

Claiming Health: Mammography Screening Decision Making of African American Women

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Purpose/Objectives: To develop a substantive theory that explains how African American women aged 50 years and older of different socioeconomic status (SES) make decisions about mammography screening.

Design: Qualitative, grounded theory.

Setting: Churches, places of employment, or women's homes in a large city in Ohio.

Sample: 30 women aged 52–72 years; 16 in the initial sample and 14 in the theoretical sample.

Methods: Audiotaped interviews and extensive written field notes; interviews were transcribed verbatim and analyzed using the constant comparison method, resulting in saturation of data.

Main Research Variables: Decision-making processes explaining mammography screening.

Findings: “Claiming health” emerged as the substantive theory explaining decisions that affect mammography screening and was embedded in the social contexts of cultural heritage and learned kinship values, religious beliefs and supports, and prior negative experiences with healthcare professionals and the healthcare system. Claiming health involved sisterhood and fellowship relationships fostered in the church. Claiming health was differentiated by age and SES, with older women of lower SES reporting greater reliance on cultural heritage and negative recollections of the healthcare system when making decisions regarding mammography. Each subconcept of claiming health was equally important and influenced decision making.

Conclusions: Oncology nurses can benefit from the information presented by assisting older women of lower SES who may have encountered negative experiences in the healthcare system to develop effective assertiveness and communication skills when interacting with healthcare professionals.

Implications for Nursing: Further research is needed to determine whether claiming health is a way of thinking about health generally or is used solely to explain experiences with mammography screening.

African American women aged 50 years and older are at greater risk of later-stage detection and poorer five-year survival of breast cancer at diagnosis when compared to non-Hispanic Caucasian women of similar age (89% versus 75%, respectively) (American Cancer Society [ACS], 2005). Extensive research has established that lower socioeconomic status (SES) is a major predictor of decreased mammography screening, the most efficacious method for early-stage detection of breast cancer abnormalities in women (ACS). The findings were confirmed in longitudinal tracking data from the first 10 years of the National Breast and Cervical Cancer Early Detection Program (Centers for Disease Control and Prevention, 2006). In the data analysis, African American women of lower SES aged 50 years and older obtained mammography screening at significantly lower rates

Key Points . . .

- ▶ African American women aged 50 years and older across socioeconomic status (SES) continue to obtain fewer mammography screenings, resulting in later-stage detection and poorer survival of breast cancer at diagnosis when compared to non-Hispanic Caucasian women and other racial, ethnic, and minority groups of similar age and SES.
- ▶ “Claiming health” can be used to explain decision making related to mammography screening.
- ▶ Claiming health integrates cultural heritage and learned kinship values, religious beliefs and supports, and sisterhood and fellowship relationships as well as prior negative experiences with healthcare professionals and the healthcare system.
- ▶ Oncology nurse educators and clinicians can assist older women of lower SES who may refute the necessity of recommended mammography screening as a result of prior experiences of discrimination to develop effective assertiveness and communication skills when interacting with healthcare professionals.

than non-Hispanic Caucasian women of similar age and SES (17.2% versus 52.4%, respectively). Recent studies also have shown that sociocultural factors, religious beliefs, fears, and fatalistic beliefs that are perpetuated by inaccurate information from family members and significant others, as well as prior negative experiences with healthcare professionals and the healthcare system, help explain lower rates of mammography screening among African American women. Despite the evidence, how African American women aged 50 years and

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older of different SES make decisions regarding mammography screening is not known (ACS; National Cancer Institute, n.d.). Because the data in the empirical literature are limited, further studies are warranted.

Background and Significance

Differences in mammography screening between African American women and non-Hispanic Caucasian women have been reported in several studies (Makuc, Breen, & Freid, 1999; McDonald, Thorne, Pearson, & Adams-Campbell, 1999; Miller & Champion, 1993). Freeman (1997) found that the differences were attributed to lack of health insurance coverage and access to health care. The evidence is consistent with a report from the Institute of Medicine (Smedley, Stith, & Nelson, 2003) that showed that women with lower use of mammography screenings reported discriminatory practices. Credible evidence showed that physicians made fewer referrals for clinical services for individuals in racial, ethnic, and minority groups as well as for those who relied on publicly assisted health services. African Americans, in particular, reported increased “wait time” and social injustices, such as the infamous Tuskegee Syphilis Study, that have resulted in beliefs of institutional racism and discriminatory practices and caused mistrust of the healthcare system. Authors of the report asserted that the heavy burden of mistrust of the healthcare system cannot be viewed in isolation of the problem of lower mammography screening. Smedley et al. concluded that, to some degree, access to health care has improved but total access has not been achieved.

