The implications of aging, health status, and survival strategies among older Black women in one large and one small urban population in Georgia

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ABSTRACT

AFRICANA WOMEN'S STUDIES

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B.A. PAINE COLLEGE, 1961
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THE IMPLICATIONS OF AGING, HEALTH STATUS AND SURVIVAL
STRATEGIES AMONG OLDER BLACK WOMEN IN ONE LARGE AND ONE
SMALL URBAN POPULATION IN GEORGIA

Advisor: Dr. Belmont Williams

Dissertation dated July, 1997

The literature on minority aging in the United States reveals a lack of adequate
research data on minorities, especially on older black women. Members of different ethnic
or minority groups are subjected to different socioeconomic problems throughout life and
especially as they grow older. This study focuses on research collected during a 1996 study
of the aging, health status and survival strategies of black females between the ages of 65 to
95, in a large versus small urban population. This study also employed quantitative survey
questionnaire methodologies, to test the hypotheses that aging, health status and survival
strategies impact the longevity of these women.

Based on the analysis of the review of pertinent research literature and standard
reference texts, a survey questionnaire was developed and tested. The survey instrument was
administered to a prescreened, random sample of women in West Atlanta and East Macon,
Georgia. One hundred and twenty surveys were administered (100%) were returned.
THE IMPLICATIONS OF AGING, HEALTH STATUS AND SURVIVAL STRATEGIES AMONG OLDER BLACK WOMEN IN ONE LARGE AND ONE SMALL URBAN POPULATION IN GEORGIA

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF ARTS

BY
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DEPARTMENT OF AFRICANA WOMEN'S STUDIES

ATLANTA, GEORGIA
JULY 1997
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Chapter 1

INTRODUCTION

Interest in the aged is not a new phenomenon. Questions on how and why people age have been asked since the beginning of our recorded history maintains Manuel. While interest in the aged is not new, the scientific inquiry of aging is a very recent practice. The growing interest in the aged is due in part to the increasing number of aged persons in the populations says Manuel. Very little has been written on the special needs and concerns of the older black woman, and an assiduous review of the literature endorses this point. Furthermore, many of the studies applicable to the aging population have included this subject as a part of the larger minority population which includes, Asians, Hispanics, Native Americans and other minority women, and have not given sufficient research or insights about black women.

The older population is increasing and is doing so at a faster rate than the population at large. We are all growing old; we all share the common experience of aging, regardless of race, creed, sex or economic condition. As time continues to pass, we all continue to age

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2Ibid., 3.
and nothing can be done to stop this process. McKenzie points out that aging is a gradual process; we do not age overnight, we develop, grow and change as we age.³

Aging is an important concern for women because women live longer than men. Life expectancy at birth since 1950 had increased to an estimated 71.5 years for men and 78.8 years for women by 1985 (see the Crossover Phenomenon Chart in Appendix). Older women outnumber men three to two and the disproportion grows larger in the 80 and older ranges says McKenzie.⁴ We all are aging but according to the literature on the subject, there has been a neglect on the needs and concerns of older women, especially older black women.

Women make up the majority of the over sixty-five age population and outnumber men in the over-eighty population by two to one. However, as Block and others have indicated, “despite their greater numbers, women have not been the focus of most major research efforts in gerontology. The majority of researchers in gerontology have been, and are, male, and so tend to focus on the aging process of males.” For that reason, this study of older women will contribute to a more general understanding of the aging process among black women. “Aging is considered primarily in terms of men, in the first place because it is they who express themselves in laws, books and legends, but even more because the struggle for power concerns only the stronger sex.” “Not enough is known about the process of blacks growing old in America as compared to what is known about growing old, in


⁴Ibid., 20.
general, in America and in the world.5 One specific reason for studying older black women is that researchers in the field of gerontology have repeatedly pointed out the need for better understanding of aging among minority populations. Therefore, the needs and concerns of this population of older women should be predominant to public policies and health care for the elderly. Women outlive men an average of seven years; thus, nearly all once-married women experience widowhood for some part of their lives affirms Worters.6 Women are twice as likely to live alone, largely because they are almost three times as likely to lose a partner in comparison to older men. Once widowed, women are much less likely than men to remarry, Worthers.7

Older people have become a very significant part of the United States population. Since the turn of the century, America has grown old and due to life expectancy for men and women by more than twenty-five years, America is likely to grow older.8 Because there is not much in the literature on older black women, we need to focus more on what this population is doing, their needs and what is being done to make life more comfortable for this group. There is an abundance of literature on aging and the elderly written by scholars


7Ibid., 144.

such as, Butler, Jackson, Palmore, Stanford, Atchely, Watson, and Neugarten to name a few, but not much has been written on black older women. There is a need to know more on the needs and what is being done to make life more comfortable for this segment of the population.

Although many important gains are being made in an effort to meet the need for health care of the aging in general, the groups being studied most are mainly the white aged. Research on the health aspects of the black aged female is lagging significantly, argues Jackson.9 Because of the emphasis on the white aged, there are few data in the literature on the black aged, especially the black aged female, Jackson.10

Most of the literature includes all people of color. This mixing of all minorities together creates a lack of information on the black aged female specifically. Several factors may account for this lack of information. First, most of the studies on the older population have emphasized the white aged, as stated earlier. Second, when non-whites are studied, results are often given in terms of data for respondents who are “white” and “non-white”, this factor is actually a mixed population which includes blacks, Hispanics, Native-Americans and Asians. Researchers have a tendency to mix several types of minority older populations together mostly because it is convenient and cost effective, Sanford.11

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10Ibid., 219.

Sanford further maintains that researchers use the justification that all older minorities regardless of specific racial or ethic background have many needs in common, thereby, lessening the need to make a distinction between ethnic minorities.\textsuperscript{12} Since this practice has encouraged the combining of minorities in research studies across all areas in the literature, it has reduced access to data on specific subgroups of the aged, such as the Black aged. "Until recently, little effort has been rendered to include the black elderly. Conversely, contemporary gerontological literature on blacks is either sparse or inaccessible."\textsuperscript{13}

Because few empirical studies have focused on health and aging of Black females, information regarding potential and present needs or use of health care services is not readily available. This lack of even preliminary information further contributes to the deficiency of knowledge on aging and health practices of older black women. Although preliminary information on aging and health practices of older black women have been collected recently, researchers still stress the need for more information on this population, Jackson, et. al.\textsuperscript{14}

\textbf{PURPOSE OF THE STUDY}

The purpose of this study is to discuss the health and aging process of black females in America. The researcher is using southwest Atlanta and southeast Macon as the

\textsuperscript{12}Ibid., 49.

\textsuperscript{13}Ibid.

geographical focus of her study. Watson states that the need for research on the health status of older black women is well established.\textsuperscript{15} The literature in the field has shown an impressive growth of research on health and aging. However, the corpus of the literature demonstrates that little attention is given to the needs and concerns of older black women.

The majority of aging blacks are women and according to the U.S. Bureau of Statistics, this age group continues to be the fastest growing population. Although many studies have focused on health and the aging process, no systematic study has been made to determine the scope of the impact of health and aging on black women. In short, the review of the literature reveals that the health care issues of older women are often approached globally and are focused on race and gender, giving only scant attention to the issues and concerns of the black elderly. The researcher's justification for engaging in this study is based on the fact that research on the health and aging of black women has generally been ignored.

This researcher's rationale for selecting southwest Atlanta and Southeast Macon is based on the demographic representation of a large urban population in comparison with a small urban community with similar socio-economic backgrounds. Also these areas were chosen because of the close proximity of cities and the researcher's familiarity with them.

**STATEMENT OF THE PROBLEM**

According to the review of literature, few systematic studies have been made to determine the impact of aging, health and survival strategies as it relates to older black women.

women. Since there is insufficient research about this age group, there is a lack of public policy and societal awareness to effectively address the needs and concerns of the black elderly woman in America. The present research study is designed to intensify some of the issues in the literature surrounding age, health status and survival strategies of the aging process within a selective sample of older black women.

A trend towards longer life expectancy and early retirement age has contributed to the emergence of a group called the “young-old” (55-74), whose characteristics are different from their older counterparts, the “old-old” age group, those 75 and older. This is still an arbitrary division which needs to be empirically tested. “While past and present history will always guide us, the characteristics and needs of the older adult will be considerably different.”

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17 Ibid., 168.


21 J.J. Jackson, “Aging Black Women and Public Policy,” Black Scholar
The need for research on the health and health care of older blacks is well-established\textsuperscript{22} and it is this concern that has given impetus to this study. The researcher is interested in the quality of life of all people and especially older black females. A number of studies in general seem to have a negative impact on the health and aging of blacks, particularly older black females, which include lifestyle behaviors, and environment, from an economic and sociopolitical standpoint. According to research studies, there are numerous factors that give evidence of the health status of blacks in general and older blacks in particular, for example, the high incidence of chronic diseases among older black women who are living longer.\textsuperscript{23}

Since there is insufficient research about this age group, there is a lack of public policy and societal awareness to effectively address the needs and concerns of older black women in America. There is a trend toward early retirement and a longer lifespan which has also compounded and contributed to this problem.

As persons age, they face more chronic illnesses. Generally, older women are more likely than men to suffer multiple illnesses and to be forced to rely on a health care system ill prepared to meet their needs. Many diseases affecting women have not been thoroughly researched. Women have been drastically under-represented or not represented at all in


\textsuperscript{23}Ibid., 194.
important health research, contends Idleburg. Older people have become a very significant part of the U.S. population. In this century, women have lived longer than men and probably will continue to do so. White females have the highest life expectancy of any race-sex group. White males were the second longest lived group until about 1970, when they were passed by black females. Black males have consistently had shorter life spans than any other group.

SIGNIFICANCE OF THE STUDY

This study is significant because it provides additional impetus on older black women in order to address their aging process, health status and survival strategies. This study is also predicated on the fact that there has been very little attempts on the study of the aging black female. Jackson contends that much of the literature view the aged as a monolithic group and this tends to distort some of the differences of aging women.

A review of the literature on aging reveals a lack of sufficient data on the black aged in general, and the black aged female in particular. The writer feels that this study on aging black women may open up new avenues of insight and more understanding for those persons who are interested in this age group, (65 and over). The most rapidly growing group of older

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black women are women who are eighty and over and it is they who have the longest average remaining lifestyle contends Pifer and Bronte.27

RESEARCH QUESTIONS

Three research questions are posed in this study to assess the health status and aging process of older black women. Answers to these questions will be given by data collected from 120 older black women in Atlanta and Macon, Georgia. The specific research questions are as follows:

1) Do those elderly black women with less socioeconomic resources live longer than those with more socioeconomic resources?

2) Why do some elderly black women with chronic disabilities and limitations function successfully while other black women with identical disabilities and limitations do not?

3) Do elderly women with high participation in church related activities live longer than those who do not attend church?

This study is limited to 120 black females who reside in an urban area of two southern cities, Atlanta and Macon Georgia. The researcher feels that these limitations do not reduce the importance or the contribution that this study can make in assisting concerned health care policy makers and providers to better understand the health and aging process of older black females.

HYPOTHESES

In carrying out the purpose of this study, the following hypotheses were tested:

HYPOTHESIS I

There will be a significant difference between those elderly black women with less socioeconomic resources and those with more socioeconomic resources.

HYPOTHESIS II

There will be a significant difference in those elderly black women with more chronic disabilities and limitation to function successfully as those with less chronic disabilities and limitations to function.

HYPOTHESIS III

Elderly black women with high participation in church related activities tend to live longer than those with relatively fewer church related activities.

LIMITATIONS

Several limitations can be identified in the planning and execution of this research project. The researcher is aware of the elusive nature of defining aging and health practices. In addition, it is realized that a longitudinal study would be an objective measurement technique. However, the utilization of a longitudinal study is beyond the scope, cost and time frame of this study. The researcher realizes that a small sample size is limiting in that it will not apply to generations of all aging black women.

This study is limited to African American females 65 to 85 plus years of age and who reside in urban sections of two southern cities, Atlanta, Georgia and Macon, Georgia. There is an abundance of material written on aging and health practices in general, however, there
is very little literature specifically on the aging and health status of African American women. These limitations however, do not reduce the importance or the contribution that this study makes in assisting concerned health care and other human service providers with a better understanding of the aging and health status of older African American women.

DEFINITION OF KEY TERMS

AGING: A broad concept that includes physical changes in our bodies over adult life, psychological changes in our minds and mental capacities, and social changes in how we are viewed, what we can expect, or what is expected of us, Atchley.\textsuperscript{28}

AGED: Refers to long livers or having lived or existed a long time, (the population aged 65 and over).

LIFESPAN: The behavior development throughout life from conception to death.

LIFE SATISFACTION: An assessment of the overall conditions of existence as derived from comparison of one's actual achievements.\textsuperscript{29}

COHORTS: Refers to the total population of individuals born during the same interval of historical time, often measured within 10 or 20 year intervals (e.g., the cohort born between 1900 and 1910). Individuals in the same age group.\textsuperscript{30}


\textsuperscript{29}L.K. George, "Life Satisfaction in Later Life," \textit{Generations} 10 no. 3 (1986): 5-8.

ELDERLY: Past middle-age, usually age 65. The retirement age is considered the beginning of old age.

SENESCENCE: The biological factors of aging. “A change in the behavior of the organism with age, which leads to a decreased power of survival and adjustment”.

CHURCH-GROUP: Those elderly women who attend church.

NON-CHURCH GROUP: Those elderly women who do not attend church.

HEALTH STATUS: Health is of major importance both to the aging individual and to society. The World Health Organization defines health status as a state of complete physical, mental and social well-being and not simply the absence of disease or infirmity. For the individual, health status is a determinant of one’s ability to perform those personal tasks which enables one to participate in society. In this study, health status is a self-reported state of physical well-being, the incidence of morbidity that may interfere with daily activities and life expectancy.

SOCIO-ECONOMIC STATUS: Lifestyle such as income, employment, family support, (i.e., children, relatives, community support), living standards (own or rent home).


SUMMARY

This chapter presented an introduction to the study on aging, health status and survival of the older black woman. In addition, the purpose of this study which was to add to the knowledge base of how black women in America perceive their health and aging process was presented. This chapter also discussed the significance of the study. Research questions on which the research hypotheses were based were also described. And finally, limitations of the study and definitions of the key terms were provided.

The related literature pertinent to the study was reviewed, summarized, and presented in Chapter II. The relevant literature on aging was divided into two (2) sections: relevant literature on aging and literature related to the variables. The review integrates previous research related to the study.
Chapter 2

REVIEW OF LITERATURE

The review of relevant literature was instrumental in identifying the information regarding the health status, aging, and survival strategies of the overall population in general and black elderly women in particular. A variety of sources, topics and disciplines were consulted in completing this review. Among the disciplines researched are psychology, sociology, public health, medicine, religion and philosophy.

Since few empirical studies have focused on health and aging of black females, there is little information regarding potential and present needs for this population. Scholars such as Jackson, Butler, Harel, Harper, Watson and Manuel, to name a few, have addressed this topic.¹ There is however, still a need for more extensive study on this population. Also contributing to the paucity of data on aged black women in the literature is the fact that so few black women have entered the health care system, so that data collection for this group has seemed unnecessary.²

This review of literature reflects those studies that are considered to be relevant to the subject as models to analyze the research among older black women. Most older black females make up a majority of the elderly and they outnumber men by nearly three to one past the age of 85.\(^3\) Whereas women live longer than men, they have more chronic health problems over a longer period and incur greater health costs and dependency.\(^4\)

**OVERVIEW OF AN AGING SOCIETY**

More people are living longer, and the quality of life for increasing numbers of persons aged 65 and over is better than that for past generations.\(^5\) For example, some programs have almost eliminated many life-threatening infectious diseases and may account for the increasing numbers of persons who survive to old age. The increased probability of reaching old age can be credited to all the successful investments and advances made by past and present generations in addressing problems across the lifespan.\(^6\) However, these are not the only indicators of social progress. Other indicators would include economic growth, new knowledge, reduction and eradication of diseases, and reduction of poverty.\(^7\) The aging of our society is characterized by two principal factors: demographic changes in our population.


\(^3\) Ibid.

\(^4\) Ibid.


\(^6\) Ibid., 20.

\(^7\) Ibid.
and the diversity of the elderly cohort groups. These factors were summarized in a report given by U.S. Department of Commerce, Bureau of Census for the Senate Special Committee on Aging as follows:

- The 65 and over population grew twice as fast as the rest of the population in the last two decades.
- The 85 and over group is growing especially rapidly, up 165 percent from 1960 to 1982.
- The death rates of the elderly population, especially women, fell considerably over the last 40 years.
- In 50 years, the ratio of people over 65 to people 18 to 64 will be almost three times as great as it was in 1950.
- The median income of elderly persons had a higher percentage increase over the last two decades than the median income of the younger adult population.
- Despite this improvement, about 1 of every 7 American over the age of 65 lives in poverty.
- Elderly women are almost twice as likely as elderly men to be poor; half of elderly widowed Black women live in poverty.
- About 8 in 10 persons 65 and over now describe their health as good or excellent, compared to others of their own age.

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Elderly men are most likely to be married while elderly women are most likely to be widowed.

The number of elderly women living alone has doubled in the last 15 years.

During the last decade, the number of elderly persons living in central cities has declined, while the number living in suburbs and small towns has increased.

One-half of those 65 and over now working do so on a part-time basis, compared to one-third 20 years ago.

PROFILE OF THE BLACK ELDERLY

In order to understand clearly the problems faced by the black elderly population, this profile is given with statistics based on the 1980 Census, including information derived from “A Portrait of Older Minorities.”

POPULATION STATISTICS

About 2.1 million (8 percent) of the black population in the United States were age 65 or over in 1980. Of that group, about 157,500 (75 percent) were age 85 or over.

Among blacks aged 60-64, there are 80 men for every 100 women, while for whites there are 87 men for every 100 women. At age 70-74, the sex ratio is much closer for both whites and blacks, but drops much faster and farther among whites at the oldest ages (85 plus). A more thorough explanation of this event will be discussed in greater detail under the heading, The Crossover Phenomena.

Older blacks suffer from what has been characterized by some scholars as “double

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jeopardy." The phenomenon of double jeopardy refers to the additive negative effects of being both old and black, or other minority, on frequently cited indicators of quality of life such as: health, income, housing, and satisfaction with life. Not only are black older persons like other elderly in most western societies seen as unproductive, but older blacks bear an additional economic, social and psychological burden as a result of entrenched racial inequality in America. In general, black older adults, compared to whites, are usually less well educated, have lower income, suffer more illnesses, have poorer quality housing and work, and according to the U.S. Special Committee on Aging, have a less satisfying quality of life.

According to Yelder, one of the most significant factors emerging at the close of the twentieth century has been the growth of the elderly population in America. The elderly population is projected to increase nearly 20 percent by 2030. The 1980 census showed that 90-percent of the 65 and older population were white (23 million), while blacks contributed only 8 percent of the older population (2 million). Life expectancy has improved greatly. By 1982 life expectancy for blacks averaged 69 years (65 years for men and 74 years for


19
women) about 6 years less than for whites. Public policies and many service delivery systems assume that the problems associated with growing older in America are the same for blacks and whites because economic security, services, housing, health care, and personal safety exist without regard to race or ethnic background. But for many of the growing number of black elderly, many of their needs and related problems are more acute. In 1964, the National Urban League introduced the idea of double jeopardy. Since then, this concept has been elaborated on and is called triple or multiple jeopardy by some scholars in describing the plight of those subjected to ageism, racism, sexism and poverty.

