Journal of Ethnic And Cultural Diversity in Social Work
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wecd20

Everyday Conflict and Stress Among Older African American Women

Patricia Flynn Weitzman PhD [a b], Robert Dunigan PhD [c d], Robert L. Hawkins PhD [e d], Eben A. Weitzman PhD [f] & Sue E. Levkoff ScD [g h]

[a] Social Medicine at Harvard Medical School, Boston, MA, USA

[b] Environment and Health Group, Inc., Watertown, MA, USA

[c] Graduate School of Social Work, Boston College School of Social Work, Chestnut Hill, MA, USA

[d] Division on Aging, Harvard Medical School

[e] Department of Urban and Environmental Policy and Planning, Tufts University, Medford, MA, USA

[f] Graduate Programs in Dispute Resolution, Boston, MA, USA

[g] Psychiatry at Brigham & Women's Hospital/Harvard Medical School

[h] Harvard Upper New England Geriatric Education Center, Boston, MA, USA

Published online: 11 Oct 2008.

Everyday Conflict and Stress Among Older African American Women: Findings from a Focus Group Study and Pilot Training Program

Patricia Flynn Weitzman
Robert Dunigan
Robert L. Hawkins
Eben A. Weitzman
Sue E. Levkoff

ABSTRACT. Older African American women are at high risk for morbidity due to anger suppression and stress. Yet sources of everyday stress and conflict in the lives of older African American women have not been documented. Such information is essential for developing health promotion programs. A focus group study was conducted with older African American women on everyday stress and conflict. Everyday stress

Patricia Flynn Weitzman, PhD, is Instructor in Social Medicine at Harvard Medical School, Boston, MA, and Research Scientist with Environment and Health Group, Inc., Watertown, MA. Robert Dunigan, PhD, is Assistant Professor in the Graduate School of Social Work, Boston College School of Social Work, Chestnut Hill, MA. Robert Dunigan participated in this project when he was a research assistant at the Division on Aging, Harvard Medical School. Robert L. Hawkins, PhD, is Assistant Professor in the Department of Urban and Environmental Policy and Planning, Tufts University, Medford, MA. He participated in this project when he was a research assistant at the Division on Aging, Harvard Medical School. Eben A. Weitzman, PhD, is Associate Professor in the Graduate Programs in Dispute Resolution, Boston, MA. Sue E. Levkoff, ScD, is Associate Professor in Psychiatry at Brigham & Women's Hospital/Harvard Medical School, and the Director of the Harvard Upper New England Geriatric Education Center, Boston, MA.

The authors would like to thank the participants for their generous help with this project.

Support for this work was provided by the National Institutes on Aging (#1R43AG15714), and the Human Resources Services Administration (#2AH70022-06).

Journal of Ethnic & Cultural Diversity in Social Work, Vol. 10(2) 2001
http://www.haworthpressinc.com/store/product.asp?sku=J051

stemmed from worries about functional disability and about accessing transportation. Everyday conflicts occurred with adult children, teenaged grandchildren, and older neighbors or peers. Conflicts with adult children centered on how the adult child was raising his/her children. Conflicts with grandchildren centered on social respect. Conflicts with neighbors/peers centered on perceived rudeness or past transgressions. Participant strategies for dealing with stress and conflict tended to be avoidant. A training program in constructive conflict strategies for older African American women is presented that draws on information gained in the focus groups.

KEYWORDS. Minority women, interpersonal conflict, stress

INTRODUCTION

It is well established that African American elders suffer from greater morbidity and mortality than European American elders. For example, African American elders have higher rates of cancer, hypertension, and diabetes (Smith & Kingston, 1997). They are also more likely to be functionally disabled and to rate their health as poor compared to European American elders (Gibson, 1991; Mendes de Leon et al, 1995; Smith & Kington, 1997). Some of the illnesses that are more prevalent among African American elderly, particularly hypertension, have been linked to anger inhibition (Kopper & Epperson, 1996; Steptoe, Fieldman, Evans, & Perry, 1996; Vogele & Steptoe, 1992; 1993). Yet few studies have focused on the everyday situations in the lives of older African American women that give rise to anger and stress. Such information is essential to developing targeted health promotion interventions for this group.

In this paper, the authors describe a collaborative project between researchers from a geriatric education center, a university-based graduate program in dispute resolution, and a private health research organization. The project involved running focus groups to identify sources of everyday stress and conflict among older African American women. Information is also presented on a pilot training intervention that was developed based on focus group information and was conducted at the end of the third focus group. The purpose in reporting this information is two-fold: (1) to fill gaps in the literature on sources of ev-

eryday conflict and stress for older African American women, and (2) to present a constructive conflict resolution training format that can be used with African American elderly women and adapted for other groups of older adults.

