

Re-imagining Healthy Aging: Perspectives of Older Black African Immigrant Women

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Abstract

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Older Black African immigrant women are among the fastest growing immigrant group in the U.S. Although U.S. and international research reveals functional status, independence, and cognitive functioning as major concepts of aging in older non-African and African American populations, absent from these empirical studies is knowledge about health and aging among Black African immigrants, particularly older women. We do not know to what extent their experience of aging might be unique and defy generalization as older adult women, African Americans, or immigrants. Older Black African immigrant women's perspectives and experiences are particularly important because of their central role in addressing family health

care needs, as well as identifying possible perspectives and health practices from their home country that may differ markedly from those in the U.S.

Grounded theory was deemed an appropriate approach for addressing the study purpose, given the lack of knowledge about older Black African immigrant women, particularly their views of health and aging, changes they might experience as a result of their transition to the U.S., and the importance of self-identity, social interactions, and contexts in life. Participants were recruited based on my established relationships with churches and other social groups that include older Black African immigrant women, theoretical sampling, and snowballing techniques. Women were eligible if they were born in Africa, were 45 years or older, immigrated to the U.S. as an adult, spoke and understood English.

Data for analysis included in-depth interviews that were recorded and transcribed verbatim, field notes, and methodological memos. Constant comparative analysis was used throughout the study. Theoretical sampling and data collection continued until there was saturation of the emerging theory. Atlas.ti 7 was used to facilitate management of the data, analytic codes and categories, and evolving themes. Additional data included responses to self-administered questionnaires, including the Attitudes to Aging Questionnaire, the Successful Aging Inventory, and the World Health Organization Quality of Life- BREF questionnaire. SPSS 19.0 (Statistical Package for Social Science) was used to analyze data from the questionnaires.

This original research disaggregated theory derived from older Black African immigrant women, a sub-group, as distinct from the larger African American population. Based on interviews with sixteen participants, the analysis and substantive theory indicated the core phenomenon experienced by the women to be “Re-imagining healthy aging,” which was informed by two categories: “Acknowledging images of healthy aging” and “Becoming aware of new images of

aging”. Action/interaction strategies identified as accepting, adapting and, managing were ways the women negotiated complicated relationships towards re-imagining healthy aging while living in the U.S.

The findings of this study reveal how at the intersections of cultures, attitudes, and beliefs, older Black African immigrant women imaged healthy aging in Africa and re-imagined healthy aging for themselves in the U.S. This research can inform clinical practice by enhancing awareness of the meaning of health and aging to older Black African immigrant women. The findings can be used in future research to guide instrument development, interventions, and health policies with aims to support healthy aging for these women.

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DEDICATION

To my husband Dwight J. McRae, from the beginning you believed in me and the importance of my studies. This PhD is ours to share. It is the result of working together and having faith in one another. Thank you for your patience as we journeyed together, for your dedication to my success in the program, and for your devotion to our family. Completing the PhD program would not be possible without your support, emotionally, financially, and spiritually, for that I am eternally grateful. I love you and I love the positive spirit that dwells in you.

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Chapter I: Introduction

The health and aging of older Black African immigrant women from sub-Saharan Africa, from where many Black African immigrants first came, is glaringly absent from aging discourse in the United States (U.S.; McBride & Lewis, 2004). Research is, therefore, needed to understand the health and aging perspectives held by older Black African immigrant women and to understand how their pre- and post-migration experiences contribute to their quality of life and health behaviors in the U.S.

Such research is important for ensuring that appropriate health care services are provided to these women. As a foundation for understanding current knowledge about this population of women in the U.S., this chapter describes the intersections of health, aging, and cultural background from the perspectives of scholars who have published research on healthy aging, along with factors that are known to affect healthy aging (Dong, Chang, Wong, & Simon 2012; Williams & Wilson, 2001).

Older Black African immigrant women in the U.S. are a highly heterogeneous group representing many countries from Africa (Grieco, Acosta, & Cruz, 2012; Wonkeryor, 2013). These women are at risk for chronic illnesses by virtue of their aging, gender, and race, as well as stress-related pre- and post-migratory environmental conditions. The vulnerability of this population is exacerbated by limited information among U.S. health providers about the women's views of aging, health, and quality of life as they age in the U.S. (Mbanaso & Crewe, 2011; Venters & Gany, 2009). This lack of knowledge means that health care providers do not have an evidence base for providing these women with the best possible care.

Aging research on older Black African immigrant women is sparse and has largely treated Black African immigrants as a homogeneous group (Rastogi et al., 2010; Troutman, Nies, & Mavelia, 2010). Current patterns of aggregating older Black African immigrant women in the same demographic category with older U.S.-born African American women may mask important information about health disparities and potential gaps in our empirical knowledge (Adler & Rehkopf, 2008). For example, a few studies have shown that older Black African immigrant women are the conveyors of their cultural heritage and traditions (Arthur, 2009; Kanya, 1997; Sellers, Ward, & Pate, 2006). If views about health and aging vary according to pre- and post-migratory experiences and cultural norms in both the home and host countries, knowledge about these views would be important for designing effective public health promotion strategies that can influence the health of a much larger community of immigrants. Such information can guide ways to maintain health advantages going into old age and contribute to our understanding of healthy aging and health disparities when formulating policies to maintain health status and positive health behaviors.

Purpose of the study

The purpose of this study is to develop a theory on healthy aging for older Black African women who have immigrated to the U.S. as adults. Specific aims are to:

1. Describe the meaning of health and aging to heterogeneous older Black African women based on their experience of immigrating to the U.S. as adults and relative to views they held in their home country.
2. Describe pre- and post-migratory activities of daily living and experiences (e.g. family and social relationships, dietary changes, spiritual activities) that participants indicate influence their views on health and aging and their health behaviors.

3. Elaborate on this theory of health and aging by triangulating the women's perspectives on their experiences with their self-reported feelings about attitudes to aging, successful aging, and quality of life.

Chapter II: Literature Review

In this chapter, older Black African immigrant women, their cultural background, and factors leading to immigration are described to get a better understanding of the population. The meaning of health and aging, described in the theoretical and empirical literature, is discussed to provide a foundation upon which to build knowledge. Relevant factors of health and aging for older immigrants aging in the U.S., acculturation, family, and social support are discussed.

Older Black African Immigrant Women

Older Black African immigrant women are a vulnerable group due to the triple jeopardy of their age, gender, and race (Ebrahim, 1996). By virtue of advancing age, these women are susceptible for increased risk of chronic diseases (Go, et al, 2013). Moreover, they experience discrimination due to race and religious affiliation (Williams & Wilson, 2001). Compounding the triple jeopardy is being invisible in society. Black immigrants, both male and female, are largely aggregated within the classification of African American. Much of the data are used to update census and survey reports (Wonkeryor, 2013). However, the extent of the vulnerability of older Black African immigrant women is unknown as they are not represented or identified as a specific group on surveys, research models, or large data sets such as the Women's Health Initiative, the Jackson Heart Study, the National Survey of Black Americans, or even studies that oversampled for minorities, such as the New Immigrant Health Survey (Jasso, Massey, Rosenzweig, & Smith, 2003; Langer, 2003; Lloyd-Jones, 2012; Sempos, Bild & Manolio, 1999). Salari (2002) discussed the implications of invisibility and exclusion on health experienced by older Arab, Middle Eastern and Muslim immigrant women in the U.S. She considered the context of the digital age, inter-group diversity, and social, cultural, and environmental interactions, which were viewed as strong factors affecting health outcomes among older

immigrants to the U.S. Similarly, Unger and Schwartz (2012) argued for adopting culturally based, conceptual models of immigrant communities with strong cultural values, suggesting that such conceptual models could lead to more valid measures of the influence of culture on health.

One of the few published studies conducted among African immigrants in the U.S. has demonstrated some key health issues that may be relevant to older Black African immigrant women. Kanya (1997) collected survey data from 52 African immigrants, both men and women, to explore their integration into the social environment of the U.S., based on predetermined themes. After assessing for stress, hardiness, self-esteem, coping resources, and spiritual well-being, Kanya found that post-migratory experiences contributed to immigrant health. Additional findings indicated that stress, self-esteem, and spiritual well-being were interactive processes that challenged immigrants culturally as they interacted in their new environment. Given the deductive design and lack of specificity concerning age and gender of the participants, it is not known how these themes are applicable to older Black African immigrant women.

In addition to a troubling lack of knowledge concerning factors that influence health for these women, pre- and post- immigration experiences exacerbate their vulnerability to chronic diseases (Upvall, Mohammed, & Dodge, 2008). What is known about older Black African immigrant women, post-migration, is that they are conveyors of cultural heritage and traditions, are disproportionately concentrated in the poorest urban areas, and reside in close proximity to one another as a form of mutual support and to share resources (Arthur, 2009; Shaw-Taylor & Tuch, 2007; Venters & Gany, 2009). We also know that the average life expectancy of women from sub-Saharan Africa is approximately 46 years of age (McCabe, 2011; WHO, 2010), which has implications for their quality of life related to chronic disease as they age in the U.S. For

example, findings from research on the pre-migratory experiences of African immigrant women, such as female circumcision and the physical demands of carrying water, in contrast to non-African immigrant women, indicate that specific cultural practices affect post-migratory quality of life and may affect health going into old age (Arthur, 2009; Atwell, Correa-Velez, & Gifford, 2007; Meadows & Melton, 2001; Pavlish, Noor, & Brandt, 2010; Smedley, Stith, & Nelson, 2003). Older Black African immigrant women undergo changes in a variety of domains, including environmental, social, and cultural domains (Arthur, 2009; Mbanaso & Crewe, 2011). These women also experience new political processes and social and economic challenges that require acquisition and application of new knowledge and communication strategies (Arthur, 2000; Arthur, 2009; Williams & Wilson, 2001).

Not a lot is known about the care of older Black women in African immigrant communities. As such, it is unknown how the concept of chronic disease is understood among African immigrants, particularly older women, whose knowledge of health may have consequences for their health and the health of their families. In fact, research has not yet clarified how Western concepts of chronic disease and healthy aging are understood among older Black African immigrants (Venters & Gany, 2011). In one of the few studies that has conducted a needs assessment of older Black African immigrants in the U.S., Darboe and Ahmed (2007) collected qualitative and quantitative data from 200 older Black African immigrant men and women across eight cities in Minnesota. The older Africans in this study were between the ages of 55 and 84 years; 80% were females and 20% were males. These researchers utilized focus groups to interview participants and collected data from self-administered questionnaires from them. The findings of the study revealed that the majority of the participants did not engage in physical activity due to environmental factors, such as weather and walking access, and did not

have access to unprocessed traditional foods. The findings further demonstrated that the participants possessed a clear sense of what constituted healthy eating but because of limited transportation, they lacked access to fresh fruits, vegetables, and ethnic foods. Furthermore, the researchers found participants' views about aging changed after immigrating; indicating that changes in social and cultural settings are important factors for healthy aging and should be considered in both research and health policies. This important study described factors that influenced health and aging in older Black African immigrant men and women, yet the methods used to analyze the qualitative data were not reported. Additional research among older Black African immigrants is needed to assess barriers and facilitators of health behaviors like physical activity, particularly among women.

Although factors related to the pre- and post-migratory health of African immigrant women have been identified (Arthur, 2009; Kanya, 1997; Mbanaso & Crewe, 2011; Wonkeyor, 2013), there are no research studies investigating attitudes to aging or factors that promote or contribute to successful or healthy aging among older Black African immigrant women in the U.S. Some researchers have examined health behaviors, self-rated health status, and perceptions of successful aging among ethnically diverse older immigrant women through hermeneutic lenses and within the context of acculturation (Dean & Wilson, 2010; McBride & Lewis, 2004; Meadows, Thurston, & Melton, 2001). Other researchers have identified common health problems and the influence of ethnicity and nativity on health among older women from immigrant and minority populations in the U.S. (Bernard, Lampley-Dallas, & Smith, 1997; Carlisle, 2012; Hopper, 1993; Williams, 2002). Yet, none of these studies explored both pre- and post-migratory experiences of older Black African immigrant women and their perspectives on health and aging.

These studies demonstrate that identifying factors that contribute to health and aging is key to the expansion of our knowledge of health and aging among older Black African immigrant women. Seeking to learn more about the pre- and post-migratory experiences of these women will, therefore, be critical to eventually developing evidence-based and culturally competent health interventions and programs.

Immigration

Immigration is hardly a new phenomenon; it has enhanced geographic cultural diversity for generations, particularly in the U.S. As a result of the 1965 U.S. Immigration and Nationality Act (P.L. 89-236), the number of immigrant adults to the U.S. continues to grow significantly. The Act made family ties the primary rationale for admitting new immigrants to the U.S. (Kennedy, 1966), an agenda that subsequent research findings suggest has succeeded (Greico, 2010). Indeed, Schwartz, Unger, Zamboanga, & Szapocznik (2010) describe the large flow of immigrants to the U.S. as originating largely from Latin America, Asia, the Caribbean, and Africa, places where collectivism (i.e., focus on family, clan, nation, and religion) and not individualism (i.e., focus on the individual person) is emphasized (Obiakor & Afolayan, 2007).

Immigrants from Africa constitute a highly diverse and rapidly growing population in the U.S. While representing only 3% of the foreign born in the U.S., Black African immigrants constitute a small but fast-growing population. The population of Black African born immigrants in the U.S. doubled in size between 2000 and 2010 to 1.6 million and outpaced earlier numbers seen after the passage of the Immigration Acts of 1980, 1986, and 1990 (Venters, & Gany, 2011). The largest numbers of Black African immigrants are located in California, New York, Texas, Maryland, and Virginia. Washington State is described as fastest

growing state for Black African immigrants because of a large aging-in-place population (Frey, 2008).

Push-Pull Factors

Push factors are those influences that drive people away from their homes, often by force (e.g., economic oppression, natural or environmental disasters, war conflicts, and political instability). *Pull* factors are those that draw people to voluntarily leave their homes (e.g., educational aspirations, employment opportunities, and the prospect of reuniting with family members) (Arthur, 2000; Gushulak & MacPherson, 2011; Mbanaso & Crewe, 2011; Smedley, Stith, & Nelson, 2003).

African immigrants have diverse reasons for moving to the U.S., including politics, war, geo-economics, famine, and religion. The U.S. offers opportunities to grow and pursue personal goals without oppressive political regimes (Mbanaso & Crewe, 2011). Many older African women emigrate from Africa to the U.S. so they can reunite with their children and grandchildren, as well as seek better economic opportunities (Arthur, 2009; Sellers, Ward, & Pate, 2006). Among Black African women who immigrate to the U.S., many have experienced violence and gender-related physical abuses prior to migration. It is also important to note that refugees, whose experiences are distinct from immigrants, do not leave their home country as a choice and usually cannot return (Barnes & Almasy, 2005). Although the refugee experience was not a focus of this research, even non-refugee immigrants have described harsh treatment from their home countries (Arthur, 2009).

Pre-immigration. Whether the decision to migrate is a push or pull situation, both scenarios cause immigrant populations to endure stress and levels of indignity related to the immigration process that can affect their health. The process of immigration is expensive and

time intensive; it involves maneuvering bureaucratic gatekeepers of both the host country and the country of nativity. For voluntary immigrants, the inconvenience of traveling great distances to an embassy and enduring many hours waiting in long lines pales in comparison to the experiences of refugees who flee their home country (Mbanaso & Crewe, 2011). Refugees do not have the luxury to plan an exodus, pack belongings, or supply documents that can prove their nationality. The long hours of waiting experienced by the elective migrant can become years for the refugee, and thereby affects the physical and psychological health of middle-aged and older refugees (Akresh & Frank, 2008; Arthur, 2000; Gushulak & MacPherson 2011). Once immigrants (or refugees) are granted a visa, the next step is medical screening to ensure they do not pose a burden to the health and social service programs of the host country; this too can cause immigrants stress. In addition, intra-regional migration or relocating multiple times is known to contribute to an overall decline in the health of immigrants even before their arrival in the U.S. (Akresh & Frank, 2008). Moreover, many studies have found that immigrant women attribute stressful pre- and post-migration experiences to a self-reported deteriorating health status in the U.S. (Gushulak & MacPherson 2011; Jasso, Massey, Rosenzweig, & Smith, 2004; Meadows, Thurston, & Melton, 2001).

