ETHNOGERIATRIC CURRICULUM MODULE

HEALTH AND HEALTH CARE OF AFRICAN AMERICAN ELDERS

This module is dedicated to the memory of the late Dr. Wilbur Watson and his many valuable contributions to the field of medical sociology, especially as it relates to ethnogeriatrics and the African American community. Much of his work is contained in this module as narrative and references.

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HEALTH AND HEALTH CARE OF AFRICAN AMERICAN ELDERS

Table of Contents

Description .................................................................................................................. 3
Learning Objectives ............................................................................................... 3

Content
   I. Introduction and Overview ................................................................. 4
   II. Patterns of Health Risk ................................................................. 6
   Culturally Appropriate Geriatric Care
     III. Fund of Knowledge ............................................................... 12
     IV. Assessment ........................................................................... 20
     V. Prevention and Treatment .................................................... 22
     VI. Access and Utilization .......................................................... 24

Instructional Strategies .......................................................................................... 30
Student Evaluation ................................................................................................. 34
References and Resources ....................................................................................... 35
Appendix A: Key Terms .......................................................................................... 47
Appendix B: Cohort Analysis of African American Elders.............................. 48
Appendix C: Annotated Bibliography .................................................................... 52

HEALTH AND HEALTH CARE OF AFRICAN AMERICAN ELDERS

DESCRIPTION
This module presents an overview of available information on health conditions among African American\(^1\) or Black elders in the U.S. with emphasis on historical influences on their health and health care. Since no separate data are available for Black elders who have immigrated from other countries, the focus is on those who were born in the U.S. The module is designed to be used in conjunction with the Core Curriculum in Ethnogeriatrics.

**LEARNING OBJECTIVES**

After completion of this module, learners should be able to:

1) Describe the status and care of older Blacks during the antebellum period of the United States.

2) Describe improvements in indicators of health, such as increased longevity of older Blacks from 1850 to 2000.

3) Describe the different assumptions that help to inform conceptions of health and illness.

4) Describe today’s African American population using the following categories:
   a) demographic characteristics,
   b) ethnic-specific patterns of social support.
   c) major causes of mortality
   d) relative risk for dementia, diabetes, and prostate cancer

5) Identify key barriers to Black elders’ participation in health and related services.

6) Explain briefly the concepts: natural causes of illness; occult and spiritual forms of illness.

7) Discuss the effects of cultural bias on misdiagnoses and errors in treatment planning for patients

8) Recommend a culturally appropriate approach to end-of-life care for African American elders.

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\(^1\) In this module the terms Black and African American are used interchangeably.
I. Introduction and Overview

A. Population Growth and Distribution

The African American population today is comprised of individuals of mixed ethnic and cultural heritage. The slave trade resulted in a diaspora from West and Central Africa to many parts of the world, including the West Indies, South America, Central America and the United States. Over the centuries in all of these parts of the world, the African has mixed with other local ethnic groups. In America this intermixing has largely been with American Indians and European Americans.

There has been continuous growth in the overall population of Blacks in the United States since 1790. In 1790, the year of the first U.S. census, the Black population numbered about 757,000. By 1890, it had grown to 7.5 million people--nearly ten times the population in 1790. By 1993, Blacks constituted the largest minority ethnic group in the United States. For example, in 1970 there were 22 million Blacks in the United States, of whom approximately 1.5 million or 7% were 65 years of age or older. Since 1970 there has been considerable growth in the population of Blacks 65 and over. The growth in the proportion of Blacks 65 and over since 1970, in comparison to the growth rate of Blacks under 18 years and those 18 to 64 years, shows a considerably more rapid rate for the older group than for the younger age groups. This pattern is accounted for in part by a decline in the fertility rate among Blacks that began in the late 1960s. Given an expectation of (1) a continuing decline in the fertility rate, (2) further improvements in health care, and (3) increased life expectancy of Blacks, this pattern of growth in the number of persons 65 and over is expected to continue (Watson, 1982).

By 1990, the population of Blacks in the United States totaled more than 30 million people. In the 2000 census, when answering the questions about “race” 34,658,190 individuals identified themselves as “Black, African American or Negro,” and another 1,761,244 said they were in that category in combination with another race. In addition to individuals born in the U.S., this includes immigrants from Haiti and other Caribbean Islands, South and Central American and from Africa who identify themselves as “Black.” In 2000, it is estimated that 2.8 million Black individuals were aged 65 or over, which accounted for 8.1% of all U.S. residents aged 65 and over. That is expected to rise to almost 10 million aged 65 and over by 2050, which is expected to be 12% of the total population of older Americans (www. census.gov). Data on the subgroups of Haitian elders or those from African or other Caribbean backgrounds are not available.

Along with growth in the population of Blacks, there have been noticeable changes in their geographical distribution in the United States. In 1890, the year of the first census in which data were made available on urban-rural distribution of Blacks, 80% of all Blacks lived in the rural southern United States. By 1970, however, the 1890 patterns were reversed: about 81% of Blacks had become concentrated in urban areas.
Nevertheless, by 1990 approximately 51% of all Blacks still lived in the southern United States.

B. Characteristics

1. Heterogeneity. Older Americans who identify themselves as Black or African American are extremely varied on almost any dimension one could name. Although many are low income, very large and growing segments are in the middle and upper income categories. Some are retired professionals, and many others have children with professional careers. Religious affiliations include Protestant, Catholic, Muslim, and none. Many are still living in the rural South, but more are in urban areas in the North and West. Educational levels vary from almost no years of schooling to those with doctorates. While many in their 70s and 80s are dependent on care from children, grandchildren, or “fictive kin,” many others are raising their grandchildren or great grandchildren. It is important for clinicians to recognize the vast array of characteristics that may be represented in older Black patients so that each patient can be treated as an individual.

2. Living Arrangements. Among community dwelling elders, African American men were more likely to live alone (approximately 24%) and less likely to live with a spouse (approximately 52%) than men from any of the four other older racial/ethnic populations. Older African American women live alone at about the same percentage as most other women (slightly over 40%), but are less likely to live with a spouse (24%). Less than 10% of both men and women live with non-relatives, but the rate is slightly higher than among other groups (Administration on Aging, 2000).

Historically, African Americans have resided in nursing homes at about half the rate of White elders (Yeo, 1993). More recent evidence shows an increase in the use of nursing homes so that except for women over age 85, a higher percent of Black men and women over 65 are in nursing homes than Whites (Kramerow, Lentzer, Rooks, Weeks, & Saydah, 1999). (See Figure 1 in section VI.)

3. Education. The Administration on Aging (2000) reported that in 1998, 44% of non-Hispanic Black Americans age 65 and over had graduated from high school, and 7% had a Bachelor’s Degree or higher.

4. Poverty. In 1997, 29% of older African American women, and 22% of older men were in poverty. This is slightly more than older Hispanics and more than twice the rate of older White Americans (Kramerow et al., 1999). The percentage increases with age and for those who are widowed or live alone.
II. Patterns of Health Risk

Many morbidity and mortality rates are higher among African American elders than in the general population. Because of decreased educational levels and decreases in personal resources, the awareness of health problems, knowledge of causes and risk factors, and capacity to access medical care may be greatly decreased.

A. Life Expectancy

Life expectancy at birth has historically been shorter for African Americans than other Americans, but the differences disappear or reverse themselves at older ages, creating the “Crossover Phenomenon.” (See Table 1.) The historical trends in the Crossover and possible reasons for it are discussed in Section III under Health History. As of 1997, Black women in the U.S. had a life expectancy at birth of 74.7 years, and Black men 67.2 years. At age 85, life expectancy for Black women is 6.7 years and 5.7 for Black men (Kramerow et al., 1999).

B. Mortality

Death rates from all causes for elders 65-74 and 75-84 are higher among Black elders than any of the other racial and ethnic groups, but for those 85 and over, the rates are higher among Whites and second highest among Blacks. However, in reporting these data, the authors caution that care should be taken in the comparisons because of questions regarding accuracy of reporting (Kramerow et al., 1999).

The leading causes of death among African Americans age 65 and over are:

- Heart Disease
- Cancer
- Stroke
- Diabetes
- Pneumonia/Influenza

The top three causes of death are the same for older Americans from White, Asian/Pacific Islander, and Hispanic backgrounds. Diabetes is a more common cause of death among Black elders than in other racial and ethnic groups with the exception of American Indians, where it is the third most common cause (Sahyoun, Lentzner, Hoyert, & Robinson, 2001). See Table 2 for death rates by disease.

Discussion of mortality among minorities frequently focuses on the concept of “excess mortality,” defined as the difference between the number of deaths actually observed in the minority population and the number of deaths that would have occurred in that group if both minority and non-minority populations had the same age- and sex-specific death rates. Coronary heart disease and stroke account for 24% of the excess mortality among Black males and 41% among Black females (Richardson, 1996).
Table 1

Life Expectancy by Age Group and Race, in Years, 1997

<table>
<thead>
<tr>
<th>Life Expectancy</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Birth</td>
<td>77.1</td>
<td>71.1</td>
</tr>
<tr>
<td>At Age 65</td>
<td>17.8</td>
<td>16.1</td>
</tr>
<tr>
<td>At Age 85</td>
<td>6.2</td>
<td>6.4</td>
</tr>
</tbody>
</table>

Source: Administration on Aging, 2000

Table 2

Death Rates among Black Americans 65 and Over, 1998
Per 100,000 Individuals

- Diseases of the Heart: 2,016
- Cancer: 1,325
- Cerebrovascular Disease/Stroke: 489
- Diabetes: 272
- Pneumonia & Influenza: 236

Source: Sahyoun, Lentzner, Hoyert, & Robinson, 2001
The death rate for all cancers is 30% higher for African Americans than for Whites.

Most causes of death have been declining among Black elders, but there are some exceptions. Lung cancer and deaths from other lung diseases such as bronchitis and emphysema have continued to increase among older Black men and women. There has also been a dramatic increase in mortality from hypertension (presumably due to stroke) since 1980 among older Black men while it decreased among older White men. Hypertension mortality rates have also increased among older Black women (Sahyoun et al., 2001).

