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Gender and Health Lifestyle: An In-Depth Exploration of Self-Care Activities in Later Life

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Abstract

Objective—Evaluate similarities and differences in the self-care domain of health lifestyle among older, rural dwelling women and men.

Method—Qualitative analysis of in-depth interview data from 62 community-dwelling older (M = 74.3 years) African and European American women and men.

Results—Both older women and men rely heavily on over-the-counter (OTC) medications and home remedies self-care; professional health care is typically sought when self-care is not effective. However, relative to men, women were more knowledgeable about different approaches to self-care, especially home remedies, they used a wider range of self-care activities, and they placed greater priority on self-care over professional health care.

Discussion—The structure of older women's and men's self-care domain of health lifestyle is similar. However, there are subtle differences in health lifestyle that are likely embedded in gendered role behavior and may contribute to women's greater health complaints.

“Lifestyle” holds a central position in current explanations for gender differences in health across the life course. In a highly influential article exploring gender-based differences in mortality and morbidity, Verbrugge (1985) observed two distinct behavioral departures between women and men related to health. First, Verbrugge noted that women and men differ in the acquisition of risky behavior. She argued that men disproportionately engage in behaviors that increase the risk of disease or injury, such as smoking and heavy alcohol use, whereas women disproportionately engage in preventive health practices such as use of vitamin supplements, seat belts, and regular screening exams. Second, Verbrugge argued that women are more likely to adopt the sick role and subsequently care for illness or injury in the early stages rather than waiting for symptoms to escalate into more complex health problems. Based on these observations, the “lifestyle hypothesis” argues that differential participation in risk, health promotive, and illness management behaviors between women and men are presumed to represent differences in “lifestyle” that contribute to gender differences in health outcomes across the life course.

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Evidence supports discrete elements of the lifestyle hypothesis. Epidemiologic evidence consistently documents greater participation in health risk behaviors by men than women. Binge drinking of alcohol and current smoking, for example, are higher among men than women at every stage of adulthood (Naimi et al., 2003). Gender differences in health protective or promotive behaviors are less consistent. Women tend to engage in preventive actions like blood pressure and cholesterol checks or routine checkups (Viera, Thorpe, & Garrett, 2006), but other behaviors like regular physical activity are more common among men than women (Troiano et al., 2008). Physician office visits are greater for women than men from age 15 through 64: women average 3.6 ambulatory visits per year whereas men average 2.6 visits per year (Cherry, Hing, Woodwell, & Rechtsteiner, 2008). Gender differences in physical activity, weight status, and smoking frequently attenuate but do not explain women's generally poorer self-rated health (Denton & Walters, 1999; Gorman & Read, 2006; Ross & Bird, 1994).

The inability of the lifestyle hypothesis to explain gender differences in health requires a return to the concept's theoretical roots. Sociologically, lifestyle is a broad concept referring to patterns of non-specific beliefs, behaviors and attitudes. The two most commonly used definitions of lifestyle applied to health, or health lifestyle, are provided by Cockerham (1995) and Abel (1991) who suggest that health lifestyle reflects individuals' patterns of behavior, beliefs, and attitudes specific to health within the context of their daily lives. The common definitions draw attention to two fundamental aspects of health lifestyle. First, by emphasizing the context of daily life, theorists like Cockerham recognize that multiple sources of stratification exist, including gender, and that they powerfully shape the way members of specific groups approach health. This point has been more fully developed in the social determinants of health literature which argues that health lifestyle is a manifestation of class or social position (Navarro, Voetsch, Liburd, Bezold, & Rhea, 2006) and potentially culture (Airhihenbuwa, Kumanyika, TenHave & Morssink, 2000), not individual choice (Hodgetts, Bolam, Stephens, 2005).

Of primary importance to this analysis, Cockerham's and Abel's definitions of health lifestyle draw attention to the patterning of health behavior at the individual level. Germane to this point is recognition that a wide variety of behaviors contribute to health. Drawing on the classic work of Kasl and Cobb (1966a, 1966b), the health behavior literature frequently differentiates between risk behaviors, such as heavy alcohol use and smoking, and health promotive behaviors like regular physical activity and a low fat, high fiber diet. However, the literature also differentiates other type of behavior like preventive or protective safety behavior (e.g., use of seat belts, breast or testicular self-examination), care seeking (e.g., seeking professional health care) and responses to illness (e.g., acceptance of diagnosis, adherence to treatment regimens) (Gochman, 1997). Different types of health behaviors serve different functions. Health promotive behaviors, preventive or protective safety behavior, and avoidance of risk behaviors are generally advocated for primary prevention purposes: they minimize the onset of poor health, injury, or disease. Care-seeking behavior and responses to illness are primarily important for secondary or tertiary prevention wherein the goal is to restore health or minimize the level of impairment or illness resulting from injury or disease.

