptually explored and described. Differentiation began while data were still being collected and continued after all focus groups had met.

According to DA, a key dimension is a conceptual perspective that has been derived from data and conceptually determined to be the best vantage point from which to make interpretations and reconstitute data.

Selection of a key dimension is a crucial conceptual strategy in DA methodology. Once selected, this key dimension serves to provide purposeful orientation to the remaining inquiry and allows the analyst to reconstitute identified dimensions and the relationships among them into a substantive theory about particular phenomena.

In selecting a perspective from the critical mass of dimensions, the analyst is methodologically obligated to audition many competing dimensions (McCarthy, 1991). In attempting to tease out dimensions that could explain differences between the older Anglo and Latino women's responses, the analyst auditioned various factors as central. Examples included religious affiliation, country of origin, years lived in the United States, and marital status.

Methodologically, the analyst attempted to discover whether the term good life could be a more abstract concept than good health, that the good life might encompass more than merely being healthy. Perhaps, for the Latino women, being healthy was simply one aspect of the good life. Perhaps, if presented with the same construct, older Anglo women would respond similarly.

To determine if both groups regarded the good life in the same way, the investigator/focus group leader posed questions to initiate discussion in the second Anglo and Latino focus groups. The investigator began with the second Anglo group, asking them to react to the responses of the first Latino group: Did they agree or disagree that the good life was the same as being healthy? They disagreed, offering their own definitions of being healthy. Their responses included, "I can stay healthy if I take good care of myself, eat right, take my medicine, listen to my doctor, do my physical therapy, exercise regularly, get enough sleep." When asked, "How important are these factors to my staying healthy?" they gave such answers as, "It's all up to me. If I work hard, I will get healthy and stay healthy. . . . Stop smoking, eat better, sleep more, walk more, remember to take my medicine."

For the Anglo participants, health was regarded as a personal, individual, and introspective construct. Participants in both Anglo groups expressed an almost puritanically colored ethic regarding "the work of staying healthy." They expressed the strong need to be in control of their health and the tragedy of losing that control through illness or functional disability or both. Further, they voiced a dogged determination to work hard at the "business of recovery" in the event that they became ill or disabled. Little was mentioned about the impact of interpersonal relationships or the importance of spirituality in relation to health and the business of staying healthy. The following remarks illustrate the notion of the "health work" and the "business of recovery" as expressed by participants in the Anglo groups: "Staying healthy is a full time job and you

can't ever take a day off.... I need to always be working at feeling my best.... I take it [staying healthy] seriously because if I don't, no one else will.... Who but yourself can you rely on? When I had my stroke I had to work every minute to get back on my feet, to get back to where I was before I got sick. Look at me now and you can see that my hard work paid off."

As the investigator and analyst discovered from the older Anglo women in the second group, the term the good life conjured images of luxury for them. They did not regard the term the good life as synonymous with good health. Responses to questions asked to elicit their perceptions regarding the term included such things as, "I would think that the good life means money, boats, a big house, nice vacations, maybe a cruise.... If you want to live the good life then you have to be careful and save for your future." This general perception held fast even after the group leader apprised the Anglo group about the discussions of Latino participants and the analyst's interpretation of those discussions.

The last of the four focus groups was conducted with the Latino women to verify findings from analyses of those collected from all previous interviews. Participants were asked questions to ascertain whether they agreed or disagreed with what the first Latino and first and second Anglo groups had said and whether they agreed or disagreed with the analyst's interpretation of the data. They voiced disagreement with the Anglo women's use of the terms good health and the good life. With this established, the interviewer then asked questions about their views regarding differences and similarities between the two terms. One question was, "What was important to their living the good life?" They responded, "Being able to laugh, being able to accept things the way they were, being close to God, not being sick, feeling peaceful, having enough money." Another question asked what they would do if bad things happened to their health: Would they try to accept it (and why or why not) or would they do something to fix it (and what would they do)?

Data from this final focus group were integrated with previously collected data. The next task for the analyst was to find a key dimension that would unite all the data. The analyst selected the dimension "degree of differentiation" from those that had been assembled and raised it to the level of key dimension or central research perspective. Conceptually, degree of differentiation denoted the incongruity between beliefs of older Anglo and Latino women regarding the meanings and values they attributed to good health and the ways in which they described good health and functioning day to day.