Jackson argues that the literature on the health of the aging black population in the United States appears to be relatively scant, fragmented, and inconclusive. He also maintains that there is an absence of funds to conduct studies on this growing segment of the population. Cox contends that not only are more people living to age 65, but once they reach that age they live longer. The population age 85 and older is projected to grow more rapidly than the 65 plus age group until around 2010, when cohorts born in the baby boom of the 1940s and 1950s begin to retire.

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Aging is a universal human condition and an essential focus for research and policy. However, de Beauvior pointed out that targeting women can help enhance our knowledge and understanding of the particular interest and concerns of middle aged and older women. De Beauvior further maintains that “by improving our awareness of this population group, we help increase the knowledge of the total aging process itself”18. Markides states that little is known about the relationship between aging and ethnicity among whites and less is available on blacks.19 However, in the years since 1977, Jackson20 and Manuel21 have focused on minority groups, especially blacks, thus helping to fill the gap in research.

The review of relevant literature will focus on the following main points 1) Aging in general and minority aging; 2) Health status of the black elderly; 3) Survival strategies of the older black woman; 4) Socioeconomic status and life satisfaction and; 5) Religion and spirituality of the black elderly. Intervening variables of education, income, employment and housing are also summarized. This review will present those studies that are perceived to be relevant to the health, aging and survival status of older blacks, especially older black women.


21R.C. Manuel, Minority Aging (Connecticut: Greenwood Press, 1982)
AGING AND BLACKS

Increased life expectancy is a growing concern for black people in the United States. The increase in the number of older black persons has brought about the need to look closer at the problems related to the social, mental, economic, and health status of the black elderly. According to some researchers, black elderly have not been expected to be in good health or to be capable of being a productive part of the community as they reach the later stages of life.

As the aging population, including blacks, continue to live longer and to remain in relatively good health, it is expected that this group will become an essential part of the community. The black elderly of today still live with and feel the impact of the "slave culture" which set the stage for the status of blacks in our society during the nineteenth and twentieth century. The "family" structure that emerged in the slave culture had a profound impression on the older blacks of the 1960s, 1970s, 1980s, and the 1990s. The underlying social stigma forced on blacks over the years is not easy to erase. However, in spite of these atrocities older black people still have an abundance of experiences to offer that cannot be

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23Ibid.

24Ibid.

25Ibid., 35.

26Ibid.

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claimed by any other group of older persons. Older blacks of today bring with them a legacy that embodies the will to survive in a society that historically denied them full human status.

Older blacks of today, from a positive perspective, have the opportunity to use their life experiences to help enhance the quality of life for all older persons. It is clearly apparent that many older black people have survived through excessive hard times but still manage to carry on productive lives in their communities. The richness of the black culture as portrayed in literature, music, religion, science and sports substantiates the fact that barriers that were imposed on them is not present in the growth and development of this cohort of our population.

AGING

Wherever there is life, aging and death are inevitable. Both aging and death are the great democratizes of the human family; they are commonalities which embrace all of us. “For everything there is a season, and a time for everything under heaven, a time to be born, and a time to die.” According to Sapp, aging and old age constitute another stage of the human journey form birth to death. Death at an advance age is good, a sign of favor and

27Ibid., 36.
28Ibid.
29Ibid.
30Ecclesiastes 3:1-2
blessing from Yahweh. In the Old Testament old age was not seen as something one dreaded or resented, rather it was something one accepted, if not welcomed. Length of days was seen as a sign of God’s favor and blessing, and death in a ripe old age was the reward of the righteous. Obviously, it is impossible to die “full of years” without experiencing old age.

AGE AS A SOURCE OF WISDOM

Despite the admission of the losses associated with aging, most traditional societies recognize the elders in their community. The elderly, those who have lived long and experienced much history are the best sources of wisdom. We can learn from those who have accumulated a lifetime of experience in living. Further testimony to the wisdom of the elderly in the Old Testament shows how it was the elders who sat at the city gates and pronounced judgment in various judicial cases. This function suggests that their years had five times the experience to make difficult decisions fair. However, it is not absolute that length of years equal depth of wisdom. “It is not the old that are wise, nor the aged that understand what is right, but the spirit in a man or woman, the inspiration of the Holy Spirit

32Ibid.
33Ibid., 74.
34Ibid.
35Ibid., 75.
36Ibid.
37Deuteronomy 21:1-9, 18-21; Psalm 107:32
that makes him or her understand." 38 This discussion demonstrates that the way in which one lives, that is, whether or not one lives a righteous life and not merely one's age determines one's true wisdom. 39 "Better is a poor and wise youth than an old and foolish king, who will no longer take advice." 40 A summary of this view is that the aged are entitled to special respect and consideration because of their wisdom and special role in society. Therefore certain obligations toward the elderly rest upon the younger generation who must care for those who serve as vivid reminders of the ultimate end of all human beings.

Growing in wisdom is not an automatic corollary to old age. Education is an endless process and learning should make us conscious of the need for a life long quest for knowledge. There should be a deliberate effort to become a life long learner. Discipline and obedience are key ingredients in learning the lessons of quality living, however, aging is not without its problems. Biblical teaching can promote positive expectations that may help to alleviate some of the burdens of ageism. Through its insights on the blessings of God, it relieves ambivalence about growing old. 41 Biblical examples help the elderly to appreciate and utilize the ultimate value and potential of growing old. 42 A supportive family helps reinforce social support for the elderly and helps to lessen the fears of aging. The Bible


39 Ibid.

40 Ecclesiastes 4:13.


42 Ibid.
shows that as God delivered Israel in its transitions, God also cares for the aging for example, Ecclesiastes states:

To your old age I am the one (who will look after you); to grey hair I will carry (you). I myself have created (you) and will lift you up; I myself will carry and deliver (you).”

HEALTH STATUS AND BLACKS

The health status of blacks historically has been worse than that of whites. Manton maintain that blacks are more likely to get heart diseases, malignant neoplasms, and cerebrovascular diseases and are more likely to get these diseases at an earlier age than their white counterparts. Also incapacitating arthritis, not a leading cause of death, is more prevalent among older blacks. Blacks are disproportionately at risk of morbidity and mortality at an earlier age than their white counterparts. Jones and Rice state that health status is the general state of equilibrium between physical incapacity and social capacity. In this study, however, the health status of older black women is assessed by self-reported state of physical well being, lifestyle behavior and socioeconomic status, such as income, education and employment are factors used in describing health status in this study.

43Isaiah 46:4


Much attention has been focused on the health status of the elderly in the United States. However, not enough is known about the process of blacks growing old in America as compared to what is know about growing old, in general, in America and in the world.47 There are still very few studies comparing blacks to blacks on any dimension.48 There is an erroneous assumption argues Beard49 of homogeneity in the black population. In her study of the health status of economically successful aged blacks, Beard noted that blacks are not all alike, even in the same social class, although there are variations that appear in association within their environment.

Black women have suffered from discrimination practices throughout their lives argues Edmonds.50 They have had to develop coping and survival mechanism to help them maintain a sense of balance when faced with social and economic problems. In addition, they have had to face substantial discrimination and prejudice in almost every area of our society. Edmonds uses the term 'triple jeopardy' in defining the older black female, because she is subjected to the negative stereotypes of ageism, sexism, and racism.51

Understanding the black aged woman is critical in gaining insights into the racial

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48Ibid., 205.


51Ibid.
mortality crossover phenomenon, which suggests that, should black aged females reach 85, they will most likely outlive their white counterparts. This has been called “racial crossover in life expectancy”. Prevailing theories range from “survival of the fittest” to the genetic inheritance theory. Edmonds acknowledges that:

The most appealing hypothesis is that socioeconomic conditions favoring one group result in lower death rates at younger ages which permit many to survive to older ages who are not physically and/or physiologically strong. The less-advantaged group, it can be further supposed, has higher death rates at the younger ages, and those who survive those early years are physically and/or physiologically more fit to continue on to older ages, even to overcome persistent socioeconomic disadvantage. Such an explanatory model, in effect, regards biological and social factors as being in interaction.

This picture portrays the aged black woman in the United States today. More research is needed, however, to determine why the aged black woman is the “survivor” of the nation. However, in spite of this positive trend, the literature on the plight of blacks in health is not very encouraging. According to recent reports, there is still great disparity in death and illness of blacks, compared with the nation’s population as a whole according to the United States Department of Health and Human Services.

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The U.S. Department of Health and Human Services Task Force on black and Minority Health\textsuperscript{56} has indicated that heart disease and stroke, homicides and accidents, cancer, infant mortality, cirrhosis, and diabetes are 80\% higher among blacks than among whites. Another major finding of the task force's report is that blacks tend to give less attention to warning signs, get fewer screening tests, and are diagnosed at later stages of cancer than their white counterparts.

White maintains that blacks consider themselves ill only when their illnesses have progressed to higher levels of severity and that perhaps some reasons for the lateness of seeking help are due to financial and child care problems, fear of hospitals, possibility of becoming a guinea pig, and fear of death.\textsuperscript{57}

By living longer, older black women are subjected to more chronic as well as acute conditions, which indicates a greater need for services. Blount cited four physical and social factors that could lead to premature dependency and need for services: social isolation, uncorrected sensory impairment, poor nutrition, and over medication.\textsuperscript{58} Blount maintained that although aged black women generally have more social support systems, their poverty denies them needed resources.\textsuperscript{59}

\textsuperscript{56}Ibid.


\textsuperscript{59}Ibid.
According to the National Center for Health Statistics, elderly black women delay seeking health services until later stages of illness. Elderly black women have higher hospital fatality rates than their white counterparts, which might support the finding that their conditions are more serious and are at later stages when they are admitted.60

The examination of black health status of older adults has been conducted in a vacuum according to Manton and Soldo.61 Few researchers have actually collected the types of data needed to explain black health status and aging. The lack of good conceptual models of older black adult health status has contributed to this lack of quality data or large and representative samples of black Americans as they move through their adult years (Manton and Soldo).62

Many blacks move into their later years with a history of poor health. Jackson argues that accumulated lack of services and economics place older blacks at greater risk than whites of the same age. Furthermore, the fact that blacks actually outlive their white counterparts in the most advanced age groups suggests that a selection factor may be at work that results in the survivor of the strongest older blacks.63


62Ibid., 206.

In a study that included elderly individuals, Breslow and Enstrom found that those who followed good health practices were in better health than those who did not.\textsuperscript{64} McGlove and Kick noted similarly improved health status among older people who engaged in a variety of preventive health behavior.\textsuperscript{65} Palmore found that elderly individuals who exercised, controlled their weight, and did not smoke were more likely than other elderly people to experience better perceived health status, as well as fewer weeks in bed, doctor's visits, hospitalization, and operations.\textsuperscript{66} Additional evidence suggests that mortality among the elderly is affected by their behavior. For example, exercise, maintaining recommended body weight, and not smoking have been shown to be related to longevity among older adults.\textsuperscript{67}

It is not clear whether the elderly can change their health status by improving their health behaviors, with the notable exception of quitting smoking.\textsuperscript{68} However, existing


evidence supports the premise that the elderly can maintain good health status if they practice good health habits.  

Blacks are disproportionately at risk of morbidity and mortality at a premature age which unavoidably affect their health status. As stated earlier, Jones and Rice stipulated that health status is the general state of equilibrium between physical incapacity and social capacity. However, in this study, the health status of older black women are assessed by self-reported state of physical well-being. Life-style behaviors of smoking, alcohol abuse/use, and socioeconomic indicators, such as income, education and employment are also used in describing health status in this study. 

Women are the fastest growing cohort of the population. In 1900, there were nearly 3 million people (male and female) over 65, and represented 4 percent of the population. Today there are over 25 million people 65 and over, representing 11 percent of the population (Black women constitute 8 percent of this number. Women live longer than men. Statistically, today, a 65 year old woman can expect to live 17.5 more years; a man of the same age, 13.4 more years. (A black woman can expect to live 5 or 6 years less than a white woman). One-third of older women live alone, 53 percent as widows. The likelihood


of older women remarrying is tenuous, since there are 5.5 times as many widows as there are
widowers, and many widowers marry younger women, whereas the marriage of older women
and younger men is frowned upon by society.\textsuperscript{73}

Statistically, women over 65 are less healthy than men (86 percent of older women
are said to have some chronic disability).\textsuperscript{74} Although older women live longer, they also
consult health care professionals more often than men do in the process of diagnosis, may
become a statistic which may account for this high percentage.\textsuperscript{75} Studies have indicated that
women cope with adversity, physical and emotional, better than do men. It appears that
women have had more experience in the area of pain, especially those who have encountered
child birth.

Since the special health needs of older black women have often been ignored by the
health care system and information services by the health care system, information services
are not always readily available, therefore, older women must take a more active role in
fulfilling their own health needs. This more active role can be fulfilled first, by learning
more about health, and second, by applying that knowledge to themselves and to their use
of the health care system.\textsuperscript{76} Health for the elderly may be conceptualized as the ability to live

\textsuperscript{73}Ibid., 6.

\textsuperscript{74}Ibid., 7.

\textsuperscript{75}Ibid.

\textsuperscript{76}Ibid., 8.
and function effectively in society and to exercise maximum self-reliance and autonomy; it is not necessarily the total absence of disease.\textsuperscript{77}

Health in the elderly is best measured in terms of functioning, that is, the degree of fitness, rather than extent of pathology. Elderly blacks tend to perceive their health according to their ability to perform activities of daily living and not according to laboratory or x-ray findings. It may be their assessments and perceptions of their health that give rise to their frequent delay in seeking care or reporting discomfort.\textsuperscript{78} Black elderly regardless of social class or income level, delay in seeking health care services.\textsuperscript{79}

As mentioned earlier, black Americans do not live as long as white Americans. In 1986, the life expectancy for blacks declined for the second consecutive year, the first back-to-back annual decline in this century.\textsuperscript{80} Black Americans are at a higher risk of death than whites throughout their lifespan, except at very advanced ages. Blacks not only do not live as long as whites, they do not live as healthy. Blacks are more at risk for ill health from several of the major chronic diseases (Heart diseases and stroke, diabetes, cancer, arthritis and hypertension).\textsuperscript{81}


\textsuperscript{78}Ibid., 61.

\textsuperscript{79}Ibid.


\textsuperscript{81}Ibid., 184.
Jackson maintains that there is a growing availability of data related to the aging Black populations but this data is hampered by several long standing problems. These problems include, 1) the persistent use of small samples, or over sampling of blacks, 2) the insufficient inclusion of all the variables that are known to affect or thought to affect black health, and 3) the frequent lack of black specific data. In much of the data, blacks are treated as if they constitute a separate population, but the usual sample design treats the total population of all races as the universe, which leads to the insufficient sampling of blacks. Jackson continues to argue that the growing availability of data related to the aging black population is usually cross-sectional, which prohibits investigations of age changes associated with the social determinants of the aging of black populations; too few studies to date, have analyzed the available data by age cohorts.

The available data about blacks rarely contain information on all of the variables that are believed to affect black health argues Jackson. Aside from race, sex, and age, very little data contains information about education, income, occupation, employment, marital status, living arrangements, accessibility and use of medical facilities; all of these variables may be social determinants of black health status. Jackson further maintains that there is an urgent


84Ibid., 79.

85Ibid.
need for a comprehensive systematic and integrated review of all of the literature, cultural, and social determinants of black health conditions and resources, including the use of resources that are related to black aging.86

Low social economic level (SEL) has been proposed as a major risk factor in mortality and morbidity, both alone and with other risk factors.87 Evidence suggests that higher SEL is associated with better health and lower morbidity and mortality. Researchers have found a relationship of SEL with blood pressure, cancer, coronary heart disease, cerebrovascular disease, diabetes, obesity and crude mortality rates. The lower socioeconomic status in older blacks are relatively worse off than comparable low socioeconomic status of whites in terms of perceived health status, restrictions of activities, work loss and number of days in bed due to disability.88 One of the ways in which individuals differ at different ages is in health status. This fact can be documented for many different conditions, maintains the United States Department of Health and Human Services.89


88Ibid., 22.

Self-perception of health is one of the few aspects of health beliefs applied to older persons. These perceptions are very important in understanding how health behaviors influence the appraisal of symptoms perceived important enough to seek treatment. Health perceptions are influenced by a number of factors. Boyer has demonstrated that they are shaped in old age by cultural norms of activity and inactivity and, more importantly, by the continuation of rewarding, roles and activities. In addition, to objectively defined health and morbidity, participation in social life and activities have greatly influenced the elderly’s perception of health.

Health is a significant factor in determining the longevity of elderly black people. Because racism has always existed in the United States, educational and preferable occupational opportunities often have not been available to the now elderly blacks in their earlier years. Therefore, very few are able to rely upon pension, savings, annuities, stocks and bonds. They are therefore relegated to dependency upon Social Security and public welfare for their existence.

THE CROSSOVER PHENOMENON

Watson stated that the 1960 Census of the population of the United States, vital statistics have shown that black females and males who live to be 70-75 years of age or older

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91Ibid., 198.

have longer life expectancies than their white counterparts.\textsuperscript{93} This phenomenon is known as the Crossover Phenomenon (the name comes from the reversal in differential life expectancy that occurs between blacks and whites after 70-75 years of age). Both black females and black males tend to have shorter life expectancies than their white counterparts up to ages 65-70. Then, for some reasons, not clearly known, there is a reversal in this pattern and blacks become the longer livers.

Watson contends that this phenomenon is puzzling and there has been very little research aimed at explaining this process.\textsuperscript{94} However, Siegel stated that there may be errors in the Census reports especially with reference to the ages of blacks.\textsuperscript{95} Edmonds argued that the prevailing theories from survival of the fittest to the genetic inheritance theory accounts for this phenomenon.\textsuperscript{96}

\textbf{SURVIVAL STRATEGIES/COPING MECHANISMS}

Survival strategies/coping mechanism is a process in which people appraise life events through their own interpretation of timing events and their personal history or scenario.\textsuperscript{97} When events challenge a person's scenario or self-esteem, survival strategies are


\textsuperscript{94}Ibid., 71.


activated that may alter the individual’s life story, aspirations or response to the event. In other words, age may be viewed from the perspective of the individual’s own life-span construct and scenario.98

Survival strategies/coping mechanisms may encompass the following events: 1) managing the situation, that is, solving problems or seeking help, 2) modifying the meaning or appraisal of the situation (from focusing on one’s own existential growth, to using humor, to refusing to think about the problem), and 3) managing stress symptoms (finding diversional activities, seeking social support, and finding a “safe place” to express frustration).99

Auerback states that health-psychological research has shown how coping can be an important determinant in an individual’s adaptation.100 Coping through the use of religious behavior appears to be a highly prevalent style especially among older adults.101 McCrae and Costa found that faith in God was rated as the most preferred and most effective coping

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98Ibid., 610.


mechanism for both problem-solving and distress reduction. Empirical studies of the relationship between religious coping and measures of distress have provided further support for the adaptability of religious coping.