A focus group was used for gathering information on this project for several reasons. First, focus groups can provide direct access to the language and concepts that participants use to structure their experiences, as well as allow for the identification of shared cultural knowledge (Hughes & Dumont, 1993). Furthermore, African American elderly populations often distrust health researchers, due to the legacy of the Tuskegee experiments and the widespread concern that minority individuals receive lower quality medical care than White individuals (McNeilly et al., in press). The more normal, relaxed social contact that focus groups provide can help overcome feelings of distrust in the target group, leading to fuller disclosure from group members (Morgan, 1993), as well as become an educative, empowering experience for participants (Hurworth, 1999).

REVIEW OF THE LITERATURE

Hypertension is highly prevalent among African American women, affecting about 33% of younger and middle-aged women, and over 75% of older women (National Center for Health Statistics, 2001; U.S. Department of Health & Human Services, 1998). Hypertension is a primary risk factor for cardiovascular disease, which is the leading cause of death and disability among women in the United States (U.S. Dept. of Health & Human Services, 1998). Among African American elderly women, the death rate for cardiovascular disease is 14% higher and the death rate from stroke is approximately 31% higher than it is for older European American women (Centers for Disease Control, 1999).

A variety of factors are linked to hypertension, including poor diet, lack of exercise, obesity, and stress (Steptoe, Moses, & Edwards, 1990; U.S. Department of Health and Human Services, 1998). For many African American elders, an additional factor is lack of access to medical care (Stoy, 1994). Targeted exercise and weight loss programs are becoming more available for older African Americans (Kumanyika & Charleston, 1992; Lewis, Raczynski, Heath, Levenson, Hilyer, & Cutter, 1993; Prohaska, Walcott-McQuigg, Peters, & Li, 2000), and health care policy is beginning to address access barriers for minority elders (White-Means, 2000). However, there are few programs for elderly African Americans that address stress reduction. Yet, Steptoe and colleagues have noted that blood pressure can be significantly elevated in response to social stress, particularly when individuals respond to a stressful so-

cial situations by inhibiting angry feelings (Steptoe et al., 1996). Furthermore, these researchers note that blood pressure responsivity to anger-inhibiting behaviors appears to increase with age in women, with older women at the greatest risk for their negative effects (Steptoe et al., 1996; Steptoe et al., 1990). This link between anger inhibition and hypertension appears strongest for older African American women, surpassing that of African American elderly men and younger African American populations (who also have comparatively high rates of anger-related morbidity) (Johnson & Gant, 1996).

Research indicates that anger inhibition and avoidant responses in relation to everyday interpersonal conflict and stress may be fairly common among the current generation of older European American women (Weitzman & Weitzman, 2000), suggesting that pre-existing conditions such as hypertension may be exacerbated in this group. African American women of the same cohort are also likely to inhibit anger in interpersonal conflicts, but little research has been done on the types of everyday interpersonal stressors they face, and how they respond to them. Research does tell us, however, that older African American women are more likely to be the head of a multi-generational household than older European American women or men (Miller et al., 1996). As such they may be subject to more daily interpersonal challenges and stressors than other groups of elderly (Miller et al., 1996). More frequent daily stressors may also stem from the greater number of days of functional disability (i.e. substantially reduced daily activity) experienced by older African American women per year compared to older European American women (Belgrave, Wykle, & Choi, 1993). Furthermore, middle-aged and older African American women are more likely to provide caregiving for a family member with dementia in their home than are their European American counterparts (Liu, McBride, & Couglin, 1994; Oxendine, 2000). And while African American caregivers' overall appraisals of burden seem lower than that of European American caregivers, they may tend to use avoidant coping strategies that lead to higher levels of emotional distress (Knight, Silverstein, McCallum, & Fox, 2000).

Since older African American women are at the highest risk for hypertension and few programs have been developed for them in the constructive management of stressful interpersonal conflicts, the following study was conducted to determine the typical responses of a group of older African American women to everyday conflict and stress and to explore the necessity and usefulness of a training intervention in constructive conflict resolution.

METHOD

Sample

Three groups of African American women, aged 60 years and older, were recruited from a senior center and community service organization located in inner-city Boston. Participants were recruited through signs and face-to-face contact inviting older African American women to participate in a discussion group on everyday stress and conflict. Women who were recruited for the third focus group were also informed that they would have the opportunity to learn skills for handling interpersonal conflict in healthy ways and would be paid for their participation. The resulting focus groups consisted of 8, 16, and 6 women (total n = 30). The authors did not have complete age data for all groups because some women refused to reveal their ages. Based on available age data, the range was 60-80 years, with a mean age of 74 years. All participants lived independently in the community. Most had grown children and grandchildren, were widowed or never married, and had extended family who lived with them or nearby. Most of the women did not feel comfortable revealing income information. We can report that all the participants resided in an economically depressed, inner-city neighborhoods, thus were likely to come from low-income households.