C. Morbidity

All ethnic populations are prone disproportionately to some conditions rather than others in comparison to other ethnic groups. The causes for this are multiple and include ethnicity, culture, education, income, and barriers encountered when accessing health care. Cultural differences regarding diet and exercise may combine to predispose individuals to some of these conditions. For African Americans, these conditions include (Mouton, 1997):

- hypertension
- coronary artery disease
- stroke
- end stage renal disease
- dementia
- diabetes, and
- certain cancers

1. Hypertension, coronary artery disease, and stroke have been recognized for decades as major risks for African American elders. In the 1980s, 37% of Black males and 64% of females age 65 and over were reported to have hypertension. There is an inverse relationship between socioeconomic status and blood pressure, so that those in poverty have a higher risk. There is some evidence that the stress of “John Henryism” (making it because of sheer determinism against overwhelming odds) may be a contributing factor to hypertension for lower income Blacks with little education (Richardson, 1996).

2. Cancer. A major type of cancer affecting older African American men is prostate cancer, in which they have a 60% excess incidence (Richardson, 1996). Black non-Hispanic males have been found to have twice the risk of prostate cancer as Black Hispanic men (Manton & Stallard, 1997).

Breast cancer incidence seems to be about the same or lower for African American women as other women, but the survival rate is lower. The survival rates appear to be improving, but the stage at which the tumor is diagnosed is still later for Black women. Factors associated with the late stage diagnosis are: limited access to care, care in public rather than private clinics, higher body mass index, and lower rates of
mammography. Cervical cancer risk is higher among African American women (Manton & Stallard, 1997).

Incidence and mortality for multiple myeloma cancer among Blacks are twice that among Whites, and the risk increases with age. (For complete discussion of causes of racial differences in cancers see Manton and Stallard, 1997).

3. Vision Problems. Blindness due to glaucoma is six to eight times more prevalent among African Americans than Whites, and the glaucoma seems to occur at earlier ages and be more aggressive as well. Blindness from unoperated cataracts is reported to be four times more common in Black elders than Whites, even though cataract surgery is the most common Medicare-funded surgical procedure (Richardson, 1996). Because of the high prevalence of diabetes, African American elders are also at high risk of diabetic retinopathy which can cause extremely low vision and blindness.

4. Hip Fractures. Although Black females have about half the risk of hip fracture as White females, the risk increases with age for both men and women. One study found that in spite of longer hospital stays, more comorbidity, and less ambulation on discharge, none of the 44 older Black hip fracture patients were discharged to rehabilitation centers, and only a few went to long-term care (Furstenburg & Mezey, 1987; Richardson, 1996).

5. Dementia. Prior studies have found a higher rate of vascular dementia among older Blacks than among Whites (Froelich, Bogardus, & Inouye, 2001). In one Baltimore study with a predominately African American population, the ratio of Alzheimer’s to vascular dementia was approximately equal (Folstein et al., 1985; Larson & Imai, 1996). Among over 5,000 elders assessed in nine California Alzheimer’s Disease Diagnostic and Treatment Centers, those individuals identified as White were more likely to be diagnosed with Alzheimer’s Disease (53%) than those from Black (46%), Hispanic (47%), or Asian (45%) backgrounds. Black elders were more likely to be diagnosed with vascular dementia (31%) than those in the other populations (Yeo, Gallagher-Thompson, & Lieberman, 1996).

In a large epidemiological study in North Manhattan, rates of dementia were compared for African Americans, Hispanics (primarily Dominicans and some Puerto Ricans), and non-Hispanic Whites. In all ages, Hispanics had the highest rates of dementia, followed closely by African Americans, both of which were much higher than the rates for the Whites. In the 85+ age group, 54% of African Americans were identified as having dementia. However, in addition to age, education was found to be highly correlated to dementia. The authors state, “With age and education controlled, ethno-racial membership loses its association with dementia” (Gurland et al., 1997, p. 252).

C. Self-Rated Health and Functional Status

African Americans have usually been found to rate their health less positively than other American elders and have more functional disabilities. See Tables 3 & 4.
D. Social Support, Family Caregiving, and Role of Church and Religion

See coverage of these topics in Section VI below.
Table 3
Percentage of Persons Who Reported Good to Excellent Health by Age, Sex, Race and Hispanic Origin, 1994-1996

<table>
<thead>
<tr>
<th></th>
<th>All Persons</th>
<th>Non-Hispanic White</th>
<th>Non-Hispanic Black</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 or older</td>
<td>72.2</td>
<td>74.0</td>
<td>58.4</td>
<td>64.9</td>
</tr>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 or older</td>
<td>72.0</td>
<td>73.5</td>
<td>59.3</td>
<td>65.4</td>
</tr>
<tr>
<td>65 to 74</td>
<td>74.6</td>
<td>76.3</td>
<td>61.6</td>
<td>68.7</td>
</tr>
<tr>
<td>75 to 84</td>
<td>68.3</td>
<td>69.4</td>
<td>56.4</td>
<td>59.7</td>
</tr>
<tr>
<td>85 or older</td>
<td>65.0</td>
<td>67.3</td>
<td>45.0</td>
<td>50.9</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 or older</td>
<td>72.4</td>
<td>74.3</td>
<td>57.8</td>
<td>64.6</td>
</tr>
<tr>
<td>65 to 74</td>
<td>75.2</td>
<td>77.5</td>
<td>59.3</td>
<td>68.5</td>
</tr>
<tr>
<td>75 to 84</td>
<td>69.8</td>
<td>71.7</td>
<td>55.3</td>
<td>59.3</td>
</tr>
<tr>
<td>85 or older</td>
<td>65.1</td>
<td>66.4</td>
<td>56.0</td>
<td>55.1</td>
</tr>
</tbody>
</table>

Source: Administration on Aging, 2000
Table 4
Percent Who Report Activities of Daily Living Limitations, 1994
Age 70 and Over

<table>
<thead>
<tr>
<th>ADLs</th>
<th>ALL</th>
<th>BLACK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing/Showering</td>
<td>8.2</td>
<td>11.5</td>
</tr>
<tr>
<td>Dressing</td>
<td>6.0</td>
<td>8.1</td>
</tr>
<tr>
<td>Eating</td>
<td>1.9</td>
<td>(na)</td>
</tr>
<tr>
<td>Getting In/Out of Bed or Chair</td>
<td>9.2</td>
<td>11.1</td>
</tr>
<tr>
<td>Walking</td>
<td>18.7</td>
<td>25.0</td>
</tr>
<tr>
<td>Getting Outside</td>
<td>7.5</td>
<td>11.0</td>
</tr>
<tr>
<td>Using Toilet</td>
<td>2.2</td>
<td>2.9</td>
</tr>
</tbody>
</table>

III. Culturally Appropriate Geriatric Care: Fund of Knowledge

Two important issues for effective geriatric care for African American elders are: 1) background knowledge of the historical events that have influenced their lives and attitudes toward health care, and 2) knowledge of their health beliefs and practices.

A. Health History

The following section was taken from the writings of the late Wilbur Watson published in Black Folk Medicine (1984).

There is general agreement that Black elders have traditionally been treated with great respect in their families. This tradition extends from known customs of preslavery civilizations on the African continent through modern customs among African American families and kinship groups in the United States. Griots, or indigenous oral historians were respected as repositories of cultural historical beliefs, legends, and facts (Watson, 1983). Their ability to recall and articulate their knowledge about former kings, wars, and important events in family or clan history--sometimes many centuries old--has been especially well respected. Even under recent conditions of the rapid industrialization of modern West Africa, Arth (1968) has observed that elderly Ibo of West Africa still enjoy great reverence in their communities. Ancestral workshop, and the belief that elders are closest to their ancestors, helps to contribute to respect for the living elderly. This custom is similar to that of the Chinese, who have traditionally venerated their aged, believing they were but one step removed from a spiritual union with their ancestors (Watson and Maxwell, 1977).

1. Up From Slavery (1619-1865). With the uprooting and importation of Blacks from West and South Central Africa, which began in the 17th century (around 1619) and marked the inception of slavery in the United States, the social conditions of life for people of African descent in North America changed sharply. From the inception of slavery through modern times, those Blacks who grew old in the United States had to withstand a variety of psychologically, physically, and socially degrading experiences resulting from the political economy of race relations in the United States. Among the determinants of the treatment of elderly Blacks in the social history of the United States, economic factors have had a significant bearing. For example, the economic interests of slave owners during the antebellum period of slavery in America made the situation of elderly disabled slaves especially tenuous. Genovese (1974) made the following observation about the economic and work-related determinants of the life chances of pre-Civil War elderly slaves:

The Whites of Maryland expressed outrage at the extent to which slave holders were manumitting their old slaves in order to escape responsibility for them. In Baltimore, as in other southern cities, incensed residents protested against the
influx of manumitted country Blacks who could only become a public charge, and fought for tough laws to curb the practice. No less staunch a pro-slavery writer than Dr. Josiah Mott of Mobile revealed the fragility of paternalistic concerns in his attack on the practice of insuring slaves. As long as the Negro is sound, and worth more than the amount insured, self-interest will prompt the owner to preserve the life of the slave; but, if the slave became unsound and there is little prospect of perfect recovery, the underwriters cannot expect fair play—the insurance money is worth more than a slave, and the latter is regarded rather in the light of a super-annuated horse (Genovese, 1974, p. 520).

Genovese also reported that some urban slave holders solved the problem of old, disabled slaves by sending them out to peddle or beg to bring in some income as well as support themselves. Insofar as White caretakers or owners were concerned, the antebellum (pre-Civil War) treatment of old, disabled Blacks ranged from full and kind concern to minimum attention to paternalism. In the negative extreme, there was indifference and sheer physical and mental abuse (Fisher, 1969).

Manumission may or may not have been an exceptional way of treating older slaves. Whatever its frequency, it was certainly not the only response to the old and disabled. It was disturbing to find in my archival research, although not surprising after reflection on the economics of chattel slavery that slavers quite often sought to sell or trade their old disabled slaves and acquire younger stock for fear of losing the investment they had made. One account reported that the appearance of "old slaves" were sometimes "doctored up," made to look younger than they actually were before they were sold. Youthful appearances would bring a better price (J. Brown, 1855, pp. 26-27; B. B. Brown, 1847, pp. 42-45, 92-93).