Paragament, et. al. have demonstrated three problem-solving styles that include: Self-directing, Collaborative, and Deferring approaches. The self-directing style is an active problem-solving stance in which the individual takes primary responsibility to resolve problems while still maintaining religiousness: “God put me here on this earth and gave me the skills and strength to solve my problems myself. The collaborative style involves both the individual and God holding joint responsibility for the problem-solving process: “God is my partner. He works with me and strengthens me.” The deferring style relinquishes responsibility for the problem-solving to God and waits for the solutions to emerge through the active intervention of God: “I let God decide and wait for a sign from Him about what I should do.”

Pargament has also asserted that religion may be very beneficial to the individual facing a crisis. For example, a cancer patient could be viewed as an actual crisis that may require a patient to confront his or her own mortality, while maintaining hope for the future

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104 Ibid., 181.
following successful surgery. Acklin et al. maintain that this confrontation with one’s own mortality may be linked to an increased importance of the sense of the meaning of life.\textsuperscript{105}

One does not have to be a religious person to recognize that religion has an enormous impact on the live of millions of people. Jourard notes that for many people religion helps make life bearable.\textsuperscript{106} Jourard further acknowledges that:

Mankind needs reasons for living and if there are none, he/she begins to die...man is incurably religious. What varies among mankind is what they are religious about. Whatever a person takes to be the highest value in life can be regarded as his god, the focus and purpose of his time and life.\textsuperscript{107}

Relationships in the realms of “Spirituality” and “religion” are sometimes ambiguous. Lapierre states that religion is often experienced as a collection of rituals, rules, patterns of life, and other behavior to which one must adhere in order to be accepted in a particular religious group.\textsuperscript{108} However, in popular use, religion is often understood as what a person does in response to specific personal beliefs about a divine being or beings.\textsuperscript{109} On the other hand, a person’s individual spirituality may or may not incorporate the rules, rituals and behaviors of a particular religious group. Prezioso defines spirituality as our ability to stand


\textsuperscript{107}Ibid., 262.


\textsuperscript{109}Ibid., 522.
outside of ourselves and consider the meaning of our actions, the complexity of our motives and the impact we have on the world around us. It is our capacity to experience passion for a cause, compassion for others and forgiveness of self. It is a process of becoming, not an achievement. It involves the ongoing process of becoming.

Attributions to God may contribute to the manner in which people cope with as well as understand health-related situations. Several theorists have discussed the role of religious beliefs and coping. Some contend that God provides moral guidance and strength. Spilka, Hood and Gorsuch suggests that people are more likely to turn to religion in times of frustration and tension. Frankl has pointed out that God may be viewed as a source of ultimate justice, rectifying unfairness in the world.

Health-related situations present a special challenge to the need to find justice, meaning and control in life. Pargament and Hahn states that the tendency to turn to God for assistance is seen more frequently in situations involving negative rather that positive

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111 Ibid., 233.


outcomes. This type of attribution appears to reflect the desire for a controllable just world, one in which an individual's ability to cope is never exceeded, without God's help.

Religious behaviors are often used by older persons to cope with stressful life events and situations. Women, in particular, frequently report religious coping behaviors and do so nearly twice as often as men (58% versus 32%). Koenig states that the extent to which religion is used in coping varies by age (older), race (black versus white), educational level (lower), occupational status (manual workers), marital status (widowed, married), region of country (south), and size of town (50,000 or less).

Lazarus has divided coping behavior into two types, instrumental types that are aimed at altering the stress-provoking event and palliative types designed to regulate emotional responses to the event. Religion may be categorized as a palliative coping behavior, in that it has an impact on regulating emotional responses to stress, rather than altering the actual circumstances themselves. Moberg further divides religious coping into two major types,

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116 Ibid., 193.


one personal and the other institutional. A personal orientation reflects a person’s values, beliefs and attitudes, while an institutional one concerns social and communal religious activity such as church attendance, fellowship with church members, relating with the minister, or other religious group activity. Although much has been written about the social support function of organized religion, researchers have repeatedly observed that personal religious coping behavior (faith, trust, prayer, and so forth) are more frequently reported as helpful by older adults during times of stress than are communal or church related behaviors (seeking support from church members, ministers, involvement in religious social activities). Koenig contends that very little is known about older adults who use religion to help them cope. Despite the large proportion of older adults who use religion in coping, there are very little data on this behavior and on the people who practice it, particularly in later life. A study conducted by Koenig at the Center for the Study of Aging and Human Development at Duke University, Durham, North Carolina, found that older people who attend religious services are both less depressed and physically healthier than those who worship at home. “Church-related activity may prevent illness both by a direct effect, using prayer or Scripture reading as coping behaviors, as well as by an indirect effect through

121 Ibid., 74.
123 Ibid., 75.
its influence on health behaviors,” Koenig says. “For example, active religious participation may indirectly prevent health problems due to poor diet, substance abuse, smoking, self-destructive behaviors, or unsafe sexual practices, because these activities are discouraged by most religious groups.”125

People who pray only at home, do not enjoy the same mental or physical health benefits as those who attend church, the study found, in part because they may be too ill to attend services. In turn, physical illness can contribute to depression. Koenig’s study also found higher rates of depression among people whose only religious activity was viewing religious television, and higher rates of physical illness among both religious television viewers and those who prayed at home.126 (The study was conducted to examine the links among three religious behaviors: church service, private prayer, and religious television viewing).

**RELIGION AND COPING WITH CRISIS**

Gross states that “When misery is the greatest, God is the closest.”127 Gross believes that religion and faith in God often becomes very significant when one’s life and happiness are threatened. Many people feel that God will provide protection and comfort. Gross further contends that for many people, these needs are likely to increase with age.128 Growing threats

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125Ibid., 46.

126Ibid.


128Ibid., 242.
of infirmity, disease, social isolation, helplessness and death are concomitants of aging. At these times, "the most important problem in regard to religious beliefs is not their logical truth, but their functional significance" contends Wise.129

Religion may be called upon when serious illness strikes one's life. Under such conditions, religion's potential to influence one's life increases for several reasons. First, religion offers the individual meaning that suggest fulfillment and hope. Second, religious faith endows the person with a sense of control when little else counters the powerlessness that accompanies severe personal distress. Third, in threatening circumstances, feelings of despair and depression may dominate, and religion can maintain or enhance self-esteem. Finally, religious institutions may offer a variety of supports through services, church groups, clergy and pastoral counselors.130

Pargament posits that seeking help from God involves at least two relational patterns. One, the person may pray for help and perceive this action as placing the problem “in the hands of God.” In this deferring mode, the person is passive, but God is active. A second, pattern called collaborative style pictures a relationship in which both the person and God are active. One might pray for aid but also hold the view that “God helps those who help themselves.”131


A study on stress and coping among older blacks by Krause and Van Tranh found that religiosity correlated with greater feelings of personal control.\textsuperscript{132} Indication suggestive of deferring and possibly collaborative control favorably affect well-being. Collaborative control is strongly affiliated with a sense that God is involved in health matters and it also appears to counter a number of signs of real physical illness.\textsuperscript{133}

Religion offers people in crisis the hope of control over their situation. It may motivate them to try to change the existing state of affairs. If that is impossible, faith always has the potential of modifying the way reality is perceived.\textsuperscript{134} Prayer and participation in ceremonies and rituals are active cognitive coping strategies that moderate stress.\textsuperscript{135} Holahan and Moss also contend that stress is often greater in the later years because of the growing awareness of the increasing probability of retirement, poor health, bereavement, the loss of a number of sources of satisfaction, and death.\textsuperscript{136} Despite the use of the terminology, the “golden years”, our society does not look favorably upon old people, leaving one’s religion and the church as one of the few remaining need-fulfilling avenues open to many elderly.


\textsuperscript{133}\textsuperscript{D.N. McIntosh and B. Spilka, “Religion and Physical Health: The Role of Personal Faith and Control Beliefs,” The Social Scientific Study of Religion 2 (1990): 167.}

\textsuperscript{134}\textsuperscript{Ibid.}


\textsuperscript{136}\textsuperscript{Ibid., 400.}
Benson and Elkin maintain that religious beliefs hold the potential for empowerment and the enhancement of self-esteem. To the extent that nature and society may limit the options available to people as they age, religious faith offers promise and potential.

With very little contradictions, research shows that religion serves positive functions throughout adulthood, especially among elderly persons in the areas of life satisfaction, mental health, and physical health. Study after study, many using national adult samples, have shown that church attendance, religious beliefs, and the social measures of religion counter distress, loneliness, depression, and personal adversity. Peterson and Roy argue that faith accomplishes these ends by providing believers with a sense of meaning and purpose that lessens anxiety. Stress is reduced by the use of prayer and religious involvement, both of which may support self-esteem.

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137Ibid.
Religion has also been found to help promote health and decrease illness, perhaps by bolstering the body’s immune system.\textsuperscript{143} Levin and Schiller surveyed more than 200 empirical studies and found that general health status and longevity correlated positively with religious commitment and involvement.\textsuperscript{144}

Many religious groups counsel and teach good health habits and oppose unhealthy behavior. The Jehovah’s Witnesses, Seventh Day Adventist and the Mormons (Church of Jesus Christ of Latter-Day Saints) are noted for their emphasis on good nutrition and wellness, and their health statistics show the benefits of their practices. King also notes the social support offered by some churches to elderly and sick members may aid in their recovery as well as enhance their resistance to illness.\textsuperscript{145}

Religion is an important part in the lives of many Americans and seems to be of the greatest importance among elderly persons. It serves many people well, helping them cope with trials and hardships of life by providing a positive sense of meaning. In our society, these needs usually become more critical as we age.


LIFE SATISFACTION

Although health is known to affect life satisfaction, Sauer reports that mainly health and solitary activities influence life satisfaction among blacks.\(^{146}\) High physical impairments lead to lower life satisfaction for both blacks and whites.\(^{147}\)

The transition to old age is a period of status and role losses. The ability to adjust or cope with these losses are central to life satisfaction in general. Sauer and Warland wrote that “the adjustment to old age has been defined in terms of morale, happiness, psychological well-being, and life satisfaction.”\(^{148}\) A review of the gerontological literature shows that there have been many persistent studies of life satisfaction among the aged. Most of these studies could be categorized as descriptive with some form of structural analysis on the subjective well-being of older Americans.\(^{149}\)

Exactly what is life satisfaction, and how is it measured? George and Bearon define life satisfaction as a relatively stable attitude toward fulfillment or achievement in one’s life.\(^{150}\) It refers to an assessment of the overall conditions of one’s aspiration as compared to one’s actual achievements in life.


\(^{147}\) Ibid.


\(^{149}\) Ibid., 200.

As far as the measurement of life satisfaction is concerned, Havighurst et al. were among the first researchers to develop an instrument. Their instrument grew out of the Kansas City Study of Adult Life, conducted during the 1950s. They believed that life satisfaction is composed of five concepts: (1) fortitude or resilience, (2) zest for life, (3) self concept, (4) mood tone, and (5) congruence between achieved and desired goals. According to the literature, perceived health, adequate income, socioeconomic status, social activity, religiosity and marital status are among the most pre-eminent predictors of life satisfaction. That is, individuals who score high on the LSI (Life Satisfaction Instrument) are those who are in good health, members of the middle or upper class, and who engage in a variety of social activities. Of the variable mentioned, perceived health and adequate income are most often viewed as being more positively correlated with life satisfaction than any other variables. For example, Spreitzer and Snyder replicated and extended earlier studies of the correlates of life satisfaction among older persons. Their findings concurred with the previous research showing the importance of perceived health condition and financial security as predictors of life satisfaction. They were also able to obtain age and sex difference for the measure of life satisfaction. From their literature, they reported that women over 65 are less likely to report high incidents of life satisfaction than men of the

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same age group. They suggested that this finding might be related to a higher incidence of
widowhood among women over 65 as compared to men over 65.153

Toseland and Sykes examined social activity as a variable that correlates positively
with life satisfaction among the elderly.154 They found that life satisfaction was predicted
by the respondent’s activity level, financial status and health status. Several scholars have
focused their attention on the use of life satisfaction to explain aging. The life satisfaction
approach seeks to determine if older persons are happy and satisfied with their past and
present life and defines their happiness and satisfaction within the context of successful
aging.155 The life satisfaction approach is a subjective rather than objective approach in that
it delineates successful aging from the position of inner happiness, satisfaction and
contentment of aging in contrast to viewing successful aging as an adjustment to external
conditions.156

Markides and Mindel interviewed more than one hundred subjects 60 years of age
and older and obtained information regarding the education, income, health and activity level

153Ibid., 454.

154R. Toseland and J. Rasch “Correlates of Life Satisfaction: An AID Analysis.”

155R. Toseland and J. Sykes, “Senior Citizens Center Participation and Other
Correlates of Life Satisfaction,” The Gerontologist 17, no. 3 (1977): 235-236.

for each\textsuperscript{157}. They found that health and activity were the strongest predictors of life satisfaction. They also found that income influenced life satisfaction indirectly through activities. Several researchers have found a high correlation between life satisfaction and religiosity. Studies have shown that the degree of religiosity increases with age, and the higher the degree, the greater the level of life satisfaction. Jackson et al. for example, pointed out that for black aged intrinsic religiosity was highly correlated with life satisfaction.\textsuperscript{158} That is, individuals with a strong belief system had a higher life satisfaction score than those who did not.

Moberg stated that most of the research on religiosity and life satisfaction has been directed at measuring extrinsic forms of religiosity, such as church attendance, tithing, and participation in church activities as opposed to intrinsic forms of religiosity, such as beliefs systems.\textsuperscript{159} Church attendance or church-related activities have been reported to relate significantly to both “happiness” and “life satisfaction” by a number of researchers such as

\begin{footnotesize}
\begin{enumerate}
\item D.O. Moberg, “Religiosity in Old Age,” \textit{The Gerontologist} 5 no.2 (1965): 78-87.
\end{enumerate}
\end{footnotesize}
O'Reilly, Palmore, Shanas and Edwards and Klemmack. These researchers found out in their studies that income level and perceived health were the two strongest indicators of life satisfaction, church-related activities, however, were the next strongest predictors of life satisfaction.

Guy examined life satisfaction and frequency of church attendance among 1,170 elderly adults residing in a southern metropolitan area (Memphis, Tennessee). She found that elderly individuals who had decreased their church attendance from earlier years had lower life satisfaction than those individuals with increased church-attendance or those who maintained the pattern of their earlier years.

Along these same lines, Graney found that religious activities were positively correlated with happiness among the “young old” (age 66 to 75, N=16), but not the “old old”


(age 82 to 92, N=17). Categories of religious activity were “never,” “sometimes”, and “at least once per week.” Koenig and Blake, confirmed Graney’s findings of a significant association between religious activity and life satisfaction in the young old (age 60-74), and additionally found no association among the old old (age 75 and older).

Cutler studied the impact of participation in voluntary associations or well-being among a national sample of 438 older adults (mean age 72). He found that church membership was the most common among all organizations participated in by the elderly. It was also the only organization whose membership was associated with well-being. Cutler explained this phenomenon by pointing out that church affiliated groups to which the older persons belonged were characterized by a greater degree of age homogeneity than with other types of associations. Cutler, also suggested a possible association between psychological well-being and religiosity in general.

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168Ibid., 156.
169Ibid.
Blazer and Palmore have followed elderly subjects the longest thus far. They examined the change in relationship of religious activities and well-being over an eighteen year time span and found that religious activities were significantly related to happiness especially among men and among participants over seventy. Their findings influenced Blazer and Palmore's thoughts that religious activities were more important than attitudes in influencing adjustment. They were led to believe that as people age, religion takes on a greater role as a predictor of well-being. Koenig, et al. In a sample of 836 older adults, found that church attendance and involvement in religious community activities were significantly related to well-being. The importance of religion in the lives of older blacks has been underscored by Taylor. He demonstrated the effect of gender, marital status, age, and urbanicity or religious participation by this group.

Several studies have noted the strong relationship between life satisfaction and church attendance in blacks. St. George and McNamara examined the relationship between psychological well-being and religious measures among 1,353 men and 1,570 women age twenty-five to fifty-four in the NORC (National Opinion Research Center at the University


171Ibid., 82.


of Chicago, 1972-1982) national surveys.\textsuperscript{174} The religious frequency of church attendance and strength of religious preference were reported to be good predictors of well-being especially among blacks.

Ortega and other scholars also reported on the powerful role played by religious factors in enhancing well-being among minority groups. They argued that despite being more likely to suffer from inadequate housing and low income, racial minorities are at least as well-off as older white adults in terms of subjective well-being.\textsuperscript{175}

Koenig and other scholars study underscores the importance of the church as a powerful source of social support for older persons, regardless of race.\textsuperscript{176} In a survey of 4,522 older adults in Alabama, life satisfaction was entered as the dependent variables. Well-being was the frequency of contact with church related friends. Explanations given for this include, 1) the church is the center of a moral community, 2) it is a community of faith where members share common beliefs that impact positively on their sense of well-being, and 3) the church serves as an extended family for its participants. Koenig et al. further maintains that religious beliefs have a positive association between religious beliefs, mental health and physical illness.\textsuperscript{177}


\textsuperscript{177}Ibid.
Life satisfaction is relative to the types of experiences older persons have had throughout their lives. It is closely related to one's philosophical point of view and cultural values. Life satisfaction for this study was based on the experiences older black women have had either positive or negative that have impacted their lives. The intent was to determine the extent to which they felt things have changed for better or worse during their lifetime. Many elderly women contend that they are relatively satisfied because they have learned to cope with their life situations. Most of these women who have a strong faith in God maintain that "God will see you through." This faith gives them the encouragement and stamina to "keep on keeping on," said one of these women. Some of the women see the ability to cope with life as their major source of life satisfaction and feel that they do not need much else. One of the respondents said and I quote her, "I have Jesus and that is enough."

Jackson, the eminent scholar on older (65 years plus) black women contends that there is "No average old black woman," even though The National Caucus and Center on Black Aged and The American Association for Retired Persons continue to define old age. Older black women are characterized in two main ways: being great or extraordinary and as victims of racism, sexism, ageism, and classism.


Interest in older black women developed out of the researcher's informal interactions with and observations of older black women in a variety of settings, such as community events, church meetings, educational institutions, as a minister's spouse and general conversations. Equally important was the fact that the researcher (given longevity) will eventually become a member of this age group.

Berry argues that empirical research on aged black women and life satisfaction is minimal. This age group however, may be included in studies that include race, age, and gender as independent variables. Since very little is known about older black women, this study will aid in our knowledge on this group in our society.

Jackson describes the older black woman as one who has lived through the Depression, periods of economic recession, and periods of economic and social segregation as members of an elite group of aged black women who have survived to reach old age.