The older Anglo women demonstrated a more differentiated regard than the older Latino women. The Anglo women viewed health as a distinct aspect of self. They tended to regard health as a specific construct

that could be viewed and discussed in terms distinct from other aspects of life. They described health largely in terms of the presence or absence of physical well-being. Illness or sickness was discussed predominantly in terms of having one or more chronic physical problem and in dealing with how problems affected one's ability to function day to day. In other words, the older Anglo women's notion of health was compartmentalized and *differentiated*. Although regarded as a part of life, it could be thought of and discussed as a stand-alone concept. The received or more usual notion of functional health was more accurately reflected by the older Anglo women's perceptions than by those of the Latino women. In addition, interventions typically implemented to maintain or restore functional health or to prevent decline were more clearly recognized by the older Anglo women than by their Latino counterparts.

In contrast, the older Latino women did not distinguish between health and self. They tended to regard health as a wholly integrated aspect of life, and, consequently, they did not perceive health as a concept that could be discussed outside the context of life and living. The analyst derived this interpretation in part from the women's responses when they were asked to say whether physical health was important, and they responded, "Sure, but there are more important things: family, God, laughter." They added to that list "relaxing" and "accepting" when asked about things that were important relative to a good life. Good health or good life, the in vivo term used by the Latino women to denote health, was apparently regarded as such an integrated part of self and living that they could not regard it as a separate entity, even for the sake of discussion. According to the key perspective "degree of differentiation," these older Latino women would be said to have a *nondifferentiated* view of health. For them, health was another part of who they were and not a thing that existed outside of themselves.

By analyzing existing data according to this "angle of vision," relationships among the many different dimensions became more evident than before. The pieces of the story and the relationships among those pieces began to become more evident. By utilizing peer rehearsal as a methodological strategy to challenge the logic of the emerging theory, however, the dimension "degree of differentiation," while admittedly useful, was deemed to be too pejorative a term to capture the essence of what was being observed in the data. Although the intent was clear, the designation conveyed something negative to the peer reviewers. They especially reacted to the use of the term nondifferentiated in connection with the Latino women's perspective of health. Therefore, searching for a better way to express what seemed in the data to be a central process, the analyst relabeled degree of differentiation as "integrality" and deemed it to be the most fruitful perspective from which to explain the observed differences between the perspectives expressed by older Anglo and Latino

women regarding the meaning of health and the value attributed to good health and their day-to-day healthful actions. Older Latino women were perceived as having a more integrated regard about health than their Anglo counterparts. From this point on, integrality became the central perspective that guided analysis, and the analyst accordingly determined salience of dimensions from this point of view. In other words, integrality enabled the analyst to view the good life, states of being, and other dimensions in a context of how they reflected cultural differences.

Integration

In the final stage of DA analysis, referred to here as the integration phase, analysts reconstitute the various pieces of the explanatory paradigm that have been identified through some grounded perspective (Schatzman, 1991). In this study, as categories were further described, they were sorted, organized, and clarified from the perspective of integrality. Analyzing data and placing them within the explanatory paradigm as context, condition, action/interaction, or consequence moved the research process along. As a strategy of DA, this was done to capture a greater world of meaning within the developing structure of this theory, which was attempting to describe and explain how functional health was perceived and choreographed by older Anglo and Latino women.

As the conceptual story was being integrated, the investigators collected and analyzed only limited additional data to challenge the validity of the emerging theory. The analyst continued to engage in the process of "self-talk" and conceptual negotiation in conjunction with staging a number of peer rehearsals with the other investigators. Additional key informants (older Anglo and Latino women who had not participated in the focus groups but who were members of the two cultures) also were recruited and interviewed to clarify and verify the emerging theory.

At a point where the investigator sufficiently reaches and describes both category saturation and depth of conceptual linkages, the theory-generation process is considered to be complete. The story or theory, representing the outcome of this research process, is reconstituted. In this study, this reconstitution culminated in providing a grounded theory developed by using the DA approach. This theory describes and explains the differences between older Anglo and Latino women's perspectives about health and day-to-day functioning as deriving from the way members of the two cultures assimilate health as an integral part of self.

RESULTS AND DISCUSSION

The results of this study are reminiscent of differences between individualist and collectivist cultures (Carpenter, 2000; Triandis, 1994;

Triandis & Gelfand, 1998; Triandis & Suh, 2002). The individualist aspects of the Anglo cultures are depicted by the introspective dimension of health as personal and individual in the Anglo women. The older Anglo women in this study consistently and repeatedly described health in terms of physical well-being or the absence of disease. Among their descriptions of being healthy were the following: "Not being sick, not feeling bad, being able to do the things I want to do, being able to do the things I need to do, walking without a cane, not needing to take as many medicines, getting a clean bill of health from [my] doctor, being able to eat whatever [I] want, and getting back to [my] old self."