Post-immigration. When immigrants arrive in the U.S., they generally attempt to adapt to their new environment and learn the language, beliefs, and customs of the new culture. Acculturation and socialization are processes of cultural change and adaptation that occur when immigrants or non-majority groups enter a dominant or host society and by which individuals or groups learn and adopt the norms and values of a host culture (Rudmin, 2003; Trimble, 2003; Wrobel, Farrag, & Hynes, 2009). During the process of acculturation, a combination of conflicts, tension, and stress often arise for immigrants in their efforts to negotiate or minimize

cultural differences between themselves and their host communities, particularly if their host countries or communities are not open to or inclusive of cultural diversity (Berry, 2007; Nelson, 2009).

Overt racism and perceived discrimination are significant stressors for immigrant groups (Al-Omari & Pallikkathayil, 2008), and acceptance or non-acceptance of new immigrants into a host society may exert adverse effects on health. Researchers have identified tensions between Black African immigrants and those who are and are not from visibly African populations due to views held about populations originating from Africa in general. These researchers have posited that these tensions may reflect a mutual lack of understanding and perspective concerning the other group's history (Shaw-Taylor & Tuch, 2007). Although there is no shortage of research on the overall health effects of racism on immigrants (Palmer, 2007; Paradies, 2006; Williams, 1997), there is a dearth of knowledge concerning the effects of racial discrimination on the health of older Black African immigrant women.

Strategies used by immigrants to adapt to a host country result in varying outcomes on their health (Berry, 2007; Nelson, 2009). Various levels of chronic, acculturative stress (e.g., increased allostatic load) derived from cultural conflicts and constraints within social structures (e.g., racism) serve as antecedents to the health disparities experienced by immigrants compared to white individuals who are native to the host country (Antecol & Bedard, 2006; Takeuchi, Leaf, & Kuo, 1988). Acculturative stress, if experienced at high levels, has negative consequences for the health of immigrants (e.g., high blood pressure, cardiovascular disease; Juster, McEwen, & Lupien, 2010).

The relationship between acculturation and health has emerged as a significant focus of discussion and inquiry among researchers as they attempt to measure effects of acculturation on

health, particularly as the number of immigrants to the U.S. has increased (Singh & Miller, 2004; Singh & Hiatt, 2006). Berry's Acculturation Theory (2003), used by researchers to address adaptation to a host country, posits that people can experience acculturation along multiple pathways and in different directions. Berry's theory identifies four processes of acculturation: assimilation (i.e., the complete adoption of the host culture), separation or encapsulation (i.e., a reaffirmation of the traditional culture), integration (i.e., biculturalism or a blending of the host and traditional cultures), and self-marginalization (i.e., withdrawal from both the host and traditional cultures). These processes were demonstrated in a cross-sectional study of depression that identified subgroups of Koreans at different acculturation levels (Choi, Miller, & Wilbur, 2009). The authors found that immigrants in the marginalized group had higher scores for depression than American non-immigrants or Korean American groups that fell in other acculturation categories. The cross-sectional nature of the study does not permit the researchers to make inferences regarding causality. However, the findings have important implications for the mental health of older Black African immigrant women, considering the stressful pre-migratory experiences and post-migratory living conditions that are often in marginalized low-income urban areas in the U.S.

In an epidemiological study, researchers explored the relationship between overweight/obesity prevalence among foreign-born individuals in the U.S. and their age at arrival to the U.S. (Roshania, Narayan, & Oza-Frank, 2008). Findings revealed a relationship between duration of residence and prevalence of overweight/obesity that varied by age on arrival to the U.S. In other words, increased length of residency was associated with higher self-reported dietary change for participants who immigrated to the U.S. at a younger age than for individuals who immigrated at an older age. Considering the population of interest for this study, these

findings may suggest that Black African immigrant women who are older at the time of immigration may experience lower dietary adaptation than Black African women who immigrated at a younger age. These findings have implications for the nutritional health of older Black immigrant women who arrive in the U.S. at an older age with limited access to familiar foods.

Meaning of Health and Aging

Health. This section focuses on health, as discussed among scholars, and then turns to factors associated with negative health outcomes and concerns for health among African immigrants. From a biomedical or clinical perspective, health is defined as the absence of disease or of any abnormal condition that impairs normal physiological functioning (Boorse, 1977). This definition was used in early healthy aging research; it presupposes that a person cannot be healthy if he or she is born with a physical defect that causes problems with functioning. This perspective, however, does not consider subjective personal and social-cultural factors related to health and the enhancement of one's health (Smith, 1981; Lyman, 2005). Since Smith's (1981) conceptualization of health as a continuum that is individually defined, investigators have sought to understand the meaning of health from the perspective of older women. For example, researchers Woods, Laffrey, Duffy, Lentz, Mitchell, Taylor, & Cowan (1988) used Smith's model of health to explore the personal meaning of health among an ethnically diverse group of women residing in Western Washington. Participants (n=528) endorsed images of well-being or the eudemonistic model of health in spite of age, education, income or ethnicity. However, the ethnic diversity of African Americans within the sample is unknown, which limits its generalizability to immigrant women, much less older Black African immigrant women.

Nonetheless, the study demonstrated the importance of self-reported images of health, aging, and well-being when considering health behaviors.

In a similar study on the personal meanings of health, researchers expanded on the concept of health as subjective and socially constructed (Damron-Rodriguez, Frank, Haass, & Reuben, 2005). These researchers explored similarities and differences in the meaning of health among older members from different ethnic groups. Ten focus groups were conducted with participants who were paired based on ethnicity and language. Participants were African Americans, Spanish-speaking Hispanic Americans, Mandarin-speaking Chinese Americans, and Cantonese-speaking Chinese Americans ages 59 to 87. Although no single definition of health emerged, the study participants conveyed a sense of optimism about aging, in spite of health symptoms, and the ability to engage in social interactions. Personal meanings of health are, therefore, viewed by older ethnic groups as socially and culturally constructed and inclusive of subjective experiences, meanings, and attributes that are defined by the individual. Perceptions of healthy aging are important when considering health behaviors and factors that affect longevity, as positive perceptions were associated with disease-preventing health behaviors (Levy and Myers, 2004).

Researchers agree that it is important to understand women's health perceptions from a culturally sensitive perspective. Thurston and Vissandjee (2005) argued that pre- and post-migratory experiences of immigrant women are best understood within a framework that considers individual and social factors when seeking to explain immigrants' adaptation to a host country. Salari (2002) contended that smaller-scale qualitative studies could provide meaningful information about ethnic community sub-cultures for developing formal care giving and aging services.

In a study considering immigrant women's perspectives on healthy aging, Unson, Trella, Chowdhry, and Davis (2008) explored perceptions of aging and adaptation strategies of older African Caribbean women in the U.S. The research results highlighted inter-ethnic perspectives on healthy aging. One limitation of this study was that the majority (84%) of the participants were born in the U.S. It is unknown how nativity and length of stay in the U.S. influences perceptions of healthy aging among African immigrants. This consideration is important as Black African immigrants in the U.S. demonstrate a growing heterogeneity within the overall Black population in this country. That diversity is often lost in research studies because data in the U.S. is often collected using standard racial classifications that aggregate immigrant Blacks whether from Africa, America, the Caribbean, or the United Kingdoms into one homogeneous category (McKinnon & Bennett, 2005; Rastogi et al., 2010; Venters & Gany, 2011).

Health concerns. Upon arrival in the U.S., African immigrants generally have better health than their host counterparts, a finding known as the "healthy immigrant effect" (Venters & Gany, 2011). However, through acculturation processes and increased duration of residency, this health advantage seems to diminish (Go et al., 2013; Singh & Hiatt, 2006). Results from health disparities research indicate that chronic diseases such as cardiovascular disease, diabetes, obesity, hypertension, stroke, and cancer disproportionately affect African Americans in the U.S. population (Go et al., 2013). Research examining the health of Black African immigrants compared to the health of African Americans born in the U.S., has found that the former describe better self-rated health and have a significant health advantage over other immigrant groups (Read, Emerson, & Tarlov, 2005). The findings from those few studies could result from selection of the healthy at the time of immigration where only the healthies are granted permission to immigrate to the U.S. Additional findings from researchers Singh and Hiatt (2006)

demonstrated overall lower mortality among African immigrant men compared to U.S.-born African American men. Although the sample size of this study was large (n=109,079) and allowed for the analysis of health behaviors among sub-groups, information on self-rated health, health behaviors, and health outcomes for older Black African immigrant women were not reported. Given the prevalence of chronic diseases among the Black population emphasis is placed on including older Black African immigrant women in research to identify health behaviors that could inform prevention programs tailored to older Black immigrant women in the U.S.

Aging. Healthy aging, successful aging, and positive aging are constructs that are used to describe forms of aging that encompass physical strength and psychological and social losses and strengths (Bowling and Iliffe, 2011; Flood, 2006; Harper & Powers, 1998; Laidlaw, Powers, & Schmidt, 2007; Woods et al., 2012). Successful aging in older ethnic immigrants is an interest of researchers. For some researchers, this interest is in part due to the increased life expectancy of older adults, advances in medical interventions, as well as the increased number of older ethnic immigrant adults in the U.S. and age-related health disparities (U.S. Department of Health and Human Services, 2010). Efforts to address age-related health disparities have included conceptualizations of successful aging (Rowe & Kahn, 1987). The researchers describe successful aging as: (1) the absence or low probability of disease and disease-related disability, (2) an active engagement with life, and (3) high cognitive and physical functioning. However, additional discourse on healthy aging has contributed to the notion that aging occurs not only through an active life style and intact cognitive orientation but also through social interactions (Onedera & Stickle, 2008; Phelan, Anderson, LaCroix, & Larson, 2004). In fact, measurements of physical limitations and psychological constructs such as self-rated quality of life have been

used to operationalize successful aging. Researchers have reported that older adults who experience physical limitations may still perceive themselves as aging well (Strawbridge & Wallhagen, 2002). For example, when asked to define successful aging, older men and women from ethnically diverse groups identified physical and functional health as important (Romo et al., 2012;). These elders also emphasized such attributes as positive attitude, adaptation, and emotional well-being as domains of successful aging.

In earlier discourse, Fry (2000) argued that the concept of aging is a social construct and that the experience of growing old, whether negative or positive, is influenced by culture. Similarly, Taylor (2001) identified positive aging as occurring through an individual's sense of place, in the form of a place attachment or place identity that is held together by an accumulation of memories that allow individuals to maintain a positive self-image and avoid negative experiences. This view concerning a sense of place is supported by research that identifies nativity as a determinant of health outcomes in immigrant populations (Angel & Angel, 2006; Carlisle, 2012). To that end, healthy aging is not a simple issue of personal and biological adaptation but also a process that can be understood through the context of community and person-environment interaction. In a qualitative study of 72 community-dwelling older adults ages 60 to 99, Reichstadt, Depp, Palinkas, Folsom and Jeste (2007) conducted 12 focus groups that discussed open-ended questions such as "What is successful aging?" After analyzing their data using grounded theory, they identified four themes: attitude/adaptation, security/stability, health/wellness, and engagement/stimulation. While the themes were interrelated, the researchers found that participants' ability to adapt to their environment and their attitudes contributed to a greater sense of successful aging. These findings were supported by participants' pursuit of

continued stimulation, ranging from learning and having a purpose in life to being useful to others and society.

In a similar study, Troutman, Nies, and Mavelia (2011) explored the perceptions of successful aging among older Black adult men and women in the southern U.S. The theory guiding this research assumed a positive developmental process involving self and others. A sample of 99 adults ages 65 to 89 years with no cognitive impairment participated in focus groups that aimed to define successful aging among older Black adults. Content analysis of data yielded six categories: independence/ability, health, mindset, activity/service, family, and spirituality. These findings are possible foci for developing new interventions to promote successful aging among older Black African Americans. Unfortunately, the study did not identify immigration status or nativity of the participants. As such, it is unclear whether the findings are relevant to the meaning of healthy aging of older Black African immigrant women or older Black African immigrants in general.

Chronic diseases disproportionately affect the health outcomes of African Americans (Go et al., 2013), particularly in old age. Results reported from the studies reviewed pose important implications for healthy aging research among older Black African immigrant women. First, nativity may inform health benefits of Black immigrants to the U.S. (Singh and Hiatt, 2006) and second, among older ethnically diverse individuals, it appears that cultural, social, and environmental contexts can exert positive or negative effects on healthy aging (Sellers, Ward, & Pate, 2006; Zhou, 2002). These implications are particularly important for future studies of older Black African immigrant women.

Summary

It is unknown if older Black African immigrant women will experience health patterns of aging that are similar to patterns already identified among other immigrant populations in studies of aging or if they will increasingly suffer from chronic illnesses (Smedley, et al, 2003).

However, current knowledge of health and aging, which is applied to these women, is based on studies of non-African immigrant populations. Since older Black African immigrant women have experienced unique challenges and possess perspectives concerning their own identities and health, it is important to explore whether current factors associated with healthy aging are similar among these women to determine if current aging-related services would meet their later-life needs in the U.S. The current study provides a foundation for future work that can identify pre- and post-migratory factors related to healthy aging of older Black African immigrant women.

Chapter III: Methodology

This chapter begins with a discussion of the philosophical underpinnings of the study. The sections that follow include a description of the design; sampling strategies; methods for gaining access to study participants; and instruments used to collect, interpret, and present data for this study. Human subjects protections and considerations are discussed as they relate to conducting the study. The chapter concludes with a description of the data analyses – both qualitative and quantitative.

Symbolic Interactionism and Grounded Theory

This study was guided by theoretical perspectives that highlight the importance of understanding the meanings individuals make of their world and interactions with others. Early work by American pragmatist George Mead was expanded and put forth by Herbert Blumer's work in symbolic interactionism (Blumer, 1969). Pragmatists assert that human beings are constantly adapting to their changing world through mindful contemplation of situations and occurrences. Blumer asserted the premises of symbolic interactionism as: first, human beings act towards things based on the meanings that the things have for them; second, meaning arises out of social interactions between people; and third, meanings are handled and modified through an interpretive process used by the person dealing with the things he or she encounters. Blumer's first premise makes a particularly important point when considering the historical context at the time of a person's interaction with and their construction of the social world. He maintained that the significance of symbolic interactionism is the meanings made by humans through a process of interpretation. Therefore, to adopt the symbolic interactionist approach when conducting research, the researcher must interact with participants and see the world from their point of view.

Grounded theory methodology is used to generate theory that is conceptually and systematically derived from data, with no preconceived hypothesis (Corbin & Strauss, 2008). The methodology is ideal when little is known about a topic and when few participants are available in the general population (Chenitz & Swanson, 1986). The goal of grounded theory is theory development to understand and interpret processes through which people live and interact, and are not from pre-conceived ideas or existing theories. Grounded theory includes purposive and theoretical sampling, the constant comparative method of data analysis, coding and categorizing, memo writing, and theory generation, all of which occur throughout the project (Corbin & Strauss, 2008).

Reconciling Afrocentrism and grounded theory. Smith (1999) has argued that researchers, who seek to explain African narratives and be understood as authentic and valid, must consider cultural norms and how they as researchers are situated in relation to those narratives. As such, I began this research by considering Afrocentrism as a philosophical approach especially in the context of my study about healthy aging of older Black African immigrant women. Muwanga-Zake (2010) has argued that Afrocentric research paradigms, such as Ubuntu – a word used to express the spirit of ‘human-ness’ or, roughly translated, to show human kindness (Bohman, et al, 2011) – should be considered and used together with Western paradigms to validate and authenticate data and to determine the usefulness of findings in African immigrant communities.

An Afrocentric paradigm assumes that contrary to existing concepts of health and aging derived from Western paradigms, it is African participants’ worldviews that determine what is or is not a problem, identify the source of that problem, and create solutions. Similarly, Broodryck

(2006) asserts that all constructs of scholarly investigation be aligned with what is known by African participants through Afrocentric methodology.

Glaser (1978) has argued that grounded theory is a perspective-based methodology and is free from bias, since participants have multiple perspectives though lived experiences. The researcher receives these perspectives as data, as patterns, and raises these perspectives to an abstract level of conceptualization. Through the tedium of the constant comparative process, researcher bias is revealed and can be minimized.