Procedure for the Focus Groups

After the purpose of the group was reviewed and informed consent obtained, the leaders of the groups (1st author for groups 2 and 3; 2nd author for group 1) explained that they were interested in understanding older women's thoughts about everyday stress and conflict, including their thoughts about situations with other people that "got on their nerves."[1] The leaders emphasized that it was very important to get a full range of different experiences and feelings and encouraged each participant to share her unique point of view. Also mentioned was the interest of physicians, researchers and service providers in understanding about everyday stress in the lives of older women in order to improve the care and services they receive. Specific questions followed the introduction: (1) what everyday situations caused them stress; (2) what situations with other people got on participants' nerves (descriptions of specific incidents and how the participant responded to the incident); and (3) what participants did to manage their stress. For the third focus group, the leaders also explained that they would receive instruction in healthy ways of handling stressful situations with other people. Each group was tape recorded and lasted approxi-

mately 1.5 hours. The training that followed the third group lasted about 1 hour.

Data Coding and Analysis

Focus group data were analyzed for emergent content areas and themes. First, transcripts were analyzed for manifest content generated in response to each of the focus group questions (see Grinnell, 1994). Transcripts were then analyzed for key themes that spontaneously emerged in relation to content areas. A theme was defined as a set of manifest generalized statements by participants about their beliefs, attitudes, values or sentiments about an issue or event (Luborsky, 1994). Themes having to do with the experiences of stress and conflict were explored, i.e., how the participant felt about the issue, attributions about the self and the other person(s), and how those attributions seemed to bear on their perceptions of stress and conflict, and on participant responses to stress and conflict. Because themes which appear frequently in a group transcript usually reflect cultural (as opposed to personal) attitudes (Luborsky, 1994), thematic analyses were chosen as appropriate for evaluating the degree to which cultural factors related to conflict and stress experiences. We also examined evaluative clauses, i.e., clauses in which the participants evaluate the topic or event, thus expressing their perceptions and personal beliefs about it (Luborsky, 1994).

Reliability

At the conclusion of the data analysis, researchers made a final check on the appropriateness and accuracy of coding categories and themes, and the appropriateness of text assignments into categories. Reliability of the research was also checked in other ways. For example, the authors carefully avoided leading questions during the focus groups. Another check on researcher effects occurred during the analysis of focus group transcripts. Discussion leaders comments and questions should be relatively short compared to the comments of the group participants (Seidman, 1991). If, when analyzing transcripts, the authors had found that discussion leader comments were equal to or longer than those of the participants, the transcript would not have been used. This did not occur.

A final issue related to reliability is social desirability. Bradburn (1983) points out that the empirical data on researcher effects show that they are small or non-existent, despite a pervasive belief to the contrary. Within a focus group, there is also the possibility that participants may influence each other by responding to ideas or comments that arise during the discussion (Morgan,

1993). The topics of concern that are raised by a group may not be subject to a group influence effect, but the individual examples provided and descriptions of individual actions may. The authors attempted to minimize group influence by emphasizing at the outset that they wanted to hear each participants' unique point of view. Weiss (1994) points out that social desirability is most likely to come into play when participants are asked explicitly about opinions, values, or beliefs, and less likely to affect responses to questions about concrete incidents. The authors attempted to minimize social desirability in a given participant's responses by focusing questions on concrete incidents and examples. Opinions, values, or beliefs were not directly assessed; rather, they were coded based on evaluative clauses.

FINDINGS

Sources of Everyday Stress and Conflict

Everyday stress: Functional disability and transportation. Participants could readily identify sources of everyday stress. Each provided multiple examples from her own life. Two primary categories of everyday stress emerged, worries about (1) current or future functional disability (n = 23; 77%), and (2) transportation to get to medical appointments, do grocery shopping, and to take care of other activities of daily living (n = 20; 67%). One woman, who was diabetic and had her leg amputated several years before, stated: "I sit sometimes and think about my leg being amputated, and there's a lot of things that I can't do because I might fall. You know I try to just accept it, but sometimes during the day I have that little flashback and get stressed about it." Another woman stated that she was afraid that she would become less mobile, and frequently worried about a future time when she would not be able to "get up and go to my own stove, reach up to my own shelf and get my coffee." Stress about having transportation to go to doctor's appointments, grocery shopping, and to take care of other daily living activities was another theme related to everyday stress. A characteristic comment about transportation was provided by one participant: "I wake up in the morning and I worry about not having enough, you know, transportation, to get where I need to." The stress and discomfort of using public transportation was also discussed. Several (n = 18 out of 20; 90%) expressed dismay over rarely being offered a seat on a crowded bus, even when they are carrying heavy bundles.