People belonging to individualist cultures have been seen as driven by personal attitudes and values, and they assign priority to personal goals (Triandis & Suh, 2002). This was repeatedly demonstrated by older Anglo women in this study, who, as a cohort, talked about working hard to stay healthy. The older Anglo women did not appear to consider the impact of interpersonal relationships or spirituality as essential to the promotion, maintenance, or restoration of health and day-to-day functioning. Instead, they seemed to depend upon themselves and relied upon their own ability to implement personally devised interventions. When prompted about these observations, these participants provided statements that included the following:

> Who can you count on but yourself? I love my children, but I would never want to burden them. . . . Sure, they [children] say they want to help but I don't let them, they have their own lives, their own problems, they don't need any more.

The Anglo participants also regarded the medical community as important helpmates and generally regarded prescribed medical regimens as beneficial. The older Anglo women strove to be the ones in control of their health and regarded lost control as a tragic consequence of illness. Moreover, they had a low regard for and limited tolerance for diminished control and dependency as demonstrated by the following remark: "The day I can't take care of myself anymore is the day I lay down and don't get up."

In contrast, the older Latino women in the study rarely described health in terms of well-being or the absence of disease. Instead, they consistently appeared to perceive health as an intimate aspect of the self. Generally, the older Latino women's notions of the attainment or maintenance of health, good health, or the good life were similar to the interdependent concept of the self as witnessed in collectivist cultures. In collective cultures, relationships and the environment are central (Gloria, Ruiz, & Castillo, 2003; Ohbuchi, Fukushima, & Tedeschi, 1999; Triandis & Suh, 2002). As evidenced by this research, older Latino women were not inclined to separate health from the business of living. These participants

described women who did not enjoy the good life as "people who are not close to their families, not close to God, have no sense of humor, or those who are not able to laugh or dance or be happy."

People from collectivist cultures have been seen as driven by group norms and beliefs (Triandis & Suh, 2002). This notion is demonstrated by the ways in which the older Latino women described health in terms of its impact on their interpersonal relationships with family and friends. The physical aspects of health were not considered important, and physicians' or medically determined interventions or both rarely were regarded as essential by older Latino women in the study. On the other hand, the Latino women regarded spirituality, the importance of God, and the act of placing their health "in God's hands" as paramount to the maintenance and restoration of health and the prevention of illness.

In this study, there was a notable difference as well between the two groups of women with regard to their perceptions of aging. In general, the older Anglo women tended to face the prospect of growing old with trepidation, whereas the older Latino women seemed to see the decline that comes with aging as natural and anticipated. As an illustration, when the investigator asked the Latino women in the second group to consider if they would answer the questions the same or differently if they were 30 years younger, one woman responded:

> Life was harder then. [I was] too busy taking care of children, husband, house. I feel sorry for the young ones who have to work. . . . Husbands don't help. You have to take care of them. They expect it. You expect to do it. Sometimes it's easier to be a widow. You have more freedom.

The Anglo women seemed to view themselves as independent and strong throughout their entire lives, and, consequently, they strove to and admitted that they would aggressively act to maintain that independence. If they were unable to maintain a certain level of independence, they adjusted their views about themselves rather than admit that they were dependent. They renegotiated and reconfigured their notion of who they were in response to the threat or actual onset of each new illness or limitation. They reidentified themselves as a way to come to terms with and accept an illness or functional limitation. These conclusions derived from responses to the investigator's questions concerning what health largely seemed to mean, including not needing to take as many medicines and getting a clean bill of health from their doctor.

In contrast, the older Latino women seemed to view aging with a newfound sense of freedom. In general, they expressed a sense of growing independence in their later years, despite illness or functional limitations. These women viewed themselves as being less encumbered by the daily responsibilities they had when they were actively raising and serving their

young families and husbands. As older women, they expressed an overall sense of contentment, an acceptance of their lives, and a gratitude for the fullness of the lives they had led. This may be seen from responses to the question, What did they do when they felt physically sick: did they pray to God for help, talk to friends or family, call their doctor? One woman said, "What can I do? I would accept it, get over it, get on with things, ignore it, because there is nothing you can do about it. If God wants you, He'll have you. You just have to be ready."