Among slaves, according to Frederick Douglass, youth were expected to respect the older slaves, less they risk severe reprimand. "A Young slave must approach the company of the older with hat in hand, and woe betide him, if he fails to acknowledge a favor of any sort, with the accustomed 'tank'ee'" (Douglass, 1855, pp. 35-40). The bonds and customs of deference among slaves, no doubt, functioned as sources of social and psychological support for old disabled slaves facilitating their coping with the harsh and inhumane demands of the slavers culture. Included among the means by which older slaves supported and cared for the health of each other was folk medicine (Smith, 1881, pp. 4-5). Support for elders was also provided by younger able bodied slaves who shared their returns from labor with the older disabled who were less able to fend for themselves (Steward, 1857, pp. 16-17).

2. Health and Longevity Since the Mid-19th Century. Despite the harsh living conditions of slavery, reconstruction and twentieth century separatism, older Blacks in the United States have continued to grow stronger and live longer. Some estimates placed the average longevity of Blacks at 21.4 years of age in 1850, with the average longevity for Whites at age 25.5.

The combination of lower living standards, greater exposure, heavier labor, and poorer medical care gave slaves a higher mortality rate than whites. The census of
1850 reported average ages of 21.4 for Negroes and 25.5 for Whites at the time of death. In 1860, 3.5 percent of the slaves and 4.4 percent of the Whites were over sixty. The death rate was 1.8 percent for the slaves and 1.2 percent for Whites (Stamp, 1965, p. 77).

These conclusions should not be accepted uncritically. The findings are based upon comparisons of aggregate data collected at the national level by the U.S. Bureau of the Census, 1850. Mortality data at the state level, for example in Virginia, for the same year did not show the same results. Savitt (1978, p. 201) found evidence that "more slaves than whites died of old age" between 1853 and 1860 in four Virginia counties. This suggests that some older Blacks lived longer than older Whites, at least in those counties. It was also reported that there were more centenarians among Blacks than Whites in 1850 (Savitt).

**a. Care of Older Slaves.** So far as Black centenarians that may have out-numbered Whites, it does not follow that older Blacks received better health care from slavers than older Whites. At least three other factors may have been operative even as early as 1850: (1) older Blacks may have been hardier in some physiological characteristics than their White counterparts and may have tended, as suggested by the crossover phenomenon, to outlive Whites after successfully coping with the health hazards that so frequently occur between childhood and mid-life. (2) While some slavers may have given humane care to older disabled slaves, it seems more believable that the care given by most was economically motivated. The longer the slave was alive and well enough to work, the greater the economic return the slaver received for his/her investment. This conclusion is consistent with the practice by some slavers of manipulating the appearances of old decrepit slaves to make them look younger, thus increasing the slavers' chances of getting a higher return when trading or selling their chattel on the auction block. (3) There may have developed within the "slave community" means of self health care that helped young and old slaves to withstand the hazards of everyday life during the antebellum period. As we have already suggested above, older Blacks among slaves were treated with deference and given health care by other slaves. Details about the kind and qualities of health care slaves provided each other are still not clear. But it is just as likely that what slaves did for themselves contributed significantly to their well being and longevity as did the support and interventions of the slavers.

**b. Changes Since 1900.** The foregoing discussion suggests that few Black elderly lived long enough to enjoy retirement, where that was permitted. Much less did elderly Blacks live leisurely and comfortably under slavery (Fisher, 1969; Genovese, 1974).

By 1900, some improvements had occurred in the longevity of Blacks: In 1900 the expectation of life for Negro females was 35 years and that of Negro males 32.5 years, as compared with 51 years and 48 years for White females and males, respectively. A Negro female baby born 30 years later could expect to live 49.5 years, or two years longer than a Negro male baby. At the same time, a White female baby had a life expectancy 13.2 years greater than a White male
Since 1940, there have been further improvements in the life expectancy of Blacks and Whites. Whether born in 1900 or 1976, White females could expect to live longest of all, followed in descending order by Black females, White males, and Black males, who had the lowest life expectancy of all in spite of these differences. The average life expectancy of each group, however, in 1976 was much greater than it was in 1900. Frazier (1957) observed that chronic diseases were especially important to any attempt to explain the differences between Black and White mortality rates. There were, for example, certain disease-related stressors that clearly had a greater negative impact on the health of Blacks than Whites and helped to explain the lower longevity of Blacks during the first half of the 20th century. At mid-century, Frazier observed the following:

After the age of five, the rates for the communicable diseases which characterize childhood are about the same for the two races. On the other hand, death rates for tuberculosis, influenza, nephritis, pneumonia, syphilis, homicides, and pellagra are uniformly higher among Negroes than Whites. Tuberculosis, influenza and pneumonia... are responsible for nearly three-fourths of the excess mortality among Negroes under 25 years of age. About 50 percent of the excess mortality among Negroes between 10 and 24 years of age is attributable to tuberculosis alone. Although in the older age groups tuberculosis accounts for a smaller proportion of deaths, influenza and pneumonia are important in all ages. For the group between 45 and 65 years of age (in the year 1950), nephritis and heart disease were responsible for 40 percent of the excess mortality (Frazier, 1957, p. 572).

Tuberculosis and pneumonia were also identified as causes of the high death rates among Blacks at the turn of the [20TH] century. Furthermore, the socioeconomic and psychological factors of ignorance, poverty, negligence, and intemperance were specified as major conditional factors helping to explain variations in the incidence of death by these diseases.

Although Blacks still die, on the average, at earlier ages than Whites, and men earlier than women in both races, many of the diseases identified above have been significantly reduced as causes of death since 1850. With the synthesis of penicillin in 1940 and its widespread prescription for rich and poor, Black and White, pneumonia has been brought under control. Along with other advances in medical technology and public-health measures (such as water and sewage treatments, nutrition education), improvements are being made in the overall quality of life in modern societies.

1) The Crossover Phenomenon. Closely related to the subject of differential life expectancy, is the crossover phenomenon. It should be noted that both Black females and males who were 80 years of age or older in 1976 had a longer life expectancy than their White female and male counterparts. This is referred to as the crossover phenomenon. Its name comes from the reversal in average life expectancy that
occurs between Blacks and Whites between 80 and 85 years of age. Both Black females and males tend to have a shorter life expectancy than their White counterparts up to age 80-85. Then, for reasons that are not entirely clear, there is a reversal in the pattern after 80 years of age.

This phenomenon is puzzling; and, unfortunately, there has been very little research aimed at developing insights that might help to explain the event. Some findings and suggested hypotheses for further study are worth noting. In a study by Manton, Poss, and Wing (1979), focusing on age-specific patterns of mortality of five leading causes of death, there were marked differences between Blacks and Whites. For example, circulatory diseases (cerebrovascular disorders) showed a consistent difference between Blacks and Whites from middle age through the later years of life. Among Blacks between 50 and 75 years of age, circulatory diseases produced a more rapid increase in mortality rates. This increase helped to explain the early Black mortality excess when compared to their White counterparts. By age 75-80, however, the excess for Blacks was overshadowed by Whites, who showed a more rapidly increasing rate of death due to circulatory diseases. Manton, Poss and Wing (pp. 297-299) have suggested a number of possible explanations for these apparent race related differences in life expectancy after 80-85 years:

- Blacks may have a greater susceptibility to hypertensive disease which, if related to physical exertion, social position, or difference in medical care, would probably be most manifest in middle age.
- The simultaneous action of hypertension and atherosclerosis among Blacks between 50 and 75 years of age may help to explain the high rates of death among Blacks due to circulatory disease in this age range.
- The greater susceptibility of Whites to atherosclerotic circulatory disease, which is also a disorder of advanced age, may help to explain the crossover phenomenon after 75-80 years of age.

Yet there are other points of view on this phenomenon. For example, Siegel (1972, pp. 54-55) suggests that the difference between Blacks and Whites at these higher ages may be explained by reporting errors in the census, especially with reference to the ages of Blacks. Moreover, some of the differences between the rates for Blacks and Whites may be explained by differential occupational, educational, and income factors (Kitagawa & Hauser, 1974; Siegel, 1972, p. 55). Clearly, this is an area in which there are more questions than answers at this point in the development of social gerontology as a field of knowledge. Further inquiry is required.

For a later set of possible explanations for the Crossover Phenomenon, see Manton and Stallard (1997).
B. Historical Experiences of Current Cohort of African American Elders

For information on the historical experiences of older African Americans that might influence their attitudes toward health and health care, see the Cohort Experience charts in Appendix B.

C. Health Beliefs

This section fosters an examination of historical conceptions of health and illness that may influence older Blacks in the U.S. Major portions of this section are based upon the studies of the late W.H. Watson published in Black Folk Medicine (1984).

1. Background. Individual and social reactions to illnesses among older Blacks have been multifaceted over the decades during and since chattel slavery in the United States. The differences have included variations in (1) categories and definitions of illness, (2) formal and common sense theories about the causes of illness and (3) modes of intervention to return the afflicted person to a state of health. Most of the literature can be divided into studies of traditional medicine and of modern biomedicine. Traditional, in this usage, refers to cross-generational patterns of thought about health and illness, and beliefs about remedies, such as herbs, that are sustained over time by simple observations and myths pertinent to their use value. Common sense theories that attempt to explain how the remedies work may span many centuries, with or without the support of scientific evidence. While modern biomedicine is dated from 1750 A.D., traditional medicine (sometimes called "folk medicine") is dated in some documents from as early as 1500 B.C.

2. Types of Healers. According to Snow (1974), practitioners of traditional medicine can be classified according to the healing practices they use and how they received the ability to heal. There are three ranks of healers, distinguishable by the sources of their healing powers: (1) those who learned the ability from others (these are the individuals considered to have the least amount of power), (2) older persons who received the gift of healing from God during a religious experience in later life (these are middle rank in power), and (3) those who are born with the gift of healing, the most powerful (Snow).

Root and herb doctors are included among the groups who learned to heal from others, and are believed to have the least amount of healing power (Snow, 1974). The services of a root doctor, who is a type of conjurer, are sought either to place a hex on someone (or induce an illness condition) or to ward off evil (de Albuquerque, 1981, p. 51). Root doctors may also be consulted for help in changing a person's luck, especially in interpersonal relationships. Roots are objects that are believed to have magical powers and can take many forms including dolls, colored stones, and red flannel bags as well as roots of plants grown domestically or in the wild (de Albuquerque). The color of the root also helps to determine its effectiveness. "A blue root wards off evil and helps in love affairs; a black root is called a death root; a red root causes evil things to happen to a person" (Hurston 1970, pp. 338-39, Roberts &
Roberts 1976, p. 52).