Research on the aged that utilizes life satisfaction scales reports that there is a relationship between income and well-being: Low income is negatively related to life satisfaction. These woman feel that religion is important to their lives. That is, it is a part

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of how they view themselves. Most of them quote the golden rule: “Do unto others as you
would have others do unto you.” This is their personal philosophy. Based on their
statements these women try to live what they believe. They believe it is right to treat other
people the way they would like other people to treat them. In spite of constraints placed on
them, many older black women have done something with their lives. Some have completed
high school, some have advanced their education to college and master’s degrees, many have
maintained relatively stable marriages and family relations. Many have bought and owned
homes and are established in their communities; some have volunteered their time and
energy for various causes, they have helped others less fortunate than themselves and they
did all this and more while working various jobs outside the home.\textsuperscript{184}

\textbf{SUPPORT NETWORKS}

1) \textbf{Social:}

Social scientists use the term “social support” to encompass a variety of actions and
tasks: offering tangible assistance, such as housing and money; offering advice; reassuring
the person that he or she is loved; and affirming the individual’s membership in a group or
network of caring others. The goal of these actions is to offset physical problems created by
illness or to counter negative emotional reactions (e.g., depression and anxiety) that often
develop with illness.\textsuperscript{185}

\textsuperscript{184}\textit{Ibid.}, 338.

\textsuperscript{185}B.J. Felton, “Coping and Social Support in Older People’s Experiences of
Chronic Illness,” in \textit{Stress and Coping} ed. M.A.P. Stephens et al. (New York:
Social support theory proposes that the “active ingredient” of social support is its ability to buffer people from the expectable negative consequences of stress. Cohen and Wills suggest that social support seems to act as a buffer against the emotional toll of stress, particular when the support creates in recipients the perception that caring people are available to them when life becomes stressful.\textsuperscript{186}

Arling stated that the most important role of social support in chronic illness is its ability to influence emotional well-being. There are two types of social support that have proved effective in chronic illness, namely, instrumental and emotional support. These two types operate in distinct ways and may offer different kinds of benefit.\textsuperscript{187}

2) \textbf{Instrumental Support.}

The provision of assistance with day-to-day problems has both practical and emotional significance to the chronically ill. Perhaps that most important role played by instrumental assistance is preventing, or at least forestalling, institutionalization.\textsuperscript{188} Kin, the most typical and most preferred providers of instrumental assistance to elderly persons, and act as informal brokers of medical care use of elderly persons by their kin.\textsuperscript{189}

\begin{flushright}


\textsuperscript{188}Ibid., 107.

\end{flushright}
3) **Emotional Support.**

Emotional support is the component of social support that is most consistently related to adjustment. This result has been found in studies of all types of stressors.\(^{190}\)

**RELIGIOUS COPING**

Koenig states that religious coping is the reliance on religious belief or activity to help manage emotional stress or physical discomfort.\(^{191}\) Koenig also contends that religious coping is common among older adults dwelling in the community, and further argues that women are more likely to be tender-minded and more likely to use religion as a coping mechanism than men.\(^{192}\)

O’Brien maintains that there is a growing amount of evidence that Judeo-Christian belief system help bolster the coping ability of the elderly with chronic physical illness.\(^{193}\) In a three-year longitudinal study, O’Brien examined the role of religion in the adjustment of patients with chronic diseases.\(^{194}\) She found that 74% of the patients noted that religious or ethical beliefs were to some degree associated with adjustments to their disease. After


\(^{192}\)Ibid., 18.


\(^{194}\)Ibid., 68.
three years of the follow-up, 27% of reinterviewed patients in the overall sample noted their reliance on religion had significantly increased.

Those reporting the most positive attitude toward religion also reported the highest degree of compliance with the therapy, and the least amount of alienation.195 Kroll and Sheehan pointed out in their study that religion played an important and often central role in the lives of many of their patients.196 They noted that religion may have a positive value in filling a void and supplying strength and meaning in life. Behaviors such as prayer, trust or faith in God, or reading religious literature such as the Bible may confer an inner peace through building up hope, encouraging positive attitudes towards the situation, and distracting the individual from senseless ruminations concerning problems over which they have little control. Believing that there is a God in control of the situation who cares about them personally, has their best interest in mind, and is responsive to their prayers, may ease the anxiety associated with their condition or situation.197 "Putting it in the hands of the Lord" may displace the burden of uncontrollable stressful situations away from the individual and thereby obtain at least temporary psychological relief contends Kroll and 


197Ibid., 109.
Sheehan.\textsuperscript{198} Taylor and Chatters state that religious organizations are important sources of informal social support for many older persons both blacks and whites.\textsuperscript{199}

Religious beliefs and activities are common among older adults today. Many individuals rely heavily upon religious behaviors to cope with emotional and physical distress that may occur in late life. Research has shown that traditional Judeo-Christian beliefs and activities may serve as a buffer against the stresses that accompany ill-health and may also protect against depression. These effects may also impact health care utilization and physical health outcomes.\textsuperscript{200}

Religious communities also provide reinforcement of beliefs that relieve anxiety and attitudes of relating to others that help maintain social relationships. In the religious communities, health destructive coping behaviors such as drug or alcohol use are discouraged, whereas mental health enhancing behavior such as service to others are encouraged.\textsuperscript{201} Judeo-Christian beliefs also emphasize the need to care for the physical body both in terms of proper nutrition (through dietary practices), protection against disease (hand cleaning, food preparation, avoidance of sexual promiscuity), and avoidance of excesses that would be inimical to health (gluttony or alcoholism). Hence there may be direct positive

\textsuperscript{198}Ibid.


\textsuperscript{201}Ibid., 19.
efforts of religious belief and practice on physical health. Religion may also provide a
cognitive framework for dealing with anger and aggression directed at self and others and
allows emotional release through rituals such as confessions and activities such as singing
and dancing.\textsuperscript{202}

Lazarus and Folkman defined coping as a process through which individuals try to
understand and deal with significant personal or situational demands in their lives.\textsuperscript{203} They
have identified several complex and continually evolving elements in the coping process.
These include situations, appraisal, coping activities, psychosocial resources and constraints,
and coping function. A model of the coping process which specifies these elements is
depicted in Figure 1.\textsuperscript{204}

None of the elements in the coping process act alone, they are closely interconnected
and are part of a process in which change in any element has ramifications for the whole
process.

1) Situations. The model begins with "situations" that people encounter,
such as major events, chronic problems, daily tasks, or other problems.

\textsuperscript{202}\textit{Ibid.}

\textsuperscript{203}R. Lazarus and S. Folkman, "Stress, Appraisal, and Coping," in \textit{Religion and
Prevention in Mental Health: Research, Vision, and Action} ed. Pargament, K.I., Manton,

\textsuperscript{204}K.I. Pargament, "God Help Me: Towards a Theoretical Framework for the
195-224.
It is important to note that people actively construct their situations as well as respond to them.

2) Appraisals. How people "appraise" a situation is an important determinant of how they will distinguish between two related aspects of their appraisal process: evaluation of the situation’s implication\textsuperscript{205} and options for handling the situation.\textsuperscript{206}


### Figure 1

**SOME DIFFERENT RELIGIOUS COPING ACTIVITIES and THEIR OUTCOMES**

<table>
<thead>
<tr>
<th>COPING ACTIVITY</th>
<th>EXAMPLES</th>
<th>OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Religious</td>
</tr>
<tr>
<td>Spiritually-based</td>
<td>trusting God for protection; turning to God for guidance</td>
<td>+++</td>
</tr>
<tr>
<td>Good Deeds</td>
<td>confessing sins; being more loving</td>
<td>++</td>
</tr>
<tr>
<td>Religious Support</td>
<td>receiving support from the clergy; receiving support from the church</td>
<td>++</td>
</tr>
<tr>
<td>Discontent</td>
<td>feeling angry with God; questioning one’s faith</td>
<td>-</td>
</tr>
<tr>
<td>Pleading</td>
<td>asking for a miracle; asking God why it happened</td>
<td>+</td>
</tr>
<tr>
<td>Religious Avoidance</td>
<td>letting God solve the problem; focusing on the world-to-come instead of the problem</td>
<td>++</td>
</tr>
</tbody>
</table>

**Size of Relationship**

- + or - modest \((r < .4)\)
- ++ moderate \((.4 < r < .7)\)
- +++ large \((r > .7)\)

McCrae has also pointed out that different kinds of events pose different types of coping demands.207

3) Coping Activities. Depending on how the situation is appraised, individuals can use any of a variety of activities to cope. Examples of such activities include information-seeking, direct action, and seeking support from others.208

4) Outcomes. Coping can impact people at a variety of levels including psychological, social, and physical.209 For example, coping may result in an altered sense of self-esteem thereby affecting the person’s psychological level. A person’s coping efforts may tend to either alienate others or enlist their support, thereby influencing social outcomes such as a reduction or increase in headache pain.210

5) Resources and Constraints. A number of personal and social factors serve as resources and constraints which shape the coping process. For example, social network may provide members with advice, guidance, and models for


209Ibid., 133.

210Ibid.
dealing with certain kinds of circumstances. While poverty, moral taboos, or psychological difficulties place important limitations on the way people cope.\footnote{G.R. Collins, \textit{Innovative Approaches to Counseling} (Waco: Word Press, 1986), 28-32.}


\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{coping_process.png}
\caption{The Coping Process}
\end{figure}

\textbf{Figure 2. The Coping Process}

\begin{itemize}
\item Resources and Constraints
\item Situations
\item Appraisals
\item Activities
\item Outcomes
\item Coping Functions
\end{itemize}

INFORMAL SOCIAL SUPPORT NETWORKS

Taylor stated that "older blacks represent one of the most severely disadvantaged groups in our society."213 Recent studies of elderly blacks and their family relations indicate that elderly blacks have extensive contact with their children and grandchildren. However, Taylor points out that research on social support networks of the elderly suffers from a lack of a clear theoretical framework from which to couch the body of empirical findings.214 It is generally acknowledged that the elderly in the United States are not isolated from their kinship networks, but rather are members of modified extended families.215

Social support is provided to the elderly in a variety of ways, including material aid such as (food, money, transportation and running errands), cognitive aid (advice, counseling, and emotional) assistance (visiting, companionship).216

The black elderly are less likely to receive money from relatives due in part to the low socioeconomic status of blacks. During emergencies blacks are more likely to give and receive financial assistance.217 Gibson's study revealed that elderly blacks utilized a more

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214 Ibid., 260.

215 Ibid., 261.


diverse pool of helpers than did whites. (The African concept of the extended family concept due to necessity.) In middle and late life, blacks were more versatile in utilizing help from family and friends. While whites were more likely to limit their support to spouses in middle life and to a single family member in old age.218

Mutran’s study of intergenerational family support argued that black families were more involved in exchange of help across generations.219 Elderly blacks in comparison to elderly whites gave more help to children and grandchildren. Elderly black parents were also more likely to receive help from adult children. Due to racial and socioeconomic effects, elderly blacks tended to receive more help from their children by virtue of their lower income and educational levels. Because of adverse economic conditions, extended families were viewed as the most enduring family form among lower-class blacks.220

McAdoo found that the majority of respondents in her study were involved in reciprocal support networks composed of both family and friends.221 Children, financial help, and emotional assistance tended to be more the prevalent type of support exchange within the family.


In a cross-cultural study of minority aging, Stanford found that 7 of 10 elderly blacks indicated providing assistance to others.\textsuperscript{222} The type of help given by older blacks was physical help or normal household chores, help during an illness, financial help, transportation, talking/counseling, food/meals. Research indicates that, when in need, the elderly are more likely to seek help from their children as opposed to siblings and other relatives.\textsuperscript{223}

Having children is an important determinant of the helping networks of elderly blacks according to a recent analyses of National Survey of Black Americans (NSBA).\textsuperscript{224} The survey showed how the presence of children was related to larger helper networks comprised of immediate family only. In absence of children, substitutions of other kin and nonkin are made. For example, childless elderly are more likely to rely upon brothers, sisters and friends. Despite these compensations, childless elderly are still at a disadvantage with reference to helper network size. Having a pool of available helpers is an important determinant in receiving support.

A consistent finding in the literature is that blacks of all ages are more likely than whites to reside in extended households.\textsuperscript{225} Although older blacks are less likely than older whites to live with a spouse, they are less likely than older whites to live alone and more


\textsuperscript{223}E. Shanas, \textit{The Health of Older People: A Social Survey}.


likely to live with more than one person. Elderly blacks are more likely than elderly whites
to welcome children, grandchildren, nieces and nephews into their households. Blacks are
also more likely to raise the children of others.\textsuperscript{226}

Taylor contends that there is very little literature on family arrangements as an
effective mechanism for pooling limited resources, mitigating economic deprivation, and
creating more viable economic units.\textsuperscript{227} "Doubling up" in extended households has an
important bearing on the economic welfare of the family and, when compared to direct cash
transfers, is usually a less expensive method of providing for needy relatives.\textsuperscript{228} Gibson
found that friends and neighbors were integral components of the support networks of middle
and late-life blacks.\textsuperscript{229}

McAdoo's study also highlights the importance of the friendship role among older
blacks.\textsuperscript{230} A recent study found that elderly blacks interacted on a frequent basis with
friends. Chatters et al maintains that nonkin in the form of friends and neighbors are integral

\textsuperscript{226}E. Shanas, “National Survey of the Elderly.” Report to Administration on

\textsuperscript{227}R.J. Taylor, “Aging and Supportive Relationships among Black Americans,” in
The Black American Elderly: Research on Physical and Psycho-social Health ed. James

\textsuperscript{228}Ibid., 267-268.

\textsuperscript{229}R.C. Gibson, “Blacks at Middle and Late Life: Resources and Coping,” in

\textsuperscript{230}H.P. McAdoo, “Factors Related to Stability in Upwardly Mobile Black
members of the support networks of elderly blacks and are important for both childless and spouseless elderly black.\textsuperscript{231}

**THE CHURCH SUPPORT NETWORK**

Historically and present day evidence suggests that black churches are extensively involved in the provision of support to their members. Church members exchange material, emotional, and spiritual assistance with one another, as well as provide information and give advise to one another. The church also plays a role in providing positive appraisal (self-esteem) and the sharing of beliefs and attitudes held by the congregation.\textsuperscript{232}

Taylor and Chatters found in their analysis that church attendance was a critical indicator of both frequency and amount of assistance received.\textsuperscript{233} They discovered that church members provided a variety of assistance such as spiritual (praying together), financial assistance, goods and services. For elderly blacks with children, as age increased the frequency of assistance from church similarly increased.

For childless elderly, increases in age were associated with dramatic decreases in the frequency of support. The very old without children were in the most disadvantageous position in terms of receiving support from church members. These findings demonstrate

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that adult children apparently facilitate linkages to church support networks for their elderly parents.\footnote{Ibid., 432.}

Achenbaum notes that similar to our own times, aging in biblical times was not without its problems, including intergenerational conflict or disharmony.\footnote{W.A. Achenbaum, “Societal Perception of Aging and the Aged,” in \textit{Handbook of Aging and the Social Science}, 2nd ed., ed Robert H. Binstock and Ethel Shanas (New York: Van Nostrand Reinhold, 1985), 132.} The commandment to “honor thy father and thy mother” conditions the well-being of younger generations on assuming the personal and social safety of the aged. While respect for old age and concern are dominant themes in the Old Testament, “they were neither easily attainable nor motivated by human generosity and compassion; in fact, “those who failed to provide the aged with care and support had to be prepared to face the consequences.” Thus, it was not taken for granted that respect, care, and support would automatically be bestowed upon the aged by younger members of their families and societies.

Jackson maintains that black churches and major black church organizations have generally been historically absent from any critical involvement in helping to shape American public and private attitudes about the aged.\footnote{J.J. Jackson, “Social Characteristics of Black Elders in Pitt County, North Carolina,” (\textit{MTEAMBE Final Report to AOA}, 1992-93), 1-75.} Available data on the formal involvement of black churches in providing instrumental and emotional support to aged blacks in their churches and communities are scant. The limited data that are available
suggest that most black churches have no formal programs that are specifically targeted toward the aged.

In 1986, Lincoln and Mamiya conducted a national survey of pastors of 610 rural and 1,531 urban black churches in the United States. Only 38.7 percent of the rural and 36.7 percent of the urban pastors in that survey were in churches that sponsored a senior citizens group. Only about 3.6 percent of the rural and 9.2 percent of the urban black churches had an outreach cooperation with elderly agencies and programs. Jackson suggests that since 55.4 percent of the rural and 47.8 percent of the urban pastors Lincoln and Mamiya interviewed were not college graduates, it is possible that many of the pastors had not been exposed to aging-oriented curricula.

While formal black church involvement in elderly-targeted programs is low, findings from a national survey conducted almost two decades ago suggested that black churches were the focal points of black elderly informal supportive networks. Taylor and Chatters found that frequency and quantity of support form black churches to aged blacks is most influenced by their frequency of church attendance. The main form of church support is


social emotional aid during illness. Aged blacks with children who were active church members were more likely to receive church aid than were those without children or those with children who were not active church members.

According to Reverend Fred L. Shuttlesworth, a noted black civil-rights leader and a Baptist pastor in Cincinnati, Ohio, most black Baptist churches have no formal support networks even for their own elderly members. The informal pastoral services are largely confined to occasional visits, prayers and communion rites to house-bound elders.

A few black Baptist churches, he said, participate in private and public funded elderly programs, but organized black Baptist public advocacy for the elderly really does not exist. This may be due in part to the lack of formal training in aging and perhaps the pastors do not fully recognize the problems of aging that are associated not only with the “graying of America,” but also with the “graying of black America” (Jackson, 1993).

CHAPTER 3
THEORETICAL FRAMEWORK

There are several theoretical implications presented in this study which are supported by current research in gerontology. First, there is the given fact of life, as years go by, persons will join the ranks of the chronologically aged and will become members of a different generational cohort as compared to their predecessors. Second, the aged as a group are becoming older. Between 1960 and 1970 the group over age 75 grew three times as great as the group 65 to 74 (37% vs. 13%).

Based on the National Council on Aging, the relative health status of the aged in general is not declining and in many respects may be improving. What appears to be happening is that improved medical care plus the changing characteristics of successive cohorts among the aged, are canceling out the negative effects of the aged growing population. Third, there is no clear and generally accepted national policy on aging. Additionally, the field of gerontology is only recently beginning to make an impact on aging.

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The present study has provided research data on an elderly minority sample of the population for which there is at present inadequate information. Studies on health and aging have seldom included the aged black woman, except as an amalgamation of all people of color. Consequently, little information exists in the literature concerning factors associated with this specific group. Since aged black women comprise the fastest growing group in America, there is a growing need to include them more specifically in the literature and a need for information to guide the planning of health services for this population.

Many theories have been advanced to explain age and health related behavioral changes. Some of these are psychological (Erikson), others biological (Tobin,) (Weg), and still others sociological. Each of these models provide competing explanations of the different dimensions of aging. It is important to note that there does not exist an all-encompassing theory of aging.

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This point is adequately stated by McKenzie:

No single theory provides an all inclusive conceptual foundation from which aging may be viewed, interpreted, and investigated. Furthermore, no such comprehensive theory appears to be forthcoming in the foreseeable future, and it is reasonable to suggest that such a theory may never become a reality. The enormous complexities involved in aging and the process of aging operate strongly against the formulation of an all-encompassing, yet function theory.\(^6\)

Since there is a lack of comprehensive theory of aging, researchers must focus their studies around theories dealing with biological, psychological, and social aspects of aging in older women.