Everyday conflict: Family and peers. With regard to everyday conflict, salient conflicts for this group of participants fell primarily into two categories: (1) those occurring with family members (n = 18; 60%), and (2) those occurring

with same-age peers, typically neighbors or other adults who used the senior center (n = 22; 73%). Participants (n = 18) indicated that family conflicts were primarily with a teenaged grandchild being raised by the participant (n = 10) or with an adult child (n = 8). A prominent theme in discussions of grandchildren conflicts had to do with a perceived lack of respect toward the participant or another adult (n = 10). One woman said conflicts with her grandchildren came up because "grandchildren don't respect, I don't like the words they use, I wash their dishes, fold their clothes, I want them to be better." Another participant provided even more detail:

> Children of today are different than my own children. My children, they knew how to act. But with my grandson, I said 'I'm on the phone go into the other room.' He's so loud, and he just gets louder. You know I wanted to take him and shake him, I'm ready to go through the roof. . . It's not just the grandchildren, it's what my son's doing with them.

The connection this participant made between the conflict over respect occurring with her grandson, and more general conflict with her adult child about how he's raising his son was typical. In fact, a theme that emerged in descriptions of conflicts with adult children had to do with how the adult child was raising his/her children. One woman explained that her grandson's "mischievous" behavior made her angry at her daughter: "his mother has to make him stop . . . I call my daughter and tell her she has to come and pick him up, he's making my nerves jump, but she can't come because she's being trained to be a secretary and all this. . ." This woman believed that her daughter was not doing enough to teach her grandson how to behave properly.

Another category of conflict was with older neighbors who lived in the same apartment complex as the participant, or peers at the senior center. Themes in neighbor/peer conflicts had to do with a neighbor's/peer's perceived rude behavior (n = 12 out of 22), or because of a longstanding dislike or grudge between the participant and the neighbor/peer (n = 10 out of 22). One woman explained:

> I just got home from the hospital and I walked by her [the neighbor], and she was talking there to Mr. J., and she says to him 'she ain't shit' when I go by. And I was going to turn around and say something to her but I said no, I ain't ready to go to jail. And when I got in my apartment I was so upset, but then I thought what's the point of going to jail for someone like her.

Another participant described a conflict that touches on issues of perceived rudeness and lingering resentment. The conflict occurred with an older neigh-

bor who had taken the participant's laundry out of the dryer (in their building's laundry room) before it was dry. The participant described herself as "really losing it" when she saw her clothes had been taken out of the dryer. In response, she took her neighbor's wet clothes out of the dryer, and threw them on the floor. When her neighbor came down and found the clothes on the floor, the participant said to the neighbor:

> Oh I shouldn't have done that, so I put them on top of the machine and offered to give her the money [to re-wash] them, but I was still mad. Now in the meantime, she took out her portable phone and calls the police, and says hurry up, quick, there's a lady here choking me. So the police come in five minutes, and I said the only thing I touched was her clothes, and I said I'll never do it again. I apologized to her, but I feel bad about it. I've been living here 16 years and I never lost it before. I just lost it I think. And you know I'm still angry at her. . . I still have that bottled up feeling toward her, when I see her in the hallway, I won't say hello to her.

Another participant described a similar amount of lingering resentment toward a neighbor because of the past actions of a neighbor. The participant felt that the neighbor was now seeking out the participant's friendship. The participant described herself as resisting her neighbor's attempt at friendliness, because she said the neighbor "carried on so ugly in the past." The participant described herself as someone "who lets the past go until she [the neighbor] says something to me, and then the past comes up." The participant continued that when the neighbor talks to her, it reminds her of the past, and "irritates the matter in my brain, but I don't say nothing to her; she irritates me. . . I let it go."

Responses to Conflict and Stress

Avoidance. Each of the neighbor conflicts above exemplifies a theme that was common in conflict situations of all types. The theme had to do with letting the issue of conflict go, i.e., not confronting the other person, thus leaving the matter (and the concomitant anger) unresolved. Even in the example of the participant who had a conflict over laundry, although she reacted by taking an action against the neighbor, when the neighbor came down to the laundry room, the participant became submissive, apologizing for her actions rather than trying to discuss the matter with the neighbor. The participant seemed to be left with unresolved anger toward her neighbor as a result. Similarly, responses to family conflicts had a submissive theme. Although most participants expressed clear feelings of anger when describing their conflicts (n = 24; 80%), using emphatic language such as "I was very upset" or "I wanted to go

through the roof," they, nonetheless, tended not to confront their family members about their anger, indicating that they usually 'let it go.'

Self-distraction. In terms of coping strategies for everyday stress, a theme emerged having to do with avoiding thinking about the source of stress by using self-distraction (n = 20; 67%). Many self-distracting coping activities were mentioned, such as doing housework, watching soap operas, knitting or sewing, talking to friends, or coming to the senior center. All of these activities were identified as helping the participant not to think about the stressful event. One participant, who talked about coming to the senior center to deal with stress, explained "you know, coming here you forget what you're going through back at the house."