According to Mitchell (1978), faith or spiritual healers are practitioners with the greatest power, and are believed to have received the gift of healing from a god. They regard themselves as vessels through which the divine will is made manifest (Hand, 1980). The laying on of hands, prayers and incantations are the methods most used to treat spiritual illness. Most individuals who acquire the power through learning or an apprenticeship are able to treat natural and/or occult illnesses, but the person who is born with the power or who receives the gift from a god is believed to be able to cure all illnesses. See the discussion below on causes of illness and approaches to intervention.

In contrast to modern biomedicine, when diagnosing disorders and selecting treatment plans, practitioners of traditional medicine tend to depend more upon: (1) the patient’s trust that the doctor has accurately perceived and properly negotiated with the patient the nature of the disorder and the treatment needed, (2) the patient’s faith in the healing powers of the doctor, and (3) the stock of folk remedies available in the cultural knowledge system of the society.

Regardless of the approach to treatment of illness, whether by a biomedical or a folk practitioner, health is thought of as a state of individual well being. Although not admitted by all folk medical practitioners, healthiness may be sustained and/or achieved through internal bodily processes, such as homeostatic mechanisms, as well as life style characteristics that include purposeful health behavior. The range of beliefs among traditional medical practitioners, unlike their biomedical counterparts, include the contention that spiritual forces can intervene in human affairs to influence sustaining and/or restoring health of an individual. Purposeful health behavior by an individual is conceived as action taken deliberately to sustain and/or achieve a state of well being. Such behavior may include following a program of exercise, a planned diet or medical regimen either of which (or a combination thereof) may be believed to be associated with healthful outcomes.

3. Causes of Illness and Approaches to Intervention

In some traditional African systems of thought, it is believed that when one has good health, one is in harmony with nature. If one is ill, a state of disharmony is said to exist (Watson, 1984). This holistic notion of health, however, is not peculiar to African systems of thought. Among the various systems of traditional medicine, most illnesses can be classified as having a natural, occultist, or spiritual origin (Murdock, 1980).

a. Types of Illness. A natural illness is a result of a physical cause, such as infection, disease, weather, and other environmental factors. Treatments of natural illnesses emphasize the uses of herbs, barks, teas, and similar natural substances. An occult illness is a result of supernatural forces, such as evil spirits, and their agents, such as conjurers (Simpson, 1970; Tallant, 1946). Evidence of occult illnesses
and concerns about the treatment thereof is equally as prominent in the literature on traditional medicine as are reports of natural illnesses. There are two important distinctions between natural and occult illnesses: (1) Occult illness is a result of supernatural, not physical causes. The conjurer uses his or her powers, as well as fetishes to induce and/or ward off illness in specific individuals. (2) While natural causes primarily induce physical illness, conjuration may affect the physical and psychological as well as the spiritual life of the person (Mitchell, 1978). Finally, spiritual illness is a result of a willful violation of sacred beliefs or of sin, such as adultery, theft or murder (Mitchell). Like the occult, spiritual forces can affect all aspects of life, ranging from the physical to the spiritual characteristics of the person (Simpson, 1970; Willer, 1971).

The foregoing discussion suggests a close relationship between the presumed cause of an illness and the type of intervention needed to correct the malady. For example, Sea Island Blacks believe that physical disorders, such as respiratory congestion and skin rash, are due to natural causes and can be treated by modern medical doctors, herbalists and other doctors of natural illnesses (Mitchell, 1978; Simpson, 1970). By contrast, illnesses and accidents that are believed to be caused by occult forces or their agents require the powers of a conjurer to produce and execute the correct treatment. In many small societies, conjurers are believed to have the ability to summon a supernatural force, such as a devil or evil spirit, either to do harm, such as inducing an illness or to expel a disorder. By the use of spells, sacred names, incantations and other magical media, the conjurer is able to summon the expression of supernatural forces. Finally, it is the power of a god acting through a religious healer or medium that is required to diminish spiritual illness or induce a return to health in the character of a person believed to be suffering from spiritual illness.

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IV. Culturally Appropriate Geriatric Care: Assessment

A. Cultural Biases and Misdiagnoses

The following section is taken from the writings of Wilbur Watson.

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In addition to the insights from examining the basic assumptions and concepts that help to shape the perspectives and practices of believers in bio- and traditional medicine, there are also non-rational factors that operate between practitioners and older clients/patients helping to influence practitioner-patient interactions and patient outcomes. Cultural biases about health and illness, and beliefs about which individuals and/or groups are most susceptible to one or another disorder are key among these factors.

Clearly, both health care practitioners and patients have cultural backgrounds through which perceptions of each will be filtered. This discussion, however, is focused on the biases of practitioners when observing their patients. Biases are prejudicial points of view focused upon an object represented by selected perceptions framed by a particular sociocultural background, such as racist beliefs about differences between Blacks and Whites in the United States. The influences of biases on decision making are often unintentional, expressed nonconsciously, and as a consequence may be difficult to control in the doctor-patient relationship.

For example, it was once believed that high rates of hospitalization for the treatment of selected mental disorders among African Americans was due to an "inherent racial susceptibility" to certain kinds of psychopathology (Thomas & Sillin, 1972; Williams, 1986). It was also believed among some psychiatrists that African Americans, as a group, tended to have low rates of depression because of their historical social and educational oppression. Somehow, being oppressed and deprived functioned as a social psychological shield against depression: Blacks were less vulnerable because they had less to lose (Prange, 1962). Epidemiological and etiological research have subsequently shown that depression and other illnesses are much more complex disorders than that suggested by the foregoing statements and must be carefully studied, including cross-cultural variations in symptoms of disorders before drawing conclusions and formulating treatment plans.

Other studies suggest that the failure to accurately diagnose symptoms of depression, manic depression and other disorders among African Americans sometimes results from preconceived notions that Blacks are "happy-go-lucky" people or some other stereotype (Adebimpe, 1981; Poussaint, 1983; Williams, 1986). Cultural insensitivity and deeply rooted prejudices, along with a lack of cross-cultural study by professionals focusing on the cultural backgrounds of their clients/patients contributes to risks of misdiagnoses and inappropriate treatment plans, especially but not exclusively in the care of older Blacks with mental disorders.

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B. Showing Respect

Particularly because of the experience of many African American elders who grew up with segregated health care and social service systems in which they faced continual discrimination, it is extremely important to show respect to them in clinical settings in order to put them at ease and establish rapport. This includes at the least, using respectful titles (e.g., Mr., Mrs.) unless they give the clinician and staff permission to do otherwise.

The knowledge of the 40-year Tuskegee Experiment, which recruited African American men with syphilis to be a part of a research project in which they were promised but never given treatment, is widely known in the African American community. This memory, in addition to the widespread discrimination most have faced in their lifetimes, are likely to provide reasons for African elders to be more than a little suspicious of health care providers, especially those who suggest any type of experimental treatment or research. Clavon (1986) and others have emphasized the importance of recognizing and respecting patients’ cultural habits, listening attentively, and encouraging conversation.

Providers have also been encouraged to examine their attitudes and stereotypes of elders from different racial and ethnic populations, especially African Americans, in light of the findings implicating referral patterns of providers in the differential utilization of services. (See the discussion in Section V.)

C. Use of Assessment Instruments

The variation in reports of the prevalence of dementia warrants carefully chosen instruments to assess cognitive and physical status in African American elders (Froehlich et al., 2001) Baker (1996) reports differences in the validity of cognitive measures with African American elders. The Activities of Daily Living scale and the Short Portable Mental Status Questionnaire are two tools that have been specially tested and shown to be reliable and valid with older African Americans (Mouton, 1997).

D. Adapting Assessment Techniques to Skin Color

Since African American elders have a wide range of skin color, it is very important for nurses and physicians to use appropriate assessments that reflect skin tone changes for conditions such as cyanosis. Skin color changes in decubitus ulcer formation are not readily apparent in dark pigmentation, so that actual skin breakdown often occurs before formation is noted (Richardson, 1996).

For a complete listing of the domains of assessment in ethnogeriatrics, see Module IV of the Core Curriculum in Ethnogeriatrics.
IV. Culturally Appropriate Geriatric Care: Treatment

A. Specialized Procedures in Cardiac Care

Numerous studies in the late 1980s and 1990s found that African Americans are less likely to undergo cardiac catheterization and coronary-artery bypass graft surgery than their White counterparts. Most studies have controlled for insurance status, but one study found that there were no effects of race among patients with private insurance. Correlates of the racial differences have included: financial or organizational barriers; clinical differences; and amount of contact the patients have with the health care system or hospitals that offer invasive cardiovascular services (Shulman, et al., 1999).

One particularly insightful study compared referral patterns of 720 internists and family physicians in videotaped interviews of scripted Black and White heart disease patients age 55 and 70 played by professional actors. Care was taken to keep all extraneous factors constant in the scripted scenarios, which were identical between the two racial groups. Analysis of race-sex interactions showed that Black women were significantly less likely to be referred for cardiac catheterization than White men (odds ratio, 0.4, 95% confidence interval, 0.2 – 0.7; p=0.004). There were no significant differences for White women or Black men compared to White men (Shulman et al., 1999). The authors state (Shulman et al., pp. 624-625):

Our findings suggest that a patient’s race and sex may influence a physician’s recommendation with respect to cardiac catheterization regardless the patient’s clinical characterization. Alternatively, these findings may be the result of other factors not included in the information we presented to the physicians. For example, data on bypass surgery and angioplasty suggest that women may have worse outcomes than men, although these effects may be due to difference in other confounding variables rather than to the sex of the patient. Why these clinical effects would influence recommendations for black and not white women is unclear.

-----Our finding that race and sex of that patient influence the recommendations of physicians independently of other factors may suggest bias on the part of physicians. However, our study could not assess the form of bias. Bias may represent overt prejudice on the part of physicians or, more likely, could be the result of subconscious perceptions rather than deliberate actions or thoughts. Subconscious bias occurs when a patient’s membership in a target group automatically activates a cultural stereotype in the physician’s memory regardless of the level of prejudice the physician has.

