

# MIDLIFE HEALTH OF AFRICAN-AMERICAN WOMEN: CUMULATIVE DISADVANTAGE AS A PREDICTOR OF EARLY SENESCENCE

Yvonne J. Combs

## ABSTRACT

*The intersection of race and gender present challenges to the studies of aging and life course. The higher rates of African-American women experiencing functional limitation in old age is but one example of disparity between black and white women during the aging process. This paper is an exploration of the relationship among, race, gender, socioeconomic status (SES), and health. Functional limitation that leads to disablement is used as the marker of health among African-American women at midlife. The National Survey of Midlife Development in the United States (MIDUS) provides the data to identify partially the relationship among present health status, lifestyle, and patterns of successful aging. In fact, preliminary findings from a MIDUS data analysis indicate that when controlling for age, SES, and self-rated health, black women have more limitations than do white women. It is hypothesized that as a consequence of limited*

---

**Social Inequalities, Health and Health Care Delivery, Volume 20, pages 123–135.**  
© 2002 Published by Elsevier Science Ltd.  
ISBN: 0-7623-0957-1

*opportunity, differing social structure and history, African-American women at midlife are more likely than their white counterparts to demonstrate patterns of health behavior that adversely affect the aging experience.*

## INTRODUCTION

This paper examines health disparity among black women at midlife. The examination accomplishes two goals. First, it identifies and scrutinizes socioeconomic status (SES) as among those social conditions or variables that impact the relationship between early onsets of functional limitations leading to disablement. In this respect, this study considers that cumulative disadvantage as indicated by comparatively lower community and individual SES impacts subsequent patterns of successful aging. From the perspective of this paper “SES is best understood in relation to the ways in which it inhibits or facilitates access to social structures that deliver health care” (Mills & Combs, 2002).

Secondly, this paper discusses findings from a preliminary analysis of subsample data found in the National Survey of Midlife Development in the United States (MIDUS) (The MacArthur Foundation Research Network on Midlife Development [MIDMAC], 1989). The preliminary finding regarding functional limitation among African-American women advances the research in identifying early signs of aging among the members of the target population.

## CUMULATIVE SOCIOECONOMIC STATUS AND HEALTH DISPARITY ACROSS THE LIFE COURSE

### *Socioeconomic Status (SES)*

Socioeconomic status (SES) is among the variables that constitute issues of access to social structures whose purpose is to deliver health care services. Varying ways of measuring SES including the fact that the social environment or communities of residence equally affect SES, make it difficult to capture its true impact. Generally speaking measurement of SES is restricted to use of individual education and household income levels as key variables. One clear measurement difficulty surfaces when consideration is given to the fact that all education experiences are not equal in quality. For example, inner city dwellers are less likely to have the facilities and equipment that contributes to successful

educational outcomes regardless of the number of years the student attends class. Similarly, brackets of gross and net income are subject to fluctuate by as little as \$1,000.00. In essence, while a \$1,000.00 difference in gross or net income would alter the placement in one income bracket or another it does not necessarily or automatically enable the household to purchase adequate health insurance. Finally, the geographic region of residence creates variability in absolute buying power. Regional differences in the cost of food, housing and transportation must be considered when evaluating the impact of income. This paper considers that individual and community SES as well as health insurance act as major inhibitors in gaining access to adequate health care facilities and services.

In the last decade the literature reflects a willingness to begin discussion of the cumulative impact of socioeconomic status (SES) on the health status of a racially and ethnically diverse aging population (Hayward & Heron, 1999; Smith, 1998, Tennstedt & Chang, 1998; House, Lepkowski et al., 1994). The current research about socioeconomic status and health posit that disease, illness and the socioeconomic status of childhood clearly affect adult life (Hayward & Heron, 1999; Marmot, 1998; Elo & Preston, 1992). African-American women who generally begin life with lower SES than do white women, continue to experience greater rates of poverty in old age. These studies substantiate the value of viewing health on a continuum rather than as a series of singular, isolated incidents. However, what remain undisclosed are theories and methodologies that fully develop and evaluate the impact of cumulative health disparity between black and white women over the life course.