These self-distracting coping strategies seemed aimed at avoidance, similar to the strategies many participants used for dealing with conflict. Reasons for using conflict and coping strategies that involved self-distraction or letting the issue go seemed to be seen by participants as minimizing the effects of the stress/conflict on the self. In other words, these strategies were seen as a kind of damage control, designed to protect the participant from further stress. In describing their conflicts or stressors, most participants tended to view the conflict or stress as potentially getting worse or more damaging to themselves if they were to try to address it directly (n = 15; 50%). Comments such as "it's not worth it" and "I have to take care of myself" were used to justify avoidant responses.

PILOTING THE TRAINING PROGRAM

After all the data collection was finished in the third focus group, we piloted a training session on skills for constructive conflict resolution. The training was designed and led by the fourth author, and focused on helping trainees develop three basic skills: active listening, reframing, and brainstorming. These skills have been identified as central to constructive conflict resolution (Deutsch, 1994). The format of the training was for the trainer to introduce each of the skills listed above, demonstrate for the participants how to enact that particular skill, and then allow the participants to practice that skill, using their own conflict examples. This approach was repeated for each of the three skill areas. Each of the three skills were defined for the group as follows:

> *Active listening* is listening carefully to what the other person is saying, and making sure that the other person knows you are listening. One of

the best ways to do this is by repeating back what the other person said to make sure you understand what the other person is upset about, and to make sure they know that you know. It is important not to interrupt and not to state what you are upset about. Opportunities for stating your position come later in the process.

Reframing is changing your approach to the conflict from a "me against you" situation to a mutual problem to be solved together. A mutual problem means that you think about the situation as *our* problem, instead of thinking on your own about how I can get what *I* want. You work *together* with the other person on how *we* can get what *we* want. Often all you need to do is to say to the other person "what can we do so that you get what you need and I get what I need."

Brainstorming is simply coming up with as many creative ideas for a solution as possible, without discussing which one is good or bad. It is important not to argue about the ideas or decide right away which ones are preferable. You just come up with them, and then decide together which solution, or group of solutions, meets everyone's needs.

The concepts are drawn from conflict resolution theory and work on interpersonal conflict in old age (Deutsch, 1973; 1994; Weitzman & Weitzman, 2000), and have been adapted by Weitzman (1999) for trainings with different groups of adults, including older adults. The focus group preceded the training because it helped raise participant's consciousness about the issue of conflict in their own lives, and prepared them to practice resolving their own real-life conflicts during the training. In fact, participants became comfortable enough with the skills being taught that at the end of the training, the group spontaneously coached one participant on how to handle a conflict with her neighbor through the use of the skills they had learned. Thus the training not only allowed for skill building, but also became a vehicle of group support for a participant who was struggling with a neighbor conflict.

At the close of the session, the authors asked for comments on how this training approach might be improved for use with other groups of older women. Several participants pointed out that the trainers should emphasize (as they had not) the importance of dealing with a conflict through the use of the three skills at the time that it happens, rather than trying to address it at some later point. They said doing this minimizes stress and makes it more likely that the person will actually address the issue. The longer one waits to address a conflict, they pointed out, the harder it becomes. In future training sessions, this point will be emphasized.

DISCUSSION

Multiple Forms of Everyday Stress and Conflict

Three key findings emerged in the focus group and pilot intervention data. First, stress in the lives of the older African American women in this study took multiple forms. Stressful fears about the loss of functional abilities, such as mobility or the ability to carry out household tasks, were common, as were stressful worries about transportation, particularly to get doctor's appointments and getting a seat when riding on public transportation.

With regard to everyday conflict, the data showed that conflicts with family members, particularly adult children and grandchildren, may be especially troublesome for older African American women, particularly those who are raising grandchildren. Concerns about social respect figured prominently into discussions about grandchildren conflicts. Other research has pointed to the issue of social respect as being very important to older African American populations (Lewis & Ausberry, 1996).

Conflicts with neighbors and peers may also be especially troublesome to older African American women, particularly those who live in densely populated urban areas. The strain of getting around in the neighborhood or the stress involved in accessing services may be compounded by neighbors perceived as unfriendly or even antagonistic. Many of the women in this study had lived in their neighborhoods for long periods of time and reported years of suppressed hostility with certain neighbors. The psychological discomfort caused by not addressing the conflict was mentioned by some women. Conflict resolution training may be particularly helpful to elders in densely populated areas, because of the greater number of interpersonal interactions experienced compared to those living in rural settings.

Avoidant Responses

A second significant finding was that participants tended to rely on avoidant responses to deal with both everyday stress and conflict. Most reported conflict responses of not approaching the other person about the problem and typically reported lingering anger. One explanation for this could be that when prompted about conflict, individuals are likely to report the ones that have not been resolved successfully; these are the conflicts that are more memorable and troubling. However, other research on older women and conflict has revealed similar avoidant responses to everyday problems (Johnson & Gant, 1996; Weitzman & Weitzman, 2000), suggesting that this finding may not be an interview effect. Socialization that encourages women to be submissive in-

terpersonally, combined with racism that historically has brought negative consequences to African American individuals who express their anger, could explain why older African American women might respond to conflict in avoidant ways.

