Older Black Women, Health, and the Black Helping Experience

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Introduction

Within cultural communities, there are natural helping resources that many individuals within that community use in their search for help. These resources can include such helpers as religious institutions, extended families, and friends, each operating on many different levels. As a public health social worker, this author is interested in further understanding (a) the role of these natural resources in relation to the black aged female in addressing her own help and health needs, and (b) how those natural resources function in combination with formal/professional assistance – either encouraging or discouraging the use of formal help. More and more, we are increasing our awareness of health and helping needs of individuals, and in this case -- older women, as viewed through their various roles such as caregivers, wives, mothers, and heads of households. Gender impacts on illness through economic circumstances, work and family responsibilities, lifestyle choices, social interaction with family members and others, as well as with health providers. Symptoms do not make a woman or man a patient–seeking professional help does (Lorber, 1997). A clear understanding of the historical tradition of 'helping' in black families and the role culture plays in seeking help is also necessary.

As females age, their proportion in the population increases. Nationally, more than 72% of persons aged 85 and over were female in 1990 (Schulz and Kerchis, 1996). Because women have a longer life expectancy than men, they comprise most of the older population. Increased knowledge regarding elderly black women and their health behavior is significant for the City of Pittsburgh and Allegheny County (Pennsylvania) since they contain one of the highest concentrations of elderly residents in the nation. More than 17 percent of the population in the City and County is age 65 and older. Among cities with a population of 200,000 or more, the City of Pittsburgh was ranked second in the percentage of elderly, after St. Petersburg, Florida (Schulz and Kerchis, 1995).

The Problem

Women are living longer than men, but not necessarily better. As they age, they are more at risk than men to become widowed, live alone, live in poverty, suffer from a chronic illness or disability (Schulz and Kerchis, 1995), and lose their informal support network (Chatters, Taylor and Jackson, 1985). This seems to be especially true for aging black women. Elderly women who were once young, vibrant, and independent, may now have to seek out new and different ways of socializing, getting from one place to another, and participating in their lives in order to remain active within their own churches, communities, social networks, and society in general. As professional helpers, we often hear stories of total independence in an aging person, until some chronic illness affects them in a way that completely changes their ability to fully function. There are other individuals who have been financially dependent on a spouse and suddenly found themselves having to provide and manage their own affairs (i.e., banking, paying bills, making financial decisions). As widows, they have to learn a new way of life and seek assistance to fill the void left by their deceased husbands. Still others have never been married and may have functioned independently as single women, until they were confronted with a chronic or disabling illness. In any of these scenarios, there may or may not be adult children to provide support. Also, in any of these scenarios, the elderly woman may have been a primary caregiver or informal helper for others, and her changes may have a tremendous impact on others under her care. The changes that are sometimes forced on these women most often require a new approach to life and a different way of doing things.

For many women, these scenarios mean increased dependence on informal and/or formal support networks,

sometimes by their own choosing, but often because they have no other choice. The literature suggests that although women typically have more family and friend relationships than men, these associations may place heavy demands on women and include conflict as well as helping support (Antonucci, 1990). Further, many older women may have, for the first time, the opportunity or need to use formal services. The dynamics and challenges related to making decisions about seeking help either informally or formally, is both complex and diverse--as are the women themselves.

Much of the literature on older women in general, identifies them as a population at risk. Older African American women possess three dominant social statuses that are evaluated negatively by the larger society (Berry, 1995). As stated by Berry (1995), these statuses are "being black, being old, and being female." As a result, they experience a 'triple jeopardy.' Given data provided by Schulz and Kerchis (1995), elderly black women residing in the City of Pittsburgh have the highest risk for living alone, in poverty, and with a disability. This correlation between poverty and health is very relevant since low socioeconomic status is a major barrier to good health.

There is very limited research on the consequences of aging and social networks for African Americans. Chatters, Taylor, and Jackson (1985) report that increasing age among African Americans is associated with a decrease in the size of the informal network, putting the oldest old (aged 75 and over) at risk for becoming socially isolated. Since women are outliving men, and elderly black women have a higher risk for poverty, disability and living alone, this is especially applicable for them. Even if the informal network is still available, it may become overburdened, needing the additional support of the formal network as well. Adult children and others in the informal network may experience role overload, role reversal or role confusion. A further strain on the members of the informal network--including spouses and adult children--is that they may be dealing with their own aging issues at the same time. There is also limited research on the role of family and friends in influencing older African Americans to use formal services (Jackson, Chatters and Taylor, 1993). Chappell and Guse (1989) suggest that older adults need help in dealing with the bureaucracy of formal networks. Informal supports can be helpful, and yet serve as a barrier to the utilization of formal services. While the informal network may facilitate exchange with the formal network, informal groups often help older adults try to manage their situations, rather than assisting them in the complex formal help-seeking process (Chappell and Guse, 1989). In some cases, informal networks may even hinder formal service networks from providing needed services to the older adult (Bass and Noelker, 1989; Chappell, 1985).