Simmons’ classic work provided the first comparative study of aging. He examined the status and treatment of the elderly in 71 “primitive societies.” Simmons was interested in discovering general trends in behavior toward the elderly. He examined three basic categories of traits: (1) habitat, maintenance, and economy; (2) political and social organization; and (3) religion and other beliefs and practices. The conclusion drawn from Simmons’ study show wide variation among the societies studied, however there were general trends which were related to the level of technological development and social organization. Simmons found that: the status of the elderly was related to the value they held as important members of the society. With higher status, a greater amount of security was expected in old age.\(^7\) Status was ascribed or achieved accordingly to specific roles and the ability of the elderly person to provide needed skills and knowledge; or, in terms of the

\(^6\)McKenzie, Aging and Old Age, 33.

authority he/she wielded over other members of the society as a result of tradition or wealth or power.  

Another finding which is important to contemporary gerontological research, and relevant to my study, is that: the welfare of the elderly and the special treatment they receive (e.g., in terms of food and maintenance) is based, to some extent, on kinship obligations and communal sharing.

Some studies adopted a role and status approach in terms of the influence of modernization. Maxwell and Silverman in their study, found that societies have a tendency to value their aged in accord with the amount of useful information they have within their control. Changes in industrialization and modernization have contributed to the obsolescence of traditional institutions. The role of the elderly as culture bearers has faded to the extent that the previous roles and prestige for the elderly have been lost.

Cowgill and Holmes hypothesized that:

... the role and status of the aged varies systematically with the degree of modernization of society and that modernization tends to decrease the relative status of aged and to undermine their security within the social system.

Their study is important in the development of a theory of aging which advances a cross-cultural perspective in the identification of universals and variations in the attitudes about

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8Ibid., 252.

9Ibid., 253.

10Ibid., 253.

aging, and the status and treatment of the elderly within a cultural context. Cowgill and Holmes listed eight variations that would account for the demographic and social characteristics of the aged in all societies. These included the aged as a minority in the population, fewer older men than woman, and mores which prescribed for mutual responsibility between old people and their children.\(^1\)

Three of the variations discussed by Cowgill and Holmes are relevant to my study. They are:

1. ...the status of the aged is high in those societies in which they are able to continue to perform useful and valued functions; however, this is contingent upon the values of the society as well as upon the specific activities of the aged.

2. ...the status of the aged is high in societies in which the extended form of the family is prevalent and tends to be lower in societies which favor the nuclear form of the family and neolocal marriage...

3. with modernization the responsibility for the provision of economic security for dependent aged tends to be shifted from the family to the State.\(^2\)

These variations may be examined for further adaptations within the cultural context of ethnic or minority sub-groups within a society. In this study, the status of elderly black women is contingent upon the values of the sub-group as well as those of the larger society. It may be assumed that the status of these elderly women will be high in situations in which they continue to perform useful or valued functions. This is most likely to occur where some form of the extended family still exists. In many industrial societies the responsibility for

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\(^{12}\)Ibid., 23.

\(^{13}\)Ibid.
provisions for the elderly has shifted, at least to some degree, from the family to the state. However, among the elderly in the United States, the state does not assume total responsibility, and varied adaptive mechanisms are utilized to compensate for this imbalance.

**SELF, SOCIETAL CONCEPTIONS AND ATTITUDES TOWARD AGING**

Social gerontology and adult developmental psychology provide several theoretical frames of references relevant to the concept of the individuals and the society about aging. Perhaps the most well known, and equally controversial point of view, is the "disengagement theory".

In this theory, there is a gradual and mutual withdrawal on the part of the individual, and the other members of society, as the aging person grows older. The decrease in social interaction is mutually agreed upon and viewed as a natural process. This theory does not consider cultural diversity and fails to recognize societies where the elderly are accorded prestige and power as they grow older.\(^\text{14}\) For the individual, disengagement is viewed as a phenomenon that is accepted without conflict and is desired by most people. This theory fails to consider those who have been relatively non-participant throughout their lifetime and have always maintained a degree of disengagement.

The "activity theory" simply states the opposite of disengagement by asserting that the individuals during old age are much the same as they were at middle age and strive to retain the same level of activity and social interaction as long as possible. The decrease in social interaction and the withdrawal from society is believed to be against the will of most.

people in old age.\textsuperscript{15} It is believed that “successful aging” is measured by the person’s ability to remain active. Consequently, new roles and new activities are sought to replace those lost.

The “disengagement” and “activity” theories constitute polar opposites; yet, both of them serve as measures of “successful aging”, on one hand, the individual who is able to withdraw has faced old age with success. Conversely, if the individual remains active he/she has been successful. The authors of these theories inflect a value judgement. The researcher’s approach avoids making such judgements, therefore, the phase “successful aging” is not emphasized in the study.

Discussions of “successful” or “unsuccessful” aging also deal with the individual’s capacity to cope with problems associated with growing older. These problems range from self-concepts about one’s personal appearance to perceived or actual isolation and loneliness. An inability to accept oneself in old age, or the conditions which come with it, may contribute to the increasing problem of alcoholism, mental illness, and suicide among the elderly.\textsuperscript{16}

Another theory which seems to take a more realistic approach in explaining human behavior in later life is the “continuity theory.” The continuity theory considers continuity as well as change in life cycle.\textsuperscript{17} Atchley maintains that the concept of continuity recognizes

\begin{footnotesize}
\begin{enumerate}
\item Ibid., 170-172.
\end{enumerate}
\end{footnotesize}
that most adults maintain their habits, personal preferences, and associations as long as possible. However, situational factors and opportunities for continuity may evoke changes. In the "continuity theory," lost roles do not have to be replaced. In this view, the individual is seen to adapt to the necessary change through the positive interaction among personal preferences, biological and psychological capabilities and experience.\textsuperscript{18}

Neugarten applies the perspectives of developmental psychology, which are concerned with continuity and change, in her study of personality and aging.\textsuperscript{19} She argues that: because there is a "cumulative record of adaptations to both biological and social events, there is a continually changing basis within the individual for perceiving and responding to new events."\textsuperscript{20} Neugarten is concerned with the adaptive mechanisms individuals elect to cope with their physical and social environments during different stages of life.\textsuperscript{21} She contends that aging must be studied within the broader context of the lifespan. This includes the social and cultural variables which have had an impact upon the individual's personality and behavioral response to change.\textsuperscript{22}

The researcher believes that there is a relationship between concepts of continuity, anthropological approaches utilize the concept of cultural continuity in behavior. In the latter

\textsuperscript{18}Ibid., 133.


\textsuperscript{20}Ibid., 648.

\textsuperscript{21}Ibid.

\textsuperscript{22}Ibid.
approach, individual perceptions of reality have a marked effect on behavior in old age as well as at any other stage of life. Thus, an individual’s mind set (what is observed to be real, what is stated as ideal, and what is perceived as reality) is seen to be an important factor in coping. Basically, the interaction between individual continuity and cultural continuity is brought out through life history data and the ways in which these continuities contribute to coping strategies.23

Self-concepts and attitudes about aging are influenced by cultural values and traditions as well as the transitions brought on by social change. For black women, in the United States, self-concepts of aging are only partially reflected in the values and attitudes of the larger society24. Wylie offers the suggestion that attitudes toward aging among African Americans may have some historical roots in African traditions and the early black experience in America. African cultural traditions which place a value on the continuity of life, the extended family, and a reverence for old age and ancestors, were not completely lost by slavery but extended their influence into the present.25

The researcher also looked at the theory of B.F. Skinner, who maintained along with other theorists that human behavior is a manifestation of learned actions and reactions. Thus, there is a stimulus-response relationship between behaviors. There is little control over what one’s genetic make-up will be, however, there is control that can be exercised over the

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23Ibid., 649.


25Ibid., 67.
conditions of life-style behaviors, that account for some of the disparity between the health status of black and white women. (Life expectancy at birth increased for black women from 68 years in 1970 to 74 years in 1990 and for white women from 76 years to 79 years).26

The theoretical positions stated above though able to explain some aspects of aging and well-being, do not explain all the phenomena of successful aging. Each contains many pitfalls that limit its ability to predict behavior among the aged27. One of the criticisms of the disengagement theory suggests that if and when disengagement occurs it is not voluntary. Rather, the society itself gradually withdrew support, positions of status, social roles, available rewards, and opportunities for meaningful social interactions from the older generation (disengagement is a reaction to socially imposed prescriptions, expectations, and sanctions, rather than a product of aging).28

The role activity theory is criticized on almost the same grounds: “the inability to develop new social roles is the result of socially imposed constraints that limit opportunities to engage in interesting activities and promote withdrawal in later maturity”.29

These theories were examined and found to be relevant for this study, and offer a useful framework for this research. While this conceptual framework may not provide an exhaustive explanation of the phenomenon under study, it is sufficient to point out that


27S. McKenzie, Aging and Old Age 36.

28Ibid., 37.

29Ibid., 37.
individual and institutional changes are needed to improve the health status and aging process of the elderly in general and the elderly black woman in particular.

LIMITATIONS

Several limitations can be identified in the planning and execution of this research project. The researcher is aware of the elusive nature of defining aging and health status. In addition, it is realized that a longitudinal study would be a more objective measurement technique. However, the utilization of a longitudinal study is beyond the scope, cost and time frame of this study. The researcher realizes that a small sample size is limiting in that it will not allow generalization to all elderly black women. Only those elderly black women who are demographically similar are included in the study.

This study was limited to black women 65 to 85 plus years of age and who reside in urban sections of two southern cities, Atlanta, Georgia and Macon, Georgia. There is an abundance of material written on aging and health in general, but very little literature specifically on the aging and health status of black women in America. These limitations however, do not reduce the importance or the contribution that this study makes in assisting concerned health care and other human service providers with a better understanding of the aging and health status of older black women in America.

THE RESEARCHER'S THEORY OF AGING

As stated earlier in the text, there does not exist an all-encompassing theory of aging. The enormous complexities involved in aging and the mere process of aging operate strongly against the formulation of an all-encompassing theory. Therefore, researchers must organize their research efforts around biological, psychological and social aging of older women.
Since most of the women in this study appear to be independent and strong willed, the researcher has centered her theory on the individual and self-care. Self-care is the practice of activities that individuals personally perform on their own behalf to maintain life, health, and well-being. This is the individual’s ongoing contribution to her personal health and well-being. Because this study of older women is focused on their self-perceived health care, this model shows how these women rely on their personal self-care and coping mechanisms when performing activities of daily living. When these women can no longer meet their personal needs because of injury, illness, or disease, other social support systems enter to assist the women by giving partial or total support. Because of the strong sense of independence observed in the women, many times they will wait until services are absolutely necessary, before asking for help. The researcher offers a model below on a self-care theory of aging.
CHAPTER 4

METHODOLOGY

The primary purpose of this study was to assess the health status of older black women and to determine the extent of the relationship between their health status, aging, and survival (coping) strategies. This chapter presents the design of the study, including a description of the samples, sampling procedure, instrumentation, data collection and data analysis procedure.

This study utilized the survey method. The survey method allowed the researcher to collect and analyze a variety of data from a selected area and to develop hypotheses for study of a broad area. Since specific questions had to be answered by the sample, of interest to the research, a group testing approach was implemented. According to Cozby, surveys are some of the most widely used techniques in the behavior sciences and education, for the collection of data. The questionnaire is the main instrument used in survey research. Survey data can provide an accurate description of what is happening in an entire population.

Polling organizations such as Gallup and Harris utilize the survey methods on a small number of people from a very large population to determine what people are thinking and how they feel about certain issues.¹ Survey results have been interpreted as a reliable and

valid representation of the opinion of a population. However, there are strengths and weaknesses involved in using the questionnaire as research tool. Cozby sites several problems that should be recognized; 1) Interviewer bias. Several biases can affect the outcome of an interview. For example, because the interview is a face-to-face interaction, the interviewer can subtly influence the respondent’s answers by inadvertently showing approval or disapproval of answers. Another bids, sometimes described as “seeing what you are looking for”, can interfere when the interviewer must interpret the person’s answers. 2) Response sets. A response set is a tendency to respond to all questions from a particular perspective rather than to provide answers that are directly related to the questions, this can effect the usefulness of data obtained from self-reports. Respondents do not always tell the truth, they may “fake good” or “fake bad” responses. Faking good leads the individual to answer in the most socially acceptable way, the way he/she thinks most people respond or the way that reflects most favorably on him/her. Faking bad is most often found in hospital and mental health settings among individuals who feel they have something to gain by being diagnosed as ill2. (Respondents may feel they have to say what they feel the interviewer wants to hear.)

Another problem is presented by the tendency of some respondents to consistently agree or disagree with survey questions. Respondents do not always tell the truth, they may fake good or fake bad and thus provide inaccurate information. As a result the researcher

2Ibid., 49.
may attempt to conceal the purpose of his or her study from the respondents, in the hope that
they will act naturally.3

Sidney Jourard has argued that people are most likely to lie when they do not trust
the researcher. Jourard asserts that if the researcher openly and honestly communicates the
purpose and uses of the research, and gives assurances that there will be feedback concerning
the results, then respondents will also be honest.4 The strengths of the questionnaire which
makes it appropriate for this study involves the ability of the researcher to gather information
about a subject while maintaining or providing for anonymity, the ease of implementation
(i.e., cost and time effectiveness), the flexibility in terms of the setting, and the large amount
of data that can be collected at once. The group approach is used in the study because it
provides the researcher with the opportunity to yield a better picture of the phenomena under
investigation. The survey will contain both closed-ended and opened-ended questions.
Since the researcher wants to assess the opinions and attitudes of older black women, the
survey will be administered to older black women only. The sample selected is considered
to be representative of the older black female population in West Atlanta and South East
Macon, Georgia.

This study also utilizes the exploratory method. The exploratory method of research
is a universally accepted method of social science investigation. The exploratory method of

3Ibid., 50.

4S.M. Jourard, “The Effects of Experimenter’s Self-Disclosure on Subjects’
Behavior”. In Paul C. Cozby (ed.) Methods in Behavioral Research (California: Mayfield
research falls into four groups: (1) to gain familiarity with the problems and gain new insights, in order to develop hypotheses; (2) to portray with factualness the characteristics of a particular individual, situation or group with or without a hypothesis; (3) to determine the frequency of a particular occurrence or association but not always, with a specific initial hypothesis; and (4) to test hypotheses and causal relationships between variables.

This research falls under the fourth group and is generally referred to as "exploratory" research. This method of inquiry must be flexible enough to allow for various aspects of the study. Selltiz points out that the method used for generating information in an exploratory study may include such methods as (1) a review of the related social science and other pertinent literature; (2) a survey of people who have had practical experience with the problem(s) to be studied; and (3) an analysis of "insight-stimulating" examples. This research used two of these approaches (approach numbers 1 and 2).

This study also employed the method of critical evaluation and selective use of existing studies. This method is a process whereby the researcher uses existing research data from various sources she considers useful to the success of the study. The researcher utilized primary and secondary data in writing her research. Primary data includes the women in the study newspapers, journals, information from the Bureau of the Census, Department of Health, Education and Welfare. National organizations such as the National Council on Aging, the National Urban League, National Center on Black Aged and National Caucus on

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6Ibid., 53.
the Black Aged, and the White House Conference Aging. Secondary data includes textbooks and periodicals.

SITE

The site of this study was in West Atlanta, Georgia and Southeast Macon, Georgia. Two urban cities, one a large urban city with a population of 394,017, and one a small urban city with a population of 106,640. These two cities were selected by the researcher because of the large population of older black women and because of the accessibility to the two cities.

SAMPLE

A purposeful sample was used in this investigation consisting of 120 older black women ranging in age from 65 to 95 years, residing in two urban cities, Atlanta and Macon, Georgia. Participants in the sample were selected from one Methodist church and one Baptist church in Atlanta, one Methodist church and one Baptist church in Macon, a senior citizen high rise center in Atlanta and a senior citizens day care center in Macon. These women are all senior citizens who have volunteered to participate in this study. The sample distribution is displayed in the following chart:
Socioeconomically, the sample was characterized as middle and low-income elderly. Subjects lived in a variety of middle and low-income settings including private homes, public housing and senior citizen housing. All participants resided in predominantly black inner city areas. The sample was divided into two age cohorts: the “young-old” 65-75, (N=64), and the “old-old” which is comprised of those 76 years and older, (N=56).

INSTRUMENTS

Four sets of data instruments were utilized in this study: (a) The Background Data Questionnaire; (b) The Life Satisfaction Index A; (c) The Revised Philadelphia Geriatric Center Morale Scale; (d) The New Adjustment Check List.

A. **BACKGROUND DATA QUESTIONNAIRE**

The Background Data Questionnaire was designed to gather information from participants on the following areas: date of birth, region of birth, formal schooling, marital status, history and perception of health.
B. MEASURES OF SUBJECTIVE WELL-BEING

The Life Satisfaction Index A (LSIA) and the Revised Philadelphia Geriatric Center Morale Scale (PGC) were selected as the instruments best likely to elicit overall measures of subjective well-being. The LSIA (Neugarten, et al., 1961) is a twenty item multidimensional scale. It is assumed to measure the single concept “life satisfaction” and is based upon the following theoretical components: (a) zest vs. apathy; (b) resolution and fortitude; (c) congruence between desired and achieved goals and, (d) mood tone. The scale has a score range from 0 to 2, with the higher score indicating higher approval with the item statement. Validity coefficients for the LSIA in the original validation study range from r=.39 to r=.55. These are similar to the validity coefficients reported for the PGC, r=.43 to r=.53. The coefficient of correlation between the LSIA and its criterion measure, the Life satisfaction Rating Scale, which was based on in-depth psychological interviews, is r=.55.

The PGC is a shorter version of the original twenty-two item Philadelphia Geriatric Center Morale Scale. The revised scale consists of a series of interrelated components of well-being: (a) attitude toward own aging; (b) lonely dissatisfaction and (c) agitation or

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8Ibid., 135.


10Ibid., 239.
anxiety. The scale was developed by Lawton in 1972\textsuperscript{11} as multidimensional measures of morale for the very old, the foreign born and the institutionalized elderly.

Reliability coefficients for the original twenty-two item PGC range from $r=.75$ to $r=.91$ for the test-retest reliability and $r=.74$ to $r=.79$ for the split half reliability. Validity coefficients range from .43 to .53\textsuperscript{12}. Internal consistency for the Revised PGC dimensions as determined by Cronbach’s alpha range from .80 to .85. A high correlation coefficient of .95 was reported between the PGC revision and the original PGC by Lawton, 1975 and Morris and Sherwood, 1975\textsuperscript{13}.

The LSIA and the Revised PGC are the two most widely used subjective well-being scales in the gerontological literature. The LSIA was devised to be used with the general population of older persons while the Revised PGC was originally developed to be used with the very old and institutionalized older persons. There is some justification for grouping the above measures into one construct. Available evidence suggests that these multidimensional measures share a common core that can be termed subjective well-being states Larson\textsuperscript{14}.


A further justification for the use of both the LSIA and the Revised PGC is the composition of the study.

C. MEASURE OF OBSERVED ADJUSTMENT

In order to determine the level of observed adjustment, the New Adjustment Check List (NACL) was used. The NACL consists of twenty items. The interrater reliability has been established as .82 for single raters and .90 for pooled estimates according to Irvin. Items included in the NACL were originally based on the Personal Adjustment Subscale of the Adjective Check List which was originally developed for measuring personality assessments based upon staff assessments. According to Gough, the Personal Adjustment Subscale depicts a positive attitude toward life more than an absence of problems and worries. The attitudinal set is one of optimism, cheerfulness, interest in others and a readiness to adapt.

