



Health and Health Care of African American Older Adults

http://geriatrics.stanford.edu/ethnomed/african_american



©iStockphoto.com/Monkey Business Images/Catherine Yeulet

Course Director and Editor in Chief: **VJ Periyakoil, MD** Stanford University School of Medicine

✉ periyakoil@stanford.edu ☎ 650-493-5000 x66209 <http://geriatrics.stanford.edu>

Author: **Rita Hargrave, MD** VA Northern California Healthcare System, Martinez; UC Davis



STANFORD
SCHOOL OF MEDICINE

eCampus Geriatrics
IN THE DIVISION OF GENERAL INTERNAL MEDICINE
<http://geriatrics.stanford.edu>

CONTENTS

Description	3
Learning Objectives	3
Introduction	4
Topics—	
Population Growth & Distribution	4
Characteristics	6
Patterns of Health Risk	
Topics—	
Life Expectancy, Mortality	7
Morbidity	8
Self-Rated Health & Functional Status	9
Culturally Appropriate Geriatric Care: Fund of Knowledge	10
Topics—	
Health History	10
Health Beliefs	13
Causes of Illness & Approach to Intervention	14
Culturally Appropriate Geriatric Care: Assessment	15
Topics—	
Cultural Biases & Misdiagnoses	15
Showing Respect, Use of Assessment Instruments	16
Culturally Appropriate Geriatric Care: Delivery of Care	17
Topics—	
Cardiovascular Disease	17
Stroke, Breast Cancer	19
Mental Health	20
End-of-Life Care	21
Access & Utilization	22
Topics—	
Disparities	22
Patient-Based Factors	22
Physician-Based Factors	23
End-of-Life Care Issues	26
Health Promotion	29
Instructional Strategies	31
Topics—	
Projects & Assignments	31
Case Study 1: Mr. S	32
Case Study 2: Mrs. P	35
Student Evaluation	36
Topics—	
Objective Questions, Essay Questions, Group Projects, Reports and Exams, Case Studies, Sample Questions	36
References	37
Links & Resources	43
Suggested Reading	44
Appendices	
Topics—	
A: Important Cultural Terminology	46
B: Cancer Survival Rates	47
C: Recent History	48
D: Cohort Experiences	50

Copyright/Referencing Information

Users are free to download and distribute eCampus Geriatrics modules for educational purposes only. All copyrighted photos and images used in these modules retain the copyright of their original owner. Unauthorized use is prohibited.

When using this resource please cite us as follows:

Hargrave, R, MD: Health and health care of African American Older Adults http://geriatrics.stanford.edu/ethnomed/african_american/. In Periyakoil VS, eds. eCampus Geriatrics, Stanford CA, 2010.

DESCRIPTION

This module presents an overview of available information on health conditions among African American or Black older adults in the U.S. with emphasis on historical influences on their health and health care.

Course Director & Editor in Chief of the Ethnogeriatrics Curriculum & Training

VJ Periyakoil, MD

Stanford University School of Medicine

Author

Rita Hargrave, MD

VA Northern California Health Care System, Martinez; UC Davis

Acknowledgements

Special thanks to the following people for their contributions to this module: Sharon Gordon, PhD; Margaret Hargreaves, PhD; Janet Lieto, DO; Elyse A. Perweiler, RN, MPP; Veronica J. Scott, MD, MPH; Wilbur Watson, PhD (deceased); Mary P. Williams, EdD, PA-C; Gwen Yeo, PhD; Motisola Zulu, BA.

LEARNING OBJECTIVES

After completing this module, learners should be able to:



1. Describe the status and care of Black older adults during the antebellum period of the United States.
2. Describe the different assumptions of Black older adults that help to inform conceptions of health and illness.
3. Describe today's African American population using the following categories:
 - a. demographic characteristics
 - b. ethnic-specific patterns of social support
 - c. major causes of mortality
 - d. relative risk for dementia, diabetes, and prostate cancer
4. Identify key barriers to Black older adults' participation in health and related services.
5. Explain briefly the concepts: natural causes of illness; occult and spiritual forms of illness.
6. Discuss the effects of cultural bias on misdiagnoses and errors in treatment planning for patients.
7. Recommend a culturally appropriate approach to end-of-life care for African American older adults.

MODULE CHARACTERISTICS



Time to Complete: 2 hrs, 0 mins



Intended Audience: Doctors, Nurses, Social Workers, Psychologists, Chaplains, Pharmacists, OT, PT, MT, MFT and all other clinicians caring for older adults.



Peer-Reviewed: Yes

Note

In this module the terms Black and African American are used interchangeably. The terms Black and African American are used to indicate persons who were born in the US as no separate data are available for Black older adults who have immigrated from other countries.

INTRODUCTION AND OVERVIEW

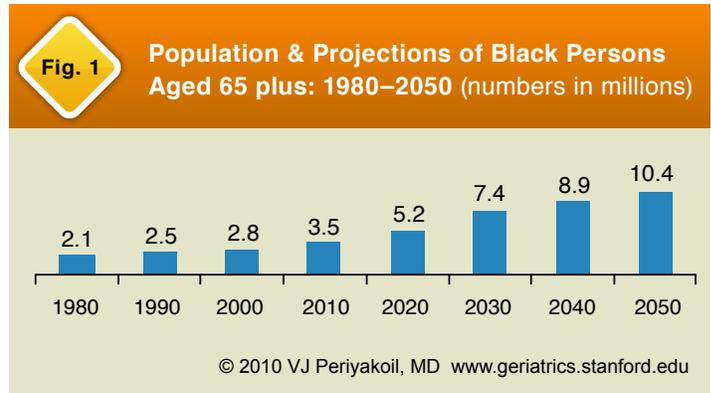
Population Growth and Distribution

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

There has been continuous growth in the overall population of Blacks in the United States since 1790. In 1790, the year of the first U.S. census, the Black population numbered about 757,000. Since 1970, there has been considerable growth in the population of Blacks. The growth in the proportion of Blacks 65 and over since 1970, in comparison to the growth rate of Blacks under 18 years and those 18 to 64 years, shows a considerably more rapid rate for the older group than for the younger age groups.

This pattern is accounted for in part by a decline in the fertility rate among Blacks that began in the late 1960s. Given an expectation of (1) a continuing decline in the fertility rate, (2) further improvements in health care, and (3) increased life expectancy of Blacks, this pattern of growth in the number of persons 65 and over is expected to continue (Watson, 1982).

By 1990, the population of Blacks in the United States totalled more than 30 million people. According to the US Census, the Black population increased by 1.3 percent, or 522,000, between 2005 and 2006. To date, over 35.6 million Americans are aged 65 and over. Over the next forty years, the number of people aged 65 and older is expected to double and the number of people aged 85 and older is expected to triple. The total 65 and older population is expected to exceed 10 million by 2050 (www.census.gov) (see **Figure 1**). Data on the subgroups of Haitian older adults or those from African or other Caribbean backgrounds are not available.



Source: Administration on Aging, 2006

Along with growth in the population of Blacks, there have been noticeable changes in their geographical distribution in the United States. In 1890, the year of the first census in which data were made available on urban-rural distribution of Blacks, 80% of all Blacks lived in the rural southern United States. By 1970, however, the 1890 pattern was reversed: about 81% of Blacks had become concentrated in urban areas. Most recently, the US Census (2006) reports New York having the largest Black population (3.5 million), followed by Florida (3 million) and Texas (2.9 million).