The purpose of this study is not to argue the methodological accuracy of satisfying universal truths but to develop a theory as a way of explaining the process of meaning making by older Black African immigrant women. Therefore, utilizing grounded theory, with its theoretical underpinnings in symbolic interactionism, and incorporating deductive and inductive tactics is an appropriate and authentic way to give voice to older Black African immigrant women as they make meaning of health and aging related to their pre- and post-migratory experiences from Africa to the U.S.

Research Design

This study used a grounded theory approach with a mixed methods design that incorporated data collection with standardized questionnaires, which was an appropriate strategy to understand the process by which older Black African immigrant women make meaning of health and aging, given their pre- and post-migratory experiences from Africa to the U.S. The design was used to capture nuances and symbols of the participants' expressions, thoughts, and emotions regarding health and aging in the U.S. Moreover, this research design facilitated my ability to understand how the participants interpreted their experiences and how meanings or images were constructed, dissolved, and reconstructed while living in the U.S.

Inductive methodology. Given that health beliefs are socially and culturally constructed and interpreted by researchers (Glanz, Rimer, & Viswanath, 2008), in-person interviewing, as an inductive method associated with qualitative research methodology was well suited for this project. Such interviews are useful in obtaining detailed information about a specific topic that might otherwise take researchers months or years of fieldwork (Streubert & Carpenter, 2011). In-person interviews provide a deeper understanding and meaning of specific issues by encouraging interaction between researchers and participants and have been shown to be a successful method of data collection in other studies on immigrants and healthy aging (Meadows, Thurston, & Melton, 2001). Additionally, in-person interviewing facilitates the process of observation in the participants' natural setting. As an observer, participants' voice, body movements, eye contact, and other verbal and non-verbal forms of communications are treated as data that allow the researcher to gain clarity on meanings and the way participants construct their world (Chenitz & Swanson, 1985).

Deductive methodology. Questionnaires were used as an additional source of data to elaborate on the participants' experiences and the developing theory. Murdaugh (1999) described methodological triangulation as the use of two different data collection methods in the same study, which suggests that triangulation results in a more comprehensive description of the phenomenon of interest. Creswell (2009) supports the use of concurrent mixed-methods designs whereby researchers may use a secondary form of data to provide additional supporting context to the research. Glaser (1978) asserts, "... the focus of deductions is on more comparisons for discovery, not on deriving an hypothesis for verification (though this may occur as a byproduct)" (p.38).

Research Participants

Theoretical sampling, defined as “the process of data collection for generating theory where the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find the data as the theory emerges” (Glaser, 1978, p.36), guided study recruitment and sampling. The initial convenience sample was selected according to the purpose and rationale of the study (Morse, 2010). Different from theoretical sampling, convenience-sampling method is used at the beginning of a project to select participants who are accessible and most likely to provide data about the phenomenon of interest to the researcher. Ideally, I wanted the participants to represent the countries of Africa in proportion to their presence in the U.S. However, the representation I sought was not easily accomplished. Subsequent theoretical sampling was based on conceptualizations from data analysis and the evolving theory.

Because little is known about this group of women, the goal was to reach theoretical saturation of data as opposed to achieving a specified sample size. The research question determines selection of whom or what is of interest; thus, theoretical sampling choices were not determined before the research began. This sampling method was flexible enough to allow for greater comparisons as concepts were revealed during data analysis. As a result, the criteria for selecting participants changed based on the concurrent data analysis and comparisons of categories and concepts. In this study theoretical saturation was reached with fourteen participants, and two additional participants confirmed saturation since nothing new was added to the themes or theory through their participation.

Inclusion criteria. Participants were eligible for this study if they: (a) were female, (b) were born in Africa, (c) were age 45 or older at the time of the study, (d) immigrated to the U.S. as adults, (e) spoke and understood English, and (f) provided informed consent to participate in the study. Enrollment in the study was open until data saturation of the evolving theory occurred, as determined through theoretical sampling.

Exclusion criteria. Women requiring physical assistance while ambulating and those with known mental disabilities were excluded from participating in the study.

Recruitment. Recruitment flyers were posted at African grocery stores and African community centers, as well as hair salons from Pierce County to North King County that serve Black African immigrant women (see Appendix A). Snowballing techniques were also used through key participants and members of the African community known to me.

Gaining access. Because I knew of eligible participants based on mutual religious affiliations, I first obtained permission from pastors at the Emerald City Community Seventh-Day Adventist Church, the Volunteer Park Ethiopian Seventh-Day Adventist Church, and the Maranatha Seventh-Day Adventist Church, according to their administrative policies, to contact potential participants in their churches. Additional recruitment was based on social connections within African communities in the area; six eligible women from different regions of Africa were already known to me. During initial recruitment efforts, I was invited to a local Somali women's group and to a Zambian women's retreat to describe my research study. Both invitations provided opportunities to learn more about these communities, meet prospective participants, and observe the interactions of the women with one another.

Data Collection

Data collection procedures. Data collection took place from February 2014 to September 2014. Following approval by the University of Washington Human Subjects Division and before enrolling participants, I used a prepared script with participants who responded to the flyers or had given an intermediary (e.g., through snowballing) permission to be contacted. The script provided information about the study and invited eligible women to participate (see Appendix B). The women were asked to identify a private and convenient meeting place and time for conducting the interviews. Upon arrival for the interviews, participants were given a consent form that described the purpose of the study, potential harms, and other necessary disclosures (see Appendix C). At that time, I reviewed the study procedures and responded to any questions regarding the consent form or the study itself. I then asked the women if they were still interested in participating in the study and had them verify their continued interest by signing the consent form.

I agreed to meet most of the participants in their homes to discuss the study and obtain signed consent. For each home visit, I presented the participant with a small assortment of fresh fruit or a small cake for two reasons. I sought to build rapport as well as demonstrate respect by following tacit social etiquette known among older Black Africans and Caribbean Africans; arriving at someone's home *empty handed* reflects poor manners.

Most interviews (14 out of 16, 87.5%), took place at the homes of the participants. The interviews were audiotaped and transcribed verbatim following the visits. Each visit began with a discussion of informed consent, privacy and anonymity, and I stressed that they had the opportunity to decline and/or withdraw at any time, without consequence. Additionally, I provided my contact information on the participants' copy of the consent to answer any

questions that might come up after the interview. Participants who were still interested in the study signed the consent form, and then I conducted individual interviews that lasted from 45 to approximately 60 minutes. Following the interview, participants completed a demographic questionnaire and three self-report questionnaires (i.e., the Attitudes to Aging Questionnaire, the Successful Aging Inventory, and the abbreviated version of the World Health Organization Quality of Life simply described in published studies as WHOQOL-BREF). The questionnaires were administered after the interview so as not to influence participants' original thoughts and descriptions (Perry and Woods, 1995). Upon completion of the data collection, each participant received \$20.00 for their participation and was offered the opportunity to review the transcript interview for accuracy.

Interviews and Questionnaires

Demographic questionnaire. A demographic questionnaire of 16 close-ended items included items about participants' current age, country of birth, last African country they lived in before immigrating to the U.S., age upon arrival in the U.S., marital status, education, duration of residence, and the relationship of family members residing in the home at the time of the interview (see Appendix D). The questionnaire was self-administered and took about 15 minutes to complete.

Interview questions. A semi-structured guide was used as a way to open the interview and was not used as a rigid set of questions (see Appendix E). The guide included opening lines as suggested by Glaser (1978) and rapport-building questions related to older Black African immigrant women's lives as a way of providing a foundation to explore more sensitive topics, such as declining health status and life experiences, which might otherwise be considered too personal to share with strangers (Corbin & Strauss, 2008). The guide also served as a place to

record memos during the interview sessions. The interviews began with a *grand tour* question, which was framed by the aims of the research: “What does healthy aging mean to you?” Follow-up questions included prompts like “How would you describe a healthy older woman?” Additional questions generated discussion about pre-migratory health experiences such as “Please describe your experiences related to health before coming to the U.S.?” and “How is your health since arriving in the U.S.?” Participants were asked about their overall state of health and their activity level as it pertains to regular exercise. They were asked to rate their health using a scale of poor, fair, good, and excellent. Additionally, during the interview sessions, participants were asked to answer yes or no if they walked or participated in physical activity two or three times per week.

The Attitudes to Ageing Questionnaire (AAQ). The AAQ (Laidlaw, Powers, & Schmidt, 2007) was designed for use by researchers, clinicians, and policymakers to measure attitudes to aging by older people (see Appendix F). It consists of 24 items that are classified in three domains (i.e., psychosocial loss, physical change, and psychological growth) and are intended to measure cultural attitudes of aging, insights of aging, and the experiences of older people in relation to the aging process. In testing the instrument, researchers collected data from 5,566 respondents from 20 WHOQOL-OLD centers, with ages ranging from 60 -100 years. Respondents were female, 59%, and male, 43%. Each subscale consists of eight items that are measured on a 5-point Likert scale with responses ranging from 1 (strongly disagree) to 5 (strongly agree). Possible AAQ scores range from 8 to 40, with higher scores on the physical change, psychological growth, and psychological loss subscales indicating a more positive attitude towards aging in that area. The total mean score for the AAQ is not typically reported; instead, the mean for each subgroup is summed and interpreted separately. Researchers reported

the Cronbach's α for each domain were 0.80, 0.80, and 0.73 respectively (Laidlaw, Powers, & Schmidt, 2007). Cronbach's α was not reported for this study given the small number of participants.

Successful Aging Inventory (SAI). The SAI (Flood, 2006) was used to quantitatively measure successful aging (see Appendix G). The SAI is composed of 20 statements that are grouped into five dimensions (intrapsychic and functional performance coping mechanisms, existential being, introspective gerotranscendence, spirituality, and retrospective gerotranscendence). Respondents indicate their reactions to the statements on a spectrum ranging from 0 (strongly agree) to 4 (strongly disagree). The total SAI score represents the sum of all items, with possible scores ranging from 0 to 80; higher scores are more suggestive of successful aging. In a study designed to evaluate sensitivity and appropriateness of use of the SAI with older adults from ethnic minority populations, researchers reported Cronbach's α was 0.90 suggesting strong internal reliability (Troutman, Nies, & Bentley, 2010).

The World Health Organization Quality of Life-BREF (brief version). The WHOQOL-BREF (see Appendix H) is based on the WHOQOL-100 (Harper and Powers, 1998). It was developed to assess quality of life in relation to the previous two weeks. The questionnaire contains 24 questions based on four domains: physical health, psychological health, social relationships, and the environment (Harper and Powers, 1998). The questions were scored on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Possible scores for all domains range from 4 to 20. For the purpose of interpretation and comparison, and consistent with previous studies using this questionnaire, scores were transformed to a range of 50 to 100, with higher scores representing a higher quality of life. Researchers validated the instrument on 300 participants from 15 centers world-wide that consisted of 50% male, 50% female. The

participants were 50% equal or less than 45 years old, 50% equal of greater than 45 years old; and health status 250 with disease or impairment and 50 well persons. Researchers reported the Cronbach's α were 0.86, 0.79, 0.63, and 0.83 respectively (Harper and Powers, 1998).

Human Subjects Protection

Prior to initiation of the study, approval was obtained through the institutional review committee from the University of Washington Human Subjects Division. Consent forms were written in English (Appendix C). Participants received \$20.00 for their voluntary participation. Each participant's privacy was protected by use of individual alpha-numeric codes instead of names as identifiers. All interviews were recorded on a digital recorder, which all of the participants consented. A professional transcriptionist was hired to transcribe recorded interviews and through contractual agreement, each electronic audio file was destroyed after transcribing the interviews. Only the researcher and the paid professional transcriptionist had access to the audio files.

Data Analysis

Data from 16 interviews were used to develop a theory of healthy aging for older Black African immigrant women. Questionnaires were used to elaborate on the emerging theory by triangulating the women's perspectives with their self-reported responses about attitudes to aging, successful aging, and quality of life.

Constant comparative analysis. Data analysis in grounded theory occurs throughout the data collection phase, using a technique called constant comparative analysis (Corbin & Strauss, 2008). In grounded theory analysis, data are analyzed during three phases: open coding, axial coding, and selective coding (Corbin & Strauss, 2008; Glaser, 1978; Glaser & Strauss, 1967).

Each phase is aimed at developing emerging themes, processes, relationships, and dimensions of the developing theory. I used coding strategies suggested by both Glaser (1978) and Corbin & Strauss (2008) to guide the data analysis, because the latter approach provided a more sequenced approach to Glaser's method of coding. Referring to Glaser's approach to coding and comparative analysis provided justification and integrity for decisions made in theoretical sampling as well as data interpretation.

The software program Atlas.ti 7 (Scientific Software Development GmbH, Berlin) was used to facilitate data management and analysis, such as managing transcripts and filing notes, and creating electronic memos during data analysis. Following the procedures for grounded theory approach suggested by Corbin & Strauss, 2008, open coding was first utilized to identify categories, properties, and dimensions. During open coding, every word, sentence, and paragraph were coded to avoid missing important connections. Each transcript was reviewed for similarities and differences. Coding was iterative until a final decision to define a code was made based on fit of texts within the code. The researcher used selective coding to develop connections between codes and to create a structure. During axial and selective coding, the researcher built up the relationships around a single category by examining conditions, phenomena, context, interactions, and consequences according to Corbin & Strauss, 2008. For this study the core category to emerge was "re-imaging healthy aging".

Open coding. Open coding refers to the process of extracting text from raw data and broadly coding each data source into a named category and then proceeding thematically, constantly comparing basic codes, properties of the codes, and dimensions of variations within the codes that give range and specificity to the concepts, thus moving beyond the concrete to more abstract and generalizable concepts derived from the data (Corbin & Strauss, 2008; Glaser,

1978; Glaser & Strauss, 1967).

Axial coding. After completing the open-coding of the interview transcript, I grouped the open codes based on their perceived relationships and formed higher-level categories (axial codes) by relating concepts to each other. This level of data analysis helps the researcher make connections among and within emerging categories to identify or specify dimensions, properties, and ranges (Corbin & Strauss, 2008). In axial coding, selective codes are grouped into a theoretical structure to enable the researcher to form the core category about the phenomenon of interest.

Selective coding. Glaser (1978) describes selective coding as coding only those variables that relate to the core variable. The goal is to incorporate all categorical dimensions, properties, and relationships leading to a substantive theory that is validated by further data collection and comparison (Corbin & Strauss, 2008).

Memo writing. Methodological memos and field notes were generated during and after the interviews. These memos served as a way of recording analytical insights that occurred to me during data collection and analysis (Corbin & Strauss, 2008).

Trustworthiness. In qualitative research, operational techniques are used to ensure the trustworthiness of data generation and analysis. In particular, qualitative researchers are generally concerned with credibility, transferability, dependability, and confirmability (Lincoln, & Guba, 1985), whereas quantitative researchers are generally concerned with internal and external validity, reliability, and objectivity. Validity is crucial to all research and refers to trustworthiness of a research study and its findings. In addition to double-checking transcriptions for accuracy, I wrote memos as a way of creating an audit trail that other researchers could

follow. I also performed member checks with two participants after the interviews to ensure accuracy of transcription and words used by participants.

Credibility. To address credibility, which involves establishing confidence in the emerging study findings (Lincoln & Guba, 1985), contents of the interviews were reviewed and confirmed with seven participants who were interested in reviewing the final transcript. Initially these participants clarified words that were unclear during transcription. Once the theory was developed, interested participants were contacted by phone and invited to participate in confirming the findings. Only two of the seven women who initially expressed interest in the study findings participated in this process. At the presentation of the theory, I did not offer an explanation of the findings to the participants, as I wanted to determine if the theory itself was sufficiently clear. One participant needed a brief introduction to the notion of concepts. After studying the tables, participants evaluated and affirmed the theory and my use of their quotations to support the theory. While developing codes and categories, confirmation of definitions and categories was achieved through consultation with an assistant professor at California State University, San Bernardino with expertise in grounded theory.

Transferability refers to the applicability of study findings to other individuals in similar situations. This was achieved by obtaining detailed descriptions of the phenomenon of interest—in this case, the process of how participants re-imagined healthy aging—in order to add content and range and to generate data (Lincoln, & Guba, 1985).

Dependability refers to the question of whether a study's findings can be repeated with consistency. This was achieved by using the same data collection method and analysis process with each participant. To aid in this process, theoretical memos were created during regular biweekly meetings with my committee chair; these memos clarified all decisions about data

analysis and theoretical sampling.