Acknowledgement of the diverse array of distinct types of health behaviors is instructive. First, it highlights the possibility that focusing on one or two types of health behavior, like health promotive and risk avoidance behavior, to the exclusion of others does not capture the complex nature of health lifestyle and its role in gender-based differences in health research. Indeed, behaviors believed to be the bedrock of a healthy lifestyle (i.e., regular physical activity and tobacco avoidance) rarely account for gender differences in health (Ross & Bird, 1994).

Second, the array of health behaviors and variation in their primary purpose suggest the manifestation of health lifestyle likely shifts across the life course. To be sure, lifestyle theorists argue that health lifestyle is different in later adulthood than early adulthood because age itself is a basis for social stratification (Cockerham, Rütten & Abel 1997); the patterns or relative clustering of distinct types of health behavior at any given time will vary between members of different age groups because each group is “acting its age”. Practically, recognizing that older adults typically manage multiple chronic conditions, the relative salience of care seeking and response to illness behaviors likely take on greater weight in the health lifestyle of older adults compared to earlier adulthood when health lifestyle emphasizes primary prevention.

Gender Differences in Health Lifestyle Elements in Later Adulthood

Gender differences in various elements of health lifestyle hold for older adults. Older men engage in more regular physical activity (Chad et al., 2005) and are less likely to abandon new physical activity regimes than women (Shimada, Lord, Yoshida, Kim, & Suzuki, 2007). Older women are more likely than older men to prefer self-care activities over receiving care from a health professional (Ganther, Wiederholt, & Kreling, 2001). Consistent with women’s preference for self-care, older women report greater use of home remedies (Arcury et al., 2009; Musil, 1998); and women are more likely than men to report using vitamins and herbs in later life (Arcury et al., 2006a). There are no gender differences among older adults in the number of ambulatory visits to health care providers (Cherry et al., 2008).

Delineating gender-based health lifestyles (i.e., patterns or clustering of health-related behavior) is essential for understanding health disparities in later life, such as why older women report poorer health than older men. To accomplish this, in-depth interview data were collected and analyzed to describe similarities and differences among older women and men in the range of self-care activities used. Data were also used to delineate gender variation in the construction of health lifestyle by considering how self-care activities are incorporated or removed from an individual’s overall health management strategy, and to document similarities and differences among older women and men in the role that self-care plays in health management. Results contribute to the literature by allowing a more complex and integrative view of health lifestyle than the traditional approach of analyzing individual health behaviors and assuming they represent “health lifestyle” (e.g., Cockerham, Hinote, & Abbott, 2006; Gorman & Read, 2006; Ross & Bird, 1994). Further, our approach provides an age-appropriate view of health lifestyle, recognizing that health needs shift from primary prevention in younger and middle adulthood to secondary prevention later in life.

Method

The data for this study are from the first component of a broader study designed to understand gender and ethnic variation in the health self-management strategies of older, rural dwelling adults. Sampling and recruitment procedures have been described in detail elsewhere (Arcury et al., 2009), and are therefore summarized here to avoid redundancy. A federally authorized Institutional Review Board (FWA #00001435) approved all sampling, recruitment and data collection procedures.

Sampling & Recruitment

Sampling and recruitment procedures were designed to create an ethnographic sample equally stratified by ethnicity (i.e., White and African American) and gender such that each cell in the recruitment table contained at least 15 participants. All sampling and recruitment occurred in three rural, south-central North Carolina counties, which were selected because of their comparatively large minority populations. These counties also represent variation on

the urban-rural continuum (<http://www.ers.usda.gov/Data/RuralUrbanContinuumCodes/2003/>), such that one is in a metropolitan area with an urban population of 2,500–19,999, one is a nonmetropolitan county with urban population of 20,000 or more, and one is a nonmetropolitan county with urban population of 2,500–19,999.

