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## Self-Rated Health Appraisal as Cultural and Identity Process: African American Elders' Health and Evaluative Rationales

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### Abstract

**Purpose**—We explored self-rated health by using a meaning-centered theoretical foundation. Self-appraisals, such as self-rated health, reflect a cultural process of identity formation, whereby identities are multiple, simultaneously individual and collective, and produced by specific historical formations. Anthropological research in Philadelphia determined (a) how African American elders appraise their health, and (b) how health evaluations reflect cultural and historical experiences within a community.

**Design and Methods**—We interviewed and observed 35 adults aged 65 to 80, stratified by gender and self-rated health. We validated theme analysis of focused interview questions against the larger data set of field notes and transcripts.

**Results**—Health appraisal reflected a complex process of adaptation and identity. Criteria for health included: independent functioning, physical condition, control and responsibility for health, and overall feeling. Evaluative rationales that shaped health appraisals were comparisons, restricted possibilities for self-evaluation, and ways of handling adversity. Evaluative rationales mitigated undesirable health identities (including low self-reported health) and provided mechanisms for claiming desired health identities despite adversity.

**Implications**—Describing the criteria and evaluative rationales underlying self-appraisals of health extends current understandings of self-rated health and illustrates the sociohistorical context of individual assessments of well-being.

### Keywords

Self-rated health; African Americans; Qualitative methods; Self-appraisal; Identity

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An important measure for health assessment is self-rated health, a single-item fixed-response question generally worded as “How do you rate your health today? Excellent, good, fair, or poor?” The response, which elicits a subjective, holistic evaluation of one’s condition, predicts mortality more accurately than age, physician ratings, and even reported symptoms. In fact, no other single measure of health can so easily identify individuals at high risk for mortality (Fayers & Sprangers, 2002; Idler & Benyamini, 1997; Mossey, 1995). Self-rated health likely reflects both a spontaneous assessment of health and a more enduring health self-concept or health trajectory (Bailis, Segall, & Chipperfield, 2003; Ferraro, Farmer, & Wybraniec, 1997).

Although epidemiological research has focused on the determinants and consequences of self-rated health, that research has not answered “*why* and *how* individuals appraise their health” (George, 2001, p. 223). Qualitative studies have concluded that interpretive processes are important to understanding self-rated health (Borawski, Kinney, & Kahana, 1996; Idler, 1994; Jylha, 1994; Krause & Jay, 1994; Silverman, Smola, & Musa, 2000). For example, Borawski and colleagues found that White elders who could not explain their self-rated health responses were 4.5 times more likely to die than those who could. A study of African American elders found that individuals who “overestimated” their health relative to their “objective” medical history used more inclusive, holistic rationales to explain their self-rated health responses. In contrast, elders who “underestimated” their health focused their self-rated health explanation on physical health issues (Idler, Hudson, & Leventhal, 1999). In interviews about the meanings of “healthy” and “not healthy,” people who self-labeled as not healthy explained their appraisals by using medical and physical health (Silverman et al., p. 153). Those who labeled themselves as healthy had more varied explanations, such as “‘being upbeat,’ ‘trusting in the Lord,’ and ‘transcending’ their health problems.” Overall, these studies suggest that transcending biomedical criteria for health is linked with better self-rated health.

Although suggestive, previous studies of self-rated health meanings have several design limitations. They are not theory based and have a narrow data collection focus; they analyze only spontaneous responses to open-ended probes about self-rated health. Importantly, data analysis strategies minimize the complexity of informants’ responses, reducing self-rated health to a list of content categories while ignoring other phenomena, such as the structure and logic of self-rated health explanations. Insight into such logic is critical to understanding self-rated health.