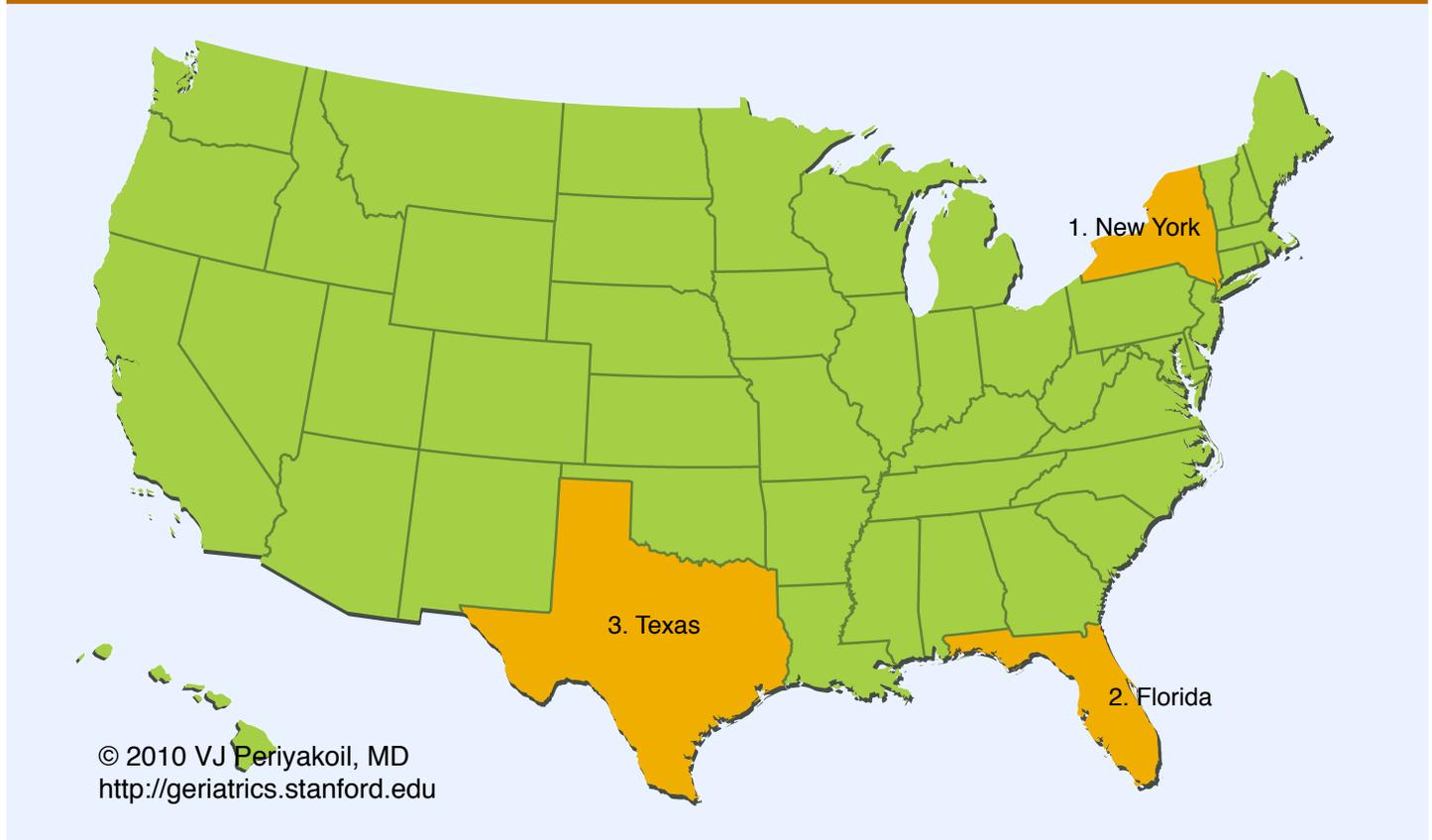
See Figure 2 on page 5.

(INTRODUCTION & OVERVIEW CONT'D)



States with the Largest African American Populations

Based on 2006 U.S. Census



(INTRODUCTION & OVERVIEW CONT'D)

Characteristics**Heterogeneity**

Older Americans who identify themselves as Black or African American are extremely varied. Although many are low income, very large and growing segments are in the middle and upper income categories. Some are retired professionals, and many others have children with professional careers.

Religious affiliations include:

- Protestant
- Catholic
- Muslim
- None

Many are still living in the rural South, but more are in urban areas in the North and West. Educational levels vary from almost no years of schooling to those with doctorates. While many in their 70s and 80s are dependent on care from children, grandchildren, or “**fictive kin**,” many others are raising their grandchildren or great grandchildren. It is important for clinicians to recognize the vast array of characteristics that may be represented in older Black patients so that each patient can be treated as an individual.

Living Arrangements

Among community dwelling older adults, African American women were more likely to live alone. In 2004, 24 percent of African American older women lived with their spouses, 33 percent lived with other relatives, 2 percent lived with non-relatives, and 41 percent lived alone. For African American older men, 56 percent of African American older men lived with their spouses, 13 percent lived with other relatives, 5 percent lived with non-relatives, and 27 percent lived alone. For African American older women, (Administration on Aging [AoA], 2006).

IMPORTANT TERM

Fictive Kin—People that are considered ‘family’, as the result of longstanding relationships, but may not be linked directly by blood ties. These individuals may be serving as the primary care giver or even as the surrogate decision makers and may be sometimes more involved than the directly related family members.

Historically, African Americans have resided in nursing homes at about half the rate of White older adults (Yeo, 1993). More recent evidence shows an increase over Whites in the use of nursing homes among Black men and women over 65 than Whites (Kramarow, Lentzer, Rooks, Weeks, & Saydah, 1999). *See Figure 3 in Access and Utilization: Long Term Care.*

Education

The AoA (2004) reported that 81% of Blacks age 25 and older, had at least a high school diploma in 2004. This proportion rose by 8 percentage points from 1994 to 2004 and the number of Black college students in fall 2004 was roughly double the number 15 years earlier.

Poverty

The poverty rate in 2004 according to AoA was 24.7% for those reporting Black as their only race. This rate was unchanged from 2003. This is a slightly higher rate than that of older Hispanics and more than twice the rate of older White Americans (Kramarow et al., 1999). The percentage increases with age and for those who are widowed or live alone.

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

PATTERNS OF HEALTH RISK

Life Expectancy

The Crossover Phenomenon

Life expectancy at birth has historically been shorter for African Americans than for other Americans, but the differences disappear or reverse themselves at older ages, creating the “**Crossover Phenomenon**” .

Closely related to the subject of differential life expectancy, the Crossover Phenomenon refers to the fact that both Black females and males who were 80 years of age or older in 1976 had a longer life expectancy than their White female and male counterparts.

Its name comes from the reversal in average life expectancy that occurs between Blacks and Whites between 80 and 85 years of age.

See Table 1 to the right.

For a discussion on Social Support, Family Caregiving, and Role of Church and Religion, see Fund of Knowledge.

Life Expectancy	White	Black
At Birth	78.3	73.3
At Age 65	18.6	16.9
At Age 85	7.2	6.8

Source: Administration on Aging, 2004

In 2002, Black males who lived to the age of 65 had a life expectancy of 79.6 years and Black women who lived to the age of 65 had a life expectancy of 83.0 years (AoA, 2004). The historical trends in the Crossover Phenomenon and possible reasons for it are discussed in Fund of Knowledge under Health History.