Their embrace of the good life enabled them to enjoy their independent status, regardless of the presence of chronic illness or functional limitation. This somewhat unburdened attitude enabled them to accept infirmity and functional decline more readily than their Anglo counterparts. The Latino women were less inclined to seek help or to take action to change what in their view may not have needed to be changed (illness). They were also far less inclined to seek professional help or to follow conventional advice and counsel than the older Anglo women, instead finding peace and satisfaction in being able to accept and deal with the hand that they had been dealt either by fate or by God.

CONCLUSIONS

Psychosocial factors in patients' health have become the focus of study in the last decade, especially social support (Gazmararian, Baker, Parker, & Blazer, 2000; Hellman & Stewart, 1994; Koukouli, Vlachonikolis, & Philalithis, 2000). Low levels of support have been associated with lower physical functioning in elderly people. It is unclear, however, if this applies to elderly people of all racial/ethnic groups. The study described here would appear to suggest that differences exist at least between elderly Anglo and Latino women and that future research should continue to look for racial/ethnic differences in the relationship between social support and health. In addition, future research should attempt to validate these findings in other age and racial/ethnic cohorts through further qualitative and quantitative study.

Findings from this study contribute much to our knowledge about women and health care and have uncovered issues that might increase sensitivity regarding beliefs, values, and practices of different cultures. Specifically, these findings and the theory generated might provide insight into the ways health care planners and practitioners can better care for elderly women of White and Latino descent. As planners and practitioners, we are usually trained in a health culture that is based predominately on White, middle-class values (Rodriguez [Ruiz], 1998). As a consequence, we may be less apt to consider different conceptualizations of health. Our ethnocentrism can lead us to disregard the notion that

concepts such as "health" are not universally regarded, that they have different meanings to individuals in general and to individuals from different cultures in particular. Latino patients' mistrust of the health care system, unconscious clinician bias, and lack of cultural competence and sensitivity have been raised as reasons for the health disparities in the Latino population (Campinha-Bacote, 1999; ORWH, 1999). Understanding the meaning given to the concept of health can only enhance our ability to provide culturally competent care to peoples of different racial/ethnic, age, socioeconomic, and gender groups, thus further elucidating the issue of health disparities in the Latino population.

Qualitative research, like that described here, may enable us to achieve a closer approximation of the real experience of our patients and sensitize us to different perspectives and world views. Dimensional analysis proved to be effective in making sense of the multitude of factors that could explain differences in cultural perceptions about functional health. It is a good approach for studies of culture and health, allowing researchers to investigate different cultural perspectives in a novel way and giving them an alternative to conducting cultural research. It seems apparent from this study that Anglo women would likely benefit from conventional interventions that focus on the maintenance or restoration of self-responsibility and assisting older people to take control of their own health. Conversely, older Latino women would be less inclined to respond positively to such a contemporary style of intervention. Instead, they would be more apt to seek attention and advice from nontraditional sources before turning to conventional health care.

Therefore, as demonstrated by findings from this qualitative study, it is recommended that health care providers set their own values aside and assume those of their patients. Health planners and providers are urged to explore the sources of hope, strength, and spirituality of these women and to enlist the help of family and friends when contemplating and attempting to deliver the entire spectrum of care. Moreover, it is paramount that they consider the possibility that older Latino women may have accepted their situations and are truly enjoying the good life despite apparent illness and functional decline. Perhaps it would be prudent for health planners and providers to extrapolate what we have learned from older Latino women and attempt to apply these tenets to their practice in other situations where there appears to be limited positive outcome from traditional care.

REFERENCES

Aday, L. A. (1997). Vulnerable populations: Community-oriented perspective. *Family Community Health, 19*(4), 1–18.

Alliance for Aging Research. (1998). *One final gift: Humanizing the end of life for women in America*. Washington, DC: Author.

Aponte, J. F., Rivers, R. Y., & Wohl, J. (1995). *Psychological interventions and cultural diversity*. Boston, MA: Allyn and Bacon.

Brogan, D. L., Haber, M., & Kutner, N. G. (2000). Functional decline among older adults: Comparing a chronic disease cohort and controls when mortality rates are markedly different. *Journal of Clinical Epidemiology, 53*(8), 847–851.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education, 38*(5), 203–207.

Carpenter, S. (2000). Effects of cultural tightness and collectivism on self-concept and causal attributions. *Cross-Cultural Research, 34*, 38–56.

Duffy, M. E. (1987). Methodological triangulation: A vehicle for merging quantitative and qualitative research methods. *Image, 19*, 130–133.