Other researchers have shown that cultural factors, such as reliance on inaccurate information, increased fears or fatalistic beliefs about breast cancer, excessive radiation exposure, and mutilation or disfigurement have resulted in lower mammography screening rates among African American women of all socioeconomic levels. In Gregg and Curry’s (1994) study, rural African American women were paralyzed by fears and fatalistic beliefs that cancer devours victims by eating its way through the body. The women’s views resulted in beliefs that cancer screening procedures are useless when trying to identify real cancer. Similar findings were reported in several studies (Bobo, Dean, Stovall, Mendez, & Caplan, 1999; Lannin et al., 1998; Mathews, Lannin, & Mitchell, 1994). Other studies found that religious beliefs affected women’s personal control and encouraged rejection of disease progression (Kinney, Emery, Dudley, & Croyle, 2002; Phillips, Cohen, & Moses, 1999), thereby limiting mammography screening. In a more recent study, Phillips, Cohen, and Tarzian (2001) found that lower- and middle-income African American women integrated a holistic perspective of the mind, body, and spirit and referred to their bodies as the “holy temple of God,” which supported their beliefs that mammography screening provided an opportunity to keep themselves healthy.

Studies on social supports were contradictory. A number of researchers found a consistent association between social supports and mammography screening in African American women (Baldwin, 1996; Bobo et al., 1999; Burack, George, & Gurney, 2000; Phillips et al., 2001; Richardson & Ball-Cook, 1998; Thompson, Montano, Mahloch, Mullen, & Taylor, 1996; Williams, Abbott, & Taylor, 1997). According to Baldwin, social supports are much more than friendships in that they function to validate women’s self-ratings of health outcomes and

choices for health care. Contradictory findings were reported by Burnett, Steakley, and Tefft (1995) and Pearlman et al. (1997). Although differences were reported, African American studies scholars concluded that social supports of biologic and nonbiologic kinship networks are integral to the health behaviors of African American women (Ashing-Giwa, 1999; Ashing-Giwa & Ganz, 1997). Herskovits (1990) discussed the complex interplay among religious beliefs, extended kinship networks, cultural factors, and the slavery experience, analogous to African Americans’ experiences in the United States during and after the slavery experience. He concluded that the factors are interrelated and have enabled African American women to deal effectively with impaired relationships, economic hardships, and mistreatment because of age, race, or SES, in addition to racism, sexism, and power inequities in complex social structures. Interestingly, Herskovits made no mention of the effect of the factors on African American women’s health, but the author postulated that religious beliefs have been passed down through generations. Findings in the empirical literature overlapped; however, information regarding African American women’s decision making related to mammography screening was virtually nonexistent. The information presented in this article may expand the findings in the literature. Therefore, the purpose of the current study was to develop a substantive theory that explains how African American women of diverse SES make decisions about mammography screening.

Methods

Qualitative, grounded theory methods (Glaser, 1978; Glaser & Strauss, 1967) guided the purposes and methodology (i.e., sampling, data collection and analysis, and interpretation of findings) of the current study. Grounded theory is an inductively derived process that moves beyond what is known about a phenomenon to understand its underlying social processes. A hallmark of the methods used is the emergence of theory from data. The theoretical foundation of the grounded theory research approach is symbolic interactionism, which espouses that individuals and their actions cannot be understood outside of their social contexts (i.e., external environment) and personal relationships with others (Coffey & Atkinson, 1996). Grounded theory methods were appropriate for the present study because they allowed for the emergence of relevant information using the voices and experiences of the women who participated.