### **Self-Appraisal as Identity Process**

Holland and colleagues’ theory of identity and agency in cultural worlds synthesizes anthropological and language-based understandings of identity (Holland, Lachicotte, Skinner, & Cain, 1998). Drawing upon that work, we suggest that self-rated health integrates a cultural process of identity formation, whereby identities are multiple, simultaneously individual and collective, and produced within particular socioeconomic and historical formations. We define *identities* as the fluid outcomes of ongoing processes that link personal meanings and cultural discourses. Identities are both public and private. “People tell others who they are, but even more important, they tell themselves and then try to act as though they are who they say” (Holland et al., p. 3). Personal meanings are a person’s own life interpretation, derived from cultural discourses and individual experience (Luborsky, 1993, 1994b; Rubinstein, 1992). Cultural discourses are shared cognitive models that explain and motivate various domains of understanding (D’Andrade & Strauss, 1992; Holland & Quinn, 1987). Aging and diminishing health can erode lifelong identity constructs (cf., Becker, 1997; Chamarz, 1983, 1991). Thus, we view identity processes as central to health self-appraisal in old age.

### **African Americans’ Self-Rated Health**

Holland and colleagues (1998) emphasize the social, cultural, and political-economic contexts in which identity takes place. This theoretical link opens a discussion of how the contexts of poverty, race, and ethnicity relate to self-rated health. African American elders’ health ratings are generally worse than those of their White counterparts, possibly due to higher morbidity and the stronger impact of morbidity on functional status among African Americans (Ferraro, 1993). African Americans may rate their health status and health trajectories more negatively than Whites, even when controlling for objective physical health. This phenomenon, described as “health pessimism” (Ferraro), has been attributed to

inequality and interpersonal maltreatment (Boardman, 2004). Self-evaluations of health may prove especially accurate for assessing the health and mortality risk of African Americans. Ferraro and Farmer (1999) found that physicians were significantly less accurate in their assessment of African American versus White patients' health.

We present findings here on the process of self-assessment that underlies self-rated health responses among African American elders. This ethnographic research describes how African American elders in a Philadelphia neighborhood appraise their health and how cultural and historical experiences shape global health evaluations.

## Methods

We used focused ethnographic interviews and participant observation. This neighborhood study extends the Health Ratings Study, a city-wide, home-based interview project assessing self-rated health and its correlates among White and African American elders in Philadelphia (National Institute on Aging Grant RO1#AG15730, Mark Luborsky, principal investigator). We selected the neighborhood of Germantown, Philadelphia, because its predominantly African American population represented a broad range of socioeconomic characteristics. It also contained a thriving, African American-oriented senior center that presented opportunities for ethnographic observation. Most participants in the neighborhood study had originally been recruited into the Health Ratings Study from Medicare-beneficiary data by using randomized direct mailings to all Medicare-eligible adults in Philadelphia. In order to obtain a sample of neighborhood residents stratified by gender and self-rated health, we recruited 6 more participants through community organizations and a senior center by using advertisements and word of mouth.

We collected eligibility information, including self-rated health, from volunteers. Inclusion criteria were (a) aged 65 to 80 years, (b) self-labeled African American, (c) United States born, and (d) residence in the Germantown neighborhood (one zip code designation plus adjoining areas that local residents considered part of that neighborhood). Exclusion criteria were (a) nursing home residence; (b) urban residence for fewer than 25 years; and (c) speech, hearing, or memory problems that would make qualitative interviewing difficult (Katzman et al., 1983). Initial recruitment materials ascertained gender and self-rated health (excellent, good, fair, poor, or bad). A subsequent screening interview collected another self-rated health report and determined eligibility. (In screening interviews, we asked respondents reporting excellent or good self-rated health whether they would have given a self-rated health response of "very good.")

## Sample

The recruitment strategy aimed to represent diversity in health and socioeconomic experiences within this cohort of African American elders. The study enrolled 35 participants, all long-term Philadelphia residents born in the United States between 1921 and 1934 (aged 67 to 79 at recruitment). We stratified participants by gender and self-rated health. In screening interviews, 9 elders reported excellent or very good self-rated health, 11 reported good self-rated health, 10 reported fair self-rated health, and 5 reported poor self-rated health. We recruited nearly equal numbers of men and women in each self-rated health category. Recruitment of participants in poor health fell short of the original target. These participants, however, provided very rich qualitative information, and a careful review indicated that this recruitment shortfall did not hamper our analysis and findings. Elders were 71.5 years old on average. Fifteen had an educational level of high school or less, whereas 20 continued their education past high school. All but 3 respondents had been married, but only one third were living with a spouse or partner at the time of our interviews.