Mortality

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

(PATTERNS OF HEALTH RISK CONT'D)**The leading causes of death among African Americans age 65 and over are:**

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

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

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

Most causes of death have been declining among Black older adults, but there are some exceptions. Lung cancer and deaths from other lung diseases such as bronchitis and emphysema have continued to increase among older Black men and women.

Since 1980, there has also been a dramatic increase in mortality from hypertension (presumably due to stroke) among older Black men while it decreased among older White men. Hypertension mortality rates have also increased among older Black women (Sahyoun et al., 2001).

Morbidity

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

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

Hypertension, Coronary Artery Disease and Stroke

These have been recognized for decades as major risks for African American older adults. In the 1980s, 37% of Black males and 64% of females age 65 and over were reported to have hypertension. There is an inverse relationship between socioeconomic status and blood pressure, so that those in poverty have a higher risk. Also, African Americans between the ages of 45-64 are 2-5 times more likely to die from heart failure than Caucasians in the same age group (Duster, 2007).

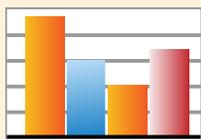
(PATTERNS OF HEALTH RISK CONT'D)

Cancer

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

Breast cancer incidence seems to be about the same or lower for African American women as for other women, but the survival rate is lower. The survival rates appear to be improving, but the stage at which the tumor is diagnosed is still later for Black women.

For a list of references regarding breast cancer patterns among African American women, see **Suggested Reading**.



For a comparison of Cancer survival rates between White and Black patients, see **Figure 2 in Appendix B**.

Factors associated with the late stage diagnosis are:

- limited access to care
- care in public rather than private clinics
- higher body mass index
- lower rates of mammography

Cervical cancer risk is higher among African American women (Manton, 1997).

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

African Americans also have higher colorectal cancer rates which increase with age (Kauh et al, 2007). Death rates for all cancers are 30% higher for African Americans, as well as lower cancer survival rates when compared to Caucasian counterparts (NIH, SEER Program).

Self-Rated Health and Functional Status

African Americans have usually been found to rate their health less positively than other American older adults and have more functional disabilities.

See **Table 2** below.

 Percent Who Report Activities of Daily Living Limitations: 1994 Age 70 and Over		
ADLs	All	Black
Bathing/ Showering	8.2	11.5
Dressing	6.0	8.1
Eating	1.9	NA
Getting In/Out of Bed or Chair	9.2	11.1
Walking	18.7	25.0
Getting Outside	7.5	11.0
Using Toilet	2.2	2.9

Source: Trends in Health and Aging, www.cdc.gov/hchs.agingact.htm

CULTURALLY APPROPRIATE GERIATRIC CARE: FUND OF KNOWLEDGE

Two important issues for effective geriatric care for African American older adults are:

1. Background knowledge of the historical events that have influenced their lives and attitudes toward health care
2. Knowledge of their health beliefs and practices.
3. Knowledge of causes of illness and interventions

Health History

There is general agreement that Black older adults have traditionally been treated with great respect in their families. This tradition extends from known customs of pre-slavery civilizations on the African continent through modern customs among African American families and kinship groups in the United States. Griots, or indigenous oral historians, were respected as repositories of cultural historical beliefs, legends, and facts (Watson, 1983).

Ancestral worship, and the belief that older adults are closest to their ancestors, helps to contribute to respect for the living elderly. This custom is similar to that of the Chinese, who have traditionally venerated their aged, believing they were but one step removed from a spiritual union with their ancestors (Watson, 1977).

Up From Slavery (1619–1865)

From the inception of slavery through modern times, those Blacks who grew old in the United States had to withstand a variety of psychologically, physically, and socially degrading experiences resulting from the political economy of race relations in the United States.

Among the determinants of the treatment of elderly Blacks in the social history of the United States, economic factors have had a significant bearing. For example, the economic interests of slave owners during the antebellum period of slavery in America made the



Five generations on Smith's Plantation, Beaufort, South Carolina.

Source: Civil War Photograph Collection (Library of Congress).
Public Domain

situation of elderly disabled slaves especially tenuous. Genovese (1974) made the following observation about the economic and work-related determinants of the life chances of pre-Civil War elderly slaves:

The Whites of Maryland expressed outrage at the extent to which slave holders were emancipating their old slaves in order to escape responsibility for them. In Baltimore, as in other southern cities, incensed residents protested against the influx of Manumitted country Blacks who could only become a public charge, and fought for tough laws to curb the practice. No less staunch a pro-slavery writer than Dr. Josiah Mott of Mobile revealed the fragility of paternalistic concerns in his attack on the practice of insuring slaves.

As long as the Negro is sound, and worth more than the amount insured, self-interest will prompt the owner to preserve the life of the slave; but, if the slave became unsound and there is little prospect of perfect recovery, the underwriters cannot expect fair play—the insurance money is worth more than a slave, and the latter is regarded rather in the light of a super-annuated horse (Genovese, 1974, p. 520).

(FUND OF KNOWLEDGE CONT'D)

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

Manumission may or may not have been an exceptional way of treating older slaves. Whatever its frequency, it was certainly not the only response to the old and disabled. It was disturbing to find in archival research, although not surprising after reflection on the economics of chattel slavery, that slavers quite often sought to sell or trade their old disabled slaves and acquire younger stock for fear of losing the investment they had made.

One account reported that the appearance of “old slaves” were sometimes “doctored up,” made to look younger than they actually were before they were sold. Youthful appearances would bring a better price (Brown, 1855, pp. 26-27; Brown, 1847, pp. 42-45, 92-93).

Among slaves, according to Frederick Douglass, youth were expected to respect the older slaves, less they risk severe reprimand. “A Young slave must approach the company of the older with hat in hand, and woe betide him, if he fails to acknowledge a favor of any sort, with the accustomed ‘tank’ee” (Douglass, 1855, pp. 35-40).

The bonds and customs of deference among slaves, no doubt, functioned as sources of social and psychological support for old disabled slaves, facilitating their coping with the harsh and inhumane demands of the slavers culture. Included among the means by which older slaves supported and cared for the health of each other was folk medicine (Smith, 1881, pp. 4-5).

Support for older adults was also provided by younger able bodied slaves who shared their returns from labor with the older disabled who were less able to fend for themselves (Steward, 1857, pp. 16-17).

CURRENT COHORT OF AFRICAN AMERICAN OLDER ADULTS: HISTORICAL EXPERIENCES

For information on the historical experiences of older African Americans that might influence their attitudes toward health and health care, **see—**
Table 3: Recent History in Appendix C
Table 4: Cohort Experiences in Appendix D

Health and Longevity Since the Mid-19th Century

Despite the harsh living conditions of slavery, reconstruction and twentieth century separatism, Black older adults in the United States have continued to grow stronger and live longer. Some estimates placed the average longevity of Blacks at 21.4 years of age in 1850, with the average longevity for Whites at age 25.5.

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

These conclusions should not be accepted uncritically. The findings are based upon comparisons of aggregate data collected at the national level by the U.S. Bureau of the Census, 1850. Mortality data at the state level, for example in Virginia, for the same year did not show the same results.

Savitt (1978, p. 201) found evidence that “more slaves than Whites died of old age” between 1853 and 1860 in four Virginia counties. This suggests that some Black older adults lived longer than older Whites, at least in those counties. It was also reported that there were more centenarians among Blacks than Whites in 1850 (Savitt).