Confirmability refers to neutrality (Lincoln & Guba, 1985), which was accomplished through the use of self reflective memos during the research study. Reflecting on my own acculturation experiences as an immigrant helped me to understand the images being conveyed by the participants.

Quantitative data analysis. The quantitative software package SPSS 19.0 (Statistical Package for Social Science, IBM, Armonk, New York) was used to analyze questionnaire data. There were no missing data. For this study, due to the small sample of participants, analysis of questionnaires were limited to descriptive statistics. Descriptive statistics for the survey data and their subscales are summarized in Tables 5 -7. The quantitative data did not meet assumptions necessary for parametric testing due to the small sample size and heterogeneity of the participants, necessitating the use of nonparametric tests for analysis of the quantitative data. Data were interpreted cautiously. Analysis of questionnaires included Spearman's ranked correlations among all subscale scores and demographic factors thought to be important for the purpose of this study. For analyses, marital status was recoded as married/partnered or not married/partnered and pre- and post-migration education level was recoded to reflect the highest level of education achieved. Kruskal-Wallis tests were used to test for differences between scale scores and religion and marital status.

Chapter IV: Findings

In the first section of this chapter, demographic characteristics of the participants are described. In the second section, I describe the process of *re-imagining* healthy aging from analyses that are grounded in the interview data. In the third and final section, findings that address the third study aim are discussed. I elaborate on the theory of *re-imagining* healthy aging and triangulate women's perspectives on their experience with their self-reported responses regarding attitudes to aging, successful aging, and quality of life.

Demographic Characteristics of Participants

Sixteen older Black African immigrant women, mean age of 59.3 years (ranging from 48 to 79), who were living in Western Washington at the time of the study participated by completing a demographic questionnaire, an interview, and three self-administered questionnaires (see Appendices D through H). The participants are presented in Table 1. The women came to the U.S. from the following countries in Africa: Kenya (n=5, 31.3%), Cameroon (n=2, 12.5%), Ethiopia (n=2, 12.5%), Nigeria (n=2, 12.5%), Somalia (n=2, 12.5%), Malawi (n=1, 6.3%), Uganda (n=1, 6.3%), and Zambia (n=1, 6.3%); see Figure 1. The average number of years spent living in the U.S. for these women was 23.4 (ranging from 1 to 46).

Ten women were married (62.5%), three were divorced (18.8%), and three were widowed (18.8%). The women had a broad range of educational backgrounds prior to immigrating to the U.S., one woman (6%) obtaining no formal education, one (6%) obtaining secondary education, five completing high school or technical training (31%), six obtaining baccalaureate degrees (37.5%), and three (18.8%) obtaining a master's degree.

Table 1

Demographic Characteristics of the Participants; N=16

<u>Characteristic</u>	<u>Frequency</u>	<u>Mean (Standard Deviation)</u>
<u>Age</u>	48-79	59.3 (10.3)
<u>Years in the U.S.</u>	1-46	23.4 (13.2)
	<u>Frequency</u>	<u>Percent</u>
<u>Country of birth</u>		
Kenya	5	31.3%
Cameroon	2	12.5%
Ethiopia	2	12.5%
Nigeria	2	12.5%
Somalia	2	12.5%
Malawi	1	6.3%
Uganda	1	6.3%
Zambia	1	6.3%
<u>Marital Status</u>		
Married/Partnered	10	62.5%
Not married	6	37.5%
<u>Highest level of Education</u>		
No formal education	1	6.3
Secondary	1	6.3
High school/technical	5	31.3%
Baccalaureate	6	37.5%
Masters degree	3	18.8
<u>Employment</u>		
Employed	12	75.0%
Not employed	4	25.0%
<u>Income level</u>		
Less than \$20,000	3	18.8%
\$50,000 to \$80,000	5	31.3%
\$80,001 to \$100,000	5	31.3%
\$100,001 to \$150,000	1	6.3%
> \$150,001	2	12.5%



Figure 1. Map of the 8 countries in Africa (Original drawing)

The participants described their religious affiliations as Christian (n=11, 68.8%), Muslim (n=3, 18.8%), and Catholic (n=2, 12.5%). Four of these participants described early home environments that were Muslim before their families later converted to Christianity. In addition, some of the women indicated in their interviews that either their husbands had more than one wife or their fathers and/or grandfathers had more than one wife.

Twelve of the women were employed (75%) and four were not employed (25%). Eight women lived with spouses and younger children (50%), four women only lived with their adult children (25%), three women only lived with their younger children (18%), and one only lived with her spouse (6.3%). The personal incomes of these women ranged from less than \$20,000 per year to over \$150,001 per year. Two participants (12.5%) reported an income greater than \$150,001 and three participants (18.8%) reported an income less than \$20,000. Income was a sensitive topic for a couple of participants who inquired about the purpose of collecting the data; these women indicated that the source of their income was their children.

Health Characteristics of Participants

The health characteristics of the participants are reported in Table 2. Eight women described their health as good (50%), seven described their health as fair (43.8%), and one described her health as poor (6.3%). Nine (56%) women reported regular exercise, and seven did not exercise regularly (43.8%). Nine women reported chronic health conditions, four had high blood pressure (25%), three had diabetes (18.8%), two (12.5%) had autoimmune disorders and one had coronary artery disease (6.3%). Of the remaining six women, five reported no health problems (31.3%) and one participant chose not to respond (6.3%). Additionally, nine women described taking a combination of prescription medications, herbal preparations, and vitamins (56.3%); four took one or more vitamins only (25%), one took one or more prescription medications but no vitamins (6.3%), and two women took no medications, herbal preparations, or vitamins (12.5%).

Table 2

Health Characteristics of the Participants; N=16

<u>Characteristic</u>	<u>Frequency</u>	<u>Percent</u>
<u>Self-rated Health</u>		
Poor	1	6.3%
Fair	7	43.8%
Good	8	50%
<u>Regular Exercise</u>		
Yes	9	56.3%
No	7	43.8%
<u>Self-reported Health Conditions</u>		
High blood pressure	4	25.0%
Diabetes	3	18.8%
Heart/coronary artery disease	1	6.3%
Autoimmune disorder, lupus, scleroderma	2	12.5%
No health problems	5	31.3%
No response	1	6.3%
<u>Medications and Vitamins</u>		
Prescription medications only	1	6.3%
Vitamins only	4	25.0%
Prescription medications and herbal preparations or vitamins	9	56.3%
No medications, herbals, or vitamins	2	2.5%

Core Phenomenon: Re-imagining Healthy Aging

The categories, themes, and axial codes that were revealed through data analysis describe a process of re-imagining healthy aging as participants thought about their experience in Africa and became aware of themselves aging in the U.S. Frequently, they expressed their memories as *“in my mind I can see..., or what I see in my mind is...”* (Participant #6). The re-imagining process toward healthy aging in the U.S. for these women—including attitudes, thoughts, and emotions

regarding their immigration experiences from Africa to the U.S.—did not have a systematic structure with clear boundaries, nor did the process of re-imagining healthy aging proceed at a defined pace or in a linear direction. It was full of emotional and physical starts and halts. The abstract categories that reflect this core phenomenon exist within a multilayered, subjective matrix of experiences, emotions, and interactions that influence each other; this matrix of intersections is presented in Table 3. The following consolidated narrative of the women’s experience represents an introduction to the process of healthy aging in the U.S.

Table 3

Core Category-level Coding of the Process of Re-Imaging Healthy Aging

Acknowledging images of healthy aging

1. Acknowledging images of healthy aging in Africa
2. Filial expectations and investing for aging
3. Acknowledging challenges to healthy aging in Africa

Becoming aware of new images of aging

1. Becoming aware of aging norms in the U.S.
2. Acknowledging challenges to healthy aging in the U.S.

Accepting

1. Accepting the reality of aging in Africa
2. Accepting loss due to discordant aging expectations
3. Accepting the reality aging in the U.S.

Adapting

1. Selecting health as a priority
2. Identifying sources of personal strength

Managing

1. Building community
2. Utilizing social resources and health care systems in the U.S.

Re-imagining healthy aging

1. Re-establishing self
 2. Creating a new aging perspective
 3. Negotiating with family members
-

Re-imagining healthy aging is the process by which older Black African immigrant women made meaning of aging and integrated images of their early aging experiences in Africa with experiences and images of aging in the U.S. In this re-imagining process, the women in this study initially made meaning of aging by recalling images from early experiences with grandmothers, older women, and aging relatives in Africa, as well as their own experiences with health care providers in Africa. Sharing descriptions of healthy aging in Africa resulted in insights about themselves aging in the U.S. They were able to identify factors they perceived as representing and influencing aging. The images of healthy aging in Africa presented by the participants were interdependent relationships where children, parents, and the environment co-exist. In Africa, family members, however distant, were mutually dependent on each other, whereas while living in the U.S., the women described norms and perceptions where parents depend less on their children or extended family members and more on social services for their needs as they age.

Considering aging in the U.S., the women revealed that their cultural expectations of aging were not in accord with images of aging in this country, as reflected in media or their communities. The women realized that investing in their children, as a means of planning for their future, was not a U.S. cultural expectation. Furthermore, the women described situations in which their adult children, in order to have successful careers in the U.S., would likely have to limit family and social activities and work more hours away from home. These notions conflicted with filial expectations of daily interactions with children, even adult children, and the life women envisioned going into old age in their native culture.

Becoming aware of this discordance marked a particular crossroads in the women's re-imagining aging. As they became aware of the discordance between their own cultural attitudes toward aging and related filial expectations and the attitudes they observed in the U.S., some

women responded with a sense of loss, followed by acceptance. Participants were observed to stare into the distance for several seconds where they seemed stalled in thought, unable to process this discordance. Three women remarked that returning to Africa was now their only option for handling the discordance. Others argued that despite their familiarity with the customs of aging in their home countries, they would remain in the U.S. because the health care is better here. These women accepted cultural differences about aging between Africa and the U.S., choosing to adapt to their new environment and proactively build a community for themselves. Adapting their cultural values to those of the host environment meant making health a priority while drawing on inner strengths through faith and a philosophy of life that fostered hope for the future. Managing health was described as making the necessary adjustments to remain healthy in this country. The women realized that building a supportive community network and utilizing the U.S. health care system and its social resources would be important steps in making their health a priority and meeting their personal aging needs, rather than relying on their adult children for social interactions and transportation. For some participants, re-establishing self and negotiating their expectations for the future often occurred during interactions with their families and their social environment. The results of the interactions were different for each participant and represented a state that was in flux and not static. By accepting, adapting, and managing – strategic categories that were derived from the interviews – many of these women were able to re-image healthy aging.

Table 3 presents the category codes that highlight the women's experiences, identifies the themes that emerged, and connects those themes to categories that bring greater clarity to the theory that represents their experience. The process of re-establishing self and re-imaging aging occurred for participants as they balanced the tensions between their interdependent,

independent, and dependent relationships with family, community, and government services. The broad categories identified in the grounded theory that emerged during the process of axial coding are illustrated in Table 4.

Table 4

Results of Axial Coding of the Core Categories

Phenomenon
Re-imagining healthy aging after immigrating to the U.S.
Causal conditions
1. Acknowledging images of healthy aging
2. Becoming aware of the new images of aging
Context
1. Interdependent nature of African culture
2. Gaining independence
Action/Interaction: strategies
1. Accepting
2. Adapting
3. Managing
Consequences
1. Re-imagining aging

Causal Conditions

The conditions that led to the process of reimagining healthy aging for the participants in this study were, first, acknowledging images of healthy aging in Africa and, second, becoming aware of aging in a new place with new images of health and aging.

Regardless of their reasons for initially traveling to the U.S. (e.g., seeking educational opportunities, economic stability, or refuge from overtly corrupt governments), all of the participants interviewed shared an idyllic image of health and aging in Africa. However, while in Africa, they believed living in America would offer a better life and health. Participant #08 explained:

... [what] we think when we are in our country is that America is all the way up there [she motions her hand above her head]. Whatever they have is the best, you know? That's why maybe I want this—because it's available. It's in America.

Acknowledging images of healthy aging.

Acknowledging images of healthy aging in Africa. The majority of the women in this study conveyed similar views of aging in Africa. They described similar pre-migratory activities of daily living and spiritual activities, and they spoke of community involvement as essential interdependence in their relationships with older women, their adult children, and community members.

Aging in Africa is looked at as a normal process. Everybody is going to go through the aging process. It is looked at as a normal process. And there is no—there is no competition, no fighting that I am aging. (Participant #03)

Once you have a nice house and your kids are off, you look forward to that path of now you'll not be a mom, but you'll be the grandma. Your kids are coming, and so usually you have a nice house. It's a full house. It's a place where people can come and relax and have tea. (Participant #04)

The participants in this study described typical activities of daily living for women in Africa. Women remain physically, socially, and politically active in Africa throughout their advancing age, as the environment and other conditions still require walking:

Women meet in the shamba [the gardens]. They till the shamba early in the morning. They come back, [and] they are tired; they do what they do. It is not like they have a club. Shamba is the club; shamba is the gym. You have to have something to do, someone is gonna come (Participant #03)

The research participants also described age-related roles in which older women remain active and vital in their community in Africa. These roles are for older women who are recognized in the community as wise because they are old.

Oh, the older women's responsibility—most of the time it's just to be there, and probably they're the wise people in the community. (Participant #01)

You might get these women who are ... "blessers" when they come. They're [called upon] to sing and dance and share the first hair of the kid. This is kind of like they're putting their blessing on the kid and all that. (Participant #01)

Other images of aging in Africa highlight the interdependent interaction of person and community.

It's different back home [in Africa], because when they age they have support. We have community back home. (Participant #01)

Filial expectations and investing for aging. Study participants provided descriptions of filial expectations. All participants, regardless of nativity, expressed attitudes and beliefs describing filial expectations as a plan for healthy aging and a determinant of their quality of life in old age. As such, having a large family ensures a certain quality of life in old age.

Yes, in our countries the kids take care of the parents. The parent is able to give everything to the kids. It's like an investment for the future. (Participant #04)

Especially, your children are your Social Security, your Medicare—everything. Your children are everything for you, which is practical. I'm not just saying that. Nobody dumps you because you are old, you know (Participant #05)

I always tell them—I always tell them, "You guys are my retirement." They know! Sometimes they fight over me (Participant #14)

Acknowledging challenges to healthy aging in Africa. Participants in this study described the cultural attitudes about health behaviors, health care, and health information in Africa. This discussion included descriptions of the differences in aging between city dwellers and village dwellers in their home countries. They also described social changes in Africa that directly impact aging.

Cultural changes. Notions of filial responsibility were described as shifting in response to technology, jobs and social relationships. For instance, older women are now caring for young children due in part to situations where adult children die as a result of AIDS or an adult daughter with young children leaves a village for the city to find work.

You find that [adult children] are moving to go and find [work] in town, and so the aging women are left at home. They are left by themselves. The care that was there before is not there right now. It's minimal ...but the care will not be [there soon] because now with this modern society, people are moving from the villages. (Participant #01)

Health care. Most participants described overall health care in Africa as good but inconsistent and unreliable. Health care for older adults, particularly older women, was uncertain and dependent on the ethical conduct of the medical provider caring for the woman at her time of need. The women relayed experiences of poor communication regarding treatment of care, disease processes, preventive health practices, follow up, and planning for care between medical providers and family members as patients. Furthermore, there is no reliable emergency service due to poor infrastructure.

I can say in Africa it is a do-it-yourself ... kind of thing. No one is going to remind you to go for a mammogram. If you go to see a doctor, there is nothing in place like to say, "Have you gone for your mammogram? Have you done this or that?" You need to

screen yourself. Women who are rich know they have to do that. It's like nobody is reminding them. (Participant #03)

No, we don't have that [preventive health care]. There is nothing like that. Nobody is going to call you to go for a mammogram ... Unless you're sick and they're suspecting that there is something going on, then you're going to have a mammogram, but they are not checking that. You don't go for Pap smears unless you're sick. (Participant #01)

OK, many people have died because there is no proper medication. When you think of that and that you are aging, and you did everything to contribute to society and ... you can't get access to medication. (Participant #10)

Health behaviors. The women knew the benefits of eating low fat food, fresh fruits, and vegetables. They all mentioned the importance of physical activity as a health promotion behavior in aging well. The participants provided many examples of informal physical activities that contribute to healthy aging.