Fourteen elders lived alone. The remainder were equally split between those who lived with a spouse or partner and those who lived with other family members.

These sociodemographic characteristics were not significantly associated ( $p \leq .05$  in chi-square analyses) with gender or self-rated health responses during the study period (measured by a dichotomous variable of self-rated health ever greater than good and self-rated health never greater than good). Therefore, findings were likely not biased by any systematic relationships between perceived health, gender, and other sociodemographic variables.

### Data Collection

We collected data through interviews and participant observation.

**Interviews**—The first author conducted multiple interviews with participants in their homes using in-depth semistructured and structured questions. Interviews were taped and lasted about 90 minutes each. Skilled transcriptionists prepared verbatim transcripts.

**Observation**—The first author conducted 3 years of ethnographic observations in community settings, including churches, the neighborhood's senior centers, and other public settings such as health education programs. Several key informants took the first author to church, social activities, their homes, or shared lunch or coffee. These activities enabled her to witness naturally occurring conversations about health appraisal. She recorded observations in field notes, which were analyzed along with the interview transcripts.

### Measures

We analyzed data from a qualitative coding of the entire set of field notes and interview transcripts. Field notes extended insights into the interview data. Measures focused on three main topics: personal health concepts, interpretation of the self-rated health question, and cognitions during self-rated health selection.

**Personal Health Concepts**—The interviewer asked participants a series of open-ended questions about how they conceptualized health, including “How would you define health in your own life?” Follow-up probes further elicited personal meanings of health.

**Self-Rated Health Answer-Category Interpretations**—The interviewer asked participants how they defined the self-rated health question's reply categories: excellent, good, fair, poor, and bad. Follow-up probes asked for dictionary-type definitions of each health category.

**Cognitive Testing Style Perspectives on the Processes of Constructing Self-Rated Health Reply**—The interviewer asked participants to “think aloud as you construct a self-rated health response.” We administered the standard question (“How would you rate your health today? Would you say it is excellent, good, fair, poor, or bad?”). After obtaining an uninterrupted answer, the interviewer asked about the process of constructing that particular reply, including the strategy for selecting a reply and the salience of the answer categories.

### Analysis

Data analysis methods featured both systematic language and cognition analysis and a hermeneutic, or case-oriented, approach customary in ethnography (Bernard & Ryan, 1998). We used NUD\*IST 5 (QSR International, Doncaster, Victoria, Australia) for text analysis. First, we reviewed all interviews and field notes in order to identify sections that contained

talk about self-rated health and other forms of health appraisals, statements about identities, or personal philosophies. The second step focused on responses to three interview questions: (a) definitions of health, (b) definitions of self-rated health response categories, and (c) the “think aloud” responses and follow-up discussion. We created an initial coding scheme by identifying topics, categories, and domains in the responses to those three focal questions (Luborsky, 1994a). Third, we refined the initial coding scheme by re-examining previously identified talk about health appraisals and personal identity in the interview and ethnographic observation data. We then applied the revised coding scheme to all data from the three focal questions, which resulted in a comprehensive list of contents, logics, and strategies of health assessment.

## Results

Two distinct sets of meanings emerged: (a) traits or criteria for health, and (b) evaluative rationales that guided construction of self-appraisal based on the health criteria. They appeared to operate independently; the cognitive reasoning processes were separate from, and not determined by, the particular features used in the reasoning.