A site-based sampling procedure (Arcury & Quandt, 1999) was used to recruit representative participants who reflect the range of knowledge, beliefs, and practices in a community (Werner & Bernard, 1994). Sites are places, organizations, or services used by members of the population of interest, in this case rural dwelling older adults. We recruited participants from 26 sites across the study counties that served different ethnic and social groups; example sites included congregate meal sites, senior centers, craft groups, churches, and local AARP affiliates. Before recruitment took place, study staff first visited each identified site to request entrée from the appropriate “gatekeeper” of the site (e.g., senior center director, pastor) and to obtain estimates of the number of women and men and the number of European Americans and African Americans at each site. These estimates were used to inform the number and approximate demographic profile of individuals to be recruited at each site. A member of the study staff was sent to each site with explicit instructions of the number of individuals to recruit. Staff approached prospective study participants as they became available at the site.

All individuals invited to participate in the study agreed, provided informed consent, and completed the interview. It is possible, however, that some prospective study participants “passively” refused by avoiding staff members while they were visiting the site. Recruited participants ($N=62$) were, on average, 74.3 years old ($SD=7.3$), and many ($n=27$) had a high school education but nearly one third ($n=19$) reported having less than a high school education. A more thorough description of this sample is reported elsewhere (Arcury et al. 2009).

Data Collection

Data were collected from February through October, 2007, by five trained interviewers. Interviewers met participants at locations of the participants’ choosing, usually their homes, explained the project, and obtained signed informed consent. Participants received a small incentive (\$10) at the end of the interview. In-depth tape recorded interviews ranged in length from about one to three hours.

Interview Content

The interview incorporated different approaches to elicit information about diverse self-care activities. First, participants were asked how they would treat common symptoms in ways other than going to a doctor or using medicines prescribed by a doctor. Common symptoms included headache, dizziness, tooth ache, rash, sunburn, nausea, constipation, diarrhea, cramps, muscle ache, sore throat, runny nose, nervousness or moodiness, and fatigue. Second, participants were asked about remedies and treatments people might use to treat a set of chronic conditions and diseases “that they do not get from their regular doctors.” These chronic conditions and diseases included arthritis, emphysema, bronchitis, asthma, cancer, high blood pressure, heart disease, diabetes, memory problems, and stroke. Third, participants were presented with common household products, herbs, and over-the-counter medicines that might be used as remedies and tonics, and for each they were asked if they ever used it, if they currently used it, if they had heard of other people using it, and for what it was used. This list included common household products that our pre-test interviews and existing literature had documented are used by older adults (Arcury et al., 2006b; Grzywacz et al., 2006), such as vinegar, honey, baking soda, Epson salts, and kerosene. It included herbs commonly used by European and African American older adults (Arcury et al., 2007),

as well as widely used OTCs and commercial supplements (Arcury et al., 2006b), such as Ben Gay ointment, Raleigh's liniment, Vicks VapoRub, and glucosamine sulfate. Finally, practices such as relaxation, meditation, biofeedback, yoga, exercise, special diets, massage, acupuncture, and self-help groups were presented to participants and they were asked if they had heard of the practice, if they used the practice, and the purpose for which they used the practice. Participants were also presented with a list of various health care practitioners including complementary medicine practitioners (e.g., homeopathic doctor, naturopathic doctor, massage therapist).

Analysis

Data analysis was based on a systematic, computer assisted approach that has been described elsewhere (Arcury & Quandt, 1998) and implemented using *Atlas.ti*, a commercially available software package for managing, coding and analyzing narrative data. All interviews were transcribed verbatim, and each transcript was edited for accuracy. Data analysis began with the collection and ongoing reflection on interview content through listening to interview recordings and reading the interview transcripts. All analyses procedures were designed to answer three primary research questions:

1. How does the range of self-care activities manifesting health lifestyle compare among older women and men?
2. Are there differences between older women and men in how health lifestyle is modified or reconstructed through the addition or removal of self-care activities?
3. How do older women and men compare in terms of the salience self-care plays in health lifestyle relative to the salience of formal health care?