Recruitment

Researchers have shown that African American women spend many hours at church involved in different activities such as worship, charity, and fellowship (Paskett, Case, Tatum, Velez, & Wilson, 1999). Therefore, an initial sample of 16 women was recruited at two large Baptist churches with a predominantly African American congregation in a large city in Ohio. After the initial recruitment (an announcement from the pulpit immediately after worship services), the researcher met with interested women in a small conference room to detail the purpose of the study and proposed schedule of contacts. Women who met the following criteria were included in the study: aged 50 years and older with no prior medical diagnosis of breast cancer, no mammography screening in the previous two years, willingness to participate in two separate

audiotaped interviews, and a total household income based on 100% of the federal poverty level. Consistent with the qualitative aim of expanding the emergent findings, another 14 women (a theoretical sample) were recruited through word of mouth by influential women in the African American community. Inclusion criteria for those in the theoretical sample did not include restrictions on date of last mammogram or total household income to allow for more variation in the sample. Theoretical sampling occurred after the first analysis of interviews and continued to refine the targets of sampling as the evolving theory took shape (Strauss & Corbin, 1998).

Ethical Considerations

The study was initiated after approval from the ministers of the churches where recruitment took place and the Institutional Review Board for Human Subjects Research at the researcher's university. All women willingly signed the informed consent, which included a statement of risks (none known) and benefits (a \$40 gift certificate to local stores), to participate in two separate interviews. They were informed that no coercion was involved, they would not be penalized for withdrawal, and their rights would be respected throughout the study.

Data Collection

Data were obtained from an investigator-developed, semi-structured interview guide. Questions assessed influences on health and mammography screening. A beginning, general question was, "What do you do to take care of yourself?" or "How do you manage your health?" Later, women were asked questions about mammography screening such as, "What are your thoughts and feelings when you hear the words mammography screening?" Another related question was, "What else comes to mind when you hear the words mammography screening?" A final question was, "What sort of things do you consider when making the decision to obtain or not obtain mammography screening?" Extensive written field notes, recording data such as the location and length of the interview and others' presence during the interview, were kept. Building on emergent data from the initial sample, additional open-ended interview questions were developed as the study evolved.

The interview guide included a separate section to gather relevant sociodemographic and health history data, such as age, total household income, highest educational level achieved, employment status, and date of last mammogram. Based on unsolicited information from the initial sample, questions regarding sociodemographic and health history data of the theoretical sample were added or expanded to include the type of work performed, work history, part- or full-time work status, religious denomination, and caregiving responsibilities. The additional questions subsequently were asked of the initial sample.

Interviews occurred at a convenient time in the privacy of the women's homes, churches, and places of employment. Most interviews (90%) included a family member, best friend, neighbor, or church member. Length of the first set of interviews ranged from 1–1.5 hours, whereas the second set of interviews of all participants, which usually took place within three weeks of the first interview, lasted 2.5–3 hours. All major findings of the experience under study were tape-recorded, and maximum variation of data occurred to support the theoretical variations (Glaser & Strauss, 1967).

Data Analysis

All data were examined using constant comparative analysis (Glaser & Strauss, 1967), beginning with the first audiotaped interview. Interviews were transcribed verbatim. Sixty separate interviews were analyzed line by line, and approximately 60 codes emerged. Data from interviews and extensive written field notes were compared to ensure that they were mutually exclusive and explained any variations (Strauss & Corbin, 1998). Caution was used in selecting the most descriptive and explicit codes that were reported by the majority of women. The codes were linked to a subcategory by noting interrelationships; for example, reading Biblical scriptures and seeking health-related information were linked to relying on religious beliefs and supports. Specifically, clues were sought to determine under what conditions African American women make decisions related to mammography screening. Actions or interactions were examined to understand the nature and extent of relationships with significant others to the emergent data. The rigorous comparative data analysis process continued until no new information was reported (Strauss & Corbin, 1998).