It might be argued that lower SES is not the primary reason for poor health and high morbidity. It could just as easily be argued that higher levels of SES facilitate access to health care services. In examining the relationship among race, SES, and health, a path analysis of this relationship might well suggest that race is the antecedent of SES. In this sense minority group membership is a significant predictor of SES and SES as an endogenous variable, has a major influence on health outcomes (Howard, Anderson et al., 2000). It is this embedded effect of low SES that facilitates structural and material access to health care. The barriers resulting from lower SES (e.g. poor housing, over-exposure to environmental hazards, access to health care facilities) are reflected in the health status of women. More especially the life course or "socio-historical" experiences of African-American women make it clear that over the life course, health disparity continues to exist (Ferraro & Farmer, 1996; McKinney Edmonds, 1993). Paradoxically, this group of women, despite reports of longevity merely live longer periods than do white women in poverty and poor health (Hayward & Heron, 1999).

### *Individual and Community SES*

Both individual and community SES play large roles in determining successful health outcomes and active life among aging African-American women (Mills & Combs, 2002; Robert & Liu, 2001). For many minorities individual SES determines access to health care facilities, skilled caregivers, and preventative health care information. However, in a more broad or macro sense, community level SES is also a major determinant of health outcomes. This is so for example, because community SES has the potential to determine living environments. A case in point is reflected in the research of Raquel Pinderhughes (1996). This study points to the fact that a significant and disproportionate number of minority populations, especially African-Americans, are compelled by lower SES to reside in areas with high levels of exposure to toxic substances. Exposure to these hazardous substances has been directly linked to higher incidents of illness and mortality. Again, over the life course the cumulative effect of SES, even at the community level, will act as an inhibitor to positive health outcomes.

### *Socioeconomic Status and Health Care Insurance*

The preliminary data analysis discussed in this paper uses health insurance as a proxy for income. When treated as a dimension of SES, health insurance coverage measures levels of accessibility to health care services and health care providers. Despite claims to the contrary while Medicare and Medicaid provide some relief, these programs fail to adequately close the gap between black and white Americans (Brown, Ojeda et al., 2000).

Reportedly, employer-based health insurance coverage accounts for the largest gap between health insurance coverage of blacks and whites. In this respect perhaps employment is the strongest predictor of health insurance coverage. However, even among those employed black populations one study asserts that African-Americans tend to be "medically indigent" (Byrd & Clayton, p. 18). Given that as a group American blacks face higher rates of under employment and unemployment than do other groups, clearly one of the structural barriers to health care access is not only employment but also the degree to which that employment provides access to responsive health care systems.

For women gaining access to the health care based on employee benefit plans presents a challenge. The challenge occurs as a result of women's employment histories. The work experiences of women are frequently interrupted by our care-giving roles as wives, mothers and daughters. The net result is that in general we spend fewer cumulative years in the workforce, relying heavily on

spousal health care plans or Medicare to meet our health care needs. The work trajectory is similarly connected to retirement life styles. Thus, women who have inadequate health care benefits prior to age sixty-five continue to face health care disparity into old age.

### *Life Course*

The life course perspective in studies of aging is particularly useful when attempting to assign causation for health status at midlife. In fact, much of the literature that governs studies of aging does so from the perspective of the life course continuum. The argument of this standpoint is that the life course perspective makes allowance for and explains the cumulative impact of experiences in the construction of patterns for aging. The multiple experiences and perspectives are due to the reality that history, social environment and social structure change over the course of individual lives (Bengtson & Schaie, 1999; Riley, 1987). These changes in turn are reflected and in large measure affect the health, patterns of aging and morbidity of the population. In short, such a perspective allows that disparities in health manifested in aging and older adults may in part be due to earlier life course events, which later affect successful aging (Hayward & Hemon, 1999; Jackson, Chatters & Taylor, 1993; Moen, Dempster-McClain & Williams, 1992). In this respect, it is argued that life course perspective is the most balanced way to study aging. Note must be made that for African-American women, early patterns of socialization differ in very disparate ways from those of white women. Thus, the cumulative effects of life course events produce a different aging experience for African-American women. In fact, as the data analysis in this paper will note, the early appearance of physical limitations in the lives of African-American women indicates that this group has the potential to experience longer periods of disability over the life course.

### *Double Jeopardy and "Gendered" Aging*

Women constitute the majority of the aging population over sixty-five. These numbers increase twofold in the over-eighty population (Doress-Worters & Siegel, 1994). Despite outnumbering men, older and aging women have yet to develop the political presence required to alter our economic status and social image as older citizens. It is this economic disparity that creates patterns of successful aging that differ based on gender (Browne, 1998). Minority women

have even higher rates of poverty than minority men and white women. In essence, aging is not the cause of poverty rather poverty is related, if not dependent on a series of financial conditions that occur in early adulthood (Choudhury & Leonesio, 1997).