Analysis proceeded in three stages. First, a case summary of each participant's interview was constructed. The lead author developed a protocol for characterizing each case. The protocol called for the extraction of specific data elements from the interview transcript for each study participant, including illustrative quotes from the individual. Extracted data elements reflected different types of behaviors relevant to self-care, including discussions of home remedy use, use (or non-use) of vitamin or mineral supplements, use of over-the-counter (OTC) products, recent use (past 12 months) or nonuse of alternative healthcare providers, other behaviors (e.g., relaxation, physical activity), and seeking formal health care. Extracted data elements and participant quotes were used to construct a case summary for each participant: the summaries described the range of self-care activities used, the participants' willingness to engage in new self-care activities, and the relative role of self-care vis-à-vis formal health care. All of the case summaries were constructed by one team member trained in the protocol, a strategy used to ensure consistency in summary creation over time. The lead author of this manuscript personally reviewed and verified the content of over one-half of the created summaries, a strategy used to avoid drift from the case summary protocol.

At the second stage of analysis the lead author used the constructed case summaries to populate a matrix designed to portray key elements of each participant's self-care activities. An important feature of each portrayal was the classification of the range of self-care activities reported by the participant, the depth of knowledge about self care activities reported by the participant, their openness to trying new self-care activities, and the relative position of self-care to formal health care. A second member of the team reviewed the constructed matrix, raising questions about suspected classification deviations. The entire team discussed each case where differences in coding emerged until consensus was reached. At the third and final stage of analysis, gender codes were added to the matrix to enable the delineation of similarities and differences in the range of self-care activities reported by

older women and men. Similarities and differences across the cases were summarized descriptively. Interview quotations supporting the interpretation of textual data are presented with participant ID number, as well as participant ethnicity and gender.

Results

Range of Self-Care Activities in Older Adults' Health Lifestyle

The vast majority of participants described a wide range of over-the-counter (OTC) medications that are kept readily available to manage ongoing conditions or that would be purchased to respond to new health problems. For example, *PART~21*, a 74 year-old European American woman, reported using *Equate* (WalMart label ibuprofen) for a headache and toothache, calamine lotion for a rash or itchy skin, Chapstick or Vaseline for chapped lips, Senokot or a stool softener for constipation, Vicks VapoRub to help relieve congestion, and aspirin for headache. Likewise *PART~27*, a 67 year-old African American man, reported using Gold Bond cream for itchy skin, cuts and scrapes, Neosporin for a mosquito bite, Alka Seltzer to help with digestion problems and for gas, laxative or stool softener for constipation; Mylanta for stomach problems; Pepto-Bismol for diarrhea; Vicks, NyQuil, or Creomulsion for a cold; Tylenol for fever; BenGay for joint pains; and Aleve to manage arthritis pain, headaches, as well as toothache and joint problems. These cases illustrate the salience of OTCs for older adults, and suggest that OTCs are a core or basic feature of health lifestyle for both older women and men.

Although all older adults in this sample reported regular use of at least one OTC, some reported a noticeably narrower range of OTCs. There were no apparent gender differences among the individuals for whom OTCs played a less salient role in health lifestyle. For example, the only OTC reported by *PART~45*, a 68 year-old European American woman, was ibuprofen for headache, aspirin for back pain, and hydrocortisone cream for rash. Infrequent users of OTCs chose home remedies as their primary alternative for self-care before turning to a conventional health care provider. This tendency was illustrated by *PART~037*, an 85 year-old European American man who reported "If something that I take for a cold or something isn't doing the job that I think it ought to do then I make an appointment to go see a doctor and see if he can find something that, or give me something that would be better than what I'm taking."

Home remedies or the use of common household products for health purposes was also a basic element of older adults' health lifestyle. The vast majority of participants reported currently using at least one home remedy, either in response to an acute condition or to manage an ongoing health problem. Although there was some mention of using home remedies as a general tonic for avoiding illness, most of the reported home remedies were used to resolve or treat acute health problems. Both women and men reported using a variety of home remedies. *PART~14*, a 65 year-old African American man, reported gargling with peroxide for mouth ulcers or sores, taking vinegar for heartburn, indigestion, and constipation, and turpentine as a topical ointment for sore muscles. Similarly, *PART~24*, an 84 year-old European American woman reported gargling with peroxide and several distinct usages for vinegar. Additionally, she reported eating prunes or taking lemon and water for constipation, and applying a baking soda poultice on bee stings and burns.

