Chapter 11
Plight of Older Americans: Insights into the Lives of African American Women

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Abstract The proportion of Americans aged 65 years and above is increasing steadily, and one in seven Americans is now in that age group. There are 126 females per 100 males in this age group. Around 9% of those in age group are non-Hispanic African Americans. The latter experience worse health and racial inequalities in health as compared to white Americans owing to their disproportionate access to resources like education, income opportunities etc. They also have a lower median income as compared to their White peers. Low-income African Americans are also disproportionately more likely to be exposed to violence and crime which in turn affects both their physical and mental health. In fact, four in five African American women are overweight or obese and are almost twice as likely to have diabetes as compared to their White peers. This community is also at a higher risk of experiencing mood and anxiety disorders which are linked to their greater mortality and morbidity rates. Despite this, this group is less likely to use healthcare services as opposed to Whites as help-seeking behaviors are driven by culturally specific attitudes and experiences. The healthcare system is now becoming more aware of this phenomenon, and several policy and healthcare culture changes have been introduced.

Keywords Older African Americans · Women · Resources · Health care

The proportion of Americans aged 65 years and above has tripled since the 1900s. Currently, one in every seven Americans is aged 65 years and above contributing to 49.2 million adults in the population in the former group. Out of this, around 56% are females, thus attributing to 126 females per 100 males. Further, among the oldest–old, there are 187 females per 100 males. A much lower proportion of older females compared to males in the population are married and around a third are widows. A substantial proportion (45%) of these aged 75 years and above live alone as per the most recent estimates. There were, respectively, 24% males and 16% females who were working or actively seeking work in the year 2017. Next, while the median income for older males has been reported to be around $31,000, the same for

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females is around $18,000, as per estimates from the year 2016. Poverty rates were relatively higher among females as compared to males (Administration on Aging, 2017a).

Almost one-fourth of the Americans aged 65 years and above are members of racial or ethnic minority populations with majority (9%) being non-Hispanic African Americans, followed by non-Hispanic Asian and Pacific Islander. Additionally, Hispanics, irrespective of race, represent 8% of this population group. Around respective 80 and 65% each of non-Hispanic White and African American males and females report their health status to be good to excellent. However, this proportion is relatively lower among oldest–old African American females (Administration on Aging, 2017b). In general, African Americans continue experience worse health and racial inequalities in health as compared to white Americans and have higher mortality rates for the majority of fifteen leading causes of death (Pullen et al., 2014). The leading causes of mortality among African Americans aged 65 years and above include heart disease, cancer, stroke, diabetes, and pneumonia/influenza. The leading causes of morbidity on the other hand include hypertension, coronary artery disease, stroke, end stage renal disease, diabetes, and certain cancers. There is known to be an inverse relation between socioeconomic status and hypertension meaning that those with a lower socioeconomic status are more prone to developing hypertension. Among cancers, while African American women appear to have a similar incidence rate as compared to women from other ethnicities, the survival rate is lower.

In 2016, among households headed by adults aged 65 years and above, while the reported median income for non-Hispanic Whites was around $61,000, and the same for African American older adults was around $44,000. Further, around 19% African Americans as opposed to 7% Whites were living in poverty in the same year (Administration on Aging, 2017b). As far as these indices are concerned, African Americans belong to lower socioeconomic status groups, and very large and growing segments also belong to middle- and upper-income groups. While a large proportion live in rural South, more live in North and West. Among older African Americans that live in community settings, older women are more like to live by themselves (Hargrave, 2010).

Low-income African Americans are also disproportionately more likely to be exposed to violence and crime which can in turn affect both physical and mental health (Pullen et al., 2014). Life expectancy at age 65 years and above among African Americans is reported to be around 17% as compared to around 19% for Whites in this category. Next, the incidence of multiple myeloma is twice as high among African Americans as compared to Whites. Older African Americans have also rated their physical health and functional status lower than their White peers in various surveys. For example, while 25% of older African Americans report experiencing limitations in walking, the corresponding proportion among Whites is around 19% (Hargrave, 2010).

Louis Israel Dublin, in the year 1920 (Noonan et al., 2016), had remarked that "An improvement in Negro health, to the point where it would compare favorably with that of the white race, would at one stroke wipe out many disabilities from which the race suffers, improve its economic status and stimulate its native abilities

as would no other single improvement. These are the social implications of the facts of Negro Health." Dublin's assertion still remains valid to date. In fact, the first comprehensive review of health disparities in the African American community as compared to the Whites was only published relatively recently in mid 1980s. To date, African Americans continue to endure significant health disparities and lack of power and actions that could help alleviate such disparities (Noonan et al., 2016).

A large body of research has demonstrated that disproportionate access to resources like education, income opportunities, etc., has resulted in health disparities between American racial minorities and the White population. Discrimination, which is defined as a socially structured and sanctioned phenomenon that is intended to maintain privileges for members of dominant groups, has also been recognized as an important determinant that contributes toward such disparities. In fact, research provides evidence for the association between perceived discrimination and poor health. Among African Americans, researchers have established an association between this social determinant of health and health disparities. Specifically, perceived discrimination among this population has been linked to diseases or conditions like hypertension, depressive symptoms, elevated C-reactive protein, and diabetes. More recently, it has also been linked to mental health issues like psychological distress, depressive symptoms, and post-traumatic stress disorder. Such associations have been documented among various age groups, including those older and genders in this population (Nadimpalli et al., 2015).