Reliability and Validity

Reliability and validity measures were addressed using rigor, truth-value, consistency, confirmation, applicability, and neutrality. Rigor was met by using data collection and interpretation techniques consistent with grounded theory research methods. Truth-value, or reproducibility, was maintained by using the constant comparative method of data analysis, whereby each piece of data was compared with others. Consistency was established by keeping detailed, transcribed written notes. In addition, the researcher wrote memos and maintained a code notebook, journal, and audit trail that were shared with an experienced mentor familiar with the research methods being used. Peer debriefing with the mentor occurred periodically to share issues and concerns as well as provide updates in data collection and analysis. Confirmation occurred by interviewing participants a second time to corroborate the findings from the first interview (Strauss & Corbin, 1998). Lincoln and Guba (1985) referred to the process as member checks used to validate conclusions with members or stake-holding groups from whom data originally were collected. Therefore, participants were asked explicit and probing questions during the second interview, such as, "Is this what you meant when you said . . .?" or, "During our last visit, you talked about _____. Could you talk more about _____ today?" Applicability was met by confirming hunches based on verbal feedback from the women in both samples to determine commonalities and the fit of the findings to results of other studies (Morse, 1989).

Results

Sample Description

The entire sample of 30 African American women was aged 52–72 years. The 16 women (53%) in the initial sample were slightly older (\bar{X} age = 62.5 years) than those in the theoretical sample of 14 women (\bar{X} age = 60 years), who represented 47% of the sample. The initial sample was poorer, with a median household income of \$14,260 for four people, and more were employed in full-time service occupations (e.g., domestic, fast

food, factory workers). Half of the initial group was retired or on medical disability. The theoretical sample reported a wider range of household income (\$10,000–\$65,000) for four people, and participants were employed in part-time and full-time positions such as hair designer, entrepreneur of beauty supplies and hair products, dental hygienist, and community worker. Most participants (88%) in the initial sample were single, widowed, or divorced, whereas 43% in the theoretical sample were married. Both groups reported completion of college credits, although more women in the theoretical sample had earned associate or technical degrees. More than half of the women in both groups reported caregiving responsibilities such as health supervision of an older family member or after-school child care. Almost all women in both groups (90%) reported Baptist religion. Half of the women in both groups obtained mammography screening during the previous two-and-a-half years, with more women reporting mammography screening during the previous three years (63% in the initial sample and 71% in the theoretical sample).

“Claiming health” emerged as the substantive theory explaining decision making related to mammography screening. The emergent theory incorporated active, deliberate, and purposeful efforts to reject or integrate healthcare professionals’ recommendations for mammography screening as well as goal-directed statements to manage health. The purpose of claiming health was to control the right to make one’s own decisions about health and mammography screening. With the exception of a few women ($n = 8$), participants rejected generally accepted physical dimensions of health, such as diet and exercise, advertised in popular lay magazines that focus on physical fitness and health promotion. Instead, they asserted that health was rooted deeply in the social, spiritual, and mental dimensions. One woman stated, “Health is much more than exercise and letting someone else tell you how you should feel. It’s about being with the Lord, taking care of yourself so you can be there for your family.”

Claiming health was embedded in the social contexts of cultural heritage and learned kinship values, religious beliefs and supports, and prior negative experiences with healthcare professionals and systems. Claiming health also involved sisterhood and fellowship relationships that were fostered in the church and supported through others’ beliefs that were handed down through generations. See Figure 1 for a description of the interrelationship of the key subconcepts.

Each concept reflected the women’s beliefs about the importance of mammography screening. For example, one older woman, who articulated views similar to others, associated endurance and longevity with deliberate decision making to forgo mammography screening. She said, “My great-grandmother was 113 when she died. She didn’t get a mammogram. She didn’t need it. All the women in my family lived a long life. They took good care of themselves. They ate from the garden, hearty foods that make you strong. I must come from good stock, so I don’t need a mammogram.”

Claiming health did not reflect any single experience or circumstance but was characterized by religious beliefs and support systems that were sources of strength. One woman stated,

The Bible tells you all about taking care of your health. It tells you about eating right and staying away from harmful stuff like cigarettes, drugs, and alcohol. The Bible includes special messages about taking care of your breast as well as your soul.