(FUND OF KNOWLEDGE CONT'D)**Care of Older Slaves**

Even though Black centenarians may have outnumbered Whites, it does not follow that Black older adults received better health care from slavers than older Whites. At least three other factors may have been operative even as early as 1850:

1. Black older adults may have been hardier in some physiological characteristics than their White counterparts and more successful at coping with the health hazards that so frequently occur between childhood and mid-life
2. The longer the slave was alive and well enough to work, the greater the economic return the slaver received for his/her investment
3. There may have developed within the “slave community” means of self health care that helped young and old slaves to withstand the hazards of everyday life during the antebellum period

Changes Since 1900

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

By 1900, some improvements had occurred in the longevity of Blacks: In 1900 the expectation of life for Negro females was 35 years and that of Negro males 32.5 years, as compared with 51 years and 48 years for White females and males, respectively. (Frazier, 1957, p. 569).

Since 1940, there have been further improvements in the life expectancy of Blacks and Whites. Whether born in 1900 or 1976, White females could expect to live longest of all, followed in descending order by Black females, White males, and Black males, who had the lowest life expectancy of all.

The average life expectancy of each group, however, in 1976 was much greater than it was in 1900. Frazier (1957) observed that chronic diseases were especially important to any attempt to explain the differences between Black and White mortality rates. There were, for example, certain disease-related stressors that clearly had a greater negative impact on the health of Blacks than on Whites and helped to explain the lower longevity of Blacks during the first half of the 20th century. At mid-century, Frazier observed the following:

After the age of five, the rates for the communicable diseases which characterize childhood are about the same for the two races. On the other hand, death rates for tuberculosis, influenza, nephritis, pneumonia, syphilis, homicides, and pellagra are uniformly higher among Negroes than Whites.

Tuberculosis, influenza and pneumonia are responsible for nearly three-fourths of the excess mortality among Negroes under 25 years of age. About 50 percent of the excess mortality among Negroes between 10 and 24 years of age is attributable to tuberculosis alone. Although in the older age groups tuberculosis accounts for a smaller proportion of deaths, influenza and pneumonia are important in all ages. For the group between 45 and 65 years of age (in the year 1950), nephritis and heart disease were responsible for 40 percent of the excess mortality (Frazier, 1957, p. 572).

Tuberculosis and pneumonia were also identified as causes of the high death rates among Blacks at the turn of the 20th century. Furthermore, the socioeconomic and psychological factors of ignorance, poverty, negligence, and intemperance were specified as major conditional factors that explain variations in incidence of death.

Although Blacks still die at earlier ages than Whites, many of the diseases identified above have been significantly reduced as causes of death since 1850. With the synthesis of penicillin in 1940 and its widespread prescription for rich and poor, Black and White, pneumonia has been brought under control. Along with

(FUND OF KNOWLEDGE CONT'D)

other advances in medical technology and public-health measures (such as water and sewage treatments, and nutrition education), improvements are being made in the overall quality of life in modern societies.

Health Beliefs

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

Background

Individual and social reactions to illnesses among Black older adults have been multifaceted over the decades during and since chattel slavery in the United States. The differences have included variations in:

1. Categories and definitions of illness
2. Theories about the causes of illness
3. Modes of intervention to return the afflicted person to a state of health

Most of the literature can be divided into studies of traditional medicine and of modern biomedicine. Traditional, in this usage, refers to cross-generational patterns of thought about health and illness, and beliefs about remedies, such as herbs, that are sustained over time by simple observations and myths pertinent to their use and value. Common sense theories that attempt to explain how the remedies work may span many centuries, with or without the support of scientific evidence. While modern biomedicine is dated from 1750 A.D., traditional or “folk medicine” is dated in some documents as early as 1500 B.C.



©istockphoto.com/ JStevensJR

Types of Healers

According to Snow (1974), practitioners of traditional medicine can be classified according to the healing practices they use and how they received the ability to heal. There are three ranks of healers, distinguishable by the sources of their healing powers:

1. Those who learned the ability from others (these are the individuals considered to have the least amount of power)
2. Older persons who received the gift of healing from God during a religious experience in later life (these are middle rank in power)
3. Those who are born with the gift of healing, the most powerful

Root and herb doctors are included among the groups who learned to heal from others, and are believed to have the least amount of healing power (Snow, 1974). The services of a root doctor, who is a type of conjurer, are sought either to place a hex on someone (or induce an illness condition) or to ward off evil (de Albuquerque, 1981, p. 51).

According to Mitchell (1978), faith or spiritual healers are practitioners with the greatest power, and are believed to have received the gift of healing from a god. They regard themselves as vessels through which the divine will is made manifest (Hand, 1980).

The laying on of hands, prayers and incantations are the methods most used to treat spiritual illness. See the next page for causes of illness and approaches to intervention.

(FUND OF KNOWLEDGE CONT'D)

In contrast to modern biomedicine, when diagnosing disorders and selecting treatment plans, practitioners of traditional medicine tend to depend more upon the patient's:

1. Trust that the doctor has accurately perceived and properly negotiated with the patient the nature of the disorder and the treatment needed
2. Faith in the healing powers of the doctor
3. Stock of folk remedies available in the cultural knowledge system of the society

Regardless of the approach to treatment of illness, whether by a biomedical or a folk practitioner, health is thought of as a state of individual well being. Although not admitted by all folk medical practitioners, healthiness may be sustained and/or achieved through internal bodily processes, such as homeostatic mechanisms, as well as life style characteristics that include purposeful health behavior. The range of beliefs among traditional medical practitioners, unlike their biomedical counterparts, include the contention that spiritual forces can intervene in human affairs to influence sustaining and/or restoring health of an individual.

Causes of Illness and Approaches to Intervention

In some traditional African systems of thought, it is believed that when one has good health, one is in harmony with nature. If one is ill, a state of disharmony is said to exist (Watson, 1984).

This holistic notion of health, however, is not peculiar to African systems of thought. Among the various systems of traditional medicine, most illnesses can be classified as having a natural, occultist, or spiritual origin (Murdock, 1980).

“Our examination of types of illnesses suggests a close relationship between the presumed cause of an illness and the type of intervention needed to correct the malady.”

Types of Illness

A natural illness is a result of a physical cause, such as infection, disease, weather, and other environmental factors. Treatments of natural illnesses emphasize the uses of herbs, barks, teas, and similar natural substances. An occult illness is a result of supernatural forces, such as evil spirits, and their agents, such as conjurers (Simpson, 1970; Tallant, 1946).

Evidence of occult illnesses and concerns about the treatment thereof is equally as prominent in the literature on traditional medicine as are reports of natural illnesses. There are three important distinctions between natural, occult and spiritual illnesses:

1. Natural causes primarily induce physical illness; conjuration may affect the physical and psychological as well as the spiritual life of the person (Mitchell, 1978)
2. Occult illness is a result of supernatural, not physical, causes. The conjurer uses his or her powers, as well as fetishes to induce and/or ward off illness in specific individuals
3. Spiritual illness is a result of a willful violation of sacred beliefs or of sin, such as adultery, theft or murder (Mitchell). Like the occult, spiritual forces can affect all aspects of life, ranging from the physical to the spiritual characteristics of the person (Simpson, 1970; Willer, 1971)

Our examination of types of illnesses suggests a close relationship between the presumed cause of an illness and the type of intervention needed to correct the malady.