I remember one time [my grandmother] was like ..., "I just have to do this [gardening], because if I don't do this, I will not sleep. I don't get tired. I can't sleep unless I do something physical. And then when I go to sleep, I sleep good." That's the point that she gave me. (Participant #07)

Back home what you eat is organic to start with. Not only food, but you do some exercises, too. You walk because there is no transportation and so that is a big help for you health-wise. The air is much cleaner than here, and so all of those things will make you healthier, you know? (Participant #08)

Health information. Participants differentiated health care and health information when

discussing challenges to healthy aging in Africa. All participants acknowledged the importance of access to more knowledge about how they can maintain good health going into old age.

No one told me that diabetes would cause a problem. I was never given the full education about diabetes or anything around diabetes. All I have been doing is when I go to the hospital, they will say, "It is up. It is down." And for the past six years everything seems to have stabilized, and I have not felt any problem due to the diabetes. (Participant #12)

City dwellers. Many participants described the difference in health of city-dwelling older women in Africa. City-dwelling older women were sought out for their views on aging health. Many knew that it was unhealthy to remain in the cities where physical activity and access to fresh produce was limited.

What I've noticed is that my grandparents [lived in a village, and] my dad's mom, that generation, lived for a very long time. My parents died in their 70s. Along with taking the Western diet, my dad and all of their generation died in their 70s ... Whatever came with the diet and everything, the people who lived in the city of my parents' generation, they were kind of like the first educated people. They reached the top of their professions. They've lived all of this fabulous life, I'm telling you, but they've all died of high blood pressure, heart disease, and all this kind of stuff. That [city] lifestyle took away some of the things that have kept people healthy for a very long time. (Participant #04)

One of the things about living in the city, most health insurance was tied to your spouse. Like my mother's health insurance was tied to her husband—my father's job. When my father quit working and went to the countryside, my mother had no health

insurance. So from the time that my father quit working to the time when I got her to the U.S., she didn't have insurance. She never saw a doctor and so she had high blood pressure, but she never knew. (Participant #09)

Becoming aware of new images of aging.

The women in this study also described images of aging in their host land as compared to Africa. They identified social, family, and environmental changes and challenges that directly affected their views of healthy aging and quality of life.

Becoming aware of aging norms in the U.S. Many participants described how aging in the U.S. changed their expectations and hopes of family support. They described Western attitudes toward aging parents as discordant from their cultural norms. Many participants hoped to return to Africa instead of growing old in the U.S. Conversely, other participants acknowledged the benefits of the health care system in the U.S., as well as the implications and challenges for healthy aging that returning to Africa might pose.

It's a light in the darkness lifestyle, and the social networking is totally different here and there. (Participant #05)

That scenario that I'm describing to you where [in Africa] they have their home and they're queen and king in their own home and having visitors coming and all this — they are missing like a fabulous part of life actually, because it isn't here. Here you have the little small unit in your children's home. It's very difficult. My parents would never live here. They couldn't, because it was just, like, what is that? (Participant #04)

Services and prevention are available here, but there is loneliness here. Most people here don't connect. There is no connection. People are so individual here.

People are foreign. That's what they talk like. You don't visit anybody, yes. You don't go to anybody's house". (Participant #01)

Acknowledging challenges to healthy aging in the U.S. Participants described environmental factors of everyday life in the U.S. and how these factors may affect their physical and mental health, and social activities going into old age.

General health. Participants were asked to describe their health since living in the U.S. They described the routine of working late and early rising, as well as the limited daylight during winter months as affecting their health going into old age.

I think my health has changed because of too much working. Though there is work in Africa and Africa is a hard place to live, it is not as much as it is here. And then there is ... Well it is physical [in Africa], but you don't feel it because the social structure is there. You have people who are doing the same thing and here it's like you work like a dog. When you go home, you are tired, then you wake up and go to it again. (Participant #03).

I think I'm sure a lot of us have diabetes, high blood pressure, heart disease here. We don't have to walk to a market. (Participant #04)

Employment. The women described factors related to employment that challenge healthy aging. Participants describe being overworked, lonely, and experiencing a lack of respect as Black Africans as factors that limited their social activity levels.

She (African friend and co-worker) was here like ten years every day, every day. I used to work in a nursing home (in the U.S.). I saw so many women with a stroke,

young, because they were working two jobs. Take a day off and have fun, you know? Anyway, she was developing diabetes and she didn't even know. (Participant #06)

In the U.S. you have to work. You have to work. Even if it is an older person that stays at home, maybe you communicate with the phone; otherwise, you cannot communicate in everyday life, unless you live in the same building. (Participant #05)

Really, I'm worried about that [my health], because I work so hard. I know that I work so hard. Then I know when I always see doctor, they say, "You're overworked. You're overworked. Calm down, you know? Take it easy." (Participant #14)

Family. Many participants expressed the importance of close family connections as it relates to quality of life in old age. They shared observations and stories of changing family relationships. They were clear that the children born and raised in the U.S. do not have opportunities to witness caring for older grandparents and extended family members. Furthermore, adult children value interactions with friends over family members.

My children, yes, that's what makes us worry and be afraid to death. The children we have today, they are so selfish and so self-centered. All they think is about themselves, and so our children are not going to take care of us the way we've seen the generation going on. They're not going to take care of us. (Participant #10)

Aging here is like, oh, I can't take care of her [grandmother or older mothers], I can't take care of him [grandfather]. If I do that, I'm going to miss my freedom, you know? Stuff like that. But back home...It's built into the life. It's expected. It's a privilege to take care of your parents. (Participant #08)

If they [adult children] are living here, they will be very busy too. It's not that they will not want to care for me, will they be able to care for me? I may have to go back to Africa ... who knows? (Participant #02)

Food. Participants confirmed the advantages and disadvantages of food availability in the U.S. that contribute to both health and disease going into old age.

They [older African women in the U.S.] are taking on the western lifestyle. The diet here is so terrible in terms of people put on weight. If you're not doing something, you are going to gain a lot of weight. That is what has happened to them. (Participant #04)

In her [older relative in the U.S.] house if you'd see, it was full of chips and Coca Cola and then go to bed. Eat chips. She had no time to cook. By the time they told the doctor, she went to her doctor and they said, "Ah, you are diabetic." She was on insulin back then. Those are the things that are happening here for Africans when they come here, the things [foods] that they choose. (Participant #06)

Social Environment. The importance of social interactions and social status were discussed as they related to healthy aging. In this area, participants described loneliness, lack of respect, and overt and perceived forms of racism as negatively affecting their health. Racially-based comments were viewed as a sign of disrespect.

There is no respect [here in the U.S.]. And then also they are just seen as Black. Only their family knows who they are. Like you finding out that your patients were teachers. In fact, in their country they would have been very respected people. (Participant #04)

So what is killing people so much, the aging population here is loneliness, big time!! You know, the most important factor for the Black immigrant women. They are the loneliest because they don't have friends. They are looking for the people who are like them. (Participant #03)

Context

The process of re-imagining healthy aging took place during interactions with family members and interacting with members from the U.S. The interactions highlighted dependent relationships with family and newly developing interdependent relationships with community and government services.

Action/Interaction: Strategies for Re-imagining Aging

The following subcategories describe the strategies toward re-imagining healthy aging that each woman in the study experienced. The definitions and quotes reveal conscious and acknowledged appraisals of personal strengths and community resources that result in aging differently in the U.S.

Accepting. This thoughtful appraisal by participants of their U.S. environment was personal, reflective, and very precise. Participants described changes in their expectations of filial duties and revealed an awareness of being ill-prepared for aging. Although the participants agreed that adult children were thought of as investments for the future, many readily admitted that their children would not be able to provide for them in old age without a larger support system, like they had in Africa. However, the women also admitted that U.S. health care was better than health care available in Africa, particularly for women. Some of these women therefore dismissed the notion of returning home, especially those women in their 50s, who

arrived in the US in their early 20s, had not invested for old age in Africa by establishing closer relationships to members in villages, or did not have a community to return to. As women interacted with the people in their host environment and their families, they acknowledged that they should remain in the U.S.

Accepting the reality of aging in Africa. Although some women preferred to return to Africa to age during retirement, they realized that health care and attitudes toward old women are not as they had pictured them from past images. Women also suggested that living in the U.S. and not in Africa diminished social connections and ties to their villages.

It's changing [in Africa] because the kids have left. They have gone to town. The economic situation, the social networking and all that, people are trying to copy the western world. They are living like people here. They're living like people in other places, because we have Facebook; we have Twitter. These people have forums and things transfer from one place to the other. They want to live like everybody else.

(Participant #01)

Accepting loss due to discordant aging expectations. The women expressed discomfort and a sense of concern that their Westernized children do not have a sense of obligation in caring for them in old age. Although the women acknowledged that certain cultural norms are lost with increased residency in the U.S., many accepted the give and take reality of losing in order to gain.

My kids are just as Americanized as everybody else. I don't expect them to take care of me like I've taken care of my mom. I would like to think that they would want to do that, but I cannot just live and say, "Well, when I get old I'll move in, you know.

(Participant #09)

For myself I do not expect anything from anyone. Life is hard for the immigrant, for their children too. So why do I want to put myself on their backs as a burden? (Participant #15)

Accepting the reality of aging in the U.S. The women realized that returning to Africa was not a reality and accepted positive aspects of aging in the U.S.

Well, here it's a First World country, and so we have a lot of medications. We have a lot of awareness on what people need to do (to remain healthy). (Participant #01)

Adapting. Adapting to their new environment meant being responsible for placing their health as a priority going into old age. For these women, many of whom are Muslim, adapting meant adjusting their perspective about health care providers and health examination practices in the U.S.

Selecting health as a priority. The women in this study viewed aging as a natural and unavoidable process. A strategy of adapting to the cultural values of their host environment meant being responsible for their health and not expecting their adult children to inquire about their health.

I want to know how to keep good health and not become a burden (Participant #15)

It's having good health insurance and having good health care and just keeping myself in good shape and good health. (Participant #09)

Identifying sources of personal strength. Women in the study described using government resources, community organizations, and churches to learn where to get health information and health services. If they could not rely on their adult children, the women also readily identified inner strengths such as having a positive attitude and drawing strength from

their religious backgrounds. Some of the women described a sense of self-efficacy about growing old.

Attitude. Participants often spoke about just doing something and having a purpose for the future. Their attitudes were always positive and without doubt or hesitation. Attitude seemed to be an important factor among those who adapted to aging in their environment in the U.S.

I said when I come to America I need to get a green card, I need to get a job. When I wanted a job, the first job I got was in telemarketing. Then I went into health care. I became a CNA so I was struggling ... I started to go to school right away. Yes, new, settled with kids, take some classes. I was, in my mind, to be a model for my kids at the same time. The only person they know is me. (Participant #03)

I think I have stopped aging, I do not feel old anymore. I did not work here for this Social Security. My son explained all that to me. So I work a little bit, I sew for ladies; I make their bati [long dress worn at home] and sell them at the women's group. I feel good I can make a little money alone. (Participant #16)

Spiritual. All the women acknowledged faith and a belief in God/Allah as responsible for their positive attitude and ability to adapt to aging in the U.S. They acknowledged that places of worship provided a means to connect with family members and others who practice their faith.

When we are sitting and eating together at Ramadan, we even use Internet connections to break Ramadan fast with my son and daughter (Participant #13)

Because if we are not helping each other, we are getting punishment from God. In America something they forget, they forget the God. (Participant #13)

Managing. For the women in this study, managing involved making necessary connections so they could remain healthy. They attempted to accomplish this by building supportive community networks and utilizing social resources for their personal needs instead of relying on their adult children.

Building a community. Building new social support networks was a process for participants that consisted of taking small steps, beginning with proximal relationships, neighbors and extending to community centers. As they tried to build networks, the women initially sensed hesitation from their American neighbors and coworkers.

We don't do lots of parties and all that, but we're just doing something that makes you connect. Then you get to know each other more. Then when you age, you're connected. I have my neighbor and my kids know the neighbors. I have invited them at my house several times, "Just come, just come". (Participant #01)

Utilizing social resources and health care systems in the U.S. The participants described utilizing community services and different health and social care resources for information about managing their health and health insurance.

At the community center, we learn where to go to get help for our health and learn how to monitoring our medical conditions and all that. That can extend life in the West. (Participant #13)

Yes, I asked. I said that I need help, you know? They help... they said that when you see your check, if you don't have enough, we want to help you with the food. Day by day it's getting better and getting better, and now, I stand on my own feet, yes.

(Participant #14)

Re-imagining Healthy Aging

The women in this study noted that it was usually during interactions with family and other members of their social environment that the women were able to reestablish their expectations for the future. These interactions were dynamic and not static.

Re-establishing self. Re-establishing self meant changing former expectations related to aging. A few of the women were expected to travel and follow their adult children from one town to the next with limited freedom.

For me, for other mothers in Africa, life was hard; we had to lose things to get bigger things. We had to change to new governments or move to different places for safety. Because of that, I can change to this new land (Participant #15)

Creating a new aging perspective. Participants considered the reality of interacting with their environment, as they grow older in the U.S.

I see it must be, I must change, I see there is no other way...otherwise I am like the old newspaper -- I will be no good for me or for anything. (Participant #15)

Negotiating with family members. The women felt it is necessary to have conversations with their children about filial expectations for the future.

I do not want my son to worry about me. I tell him I have some money. One lady she took me to African grocery store in North Seattle. It was good to see more foods and other people. (Participant #16)

Summary of Interpretive Findings

This chapter has described the participants, interpretive findings, and processes toward re-imagining healthy aging. Processes experienced by older Black African immigrant women

were described as acknowledging images of healthy aging, becoming aware of new images of aging, accepting, adapting, managing, and re-imagining aging. The women's images of aging in their home country were not a realistic expectation for their future while living in the U.S. The women accepted both the positive and negative aspects of living in the U.S. They adapted to different aging expectations by making their health a priority, and they managed their health by building community. Re-imagining aging took place during social interactions and as they interacted within their environment.

Findings From Questionnaires

Descriptors of questionnaire responses. In this section, findings from the questionnaire data are reported. The Attitudes to Aging Questionnaire and Successful Aging Inventory scores were used to measure the participants' attitudes towards their own aging and qualities of successful aging, as well as to identify women with low or high attitudes to aging and successful aging, for comparison with the qualitative results from the interviews (see Tables 5 and 6). Similarly, the WHOQOL-BREF scores were used to identify women who exhibited positive or negative quality of life (see Table 7). Spearman's ranked correlations between different scale scores are reported in Table 8. Spearman's correlation among scale scores and age and years in the U.S. are reported in Table 9. Kruskal-Wallis was used to test for differences among scale scores and religion and marital status.

The Attitudes to Aging Questionnaire (AAQ). The mean score for the psychological loss subscale in this study was 32.5 with a standard deviation (SD) of 5.4; the mean score for the physical change subscale was 28.5 with an SD of 5.9; and the mean score for the psychological growth subscale was 33.4 with a SD of 4.2.

Table 5

Attitudes to Aging Questionnaire, N=16

Subscales	Participants scores Range (8-40)	Mean	SD
Psychosocial loss	19-38	32.5	5.4
Physical change	15-39	28.5	5.9
Psychological growth	26-40	33.4	4.2

The Successful Aging Inventory (SAI). The participant scores in this study ranged from 53 to 79 with a mean of 67, and a SD of 8.0; see Table 6.

Table 6

Successful Aging Inventory Scale, N= 16

Successful Aging Inventory (SAI)	Participant Scores Range (0-80)	Mean	Standard Deviation
Overall score	53-79	67.3	8.0

The World Health Organization Quality of-Life -BREF. The mean score for the physical subscale was 75.8 (SD 15.9); the mean score for the psychological subscale score was 76.5 (SD 15.9); the mean score for the social subscale was 79.6 (SD 16.6); and the mean score for the environment subscale score was 74.2 (SD 15.9); see Table 7. The mean scores were higher because not all women's scores were higher than the median.