Race-related stress, resulting from social and historical experiences of discrimination, impacts older African Americans health as stated above. Further, age also impacts mental and physical response to such experiences of racism. The latter have deprived the community of equal access to education, employment, health care, housing, and political participation, thus leading to increased rates of mental health disorders. Productive aging is also hindered by limited access to community resources like grocery stores, pharmacies, culturally competent health and aging service providers, transportation, housing, etc. (American Psychological Association).

Older African American women are viewed within the community as resourceful, energetic, courageous, hard-working are key figures in the stability and continuity of the black family and the community. Their sense of self-worth, belonging and history, and their ability to preserve their family is highly reputed within the community (Dena et al., 1998). Even today older African American women pass on cultural understandings to the younger generation (Peterson, 1990). However, given the years of discrimination, the African American women have had impaired aging progress owing to poorer health and well-being-related outcomes (Baker et al., 2015).

There is still limited literature that has specifically focused on older African American women in terms of identifying and analyzing factors that may impair their successful aging. The latter is more than a pathological and non-pathological state and includes avoiding disease and disability, high cognitive and physical functioning, and remaining productive and actively engaged (Baker et al., 2015). Methods through which research data are gathered, defined, and validated have been long challenged by feminists owing to the male bias in research. Alternative theories have therefore been provided, and the notion that gender influences behavior and lifestyle has been

legitimized. Specifically, research among African American women has not always focused on the complex interactions between race, ethnicity, age, and sexual orientation, and researchers may have long ignored their potential impact on behaviors (Wyche, 1993).

Physical and Mental Health Outcomes and Health-Seeking Behaviors

Physical health: While African American women are perceived to retain youthful features until older age ("Black Don't Crack"), they perform poorly on almost all other health indicators than women in any other racial or ethnic group (Belgrave & Abrams, 2016). Physical and mental well-being and successful aging are impaired among African American women and other minorities due to challenges posed by social change, exclusion, violence, discrimination, and cultural alienation (Baker et al., 2015). Not only do that experience excess morbidity associated with obesity, diabetes, and adverse birth outcomes, they also experience greater mortality rates associated with breast and cervical cancer, cardiovascular disease, and HIV/AIDS. In fact, four in five African American women are overweight or obese and are almost twice as likely to have diabetes as compared to their White peers (Belgrave & Abrams, 2016).

Physical activity: Physical activity, a primary source to prevent several health-related issues, is found to be lower among the African American population. Further, there is evidence that African American women are among the least active members of the society. While physical activity has been actively promoted as an affordable and effective means to prevent and treat chronic disease and to improve quality of life and well-being, racial/ethnic disparities persist. Research efforts have suggested that such disparities may be overcome by employing more culturally sensitive physical activity interventions and strategies. It is also important to understand that what women believe is involved in physical activity in terms of range of activities (Sebastião et al., 2015). The social cognitive theory suggests that it is important to understand how complex interactions between individual or personal factors and the social and poor physical environment (crime, access to facilities) shape physical activity among older adults. The theory also emphasizes on the need to identify the determinants of behavior including barriers and motivations. Primary motivation for doing physical activity among older African American women is to maintain good physical and mental health. Social support from family, friends, or community is also considered important factors. Barriers that may prevent women of this community to engage in physical activity include weather, time, and physical limitations. Family responsibilities have also been documented to prevent women from participating in physical activity (Gothe & Kendall, 2016).

Mental Health: Older adults, including women, the proportion of which is rapidly growing the American population are now at the forefront of changing healthcare

policy as healthcare providers have grown culturally sensitive and are providing community-based care. Most initiatives have, however, only focused on community settings and have aimed at improving health and quality of life along with mitigating illness, and fewer have focused on mental health disparities and healthcare services utilization. Specifically, even fewer efforts have focused on the former among African American older adults (Wharton et al., 2018).

Not only do African American older adults bear a disproportionate burden of chronic health diseases and have a shorter life expectancy than their White peers, but mental health disparities are especially a concern in this population. This is because mortality and morbidity are both associated with mood and anxiety disorders. While accurate statistics are not known, it is estimated that a quarter of this population in the community settings experiences depressive symptoms. Further, African American older adults, as compared to Whites, are 44% more likely to experience the onset of depression over a 10-year period, but they still are less likely to seek formal care for the same. This is because due to cultural and experiential reasons and stigma associated with mental illnesses, older African Americans mistrust aspects of the healthcare system (Wharton et al., 2018).