CULTURALLY APPROPRIATE GERIATRIC CARE: ASSESSMENT

Cultural Biases and Misdiagnoses

Cultural biases about health and illness, and beliefs about which individuals and/or groups are most susceptible to one or another disorder is key among these factors.

Clearly, both health care practitioners and patients have cultural backgrounds through which the perceptions of each will be filtered. This discussion, however, is focused on the biases of practitioners when observing their patients. Biases are prejudicial points of view focused upon an object represented by selected perceptions framed by a particular sociocultural background, such as racist beliefs about differences between Blacks and Whites in the United States.

The influences of biases on decision making are often unintentional, expressed unconsciously, and as a consequence may be difficult to control in the doctor-patient relationship (Watson, 1982, 1984).

Biases Regarding African Americans

The beliefs about African Americans are as follows:

- It was once believed that high rates of hospitalization for the treatment of selected mental disorders among African Americans was due to an “inherent racial susceptibility” to certain kinds of psychopathology (Thomas & Sillin, 1972; Williams, 1986)
- Some psychiatrists believed that African Americans, as a group, tended to have low rates of depression because of their historical social and educational oppression. Somehow, being oppressed and deprived functioned as a social psychological shield against depression: Blacks were less vulnerable because they had less to lose (Prange, 1962)

Research regarding these biases reveals the following:

- Epidemiological and etiological research have subsequently shown that depression and other illnesses are much more complex disorders than suggested by the foregoing statements and must be carefully studied, including cross-cultural variations in symptoms of disorders, before drawing conclusions and formulating treatment plans
- Though some studies report that African Americans are more likely than White older adults to be diagnosed as schizophrenic and less likely to be diagnosed with mood disorders, ethnic differences in the prevalence of these disorders is reduced
- The two most comprehensive community based studies, the Epidemiological Catchment Area (ECA) Survey (1980–1985) and the National Co-Morbidity Survey (1990–1992) contained only several hundred ethnic minority older adults (African American, American Indian and Alaskan Natives, Asian American and Pacific Islanders, or Hispanic Americans). Numerous authors have reported that misdiagnosis and clinical bias commonly occur in the psychiatric assessment of African American patients of all ages
- Other studies suggest that the failure to accurately diagnose symptoms of depression, manic depression and other mood and anxiety disorders among African Americans sometimes results from preconceived notions that Blacks are “happy-go-lucky” people or some other stereotype (Adebimpe, 1981; Poussaint, 1983; Williams, 1986)

Cultural insensitivity and deeply rooted prejudices, along with a lack of cross-cultural study by professionals focusing on the cultural backgrounds of their clients/patients, contribute to risks of misdiagnoses and inappropriate treatment plans, especially but not exclusively in the care of Black older adults with mental disorders.

(ASSESSMENT CONT'D)**Showing Respect**

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

The 40-year Tuskegee Experiment, which recruited African American men with syphilis to be a part of a research project in which they were promised but never given treatment, is widely known in the African American community.

This memory, in addition to the widespread discrimination most have faced in their lifetimes, are likely to provide reasons for African older adults to be more than a little suspicious of health care providers, especially those who suggest any type of experimental treatment or research. Clavon (1986) and others have emphasized the importance of recognizing and respecting patients' cultural habits, listening attentively, and encouraging conversation.

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

Use of Assessment Instruments

The variation in reports of the prevalence of dementia warrants carefully chosen instruments to assess cognitive and physical status in African American older adults (Froehlich et al., 2001). Baker (1996) reports differences in the validity of cognitive measures with African American older adults.

The Activities of Daily Living Scale (ADL) and the Short Portable Mental Status Questionnaire (SPMSQ) are two tools that have been specially tested and shown to be reliable and valid with older African Americans (Mouton, 1997).

ADL & SPMSQ ONLINE

- Katz ADL—http://geriatrics.stanford.edu/culturemed/overview/assessment/assessment_toolkit/index.html 
- SPMSQ—http://geriatrics.stanford.edu/culturemed/overview/assessment/assessment_toolkit/spmsq.html 



© iStockphoto.com/Jeffrey Banke/Diane Diederich/Catherine Yeulet

Adapting Assessment Techniques to Skin Color

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

CULTURALLY APPROPRIATE GERIATRIC CARE: DELIVERY OF CARE

This section will summarize health promotion and treatment issues for African American older adults suffering from the following conditions:

- Cardiovascular Disease
- Stroke
- Breast Cancer
- Depression
- Dementia
- End-of-Life

Cardiovascular Disease

Hypertension is a devastating illness for African Americans, among whom it appears at an earlier age and produces higher rates of mortality and morbidity when compared to White patients. Many African American patients have biological factors which increase their vulnerability to hypertension, including their greater salt sensitivity, lower plasma rennin levels and increased tendency for volume expansion.

Recent Studies and Findings

Current research on treatment of hypertension suggests that beta-blockers are often less effective in controlling hypertension for African Americans.

Antihypertensive Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT)

This recent study, in which 35% of the patients were African American, demonstrated that the **diuretic chlorthalidone**:

- Was associated with greater reductions in blood pressure (BP) than the angiotensin-converting enzyme (ACE) inhibitor lisinopril
- Was also associated with a relative risk reduction in stroke compared with lisinopril.

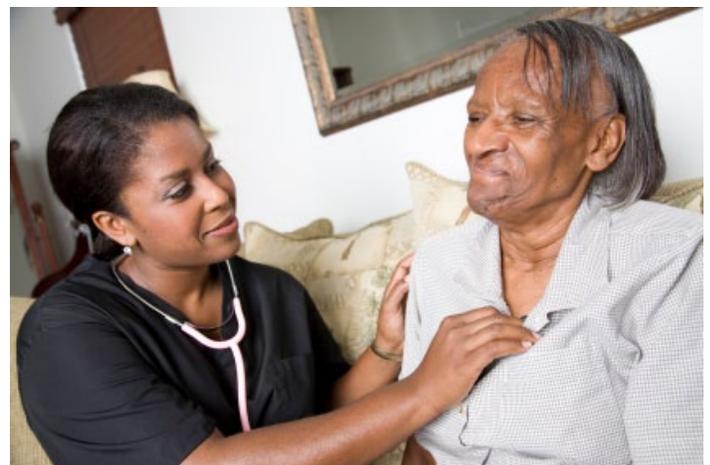
However, the increased stroke risk associated with lisinopril was experienced among African American but not non-African American patients. ALLHAT did not permit combination therapy with ACE inhibitors plus diuretics; therefore, the benefits of such regimens in this patient population could not be assessed.

Losartan Intervention For Endpoint Reduction in Hypertension (LIFE) Study

In this study, in contrast to the overall study population, African American patients with left ventricular hypertrophy treated with atenolol were at lower risk of experiencing the primary composite end point (death, myocardial infarction, and stroke) than African Americans treated with losartan, with or without diuretics.

African American Study of Kidney Disease and Hypertension

On the other hand, in the African American Study of Kidney Disease and Hypertension, African American patients treated with the ACE inhibitor ramipril had a significantly lower incidence of the primary composite end point (glomerular filtration rate reduction, end-stage renal disease, or death) than African Americans treated with the calcium channel blocker amlodipine.



© iStockphoto.com/Steve Debenport

(DELIVERY OF CARE CONT'D)**Combination Therapy**

Although the use of diuretics in African American patients may be a logical first-line choice for BP reduction, most patients will require combination therapy. African American patients with systolic BP $>$ or \approx 15 mm Hg above target level or a diastolic BP $>$ or \approx 10 mm Hg above target should be considered for first-line combination therapy.