Table 7

The World Health Organization Quality of Life-BREF; N=16

Domains	Participant scores Range (0-100)	Mean	Standard Deviation
Physical	50-100	75.8	15.9
Psychological	50-100	76.5	15.9
Social relationships	33-100	79.6	16.6
Environment	34-100	74.2	15.9

Correlational Analyses

Although the sample size is small and analyses were challenging to interpret, Spearman's ranked correlations among subscale scores showed significant correlations ($p < 0.05$) among the Attitudes to Aging Questionnaire scores, the Successful Aging Inventory scores, and the World Health Organization Quality of Life –BREF (WHOQOL-BREF) scores (see Table 8). There were moderate to highly significant correlations among some subscale scores that were statistically significant ($r = .520 - .908$). The SAI was significantly correlated with the AAQ1-psychological loss and AAQ2-physical change, as well as the WHOQOL-BREF psychological and environmental subscales.

There were no significant correlations among subscale scores and age and years in the U.S. (see Table 9). Kruskal-Wallis was used to test for differences among scale scores by religion and marital status. There were no statistically significant differences among subscale scores by marital status, but there were differences by religion. The AAQ psychological growth subscale score and the WHOQOL-BREF psychological and environment subscale scores were significantly higher for participants who are Muslim compared to participants who are Christians or identified as Catholics ($p < .05$).

Table 8

Spearman's correlations among subscales scores; N=16

	AAQ1	AAQ2	AAQ3	SAI	PHYS	PSYCH	SOCIAL	ENVIR
AAQ1	–	.520*	.419	.538*	.377	.481	.105	.442
AAQ2	.520*	–	.358	.545*	.692**	.597*	.441	.614*
AAQ3	.419	.358	–	.389	.197	.593*	.136	.433
SAI	.538*	.545*	.389	–	.435	.720**	-.087	.576*
PHYS	.377	.692**	.197	.435	–	.423	.472	.526*
PSYCH	.481	.597*	.593*	.720**	.423	–	.222	.908**
SOCIAL	.105	.441	.136	-.087	.472	.222	–	.420
ENVIR	.442	.614*	.433	.576*	.526*	.908**	.420	–

AAQ 1 =Attitudes to Aging: Psychosocial loss; AAQ 2= Attitudes to Aging: Physical change; AAQ 3= Attitudes to Aging: Psychological growth

SAI= Successful Aging Inventory

World Health Organization Quality of Life –BREF: PHYS= Physical health; PSYCH= Psychological; SOCIAL= Social relationships; ENVIR= Environment

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Table 9

Spearman's correlations between subscale scores and age and years in the U.S.

	AAQ1	AAQ2	AAQ3	SAI	PHYS	PSYCH	SOCIAL	ENVIR
Age	-.282	-.081	-.243	-.087	.149	.027	.147	.205
Years in U.S.	-.230	-.160	-.018	-.077	.263	-.008	.276	.110

AAQ 1 =Attitudes to Aging: Psychosocial loss; AAQ 2= Attitudes to Aging: Physical change; AAQ 3= Attitudes to Aging: Psychological growth

SAI= Successful Aging Inventory

World Health Organization Quality of Life –BREF: PHYS= Physical health; PSYCH= Psychological; SOCIAL= Social relationships; ENVIR= Environment

* Correlation is significant at the 0.05 level (2-tailed).

**Correlation is significant at the 0.01 level (2-tailed).

Triangulating the Data

To elaborate on the women's healthy aging experiences and expectations for themselves, the self-report data on attitudes to aging, successful aging, and quality of life were triangulated with the qualitative data. Further analyses of individual scores on the AAQ, SAI, and BREF revealed extreme scores that were less than or greater than one standard deviation from the mean on all three measures; lower scores reflecting negative attitudes to aging, successful aging and quality of life and higher scores reflecting positive attitudes. Participants whose mean scores were extreme in a specific domain were reviewed to explore their relevance to the narrative data and the evolving theory. Two participants had at least three low scores in two scales, and two participants had at least three high scores in two scales. Interestingly, these extreme scores corresponded to the women's views on health and aging, based on statements they made in the interviews. The experiences of these particular participants are integrated and presented for review as one case study. The findings among the four participants' interviews with extreme scores support this consolidated narrative.

A Consolidated Exemplar of the Diversity in the Process of Re-imaging Aging

This section triangulates the demographic, interview, and questionnaire responses of participants' who had extreme scores on study subscales. It serves as an exemplar of the diversity inherent in the process of re-imaging healthy aging. The pseudonym, Zenobia, is used to represent this consolidated "participant" and capture the range, depth, and meaning of the core categories and process of re-imaging healthy aging. This consolidated case study is based on my interpretation of these data and my experience with the participants during our time spent together.

Zenobia is a 66-year-old widow who left her African home in Kenya in her late 30s and lived in Saudi Arabia before moving to the U.S. She was educated and employed as a social worker in her home country. She described herself as the youngest in a Muslim family of nine children born in Africa. During the interview Zenobia was uncertain about her future and concerned that her children will forget her in her old age. This uncertainty was evident in her questionnaire scores. Zenobia's AAQ psychosocial loss score was high, indicating a more positive attitude to aging. Her AAQ physical domain and psychological growth scores were low, indicating a more negative attitude to aging. Similarly, her SAI score was only slightly lower than most other participants, indicating her view of her successful aging was at least "good." Her WHOQOL-BREF scores varied; physical and environmental scores indicated good well-being, but her psychological and sociological scores were lower, indicating poorer well-being.

Acknowledging images of healthy aging.

Acknowledging images of aging in Africa. Zenobia remembered her mother and grandmother working together in the shamba, meeting other women and discussing the latest activities in their village.

... there is more [of a] preference [toward] getting more active, as you get older, than just laying at home—Get up and doing something! Even people who are alone in their homes ... there are people in the villages who are gonna come to your home [to visit you]. (Participant #03)

Yes, they have gardens. When sitting there, [a woman] can talk to the neighbor. What can I say—they have a little piece of land where they can sit and talk to the neighbor, the next-door neighbor of the other land. (Participant #07)

We have naming ceremonies. [Older women] will come, and they will name the baby ... it is kind of like a little party, like they're coming to welcome the kid into society. [And] there will be a shaving ceremony, like the first hair, where you just do not shave it. The shaving—it's for some a cultural thing. (Participant #01)

Zenobia shared times when older siblings would return home from working in the city or abroad to visit her parents and grandparents prompting visits from villagers. At those visits there was usually a flurry of activity around the house – repairs to the house or the purchase of a new cow, goat, or chickens just to name a few.

It's built into the life. It's not expected. It's a privilege to take care of your parents. (Participant #08)

I mean, it's just a nice time. If you have a nice house, you enjoy it. A house is not for yourself. A house is for you and your community ... I mean [my parents'] house is just like going for a holiday. People come and there is food. That is what they do ... People come to them for advice, and so they're just sages. They are old wise people. It is so nice. (Participant #04)

In addition to demonstrations of love and respect within family settings, the caring of older adults extended to members in the community. There was an interdependent relationship that existed within communities, underscoring the spirit of 'Ubuntu'. Sometimes Zenobia's mother would leave the shamba early to begin the evening meal, and her grandmother would remain to nap under a tree. There were times that she had to get her grandmother as the day came to a close.

I just have to do this, because if I don't do this, I will not sleep. I don't get tired. I can't sleep unless I have something physical, and then when I go to sleep, I sleep good. That's the point she gave me. (Participant #7)

Zenobia recalled an occasion when, at the shamba, her grandmother fell and cut her leg. She did not alert anyone, thinking the bleeding would be self-limited if she rested under her tree. However, as evening drew near and she was not home, her absence was noticed by neighbors and other community members. They found her under her tree having lost a great deal of blood and took her to the hospital.

If they don't see you around, they will know to ask and they will come and knock at your door to find out how you are doing. (Participant #12)

Although there exists a strong sense of caring within families and communities, the same caring was not always evident in health care policies or the health care system in Africa.

Filial expectations and investing for aging. When it was time for Zenobia to be sent off to school, her older siblings provided money for school fees, room and board, and travel expenses. Upon graduation and securing a steady job, it was expected that she would send remittances to her parents and grandparents. There was never a question about what was expected. As a matter of fact, one of Zenobia's co-workers in the U.S. did not understand why Africans have large families, given their economic disadvantage. Zenobia explained:

You have many kids because you know that they will take care of you in old age. (Participant #9)

Acknowledging challenges to healthy aging in Africa. Once in the hospital, the local physician saw her grandmother. First, they waited for what seemed like a very long time to be seen by the triage nurse. There was no effort made to ensure her grandmother's comfort or

relieve her pain. The physician confirmed the wound was deep and voiced concerns about the ability to save her leg. He added that her blood test was positive for diabetes and that would complicate wound healing. He sutured the wound and expressed there was nothing further to do.

The system in Africa and the treatment—it is as if they [health professionals] think, “I’m not going to waste my time treating this 80-year-old person.” Just something simple like that. It doesn’t matter. You’ve lived your life. Although someone is not telling you that, you feel it. (Participant #01)

Zenobia’s sister, a physician in Wales, was notified and arrived the following day. After a long conversation with the admitting physician, her grandmother received proper care to ensure stable blood sugar levels and prevent infection along with health education regarding diabetes.

Becoming aware of new images of aging.

Becoming aware of aging norms in the U.S. After arriving in the U.S., married with two children, Zenobia and her husband found work and extended their family. They worked hard and very long hours, sometimes working two jobs. Zenobia worked in a hospital and nursing home.

What I see here on TV about women aging -- I see women being alone. Sometimes they show adult home and a stranger is taking care and they will have their routine. I know that that someone else is there taking care of that person and giving them food, and they are not really at that age where they cannot take care of themselves; they are not that old and they are in those [eldercare] homes. (Participant #11)

Acknowledging challenges to healthy aging in the U.S. Zenobia sometimes felt all they were doing was working. She admitted the weather and limitation for outdoor activities contributed to weight gain of almost 30 pounds and eventual diabetes and hypertension.

The difference here also, is the food people eat, and the lifestyle is a car to drive ... from your house you're sitting in a car and then work, the car and then to bed. Sitting, get up, get in a car, get back home, get in the bed. (Participant #3)

Zenobia endeavored to build friendships through work and in the community. She described facing discrimination due to race and being Muslim.

Quality of life to me is what you feel inside. Not what you have; it's just what you feel inside. You're at peace. You're in a relationship with your families or neighbors, and everybody is so friendly to you and they respect you. Here you're always seen as different, even if they understand you, they'll say ... what? You can tell that they understood what you are saying, but just to irritate you or just to make you feel ... (Participant #08)

Action /interaction strategies: accepting.

Accepting. After acknowledging advantages and disadvantages of living in the U.S., Zenobia accepted the differences and decided to work through expectations of aging that were not consistent with life in the U.S. Zenobia recalled a happier time during the wedding of her son, before his divorce. With a fixed stare she described the joy she felt as she considered how her family would grow in the U.S.

I work in Qatar for 15 years as a health aid in the hospital. You know, they call me [by ethnic origin]; here I am an American, yes I am a citizen. (Participant #10)

I have many factors against me, and I cannot control those facts. So if someone is mistreating me because I am Black, I cannot control that, so I don't let that kill me. I don't let that make me feel like I am not worth it. I push on for what I can get and what I know I can do. (Participant #9)

Like my colleagues back at home, when you're married it's kind of like if I have a boy, I've got a daughter — that's how it is. If my daughter gets married, I added myself a son. That's how it is. You love the son and you love the daughter, but here it's not like that. It's like you lost someone is how I look at it. When someone gets married here, you think that you've lost someone. (Participant #1)

Accepting the reality of aging in Africa. Zenobia gave thought to returning to Africa, to her mother's village. She thought of the neighbors and friends who visited her parent's home and considered returning to Africa as the best option to relieve her loneliness. She realized her family no longer lived in the village, she knew few people there, and her husband's village was unfamiliar to her. Zenobia remained in a state of loneliness for some time.

What I really want to do is go back home. That's what I really want. But, if you go home, who's there? Who is going to take care of you? (Participant #08)

The people, we came here so young, and so we had never invested back home. We didn't have the money to do that. Now when we are aging, we really want to go back. But when you go back, you feel threatened, because people have progressed in Kenya. You imagine, how am I going to live there? (Participant #10)

It's better here [U.S.] than to be there [Africa], because doctors and hospitals — they still are not good [in Africa]. (Participant #06)

Accepting loss due to discordant aging expectations was difficult for Zenobia. She felt her adult children never really saw how older parents were treated and cared for in her culture. Her parents came to visit but did not remain because they were lonely and missed their village.

We are in the middle, and then also culturally the same thing; we are not Americanized. We are in the middle. It will be tough for us I think, and then also there

will be a lot of hurts because you expect your kids to treat you the way that we treated our parents. But they are not going to do that, because they don't know. They didn't see it. They didn't learn about it and so they wouldn't know. We'll be hurting in our old ages. (Participant #8)

Yes, for example, your mom or your dad is here [in the U.S.]. You are showing your children how you are respecting your parents. They [my children] are taking that lesson. That's a lesson that you are giving your children, when you kiss your mom [and ask], "You need anything? Now I am going. Call me if [there is] something you need." Your children they are seeing, yes? They are seeing it, and they are doing the same thing for you. You understand what I mean? That is why we are not sending our parents to home care. (Participant #13)

For myself I do not expect anything from anyone. Life is hard for the immigrant, for their children too. So why do I want to put myself on their backs as a burden? (Participant #15)

Accepting the reality of aging in the U.S. Reflecting on advantages and disadvantages of living in the U.S., Zenobia realized that while working to provide educational opportunities and advantages for her children, they became Westernized in their attitudes about aging and caring for older adults. She realized the difference was not in the degree of love her children had for her, just what was expected of them. Her children knew she had social security and thought money and access to health care was sufficient for healthy aging. They provided money to make up for any difference in housing costs but could not readily visit or call every day.

We at our age in our 50s, we're starting to think okay, if all of these people have tried going back and now they're coming back at old age, what are we doing? Maybe we need to feel comfortable and know that we're here to stay. (Participant #10)

Adapting. Adapting to aging in the U.S meant a careful consideration of what factors contribute to being healthy in old age. Reluctantly she saw her doctor and revealed circumstances that contributed to her melancholy. Her doctor suggested she share her feelings with one of the women in her mosque. This was difficult to do because African women can be very private.

It comes from my heart. I feel, OK, now ... the environment or the context has changed and I need to adapt to the new context and learn how to live in the new environment. (Participant #12)

One morning Zenobia received a reminder for her annual physical examination. She was not taking medications for high blood pressure and diabetes as prescribed.

For me, I was not good with the doctors. I did not want a man doctor, but it is not like back home. The doctors here have to do certain things you know. It is a rule. Yes, they will give you a lady doctor, or nurse practitioner. (Participant #15)

Selecting health as a priority. Zenobia knew aging is a natural process and realized she must take an active role in maintaining her health. She decided to make her health a priority.

I exercise regularly; I eat very healthy. [Chronic illness] runs in our family, and I know like the physical tests and so whatever I need to do, I make sure that I do it so that I can live as long as possible. I don't want to be 90 and be horribly sick and kind of weak or broken. (Participant #9)

Identifying sources of personal strength. Zenobia gave thought to her attitude about the differences between her culture and American culture. She relied on her practice of praying daily to provide a new perspective and attitude about aging. She knew that being busy and having a purpose was important.

I have to be very positive in life. (Participant #9)

How do I do it? You know what? I think I can do it. (Participant #14)

Managing. Zenobia knew the importance of being a part of a larger community. She remembered older women in Africa meeting at the shamba to plan the care of children whose parents had died as a result of the AIDS epidemic. She was pleased to receive an invitation to a community meeting.

Building community. Zenobia started participating in women's groups and joined a weekly yoga class. She was volunteering at the community center, provided after-school supervision to several girls, and was trying to find a way to give them sewing lessons.

Sometimes we talk with my friends, you know? We have to build up relationships for each other and how we can help each other.... (Participant #05)

Utilizing social resources and health care systems in the U.S. At the community center she learned about the U.S. health care process and how to sign up transportation assistance. She found interpreting services for her friends and herself when English was too difficult.

Before I did not understand the [medical] tests, you know. Sometimes they say come again to do this test or that test. If I do not go, they send me a letter in the mail.

Health care is good here. (Participant #16)

Re-imagining healthy aging.

Re-establishing self. Zenobia chose to remain in Washington State in her apartment to gain a sense of stability and community for the future. She conceptualized healthy aging in relation to functioning in her new environment.