We identified four criteria for health: (a) independent functioning, (b) physical condition, (c) personal responsibility and control, and (d) overall feeling. Independent functioning, the most frequently mentioned criterion, involved the ability to move about and engage in daily activities without strain. Functioning went beyond activities of daily living and evoked a spiritual discourse on thankfulness for even the most basic abilities (cf., Agee, 2000). The second criterion, the physical condition of one’s body, was the closest to biomedical health assessment, evoking a notion that the body functions as a machine. These statements included physical descriptions of disease versus normal functioning, disease severity, and the need for medications and medical care. The third criterion was personal responsibility to control one’s health. Elders said they should try to maintain their health; “do the right thing” to control chronic conditions; follow and sometimes purposefully reject medical recommendations; seek quality medical care; and practice “good living” through diet, exercise, and avoiding stress. The “power of positive thinking” was conceptually related to this control of health. Finally, a relatively unelaborated health criterion was the assertion that health is “how you feel.” Nine of 34 respondents mentioned exactly these words in their health definitions, referring either to an “overall” feeling or to how a person feels from day to day. Other studies of self-rated health determinants have described these same health criteria (Borawski et al., 1996; Idler et al., 1999; Krause & Jay, 1994; Silverman et al., 2000).

About half of the elders ( $n = 17$ ) used health criteria in their think-aloud responses. However, 68% of them ( $n = 23$ ) utilized *evaluative rationales* in order to explain their self-rated health in think-aloud responses (Table 1). By rationales, we mean logical arguments, not a list of features. Rationales function as procedural tools or resources, grounded in broader cultural or figured worlds, that are also evident in wider processes of identify formation and self-appraisal. A few rationales were employed only to explain specific ratings, but most of them were used flexibly in conjunction with a number of different health ratings.

### Comparative Rationales

Almost half of the think-aloud explanations contained comparative evaluations. These revealed culturally constructed reference points by which individuals appraised their own relative condition. The comparative rationales converged around three idioms:

1. I'm doing well, considering my age, limitations, disease, ethnicity, or gender (29% of responses).
2. I could be better, I could be worse (12% of responses).
3. Others are worse off, so I am thankful and feel blessed (15% of responses).

These idioms provided respondents with meaningful cultural frameworks within which to locate their self-evaluations. They tended to either justify a rating of good to excellent or confer a positive stance toward a rating of fair to poor. These idioms are fairly discrete, although at times elders played one against another.

**I'm Doing Well, Considering**—The 10 think-aloud responses that used the rationale “I'm doing well, considering,” included statements such as “I'm doing well for my age,” or “I'm doing well with my diabetes.” Such rationales functioned to elevate one's self-rating when compared with various reference groups (other old people, other people with diabetes). Additionally, elders referred to their success according to one health criterion (maintaining physical functioning, controlling chronic disease) in order to mitigate the impact of problems with another criterion for health (pain, presence of life-threatening disease). Participants also compared personal against expected experiences of aging. Expectations of aging included a gradual “slowing down,” “wear and tear,” or increasing “aches and pains.” Some stated that they were doing better than could be expected for their age or that their problems were natural to the aging process.

**Could Be Better, Could Be Worse**—The four individuals who used the “could be better, could be worse” idiom in their think-aloud responses all had fair or good health ratings. Placing one's self in the middle of health ratings leaves open the possibility of upward or downward mobility, and this idiom's use reflected liminality (being between states) with respect to their anticipated future. In using this idiom, elders seemed to be expressing satisfaction with their health evaluations, but also suggested the desire for an improved condition. One woman with chronic back pain, who rated her health as fair, used the exact words “could be worse, could be better” to rate her health. She repeatedly expressed desire for improved health and overall life conditions. However, she simultaneously acknowledged that feeling dissatisfied could be seen as lacking gratitude. Each time she gave a “could be better, could be worse” evaluation of her health or her life, she also concluded with a reconciliation that things were alright overall. Her case illustrates the subtle yet powerful difference between saying only that things could be better (expressing dissatisfaction) versus saying that things could be worse (expressing gratitude). People often creatively shifted between these discourses even throughout one interview. The following exchange between Carmit McMullen (CM) and a participant (P) exemplifies this discourse:

CM: What do you think the next chapter's going to be in your life?