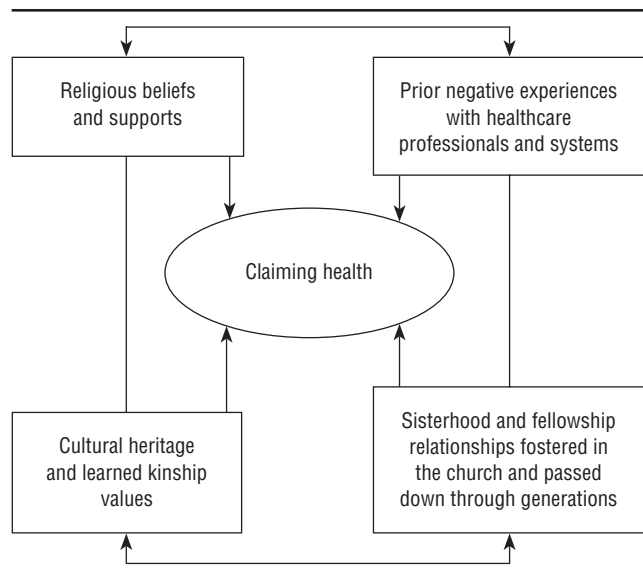


Figure 1. Interrelationship of Key Subconcepts of Claiming Health

Several women reported that sustained, nonbiologic relationships with others and loyalty to the church supported their decision making about mammography screening. The following conversation occurred between two women who belonged to the same choir group. The first woman implied religious beliefs and social support, saying, “My decisions about getting mammograms rest entirely with the teachings of the Lord, but I’m so glad you were there to help me draw on my strengths when I go for the tests.” The second woman’s response illustrated that obligations were determined from social support. “Sisters in Christ can always depend on one another. You know our preaching corresponds with the existence of another, and that means going along to support one another.”

More than half (60%) of the women stated that negative attributes of male physicians had influenced their use of healthcare services. The attributes, such as aloofness, arrogance, a hurried manner, impatience, and cultural insensitivity, had a negative effect on how the women interpreted information and encouraged women’s silence. One woman stated,

After he put on my cast, he said, “I can’t wait until I get home and tell my mother that I saw a black woman with her bra on.” I was so hurt by what he said. He really insulted me. Of course I cried. I started to write a letter to the hospital’s administrators to let them know about him but decided it was not even worth it.

Other women articulated self-confidence when navigating the healthcare system. They reported being assertive and using confrontation skills when interacting with healthcare providers. One woman stated,

My personal experiences with doctors and nurses have been good because I’m a very persistent person. If there’s something I don’t like, I tell them because my kids are very important to me. Going to the emergency room is usually a good experience, but if it’s somebody new on duty, you have to teach them how to respect you. I look them dead in the eyes and say, “I’m a customer and I deserve to be treated with dignity and respect.”

Almost all of the women (97%) acknowledged that beliefs about health were learned from communal kinship values derived largely from plantation life during the slavery experience and a religious orientation that supported perseverance, strength, and self-determination. The views were included with socialization of succeeding generations. One woman echoed the views of others when she said,

We learned it from our kinfolks! It started back during slavery. Momma and Granny taught us about taking care of ourselves. We didn't go outside the family. Sister and me taught our children to do the same thing. That's how we learned to survive.

Claiming health was grounded in skepticism, and some women declined mammography screening because they needed additional information and felt powerless when interacting with healthcare professionals. Skepticism was associated with "conjuring up" deep-rooted beliefs resulting in a misleading, bleak interpretation of cancer. One woman explained conjuring as,

I claim my health; that's why I just don't want to know nothing about it. It's the fear of not knowing and not wanting to know. Cancer is a scary thing. By the time it's detected, it spread all through your body. It's too late. I don't care what nobody says, mammograms aren't for black women. Nobody can convince me that we need them.

Negative recollections of the historical slavery experience (being treated as nonhuman, devalued, property, free without resources, and separate but equal) and of de facto segregation, permeated the data. Such experiences influenced racial attitudes and beliefs and negative perceptions about healthcare professionals. The younger women, aged 50–59 years, were cognizant of the impact of discrimination and racism, which categorized individuals into groups primarily on the basis of race or skin color. Instead of letting experiences with racism or discrimination affect their attitudes toward mammography, however, participants recognized the importance of mammography screening for their breast health. One woman described her views by saying,

Sometimes you think about the bad experiences that our ancestors had with doctors and hospitals. I know it wasn't all pleasant and equal back then. But I believe that you have to let those things go. All doctors aren't bad. I've had some good experiences and some bad, but I don't let that hold me back from getting my proper health checks.