Blacks and Help-seeking Behavior

Although the majority of blacks use the informal network the time sequence is unclear. Social exchanges undoubtedly occur before and after contact with professional helpers (Neighbors, 1984). There is little research on aged African American women as a unique and diverse group. Both empirical research, and especially qualitative research, on them is minimal (Padgett, 1989). Conclusions drawn by the NSBA (Neighbors, 1988) indicate the need for future research to focus on how the social network functions, both as an alternative treatment source and as a referral system. Neighbors (1988), who focused much of his analysis of the NSBA on help-seeking behavior, also suggests that more information is needed on *when* black social networks facilitate and *when* they hinder access to professional helpers. He reports that patterns of use in the NSBA varied depending upon the type of problem the person was experiencing (Neighbors, 1988). In summarizing the findings of the National Survey, Neighbors (1988) further concludes that it is important to arrive at some conception about those conditions for which it is reasonable to have professionals intervene and those for which the natural community support system does an adequate job. Understanding what African Americans perceive as problems that are more appropriately resolved within the informal support network is especially important for designing the focus and content of health care educational messages, should it seem necessary to modify black illness behavior (Neighbors, 1988).

An emerging area of research examines family, friends, and nonkin sources of informal support to elderly black adults. Empirical research (Taylor and Chatters, 1986) documents that as a group blacks are involved in extensive family and friendship networks, characterized by the frequent exchange of goods and services and socioeconomic support. Quantitative research using sample survey methods documents frequent interactions between elderly blacks and their children and grandchildren. Despite these efforts, there remains a paucity of high-quality research and information on the nature and functioning of the family and nonkin support networks of elderly blacks (Taylor and Chatters, 1986).
Much of the literature (Kleinman, 1978; Eisenberg, 1980; Neighbors, 1984 Greene, 1995; Spector, 1996) on *help-*

seeking behavior suggests a process that an individual goes through in response to an illness or health related problem. Each of these authors discuss a theory related to the helping-seeking process, which could serve as a model for studying elderly black women.

Chrisman (1977) introduced a *health seeking* process as a comprehensive scheme for examining a person's reaction to sickness. This model is an attempt to conceptualize a person may experience with sickness *holistically* as *natural histories of illness* (Chrisman, 1977). The process described by Chrisman (1997) involves steps taken by an individual who perceives a need for help as he or she attempts to solve a health problem. Chrisman's model includes: (a) *symptom definition,* (b) *illness-related shifts in role behavior,* (c) *lay consultation and referral,* (d) *treatment actions, and* (e) *adherence.* Chrisman also suggests that an *evaluation*, during the episode, of one's past actions may influence change in current behavior. He (Chrisman, 1977) refers to the *degree of insularity* of particular life styles in the United States (Chrisman, 1977) and suggests that intra-group communication and support processes tend to effect the directions toward which people turn for help. He also suggests that these individuals share health beliefs and practices and are influential in the maintenance of them,
on the part of the ill person.

Chrisman (1977) believes that symptom definition is a predominantly cultural factor and agrees with Kleinman and Eisenberg (1978), that people develop 'culturally based explanatory models' of the mechanics of their illness. These models are the ethnomedical categories that allow meaning to be applied to the experience (Kleinman, 1978). On the other hand, role shifts and lay consultation and referral, are viewed as more social factors, in that role shifts relate to the negotiation process regarding social role obligations. Both the shift and lay consultation involve bringing one's health status to the attention of others, who then become involved in the events of the illness episode. However, he also points out that each factor may have some social and cultural overlap (Chrisman,1977). For example, lay consultation occurs in a more sociocultural context during the illness episode, in that it can involve the social network of significant others as they identify the illness, suggest treatment actions and recommend help. These activities generally imply the existence of shared health beliefs and practices. Treatment action and adherence combine social and cultural factors in the same manner (Chrisman, 1977).