The combination of race and sex further expand the complexity of studying aging among minority women. As Kart historically notes in *The Realities of Aging, an Introduction to Gerontology*, a 1978 study by Dowd and Bengston, documents that the coupling of age and ethnic diversity precipitate “double jeopardy” (Kart, 1997; Ferraro & Farmer, 1996; Blakemore & Boneham, 1994). This paper further notes that as a result of the compounding impact of race and gender, aging experiences differ for African-American women. The difference is largely associated with being a member of a racially and often culturally diverse group (Whitfield & Baker-Thomas, 1999).

What is postulated here is that cumulative differences not wholly related to measures of socioeconomic status have a profound and dramatic affect on the health of African-American women in the development of successful patterns of aging. For this group of aging women, successful aging may well be formed both by early socialization and by the cultural traditions that beget perceptions of aging (Blackmore & Boneham, 1994; McKinney Edmonds, 1993).

### *Socioeconomic Status and Successful Aging*

Consideration of successful aging as the ideal state in the aging process requires that the concept be situated within the contextual dimensions of the general aging process. In this light the discussion briefly acknowledges the parameters of normal aging.

True senescence, sometimes referred to as normal aging in concert with the categorizations of gerontologist, Bernice Neugarten, may be said to begin at about age fifty to fifty-five (Rowe & Kahn, 1998). Specifically and by definition of normal aging, individuals may begin to experience “risky physiological changes”. While such things as blood pressure, diabetes, and heart and lung disorders are not necessarily inevitable in all aging persons, the risks associated with changes in these physiological functions increase as a condition of normal aging (Kart, 1997).

In the analysis of the MIDUS data, readers will note that the number of health limitations reported for African-American women appear as early as age twenty-five. This is nearly twenty-five years earlier than the beginning of the true senescence or normal aging that Bernice Neugarten’s theory defines as beginning at about fifty years of age (Rowe & Kahn, 1998). This is the time at which biological and physiological changes most noticeably occur. This early

onset of senescence now takes on a different meaning when applied to the aging experience of African-American women. Redefining normal aging within the context of the experience of African-American women, now aligns the aging experience with the theoretical perspective offered by the weathering hypothesis. In essence, this hypothesis captures the notion that despite efforts to alter individual health behaviors among disadvantaged populations, the net effect of structural racism has a cumulative impact on the life expectancies of these populations. Much like the gradual erosion of land by environmental elements human bodies “weather” or erode in response to environmental assault (Geronimus, 1996).

As noted in the MacArthur Foundation’s Research Studies on Successful Aging, the processes of senescence or normal aging and the rate at which they occur are not solely related to genetics. Rather lifestyle, social environment and social structure affect the process of normal aging (Rowe & Kahn, 1998; Elder, 1974; Riley, 1987; Featherman & Lerner, 1985). Especially for racial and ethnic minorities the aging process in general and successful aging in particular is adversely impacted not only by the biological process but also by the structural inequalities of socioeconomic status (O’Rand, 1996, Markides & Black, 1996; House, Lepkowski et al., 1994). This is more clearly illustrated by adopting the model of successful aging (Fig. 1).

This model suggests an overlapping relationship among three dimensions of aging and the concept of successful aging. Ideally aging members of society will have the three dimensions in balance thus producing lifestyles that maximize their opportunities to experience aging in a positive manner. In essence, the model focuses on modifications of health behavior overlooking structural barriers related to the social environment (Feinstein, 1993). Acknowledgment of historical, structural barriers becomes critical when examining the life cycle health disparity experienced by African-American women as they age. In fact, the U.S. Department of Health and Human Services Task Force on Black and Minority Health suggested that minority health is influenced by specific “social

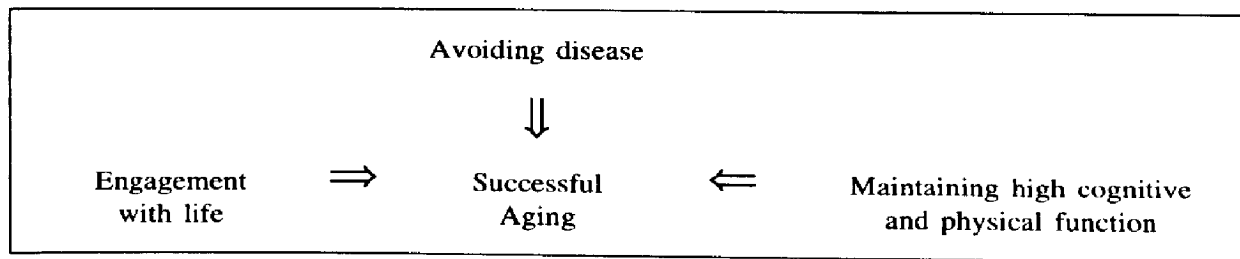


Fig. 1. Model of Successful Aging.  
(Rowe & Kahn, 1998).