I must change, I see there is no other way ... otherwise I am like the old newspaper – I will be no good for me or for anything. (Participant #15)

... Here I am an American, yes I am a citizen. I go where I want to go. I fly to Chicago to see friends or to California to bury people from my country. I can do what I want. I have my business. As long I do not break the law, nobody bothers me. (Participant #13)

I think it is ok that I stay here. [older ladies in the apartment complex] call me sometime just come over to visit. In this apartment, it is not the best, but everyone can look in to see me. I am not afraid to grow old in this place. (Participant #16)

Creating a new aging perspective. Zenobia thought of interacting with her environment as she grew older in the U.S. She considered the convenience and affordability of nearby transportation, the proximity of close friends, and members from her religious group.

I think it's a lifestyle. You have to program how you want to live. That's what I have done. How I want to see life. (Participant #9)

Negotiating with family members. Zenobia discussed ways to ensure ongoing communication with her children.

I see in their eyes, my children's eyes, they worry about me. But they are tired. They have to fight to keep going every day because they are Black, you know. They are tired. (Participant #15)

Summary of Findings

This chapter described the study findings. Healthy aging for older Black African immigrant women involved processes described as acknowledging images of healthy aging, becoming aware of new images of aging, and accepting, adapting, managing, and re-imagining healthy aging. Their concept of re-imagining healthy aging was enhanced by questionnaire results that identified these women as having positive attitudes to aging and quality of life. However, there were discrepancies between attitudes to aging, successful aging, and quality of life as measured by questionnaire and based on interview responses. A few women who were active with their families and within their communities reported more negative attitudes to aging and their own successful aging and lower quality of life. The women with negative attitudes to aging were mothers, with clear expectations of filial piety, whose young adult children were born and raised in the U.S. Becoming aware of new images of aging among these women, limited their progression toward re-imagining healthy aging. Interestingly, a few younger mothers were able to progress toward reimagining healthy aging. Along with being engaged in family matters, these women were more engaged in community activities. Older women, with older adult children were able to advance through the processes of accepting both the cultures of their home and host countries, adapting to changing norms by making their own health a priority, and managing their future by building community and utilizing available resources from both countries. These processes took place within the contexts of their lives as a mother, immigrant, and as members of a racial minority population, and as visibly older Black women.

Chapter V: Discussion

In this chapter, the findings of my study are discussed in relation to published research and theories about healthy aging.

This is the first study to specifically investigate healthy aging in older Black African women who immigrated to the U.S. as adults. The findings of this study offer an important scientific contribution to what we understand about this population, particularly the factors that contribute to their healthy aging. These findings may serve as a starting point for future research among older Black African immigrant women and clinical interventions for promoting their health.

The main process experienced by the women in this study was “re-imagining healthy aging.” Pre-migratory healthy aging was imaged and defined by the women in this study as a natural phase of life, a time in which to look forward. Additionally, old age afforded them a sense of value within African communities, an honor that was not attainable unless one was old. The participants in this study observed that in Africa older women had implicit social connections through family, community- and church-related activities that gave them a purpose in old age. Every participant, regardless of her country of birth, emphasized functional health as contributing to healthy aging. Gardening—or as the Kenyans referred to it, going to shamba—was a primary source of activity and a way to engage in physical exercise while ensuring a food supply for their families. Successful aging for the participants in this study meant finding a way to adapt these active lifestyles of their home countries to the cultural values of their host environment and accept responsibility for their health and aging.

As the participants in this study identified positive images of healthy aging from their home countries in Africa that influenced their expectations for aging, they also identified factors

that made healthy aging difficult in Africa. These women recognized sociocultural norms regarding healthy aging among older women in the U.S., differing expectations of responsibility of U.S. family members toward caring for aging women, and changing family dynamics that affected their own expectations for aging. In this context, the participants' re-imagining of aging was borne out of their desire to remain close to their adult children, extended family members, and community while not serving as an additional burden or demand on their lives.

This process, in which the study participants *re-imagined* their perspective on healthy aging, has clear health implications for these women and other older Black African immigrant women who currently live in the U.S. For instance, Romo et al. (2012) conducted a qualitative study to identify perceptions of successful aging among an ethnically diverse population of older adults living with disabilities. The researchers found that despite living with physical disabilities research participants felt they were aging successfully. The participants focused on acknowledging a new reality of aging, on their strengths, the importance of faith, and adapting to physical and health related aging. The study findings suggested that although environment and chronic diseases impact health, having a positive attitude toward aging could improve both health and well-being. The women in this study had positive attitudes to aging and high scores on the WHOQOL-BREF indicating high quality of life.

In a more recent study examining perceptions of successful aging, Troutman et al. (2011) gathered SAI scores (which measured purposefulness, spirituality, intrapsychic factors and spirituality, and gerotranscendence) for 100 Southern Black adult men and women (though primarily women), whose ages ranged from 61 to 89. The participants had a mean SAI score of 64.05 with an SD of 10.79, and the participants described having a good mindset and remaining

engaged in community service as important factors in successful aging. Likewise, in this study the SAI scores served to measure participants' perspectives on successful aging. The older Black African immigrant women in my study had a mean SAI score of 67.3 (SD 8.05), which also is suggestive of successful aging; the theoretical maximum score is 80 (see Table 7). However, the current suggests a significant difference among subscale scores by religion. This finding could be a Type 1 error, given the small sample size.

The women also identified the pace of life in the U.S., long hours at work, high cost of living requiring two incomes, and the climate in Washington State as limiting physical activity and family time. They described relying on their faith and having a positive attitude as part of their strategy to adapting to aging in the U.S. Additionally, they described participating in community groups to obtain more information on ways to enhance health and quality of life as they moved into old age. Despite positive healthy aging perspectives of the participants, both qualitatively and quantitatively, there were differences in scale scores among the participants. These differences in scores reflect differences in the participants' attitudes to aging as well as differences in where they were currently located in the process of *re-imagining* healthy aging.

In re-imagining healthy aging and considering both the customs of their home countries and their new countries, the women in this study identified management of familial support, loneliness, and physical activity as important factors in aging successfully. The significance of loneliness to the participants in this study may directly parallel the findings in the work of Sellers, Ward, and Pate (2006), who conducted focus groups to explore dimensions of depression and well-being among five Black African immigrant women in the U.S. (mean age of 43). These investigators found that depression was a major health concern for these participants. They analyzed qualitative data line-by-line, revealing four dimensions related to depression:

perceptions, contextual factors, symptom manifestations, and cultural coping mechanisms. The authors then suggested that future research should apply a grounded theory design to develop a theory that better explains depression among this group of women. Concern for depression was not identified as a concern among the participants in the current study. However, the majority of women acknowledged that feelings of loneliness contribute to positive or negative attitudes toward aging and quality of life.

The current study also highlights that older Black African immigrant women have filial expectations of their children that are not captured in published research on healthy aging. The term *filial piety* is commonly used among researchers (Laidlaw, Wang, Coelho, and Powers, 2010; Unger & Schwartz, 2012) to describe the respect and support shown for elders and others in authority by sons and daughters. Within the process of re-imagining healthy aging, the women in this study endorsed concepts of investing for aging and adapting that run parallel to themes of filial piety. In this context, the women referred to their children as investments for the future and old age, a perspective that could also be articulated as filial piety. This perspective is clearly related to the cultural expectations they bring with them from their home countries, as Africa's current health-care system relies strongly on expectations of filial piety in the provision of care for older men and women (Oppong, 2006; Peil, 1991). A few of the women who had lower scores on the questionnaires and who were unable to move into the process of re-imagining healthy aging verbalized uncertainty about healthy aging for the future, particularly in relation to concerns regarding the availability of their children to meet expectations for filial piety.

Filial piety is a common finding among published healthy aging research in Asian populations. The findings in the current study are similar to those of a study that compared attitudes to aging and filial piety expectations among 130 community-dwelling older Chinese

living in Beijing, China, Chinese immigrants in Edinburgh, and older Caucasian people born in the United Kingdom (U.K.; Laidlaw et al, 2010). In that study, the authors identified an unexpected difference in Attitudes to Aging Questionnaire scores when comparing a sample of older Chinese-born participants living in Beijing to older indigenous U.K.-born participants living in the U.K, and older Chinese-born immigrants living in the U.K. They found that the older Chinese-born immigrant participants in the U.K. and the older U.K. born participants were more similar on aging attitudes than the older Chinese-born participants in Beijing, yet both the Beijing group and the Chinese-born immigrants had similar expectations of filial piety. Past studies have also suggested that Asian Americans and African Americans tend to be highly filial compared to other cultural groups in the U.S. (Pinquart & Sorenson, 2005); however, these studies have not included filial expectations of older African immigrants, and it is not clear that current questionnaires on this concept address the experience of older Black African immigrant women.

Identifying and reducing gaps in our knowledge, as I have attempted in this study, is key to reducing health outcome disparities. Indeed, filial support has been shown to contribute to quality of life and well-being among older Africans in Africa (Kodwo-Nyameazea & Nguyen, 2008; Opongo, 2006). An interesting next step in the development of this research would be to conduct a study that examines correlates and expectations for filial piety among older Black African immigrant men and women as it relates to healthy aging. Identifying expectations for filial piety is important for future researchers, as it would provide insights about effective health-care services for this population of aging women by facilitating connections with adult children.

Although most of the participants in this study lived with family members and had good social support networks, their awareness of changing family dynamics due to their new

environment may be problematic for their aging health. Indeed, despite their high scores on the SAI and their ability to re-image successful aging, the participants in this study tended to be unprepared for aging in the U.S. The women made sacrifices in order to immigrate to the U.S. and improve their families' futures, and the money they earned in the U.S. was usually allocated toward advancing their children's education and providing them with every possible advantage. These circumstances made the decline in familial piety, as perceived by the women, an important concern—they did not wish to become a burden to their children, yet they were not necessarily well-positioned to improve their health in the U.S. Researchers and health-care providers must recognize that these kinds of cultural and socio-environmental factors may impact interventions and health promotion activities. In light of the possible decline of an important cultural aspect of African women's lives—filial piety—community centers and other locations where women meet can serve as a valuable resource for not just obtaining community event information but also transmitting important health care knowledge, opportunities, and services.

Conclusion and Implications

Strengths and Limitations. The strength of this study is its mixed-methods approach, which allowed me to understand perspectives of healthy aging of older Black African immigrant women and compare them with their scores on attitudes to aging, successful aging and quality of life. However, there are also several limitations to the study. All studies that rely in part on subject self-reports have a degree of difficulty precisely identifying what might be considered *objective truth*, and that was certainly the case in this study, which occurred at an early stage of inquiry and performed by a new researcher. Additionally, given the study's finding on filial piety, a formal question to participants concerning the number of children in each family would have been helpful, but answers to this question were not recorded systematically.

Another limitation is that the small number of participants significantly reduced my ability to make inferences and limited opportunities to test for associations among the quantitative measures. Although I conducted non-parametric tests in an effort to generate questions, meaningful findings about these measures were limited, given the small sample size. In addition, internal consistency testing of the measures was also unreliable, due to the small sample size, and therefore was not reported. However, conducting inductive analysis with this small sample size provided additional perspectives and raised important questions related to the qualitative findings, particularly about the importance of religion, physical activity, and access to health information in the lives of the participants.

I learned the importance of religion and filial piety in the women's lives and observed well-meaning family members trying to "help" the research participants complete the questionnaires (even though the women were encouraged to complete the questionnaires without assistance from adult children). More importantly, the sample size was sufficient to achieve theoretical saturation of the concepts. The core categories, along with the cautiously considered quantitative findings, lay an important foundation for looking at a larger sample of older Black African immigrants. Further research can provide comparative insights about the experiences of the women in Western Washington and whether they have had a different experience from similar populations in other areas of the country.

Implications for Nursing Education and Practice

This study has significant curricular and clinical implications for nurses and primary care health providers. The study suggests a need for the development of educational programs and continuing education programs to support Black African immigrant women's efforts to re-image aging. Health-care workers should learn the importance of filial piety and its cultural decline in

the U.S. for this population. The health-care provider should assess for negative attitudes to aging and probe for the cause of negative attributions. For example, during clinical encounters with these women, nurses and primary care health providers should consider including family members in the care and factors that might foster adverse health outcomes, such as loneliness. In addition to clinical encounters, nursing curricula can be developed to include the importance of assessing evidence of negative attitudes to aging and identify possible factors that prevent it.

Implications for Nursing Research

An important finding in this study is that older Black African immigrant women indicated lifestyle and environmental changes that limit physical and social activity. They also identified filial piety as an important factor for healthy aging. Future research on healthy aging in this population could explore expectations of filial piety among adult children, a larger sample size of older Black African-born immigrants, African Americans, and non-African-born Black immigrants. To adequately perform this research, it might also be necessary to revise existing measures developed by Sung (1995) and Wang (2003) and expand on the theoretical constructs for studying filial piety among members of these populations and to address the influence of filial piety on health and well-being of older African immigrant women. By taking these steps findings can be generalized to older Black African immigrant women in the U.S. and used to identify ways for enhancing their health as they move into old age. For example, researchers can explore the efficacy of current practices by adult children, support groups or government agencies, and religious organizations on perceived health and aging expectations of their parents. To that end, I plan to expand both the qualitative and quantitative methods of this study to include a larger sample size of older Black African immigrant women, older African American

women, and older African Caribbean women to further explore these findings and generate hypotheses for testing in future research.

Conclusion

This study examined a significant health issue in a heterogeneous, understudied population. The questionnaire scores from the study indicate that older Black African immigrant women had a good quality of life, positive attitudes to aging, and were aging successfully. The study's findings concerning re-imagining healthy aging emphasize filial piety and loneliness as contributors to older Black African immigrant women's healthy aging. Other contributors are maintaining close family and community connections and having a purpose for living. This study showed that older Black African immigrant women living in the U.S. identify a high quality of life and positive attitudes about their future while simultaneously expressing a loss of continuity in their family support. The study also demonstrates how the principle of filial piety toward elders is not only a cultural custom or social tradition but also an idea that extends outward into communities and that can potentially be used by health-care workers to support older Black African immigrant women's progress toward a healthy future.

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Appendix A: Recruitment Flyer

Health and Aging

Hello...

My name is Sharon McRae and I am a PhD student at the University of Washington. I am conducting a study on the healthy aging of Black African immigrant women. I am recruiting women 45 years and above who were born in Africa, immigrated to the U.S. as adults, and would be willing to take about 1 hour to complete an interview and complete some questionnaires.

If you would like to take part in the study, or hear more information, please contact me, Sharon G. McRae at (206) 850-9966.

Thank you

Sharon G. McRae, MSN, ARNP



Appendix B: Telephone Recruitment Message

Hello, My name is Sharon McRae and I am a PhD student at the University of Washington.

Thank you for your interest in the study. [or] I was given your name by _____, who said that you might be interested in participating in the research I am conducting on the healthy aging of older Black African immigrant women. I am recruiting women 45 years and above who were born in Africa, immigrated to the U.S. as adults, and would be willing to take about 1 hour to complete an interview and complete some questionnaires.

If you would like to take part in the study, the interview would be conducted at your convenience in a location chosen by you and will be digitally recorded. Following the interview, you will be asked to complete several questionnaires about your basic background and your thoughts and feelings about health, aging, and quality of life. If you choose to participate in the study, all of your information will be kept confidential, and your name will never be included with any study data or study reports. I also want to let you know that your participation in the study is completely voluntary, and you may withdraw at any time.

Does this sound of interest to you and would you be willing to have an interview scheduled?

[If yes, schedule the interview.]

[If no, thank the participant for her time.]

Appendix C: Consent Form

UNIVERSITY OF WASHINGTON CONSENT FORM Healthy Aging of Older Black African Immigrant Women

Researchers: Sharon G. McRae, MSN, ARNP: PhD Student, School of Nursing, 206-850-9966

Barbara Cochrane, PhD, RN: Faculty Advisor and Professor, School of Nursing,
206-685-0836

Researchers' statement

We are asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not. Please read the form carefully. You may ask questions about the purpose of the research, what we would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions, you can decide if you want to be in the study or not. This process is called "informed consent." We will give you a copy of this form for your records.