Although used by both women and men, home remedies appeared to play a more central role in the health lifestyle of women than men. Women had substantially greater depth of knowledge and subsequent reliance on home remedies. Women would speak coherently about their use of home remedies, frequently able to link specific remedies to specific ailments, or they had an explanation for why a specific remedy was able to resolve its targeted health concern. *PART~46*, a 74 year-old African American woman, illustrated this

detailed knowledge. *PART~46* would prepare a spearmint tea for nausea, whereas she would prepare a ginger tea and chamomile tea for acid reflux problems and difficulty sleeping, respectively. *PART~46* further elaborated how she would use warm water and vinegar to alleviate bloating and gas, baking soda and warm water for indigestion, and tonic water with quinine for leg cramps. Men, by contrast, had a generally shallow understanding of the home remedies they reported using. Indeed, many of the home remedies reported by men appeared to be simple artifacts of childhood: their mother encouraged use and the behavior pattern persisted to the present day without an understanding of why. This is best summarized by participant *PART~19*, a 65 year-old African American man who said:

No most of the time if anything else I mostly go to the doctor now you know. With my mother living you know I didn't have to go to the doctor for everything. She could get up something and my grandma and great-grandmother lived here they dug up something and you didn't have to go to the doctor but people done got away from all that you know. There are a few people that deal with that stuff.

Beyond OTCs & Home Remedies—Elements of health lifestyle surrounding the core role of OTCs and home remedies differed between older women and men. Men's health lifestyle infrequently went beyond the use of OTCs and home remedies. *PART~27*, a 67 year-old African American man, represents the few men whose health lifestyle went beyond the use of OTCs and home remedies. He reported using home remedies for both acute symptoms and problems (e.g., drinking cold water or juice for an upset stomach) and for managing a chronic health condition (i.e., using vinegar and water to control blood pressure). He reported regular use of an over-the-counter salve for muscle and joint relief, and regular stretches and exercises to manage a chronic back problem. He also reported seeking care from a chiropractor and acupuncturist for his back pain.

More women than men had a lifestyle incorporating a wider range of self-care activities beyond home remedies and OTCs. The majority of women complemented their use of home remedies and OTCs with supplements. In most cases the supplements reported by women were vitamins and minerals, either in the form of a combined product like a multivitamin, or in the form of multiple supplements. Additionally, though, comparatively more women than men reported using contemporary supplements such as glucosamine, chondroitin, and fish oil. *PART~47*, a 67 year-old African American woman, illustrates those women: she reported using a variety of supplements (i.e., ginseng, glucosamine, and Echinacea), attending a self-help group, and "sometimes" using relaxation techniques to relieve stress. She also reported enjoying receiving treatment by an acupuncturist.

Adding and Removing Elements from Health Lifestyle

Comparatively more women than men were open to trying new self-care activities, and both women and men outlined a comparable strategy of experimenting with a new self-care activity. In most cases, both women and men reported that they would experiment with a new self-care activity wherein they would try it for two to three days, at which point they would evaluate whether or not the self-care worked. If it worked, treatment would continue; otherwise, it was abandoned and professional help was sought out. This general strategy is clearly conveyed by *PART~029*, a 78 year-old African American woman, when she describes what she would do if her ankles swelled:

Well if they won't go down. You know these ankles, they're not going down and I've done soaked them two nights, I'm just saying two nights, so the third night you're not down and you're still tired and puffy I think I should see the doctor. Maybe my kidneys is not doing just fine. [Interviewer: So it'd have to be there for a while?] Well I'm going to, I'd say three days. I'd give anything three days to get

by. I ain't going to go weeks and weeks now with a swollen up ankle because that's against the rules and regulations.

Nevertheless, there were notable differences between women and men in arriving at the decision to incorporate a new self-care activity into their health lifestyle. Men were generally more skeptical and less trusting than women of self-care activities. The general skepticism was best summarized by *PART~002*, a 67 year-old African American man, who stated "...I wouldn't want to get into that. I only deal with what the doctors said because I don't use the remedies because I can't read up on it. If I got a problem, I'll take it to the doctor to talk about, and he will take it from there." Among those few men who were willing to try a new form of self-care, the willingness to try followed a recommendation by a family member or a trusted friend. Men, therefore, were generally reluctant to amend their health lifestyle by experimenting with new forms of self-care and, when they did, it was usually based on recommendations provided by others, frequently a spouse or daughter.