characteristics.” The Task Force lists demographic profile, nutritional and dietary practices, environmental and occupational exposures, and stress and coping patterns as challenges to the physical well-being of Blacks and other ethnic minorities (McKinney Edmonds, 1993). Despite the age of the study (1985), the information retains its validity when consideration is given to the current poverty and health statistics of African-American women. It has been well documented that this group of women has higher rates of poverty and poorer health than do their white counterparts (Doress-Worters & Siegal, 1994).

As key concepts in the study of aging, the notions of normal aging and successful aging serve to distinguish, but more especially to interweave and support the theory that aging may not only be a managed experience but one that is individually constructed (Gubrium, Holstein & Buckholdt, 1994). In this sense, over the life course and even into late life, individuals have the opportunity to modify their lifestyles and thus positively alter the impact of normal and usual aging. The alteration in lifestyle may well be the development of a successful aging blueprint. This notion will have special significance when recommending health behavior interventions at midlife. However, such an approach assigns the onus for positive health outcomes to those who experience differential and disparate health outcomes. Such an approach continues to ignore the importance of structural and material support in reducing the cumulative effect of disparities experienced over the life course. In short, studies of aging have not successfully isolated behavioral inhibitors of successful aging from those that are social and associated with limited or inadequate access to resources (Feinstein, 1993).

## **THE PRELIMINARY STUDY**

To date there is no evidence that the MIDUS data has been used to investigate the linkages among race, gender and health disparity. Yet it has been well documented that as of 1999, minority elders 65+ represent 27.9% of the U.S. population (AARP, 1999). Currently, African-Americans are 8% (2,677,912) of America’s 65+ population (33,202,067). Additionally, in 1996 the U.S. Bureau of the Census issued a special report. In that report women represented the majority of the population over sixty-five years of age.

### *Methods*

In a cross sectional sub-sample drawn from The National Survey of Midlife Development in the United States (MIDUS) this preliminary study makes



suppositions and validates the health status of African-American women over the life course. The sub-sample is of black and white women, 25 to 74 years of age ( $N = 1862$ ). Measurements were made in the areas of number of physical limitations, self-rated health, whether or not the individual had health insurance, and the highest level of education they had achieved. Physical limitation was assigned based on whether the respondent had a prescription for medication and whether they had any health issues related to mobility or lung capacity or all three. Defining limitation in this fashion expands the definition beyond those found in previous literature. The maximum number of limitations possible in accordance with the selected criteria was nine. The self-rated health scale ranged from 1, when the respondent rated her health as poor, to 8 when she said she didn't know. The health insurance coverage variable was categorical and indicted by responding either "yes" or "no." The highest education was coded to reflect the general level of education rather than the actual and cumulative number of years of schooling. For example, the number "6" indicates that the level of education attained was 1–2 years of college, with no degree and not the completion of six years of schooling (Table 1).

**Table 1.** Descriptive Statistics – Women ( $N = 1,862$ ).

AGE	25–34	35–55	56–65	66–75
<i># Limitations</i>				
White	0.6	0.7	1.0	1.8
Black	1.4*	1.3*	2.0	3.0*
<i>Self-rated health</i>				
White	3.6	3.6	3.5	3.4
Black	3.4	3.3*	3.0*	2.8*
<i>Insured</i>				
White	0.7	0.8	0.8	0.6
Black	0.6	0.7	0.5*	0.4*
<i>Highest education</i>				
(a)				
White	7.1	6.9	7.0	6.2
Black	6.3*	6.7	6.0	5.7
%, ( $N$ )	21 (391)	22 (410)	24 (447)	33 (614)

Source: National Survey of Midlife Development in the United States (MIDUS) 1995–1996.

\*[ $p$ ] = < 0.05.

(a) 6 = 1–2 years of college, no degree.

### *Findings*

Findings of this MIDUS analysis are not new to observations about the health differences between blacks and whites. These findings do, however, suggest that for black women the markers of age found in reports of declining health and low socioeconomic status exist in young adulthood and persist throughout the life course. This finding necessarily develops an argument for early intervention in producing equitable health outcomes for women of color.