In a study with older European American women, Weitzman and Weitzman (2000) found that women believed avoidant responses protected them against negative health effects that would follow from being more assertive during conflict. Likewise, in a study of older women with breast cancer, Adler found that many women believed that a polite, non-confrontational attitude in interactions with doctors would gain them better care than an assertive attitude (Adler, McGraw, & McKinlay, 1998). The older African American women in this study similarly seemed to believe that avoidant responses to conflict were more self-protective than assertive ones. However, in post-training feedback, participants suggested that avoiding confrontation about a problem increases stress. Future research can explore if the benefits of being assertive are perceived as context specific.

The stress coping strategies reported by these participants tended also to be avoidant, aimed at taking the participant's mind off her problems. Techniques to take one's mind off of a problem may be adaptive for dealing with intractable problems, such as a progressive illness; whereas, more active, problem-focused strategies, such as the ones in the training protocol, may be more functional for problems that are amenable to change (Shaw et al., 1997). The authors did not ask participants if they used coping strategies differentially (certain types of strategies for certain problems) or if they used the strategies they identified more universally. Selman et al., (1980) point out that individuals tend to use the same strategies for dealing with conflicts across situations. In terms of coping strategies, it seems possible that individuals may do the same. For those who tend to use avoidant strategies, it may be that they view most of their problems as intractable.

Helping individuals to understand that many conflict situations can be changed if responded to constructively and actively may be an important component of constructive conflict resolution training, especially for older African American women. It may also be important to emphasize that there can be health costs associated with avoidant responses to conflict, since older African American (and European American) women may believe that avoidant responses are protective of their health.

On a final note with regard to stress coping by participants, it was interesting to find that none reported the use of prayer as a coping strategy. This finding is consistent with other research on older African American caregivers (Fox, Hinton, & Levkoff, 1999), and stands in contrast to research showing older African American women to rely heavily on prayer in times of stress

(May, Caldwell, & Jackson, 1996). Future research to understand the differential use of prayer for stress coping by older African Americans seems warranted.

Conflict Resolution Training and Health

The third issue addressed in this study is that constructive conflict resolution training, via a group format in a familiar setting, may be an effective tool for mental health promotion among older African American women. Research suggests that older African American women are unlikely to seek services for interpersonal problems through private or community mental health services (May et al., 1996), and that the feelings of distrust about the system of mental health care may cause African American women to avoid seeking professional mental health services altogether (Neal & Turner, 1991; Sussman, Robins, & Earls, 1987). May et al. (1996) suggest that successful mental health promotion for older African American women may depend upon the delivery of services in highly-frequented, commonplace settings such as senior centers, assisted living residences, and churches. The apparent comfort of our participants with discussing everyday problems with a group of their senior center peers suggests that a peer group format in a familiar setting may, indeed, be an appropriate vehicle for mental health promotion with older African American women.

Deutsch (1994) points out that in order for training in constructive conflict resolution to be effective for a given group, the training must reflect real-life situations familiar to that group. Preceding the training with a focus group allowed both the leaders and the participants to identify real-life conflict situations which were then integrated into the training session to make it more accessible, relevant, and useful. The focus group also allowed the leaders to identify and incorporate the language of the participants for describing their stress and conflict experiences into the training which helped make the training more culturally appropriate. The real-life examples gathered through this study might be incorporated into future interventions, particularly to encourage participants who seem reluctant to talk about their own lives. Pointing out at the opening of the training, for example, that some older African American women have said that they have conflicts with their neighbors or conflicts with grandchildren who are disrespectful, can help other older African American women participants identify and talk about similar situations from their own lives. It is also very useful for further cultural adaptation to elicit feedback from trainees at the end of the session on how to improve the training.

The need for culturally-appropriate interventions for constructive, active management of interpersonal challenges by older African American women

may not only be relevant to their interpersonal relationships and levels of stress, but also to their ability to access optimal medical care. In an experimental study, Krupat et al. (1999) showed that the effect of patient assertiveness on doctor behavior varied by patient characteristics. Doctors were more likely to order a thorough round of tests when the assertiveness came from an older African American woman, than when it came from patients who were younger, or male, or of another race. Krupat speculates that doctors in the study may have anticipated assertive behavior less from an older African American woman, and as a result responded in a more vigorous fashion when they encountered such behavior. Training in active, assertive strategies for dealing with stressful interpersonal situations, then, may not only improve the stress experienced by older African American women, but also for the quality of medical care they receive. It also challenges the perception, held by women in the Adler study and here, that being non-confrontational is always self-protective, and underscores the possibility that the benefits of a given stress coping or conflict strategy may be context specific.