B. End of Life Care

Active end of life care planning is not an unfamiliar concept to most African American elders. Providers who have these discussions, however, should remember that elders might be reluctant to participate due to an understandable mistrust in the health care system based on past history of segregation and discrimination toward African Americans. Several studies suggest that African Americans are less likely to complete advance directives such as do-not-resuscitate (DNR) orders or living wills
Elders may feel that if they decided to opt for “do-not-resuscitate,” that would give the system the license to provide sub-standard care or give up on them ‘too-soon’. Religious beliefs may also play a role, in that many older African Americans believe that God is ultimately in control, and is the only one who can determine the timing of death.

Among both African American patients and physicians, more have been found to favor aggressive life prolonging treatment in the case of terminal illness than among comparison White groups (Caralis, 1993; Hopp & Duffy, 2000; Mebane, Oman, Kroonen, & Goldstein, 1999; Mouton, 2000). Mouton (2000) points out that life support may be equated with life, and that any effort at withholding life-sustaining therapies might be seen as another attempt of genocide by predominantly Caucasian institutions, recalling the history of unethical experiments on African Americans, such as the Tuskegee Syphilis Study. Some will request tube feeding even in the face of terminal illness. Providers, then, should be very sensitive to issues regarding refusal or withdrawal of tube feedings.

Some African-American families may request that certain diagnoses or disease prognoses be withheld from the patient to shelter them from disturbing information. Other patients and families favor forthright discussion of all medical issues and treatment plans. Some patients may prefer that their loved ones be the conduits for information. So direct provider-patient communication may be limited by patients’ desire not to know the full implications of their illness.

The loved ones may be a patient’s family members or ‘fictive kin’. ‘Fictive kin’ are people that are considered ‘family’, as the result of longstanding relationships, but may not be linked directly by blood ties. These individuals may be serving as the primary care giver or even as the surrogate decision makers and may be sometimes more involved than the directly related family members.

Extreme tact and sensitivity are called for when having discussions about advance care planning and end of life issues. Ensure that you have adequate time and that patient’s family is present. Since trust is so critical in adequate end-of-life care with African American elders and their families, it is very important for the provider to have built a trusting relationship with the patient and family in the past. In all cases it may be helpful to ask the patient or family their understanding of the illness and treatment options, and use this as the basis for further discussion. Also many of the elders may have strong religious beliefs, and so having a trusted spiritual counselor as part of the team may be helpful for patients.

C. Health Promotion

See recommended procedures based on risk in Module V of the Core Curriculum in Ethnogeriatrics.
VI. Utilization and Access

It is important for providers to understand that cultural norms, historical context, the value of family, and religious beliefs are key determinants of social and kinship networks which in turn affect health behavior and outcomes in all elders, including African American elders. Belief systems and tradition impact on health care utilization and provide a basis on which health care providers should deliver culturally sensitive care. Literature has shown that older African Americans are more likely to rate their health as fair or poor than White elders and are less inclined to seek health care early in the course of a disease. African America elders are less likely to practice preventive health behaviors such as obtaining breast or prostate cancer screening. On the other hand, health providers are less likely to offer some of these services to African American elders than they are to their White counterparts. Religion plays a major role in determining the health beliefs and behaviors of African American elders. Quality of life and life satisfaction are enriched by increased frequency of contact with friends and the availability of family help (Adams & Jackson, 2000).

A. Social and Kinship Networks: Use and Effects on Health Behavior

Much of the research on informal networks, church supports, and extended family in the Black community was done in the early to mid 1980s. Intergenerational family support and support from the extended family has been the hallmark of health care in the African American community. Formal and informal supports are used by both Whites and Blacks in need of help. However, Blacks have more active social support networks, with mechanisms in Black families that serve to expand network membership through creation of "fictive" kin (Johnson, 1990). Family support behavior among Blacks is grounded in respect for each generation. Among older African Americans, much of this support is the result of socioeconomic factors (Mutran, 1985), although cultural tradition is pervasive in caregiving to parents, siblings and other relatives (Fried & Mehrotra, 1998). Studies have shown high levels of social interaction and strong emotional bonds between elderly blacks and their extended families, which is facilitated by the presence of an adult child and proximity to immediate family and relatives (Taylor, 1991).

1. Informal Caregiving. Comparisons of informal caregiving by Black and White older adults showed that Blacks were more likely to be caregivers and more likely to assist friends. Blacks have frequent contact with family, relatives, friends and neighbors, although they utilize the members of their network differently for emergency and non-emergency situations (Petchers & Milligan, 1987). It has been noted that the probability of caregiving in African Americans increased in those who are married, with substantial amounts of care to others with health problems and disability provided by those older than age 65 (McCann et al., 2000).

Receiving formal services was found to have no association with a reduction in use of informal service supports among Blacks. In testing two contradictory hypotheses,
"compensatory" and "substitution," substitution of formal services for informal services was found to be the case in Whites (Miner, 1995). Similar research has shown that African American females receive more help from relatives and friends, while males tend to receive more assistance from their families. In cases of childlessness, support was received from varied sectors—family or the formal support network. In the case of some of the oldest old African Americans, particularly females and those without children, the principle of "substitution" was operative (Perry & Johnson, 1994).

In a study of African American caregiving for a relative with Alzheimer's disease, it was shown that caregiving, a traditionally female role, is not only a traditional family value, but an act of love, and that frequently, social supports serve to mediate caregiver burden (Steritt & Pokorny, 1998). It has been noted that Black caregivers report less depression than White caregivers and have greater self-efficiency in managing caregiving problems (Haley et al., 1996). Although African Americans have been found to be in potentially more severe caregiving situations than Whites, they had more favorable psychological indicators of stress. While Black and White caregivers differed in coping responses, they did not differ in social supports in caring for someone with Alzheimer’s disease (Wallsten, 2000).

2. Long Term Care. African American elders are frequently supported in adhering to their health care regimens by family members, rather than formal support providers. Family members also act as coordinators of care, including transportation, medication management, diet, exercise and monitoring chronic illness (Jennings, 1999). This is further supported by the fact that most African Americans with functional disabilities and health problems remain at home, with supportive care provided by immediate or extended families and informal support networks in the church or community. Past experiences of Black elders have demonstrated that utilization of institutions for the purpose of "rehabilitation," rather than as nursing homes was more common (Mavundla, 1996). Lower rates of institutionalization by older African Americans have been accounted for by higher use of paid home care, informal-only care or no care (S. P. Wallace, Levy-Storms, Kington, & Andersen, 1998).

In 1999, data was released by the National Center for Health Statistics that for the first time showed nursing home utilization by African Americans equal or greater than that by older White Americans in most age and sex categories. (See Figure 1.) In all of the three age groups of older men, and in all but the oldest women, a higher proportion of Black elders resided in nursing homes.
Nursing Home Residents

Figure 1

Source: Kramerow et al., 1999, p. 86.
3. Role of Church and Religion. In a study looking at frailty and family and church support among African American elderly, the frail elderly were more likely to use community services and less likely to report feeling close to family. However, it was noted that family contact, feeling the church was important, and receiving church support was the same for both the frail and non-frail, thus emphasizing that one cannot assume that families and churches support the most vulnerable elderly (Bowles et al., 2000).

The value of religion, reading religious materials, listening to religious programs, prayer and other forms of non-organized religious participation are part of the fabric in the life and culture of older African Americans. Studies done in the early 1990s indicate that while the church is a significant contributor to feelings of well-being in elderly Blacks, the family network is viewed as more supportive than the church network (Walls & Zarit, 1991). Later reviews of the literature suggest that churches provide significant amounts of "non-kin" support to older African Americans. Particularly in rural communities, or communities with few services, churches play a special role, often serving as the "provider" of services. Ministers and church members form part of the caregiving and "expressive" or emotional support network needed by the older adult. The frequency of church attendance has been found to impact the amount and frequency of care received. It has been noted that for certain groups of elderly African Americans, friends and church members may be of greater importance than previously thought (Fried & Mehrotra, 1998; Taylor & Chatters, 1986).

The role of church-based programs in enhancing social integration for older African Americans and building a community-based infrastructure of supportive and health-related services cannot be overlooked. In many communities, the church may be the site of: a senior nutrition center or medical day care program; blood pressure and other medical screenings; provide immunizations; outreach programs; home care services such as shopping, friendly visiting, meals; or a senior citizen subsidized housing facility. By providing direct services, churches therefore act as a supplement to informal family caregiving and are positioned to refer to other community-based service agencies (Fried & Mehrotra, 1998).

C. Health Promotion

When exploring outcomes and quality of care, it is important to note that African Americans tend to emphasize the "process" of care (Fongwa, 2001). Consistent with what is reported anecdotally, African Americans are at risk of underutilization of preventive services. In a large epidemiological study of cancer prevention services among men and women age 70 and over in the Piedmont area of North Carolina, the Black respondents reported significantly lower use of Pap testing, clinical breast examination, mammography, rectal examinations, and fecal occult blood testing. When levels of education, income, and insurance coverage were controlled for, however, the racial differences in cancer prevention services were no longer significant (Hegarty, Burchett, Gold, & Cohen, 2000). Increasing frequency of office or
clinic visits can significantly impact prevention in this population and improve outcomes (Wright, Fortinsky, Covinsky, Anderson, & Landefeld, 2000).

African American elders may rely on varied resources to gain medical education and to take care of themselves. This includes traditional health care providers, but because of cultural and religious beliefs they may rely on less traditional providers or input from clergy or other African American folk remedies (Fahie, 1998).

**B. Barriers to Access**

Access to health services differs among races and is influenced by income, geography, culture, and type of health care coverage. Based on personal history and experience, many African Americans view receiving health care as a degrading, demeaning or humiliating experience. Some may even fear or resent health clinics, because of the long waits, medical jargon, feelings of racism or segregation, loss of identity, and a feeling of powerlessness and alienation in the system (Spector, 2000). Often poverty, lack of transportation, or non-compliance with previously prescribed therapeutic regimens act as further deterrents for older African Americans to seek health care.