PURPOSE OF THE STUDY

The purpose of this study is to learn more about older Black African immigrant women's perspectives on health and aging. This information is important for understanding what contributes to successful aging and health among these women.

STUDY PROCEDURES

If you agree to join this study, you will be asked to complete an interview and some forms about your thoughts and feelings on health and aging. The interview will be digitally recorded and the recording transcribed verbatim afterwards so that I can be sure I have an accurate record of what you tell me. You will be asked to describe your experience of health and aging as an older Black African woman who has immigrated to the U.S., including your thoughts before and after coming to this country.

At the end of the interview, you will be asked to fill out several forms that ask about your basic background and your thoughts, feelings and attitudes about health and aging and quality of life. Some of the most sensitive questions on those forms ask how much you agree or disagree with some statements (for example, I am losing my physical independence as I get older; I think of my loved ones who have passed away and feel close to them") and how satisfied you are with your sex life. About 20 to 30 women are expected to participate in this study. You will be asked not to include proper names or other identifying information on the forms or during the interview, which will take about approximately 60 minutes overall. You have the right to refuse to answer any questions during the interview or on the forms.

A smaller number of participants in the study (about 10) may also be asked to schedule a second interview 1 to 2 months after this first interview, so that I can get their feedback on early findings from the study. If you are asked to have this second interview and agree, the interview would be scheduled at a time and place that is convenient for you. During that interview, I will describe what I am learning so far from women in the study and then ask for your thoughts about those findings and whether or not there is different or additional information that I should know about and understand. The second interview will also be digitally recorded and transcribed verbatim afterwards so that I have accurate information about what you tell me. You will not be asked to complete any forms after the second interview, which will take about 45 to 60 minutes. You have the right to decline to have this second interview. You may request to hear the digital recording and erase any part you do not want to keep. If it is scheduled, you can refuse to answer any questions at any point in time.

RISKS, STRESS, OR DISCOMFORT

Risks for participation are minimal and limited to possible distress or sad feelings as a result of answering questions about your health and aging and talking about your experience both before and after coming to this country.

All digital recordings of the interviews and actual questionnaires will be identified by code number only (a unique code number assigned to each participant), and you will be asked not to use proper names or other identifying information during the interview. The link between your code number and contact information will be kept separate from the recording in a password-protected computer file that only the PI and her faculty sponsor will be able to access. Your contact information and the link to the study code number will be kept only to contact you for the second interview. Once that interview is completed and transcribed, the contact information and link to your study code number will be completely destroyed. If you do not have a second interview, your contact information and link to your study code number will be destroyed after all second interviews are completed. The digital recordings of all first and second interviews will be erased once they are transcribed and the transcription is verified for accuracy. The transcripts – which will not have any identifying information – will be kept indefinitely. Overall grouped information from the study or excerpts from the interview transcripts may be reported in professional journals and/or at conferences. However, under no circumstances will names or any personally-identifiable information be included in any publication, presentation, or other report.

BENEFITS OF THE STUDY

Although you are not expected to benefit personally from being in this study, some women do find it helpful to talk about their thoughts and feelings. The information we learn from the study may help other older Black African immigrant women in the future, because health care providers will have a better understanding of their experience and health care needs.

CONFIDENTIALITY OF RESEARCH INFORMATION

All of the information you provide will be kept confidential. However, if we learn that you intend to harm yourself or others, we must report that to the authorities.

OTHER INFORMATION

You may refuse to participate and you are free to withdraw from this study at any time without penalty or loss of benefits to which you are otherwise entitled. There is no cost for participating in the study other than the time it takes to complete the interviews and forms. If you decide to participate in the study, you will receive \$20.00 cash in appreciation for your time and effort.

Printed name of study staff obtaining consent	Signature	Date
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Subject's statement

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, I can ask one of the researchers listed above. If I have questions about my rights as a research subject, I can call the Human Subjects Division at (206) 543-0098. I will receive a copy of this consent form.

I have received \$20.00 as a gift for my participation.

Printed name of subject	Signature of subject	Date
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Copies to: Researcher
 Participant

Appendix D: Demographics Questionnaire

ID _____

Demographic Questionnaire

What is your age?			
Please circle the name of your country of birth and write in how long you lived there.	Angola	Mali	Kenya
	Madagascar	Senegal	Liberia
	Niger	Zambia	Malawi
	Nigeria	Zimbabwe	Mozambique
	Sudan	Benin	Sierra Leone
	Republic of Congo	Botswana	Somalia
	Cape Verde	Cameroon	Uganda
	Ghana	Ethiopia	Other (please specify):
What country did you live in right before you migrated to the United States? How long did you live there?			
In what other countries have you lived for more than 1 year?			
Income level	<input type="checkbox"/> Less than \$20,000 <input type="checkbox"/> \$20,000--\$50,000 <input type="checkbox"/> \$50,000--\$80,000 <input type="checkbox"/> \$80,000--\$100,000 <input type="checkbox"/> \$100,000--\$150,000 <input type="checkbox"/> \$150,000 and over		
Marital Status	<input type="checkbox"/> Never married <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Partnered (living in a married like relationship)		

ID _____

What is your faith/ religion?	
Education in Africa	<input type="checkbox"/> Did not attend school <input type="checkbox"/> Secondary school (Level __) <input type="checkbox"/> High School <input type="checkbox"/> Technical school/vocational training before high school __; after high school <input type="checkbox"/> Some college or Associates Degree <input type="checkbox"/> Baccalaureate degree <input type="checkbox"/> Masters degree <input type="checkbox"/> PhD. <input type="checkbox"/> No answer
Current education	Secondary school (Level __) __ High School __ Technical school/teacher training __ Baccalaureate degree __ Masters degree __ PhD. _____ No answer __
Which of the following best describes your current employment situation	<input type="checkbox"/> (circle) employed full time/part time <input type="checkbox"/> homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Student

ID _____

<p>What type of work do you do now that you are in the U.S.? Please describe</p>	<p>___ Administrative: (Managerial, Professional specialty, etc.): ___ ___ Technical: (Sales, computer support, administrative support, etc.) ___ Service: (police, health or food service, nursing or teaching assistant, etc.) ___ Other(please describe) _____</p>
<p>What type of work did you do before you left Africa? Please describe</p>	<p>___ Administrative: (Managerial, Professional specialty, etc.): ___ ___ Technical: (Sales, computer support, administrative support, etc.) ___ Service: (police, health or food service, nursing or teaching assistant, etc.) ___ Other(please describe) _____</p>
<p>Do you have any health problems? If so, please describe</p>	
<p>Who do you see for your regular health care (for example, doctor, nurse practitioner, healer). We are interested in the type of provider, not their name.</p>	
<p>Please list the medicines or supplements you take for your health</p>	<p>Prescription: Herbals: Vitamins:</p>
<p>Who lives with you (for example, husband or partner, children, other relative, friend).</p>	

Appendix E: Interview Question Guide

AGING

1. I am interested in your perspective on growing old or **aging**. **What does aging mean to you?**
2. Has your perspective on aging changed from when you were in Africa and now that you are in the U.S. Can you tell me more about that?

Prompts

3. How would you describe the way people view **aging** women in your home country?
4. What are older women's daily activities or responsibilities like in your home country?
5. How are views of aging women and their daily activities similar or different in the U.S.?
6. What do you think are important factors that help older Black African immigrant women to **age** well or successfully in the U.S.?
7. Now that you are in the U.S, what helps you **age** well?
8. What sorts of things make it difficult for you to **age** well or successfully here in the U.S.?

HEALTH

9. I am interested in your perspective on health. **What does being healthy mean to you?**
10. Has your perspective on health changed from when you were in Africa and now that you are in the U.S. Can you tell me more about that?
11. Please describe your **health** before coming to the U.S.?
12. Please describe your **health** changed since living in the U.S.?
13. What factors do you think contributed to the change in your **health**?

Prompts

14. In what ways are your **health practices in the U.S. the same or different from those in Africa?** [Prompt about physical activities, spiritual well being, financial, family as below]
15. How would you describe **health** for older women in your home country? How independent are they in their daily lives?
16. Are views of older women's health similar or different in the U.S.? Ask about health care providers, MD's, nurses
17. How physically active are you now? Do you have assistance or a companion with you when you are away from home?
18. What do you think are important factors for good **health** in the U.S.?
19. Do you think **aging** well and **healthy aging** are similar and/or different?

Appendix F: The Attitudes to Ageing Questionnaire

ID _____

ATTITUDES TO AGEING QUESTIONNAIRE (AAQ-24)

Instructions

This questionnaire asks you how you feel about growing older.

Please answer all the questions. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures, and concerns. We ask that you think about your life in general.

For example, thinking how you feel in general, a question might ask:

I dislike growing older

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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You should circle the number that best fits how true the statements are for you. So you would circle the number 4 if you dislike growing older "Very much", or circle number 1 if you are "Not at all" concerned about growing older. Please read each question, assess your feelings, and circle the number on the scale for each question that gives the best answer for you.

Thank you for your help

ID _____

The following questions ask **how much you agree** with the following statements. If you agree with the statements an extreme amount circle the number next to "strongly agree". If you do not agree with the statements at all, circle the number next to "Strongly disagree". You should circle one of the numbers in between if you wish to indicate your answer lies somewhere between "Strongly disagree" and "Strongly agree".

1. As people get older they are better able to cope with life.

Strongly disagree 1	Disagree 2	Uncertain 3	Agree 4	Strongly agree 5
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2. It is a privilege to grow old.

Strongly disagree 1	Disagree 2	Uncertain 3	Agree 4	Strongly agree 5
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3. Old age is a time of loneliness.

Strongly disagree 1	Disagree 2	Uncertain 3	Agree 4	Strongly agree 5
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4. Wisdom comes with age.

Strongly disagree 1	Disagree 2	Uncertain 3	Agree 4	Strongly agree 5
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5. There are many pleasant things about growing older.

Strongly disagree 1	Disagree 2	Uncertain 3	Agree 4	Strongly agree 5
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6. Old age is a depressing time of life.

Strongly disagree 1	Disagree 2	Uncertain 3	Agree 4	Strongly agree 5
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7. It is important to take exercise at any age.

Strongly disagree 1	Disagree 2	Uncertain 3	Agree 4	Strongly agree 5
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PLEASE TURN OVER THE PAGE

The following questions ask **how true** the following statements are for you. If the statement is “Extremely” true for you, circle the number next to “Extremely true”. If the statements are not true for you at all, circle the number next to “Not at all true”. You should circle one of the numbers in between if you wish to indicate your answer lies somewhere between “Not at all true” and “Extremely true”.

8. Growing older has been easier than I thought.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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9. I find it more difficult to talk about my feelings as I get older.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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10. I am more accepting of myself as I have grown older.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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11. I don't feel old.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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12. I see old age mainly as a time of loss.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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13. My identity is not defined by my age.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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14. I have more energy now than I expected for my age.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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15. I am losing my physical independence as I get older.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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16. Problems with my physical health do not hold me back from doing what I want to.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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17. As I get older, I find it more difficult to make new friends.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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18. It is very important to pass on the benefits of my experiences to younger people.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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19. I believe my life has made a difference.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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20. I don't feel involved in society now that I am older.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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21. I want to give a good example to younger people.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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22. I feel excluded from things because of my age.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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23. My health is better than I expected for my age.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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24. I keep myself as fit and active as possible by exercising.

Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
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THANK YOU FOR YOUR HELP!

Appendix G: The Successful Aging Inventory

ID _____

Successful Aging Inventory

Read each statement carefully. Circle the answer that matches how you feel right now.
Remember there are no right or wrong answers.

1. I manage to do the things that I need to do to take care of my home and to take care of myself (eating, bathing, dressing).	Hardly ever 0	Sometimes 1	About half the time 2	Most of the Time 3	Almost always 4
2. I have been able to cope with the changes that have occurred to my body as I have aged	Hardly ever 0	Sometimes 1	About half the time 2	Most of the time 3	Almost always 4
3. I look forward to the future.	Hardly ever 0	Sometimes 1	About half the time 2	Most of the time 3	Almost always 4
4. I feel able to deal with my own aging	Hardly ever 0	Sometimes 1	About half the time 2	Most of the time 3	Almost always 4
5. I feel able to cope with life events	Hardly ever 0	Sometimes 1	About half the time 2	Most of the time 3	Almost always 4
6. I can come up with solutions to problems.	Hardly ever 0	Sometimes 1	About half the time 2	Most of the time 3	Almost always 4
7. I am good at thinking of new ways to solve problems	Hardly ever 0	Sometimes 1	About half the time 2	Most of the time 3	Almost always 4
8. I enjoy doing creative new things or making things.	Hardly ever 0	Sometimes 1	About half the time 2	Most of the time 3	Almost always 4
9. I am in a positive, pleasant mood.	Hardly ever 0	Sometimes 1	About half the time 2	Most of the time 3	Almost always 4
10. I think of my loved ones who have passed away and feel close to them	Hardly ever 0	Sometimes 1	About half the time 2	Most of the time 3	Almost always 4
11. I spend time in prayer or doing some kind of religious activity.	Hardly ever 0	Sometimes 1	About half the time 2	Most of the time 3	Almost always 4
12. As I have aged, the way I think of the world has changed.	Strongly disagree 0	Somewhat disagree 1	Neither agree nor disagree 2	Somewhat agree 3	Strongly agree 4
13. I would rather have a few close friends than many casual ones.	Strongly disagree 0	Somewhat disagree 1	Neither agree nor disagree 2	Somewhat agree 3	Strongly agree 4
14. Sometimes there can be two right answers to a problem or situation.	Strongly disagree 0	Somewhat disagree 1	Neither agree nor disagree 2	Somewhat agree 3	Strongly agree 4
15. A relationship with God or some higher power is important to me.	Strongly disagree 0	Somewhat disagree 1	Neither agree nor disagree 2	Somewhat agree 3	Strongly agree 4
16. I feel interest in/concern for the next generation.	Strongly disagree 0	Somewhat disagree 1	Neither agree nor disagree 2	Somewhat agree 3	Strongly agree 4
17. My life is meaningful.	Strongly disagree 0	Somewhat disagree 1	Neither agree nor disagree 2	Somewhat agree 3	Strongly agree 4
18. I am overall satisfied with my life right now.	Strongly disagree 0	Somewhat disagree 1	Neither agree nor disagree 2	Somewhat agree 3	Strongly agree 4
19. I feel that I serve a purpose in this world.	Strongly disagree 0	Somewhat disagree 1	Neither agree nor disagree 2	Somewhat agree 3	Strongly agree 4
20. Being the age that I am now is as good or better that I thought it would be.	Strongly disagree 0	Somewhat disagree 1	Neither agree nor disagree 2	Somewhat agree 3	Strongly agree 4

Appendix H: The World Health Organization Quality of Life- BREF

ID _____

THE WHOQOL-BREF

This assessment asks how you feel about your quality of life, health, or other areas of your life. Please answer all the questions. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response. Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last two weeks.

		Very poor	Poor	Neither poor nor good	Good	Very good
1	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about how much you have experienced certain things in the last two weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3	To what extent do you feel that (physical) pain prevents you from doing what you need to do?	1	2	3	4	5
4	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5	How much do you enjoy life?	1	2	3	4	5
6	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7	How well are you able to concentrate?	1	2	3	4	5
8	How safe do you feel in your daily life?	1	2	3	4	5
9	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things in the last two weeks.

		Not at all	A little	Moderately	Mostly	Completely
10	Do you have enough energy for everyday life?	1	2	3	4	5
11	Are you able to accept your bodily appearance?	1	2	3	4	5

ID

		Not at all	A little	Moderately	Mostly	Completely
12	Have you enough money to meet your needs?	1	2	3	4	5
13	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15	How well are you able to get around?	1	2	3	4	5

The following questions ask you to say how **good** or **satisfied** you have felt about various aspects of your life over the last two weeks.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16	How satisfied are you with your sleep?	1	2	3	4	5
17	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18	How satisfied are you with your capacity for work?	1	2	3	4	5
19	How satisfied are you with yourself?	1	2	3	4	5
20	How satisfied are you with your personal relationships?	1	2	3	4	5
21	How satisfied are you with your sex life?	1	2	3	4	5
22	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24	How satisfied are you with your access to health services?	1	2	3	4	5
25	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

		Never	Seldom	Quite often	Very often	Always
26	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

THANK YOU FOR YOUR HELP