P: I hope it'd be a better chapter. I get so, I knows there's people out here that hurt, are far more worse than I ever will hurt. And I thank God for, oh, a lot, just being here. And, oh, but I was just hoping that things might, would get better.

This woman is struggling with the implications of a specific evaluative stance—wishing for improvement in her condition. She seemingly repairs the transgression of complaint by interjecting a more spiritually based discourse on being thankful for what God has given.

**Others Are Worse Off**—In contrast to the better/worse rationale, asserting that “others are worse off” does not explicitly suggest lack of acceptance or the desire for improvement in one's condition. In this group of African American elders, the sanction against

complaining or being dissatisfied presented a strong force. Complaining could imply that you were not satisfied with what God had given you or that you were not strong enough to cope with hardships. Another aspect that mitigated complaint was the expectation of a hard life. Hardship itself was no reason for complaint because participants believed that life was hard and that one's ancestors faced more hardship than did current generations (Agee, 2000).

Five think-aloud responses included the idiom of "others are worse off" in order to explain ratings that ranged from fair to excellent. (Elders who rated their health as poor also used this idiom, but not in the think-aloud response. Therefore, this idiom was used in all health states.) In contrast to the better/worse rationale, this "others are worse off" rationale focused on being content and grateful to God for even the most basic things.

Participants—especially elders experiencing much pain or disability—used statements like "others are worse off" as buffers against low self-evaluation. One woman explained why she refused to complain about her pain, saying, "I don't think that I should 'cause life has been good' ... 'cause things could have been much worse." A severely disabled woman said, "At least I have my right mind." Another woman repeatedly countered statements of despair with a phrase such as "then I say to myself, things could be worse." She explained her struggle against depression:

Well I pray. A lot. I always talk to the Lord, and I ask him to help me through this, you know. And I think I know he's looking down, you know, and it could be worse. Then I look at it like that. It could be worse. You know? And I look at so many other people, at least I can walk to the door sometime, you know.

Although this grateful outlook was protective, it was also a source of shame when elders felt their health assessments reflected complaint. One deeply religious woman who changed her self-rated health from poor to fair during the study explained:

Sometime I get tired of myself. You know, I'm always complainin' and you know ... once you keep complainin' so much, you think. I said, "Now why am I complainin' so much?" So many, it's people that I hear worse off than I am, you know.

### **Restricted Possibilities for Self-Evaluation**

Health appraisals that restricted possibilities for self-evaluation included disavowal of the excellent or "perfect health" category and a feeling of being trapped in a poor health rating.

**Perfection Is Impossible**—Four individuals stated in their think-aloud responses that excellent or perfect health was impossible. One man explained that excellent health was impossible in old age and defined it as "Nothing's wrong and you're bouncing along like you're 19 or something." Another expression was that one or more chronic health problems eliminated the option of excellent health. A few elders denied the possibility of excellent health because they perceived limitations on their knowledge about their health.

Other participants explained that perfection was generally impossible (not only with respect to one's health). This notion was highly elaborated and culturally salient. Our data suggest that the impossibility of perfection can pertain to the physical body, one's life overall, or to the world as a whole. One woman who rated her health as very good claimed in response to the think-aloud question that "Nobody can be actually excellent because nobody's perfect, the body's not perfect." Later, she extended this reasoning in the evaluation of her life overall:

There's always room for improvement. I'm not perfect. I make mistakes. I try to do the right thing. I believe in doing the right thing. But basically if I was perfect, I, I would be Jesus, and I'm not Jesus ... [Excellent is] something you're striving ... I don't think anyone can actually be the perfect whatever...

For this woman, claiming perfection would show a lack of humility before God. Similar statements about the impossibility of perfection appeared in other interviews, yet not all elders adhered to the notion that perfection was unattainable because it was divine. Some shied away from the absolute standard of perfection because they saw reality as imperfect and health as relative, not absolute. Another secular explanation was that excellence could not be sustained over any period of time: "I think for the human being there's no such thing as excellent. Certain periods of your life, excellent. But when you take the overall scope, no."