Although certain combinations have been shown to be effective in non-African American patients, the choice of drugs for combination therapy in African American patients may be different (Ferdinand, 2003).

Mortality Rates

Heart disease is more likely to cause death among African Americans than White Americans, especially among women. The age-adjusted mortality rates from heart disease for African American women are one third higher than for White women. Jha et al. (2007) studying a large cohort of women, found that African American women less often received appropriate preventive therapy and adequate risk factor control despite a greater risk for congestive heart disease event risk. The authors suggest that African American women need more effective interventions to reduce their risk factors for heart disease.

Coronary heart disease mortality is more common in African American older adults than compared to White older adults. Ethnic differences in mortality rate have been attributed to the fact that African Americans have a higher prevalence of cardiac risk factors, significant delays in seeking care, lower quality of care and inadequate access to long-term care after the acute event.

Mehta (2006) reported that African Americans compared to Whites with ST-elevation myocardial infarction were significantly more likely to suffer in-hospital stroke, bleeding and 5 year mortality despite their younger age. Consistent with earlier studies, Mehta reported that revascularization rates were significantly lower in African Americans. Ethnic differences in utilization of this procedure were

“Heart failure is a national epidemic, affecting nearly 5 million persons in the United States. African Americans have a higher incidence and prevalence of heart failure than members of other racial groups.”

attributed to patient factors (differences in angiographic factors, patient's preferences, and insurance/ socioeconomic status) and physician's cultural and racial biases.

African Americans' increased vulnerability for strokes may be due to their increased prevalence of hypertension and higher systolic and diastolic blood pressures at admission and lower fibrinogen levels.

Recent Studies on Heart Failure

Heart failure is a national epidemic, affecting nearly 5 million persons in the United States. African Americans have a higher incidence and prevalence of heart failure than members of other racial groups.

Though many studies have suggested that African American patients receive less intensive and poorer quality of care than White patients, other studies suggest that there are not significant ethnic differences in quality of care.

Rathmore, et al. (2003) reported that Black Medicare patients compared to White patients hospitalized with heart failure received comparable quality of care, had slightly higher readmission rates and had higher survival rates. Left ventricular dysfunction, a common pathophysiological component of heart failure, is associated with hemodynamic abnormalities, neurohormonal activation and cellular alterations which lead to vascular and myocardial remodeling. Endothelial dysfunction and diminished nitric oxide bioavailability are also associated with heart failure.

(DELIVERY OF CARE CONT'D)

The African American Heart Failure Trial (A-HeFT)

Current studies suggest that endothelial dysfunction and decreased bioavailability of nitric oxide may be more prevalent in African Americans. The African American Heart Failure Trial (A-HeFT) reported significantly reduced mortality after treatment with fixed doses of isosorbide dinitrate-hydralazine added to standard neurohormonal blockade (Taylor, 2005).

This treatment intervention improved survival, decreased heart failure hospitalization rates and improved quality of life in African American patients with advanced heart failure. The results of this study suggest that nitric oxide enhancing therapy may be an effective new treatment for heart failure.

Stroke

Stroke-related mortality is higher in women than in men. Women accounted for 62% of the US stroke related deaths in 2002. African American women appear to have almost twice the risk of first-time stroke compared to Whites. Qureshi et al. (2006) in a prospective study examined racial and gender differences in long-term survival following ischemic stroke in a well defined cohort of patients.

The authors reported that African American women had a higher rate of mortality (relative risk 2.1) after adjustment for all potential confounders except diabetes mellitus. After adjustment for diabetes, the difference was insignificant, although a 70% greater risk of 1-year mortality was still observed.

The authors concluded that, compared with Whites and men, African American women have a lower 1-year survival following ischemic stroke. This phenomenon may be due to factors such as the higher prevalence of diabetes, obesity and metabolic syndrome in African American women and ethnic difference in the modification of risk factors such as hypertension, elevated cholesterol and smoking.

“Several studies suggest that African Americans are less likely to complete advance directives such as do-not-resuscitate (DNR) orders or living wills.”

Authors also noted that ethnic and gender differences in utilization of medical interventions (e.g. end-arterectomy) contribute to differences in the risk of recurrent stroke and cardiovascular death in patients with ischemic stroke. The authors suggested more monitoring, counseling and risk factor modification for African American women.

Breast Cancer

Breast cancer continues to be diagnosed at later stages of the illness in African American women compared to White women. A new study suggests that poorer communication of mammogram results may not allow Black women to benefit fully from mammography screening and may underlie their later diagnosis of breast cancer (Jones, et al. 2007).

The investigators reported that communication of mammogram results was problematic for 14.5 percent of the women in the study (12.5 percent had not received their screening result, and 2 percent had received their result, but their self-report differed from the radiology record).

Inadequate communication of mammogram results was nearly twice as common among Black women as White women (21 vs. 11 percent), even after adjustment for other socio-demographic, clinical, and care access factors. Also, abnormal results were more likely to be inadequately communicated to Black women (31 percent of abnormal results vs. 19 percent of normal results), but not to White women.

(DELIVERY OF CARE CONT'D)

Among women in the study who had abnormal results, 44 percent of those in the inadequate communication group (many of whom believed their mammogram was normal) compared with 29 percent of those in the adequate communication group did not receive adequate follow-up.



©iStockphoto.com/Cheryl Casey

Mental Health**Depression**

Several studies have identified ethnic differences in treatment interventions between African American and White older adults.

A 2002 study by Rollman revealed that primary care physicians were less likely to counsel African American compared to White patients with depression, although these ethnic differences were not significant when the authors made adjustments for education and socioeconomic status. Prescriptions of antidepressant medications have increased significantly over the past 15 years across the life cycle.

Blazer et al. (2005) found that African American older adults were less likely to take antidepressants and were less likely to receive newer antidepressants (serotonin reuptake inhibitors).

Dementia

Cognitive impairment in the elderly is an important cause of functional impairment and significantly reduces the quality of life among older adults. Cross-sectional studies have found a higher prevalence of cognitive impairment and dementia in African Americans compared to Whites.

Proposed biological factors associated with increased vulnerability to dementia for African Americans are:

- Exposure to environmental agents (e.g. lead or mercury)
- Poor access to health care

- Elevated rates of infection and malnutrition

Other proposed factors are:

- Higher prevalence of vascular-related cognitive impairment
- Lower educational attainment and literacy rates

Validity of Neuropsychological Testing Instruments

Though neuropsychological testing is pivotal to the diagnosis of dementia, many factors may affect the validity of the test instruments including:

- The patient's degree of acculturation
- Ethnic differences in performance on cognitive tests
- Measurement bias in the assessment instruments (Hargrave, 2006b)

Neurocognitive research suggests that higher levels of education serve as a protective factor against cognitive decline ("cognitive reserve") (Hargrave, 2006). Premorbid educational experiences are thought to increase the individual's capacity to cope with advancing brain pathology, alter the clinical expression of dementia and influence the neurophysiological heterogeneity observed in dementia. (Alexander, et al. 1997).