CONCLUSION AND LIMITATIONS

It is important to remember that this was an exploratory study with very small groups of participants. As such it raises questions and points to certain avenues for future research with representative samples that might prove fruitful. It does not, however, provide information that is generalizable. Rather, these data identify some of the issues that may cause urban, community-dwelling older African American women worry and stress. They also identify with whom troublesome everyday conflicts may occur, and the issues over which they may occur. This information can help in the development of new hypotheses for later testing. Some questions raised by this study that might be investigated in future research include: (i) under what stress conditions might older African American women use more approach-oriented strategies? (ii) what are their beliefs about the appropriateness/effectiveness of different types of coping and conflict strategies? (iii) how does worry about functional disability and transportation affect the self-care and help-seeking behaviors of older African American women?

Another piece of information gained in this study relevant to program development for older African American women is that group training in a commonplace setting may be an effective means of helping members of this group acquire constructive strategies for dealing with interpersonal challenges, which several bodies of research point to as important. The spontaneous coaching in constructive conflict resolution that participants offered to a fellow participant

at the end of our training session indicates that the concepts were well integrated by the group in the short term. Research suggests that cognitive training interventions to build social skills can reduce stress in older adults and lead to lasting behavior change (Chesney, 1996). Future evaluation research can determine if this approach contributes to lasting behavior change as well.

NOTE

1. In piloting the focus group questions, interpersonal conflicts were described by group members as situations with other people that "get on your nerves."

REFERENCES

Adler, S., McGraw, S., & McKinlay, J. (1998). Patient assertiveness in ethnically diverse older women with breast cancer: Challenging stereotypes of the elderly. *Journal of Aging Studies*, *12*, 331-350.

Belgrave, L., Wykle, M., & Choi, J. (1993). Health, double jeopardy, and culture: The use of institutionalization by African-Americans. *The Gerontologist*, *33*, 379-385.

Bradburn, N.M. (1983) Response effects. In P. Rossi, J. Wright, & A. Anderson (Eds.), *Handbook of survey research*. New York: Academic.

Centers for Disease Control (1999). *Chronic Disease Prevention: Minority and Ethnic Groups*. Washington, DC: Author.

Chesney, M.A. (1996). New behavioral risk factors for coronary heart disease: Implications for interventions. In K. Orth-Gomer & N. Schneiderman (Eds.), *Behavioral medicine approaches to cardiovascular disease prevention* (pp. 169-182). Hillsdale: Erlbaum.

Deutsch, M. (1973). *The resolution of conflict*. New Haven, CT: Yale.

Deutsch, M. (1994). Constructive conflict resolution: Principles, training, and research. *Journal of Social Issues*, *50* (1), 13-32.

Fox, K., Hinton, W., & Levkoff, S. (1999). Take up the caregiver's burden: Stories of care for urban African American elders with dementia. *Culture, Medicine, & Psychiatry*, *23*, 501-529.

Gibson, R.C. (1991). Age-by-race differences in the health and functioning of elderly persons. *Journal of Aging & Health*, 3, 335-351.

Gillium, K. (1996). Epidemiology of hypertension in African American women. *American Heart Journal*, *131* (2), 385-395.

Grinnell, R. M. (1994). *Social work research and evaluation*. Itasca, IL: Peacock.

Hughes, D., & Dumont, K. Using focus groups to facility culturally anchored research. *Australian Journal of Community Psychology*, *31*, 775-806.

Hurworth, R. (1999, July). *Can focus groups be rigorous?* Paper presented at the annual meeting of the Association for Qualitative Research Conference, Melbourne, Australia.

Johnson & Gant (1996). Coping with stress. In Neighbors &Jackson (Eds.), *Mental health in black America*. Newbury Park, CA: Sage.

Knight, B., Silverstein, M., McCallum, T., & Fox, L. (2000). A sociocultural stress and coping model for mental health coutomces among African American caregivers in Southern California. *Journal of Gerontology: Psychological Sciences*, *55B*, P142-150.

Kopper, B. A., & Epperson, D. L. (1996). The experience and expression of anger: Relationships with gender role socialization, depression, and mental health functioning. *Journal of Counseling Psychology*, *43* (2), 158-167.

Krupat, E., Irish, J., Kasten, L., Freund, K., Burns, R., Moskowitz, M., & McKinlay, J. (1999). Patient assertiveness and physician decision-making among older breast cancer patients. *Social Science and Medicine*, *49*, 449-457.

Kumanyika, S., & Charleston, J. (1992). Lose weight and win: A church based weight loss program for blood pressure control among Black women. *Patient Education and Counseling*, *19*, 19-32.

Lewis, C., Raczynski, J., Heath, G., Levenson, R., Hilyer, J., & Cutter, G. (1993). Promoting physical activity in low-income African-American communities: The PARR project. *Ethnicity and Disease*, *3*, 106-118.

Lewis, I. D., & Ausberry, M. S. C. (1996). African American families: Management of demented elders. In G. Yeo and D. Gallagher-Thompson (Eds.) *Ethnicity and the Dementias*, pp. 167-174. Washington, DC: Taylor & Francis.