D. DATA COLLECTION

The fieldwork for this study was conducted over a period of six months from March, 1996 to August, 1996. The traditional method of participant-observation and informal surveys were the primary means of collecting data. In the first phase of the study, a preliminary phone interview was conducted to obtain a general profile of the socio-economic


16Ibid., 134.

characteristics of the area and of the women specifically and to become acquainted with the subjects.

**PHASE I**

Appointments were made during the first month to meet and talk with the directors of the senior high rise center and the senior citizen day care center. The researcher also talked with pastors and presidents of senior citizen groups in four churches. In the meetings, the researcher was able to describe the research project and was able to gain the confidence and support of the personnel most frequently involved with working with the elderly. A discussion followed, which focused on the sparsity of available research data based on black elderly women and the need for black women to be better represented in research studies. Participants were asked to volunteer for the study and were given assurances of confidentiality.

The data was collected by two interviewers and the researcher. The two interviewers were college graduates and had expressed an interest in developing an understanding of older persons. A total of 120 women were interviewed. Establishing a rapport and a sense of comfortableness for both the interviewee as well as the interviewer was on of the primary goals of the interviewing process. Before collecting the data, the researcher spent time at the individual sites so as to become familiar with the participants. In addition, the researcher conducted a brief training session which focused on enhancing interviewing qualities such as friendliness, concern, patience, and the ability to listen attentively with a non-judgmental attitude. Finally, interviewers were familiarized with all the data instruments and an effort
was made to pace the interviewing sessions to the individual needs of the participants. The following is a summary of the interviewing process:

(A) A thorough explanation of the project was given to the participants and questions in any were answered. It was explained by the researcher that the information obtained would be held in strict confidence and used only for research purposes.

(B) The information was obtained for each of the following age categories: the "Young-Old" group (65-75 years, N=64) and the "Old-Old" group (76 years and older, N=56)

(C) Each participant was given copies of the data instruments to refer to while the interviewer explained the directions and scale items. The data instruments consisted of: The Background Data Questionnaire, The Revised Philadelphia Geriatric Center Morale Scale, The New Adjustment Check List and The Life Satisfaction Index A were given. (Copies of the instruments are presented in the appendices.)

PHASE II

The following procedure was used to obtain the observed adjustment data:

(A) Two interviewers and one staff person from each program site, who worked on a day-to-day or weekly basis with the participants were trained in the use of the New Adjustment Check List (NACL).

(B) Training consisted of the following:
   (1) discussion of NACL
   (2) instructions on the use of the NACL

(C) On completion of training the interviewers (on the day of the test) administered the test.

SUMMARY

The primary concern of the researcher in the selection of participants for the study was that they must be physically and mentally able to take part in the research. Elderly women were interviewed from two senior centers (which included women from housing projects, one-family and two family dwellings), two Baptist and two Methodist churches, the
idea in this selection being to compare the kinds of problems, fears, social interactions and survival (coping) strategies of elderly women in varied living arrangements.

The researcher used a purposeful sample, however the backgrounds of the women reflect socioeconomic differences which are representative of this study. The women represented a range of incomes and lifestyles with those below the established poverty level and included members of the elite families of the area and others who regard themselves as financially secure.

The participants were from varied living arrangements (i.e., alone, with spouse, or relative). Finally, these women had different levels of activity and social interaction within the neighborhood and the larger community. Differences in activity patterns among the women varied from those who had extremely active social involvements to those who were considered homebound and very inactive.

The participants in the study reflects the heterogeneity of the areas researched and while the researcher viewed this sample as representative of a cross-section of the areas studied, she does not know whether or not the study was representative of the elderly women of the cities of Atlanta and Macon, Georgia.

The researcher selected sixty (60) elderly black women from each city because she felt that number was sufficient to provide the information needed as a basic for beginning to understand the aging, health and survival strategies of older black women. Because intensive studies entail a long process, the researcher considered one hundred and twenty women (60 women from each area) to be enough for one research to attempt within the time frame of this study. An important part of the field experience involved the informal
interaction with the participants at their homes and at social functions (e.g., church meetings, Hot Lunch Programs, church services). These were daytime events since few women went out at night. These informal meetings continued throughout the period of the study as the researcher was invited to attend special functions, a club meeting or a telephone visit.

Information was obtained from prepared questions and was intended to elicit quantitative data. Less structured questions on attitudes, beliefs and concepts of aging do not appear on the interview schedules. This kind of data were obtained more readily from informal conversations where the participants were allowed to make comments. The interview schedule was used primarily as a guide and provided space to record the responses.

Questions on health generally evoked an eager response. Many were delighted to describe their symptoms and tell the researcher of their medical history. The data collected provide a fairly complete picture of the aging, health and survival strategies for each woman in the study.
Chapter 5

FINDINGS AND RESULTS OF THE STUDY

This chapter presents the findings of the study using illustrations and written descriptions. The analyses include the use of tables and figures which will show the hypotheses of this study and selected sample characteristics. The findings in this study are organized into the following sections: 1) Demographic Data; and 2) Hypotheses and Related Concepts.

Demographic Data

Demographic data used in the study were obtained through the use of the Philadelphia Geriatric Morale Scale, by M.W. Lawton, and the Life Satisfaction Index A, by B.L. Neugarten, R.J. Havighurst and S.S. Tobin. Demographic data include age, place of birth, years of formal schooling, perceived health, overall life satisfaction, marital status and occupational work history, as shown in Table 1

Place of Birth

As shown in Table 1, of 120 subjects, 102 (or 85%) were born in Georgia and 17 (or 15%) were born outside Georgia. The majority of the “church group” born in Georgia were 82.3 percent those born outside of Georgia were 17.7 percent. For the “non-church group”, those born in Georgia were 92.5 percent and those born outside of Georgia were 7.5 percent.
**Education**

The data in Table 1 showed that 16.4 percent of the “church group”, compared to 12.5 percent of the “non-church group” had completed at least six years of formal schooling, while 41.4 percent of the “church-group” compared to 60 percent of the “non-church group” had completed between 7 to 12 years of formal schooling. Approximately 11.3 percent of the “church group” and 10 percent of the “non-church group” had attended college while 8.8 percent of the “church group” and 7.7 percent of the “non-church group” had completed college. Of the “church group”, 18.8 percent completed graduate school versus 10 percent of the “non-church group”.

**PERCEIVED HEALTH**

Of the 120 subjects investigated, 48.8 percent of the “church group” compared to 45 percent of the “non-church group” rated their health as good. When asked to compare their health to that to that of others their age, 53.8 percent of the “church group” and 53.8 percent of the “non-church group” rated their health the same as others their age.
### Table 1
Demographic Profile of Respondents

<table>
<thead>
<tr>
<th>Descriptive Variable</th>
<th>“Church Group”</th>
<th>“Non-Church Group”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Place of Birth:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>65</td>
<td>82.3</td>
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<tr>
<td>Outside of Georgia</td>
<td>14</td>
<td>17.7</td>
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<tr>
<td>Education:</td>
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<td></td>
</tr>
<tr>
<td>1st-6th Grade</td>
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<td>16.4</td>
</tr>
<tr>
<td>7th-12th Grade</td>
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<td>41.4</td>
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<tr>
<td>Some College</td>
<td>9</td>
<td>11.3</td>
</tr>
<tr>
<td>Completed College</td>
<td>10</td>
<td>12.5</td>
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<tr>
<td>Education (Cont’d)</td>
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</tr>
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<td>Some Graduate School</td>
<td>3</td>
<td>3.8</td>
</tr>
<tr>
<td>Completed Graduate School</td>
<td>15</td>
<td>18.8</td>
</tr>
<tr>
<td>Perceived Health:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>39</td>
<td>48.8</td>
</tr>
<tr>
<td>Fair</td>
<td>38</td>
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<tr>
<td>Poor</td>
<td>3</td>
<td>3.8</td>
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<tr>
<td>Perception of own health:</td>
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</tr>
<tr>
<td>Better</td>
<td>31</td>
<td>39.2</td>
</tr>
<tr>
<td>Same</td>
<td>47</td>
<td>53.8</td>
</tr>
<tr>
<td>Worse</td>
<td>1</td>
<td>1.3</td>
</tr>
</tbody>
</table>
LIFE SATISFACTION

In response to the question: “How satisfied are you with your life today?”, 48.5 percent of the “church group” compared to 57.5 percent of the “non-church group” responded “very satisfied”, while 43 percent of the “church group” and 33 percent of the “non-church group” responded “satisfied”. In response to the question, each subject had a choice between three alternatives: very satisfied, satisfied and some what satisfied. Approximately 13 percent of the total sample reported being somewhat satisfied.

MARITAL STATUS

As shown in Table 2, the majority of the subjects were widowed--50 (62.5%) of the “church group” and 25 (62.5%) of the “non-church group” were widowed (see Appendix B). As illustrated in Table 2, subjects indicated how long they had been widowed. The longest length of widowhood was 26-30 years reported by 11 (20.7%) of the “church group” and 3 (4.5%) of the “non-church group”. Interestingly enough, this finding agrees with the literature that women outlive men an average of seven years. Thus, nearly all once-married women experience widowhood for some part of their lives.

EMPLOYMENT

Table 2 reveals that 66.3 % of the “church group” had worked full time at some time in their lives as compared to 75% of the “non-church group”. Both groups worked in the educational, non-agricultural and domestic fields. Approximately one-half of the women in the study were middle-class. The majority of the women in the middle-income status worked in the field of education.
Table 2
Life Satisfaction, Marital Status, Work History, Occupation

<table>
<thead>
<tr>
<th>Descriptive Variable</th>
<th>&quot;Church Group&quot;</th>
<th>&quot;Non-Church Group&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Overall Life Satisfaction:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Satisfied</td>
<td>35</td>
<td>39.2</td>
</tr>
<tr>
<td>Satisfied</td>
<td>34</td>
<td>53.8</td>
</tr>
<tr>
<td>Fairly Satisfied</td>
<td>11</td>
<td>1.3</td>
</tr>
<tr>
<td>Marital Status:</td>
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<td></td>
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<tr>
<td>Married</td>
<td>19</td>
<td>23.8</td>
</tr>
<tr>
<td>Divorced</td>
<td>8</td>
<td>10.0</td>
</tr>
<tr>
<td>Separated</td>
<td>3</td>
<td>3.8</td>
</tr>
<tr>
<td>Widowed</td>
<td>50</td>
<td>62.5</td>
</tr>
<tr>
<td>Never Married</td>
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<td></td>
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<tr>
<td>Work History:</td>
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<tr>
<td>Currently Employed</td>
<td>8</td>
<td>10.7</td>
</tr>
<tr>
<td>Not Currently Employed</td>
<td>66</td>
<td>88</td>
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<tr>
<td>Worked full-time (until retirement--age 65+)</td>
<td>53</td>
<td>66.3</td>
</tr>
<tr>
<td>Occupation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educator</td>
<td>26</td>
<td>32.9</td>
</tr>
<tr>
<td>Health Assistant</td>
<td>6</td>
<td>7.6</td>
</tr>
<tr>
<td>Clerical</td>
<td>1</td>
<td>2.6</td>
</tr>
<tr>
<td>Non-Agricultural</td>
<td>5</td>
<td>12.8</td>
</tr>
<tr>
<td>Domestic</td>
<td>4</td>
<td>10.3</td>
</tr>
<tr>
<td>Housewife</td>
<td>3</td>
<td>7.7</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>41</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-70</td>
<td>18</td>
<td>21.4</td>
</tr>
<tr>
<td>71-75</td>
<td>24</td>
<td>30</td>
</tr>
<tr>
<td>76-80</td>
<td>16</td>
<td>20.2</td>
</tr>
<tr>
<td>81-85</td>
<td>11</td>
<td>13.9</td>
</tr>
<tr>
<td>86-90</td>
<td>6</td>
<td>7.6</td>
</tr>
<tr>
<td>91+</td>
<td>5</td>
<td>6.4</td>
</tr>
</tbody>
</table>

FAMILY STRUCTURE

According to Table 3, one half of the subjects, (51%) lived alone, (21%) lived with children, while (28%) lived with relatives. This finding agrees with the literature which
states that older women are twice as likely to live alone, largely because they are almost three times as likely to lose a mate in comparison to older men. Item number 10 under family structure in Table 3, "Do you have children?" of the "church group" 58 (73.4%) said ‘yes’ and 21 (26.6%) said ‘no’, while 34 (85%) of the "non-church group" said yes’ and 6 (15%) said ‘no’. The findings indicated that the majority of the subjects have children. Item 11: "Do you own or rent your home?", as shown in Table 3, 59 (73.8%) of the "church group" and 14 (36.8%) of the "non-church group" own their own home; and 21 (26.3%) of the "church group" and 24 (63.2%) of the "non-church group" rent.

Table 3
Family Structure of Respondents

<table>
<thead>
<tr>
<th>&quot;Church Group&quot;</th>
<th>N</th>
<th>%</th>
<th>&quot;Non-Church Group&quot;</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Do you have children?&quot;</td>
<td></td>
<td></td>
<td>&quot;Own Home&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>58</td>
<td>73.4</td>
<td>Yes</td>
<td>34</td>
<td>85.0</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>26.6</td>
<td>No</td>
<td>6</td>
<td>15.0</td>
</tr>
<tr>
<td>&quot;Church Group&quot;</td>
<td>N</td>
<td>%</td>
<td>&quot;Non-Church Group&quot;</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>&quot;Do you rent or own your home?&quot;</td>
<td></td>
<td></td>
<td>&quot;Own Home&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own Home</td>
<td>59</td>
<td>73.8</td>
<td>Own Home</td>
<td>14</td>
<td>36.8</td>
</tr>
<tr>
<td>Rent</td>
<td>21</td>
<td>26.3</td>
<td>Rent</td>
<td>24</td>
<td>63.0</td>
</tr>
</tbody>
</table>

SUPPORT SYSTEMS

As shown in Table 4, the respondents of the "church group" received 31.6% of its support from the family, 15% from the church and 18.8% from organizations. The "non-church group" received 23.1% from the family 12.8% from the church and 15.4% from organizations.
Table 4
Support Systems

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Church Group&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family/Friends</td>
<td>25</td>
<td>31.6</td>
<td>54</td>
<td>68.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Church</td>
<td>12</td>
<td>15</td>
<td>68</td>
<td>85.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizations</td>
<td>15</td>
<td>18.8</td>
<td>65</td>
<td>81.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Non-Church Group&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>9</td>
<td>23.1</td>
<td>30</td>
<td>76.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Church</td>
<td>5</td>
<td>12.8</td>
<td>34</td>
<td>87.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizations</td>
<td>6</td>
<td>15.4</td>
<td>33</td>
<td>84.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MAJOR HEALTH STATUS (HEALTH OPINIONS)

The respondents gave their personal opinions on health related matters by responding to the following questions. Item 1: “How good a job do you feel you are doing in taking care of your health?” 43 (36.3%) of the “church group” reported very good, 48 (41.3%) reported good, 9 (5.0%) reported excellent, and 13 (16.3%) reported fair, none reported poor. Of the “non-church group”, 14 (35%) reported very good, 15 (37.5%) reported good, 4 (12.5%) reported excellent, and 6 (16.3%) reported fair, none reported poor. Therefore, the typical respondent indicated that she was taking good care of her health.

“Compared with one year ago, would you say that your health is now better, worse, or about the same as it was last year?” 17 (43.6%) of the “non-church group” responded better, 1 (2.6%) responded worse and 21 (53.8%) indicated their health to be the same as it was one year ago. Of the respondents from the “church group”, 31 (39.2%) responded better, 1 (1.3%) responded worse and 47 (53.8%) responded the same as one year ago. The findings reveal that the majority of the subjects from both groups reported their health to be about the same as it was last year.
“Do you feel that you get as much exercise as you need, or less than you need?” 38 (48.7%) of the “church group” indicated that they get as much exercise as needed and 15 (19.2%) indicated that they get less exercise than needed. The “non-church group” reported 17 (45%) as much as needed and 8 (21.6%) less than needed. “Do you exercise on a regular basis?” The majority of the “church group” 47 (58.8%) and the “non-church group” 18 (45%) do not exercise on a regular basis, but 30 (37.5%) of the “church group” and 18 (45%) of the “non-church group” exercise on a regular basis (See Table 5, item 1).

Item 2, Table 5: “How often do you walk?” Of the church group 24 (30.8%) indicated that they walk daily, while in the “non-church group”, 8 (21.1%) of the “church group” and 2 (5.3%) of the “non-church group” indicated that they never walk. Item 3, Table 5: “In the past year, how often did you have trouble remembering things?” In response to this question, each subject choose between four alternatives: frequently, sometimes, rarely and never. When the responses to the frequently and sometimes were grouped 13 (16.5%) of the “church group” said frequently and 46 (58.2%) said sometimes, of the responses rare and never, 16 (20.3%) of the “church group” said rare and 3 (3.8%) said never. The “non-church group” responded as 3 (7.9%) frequently, 24 (63.2%) sometimes, 6 (15.8%) rare and 4 (10.5%) never. The subjects reported that they sometimes had difficulty in remembering things.