In contrast, many of the women aged 60 and older were less sympathetic with healthcare professionals regarding past experiences of discrimination and racism, with male physicians especially. They provided detailed and explicit descriptions that conveyed beliefs about health care that were restricted to unethical genocide of and experimentation on African Americans. The women were particularly judgmental and insisted that screenings were a learning tool for healthcare professionals that would result in intentional harm. Because of their beliefs, the women refuted the benefit of screenings for early detection of breast cancer. One woman stated,

I stopped getting mammograms because I don't believe mammograms are for black women. How do we know that doctors know what they're talking about? They could just be practicing on you. Learning on you for someone else! Show me one test that says mammograms are for black women; that's the kind of results that I want to see.

Discussion

The substantive theory of claiming health that emerged from the data has not been reported in previous research. It was embedded in the social contexts of cultural heritage and learned kinship values, religious beliefs and supports, and prior negative experiences with healthcare professionals and the healthcare system. Sisterhood and fellowship relationships that were acquired or fostered in the church and handed down through generations provided a sense of group identity and therefore were equally important in the women's decision making. The findings in the current study corroborated findings in previous studies (Baldwin, 1996; Bobo et al., 1999; Burack et al., 2000; Phillips et al., 2001; Richardson & Ball-Cook, 1998), but those researchers did not distinguish between the types of social networks reported in the present study. McAdoo (1997) confirmed that sisterhood and fellowship relationships were legitimized and endorsed during the slavery experience to provide family support networks and survival during continuing adversity. The current study's findings are corroborated by others (Carlton-LaNey, Hamilton, Ruiz, & Alexander, 2001; Pearson, Hunter, Ensinger, & Kellam, 1990) who reported that social networks provided a protective system for sharing advice and guidance and distributing meager resources.

Since the 1990s, increased emphasis has been placed on the use of models and theoretical frameworks in clinical practice. Commonalities in the frameworks include roles, resources, and relationships involved in social supports or networks. Lazarus and Folkman (1984) incorporated social support (resources) as a subcategory in their four-component framework. Litwak (1985) proposed a task-specific model that included family, friends, and formal helpers in which each person included in the network pattern provides assistance when needed. More recently, Chak (1996) identified three dimensions of social support that have a profound influence on the health and well-being of individuals: emotional support (e.g., listening, trust, esteem), informational support (e.g., advice, guidance, feedback), and instrumental support (e.g., physical and other tangible aid). With the exception of instrumental support, each of the frameworks was partly reflected in the findings.

Religious beliefs and supports provided emotional and social support to the women, who also revealed that the church ministry focused on the importance of their social networks in the church, which had a significant impact on their views and beliefs of unpleasant situations with healthcare professionals and systems. Emphasis also was placed on the church ministry and congregation in the empirical literature (Manns, 1997; Nivens, 1998), which also was found in previous studies (Baldwin, 1996; Bobo et al., 1999; Lannin et al., 1998; Phillips et al., 1999; Thompson et al., 1996; Williams, 1998).

In explaining differences, older age and lower SES were important socializing factors when the women were interacting with individuals from different racial or ethnic groups or people in powerful, influential positions. For example, women of lower SES aged 60 years and older tended to focus on unpleasant interactions with healthcare professionals and the healthcare system. Experiences that caused women to distrust the healthcare system may have been perpetuated in the world in which they grew up and lived. Negative experiences corroborate disharmony with healthcare professionals, which may have provided a catalyst for perceptions of

racism and institutional discrimination. All women reported cultural beliefs about mammography screening; however, the older women of lower SES reported greater reliance on the traditions of significant others, which resulted in lower mammography screening. The traditions have enabled African Americans to persevere and prevail in the face of unbelievable obstacles in the past and have provided an opportunity to socialize others (McAdoo, 1997).

Some physicians may unconsciously label individuals with lower earnings and higher rates of poverty. Smedley et al. (2003) found that some physicians consider racial, ethnic, and minority status as well as SES when making referrals for expensive technologies. This perspective perpetuates racism and stereotypical views of racial, ethnic, and minority groups and corroborates the belief that people who rely on public assistance programs or charitable support for healthcare services are at fault for their pathologies or the predicament of poverty (Ryan, 1972).