One study demonstrated that community-based service use was significantly lower among black diabetic elders (Witucki & D. C. Wallace, 1998). Recent studies about access to health care, utilization rates, health status and outcomes have been done for many specific disease categories. In general, poorer health status among African Americans was not found to be influenced by access to health care (Harris, 2001).

Numerous studies about access to health care which look at the role of race and income have been done. Studies on limited access to health care by older African Americans due to economic inequalities, discrimination, and life style factors are inconsistent, although health status and insurance have been important predictors of use (Miller et al., 1997). Many elderly African Americans are categorized as "dually eligible" for both Medicare and Medicaid. In many instances, these individuals are enrolled in a managed care plan or are served by a community health center. It has been shown that clinics provide better access to dual eligibles than non dual-eligibles and to non-White compared to White dual eligibles (Basu, 2001). Persons with Medicare and private or Medicare and public coverage (Medicaid) are more likely to have a regular source of medical care, although older adults on Medicare and public assistance or Medicare only coverage were twice as likely to have unmet medical needs than those with Medicare and private insurance (Cohen, 1997).

Access to health care and health-information seeking behavior are influenced by mobility, literacy, social networks, and community structure. African Americans are more likely to live near high-technology hospitals than Whites, but are not as likely to travel to a high-technology hospital to obtain care (Blustein & Weitzman, 1995).
D. Recommendations for Increased Utilization of Health Care Services

In conclusion, provision of health care to older African Americans must give consideration to culture and tradition, with the acknowledgement that social and kinship networks, community, extended family, and the church are all significant players in the health care and support service system. Identification of unique points of access to health care and supportive services will differ by community, but must be the focus of the contemporary health care provider who is serving African American elders. Community leaders, church elders, and other "communicators" should be incorporated in Boards and be involved in health care planning for the community. It is only through cultural awareness and sensitivity that improved access to and utilization of health care services, positive health behaviors and successful outcomes will be attained, not only for African American elders, but for all racial and ethnic groups.
INSTRUCTIONAL STRATEGIES

1) Visit a local nursing home or personal care home for older Blacks for a pre-arranged question and answer session featuring older Blacks (men and women, preferably) talking about the history of their health and health care.

2) Participant observations through grand rounds and/or case conferences can also be useful ways of developing and reinforcing insights into conceptions of illness and treatment approaches.

3) Invitations to a traditional medicine practitioner to make a class room presentation and/or visit his/her office to discuss his/her conceptions of illness, treatment and health.

4) Observe a case conference of an interdisciplinary team meeting with a focus on an older Black patient.

5) Assigned readings, lecture, and discussion can be augmented with the following assignments:

   a) downloading the latest data on life expectancy and mortality rates for elders from different ethnic populations from web sites (e.g., Trends in Health and Aging at www.nchs.gov) and making comparisons,

   b) interviewing African American elders on the help they give and receive, or other specific topics (see suggestions for organizing interviews in Appendix C of the Core Curriculum in Ethnogeriatrics),

   c) presenting the results of the interviews in class to compare and discuss similarities and differences,

   d) group projects that address individual disease risks, such as diabetes, by researching the ethnic specific incidence and prevalence for African Americans, their risks of complications, followed by conducting interviews with African American elders who have the disease,

   e) a field trip to a historical museum (e.g., Carver Museum in Tuskegee, Alabama) on African American History to see film, pictorial displays and other objects pertinent to the health history of Blacks,

   f) film and video, such as “Old Black and Alive” produced by the National Center on Black Aged, Washington, D.C.,

   g) problem posing discussions
**Cases**

**Case of Mrs. H.**

Mrs. H. is an 83-year-old African American woman with Type II Diabetes and severe diabetic retinopathy. She is widowed and lives alone in a small house she bought with income from 45 years of working as a domestic. She is very proud of her home but cannot see well enough to keep it up. She has two surviving children, but both live several hundred miles away, and she doesn’t see them often. Until two years ago she was active in the local senior center where she participated in crafts programs. She was also active in her church. Now, however, unless someone comes by to pick her up, she can’t participate in either because she can’t see well enough to walk or take the bus.

Her physician recently retired and referred her to a new doctor. She called the senior transport service for a reservation for the day of her appointment and was told they would have to pick her up three hours before her appointment because the day was so busy. When she arrived at the clinic, the receptionist asked her lots of questions and asked Mrs. H. to fill out many pages of forms. Finally after two hours of waiting, the nurse came to the waiting room and called, “Ruby, the doctor is ready to see you.” The doctor seemed rushed and preoccupied. During their conversation he told her about a new research project she was eligible for that would provide a new treatment for her diabetes, low vision assistive devices, and homemaker services. She said she would think about it.

When the nurse called two days later to enroll her in the project, Mrs. H. said she didn’t want anything to do with the experiment and didn’t want anyone coming to her house.

**Questions for Discussion:**

1. What could have accounted for Mrs. H.’s negative reaction to the opportunity for extra help?

2. What could have been done to make Mrs. H.’s initial experience with her new doctor more satisfactory?

3. What kind of assistance might be given to Mrs. H. and how might it be made acceptable?
Case of Mrs. W.

Mrs. W., a 78-year old African American woman, was brought to the emergency room (ER) complaining of severe abdominal pain. Her history revealed intense chronic abdominal pain for ten years that had begun soon after she had back surgery. She had initially seen many doctors for the pain. The physicians had done multiple tests over the years including an upper and lower endoscopy, and a CT scan several years ago (which had been negative at that time). Mrs. W. had been told that she probably had irritable bowel syndrome and was advised about diet and life style changes. A few months ago, Mrs. W. had switched providers again, and this provider had detected an anemia and splenomegaly on exam and did a redirected work up which revealed Acute Myelogenous Leukemia (AML). The physician explained that fact briefly to Mrs. W. and scheduled her to be seen by an oncologist. Mrs. W. did not follow up with the oncologist as she felt that the oncologist would be just another new physician that she had to deal with who probably would not be able to help her to feel better. She quite frankly was tired of seeing multiple providers and getting numerous tests and still having to endure the suffering imposed by the pain, which the physicians were not trying to alleviate.

The ER doctor reviewed Mrs. W.’s records, gave her one shot of Demerol (which partially helped her pain but made her feel ‘phased-out’), and criticized her for not following up with the oncologist. “But, I don’t have bone cancer; my bones don’t hurt. What is wrong with you doctors? It is my stomach that hurts. not my bones” complained an irate Mrs. W. who couldn’t see any connection between her stomach pain and tests they had done on her bone marrow.“ In her mind, Mrs. W. couldn’t understand how she could have leukemia because her symptoms did not match those she had been told were part of leukemia – fatigue and fever, in particular. “No cancer,” she kept telling her doctors, “I know I don’t have it.” To her the diagnosis didn’t explain her abdominal pain.

The physicians could not understand why Mrs. W. was clearly refusing to see and accept the evidence that was so clear and obvious for leukemia. “She is in denial,” declared the ER doc and called for an oncologist consult. The oncologist who reviewed her records and examined her felt that at this point, hospice would be the best option. So the ER doctor called for the hospice nurse to consult. The hospice nurse went in to see Mrs. W. and started talking about home hospice. Suddenly Mrs. W. started to sob uncontrollably and scream, “You are trying to kill me,” over and over again.

Shortly before Mrs. W. died four weeks after that last diagnosis in the ER, she said, “They take the x-rays. They give me every kind of test. But I still don’t know any more than I did before I went to the doctors.”

Background: The frustration from the endless search for relief had brought Mrs. W. to the conclusion that the reason doctors would not identify and treat her pain was that during that first surgery some medical error must have occurred. She assumed the error was apparent to every subsequent doctor who examined her. By the time she came to
the emergency room and was hospitalized for what was to be her last time, her distrust had blossomed into a conspiracy theory.

Questions for Discussion
1. How might knowledge of African American health history and the experiences of Mrs. W.’s cohort have helped the health care providers understand her lack of acceptance of the diagnosis?

2. What types of interventions might have helped Mrs. W. understand and cope with her situation more realistically?

3. If the health care team felt that Mrs. W. was terminally ill, what recommendations would you have for them for talking about end of life care in a culturally appropriate way?

*This case is adapted from an article by LaVera Crawley (2001) featured in the Knight Ritter/Tribune newspapers.
STUDENT EVALUATION

Health status information in this module lends itself to objective questions to evaluate student’s retention of the information. Essay questions can be used to evaluate their understanding of the sources and limitations of the data. Group projects, individual written and oral reports, short essay exams, and multiple choice tests can also be used in the evaluation of student performance. The cases in the Instructional Strategies Section can be used as take home or essay questions. Some other examples of pre-/post-test questions are given below.

1. To the best of your knowledge describe the health care of older Blacks during the antebellum period of the United States. How did slavers differ in their care of older disabled slaves? In what way did slaves care for each other?

2. To what extent did health care for older Blacks improve after the Civil War? What were the indicators of improvement or the lack thereof?

3. Describe twentieth century developments in the health and health care of older Blacks.

4. Write a brief definition of the following terms:
   - Natural illness
   - Occult illness
   - Spiritual illness

5. Describe the problem of misdiagnosis and the nature of cultural bias in medical practices as it applies to elders from African American backgrounds. How can biases be minimized in health professional practices?

6. How does the role of the church and religion affect health and health care for African American elders.

7. Name three conditions for which older African American are at increased risk; name two for which they are less risk than other older Americans.
REFERENCES


INTERNET RESOURCES

WEBSITES:


http://www.census.gov.


http://www.cdc.gov/nchs/fastats

http://www.cdc.gov/nchs/products/

http://www.cdc.gov/nchs/datawh.htm

http://www.cdc.gov/nchs/about/otheract/aging/trendsoverview.htm

SUGGESTED READINGS


Jackson, J. S. (Ed.). (1988). *Black American elderly: Research on physical and
psychosocial health. New York: Springer.


Appendix A

KEY TERMS

**Antebellum** - events belonging to the period prior to the Civil War in the United States.

**The Crossover phenomenon** - The probability that an older Black American will live longer than his or her White counterpart after a given age.

**Conjure**: To summon a devil, spirit, or supernatural force to appear or act by invoking a sacred name or by some spell; to call forth or send away by magic arts.