An important counterpoint was the claim that perfection, and any other possibility, must remain open because God's power was unlimited. In this counterpoint, denying any possible future was interpreted as a lack of faith in God's power. These radically different conceptions of perfection may reflect theological differences between congregations or contradictory elements within the African American Christian tradition.

**Feeling Trapped in Poor Health**—At the opposite end of the health-appraisal spectrum, another evaluative logic restricted possibilities for self-appraisal. Two elders in poor health said they had "no choice" but to rate their health as poor. One woman, whose knee had been fused surgically, explained her rating of poor health: "Cause I know it, you know. You know it when you can't walk, you can't get up or whatever. You know, you can't say, well, it's fair. No, it's not. It's poor." A man with multiple health problems said his health was poor because "... there's too many things wrong with me at one time for me not to consider it anything but poor. I got ... bad heart, I got Parkinson's, I got a swollen prostate, I got cataracts in my eyes. And so roll them all together and I'm a mess." Soon afterwards, he explained that he saw no potential for any better health appraisal in the future. Although not in the think-aloud response, one other woman rated her health as poor and used this rationale in order to explain her health appraisal. She reflected upon the futility of trying to maintain hope for improvement with the prognosis of end-stage emphysema. For these reasons, she called her health very poor and even bad at times.

Given the generalized definition of poor health as a hopeless, helpless state of suffering, elders felt trapped in the rating of poor health. Indeed, several elders who rated their health as good or fair constructed personal meanings that kept the trap of poor health at bay. Despite significant, chronic health problems and disabilities, as well as the likelihood of rapid health decline in the near future, these elders refused to even discuss poor health. Their statements suggest direct avoidance of self-attributions of health that carry negative connotations of laziness, failure, or resignation. One elder defined poor health simply as "undesirable."

### **Rationales of Resilience and Vulnerability to Adversity**

A third evaluative rationale, related to resilience and vulnerability to adversity, provided strategies for upholding the dignity of the self in the face of hardship. It also related to lack of complaints and bearing one's burdens gracefully.

**I Have No Complaints, Nothing's Unbearable**—Four elders, all of whom rated their health as good, stated in their think-aloud explanations that they had no complaints or that their existing health problems were not "unbearable." Their statements were relatively unelaborated, perhaps because making such statements posed no difficulty. However, other



interview data showed that this rationale reflects a general stance toward coping with hardships. Its apparent simplicity is deceiving because it taps into sanctions against complaint and the desire to demonstrate resilience, thankfulness, and faith.

**I Don't Let Things Get to Me**—Another cluster of rationales widely used to evaluate the experience of health problems in terms of resilience or vulnerability to adversity was identified in interviews and field notes (though not in the think-aloud responses). Elders claimed that the effect of potential stressors was related to one's ability to manage their proximity or impact to the self. Such sentiments were expressed as: "not letting things get to me," "not dwelling on things," or "I keep hope behind me." Elders directly stated that their ability or failure to uphold these strategies was a major part of health evaluation. Respondents widely conceived of worrying as a source of ill health. Being "worn down by worries" was part of several definitions of poor and bad health, and many elders said they tried "not to dwell on" their problems. A few said they "handed over" their problems to the Lord or to Jesus, and others expressed more secular notions of deflecting stress away from one's self. Protecting oneself from the harsh realities of everyday life, the internalization of pain, and depression were all components of positive self-evaluations that demonstrated resilience in the face of adversity.

## Discussion

This theoretical grounding and rich qualitative data contributes a new perspective on the dynamics of health assessment. Our findings support prior studies on elders' criteria for healthy aging, such as the ability to perform daily activities without pain or assistance, the body's physical condition, control over health, and embodied experience as features determining health rating. However, such criteria are not the sole determinants of subjective health appraisals.