More recently, spirituality and religion have been incorporated into treatment considerations as recognition has grown regarding the role of the former in shaping an individual's life. Serving as facilitators in healthy development, African American churches are the cornerstones of many communities. The churches offer both spiritual healing and community-based mental health services. The theory of social ecology suggests that successful community-based interventions require working the multilevel community systems to engage individuals within their social networks. Such interventions are thus required to address the disparities in mental health care among older African Americana adults (Wharton et al., 2018).

Body image: At an individual level, a human body is experienced with regard to physically determined experiences, such as health, illness, body size, and ability, and at a social level, they are constructed and appraised through various lenses including gender and age. Such social experiences of being objectified by or assessed physically by others tend to be psychologically internalized. This internalization then produces a range of physical and mental health responses. Such experiences are particularly important for aging women. While the American population in general is aging, it is disproportionately women, and body image has been established as an important component of both physical and mental health among them. Such body perceptions and their associations with health vary by ethnic groups (Sabik, 2012).

Western culture specifically promotes women's evaluation on the basis of their physical appearance. This idea is particularly harmful for older women as they move farther from the youthful ideal but are still subject to evaluation (Sabik, 2012). An increased awareness among older women regarding the association between beauty and youth may lead them to perceive themselves negatively, thus affecting body image and self-esteem. In turn, both ageism and lower body image are independently associated with poor psychological well-being. Older adults, especially women who perceive the aging process negatively, are more susceptible to experience deleterious

health and well-being consequences. As per the social expectancy theory, an individual's self-perceptions are influenced by their cultural values. Specifically, one's cultural understandings provide explanations for who would be considered attractive or not based on which individuals tend to develop their self-concept, including body and health-related perceptions. Therefore, older women who experience more age-based discrimination are more likely to perceive that they are treated differently and negatively so. Negative age-related stereotypes that women may be exposed to may lead them to direct it inwards. The latter is associated with lower life expectancy, impaired memory, high blood pressure and heart rate, and impaired motor skills (Sabik, 2015).

Research shows that body dissatisfaction is frequently linked to depression among older women. It is particularly important to note that the rates of depression among women are much higher than men. This relationship between age, gender, and body image is multifaceted, and it is important to understand that there is heterogeneity within older women. Research suggests that there are ethnic group-based differences that suggest that experiences of the body are not uniform across all older women. Several research efforts have suggested that African American culture is more accepting of the different body shapes and sizes which act as a buffer against this body dissatisfaction among older women of the community. There is a general preference for large body sizes which is associated with health and prosperity. Next, among this community, physical attractiveness is defined in terms of stylishness than the physical body. It has been argued that as compared to older American counterparts, African American women may be more satisfied with some aspects of the body. However, still little is known about the association that these perceptions of body image have with mental health issues among older African American women (Sabik, 2012).

Health services utilization: While regardless of race, those with insurance are more likely to use health-related services, specifically over 20% African American women have no health insurance and are also less likely to have one based on employment as compared to their white counterparts. Further, among the former, help-seeking behaviors are driven by culturally specific attitudes and experiences. Research suggests that experiences with racism and sexism have had a significant effect on the women of color in terms of morbidity and mortality mediated through stress or other pathways (Pullen et al., 2014).

Racism, classism, and sexism of the ethnic minorities done to main the status quo have been blamed for the existing health disparities. It has been argued that past and current repression and oppression of this community is linked to cultural barriers to healthcare utilization. One of these cultural barriers includes religious and cultural codependence, and the other is interracial dissonance. While education and economic status are often stated to be unequivocally related, this may not be the case for all ethnic groups. Until recently, there has been reports of wage gap between African Americans and the Whites. Currently, while there are 4 million fewer poor Whites than 30 years ago, White to African American poverty ratio is 1:3. Also note that median household income among White household is 8 times greater than African

American households. This socioeconomic racial disparity persists through disproportionate access to education, employment, housing, and justice system. Although this community was awarded citizenship in 1865, still they are disenfranchised and continue to be punished severely and are unprotected under the law (Chandler, 2010).

Further, the medical institutions' western biomedical beliefs coupled with limited recognition of alternative beliefs and practices may further deter African Americans, including African American women from using the available health services. African American women are likely to have social networks that may influence their patterns of healthcare utilization. African American women also have high religious involvement, and there is evidence suggesting that more religious women of the community are less likely to use preventive and healthcare screening facilities, thus relying more on spiritual beliefs (Pullen et al., 2014). As research on these disparities grows, both researchers and healthcare providers are now becoming more aware of the oppression and suppression faced by this community and its role in health-seeking behavior. Hence, they are becoming more and more mindful of the phenomenon of cultural mistrust (Chandler, 2010).

Following health care-related strategies have been suggested to facilitate successful and productive aging among older women of this community (American Psychological Association):

1. Understanding the impact that everyday racism has through their lived experiences
2. Acknowledging their past and present experiences and being empathetic toward it
3. Providing equal access to resources and other shared spaces
4. Provide resources that enhance positive racial group identity
5. Encourage and celebrate their cultural belongingness
6. Limit exposure to and be mindful of culturally insensitive events or incidents
7. Seek training for culturally competent geriatric care
8. Facilitate culturally sensitive mental health services.

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