**Fetish**: A Portuguese word meaning charm; may also be called a Talisman. A material object, whether natural, as the tooth or claw of an animal, or artificial, as a carving in wood or bone that is believed to possess magical powers or to be endowed with energies or qualities capable of bringing to successful issue the designs of the owner, preserving him from injury, curing disease, etc. The fetish is regarded as the abode, sometimes temporary, of a supernatural spirit or power, and gains its potency from the indwelling of the spirit.

**Fictive Kin**: people that are considered ‘family’, as the result of longstanding relationships, but may not be linked directly by blood ties.

**Holistic health**: individual is in harmony with nature; body, mind and spirit are in harmony or balance.

**Longevity** - the average number of years lived by members of a group.

**Manumission** - the act of freeing a slave.

**Natural illness**: a result of a physical cause, such as infection, disease, weather and other environmental factors.

**Occult illness**: results from supernatural forces, such as evil spirits, and their agents, such as conjurers. May affect the physical and psychological well being as well as the spiritual life of the person.

**Paternalism** - protection and control, like that of a minor child by a parent, exercised by the government over the governed employer over employee, or in similar relationships such as slaver over slave, or the United States Bureau of Indian Affairs over Native Americans on reservations.

**Spiritual illness**: a result of willful violation of sacred beliefs or sin, such as adultery, theft, or murder. Can affect all aspects of life.
## AFRICAN AMERICANS
### SIGNIFICANT DATES AND PERIODS IN RECENT HISTORY

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PERIODS AND EVENTS</th>
<th>POPULATION (in 1000s)</th>
</tr>
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<tbody>
<tr>
<td>Late 1800s</td>
<td>Chaos of Reconstruction Era in South; legal marriages, families united after emancipation; violence toward colored people, Ku Klux Klan founded, schools for freedmen burned; “Separate but Equal Doctrine” legalized inequality, Jim Crow Era began; Tuskegee Institute founded by Booker T. Washington, and other Historically Black Schools and Colleges founded; first colored graduate from West Point.</td>
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<tr>
<td>1900 - 1909</td>
<td>National Association for the Advancement of Colored People founded by leading members of white and colored communities, including W.E.B. DuBois; initial migration of colored people from the South to the urban North.</td>
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<tr>
<td>1910 - 1919</td>
<td>The Urban League was founded to assist migrants; WWI included 100,000 Negro soldiers who fought overseas; colored units honored for their valor; Ku Klux Klan (KKK) active; “Red summer” when GIs and others victims of bloody anti-colored rioting.</td>
<td>9,800</td>
</tr>
<tr>
<td>1920s</td>
<td>KKK claimed 5 million members; 40,000 robed Klansmen marched in Washington, DC; one million Negroes migrated from the South to the urban North; rise of arts and music, especially jazz, centered in Harlem; Marcus Garvey preached racial pride and &quot;Back to Africa&quot;; labor and radical political movement emerged; Brotherhood of Sleeping Car Porters affiliated with AFL.</td>
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<td>1930s</td>
<td>Depression: thousands lost jobs and sharecroppers destitute; Negro political leaders assisted in framing New Deal; poll tax, segregated schools and anti-miscegenation laws existed in South; de facto segregation in North; track star Jesse Owen won Olympic gold; Marion Anderson denied right to give concert; Social Security legislation enacted; Hitler invaded European countries; boxer Joe Lewis became an idol for Negroes.</td>
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<td>1940s</td>
<td>Over a million Negro men and women served in segregated armed forces in World War II; Tuskegee Airmen fought with distinction; Executive Order 8802 banned discrimination in defense plants prompting migration to North and West; armed forces officially desegregated.</td>
<td>11,800</td>
</tr>
<tr>
<td>1950s</td>
<td>Korean War; Brown vs. Board of Education Supreme Court ruling ended “Separate but Equal Doctrine” in education; Montgomery Bus Boycott began non-violent Civil Rights Movement; lunch counter sit-ins and civil disobedience began; Jackie Robinson first Negro baseball player in major leagues.</td>
<td>12,900</td>
</tr>
<tr>
<td>1960s</td>
<td>March on Washington; President Kennedy assassinated; President Johnson signed Civil Rights Act and Voting Rights Act; Medicare legislation enacted; Vietnam War began; Martin Luther King, Jr. and Robert Kennedy assassinated; riots in Northern cities resulting in white backlash.</td>
<td>18,900</td>
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<td>1970s</td>
<td>Affirmative Action implemented gradually; increasing number of elected Black officials; increasing political conservatism; TV series “Roots” taught Black history.</td>
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<td>1980s</td>
<td>Jesse Jackson ran for the nomination for President of the U.S. twice; Rainbow Coalition established; Dr. Ronald McNair died on the Space Shuttle Challenger; rise of the Black Muslims.</td>
<td>28,900</td>
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<td>1990s</td>
<td>War with Iraq; Healthy People 2000 set goal to improve minority health; Dr. Mae Jamison was first Black female to fly in space; Rodney King beaten, African Americans riot in Los Angeles; Million Man March, Million Woman March; affirmative action legislation reversed.</td>
<td>30,000</td>
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### COHORT EXPERIENCES - AFRICAN AMERICAN ELDERS

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<tr>
<td>Urban migration</td>
<td>Harlem Renaissance</td>
<td>WWII: segregated troops; factory work in North &amp; West</td>
<td>Civil Rights Movement &amp; Law</td>
<td>Jesse Jackson ran for President</td>
</tr>
<tr>
<td>NAACP and Urban League founded</td>
<td>Marcus Garvey's Back to Africa Movement</td>
<td>Desegregation in plants, schools, and military</td>
<td>Dr. Martin L. King, Jr. led non-violent then assassinated</td>
<td>Black Muslims</td>
</tr>
<tr>
<td>Ku Klux Klan active</td>
<td>Klan marched on Washington</td>
<td>Montgomery Bus Boycott</td>
<td>Affirmative Action</td>
<td>Rodney King trial</td>
</tr>
<tr>
<td>WWI and the “Red Summer”</td>
<td>Depression</td>
<td>Jackie Robinson</td>
<td>Political activism</td>
<td>Million Man &amp; Woman Marches</td>
</tr>
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<td></td>
<td>Jesse Owens &amp; Joe Lewis</td>
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<td>Kennedy assassinations</td>
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<td></td>
<td></td>
<td></td>
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<td>Declining Affirmative Action</td>
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### CURRENT AGE COHORTS

<table>
<thead>
<tr>
<th>85+</th>
<th>75-85</th>
<th>65-75</th>
<th>55-65</th>
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<tbody>
<tr>
<td>Children &amp; Adolescents</td>
<td>Children</td>
<td>Children &amp; Adolescents</td>
<td>Children &amp; Adolescents</td>
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<tr>
<td>Young Adults &amp; Middle Aged</td>
<td>Adolescents &amp; Young Adults</td>
<td>Adolescents &amp; Young Adults</td>
<td>Adolescents &amp; Young Adults</td>
</tr>
<tr>
<td>Middle Aged &amp; Young Old</td>
<td>Young Adults &amp; Middle Aged</td>
<td>Young Adults &amp; Middle Aged</td>
<td>Young Adults &amp; Middle Aged</td>
</tr>
<tr>
<td>Young Old &amp; Old</td>
<td>Middle Aged &amp; Young Old</td>
<td>Middle Aged &amp; Young Old</td>
<td>Middle Aged &amp; Young Old</td>
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<tr>
<td>Old</td>
<td>Old</td>
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Appendix C

ANNOTATED BIBLIOGRAPHY

Health History


The author points out that old slaves were mistreated. Brown recalls that an old slave by the name of Mirney, the mother of thirteen children, was stoned by her master because she would not run fast enough for him. Her master even laughed at her after the stone broke her arm. The writer argues that slaves, young and old, were "doctored" up to look younger when they were being sold. He also states that old "Aunties" and "Uncles" generally took care of the sick. They learned this "trade" from other slaves over the years. He asserts that younger slaves respected elder slaves.


The author, William Wells Brown, states that one of his jobs was to prepare the old slaves for the slave market. Mr. Brown was ordered to shave the old men's beards and pluck out their gray hairs. If there were too many gray hairs, he colored them Black. After "doctoring" the slaves, they looked ten or fifteen years younger. The owner passed those old slaves off as being middle aged; thereby cheating the buyers, especially in ages of the slaves which they bought. Mr. Brown also mentions a slave called 'Uncle Frank,' who was a fortune teller. He told slaves' and Whites' fortunes and was well respected.


One of the writers, William Craft, points out that although his old master had the reputation of being a very humane and Christian man, he thought nothing of selling his aged father and mother, at separate times, to different slave owners. He also argues that his aged parents were very religious and devoted to the service of God. The reason his master sold his parents, and other aged slaves, was that "they were getting old, and would soon become valueless in the market, and therefore he intended to sell off all the old stock, and buy in a young lot." This action was typical of many slave owners.
The writer, Frederick Douglass, states that the mechanics were called "uncles" by all the younger slaves, not because they really sustained that relationship to any, but according to plantation etiquette, as a mark of respect, due from the younger to the older slaves. The orator declares, "strange, and even ridiculous as it may seem, among a people so uncultivated, and with so many stern trials to look in the face, there is not to be found, among any people, a more rigid enforcement of the law of respect to elders, than they maintain." He continues to say that "a young slave must approach the company of the older with hat in hand, and woe betide him, if he fails to acknowledge a favor, of any sort, with the accustomed 'tank'ee," etc. So uniformly are good manners enforced among slaves, that I can easily detect a 'bogus' fugitive by his manners," contends Douglass. The orator concludes that "...it is considered bad luck to...'sass' the old folks."

The editors provided a brief state-by-state description of specialized health care of older Blacks in the United States. It was estimated that nearly 100 "old folks homes" for Blacks had been established in the United States by 1914. Included in this book are brief descriptions of nursing homes and homes for the aged and selected aspects of the quality of care. These are also notes on family caregiving and church contributions to health care for the aged. Also documented are locations in some states where city governments were important contributors to care for older Blacks, and in other cases some states themselves established institutions for older disabled persons. In regard to "old folks' homes," it was shown that churches and women's clubs were major supporters of these facilities and, in some instances actually established and maintained through their own resources long-term care facilities for older Blacks.