Evans, R. L. (1999). Perceived functional health of disabled elderly persons on a follow-up program for primary care. *Psychological Reports, 84*(2), 553–555.

Fries, J. G. (1997). Can preventive gerontology be on the way? *American Journal of Public Health, 87*, 1591–1592.

Gale, B. J. (1994). Functional health of older women: Three dimensions. *Journal of Women and Aging, 6*(1), 165–185.

Gale, B. J. (1995). Dimensions of health functioning. *Women and Aging in Arizona*. Phoenix: Soroptimist International of Phoenix, Inc.

Gale, B. (1998). *Sociocultural influences on functional health in women* [Abstract]. [On-line]. Available: http://crisp.cit.nih.gov/

Gale, B. J., & Erickson, J. R. (1997). How race affects health services used by older women. *Women's Health Care International, 18*, 221–132.

Gazmararian, J., Baker, D., Parker, R., & Blazer, D. G. (2000). A multivariate analysis of factors associated with depression: Evaluating the role of health literacy as a potential contributor. *Archives of Internal Medicine, 160*(21), 3307–3314.

Geiger, H. S. (2001). Racial stereotyping and medicine: The need for cultural competence. *Canadian Medical Association, 164*(25), 1699–1701.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory strategies for qualitative research*. New York: Aldine.

Glass, T. A. (1998). Conjugating the "tenses" of function: Discordance among hypothetical, experimental, and enacted function in older adults. *Gerontologist, 38*, 101–112.

Gloria, A. M., Ruiz, E. L., & Castillo, E. M. (2003). Counseling and psychotherapy with Latino and Latina clients. In T. B. Smith (Ed.), *Affirming diversity in counseling and psychology* (pp. 167–189). Boston: Pearson.

He, W. (2002, September). *The older foreign-born population in the United States: 2000* (U.S. Census Bureau, Current Population Reports, Series P23-211). [On-line]. Available: http://www.census.gov/prod/2002pubs/p23-211.pdf

Hellman, F. A., & Stewart, C. (1994). Social support and the elderly client. *Health Nurse, 12*(5), 51–60.

Hetzel, L., & Smith, A. (2001, October). *The 65 years and over population: 2000* (U.S. Census Bureau, Current Population Reports, Series C2KBR/01-10). [On-line]. Available: http://www.census.gov/prod/2001pubs/c2kbr01-10.pdf

Hinds, P. S., & Young, K. J. (1987). A triangulation of methods and paradigms to study nurse-given wellness care. *Nursing Research, 36*, 195–198.

Kass, B. L., Weinick, R. M., & Monheit, A. C. (1999). *Racial and ethnic differences in health, 1996* (MEPS Chartbook No. 2, AHCPR Pub. No. 99-0001). Rockville, MD: Agency for Health Care Policy and Research.

Kools, S., McCarthy, M., Durham, R., & Robrecht, L. (1996). Dimensional analysis: Broadening the conception of grounded theory. *Qualitative Health Research, 6*, 312–330.

Koukouli, S., Vlachonikolis, I. G., & Philalithis, A. (2000). Socio-demographic factors and self-reported functional status: The significance of social support. *BMC Health Services Research, 2*(1), 20.

Lee, Y. (2000). The predictive value of self-assessed general, physical, and mental health on functional decline and mortality in older adults. *Journal of Epidemiology in Community Health, 54*(2), 123–129.

Liao, Y., Cooper, R. S., Cao, G., Durazo-Arivzu, R., Kaufman, J. S., Luke, A., & McGee, D. L. (1998). Morality patterns among adult Hispanics: Findings from the NHIS, 1986 to 1990. *American Journal of Public Health, 88*, 227–232.

Marin, G., & Marin, B. V. (1991). *Research with Hispanic populations*. Newbury Park, CA: Sage.

Mays, V. M., Cochran, S. D., & Sullivan, J. G. (2000). Health care for African Americans and Hispanic women: Report on perceived health status, access to care, and utilization patterns. In C. J. Hogue, M. A. Hargraves, & K. S. Collins (Eds.), *Minority health in America* (pp. 97–123). Baltimore: John Hopkins University.

McCarthy, M. C. (1991). *Interpretation of confusion: Conflicting models of clinical reasoning among nurses*. Unpublished doctoral dissertation, University of California, San Francisco.

McCarthy, M. C. (2003a). Detecting acute confusion in older adults: Comparing clinical reasoning of nurses working in acute care, long-term, and community health care environments. *Research in Nursing and Health, 26*(3), 203–212.