The multivariate analysis, however, further substantiates evidence of health disparity between black and white women. When controlling for age, SES (education and health insurance), and self-rated health, black women have more limitation than do white women (Table 2). The *F*-score of 0.27 suggest that in this particular model of interaction, race explains nearly one-third of the health disparity between these two groups of women.

These findings are consistent with similar studies offering little that is new in observations about the health and aging status of African-American women. However, what is new to the study of limitation is identification that among black women the number of reported physical limitations begins to manifest at earlier ages than it does for white women. This disparity continues across the life span.

**Table 2.** Multivariate Analysis Predicting Race Differences in Limitations  
(*N* = 1,862)

	Unstandardized Coefficient ( <i>p</i> -value)
Black women	0.40* (0.0176)
Self-rated health	-0.09* (0.0001)
Insured	-0.46* (0.0001)
Highest Education	-0.05* (0.0097)
Age 36-55	0.09 (0.5034)
Age 56-65	0.44* (0.0012)
Age 66-75	0.86* (0.0001)
<i>F</i> -score	4.6
<i>R</i> <sup>2</sup>	0.27

Source: National Survey of Midlife Development in the United States (MIDUS) 1995-1996.

\* = *p* ≤ 0.05.

## CONCLUSION

The literature cited herein is representative of current trends in the research on gender, health and aging. Clearly the aging patterns of African-American women are issues made complex by diversity in cohort and social structure. Yet there are no complete theoretical frameworks that homogenize the life course experiences of this group of women. For the most part theories emerge from combining several features and dimensions of research work in the field of aging. Furthermore, existing approaches to studies of aging for both black and white women focus on the aging and health experiences of women in the age category of sixty-five and older. Yet this preliminary analysis demonstrates that among black women, onset of limitation, presumably a marker of true aging, begins as early as age twenty-five. To date, research that focuses on the health and aging of African-American women is sketchy at best. This is especially true for research efforts that target black women at midlife. In fact, no empirical studies using the National Survey of Midlife Development in the United States currently exist. Yet it has been documented that aging black women present differences in menopausal events, have higher rates of death from breast cancer, have higher incidence of diabetes and have skin that ages in a fashion different from that of her white counterparts.

Moreover, studies that explore the impact of historical and cumulative socio-economic (SES) disparities are needed. In the case of the racial and ethnic aging experience, the cumulative nature of life course events is useful. The theory provides the basis for explaining pervasive and cumulative health inequalities among aged minorities (Feinstein, 1993).

Finally, well-documented assessment of cumulative effects of SES on health may substantiate claims for equalization and redistribution of health care assets. Such studies facilitate planning of early interventions at the behavioral and structural levels to promote patterns of successful aging among African-American women.

## REFERENCES

- American Association of Retired Persons (AARP) (1999). *Boomers approaching midlife, how secure a future?* Public Policy Institute of the American Association of Retired Persons. Washington, D.C.: AARP.
- Bengston, V. L., & Schaie, K. W. (Eds) (1999). *Handbook of theories of aging*. New York: Springer Publishing.
- Blakemore, K., & Boneham, M. (1994). *Rethinking aging, age, race and ethnicity, A comparative study*. Buckingham: Open University Press.