The study includes detailed descriptions of selected features of the lifestyles, health characteristics and health care of Black Americans, including selected discussions of older Blacks during the antebellum period of the United States.

The writer asserts that his mother was blind and very old and was living in a little hut in the woods, "...after the usual manner of old, worn-out slaves." Mr. Grandy recalls that some slaves, including old slaves, were treated so badly that they asked God to take them away from that life.
Hughes, L. (1897). *Thirty years a slave: From bondage to freedom. The institution of slavery as seen on the plantation and in the home of the planter: Autobiography of Louis Hughes* (pp. 43-45). Milwaukee: South Side Printing Co.

The author states that when a slave woman was too old to do much of anything, she was assigned to be in charge of young babies in the absence of their mothers. He concludes that it was rare that she had anyone to help her. Mr. Hughes suggests that his mistress was very cruel.


This study focuses on social factors, selected demographic, and health characteristics of older persons in the Southeastern U.S. In addition to the historical development of the region of the U.S. referred to as the "Black belt," the analysis examines the relationship between income and health in the Black belt. There is also a focus on population change, largely accounted for by out migration and indicators of health of older Blacks.


The author, an ex-slave, told how his grandmother cared for him during slavery. He mentions that an old Black "root" doctor told his master that Cella, a slave, poisoned his mother and father. This "root" doctor gave his parents some medicine and they recovered from their illness. The author suggests that his mistress was cruel to old house slaves, including Jinny, the cook. Mr. Smith also discusses another Black doctor who was also a fortune teller. The fortune teller told Smith that he would escape to freedom, which he did.

Steward, A. (1857). *Twenty-two years a slave, and forty years a freeman* (pp. 16-17, 24-25, 27). Rochester, N.Y: William Allring, Publisher.

The author, Austin Steward, states that on his master's plantation in Virginia, it was the usual practice to have one of the old slaves set apart to do the cooking. All field slaves were required to give into the hands of the cook a certain portion of their weekly allowance either in dough or meal, which the cook prepared. He pointed out that his mistress had older servants punished by having them severely whipped by a man, which she never failed to do for every trifling fault.


Part I of this book develops detailed descriptions of selected cross-cultural features of health care of older Africans and African Americans. Included are discussions of beliefs about the dying and the dead and their treatment in the process of dying; and the
significance of older Blacks as repositories of historically important information.

**Conceptions of Health**


Data from a 1979 statewide household survey of 2,146 older Virginians (aged 60 and older) were analyzed to determine whether race had an effect on subjective economic well-being. The research showed that race had an independent effect; older Blacks had lower subjective economic well-being than older Whites, even when economic and social variables were controlled. Black and White respondents who were in better health and had fewer visits to a physician, and White respondents who were married and older, had greater subjective economic well-being. Individuals with higher economic levels, diverse income sources, fewer dependents and higher education had higher levels of subjective economic well-being in regression models for Blacks and Whites. Home ownership was not a significant variable for either race. The study concluded that the combined effects of income, education and other socioeconomic variables were even more significant than race in the association of these variables with subjective economic well-being.


In this study, Blake reports on selected findings from his research on attitudes toward modern, versus folk medicine among older Blacks on the Sea Islands off the southeastern coast of South Carolina. Blake focuses, in particular, on the relationships between folk beliefs about living in harmony with nature, islander perspectives on uses of herbal remedies in response to illness, and attitudes of older Sea Islanders toward modern medicine. Blake also shows that folk medicine in the Sea Islands is primarily practiced by older Black women, who tended to be members of the lower economic classes and lived in small kinship-based villages where trust in them was enhanced by their local residence, common culture, and easy access.


Data for the study of the relationship between subjective well-being (happiness and social status, personal and economic resources, health) and stress factors in 581 Blacks aged 55 and older were obtained from the 1979-80 National Survey of Black Americans. Included were measures of health disability, health satisfaction, life problem stress, and happiness. Lower happiness ratings were associated with being younger, being widowed or separated from one's spouse, and with high levels of stress and low levels of health satisfaction. Health disability had a negative
influence on happiness through its association with higher stress levels and reduced health satisfaction. In addition to the direct effects of age on happiness and being widowed or separated, other social status and resource factors were important in predicting intermediate factors related to health status, satisfaction, and stress.


The purpose of this study was to examine behaviors and background characteristics associated with negative attitudes toward the self in an elderly population. Among the questions addressed were whether personal characteristics distinguish between high and low self-esteem groups and whether symptoms of depression and anxiety were greater for low than for high self-esteem groups. Subjects interviewed were 250 men and women aged 65 and older from large housing projects in Miami, Florida. Anglo, Black, and Cuban American elderly were equally represented. Self-esteem was measured by Rosenberg's Self-Esteem Scale, Coopersmith's Self-Esteem Inventory, and Brown's Self-Report Inventory. Health status was measured by self-report and the Rapid Disability Rating Scale. Dependent variables were measured by Rotter's Internal-External Locus of control Scale and Hopkin's Symptom Checklist. Results indicated that self-esteem was highest in Anglos and lowest among Cubans. Blacks reported more negative ratings on health variables than did other groups. High and low self-esteem groups did not differ in age, income, education, or living arrangements. The low self-esteem group reported poorer health, more daily pain, and greater disability at statistically significant levels. Elderly with low self-esteem reported more somatization, anxiety, depression, and external control orientation than those with high esteem. Tables are included.


The 19 conference papers in this collection discuss the physical and psychosocial health of the Black elderly. Topics include the following: the role of Black universities in research on aging Black populations; research on the demographic makeup of Black aging populations, cancer prevention and control, socioeconomic predictors of health in the later years, and the nature of formal and informal social participation; basic differences between Black and White older adults in the areas of social participation, nutrition, obesity and diabetes, hypertension, and dementing illnesses; the role of social factors in the subjective well-being of older Blacks, family and social supports, health-seeking behavior, health attitudes and health promotion/prevention, work, retirement, and disability; methodological issues in survey research, case-control epidemiological research and clinical trials; and major themes related to future research on aging Black populations.

This quantitative-descriptive study was designed to investigate differences between the life satisfaction of urban Black institutionalized and noninstitutionalized aged and to identify probable causative factors. The study was conducted in a low-income high rise apartment building for the aged in several nursing homes in a Midwestern metropolitan city. Participants included 22 institutionalized and 23 non-institutionalized urban Black subjects ranging in aged from 65 to 92. Data were collected using the Mental Status Questionnaire, the Crichton Royal Behavioral Rating Mental Scale, the Life Satisfaction Index-Z Scale, and a Life Satisfaction Interview Schedule. Data were combined for the total sample and examined through stepwise multiple regression to determine what percentage of variability in life satisfaction could be explained by all of the variables examined together. The non-institutionalized Black aged exhibited higher life satisfaction than institutionalized Black aged on the four components measured, resolution and fortitude, zest for life, congruence between described and achieved goals, and mood tone. Perceived health was an important determinant of life satisfaction. Less support was established for education, income, occupation, political activity, personality variables, and religion as indicators for life satisfaction. Variables related to basic survival (living arrangements), support system, and independence emerged as significant correlates.


Mitchell's study of folk medicine shows the significance of the pharmacist in Jamaica as (1) intermediary between the modern medical doctor and the patient and (2) lay diagnostician, with implications for pharmacist-consumer relationships in other societies as well. In addition to corroborating the significance of faith and trust in the practitioner-patient relationship, Mitchell's study of folk medicine reveals various ways in which therapeutic interaction between the pharmacist and the customer differs from the relationship between the modern medical doctor and the patient. For example, the folk patient has more control over the direction and duration of practitioner-patient interaction than does the patient in the modern doctor-patient relationship, and pharmacists do not challenge nor attempt to counter the customer's use of popular or lay medical concepts in selecting medications.


Primm draws attention to lack of public education about uses of folk remedies, over-the-counter drugs, and prescription medicine, and how the misguided use of two or more drugs can have deleterious effects. He begins with a focus on older poor Blacks in the rural South, and expands to focus on all elders, particularly users of folk remedies.

elderly of social welfare services delivered by volunteers. *Journal of Gerontological Social Work, 4,* 81-94.

This study investigated the relationships among morale, certain life conditions, and the use of social welfare services delivered by predominantly young White volunteers to elderly Blacks living in a small Southern town. All 55 aged Blacks (aged 60 to 92) using the Congregate Meals Program in this community were administered a 114-item questionnaire that included a 20-item morale measure and measures of housing and health status, finances, and social involvement. Morale was generally high. Low morale scores were significantly related to sight and hearing difficulties; the diagnosis of two or more major health problems beyond sight and hearing; lack of stamina; and worry about financing possible future medical expenses. The elderly used the Congregate Meals Program for nourishment and for social needs, but its use was not associated with morale. Although the entire sample maintained a high level of social involvement, social involvement was not related to morale. A major concomitant of high morale was the utilization of social services that fostered the elderly's physical and social mobility. It was concluded that service delivery by Whites did not hinder service utilization by these Black elderly.


In this pilot study, 288 elderly African American and 482 White residents of 10 nursing homes in Wayne County, Michigan, were compared for neurological impairment. The frequency of diagnosis of neurological impairment was equivalent for African American and White males, but greater for African American females than for White females. Cerebral vascular accident (CVA or stroke) and nonspecific dementia were the most common neurological diagnoses for all groups. For males but not females, there was a statistically significant difference in the causes of neurological impairment, with more African Americans diagnosed as having CVA, and more Whites diagnosed as having nonspecific dementia. While the incidence of neurological impairment in African Americans exceeded that of Whites, predominantly White nursing homes offered more sophisticated care. This suggests the need to review the means by which comprehensive nursing home care may be expanded in the African American community.

This study proceeds from the assumption that a full understanding of the social and psychological behavior of Afro-Americans, like that of any group, must take into account their social historical and biographical backgrounds. For example, because the social and developmental histories of most of today's older Afro-Americans are traceable to states in the Southeastern region of the country, inquiry should begin with a careful description of the culture and patterns of social change that shaped the historical context of individual and group development in that part of the country. Within this broad context, Watson develops a discussion of the interfaces of folk and modern medicine and the associated (or conflicting) beliefs and values, and patterns of consumption of folk medicine among older Afro-Americans in the southern United States.