Beyond a checklist of criteria, complex culturally derived tools for self-evaluation, which we call *evaluative rationales*, emerged as important forces underlying health assessments. Notably, evaluative rationales do not refer to the features of health per se, but to the cultural logic or idioms employed to rate one's health according to a set of criteria. Comparisons, restrictions of possibilities for self-evaluation, and rationales of resilience and adversity were cultural tools for fashioning self-appraisals, which are inherently statements of identity. Overarching themes included the elaborate cultural discourse on the possibility of perfection and the perceived consequences of claiming perfection. Similarly, sanctions against complaint emerged as a significant theme that cut across both criteria and evaluative rationales. Together, the criteria and rationales underlying self-appraisals of health illustrate the sociohistorical context of individual standards for assessing well-being.

Elders generally engaged a discourse on faith, acceptance, and lack of complaint at the point where they felt they could do little to improve their health. An important counterpoint to this discourse on acceptance was the notion that one should strive for self-improvement and control over one's destiny by taking responsibility for health, exercising, eating right, and not relying on others for help. Tensions between these discourses on control and acceptance formed a cultural dilemma. Some elders enhanced their self-evaluations by claiming that they controlled or improved their health. For others who felt little control over health, this discourse on control denoted a personal failure and the discourse on acceptance provided a more positive health identity.

To summarize, aging and concomitant physical decline provide ample opportunities for disruption, yet individuals' experiences of aging are not necessarily disruptive. An important element of this process is the narrative and autobiographical project of identity management

in old age. Identity management in old age involves reconciling cultural discourses and personal meanings with embodied experience. Physical and emotional health certainly play a part in the health identities that individuals create (or are allowed to claim) for themselves. However, we have shown how one group of African American elders creatively used evaluative rationales—cultural tools produced in specific social and historical contexts—in order to transcend the specifics of health or disease. Their resulting health appraisals were generally powered by the motivation to uphold desired identities, a phenomenon that likely transcends this group. Previous studies (Borawski et al., 1996; Idler, 1994; Jylha, 1994; Krause & Jay, 1994; Silverman et al., 2000) suggest that transcending biomedical criteria for health may be a strategy for maintaining a desired self-rated health or health identity, even in the face of physical problems. Our data further support this argument.

This neighborhood ethnography enabled us to understand African Americans' health appraisals within a particular, shared social and historical situation. Due to the sample size and focus, these findings have limited generalizability. However, we describe analytic factors that future studies could evaluate in different African American communities that vary by region or in other communities that share social and historical situations.

Future research could address evaluative rationales and transcending biomedical health criteria in light of the epidemiological notion of health pessimism among African Americans, especially in light of its relationship to experiences of inequality (Boardman, 2004). Our qualitative findings cannot directly address these epidemiological constructs, but they suggest a complexity in the relationship between health appraisal and personal and collective experiences of hardship that probably defies simplistic labels such as “optimism” or “pessimism.” By presenting self-rated health in a theoretical framework of identity, we hope to stimulate new avenues for investigating health assessment and self-appraisal.

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**Table 1**  
 Think-Aloud Self-Reported Health Responses: Respondents Mentioning Each Category of Personal Health Meanings (N= 34)

Personal Meaning of Health	n	%	Excellent (n = 2)	Good (n = 20)	Fair (n = 9)	Poor (n = 4)
Criterion for health (N)	(29)	(85)				
Independent functioning	7	21	—	4	2	1
Physical condition	9	26	—	5	1	3
Personal responsibility and control	6	18	1	5	—	—
Embodied experience (how I feel; pain)	14	41	—	10	3	1
Evaluative rationale (N)	(23)	(68)				
Comparison	16	47				
Could be better, could be worse	4		—	2	2	—
Doing well, considering	10		—	7	3	—
Others worse off	3		1	1	1	—
Range of possibilities	6	18				
Can't say anything but bottom	2		—	—	—	2
Not perfect/can't say top	4		—	4	—	—
Resilience and vulnerability to adversity	4	12				
Nothing bothering me	4		—	4	—	—

*Notes:* One respondent did not provide a think-aloud response. Respondents often mentioned more than one personal meaning. Finally, the frequency for a given personal meaning does not necessarily indicate its importance or cultural salience.