Item 4, Table 5: “Do you have or have you ever had any of the following conditions and impairments. The subjects were given a list of 13 conditions and impairments and were asked to state yes or no. Of the 13 conditions and impairments, the majority of both groups checked the following conditions: arthritis-52 (65.8%) for the “church group” and 30
(76.9%) for the “non-church group”. High blood pressure-49 (61.3%) for the “church group” and 22 (85%) for the “non-church group”. The respondents who wear eyeglasses included 69 (88.5%) of the “church group” and 36 (94.7%) of the “non-church group”, while those subjects with cataracts included 28 (35%) of the “church group” and 14 (35%) of the “non-church group”. Of the 13 conditions and impairments reported, arthritis, high blood pressure, wearing of eyeglasses and cataracts rated high for both groups (see Table 5 for a complete list).
Table 5
Respondent's Perceived Health

<table>
<thead>
<tr>
<th>“Church Group”</th>
<th>N</th>
<th>%</th>
<th>“Non-Church Group”</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you exercise on a regular basis?</td>
<td>Yes</td>
<td>30</td>
<td>37.5</td>
<td>Yes</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>47</td>
<td>58.8</td>
<td>No</td>
<td>19</td>
</tr>
<tr>
<td>How often do you walk?</td>
<td>Daily</td>
<td>24</td>
<td>30.8</td>
<td>Daily</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Once a week</td>
<td>5</td>
<td>6.4</td>
<td>Once a week</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>12</td>
<td>15.4</td>
<td>Never</td>
<td>5</td>
</tr>
<tr>
<td>In the past year how often did you have trouble remembering things?</td>
<td>Frequently</td>
<td>13</td>
<td>16.5</td>
<td>Frequently</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>46</td>
<td>58.2</td>
<td>Sometimes</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>16</td>
<td>20.3</td>
<td>Rarely</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>3</td>
<td>3.8</td>
<td>Never</td>
<td>4</td>
</tr>
<tr>
<td>Do you have or have you ever had any of the following conditions and impairments:</td>
<td>Yes (%)</td>
<td>No (%)</td>
<td>Yes (%)</td>
<td>No (%)</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td>3 (3.8)</td>
<td>77 (96.3)</td>
<td>30 (76.9)</td>
<td>8 (20.5)</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>12 (15.6)</td>
<td>64 (83.1)</td>
<td>13 (32.5)</td>
<td>26 (6.5)</td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>49 (61.3)</td>
<td>3 (38.8)</td>
<td>22 (55.0)</td>
<td>18 (45.0)</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>8 (10.0)</td>
<td>-</td>
<td>2 (5.0)</td>
<td>38 (95.0)</td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td>5 (6.3)</td>
<td>72 (90.0)</td>
<td>5 (12.9)</td>
<td>34 (87.2)</td>
<td></td>
</tr>
<tr>
<td>Cataracts</td>
<td>28 (35.0)</td>
<td>75 (93.8)</td>
<td>14 (35.0)</td>
<td>26 (65.0)</td>
<td></td>
</tr>
<tr>
<td>Poor Circulation</td>
<td>30 (37.5)</td>
<td>52 (65.0)</td>
<td>16 (40.0)</td>
<td>24 (60.0)</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>5 (6.3)</td>
<td>50 (62.5)</td>
<td>6 (15.0)</td>
<td>34 (85.0)</td>
<td></td>
</tr>
<tr>
<td>Broken Hip</td>
<td>1 (1.3)</td>
<td>74 (93.7)</td>
<td>-</td>
<td>40 (100)</td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>12 (15.0)</td>
<td>79 (98.6)</td>
<td>5 (12.5)</td>
<td>35 (87.5)</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>7 (8.8)</td>
<td>68 (85.0)</td>
<td>2 (5.0)</td>
<td>38 (95.0)</td>
<td></td>
</tr>
<tr>
<td>Alzheimer’s Disease</td>
<td>3 (3.8)</td>
<td>73 (91.3)</td>
<td>-</td>
<td>40 (100)</td>
<td></td>
</tr>
<tr>
<td>Hardening of the Arteries</td>
<td>3 (3.8)</td>
<td>77 (96.3)</td>
<td>3 (7.5)</td>
<td>37 (92.5)</td>
<td></td>
</tr>
<tr>
<td>Troubleshoot</td>
<td>21 (26.3)</td>
<td>59 (73.8)</td>
<td>7 (17.5)</td>
<td>33 (82.5)</td>
<td></td>
</tr>
</tbody>
</table>
ACTIVITIES OF DAILY LIVING (ADLs)

Item 1, Table 6: When the Respondents were asked, “Because of a health or physical problem, do you have any difficulty with the following daily activities?”: bathing or showering, dressing and eating. For bathing and showering, both groups rated ‘No’—73 (91.3%) for the “church group” and 34 (85.1%) for the “non-church group” and 7 (8.8%) from the “church group” and 6 (15%) of the non-church group”. As shown in Table 6, the majority of the women did not have trouble with activities for daily living.

Item 2, Table 6: “Do you use any special equipment or aids in your activities for daily living?” Of the two groups responding, 14 (17.7%) of the “church group” said yes and 65 (82.3%) said no, while 9 (23.7%) of the “non-church group” said yes and 29 (76.3%) said no. Therefore, the majority of the subjects do not use any special equipment or aids in their activities for daily living (See Table 6).

EYE CONDITION

Item 3, Table 6: “Do you have any of the following eye conditions?”: cataracts, glaucoma, color blindness, blindness in one eye, and trouble seeing with one or both eyes even when wearing glasses?” The respondents answered as follows: cataracts-28 (35%) of the “church group” said yes and 26 (65%0 said no. Glaucoma-12 (15.6%) of the “church group” said yes and 65 (85.4%) said no, while 6 (16.2%) of the non-church group said yes and 31 (83.8%) said no. Color blindness-5 (6.4%) of the “church group” said yes and 73 (93.6%) aid no, while 39 (100%) of the “non-church group” said no and none reported yes.
Table 6
ACTIVITIES OF DAILY LIVING (ADLs)

<table>
<thead>
<tr>
<th>Item 1: Because of a health condition do you have any difficulty with the following:</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Item 1: Because of a health condition do you have any difficulty with the following:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 2: Do you use any special equipment or aids in your activities for daily living</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Item 2: Do you use any special equipment or aids in your activities for daily living</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 3: Do you have:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Item 3: Do you have:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>“Church Group”</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
<th>“Non-Church Group”</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>7</td>
<td>8.8</td>
<td>73</td>
<td>91.3</td>
<td>Bathing</td>
<td>6</td>
<td>15.0</td>
<td>34</td>
<td>85.0</td>
</tr>
<tr>
<td>Dressing</td>
<td>1</td>
<td>1.3</td>
<td>79</td>
<td>98.8</td>
<td>Dressing</td>
<td>2</td>
<td>5.0</td>
<td>38</td>
<td>95.0</td>
</tr>
<tr>
<td>Eating</td>
<td>1</td>
<td>1.3</td>
<td>79</td>
<td>98.8</td>
<td>Eating</td>
<td>2</td>
<td>5.0</td>
<td>38</td>
<td>95.0</td>
</tr>
<tr>
<td>Item 2: Do you use any special equipment or aids in your activities for daily living</td>
<td>14</td>
<td>17.7</td>
<td>65</td>
<td>82.3</td>
<td>Item 2: Do you use any special equipment or aids in your activities for daily living</td>
<td>9</td>
<td>23.7</td>
<td>29</td>
<td>76.3</td>
</tr>
<tr>
<td>Item 3: Do you have:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Item 3: Do you have:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cataracts</td>
<td>28</td>
<td>35.0</td>
<td>52</td>
<td>65.0</td>
<td>Cataracts</td>
<td>14</td>
<td>35.0</td>
<td>26</td>
<td>65.0</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>12</td>
<td>15.6</td>
<td>65</td>
<td>85.4</td>
<td>Glaucoma</td>
<td>6</td>
<td>16.2</td>
<td>31</td>
<td>83.8</td>
</tr>
<tr>
<td>Color Blindness</td>
<td>5</td>
<td>6.4</td>
<td>73</td>
<td>93.6</td>
<td>Color Blindness</td>
<td>-</td>
<td>-</td>
<td>39</td>
<td>100</td>
</tr>
<tr>
<td>Blind in one eye</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Blind in one eye</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

PERCENTAGE OF AGREEMENT BY GROUP ON THE LSIA

Ten or greater percentage points of disagreement between the two groups was found on six of the twelve positively worded items. On two of the six items, the “non-church group” had the larger percentage of agreement. Five of the seven negatively worded items differentiated between the groups by at least ten percentage points. The only significant difference found for this measure occurred when the participants were asked to respond to:
(1) "when I think back over my life, I did not get most of the important things I wanted"; chi
square \((2, \text{114}) = 5.6, P \leq .05\); and (2) "compared to others, I make a good appearance"; chi
square \((2, \text{115}) = 6.34, P \leq .04\) (See Table 7).

Therefore, these findings indicate that even though significant differences between
the two groups were revealed for the two items, there were no significant differences. Thus,
Hypothesis 1 was not supported.

<table>
<thead>
<tr>
<th>LSIA Statements</th>
<th>“Church Group” ((N=80))</th>
<th>“Non-Church Group” ((N=40))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Statements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Older, better</td>
<td>56</td>
<td>29</td>
</tr>
<tr>
<td>(2) Got breaks</td>
<td>49</td>
<td>25</td>
</tr>
<tr>
<td>(4) Happy as when younger</td>
<td>40</td>
<td>24</td>
</tr>
<tr>
<td>(6) Best years</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>(8) Interesting future</td>
<td>43</td>
<td>23</td>
</tr>
<tr>
<td>(9) Interesting as ever</td>
<td>46</td>
<td>24</td>
</tr>
<tr>
<td>(11) Feel age, doesn’t bother</td>
<td>59</td>
<td>24</td>
</tr>
<tr>
<td>(12) Look back-satisfied</td>
<td>68</td>
<td>36</td>
</tr>
<tr>
<td>(13) Not change past</td>
<td>48</td>
<td>29</td>
</tr>
<tr>
<td>(14) Good appearance*</td>
<td>60</td>
<td>35</td>
</tr>
<tr>
<td>(15) Made future plans</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>(18) Feel good about age</td>
<td>72</td>
<td>34</td>
</tr>
<tr>
<td>(19) Got what expected</td>
<td>57</td>
<td>34</td>
</tr>
<tr>
<td>Negative Statements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Now dreariest</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>(5) Could be happier</td>
<td>27</td>
<td>11</td>
</tr>
<tr>
<td>(7) Boring-monotonous</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>(10) Old-tired</td>
<td>34</td>
<td>11</td>
</tr>
<tr>
<td>(16) Didn’t get things*</td>
<td>33</td>
<td>10</td>
</tr>
<tr>
<td>(17) Depressed often</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>(20) Think often about future</td>
<td>45</td>
<td>25</td>
</tr>
</tbody>
</table>

* Results Significant
THE PGC AND LSIA REPORTED SCORES

Estimates of overall satisfaction and well-being were obtained by using the Revised Geriatric Center Morale Scale (PGC) and the Life Satisfaction Index A (LSIA). The means for the “church group” and the “non-church group” are presented in Table 10. The participants’ responses to the PGC were similar, no significant differences were revealed. Thus, Hypothesis 2 was not supported.

Table 8
Means on the Revised Philadelphia Geriatric Center Morale Scale and the Life Satisfaction Index A

<table>
<thead>
<tr>
<th>Groups</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revised Philadelphia Geriatric Center Morale Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Church Group”</td>
<td>80</td>
<td>.39</td>
</tr>
<tr>
<td>“Non-church Group”</td>
<td>40</td>
<td>.44</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Life Satisfaction Index A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Church Group”</td>
<td>80</td>
<td>.91</td>
</tr>
<tr>
<td>“Non-Church Group”</td>
<td>40</td>
<td>.92</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td></td>
</tr>
</tbody>
</table>

PERCENTAGE DIFFERENCES ON THE PGC ITEMS

This scale measured seventeen statements. The measure of these statements were relevant for Hypothesis 3. The results revealed only two significant differences. The “non-church group” (70%) stated that they had as much pep as they did last year, chi square (1, 119) = 5.62, P ≤ .02.
When Respondents were asked, “as you get older, do things get better, worse or remain the same, marginally significant results were shown for the “things get worse” item. This pattern suggested that more of the “church group” (33.3%) than the “non-church group” (25.0%) felt that things get worse as they get older; chi square (3, 119) = 6.35, P ≤ .69 (See Table 9).

Table 9
Percentage Differences by Group with PGC

<table>
<thead>
<tr>
<th>PGC Statements</th>
<th>“Church Group” (N=80)</th>
<th>“Non-Church Group” (N=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Positive Statements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) As much pep as last year*</td>
<td>39</td>
<td>48.8</td>
</tr>
<tr>
<td>(3) Feel lonely</td>
<td>12</td>
<td>15.0</td>
</tr>
<tr>
<td>(5) See enough of friends/relatives</td>
<td>50</td>
<td>62.5</td>
</tr>
<tr>
<td>(8) Get older, things better</td>
<td>56</td>
<td>70.9</td>
</tr>
<tr>
<td>(10) Happy as when younger*</td>
<td>40</td>
<td>53.3</td>
</tr>
<tr>
<td>(15) Satisfied with life</td>
<td>34</td>
<td>42.5</td>
</tr>
<tr>
<td>Negative Statements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Things get worse</td>
<td>21</td>
<td>26.3</td>
</tr>
<tr>
<td>(4) Little things bother me</td>
<td>25</td>
<td>31.3</td>
</tr>
<tr>
<td>(6) Older-less useful</td>
<td>27</td>
<td>33.8</td>
</tr>
<tr>
<td>(7) Worry-can’t sleep</td>
<td>20</td>
<td>25.0</td>
</tr>
<tr>
<td>(9) Life not worth living</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>(11) Lot to be sad about</td>
<td>68</td>
<td>85.0</td>
</tr>
<tr>
<td>(12) Afraid-lots of things</td>
<td>14</td>
<td>17.5</td>
</tr>
<tr>
<td>(13) Get mad more often</td>
<td>11</td>
<td>13.8</td>
</tr>
<tr>
<td>(14) Life is hard</td>
<td>8</td>
<td>10.0</td>
</tr>
<tr>
<td>(16) Take things hard</td>
<td>20</td>
<td>25.3</td>
</tr>
<tr>
<td>(17) Get upset easily</td>
<td>19</td>
<td>23.8</td>
</tr>
</tbody>
</table>

* Results significant

OBSERVED ADJUSTMENT

The reported observed adjustment scores were the average scores on the New Adjustment Check List (NACL). The means for the two groups are presented in Table 10. The mean adjustment scores for the two groups yielded no significant difference.
### Table 10
**Observed Adjustment Measure**

<table>
<thead>
<tr>
<th>Groups</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Church Group”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Adjustment</td>
<td>74</td>
<td>92.5</td>
</tr>
<tr>
<td>Low Adjustment</td>
<td>6</td>
<td>7.5</td>
</tr>
<tr>
<td>“Non-Church Group”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Adjustment</td>
<td>35</td>
<td>87.5</td>
</tr>
<tr>
<td>Low Adjustment</td>
<td>5</td>
<td>12.5</td>
</tr>
</tbody>
</table>

### Table 11
**Summary of Hypothesis Testing**

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Concept Tested</th>
<th>Significant (S)</th>
<th>Not significant (NS)</th>
</tr>
</thead>
</table>
Chapter 6

CONCLUSIONS, DISCUSSION, LIMITATIONS AND RECOMMENDATIONS

This study was designed to determine the extent to which elderly black females cope with aging and health, and to explore how socioeconomic status and social network system enhance their health and well-being. The study began with the differences in the problems of aging, how these elderly women conceived of their problems, and how they coped with their aging and circumstances. In particular, many aged blacks have been victims, to some extent, of inadequacies in income, poor housing, limited education and unequal access to health care. The effects of these factors on the process of aging is speculative. Yet, they conceivably create problems which differ from those the majority of the elderly population must face. This is not to say that members of other ethnic groups do not have similar problems. However, in this research, the focus is on the ways elderly black women perceive of their problems and how they handle them during their later years.

Prior life experiences help to shape individual attitudes about aging. In turn, such attitudes and expectations influence the way people perceive their problems and the choices they make in dealing with them. Thus, survival strategies are built in the mind of the individual as part of a cognitive process of adapting to perceived problems in response to certain situations.
The women in this study represent a heterogeneous group, that is, they differ from one another in terms of education, work status, income, health, activity patterns, living arrangements and personality. Still, there are similarities in their attitudes on aging and their behavioral responses to the processes of aging. These similarities may be attributed to cultural commonalities and other experiences which have led to similar behavior used in the past by their mothers and grandmothers and they consistently return to those survival or coping strategies which have cultural bases such as family, religion.

In this study, aging in itself is not seen as a problem by the women, and they did not discuss their aging. Instead, they perceived aging as a natural process and a part of life. In spite of the negative concepts of aging and the emphasis on being young in American society, the older women in this study expressed a positive attitude toward aging. However, there are problems associated with the later years of life, for example, decreased income, decreased mobility and declining health. The women in the study had an attitude which seemed to suggest that their daily problems are part of the process of aging and are handled as any other problem. A comment made by one of the women was; “Getting old is no big deal, it is just one more thing to deal with.” Notwithstanding, aging entails more than this statement implies. Being older may not be a big deal, however, the circumstances surrounding aging in America as a member of a minority group presents some unique problems.

The findings are summarized in terms of the general trends of aging, perceived health and survival strategies which are prevalent among the women in this study. The findings also suggest that individuals allow prior life experiences, situations, expectations and beliefs
from their earlier years to help shape their perception of problems and rely on earlier experiences in determining what they view as responses to their problems. The nature of these responses may vary among individuals, yet, there are many consistencies when the group is viewed as a whole. Survival strategies or coping mechanisms include: 1) a strong support network which consists of kin, friends, neighbors and social service workers, 2) religious beliefs (the concept of Jesus as Liberator) and 3) a strong work ethic, self-help, and pride that comes with feeling a sense of independence.

Among the women in the study, family and friends are involved in a reciprocal exchange system which helps to provide many of their basic needs (such as transportation, shopping). The social service worker is a primary link through which many of their basic needs are met, but the kin network is utilized most often. When asked about the source of help for problems such as, money, food, transportation, or companionship, the kinship group is named as the first choice. The women can depend on those they have defined as their primary links, and they feel secure in knowing that their basic needs are being met by these sources. The women utilize the family network as a primary means of providing basic needs and as a support system to help provide a positive and protective atmosphere in which to grow old. The strength of the family is seen as the primary survival mechanism, although many of the women utilized others outside the family.

Many of the women demonstrated a strong sense of pride. This is based on their positive attitudes toward independence and self help. Some of the women, even with obvious physical impairments, preferred to make their own meals rather than accept meals prepared by such programs as “Meals on Wheels”. One of the women stated that she needed
the services of the health clinic, but because of the impersonal and insensitive treatment received, and because of the long wait to see a doctor at the facility, she decided to refuse treatment.

Religion, for many of the women, has provided the consolation in times of distress and becomes a survival mechanism when things become difficult. Most of the women stated that they relied heavily on the power of prayer. Prayer is used as a means of adjusting and responding to the vicissitudes of their daily life. Along with prayer, other religious activities such as, religious programs on television, church activities, Bible study, prayer meetings, and scriptural resources play a prominent role in many of these elderly women’s lives. All of these activities are used as resources, and provide satisfaction in times of distress due to their chronic health problems, functional declines and approaching end of life.

Theoretical considerations in the study of aging among ethnic and minority group members seldom account for cultural differences. The current gerontological theories are based almost entirely upon middle-class adjustment model. In chapter four, several theories are viewed but do not adequately explain patterns observed among most of the women in the study. The researcher has devised a model for this study based on the self-care practice of activities performed by the women. However, as stated by McKenzie, in “Aging and Old Age”, no single theory provides an all inclusive conceptual foundation from which aging may be viewed.

Changes occur continuously throughout the lifespan and elderly individuals are equipped with a number of adaptive mechanisms to meet these demands. Most of the women have been able to redefine their physical condition in terms or roles, activities and
relationships. Some of the women have been able to substitute new roles and activities for old ones. Finally, most of the women have been able to evaluate their personal feelings about aging and to readjust values, beliefs, and personal goals in order to incorporate these factors into a satisfactory and meaningful life. In spite of the difficulties of being elderly, a minority, and female, in a society which values being young, these women appear to handle their aging and health problems very well.

The results of this study suggest that age is significantly related to perceived health and shows how these women cope with their problems throughout their lifespan. The item by item comparison of the performance of the two age groups “church versus non-church” on the measure of perceived health, life satisfaction and the Philadelphia Geriatric Center Morale Scale, indicated that both groups agreed that things were better than they had expected when they reached their current age levels. However, the “non-church group” was more pessimistic about the future and saw life as more dreary and empty than the “church group”.