Women, by contrast, appeared more predisposed to use self-care activities as their first line of response to new or re-emergent health problems. Like men, women frequently experimented with new self-care activities based on the recommendations of family and trusted friends. However, comparatively more women than men were actively engaged in seeking new alternatives to fold into their health lifestyle, typically from print material. *PART~033*, a 72 year-old European American woman, reported "I have read in books about different items that affects some of the things that I have [referring to diabetes] and I'll take those vitamins to help me to stay healthy." She then goes on to describe how she learned to combine vitamins, such as a B-complex vitamin with vitamin C, to maximize their effectiveness. She also went on to report a variety of herbs (e.g., cinnamon for diabetes and garlic for her heart) that she learned about from reading books like *Grandma Putt's Old-Time Vinegar, Garlic, Baking Soda, and 101 More Problem Solvers: 2,500 Super Solutions for Your Home, Health, and Garden*. Knowledge acquired from reading was then shared with other women via informal social networks, such as church groups.

Self-Care versus Formal Care in Older Adults Health Lifestyle

Women and men held different views of the importance of self-care activities relative to formalized health care. Although they reported using OTCs and various home remedies, men generally deferred to the expertise and value of formalized health care. Very few men described an integrated health lifestyle wherein self-care was placed on equal footing with recommendations made by health care providers (like doctors or nurses) or allied health care professionals like pharmacists. *PART~38*, a 76 year-old African American man, exemplifies this reliance on health care providers; he typically bypasses self-care and seeks professional assistance with most health problems ranging from warts or lost appetite, to painful urination or trouble with balance. He reports being open to different forms of treatment, including self-care with home remedies, but only if they are supported or recommended by his doctor.

[Interviewer: So what if your doctor suggested that you take some vinegar?] I would. What I'd want to know is how often and when. That's all I want to know.

[Interviewer: So you don't want to know why he wants you to take it?] Oh I'd want to know why, yeah. The reason. If he tells me to take it then I want to know why yeah, but if he tells me to take it I'm going to take it.

By contrast, women were more likely to describe a health lifestyle whereby self-care was integrated with other forms of care. Whereas nearly three quarters of men reported primary reliance on health care providers (after OTCs or other forms of self-care fell short), only a minority of women reported deferring to health care providers. Rather, many women described strategies wherein self-care and those advocated by formalized medicine were

considered equally relevant and important. Women who placed self-care on equal footing with that provided by formal health care typically delineated a clear dividing line between the types of conditions that would be handled with self-care as opposed to those for which professional oversight would be sought. This dividing line was typically shaped by previous experience, or conversely, experience of new or unusual symptom. *PART-033* illustrates the type of delineation and decision making many women reported.

Well most of the time I think about it and if I think the doctor can do anything about it I'll go to him. If it's a necessity. But if it's something I think I can handle I do it myself. Just like for my kidneys and my bladder, you can use cranberry juice, that's very good and you drink a certain amount of that and it's okay but if you get a type of infection that you can't get rid of you've got to go to the doctor then. [Interviewer; Okay if you ever had problems with balance or being unsteady or falling, what would you do for that?] I'd probably have to go to the doctor for that one. Because I wouldn't know what's going on. Well with my problems it could be my blood pressure or it could be my sugar that's messing up which I have been to the doctor on sugar already. So to me that would be one of the things I'd have checked out because you never know when you're going to have a stroke that can come all of a sudden. I've had them or the doctors told me I've had them.

Discussion

This study addressed conceptual issues undermining the usefulness of the lifestyle hypothesis to explain gender differences in health. A significant conceptual gap in previous health lifestyle research is consideration of a broader scope of behaviors relevant to health, and recognition that different domains of behavior likely take on greater salience at different periods in the life course. Although health promotive behaviors like physical activity and diet are never irrelevant, the salience of self-care as well as care-seeking and illness response behavior is elevated in later life when adults manage multiple chronic health conditions. These conceptual gaps undermine conclusions drawn from lifestyle research focused on gender disparities, or other health disparities research.

The primary finding of this study is that older women and men have similar health lifestyles. Regardless of gender, OTCs and home remedies are at the center of older adults' health lifestyle: they are commonly used to manage chronic conditions and they are typically the first response to health deviations. Some older women and men engage in additional self-care activities such as taking herbal or vitamin supplements, engaging in regular physical activity, or practicing relaxation techniques. Importantly, though, relatively few older adults augment their basic self-care regimen of OTCs and home remedies with these behaviors. These results are consistent with other quantitative studies of older adults reporting that self-care using various foods (e.g., prunes for constipation) or household products (e.g., salt water gargle for sore throat) is typically used before care is sought from health care providers (Stoller et al., 1993; Musil et al., 1998). Our results complement and extend previous research by capturing adults' descriptions of their own behavior and situating them in a broader rubric of health lifestyle. That is, participants articulated a common progression of health management activities: OTCs and home remedies are given 2 to 3 days to work before seeking help from the formal health care system. This extension suggests that the general structure of older adults' health lifestyle is highly consistent, regardless of gender.