Several population-based studies in the area of ethnicity and dementia have shown:

- The prevalence and incidence rates for dementia appear to be higher among Blacks relative to non-Hispanic Whites
- Neuropsychiatric manifestations may show differential frequencies according to ethnicity
- Cross-ethnic differences have been identified in terms of both the provision of care as well as the positive and negative psychological outcomes of family caregivers (Harwood, 2000)

(DELIVERY OF CARE CONT'D)

End-of-Life Care

Active end-of-life care planning is not an unfamiliar concept to most African American older adults. Providers who have these discussions, however, should remember that older adults might be reluctant to participate due to an understandable mistrust of the health care system based on past history of segregation and discrimination toward African Americans.

Several studies suggest that African Americans are less likely to complete advance directives such as do-not-resuscitate (DNR) orders or living wills (Caralis et al., 1993; Eleazar et al., 1996; Hopp & Duffy, 2000; Mouton, 2000).

Older adults may feel that if they decided to opt for “do-not-resuscitate,” that would give the system the license to provide sub-standard care or give up on them ‘too-soon’. Religious beliefs may also play a role, in that many older African Americans believe that God is ultimately in control, and is the only one who can determine the timing of death.

Among both African American patients and physicians, more have been found to favor aggressive life prolonging treatment in the case of terminal illness than among comparison White groups (Caralis, 1993; Hopp & Duffy, 2000; Mebane et al., 1999; Mouton, 2000).

Mouton (2000) points out that life support may be equated with life, and that any effort at withholding life-sustaining therapies might be seen as another attempt at genocide by predominantly Caucasian institutions, recalling the history of unethical experiments on African Americans such as the Tuskegee Syphilis Study.

Some older adults will request tube feeding even in the face of terminal illness. Providers, then, should be very sensitive to issues regarding refusal or withdrawal of tube feedings.

Some African-American families may request that certain diagnoses or disease prognoses be withheld from patients to shelter them from disturbing information.

**Discussions on Advance Care Planning and End-of-Life Issues**

Extreme tact and sensitivity are called for when having discussions about advance care planning and end of life issues.

Providers must allow adequate time for these discussions and ensure that the patient’s family is present. Since trust is so critical in adequate end-of-life care with African American older adults and their families, it is very important for the provider to have built a trusting relationship with the patient and family in the past. In all cases, it may be helpful to ask the patient or family their understanding of the illness and treatment options, and use this as the basis for further discussion.

Also, many of the older adults may have strong religious beliefs, and so having a trusted spiritual counselor as part of the team may be helpful for patients. **See recommended procedures based on risk in the Delivery of Care Module of the Ethnogeriatrics Overview:**

http://geriatrics.stanford.edu/culturemed/overview/delivery_of_care/



Other patients and families favor forthright discussion of all medical issues and treatment plans.

Some patients may prefer that their loved ones be the conduits for information. Direct provider-patient communication may be limited by patients’ desire not to know the full implications of their illness.

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

ACCESS AND UTILIZATION

Disparities

African American older adults are more likely to experience poor access to medical care compared to White older adults. **Three important causes of ethnic disparities in health care are**

- | | | |
|--|---|--|
| <ol style="list-style-type: none"> 1. Patient-Based Factors 2. Physician Practice Patterns 3. End-of-Life Care Issues | } | <p>Medication
and Health
Care Utilization
Patterns Affect
All Three</p> |
|--|---|--|

1. Patient-Based Factors

Medical anthropologists suggest that African American older adults have culturally-derived perceptions of illness and socially reinforced health behaviors which significantly influence their help-seeking behaviors. These perceptions and behaviors contribute to their delayed entry into primary care clinics and hospitals. Some African American older adults believe that illness is an expression of divine punishment for sinful behavior. Others consider illness a result of exposure to cold air and various environmental impurities.

“Many African American older adults use home remedies for self-treatment before seeking professional medical advice.”

Spiritual and Home Remedies

Some African American older adults believe that good health is an indication that one's body and spiritual life are in harmony and that illness can best be cured through prayer and faith. Many African American older adults use home remedies (salves, teas, herbs and over the counter medicines) for self-treatment before seeking professional medical advice.



Since they often do not disclose their use of these products to their health providers, physicians and nurses working with African American older adults need to promote open discussion in their working relationship to minimize the potential for dangerous drug interactions (Brangman, 1995).

Emergency Room Utilization

Some investigators report that African American older adults use a crisis oriented approach to health care services, more often coming to hospital emergency rooms and less often having a primary care provider. African American older adults express higher levels of dissatisfaction with physician services, and perception of poor treatment may contribute to their tendency to avoid primary care (Sherkat, 2007). However, delaying treatment until emergency services are required may increase mortality rates (Brangman, 1995).

Additional Factors

Additional patient-based factors include:

- low socioeconomic status
- inadequate health insurance coverage
- underestimation of their health risks
- lack of trust in the health care system

(ACCESS & UTILIZATION CONT'D)**Use of Long-Term Care**

Studies of African American older adults' utilization of community-based long term care services have produced contradictory results. Though many studies report that African American compared to White older adults are less likely to use adult day care or in-home assistance services, other studies have reported that they have equivalent or higher utilization rates of these services.

Nursing Home Use

Most studies report lower use of nursing homes by elderly African Americans and attribute this phenomenon to:

- patient preference
- geographic distance of facilities from minority communities
- socioeconomic differences
- discriminatory referral patterns by health care providers.

2. Physician-Based Factors

Interviews and surveys of physicians suggest that many health care providers have limited knowledge about factors that contribute to ethnic differences in access to and utilization of medical services by African American older adults.

Wallace, et al. (2007) surveyed 236 physicians at three teaching hospitals and reported that the majority of them were unfamiliar with specific end-of-life preferences of African American older adults who often do not have advanced directives and refuse referral to hospice and palliative care programs. Many Whites and non-U.S. born Black physicians did not perceive that the Tuskegee experiment had a significant impact on the medical decision-making of African American patients.

SUGGESTIONS FOR IMPROVING CARE OF AFRICAN AMERICAN OLDER ADULTS

Because the physician's perception of the patient is an important component of the working relationship, Wallace and Pekmezaris (2007) advocated further cultural sensitivity training to improve knowledge and hopefully care of the African American patient afflicted with life-limiting illness.

The physician should assess the cultural background of each patient and inquire about the values that may affect care at the end of life.

Physicians should:

- Utilize specific questions aimed at dealing with cross-cultural issues in end-of-life care (Searight, 2005)
- Incorporate culturally-sensitive guidelines such as the Federal Cultural Linguistic Appropriate Services (CLAS):



www.omhrc.gov/CLAS



People in photo are models. Right © Thinkstock/Comstock Images/Getty Images

History of Maltreatment and its Effects

The long history of maltreatment of African Americans by the medical system has created a collective memory of exploitation and inferior care that remains an obstacle to effective patient-physician relationships.

(ACCESS & UTILIZATION CONT'D)

Qualitative interviews suggest that many African Americans older adults prefer to be kept alive on life supports because of their mistrust of the medical system and fear of suboptimal care (Blackhall, 1999).

Effects of Segregated Training

In addition the history of segregated training for health care providers has left a legacy of under-representation of minority health professionals and contributes to the social distance between African American patients and their health care providers. These socioeconomic and class differences partially account for African Americans' lower satisfaction with health care providers compared to White patients.

The legacy of mistrust, exclusion and persistent racial bias (overt or covert) is likely to affect patterns of and responses to communication between health care providers, patients and family members (Welch et al. 2005).