In contrast to the older participants in the study, the younger women's (aged 50–59 years) higher educational attainment and potential for higher income (half worked in part-time positions) may have increased their interaction with those of different genders or racial or ethnic groups. In addition, they may have solicited social interactions to exchange personal information regarding negative experiences with healthcare professionals. Another logical explanation of their views about mammography is that the women who reported increased sophistication in interacting with others may not have considered racial disharmony when navigating healthcare services.

The findings of the current study provide an increased understanding of African American women's decision making related to mammography screening. The women integrated the social contexts of the church ministry handed down through generations such as biologic and nonbiologic sisterhood and fellowship relationships and cultural beliefs and learned kinship values. They derived particular strengths and resources (traditions supporting health beliefs) from varying social contexts when making decisions related to mammography screening. Differences were reported regarding encounters in the healthcare system, which may be because some women alienated themselves and focused on the negatives regarding delivery of healthcare services, whereas others exercised their right to receive available health services. Nevertheless, all findings were explicit and derived from the voices and experiences of the participants.

Study Limitations

All audiotaped interviews were collected by one individual; therefore, eliminating all bias from the study was virtually impossible. To address this ethical implication, interviews were shared with a senior researcher. After a thorough and independent examination of the data, the senior researcher confirmed the findings. Some women may have participated because of the monetary remuneration. Lee (1993) acknowledged that remuneration is acceptable and, in some instances, recommended to recruit skeptical or "hard-to-reach" groups into studies or interventions. The women, recruited primarily from Baptist churches, may have brought a biased perspective to the findings because of their similar religious beliefs. In addition, espoused values supporting increased accountability and charity or "service to others" that are prominent in many Baptist churches

may have influenced participation in the study. Theoretical sampling from other networks offset that limitation.

Social class differences between some of the participants and the researcher may have influenced the interview process and verbal exchange of information. Although the women divulged personal information about health and mammography screening, indicating a willingness to share their experiences with others, the possibility exists that similarities in ethnicity between participants and the researcher increased the women's interest and involvement in the study and, therefore, increased the researcher's trustworthiness. The assumption should not be made that the results of this study are verifiable in other racial or ethnic minority groups or that they will hold up in other situations. Therefore, the results are specific to this group of African American women and are historically and culturally bound (Thorne, 1997). Because the findings of this grounded theory study were not reported in previous studies, they offer important insights for understanding decision making related to mammography screening among African American women.

Implications for Nursing

Further research is needed to extend the results of the current study. Sisterhood and fellowship relationships that were fostered in church should be examined in a larger, more representative group of African American women. Cultural considerations were implicit but were not stated directly in previous studies. Because reliance on traditional, nonwesternized beliefs was an important influence in the decision making of older African American women of lower SES, additional studies are needed to examine the effects of collateral information from significant others regarding management and follow-up of cancer diagnosis and treatment options. Additional studies are needed to determine whether the findings of the current study are also true for African American women with higher SES or in other religious groups.

Additional studies are needed to determine whether claiming health is a way of thinking about health generally or is used solely to explain experiences with mammography screening. The information would be invaluable to researchers in oncology nursing and healthcare professionals for understanding the social processes and contexts associated with decision making. Psychometric instruments that measure the social processes and contexts that were reported in this article should be developed. Quantitative data from the instruments could be used to develop and implement tailored, culturally sensitive interventions that support increased mammography screening among African American women. Longitudinal studies are needed to examine potential changes in claiming health in different situations and how social contexts may change over time or be illustrated in other cancer diagnoses affecting the health and well-being of African American women and their significant others. The new epistemology generated from the current study may expand knowledge and be useful to oncology nurse educators and clinicians to deliver more culturally sensitive interventions, resulting in increased mammography screening among African American women. Perhaps most importantly, oncology nurses can benefit from the information presented in this article by being able to better assist older women of lower SES who may have had negative experiences in the healthcare system to develop effective assertiveness and communication skills when interacting with healthcare professionals.

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