McCarthy, M. C. (2003b). Situated clinical reasoning: Distinguishing acute confusion from dementia in hospitalized older adults. *Research in Nursing and Health, 26*(2), 90–101.

Mills, R. J., & Bhandari, S. (2003, September). *Health insurance coverage in the United States: 2002* (U.S. Census Bureau, Current Population Reports, Series P60-223). [Online]. Available: http://www.census.gov/prod/2003pubs/p60-223.pdf

Minkler, M., Schauffler, H., & Clements-Nolle, K. (2000). Health promotion for older Americans in the 21st century. *American Journal of Health Promotion, 14*(6), 371–379.

Molina, C. W., & Aguirre-Molina, M. (1994). *Latino health in the US: A growing challenge*. Washington, DC: American Public Health Association.

Morgan, D. L. (1988). *Focus groups as qualitative research*. Newbury Park, CA: Sage.

Moy, E., Bartman, B. A., Clancy, C. M., & Cornelius, L. J. (1998). Changes in usual sources of medical care between 1987 and 1992. *Journal of Health Care for the Poor and Underserved, 9*, 126–139.

National Coalition of Hispanic Health and Human Services Organizations. (1995). Meeting the health promotion needs of Hispanic communities. *American Journal of Health Promotion, 9*, 300–311.

National Institute of Nursing Research. (1994). *Long-term care for older adults. A report of the NINR Priority Expert Panel on Long-term Care*. Bethesda, MD: U.S. Department of Health and Human Services.

Office of Research on Women's Health (ORWH). (1999). *Agenda for research on women's health for the 21st century: A report of the Task Force on the NIH Women's Health Research Agenda for the 21st Century, Volume 1. Executive Summary* (NIH Publication No. 99-4385). [On-line]. Available: http://www4.od.nih.gov/orwh/report.pdf

Ohbuchi, K. I., Fukushima, O., & Tedeschi, J. T. (1999). Cultural values in conflict management: Goal orientation, goal attainment, and tactical decision. *Journal of Cross-Cultural Psychology, 30*, 51–71.

Ory, M. G., Abeles, R. P., & Lipman, P. D. (1992). *Aging, health and behavior*. Newbury Park, CA: Sage.

Robrecht, L. C. (1995). Grounded theory: Evolving methods. *Qualitative Health Research, 5*(2), 169–177.

Rodriguez [Ruiz], E. R. (1998). Addressing the needs of diverse racial/ethnic populations. In S. Roth-Roemer, S. Robinson Kurpius, & C. Carmin (Eds.), *The emerging role of counseling psychology in health care* (pp. 356–393). Evanston, IL: Norton.

Rowe, J. W., & Kahn, R. L. (1998). *Successful aging*. New York: Pantheon.

Schatzman, L. (1980). *Dimensional analysis: Outline in preci form*. Unpublished manuscript. University of California, San Francisco.

Schatzman, L. (1986). *The structure of qualitative analysis*. Paper presented at the World Congress of Sociology, New Delhi, India.

Schatzman, L. (1991). Dimensional analysis: Notes on an alternative approach to the grounding of theory in qualitative research. In D. R. Maines (Ed.), *Social organization and social process* (pp. 303–314). New York: Aldine de Gruyter.

Strauss, A., & Corbin, J. M. (1990). *Basics of qualitative research*. Newbury Park, CA: Sage.

Triandis, H. C. (1994). *Culture and social behavior*. New York: McGraw-Hill.

Triandis, H. C., & Gelfand, M. (1998). Converging measurements of horizontal and vertical individualism and collectivism. *Journal of Personality and Social Psychology, 74*, 119–128.

Triandis, H. C., & Suh, E. M. (2002). Cultural influences on personality. *Annual Review of Psychology, 53*, 133–160.

Van Nostrand, J. R., Furner, S. E., & Suzman, R. (Eds.). (1993). *Health data on older Americans: United States, 1992* (DHHS Publication No. PHS 93-1411). Washington, DC: U.S. Government Printing Office.

Wallace, R. B. (1997). Variability in disease manifestations in older adults: Implications for public and community health problems. In T. Hickey, M. A. Speers, & T. R. Prohaska (Eds.), *Public health and aging* (pp. 75–86). Baltimore: Johns Hopkins University.

Zambrana, R. E. (1987). A research agenda on issues affording poor and minority women: A model for understanding their health needs. *Women & Health, 12*(3–4), 137–160.