Liu, K. McBride, T., & Coughlin, T. (1994). Risk of entering nursing homes for long versus short stays. *Medical Care*, *32*, 315-327.

Luborsky, M. R. (1994). The identification of themes and patterns. In J. Gubrium & A. Sankar (Eds.), *Qualitative methods in aging research* (pp. 189-210). Thousand Oaks, CA: Sage.

May, V. M., Caldwell, C. H., Jackson, J. S. (1996). Mental health symptoms and service utilization patterns of help-seeking among African American women. In Neighbors & Jackson (Eds.), *Mental health in black America*. Newbury Park, CA: Sage

Mendes de Leon, C.F., Fillenbaum, G.G., Williams, C.S., Brock, D.B., Beckett, L.A., Berkman, L.F. (1995). Functional disability among elderly blacks and whites in two diverse areas: The New Haven and North Carolina EPESE. *American Journal of Public Health*, *85*, 994-998.

McNeilly, M., Musick, M., Elfand, J. Baughman, J., Toth, P., Saulter, T., Sumner, L., Sherwood, A., Weitzman, P.F., Levkoff, S., Williams, R., & Anderson, N. (in press) Engaging minority populations for psychophysiologic research: Challenges in trust-building and recruitment. *Journal of Mental Health and Aging*.

Miller, B., Campbell, R., Davis, L., Turner, S., Giachello, A., Prohaska, T., Kaufman, J., Li, M., & Perez, C. Minority use of community long-term care: A comparative analysis. *Journals of Gerontology*, *51B*, S70-S81.

Morgan, D. (1993). *Successful focus groups*. Newbury Park, CA: Sage.

National Center for Health Statistics (2001). *Hypertension*. Washington, DC: Centers for Disease Control.

Neal, A. N., & Turner, S. M. (1991). Anxiety disorders research with African Americans *Psychology Bulletin*, *109* (3), 400-410.

Oxendine, J. (May 2000). Who is helping the caregivers? *Closing the Gap: A Newsletter of the Office of Minority Health*.

Prohaska, T.R., Walcott-McQuigg, J., Peters, K.E., & Li, M. (2000). Recruitment of older African Americans into church-based exercise programs. *Journal of Mental Health and Aging*, *6*, 53-66.

Seidman, J.E. (1991) *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. New York: Teachers College.

Selman, R. L., Beardslee, W. Schultz, L. H., Krupa, M., & Podorefsky, D. (1986). Assessing adolescent interpersonal negotiation strategies: Toward the integration of structural and functional models. *Developmental Psychology*, *22*, 450-459.

Shaw, W. S., Patterson, T. L., Semple, S. J., Grant, I., Yu, E. S., Zhang, M. Y., He, Y. L., & Wu, W. Y. (1997). A cross-cultural validation of coping strategies and their association with caregiving distress. *The Gerontologist*, *37* (4), 490-504.

Smith, J.P., Kington, R.S. (1997). Race, socioeconomic status and health in late life. In L.G. Martin & B.J. Soldo (Eds.). *Racial and Ethnic Differences in the Health of Older Americans*. (pp. 106-162). Wash., D.C.: National Academy Press.

Steptoe, A. Fieldman, G. Evans, O. & Perry. (1996). Cardiovascular risk and responsivity to mental stress *Journal of Cardiovascular Risk*, *3*, 83-93.

Stoy, D.B. (1994). Recruitment and retention of women in clinical studies. In *Institute of Medicine, Women and Health Research: Ethical and legal issues of including women in clinical studies* (2 vols.). Washington, DC: National Academy Press.

Sussman, Robins, & Earls (1987) Treatment-seeking for depression by black & white Americans. *Social Science & Medicine*, *24* 187-196.

U.S. Department of Health and Human Services (1998). *National Women's Health Information*. Washington, DC: Author.

US Department of Health and Human Services (1997). *Women's health in the medical school curriculum*. DC: Author.

Vogele, C., & Steptoe, A. (1993). Anger inhibition and family history as modulators of cardiovascular responsivity to mental stress in adolescent boys. *Journal of Psychosomatic Response*, *37* (5), 503-514.

Vogele, C. & Steptoe, A. (1992). Emotional coping and tonic blood pressure as determinants of cardiovascular response to mental stress. *Journal of Hypertension*, *10*, 1079-1087.

Weiss, R. S. (1994). *Learning from strangers*. New York: Free Press.

Weitzman, E.A. (February, 1999). *UMass Elder Leaders: Constructive Conflict Resolution*. Training presented at the University of Massachusetts Gerontology Department Annual Conference.

Weitzman, P.F. & Weitzman, E.A. (2000) Interpersonal negotiation strategies in a sample of older women. *Journal of Clinical Geropsychology*, *6*, 41-51.

White-Means, S. (2000). Racial patterns in disabled elderly persons' use of medical services. *Journal of Gerontology: Social Sciences*, *55B*, S76-S89.