- Brown, E. R., Ojeda, V. D., Wyn, R., & Levan, R. (April, 2000). Racial and ethnic diversities in access to health insurance and health care. UCLA Center For Health Policy Research and Kaiser Family Foundation.
- Browne, C. V. (1998). *Women, feminism and aging*. New York: Springer Publishing Company.
- Byrd, M. W., & Clayton, L. A. (2000). *An American health dilemma*. New York: Routledge.
- Choudhury, S., & Leonesio, M. (1997). Life-cycle aspects of poverty among older women. *Social Security Bulletin*, 60(2), 17–37.
- Doress-Worters, P. B., & Siegal, D. L. (1994). *A book for women over forty, the new ourselves, growing older, women aging with knowledge and power*. New York: Simon and Schuster.
- Elder, G. H., Jr. (1974). *Children of the great depression*. London: University of Chicago Press.
- Elo, I. T., & Preston, S. H. (1992). Effects of early life conditions on adult mortality: a review. *Population Index*, 58, 186–212.
- Featherman, D. L., & Lerner, R. M. (1985). Otogenesis and sociogenesis: Problematics for theory and research about the development and socialization across the lifespan. *American Sociological Review*, 50, 659–676.
- Feinstein, J. (1993). The relationship between socioeconomic status and health: a review of the literature. *The Milbank Quarterly*, 71(2), 279–323.
- Ferraro, K. F., & Farmer, M. M. (1996). Double Jeopardy, aging as a leveler, or persistent health inequality: a longitudinal analysis of white and black Americans. *Journal of Gerontology: Social Sciences*, 51B(6), S319–S330.
- Freedman, V., & Martin, L. G. (1998). Understanding trends in functional limitations among older adults. *American Journal of Public Health*, 88(10), 1457–1462.
- Geronimus, A. T. (1996). Black/white differences in the relationship of maternal age to birthweight: a population-based test of the weathering hypothesis. *Social Science Medicine*, 42(4), 589–597.
- Gubrium, J. F., Holstein, J. A., & Buckholdt, D. R. (1994). *Constructing the life course*. New York: General Hall.
- Hayward, M. D., & Heron, M. (1999). Racial inequality in active life among adult Americans. *Demography*, 36(1), 77–91.
- Howard, G., Anderson, R. T., Russell, G., Howard, V. L., & Burke, G. L. (2000). Race, socioeconomic status, and cause-specific mortality. *Annals of Epidemiology*, 10(4), 214–223.
- House, J. S., Lepkowski, J. M., Kinney, A. M., Mero, R. P., Kessler, R. C., & Herzog, A. R. (1994). The social stratification of aging and health. *Journal of Health and Social Behavior*, 35, 213–234.
- Jackson, J. S., Chatters, L. M., & Taylor, R. J. (1993). Status and functioning of future cohorts of African-American elderly: conclusions and speculations. In: J. S. Jackson, L. M. Chatters & R. J. Taylor (Eds), *Aging in Black America* (pp. 301–316). Newbury Park: Sage Publications, Inc.
- Kart, C. S. (1997). *The realities of aging, an introduction to gerontology*. Needham Heights: Allyn and Bacon.
- Markides, K. S., & Black, S. A. (1996). Race, ethnicity, and aging: the impact of inequality. In: R. Binstock & L. George (Eds), *Handbook of Aging and the Social Sciences* (4th ed., pp. 153–170). San Diego: Academic Press.
- Marmot, M. (1998). Contribution of psychosocial factors to socioeconomic differences in health. *The Milbank Quarterly*, 76(3), 403–448.
- McKinney Edmonds, M. (1993). Physical health. In: J. S. Jackson, L. M. Chatters & R. J. Taylor (Eds), *Aging in Black America* (pp. 151–166). Newbury Park: Sage Publications.

- Mills, T. L., & Combs, Y. J. (2001). *Environmental factors, income inequity, and health disparity: Emerging research and policy implications for black Americans*. Fall/Winter 2002. (In press).
- Moen, P., Dempster-McClain, D., & Williams, Jr., R. M. (1992). Successful aging: A life course perspective on women's multiple roles and health. *American Journal of Sociology*, 97, 1612-1638.
- O'Rand, A. M. (1996). The cumulative stratification of the life course. In: R. Binstock & L. George (Eds), *Handbook of Aging and the Social Sciences* (4th ed., pp. 188-207). San Diego: Academic Press.
- Pinderhughes, R. (1996). The impact of race on environmental quality: An empirical and theoretical discussion. *Sociological Perspective*, 39(2), 231-248.
- Riley, M. W. (1987). On the significance of age in sociology. *American Sociological Review*, 52, 1-14.
- Robert, S. A., & Liu, L. W. (2001). Age variation in the relationship between community socio-economic status and adult life. *Research in Aging*, 23(2), 233-358.
- Rowe, J. W., & Kahn, R. L. (1998). *Successful Aging*. New York: Pantheon Books.
- Smith, J. P. (1998). Socioeconomic status and health. *American Economic Review*, 88, 192-196.
- Tennstedt, S., & Chang, B. (1998). The relative contribution of ethnicity vs. socioeconomic status in explaining difference in disability and receipt of informal care. *Journal of Gerontology: Social Sciences*, 53B(2), S61-S70.
- The MacArthur Foundation Research Network on Midlife Development (MIDMAC) (1989).
- U.S. Bureau of the Census (1996). 65+ in the United States. *Current Population Reports, Special Studies*, 23-190. Washington, D.C.: U.S. Government Printing Office.
- Verbrugge, L., & Jette, A. M. (1994). The disablement process. *Social Science and Medicine*, 38(1), 1-14.
- Whitfield, K., & Baker-Thomas, T. (1999). Individual differences in aging minorities. *International Journal of Aging and Human Development*, 48(1), 73-79.