Chrisman (1977) acknowledges that this health-seeking behavior model does not refer to everyday behaviors of well persons or chronically ill persons whose activities are related to prevention of illness or maintenance of an impaired health status. It also does not refer to the daily life events that trigger a concern with health and the inception of care seeking. The steps in the process are not necessarily sequential and some elements may be skipped. Again, the process refers to behavior individuals may exhibit during an acute illness (Chrisman, 1977).

Gender, the Social Construction of Illness and Spirituality

Another consideration in examining health behavior in elderly black women is Judith Lorber's (1997) explanation of *gender and the social construction of illness.* Lorber (1997) explains that we usually consider physical health as a state in which people can do what they have to do and want to do, and illness as something that disturbs the physiological equilibrium of the body. What we actually experience as illness is a disturbance of our social lives, keeping us from going about out usual pursuits. It is a situation that may or may not be the result of actual bodily dysfunctioning. The perception that something is wrong and the guesses as to the cause are always experienced within a social context (Lorber, 1977). In other words, we define something as a problem and speculate about the causes based on our social and cultural frame of reference. She further states (1977) that many risky behaviors in adulthood, such as drinking and cigarette smoking, seem to be a matter of individual choice;
However, a closer look reveals that social factors linked to gender, race and ethnicity, and economics, produce the situational circumstances that influence health related behaviors. Because illness is socially constructed, physicians and patients may see the same set of symptoms (or lack of them) entirely different. Health planning policies based on data which assume that all blacks, regardless of their health status, economic status, age or gender, exhibit the same patterns of illness behavior are too simplistic to have a meaningful impact upon the groups toward which they are targeted (Neighbors, 1985).

Spirituality appears to be very important to black women, in general, according to Phillips (1993). Prayer and specific beliefs and perceptions about God and the meaning of life are of particular importance in coping efforts of black women facing difficult life events. Religiosity and spirituality have emerged as critical factors of their efforts

to understand, interpret and cope with adversity (Neighbors, Jackson, Bowman and Gurin, 1983; McKay, 1989; McAdoo, 1992; Mattis, 1995). Behaviors reported in response to symptoms include ignoring or forgetting that the symptoms exist until the condition becomes disabling, praying and living by religious principles, using home remedies and self-medication, and relying on women within their own social network as important support for health concerns (Tessaro, Eng, and Smith, 1993).

The Black Helping Experience

Martin and Martin (1985) address the helping tradition of the black family. Historically, black families have always functioned in a pattern of exchange. The helping tradition was a part of the African culture, even prior to slavery. Despite the diversity of traditional African societies, one feature shared by nearly all of them was that life was organized around the family. Kinship bonds were so strong in traditional African families that sometimes smaller family units (nuclear families) would become part of a larger extended family network, which would then make up a clan, with several clans making up a tribe or community. The traditional African kinship system was one that reached out, linking each person to everyone else. It was the extended family ties that were the basis for caregiving. One did not have to be a relative by blood or marriage to receive help in traditional African society. The feeling of helping and sharing was so deeply rooted in the African way of life (regardless of the tribe) that everyone was treated like kin. Even during slavery, the slave family included both kin and nonkin. Traditional black belief regarding health did not separate the mind, body and spirit. The old and the young were cared for by all members of the community. The elderly were held in high esteem because African people believed that living a long life indicated a person had the opportunity to acquire much wisdom and knowledge.

Conclusion

Historically, in this country, elderly black women have experienced oppression for much of their lives. During their lifetime, their only alternative in many cases has been to fend for themselves (Abramovitz, 1988). They are part of a cohort that came into adulthood at a time when prejudicial behavior on the part of health and service providers was the norm. They have a long legacy of reinforcement of utilizing an informal network and they must be viewed sensitively and culturally through that historical lens. Institutionalized racism, ageism and sexism add to their perception of barriers to formal help. There are a number of health problems that affect the health and well-being of these women; however, because they rely heavily on cultural (and spiritual) tradition, healthcare is not always a first choice for them (Office of Women and Minority Health, 1996).

It is critical for all ‘helpers’ to understand the historical and cultural context and its significance in contemporary patterns of health beliefs and practices, especially as they get translated into health. The social work profession must take the lead in helping other providers value the critical role that culture plays in the lives of black women, their health and their health behavior (Gaston, Barrett, Johnson and Epstein, 1998). We must continue to gather and use culturally relevant information that will engage policymakers and formal providers and encourage them to address issues related to cultural sensitivity and competency throughout all levels and aspects of health and care.