Despite similarities in the general structure, our results indicate subtle differences in older women's and men's health lifestyle. Home remedies are more salient to women's health lifestyle than men's. Although both women and men use home remedies, women are more knowledgeable about how home remedies work and which remedies to apply to what conditions (Arcury et al., 2009). This knowledge translates into greater "informed use" and confidence

in home remedies by women than men. By contrast, men's use of home remedies is largely an artifact of childhood: they continue using remedies recommended by mothers or grandmothers during childhood without knowing why. Women's greater knowledge of home remedies and their correspondingly greater salience in women's health lifestyle is likely the result of primary responsibility for the household production of health across the life course (Cancian & Oliner, 2000). Another subtle gender difference in health lifestyle is that older women engaged in a wider variety of self-care behaviors than men, including health promotive behaviors (i.e., vitamins) or the use of contemporary supplements like Echinacea or glucosamine for secondary prevention of health decline. These results are consistent with Verbrugge's (1985) observation and previous research indicating that use of these supplements is generally greater among older women than men (Arcury et al., 2007). However, they extend results from previous research by situating these behaviors in a more complete range of self-care activities relevant to older adults' health lifestyles.

In terms of understanding health disparities, perhaps the most meaningful difference between women's and men's health lifestyle is the relative salience of self-care activities relative to health care seeking behaviors. Our results suggest that women are more committed than men to existing home remedies or OTCs, and they are more willing to try new home remedies or OTC medications. This behavior is consistent with Verbrugge's (1985) observation that women adopt the sick role more quickly than men. It is also consistent with evidence indicating that women prefer self-care over professional care (Ganther et al., 2001), and that older women are less likely than men to seek health care for common problems (Musil, 1998). However, such behavior is potentially problematic and could contribute to health disparities if greater commitment to self-care activities forestalls receipt of potentially more effective care. If both women and men use home remedies or OTCs first, but women are more likely to experiment with new remedies and they have greater faith in their effectiveness; such experimentation and subsequent delays in formal health care seeking could contribute to greater health problems for older women than older men. Although such a comment must be viewed as speculative, the important point is that such a speculation and subsequent hypothesis testing is only possible if health lifestyle researchers consider behaviors from different domains (e.g., health promotive, self care, risk reduction) simultaneously. Indeed, the more recent social determinants of health literature would argue that social class or culture may contribute to systematic between-group differences across a variety of discrete behaviors that collectively contribute to health disparities (Navarro, Voetsch, Liburd, Bezold, & Rhea, 2006).

The conclusions of this study must be considered in light of its limitations. The transferability of our results is unknown because our sample consisted of older adults from the two dominant ethnic groups living in three counties in rural North Carolina. The generalizability of our results is enhanced, recognizing that they are consistent with results from rural and urban samples from other parts of the country (Stoller et al., 1993; Musil et al., 1998); nevertheless, it remains unclear whether the pattern of behaviors observed in this study will hold in other contexts. Next, our analysis focused on gender differences in health lifestyle, but it is possible that other bases of social stratification such as educational attainment or ethnicity may modify the observed results (Cockerham, Rütten & Abel, 1997). For example, European American women reported use of contemporary supplements like Echinacea or glucosamine more frequently than African American women. This suggests that ethnicity may further refine gender differences in older adults' health lifestyles. This is an issue that awaits further research.

Limitations notwithstanding, the results of this study advance conceptual understanding of the potential role that health lifestyle plays in gender differences in health during later life. The results suggest that older women and men have comparable health lifestyles; the first

response to apparent health problems is either home remedies or over-the-counter medications. However, there are subtle, yet meaningful differences in women's and men's health lifestyle. Women use a wider variety of self-care activities than men, they are more likely to experiment with new self-care activities and they place greater emphasis on self-care activities relative to professional health care. These subtle differences are only observable when activities from multiple behavioral domains are viewed at the same time: something that has not been done in previous lifestyle research. Although they must be viewed as speculative, the results suggest that gender differences in later life health may be due, in part, to women's greater use of self-care activities that may delay more effective treatments.

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