Overall, there was no difference in how the two groups were viewed in terms of observed adjustment. There was no real negative bias towards aging, as the literature sometimes implies. The majority of the women felt good about their age. It is believed that the researcher’s experience, empathy, and willingness to go beyond the specified time limits for each interview, allowed the Respondents to speak freely and be more reflective. Thus, a clearer picture was conveyed about the samples’ feelings regarding aging. Those respondents rated as high in adjustment regardless of “church group” or “non-church group” were considered on the New Adjustment Checklist as “alert”, “considerate”, “efficient”,

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“fair-minded”, “healthy”, “loyal”, “organized”, “practical”, “thoughtful”, “trusting”, and “warm”, and in general, had few low adjustment characteristics listed on the checklist. Subjects rated as low in adjustment were viewed as “boastful”, “conceited”, “cynical”, “discontented”, “fussy”, “haughty”, “moody”, “pretentious”, and “weak”, and tended to have few positive characteristics of the high adjustment persons.

It was hypothesized that there would be a greater difference between the church group and the non-church group. However, the opposite trend occurred and the mean scores for the “church” and the “non-church” groups were very similar. It was very interesting to note that most of the women in both groups scored high on the statement “I feel good about my age”. One of the respondents said, “Well age is just a number”. This suggests that there was no real negative bias toward old age as stated earlier. The scores on the Philadelphia Geriatric Center Morale Scale (PGC), indicated that there was no significant difference between the two groups. This is not too surprising since the PGC was developed to measure the health and well-being of the poor, the elderly and the non-mainstream elderly.

Since the subjects in this study were black, urban, middle and low-income women, it was decided to use the Life Satisfaction Index A and the Revised Philadelphia Geriatric Morale Scale as measures of aging and survival strategies. The Revised PGC discriminates more clearly between well-being and aging. The PGC was developed to measure the health and well-being of the poor, the elderly, and the non-mainstream elderly, while the LSIA was designed to measure subjective well-being among the middle class mainstream elderly. The major source of difference between the two groups on the measures of health and well-being, was the differential to the negative items. These data have a tendency to support Lohman’s
contention that negatively worded statements may distinguish more readily between the
"satisfied" and the "dissatisfied", because it is usually easier to agree than disagree with
statements.¹ Thus, those elderly women agreeing with most statements may be giving the
"expected" or "easiest response as compared to those who disagreed with the statements.²
One might argue that with the elderly, it is easier to agree than to disagree. It may also be
that many of the respondents have less interest in ego power or perhaps have redirected their
energies into other activities (lost of love one, failing health). Another possibility maybe
that these elderly women have integrated or accepted the negative stereotypes placed on the
elderly by society and subsequently have a tendency to agree more with the negatively
worded items.

The majority of the elderly women in the "church" and "non-church" groups scored
about the same on all of the measures. None of the women in the groups were homebound.
Hence, a selective factor may be operating here. That is, elderly black women who seek out
and participate in activities outside the home are healthier, more active and out-going
individuals, who have a higher sense of satisfaction and well-being as compared to others
of their age. Most of the women in this study have faced a multiplicity of problems created
by society, but their reported scores suggest that they are successfully coping with their life
situations.

¹N. Lohman, "A Construct Validation of Seven Measures of Life Satisfaction
²Ibid., 2.
SOCIAL SUPPORT SYSTEMS AND AGING

Currently, older blacks represent a biologically superior population primarily because they represent survivors of the cohort group who were oppressed by many hazards and who were able to adjust and adapt in varied ways to their surroundings. In short, these elderly women are the survival of the fittest. The support systems of the elderly and especially the widowed are of major interest because both being old and widowed promote alienation from family and society. Lopata argues that widows, in particular, have a problem maintaining their social life and standard of living because the loss creates a financial problem. The widowed elderly blacks turn most frequently to their children for companionship in contrast to the married who call on their spouse for their needs. Both friends and neighbors are called on more by the widowed than the married as a source of companionship. In times of special needs such as transportation, many of these elderly women call on their fictive kin, someone who is treated like a relative but not related by blood or marriage, when there is no relative close by.

Taylor argues that the majority of elderly adults prefer to maintain independent living situations but widowhood, declining health, and decreasing income are compelling reasons for the elderly to move in with adult children or other relatives.

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4Ibid., 10.

CHURCH AS SUPPORT SYSTEM

Religiosity concerns itself with human dignity at every stage in the lifespan. For the elderly, religion helps to enhance the later years in life. Religion equips and aids the elderly in making the later years of life a time of spiritual fulfillment. Religion may also assist the elderly in turning within themselves to find the resources needed to meet their problems and fears which seem to accompany one's later years. In illness, trouble, and losses as well as joy and happiness, the community of faith offers strength, and comfort in many forms.

Several reviews of the literature have identified a positive effect of religion on physical and mental health at all ages. Previous studies have found that religious (church) attendance is significantly related to health and well-being and life satisfaction. However, this study indicated that both the "church group" and the "non-church group" scored about the same, indicating very little significance between the two groups. This could suggest that both groups possess a strong sense of spirituality even though one group has high church attendance. Many of the women have demonstrated phenomenal strength and resilience. However, most of the women have some restricted level of mobility or chronic disease (i.e., high blood pressure, arthritis). Despite the presence of these chronic conditions, multiple health problems and impairments, these women indicated an overwhelming satisfaction with their health. Very few of these women indicated that they had some level of disability, yet one could obviously see that many of them had some level of disability.

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This research demonstrated that these elderly women are very positive about their overall evaluation of their health and satisfaction with life. The women use various survival strategies to help them with their life problems. For example, individual prayer and prayer request from the church and church members may be used when there is an illness. Friends and neighbors may be called upon to help with transportation. The extended family may also be utilized. Fictive friends are used also as previously stated.

Religious activities such as church attendance and other involvement in the religious community helps to cultivate close relationships with peers. These relationships are shaped by value systems, shared world views, and a common hope in life and death. Thus, the support system provided by church members in later life is important because of the limitations of social support that occurs as a result of sickness and death of family members and friends. The religious community may also provide support by visiting their sick members, listening and encouraging, as well as meeting spiritual needs through prayer. Because later life can be a time of both physical and emotional stress, it may be at this time that coping behaviors are truly tested. Old age can bring with it a loss of control over life, an uncertain future, and a physical body that responds less to one’s needs at this time, when other coping behaviors depending on health, and social support are no longer available. Most of the women in the study have found ways of living with their chronic disease including accepting it as a problem to be dealt with, and lowering their expectations, including concerns over physical problems that dominate their everyday life.
PRAYER AS A COPING MECHANISM

The use of prayer is prevalent in coping among the elderly dealing with health problems or bereavement. Many elderly black women respond to worries with prayer as a coping reaction. Findings reveal that prayer is practiced at all ages, but is used most by older adults. Prayer has been characterized as a source of strength healing and deliverance. It is used as a means of adjusting to and responding to the vicissitudes of life. Prayer may also play a prominent role as people age due to chronic health problems and functional decline, as well as the approaching end of life. Data on older adults from the National Survey of Black American indicated that all of its respondents reported praying and 78% stated that they pray everyday. Along with prayer, activity was used by the participants in this study, as a mechanism for coping with life stressors. Active involvement in social activities helped the subjects to counter loneliness, depression, low self-esteem, and overall life satisfaction.

The results of this study provided some insight into how elderly blacks perceive of their health and aging. The response pattern suggested that most of these women view their aging process as good and reported very little dissatisfaction with life. It is interesting to note that these perceptions are not supported by many of the studies on the elderly and church participation. It was found in previous studies that person with high church participation had a better quality of health than non-church attending persons. These perceptions by the women in this study did not significantly correlate with the previous

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studies. These findings suggest that for this sample, how one perceives her life and well-being are better predictors of health. One explanation for this finding not being significant might be that it reflects the strong sense of self-health and independence exhibited by these women to take care of themselves as long as they can. Also, these women have built up strong survival or coping mechanisms that enable them to endure their chronic ailments and problems of life.

LIMITATIONS OF THE STUDY

The present study was limited to those elderly women of urban Atlanta and Macon, Georgia who were black females sixty-five and older, who were divided into “church group” and “non-church group”. The “non-church group” were members of senior centers and were also very active in senior activities. The “church group” were members of the Baptist and Methodist denominations. Elderly females who were homebound were not represented in the study. Elderly females in the community who did not attend church and who did not live in senior centers were not represented. However, despite these limitations, the data provide useful preliminary information on an under-researched population.

RECOMMENDATIONS

1. That health providers and others who work with the elderly are better educated on the myths and realities of aging.

2. That the black church becomes more thoroughly informed on their aging members and learn how to help assist them more as they continue to age.

3. An increase in funding for research on elderly black women’s health issues and that this cohort is adequately represented in research studies.
4. That future research concentrate more on the factors related to the maintenance of well-being rather than its measurements. In this way, the influence of senior day care programs, senior centers and senior church groups will play a primary role in the health and well-being of the elderly.
AGREEMENT

The attached questionnaires are part of a research study on health, aging and the survival strategies among older African American women in Atlanta, Georgia, a large Urban population, compared with older African American women in Macon, Georgia, a smaller urban population.

The data that will be obtained by these questionnaires will only be used in my dissertation and shared within my department. The names of the individuals will not be revealed without the authorization of the participants.

Thank you for your participation.

RESEARCHER

________________________________________

Participant’s Name ________________________

Participant’s Location _______________________

Date: ___________________________
Background Data Questionnaire

1. Name

2. Address

3. Age ___________ Date of birth ________________

4. Where were you born?
   (If other than Pittsburgh, when did you come here?)

5. How many grades of school did you finish?
   1 2 3 4 5 6 7 8 9 10 11 12 Some College____
   Finished College____ Graduate School____ Finished Graduate School____

   Have you had any other schooling or training? ________________

   If yes, explain ____________________________________________________________________

6. Perceived Health:
   a) In general, do you consider yourself to be in good health, fair health or poor health?

      Good Health____ Fair Health____ Poor Health____

   b) Taking your overall health status into account, would you say that your health at this moment is better, about the same of worse than that of other people your age?

      Better____ About the Same____ Worse____

   c) Taking your overall health status into account, how would you rate your level of happiness and satisfaction with life?

      Very Dissatisfied____ Somewhat Satisfied____
      Somewhat Dissatisfied____ Very Dissatisfied____

7. Are you married____; Divorced____; Separated____; Widowed____: 134
or have you never been married? _____

8. Work:

a) Have you ever had a full time job? Yes____ No____

If Yes: What was the last full time job you had?

____________________________________________________

What did you do? ______________________________________

____________________________________________________

For how long? _________________________________________

Are you working now? ________________________________

If No: Reasons, what did you do instead

____________________________________________________

____________________________________________________

____________________________________________________

If Married: If husband worked, what did he do? __________

____________________________________________________

____________________________________________________

If widowed, for how long? ____________________________

9. Family structure:

Do you live alone, with children or other family members?

Alone_____ With child(ren)____ With relative_____
Background Data Questionnaire (contd.)

10. Do you have children

Yes_____ No_____

11. Do you own your home or rent

Own home_____ rent_____

12. Support systems:

Do you receive support from family?

Yes_____ No_____

Do you receive support from the church?

Yes_____ No_____

Do you receive support from organizations or groups?

Yes_____ No_____

B. Major Health Status (Health Opinions)

Now I would like to ask you about your personal opinions on health related matters.

1. How good a job do you feel you are doing in taking care of your health?

Very good_____ Good_____ Excellent______ Fair_____
Poor____

2. Compared with one year ago, would you say that your health is now better, worse, or about the same as it was last year?

Excellent______ Very good______ Good______ Fair_____
Poor____

3. Do you feel that you get as much exercise as you need, or less than you need?

As much as needed______ Less than needed____
Background Data Questionnaire (contd.)

4. Do you exercise on a regular basis?

Yes_____ No_____ 

5. How often do you walk?

Every day_____ 2-3 days a week_____ 1 day a week_____ 
Less than one day a week_____ Never_____ 

6. People find that as they get older they have more trouble remembering things. In the past year, how often did you have trouble remembering things?

Frequently_____ Sometimes_____ Rarely_____ Never_____ 

7. Do you have or have you ever had any of the following conditions and impairments:

a. Arthritis of any kind or rheumatism  
   Yes_____ No_____ 

b. Diabetes  
   Yes_____ No_____ 

c. High blood pressure  
   Yes_____ No_____ 

d. Cancer  
   Yes_____ No_____ 

e. Obesity  
   Yes_____ No_____ 

f. Cataracts  
   Yes_____ No_____ 

g. Poor circulation  
   Yes_____ No_____ 

h. Osteoporosis (soft bones)  
   Yes_____ No_____ 

i. Broken hip  
   Yes_____ No_____ 

j. Heart disease  
   Yes_____ No_____ 

k. Stroke  
   Yes_____ No_____ 

l. Alzheimer’s Disease  
   Yes_____ No_____ 

m. Hardening of the arteries  
   Yes_____ No_____ 

8. Do you have trouble biting or chewing any kind of food such as meat or apples?

Yes_____ No_____
Background Data Questionnaire (contd.)

C. Activities of Daily Living (ADLs)

1. Because of a health or physical problem, do you have any difficulty with the following:

   - Bathing or showering
     - Yes___  No___
   - Dressing
     - Yes___  No___
   - Eating
     - Yes___  No___

2. Do you use any special equipment or aids in your activities for daily living?

   - Yes___  No___

   If yes, what special equipment do you use?

D. Eye Condition

1. Do you have:

   a. Cataracts
   - Yes___  No___

   b. Glaucoma
   - Yes___  No___

   c. Color blindness
   - Yes___  No___

   d. Blindness in one eye
   - Yes___  No___

   e. Any trouble seeing with one or both eyes even when wearing glasses?
   - Yes___  No___

2. Do you use eyeglasses?

   - Yes___  No___

3. Have you ever had an operation for cataracts?

   - Yes___  No___

4. Do you have lens implants?

   - Yes___  No___

5. Do you wear a hearing aid?

   - Yes___  No___
LIFE SATISFACTION INDEX A

1. As I grow older, my life seems better than I thought it would be.
2. I have has a better life than most of the people I know.
3. This is the dreariest time of my life. (Probe)
4. I am just as happy as when I was younger.
5. My life could be happier than it is now. (Why?)
6. These are the best years of my life. (Why?)
7. Most of the activities I participate in are boring or monotonous. (Why?)
8. I expect interesting and pleasant events to happen to me in the near future.
9. My life is as interesting to me today as it ever was.
10. I feel old and somewhat tired.
11. I feel my age but it does not bother me.
12. As I look back on my life, I am fairly well satisfied.
13. I would not change my past life even if I could.
14. Compared to other people my age, I make a good appearance.
15. I have made plans for what I will be doing a month or a year from now.
16. When I think back over my life, I did not get most of the important things I wanted.
17. Compared to other people, I feel depressed too often.

AGREE | DISAGREE | NO OPINION

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LIFE SATISFACTION INDEX A (continued)

<table>
<thead>
<tr>
<th>AGREE</th>
<th>DISAGREE</th>
<th>NO OPINION</th>
</tr>
</thead>
</table>

18. I feel very good about my age.

19. I have received pretty much what I expected out of life.

20. I often think about the future.
Revised Philadelphia Geriatric Center Morale Scale

1. Things keep getting worse as I get older:
   Yes____  No____

2. I have as much pep as I did last year:
   Yes____  No____

3. How much do you feel lonely?
   Not much____  A lot____

4. Little things bother me more this year:
   No____  Yes____

5. I see enough of my friends and relatives:
   Yes____  No____

6. As you get older you are less useful
   Yes____  No____

7. I sometimes worry so much that I can't sleep
   No____  Yes____

8. As I get older, things are better, worse, or the same as I thought they would be:
   Better____  Worse____  The same____

9. I sometimes feel that life isn't worth living
   Yes____  No____

10. I am as happy now as I was when I was younger
    No____  Yes____
Revised Philadelphia Geriatric Center Morale Scale (contd.)

11. I have a lot to be sad about
   No____   Yes____

12. I am afraid of a lot of things
   Yes____   No____

13. I get mad more than I used to
   Yes____   No____

14. Life is hard for me most of the time
   No____   Yes____

15. How satisfied are you with your life today?
   Very satisfied____   Satisfied____   Fairly satisfied____   Not satisfied____

16. I take things hard
   Yes____   No____

17. I get upset easily
   No____   Yes____
New Adjustment Check List

Directions: Below you will find a list of adjectives. Each adjective is accompanied by three defining synonyms. Please read each set quickly and put a check (✓) beside each adjective you consider to be descriptive of _________________.

(Name of person)

Work quickly and do not spend too much time on any item.


_____ 2. Boastful: conceited, pompous, vain.

_____ 3. Conceited: stuck-up, vain, egotistical.


_____ 7. Efficient: capable, competent, effective.

_____ 8. Fair-minded: just, equitable, right and proper

_____ 9. Fussy: restless, unsettled, agitated

_____ 10. Haughty: arrogant, insolent, presumptuous

_____ 11. Healthy: excellent, well, feeling good

_____ 12. Loyal: faithful, devoted, true

_____ 13. Moody: sad, gloomy, capricious

_____ 14. Organized: systematic, coordinated, arranged

_____ 15. Practical: useful, pragmatic, effective

_____ 16. Pretentious: artificial, unnatural, affected

_____ 17. Thoughtful: careful, serious, judicious
New Adjustment Check List (contd.)

____ 18. Trusting: accepting, believing, embracing

____ 19. Warm: responsive, affectionate, cordial

____ 20. Weak: feeble, indecisive, gutless
Age of Respondents

- 71-75: 26.7%
- 81-85: 15.0%
- 86-90: 5.0%
- 91-95: 7.5%
- 76-80: 19.2%
- 65-70: 26.7%
Educational Level of Respondents

- 7th-12th Grade: 47.5%
- 1st-6th Grade: 15.0%
- Some College: 10.8%
- Finished College: 8.3%
- Finished Grad. School: 15.8%
- Some Graduate School: 2.5%

Source: Survey data collected by Larma Whelchel from 120 respondents
Educational Level of Respondents

"Church" and "Non-Church"

Church
- Elementary: 41.3%
- Jr./Sr. High: 16.3%
- Some College: 11.3%
- B.A.: 8.8%
- Some Grad. School: 18.8%
- M.A.: 10.0%

Non-Church
- Elementary: 60.0%
- Jr./Sr. High: 12.5%
- Some College: 10.0%
- B.A.: 7.5%
- Some Grad. School: 10.0%
- M.A.: 10.0%

Source: Survey data collected by Larma Whelchel from 120 respondents
Marital Status of Respondents

Source: Survey data collected by Larma Whelchel from 120 respondents
Most older people have at least one chronic and many have multiple conditions. The most frequently occurring conditions per 100 elderly were:

- Arthritis
- Hypertension
- Heart Disease
- Hearing Impairments
- Orthopedic Impairments
- Cataracts
- Sinusitis
- Diabetes
- Visual Impairments

Source: "A Profile of Older Americans" by the American Association of Retired Persons and the Administration on Aging, and the U.S. Bureau of the Census.
WE'RE LIVING LONGER

A person born in 1900 could expect to live to age 47.3

A person born in 1950 could expect to live to age 68.2

A person born in 1990 could expect to live to age 75.4

A person born in 2050 could expect to live to age 82.1

Source: Atlanta Journal-Constitution, August 28, 1995
THE CROSSED OVER PHENOMENON

FEMALE

YEARS OF LIFE REMAINING

AGE IN YEARS

— White — Black

Source: National Center for Health Statistics (1982)
A Model of the Researcher's Self-Care Theory
(Dark Arrows denote strengths of influence)
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