Discriminatory Patterns

Discriminatory provider practice patterns are also a significant source of ethnic differences in health care outcomes. Health services research has reported that physicians are less likely to provide African American older adults with appropriate medical interventions such as:

- Breast cancer screening
- Recommended treatment (breast conserving surgery plus radiation) instead of mastectomy for local breast cancer
- Treatment with newer antidepressants
- Post-hospitalization follow-up inpatient treatment for mental illness
- Revascularization procedures after angiography
- Treatment with beta blockers after myocardial infarction
- Implantable cardioverter-defibrillators or coronary revascularization procedures after cardiac arrest

- Thrombolytic drugs or primary angioplasty after acute myocardial infarction
- Cerebral angiography, anticoagulant therapy, or carotid endarterectomy after transient ischemic attacks
- TPA after ischemic stroke

It is important for providers to understand that cultural norms, historical context, the value of family, and religious beliefs are key determinants of social and kinship networks which in turn affect health behavior and outcomes in all older adults, including African American older adults.

Belief systems and tradition impact health care utilization and provide a basis on which health care providers should deliver culturally sensitive care. Literature has shown that older African Americans are more likely to rate their health as fair or poor than White older adults and are less inclined to seek health care early in the course of a disease. African American older adults are less likely to practice preventive health behaviors such as obtaining breast or prostate cancer screening.

On the other hand, health providers are less likely to offer some of these services to African American older adults than they are to their White counterparts. Religion plays a major role in determining the health beliefs and behaviors of African American older adults. Quality of life and life satisfaction are enriched by increased frequency of contact with friends and the availability of family help (Adams, 2000).

**Social and Kinship Networks:
Use and Effects on Health Behavior**

Much of the research on informal networks, church supports, and extended family in the Black community was done in the early to mid 1980s. Inter-generational family support and support from the extended family has been the hallmark of health care in the African American community. Formal and informal supports are used by both Whites and Blacks in need of help.

(ACCESS & UTILIZATION CONT'D)

However, Blacks have more active social support networks, with mechanisms in Black families that serve to expand network membership through creation of “fictive” kin (Johnson, 1990). Family support behavior among Blacks is grounded in respect for each generation. Among older African Americans, much of this support is the result of socioeconomic factors (Mutran, 1985), although cultural tradition is pervasive in caregiving to parents, siblings and other relatives (Fried, 1998).

Studies have shown high levels of social interaction and strong emotional bonds between elderly Blacks and their extended families, which is facilitated by the presence of an adult child and proximity to immediate family and relatives (Taylor, 1991).

Informal Caregiving

Comparisons of informal caregiving by Black and White older adults showed that Blacks were more likely to be caregivers and more likely to assist friends. Blacks have frequent contact with family, relatives, friends and neighbors, although they utilize the members of their network differently for emergency and non-emergency situations (Petchers, 1987).

It has been noted that the probability of caregiving in African Americans increased in those who are married, with substantial amounts of care to others with health problems and disability provided by those older than age 65 (McCann et al., 2000).

In a study of African American caregiving for a relative with Alzheimer’s disease, it was shown that caregiving, a traditionally female role, is not only a traditional family value, but an act of love, and that frequently, social supports serve to mediate caregiver burden (Steritt, 1998). It has been noted that Black caregivers report less depression than White caregivers and have greater self-efficiency in managing caregiving problems (Haley et al., 1996).

Although African Americans have been found to be in potentially more severe caregiving situations

than Whites, they had more favorable psychological indicators of stress. While Black and White caregivers differed in coping responses, they did not differ in social supports in caring for someone with Alzheimer’s disease (Wallsten, 2000).

White caregivers are more likely to be spouses whereas African American caregivers are more likely to be adult children, extended relatives or friends. (Dilworth-Anderson 2002)

In general African American caregivers as compared to White caregivers are more likely to be younger, unmarried, have less formal education and fewer financial resources (Haley, 1996).

Because of their lower income and higher poverty rates, the financial stress of caregiving may pose more of an emotional burden on African American caregivers. African American compared to White caregivers are more likely to provide more hours of care, higher intensity care and to report unmet needs in terms of support and access to services (Pinquart, 2005; McCann, et al., 2000).

Many African American caregivers are also actively caring for more than one person, such as children, grandchildren or other family members (McCann, 2000). Even though African American caregivers are caring for severely debilitated older adults and other family members, they are less likely than White caregivers to use formal care services such as nursing homes (Wallace 1998).

Previous research may have overestimated the availability and extent of support that African American caregivers receive from other family members (Cox, 1996). Though there may appear to be a large family network available for caregiving, interviews with some African American caregivers indicates in some cases that there are few opportunities for shared responsibility and shared decision making and as a result one primary caregiver becomes the sole decision-maker.

(ACCESS & UTILIZATION CONT'D)**Caregiver Burden**

Studies of ethnic differences in caregiver burden have revealed conflicting results. Some studies report that caregiver burden and depression are more common in White caregivers (Pinquart, 2005) while other studies have not found this relationship. These conflicting results may be the result of differences in sampling strategies, decreased sensitivity of measure of burden among ethnic minorities and limited self disclosure among African American caregivers to White interviewers.

Though some investigators report no differences in self-reported ratings of health between African American and Caucasian caregivers, other studies have found greater prevalence of self-reported symptoms and poorer perceived health among African Americans (Pinquart, 2005).

Haley et al. (2004) reported that African American caregivers engaged in more unhealthy behaviors (e.g. over- or under- eating, drinking alcohol or lack of exercise). Qualitative research analyzing the content of African American caregiver interviews have found recurrent themes of burn out, loss and alienation that are not captured in the survey instruments often used in social gerontology literature.

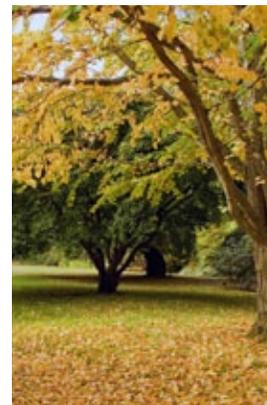
Long-Term Care

African American older adults are frequently supported in adhering to their health care regimens by family members rather than by formal support providers. Family members also act as coordinators of care, including transportation, medication management, diet, exercise and monitoring chronic illness (Jennings, 1999).

This assertion is further supported by the fact that most African Americans with functional disabilities and health problems remain at home, with supportive care provided by immediate or extended families and informal support networks in the church or community. Past experiences of Black older adults have demonstrated that utilization of institutions for the purpose of “rehabilitation,” rather than as nursing

homes was more common (Mavundla, 1996). Lower rates of institutionalization by older African Americans have been accounted for by higher use of paid home care, informal-only care or no care (Wallace et al. 1998).

In 1999, data was released by the National Center for Health Statistics that for the first time showed nursing home utilization by African Americans equal or greater than that by older White Americans in most age and sex categories (See Figure 2). In all of the three age groups of older men, and in all but the oldest women, a higher proportion of Black older adults resided in nursing homes. **See Figure 3 on page 27.**

3. End-of-Life Care Issues**Palliative and Hospice Care**

Several studies describe significant ethnic differences in palliative and hospice care settings. African American compared to White older adults nearing end of life tend to receive higher rates of high intensity, hospital based care, are more likely to die in hospitals and prefer more aggressive life-sustaining treatment (Garrett 1993, O'Brien et al. 1995). Family members of African Americans were more likely to report lower overall satisfaction with end of life care as compared to families of White decedents.

Family members of African Americans of deceased older adults more often reported concerns about physician communication, being informed about treatments, what to expect and receiving support for their own needs while a loved one was dying.

Lack of Studies on Hospice Care and Ethnic Older Adults

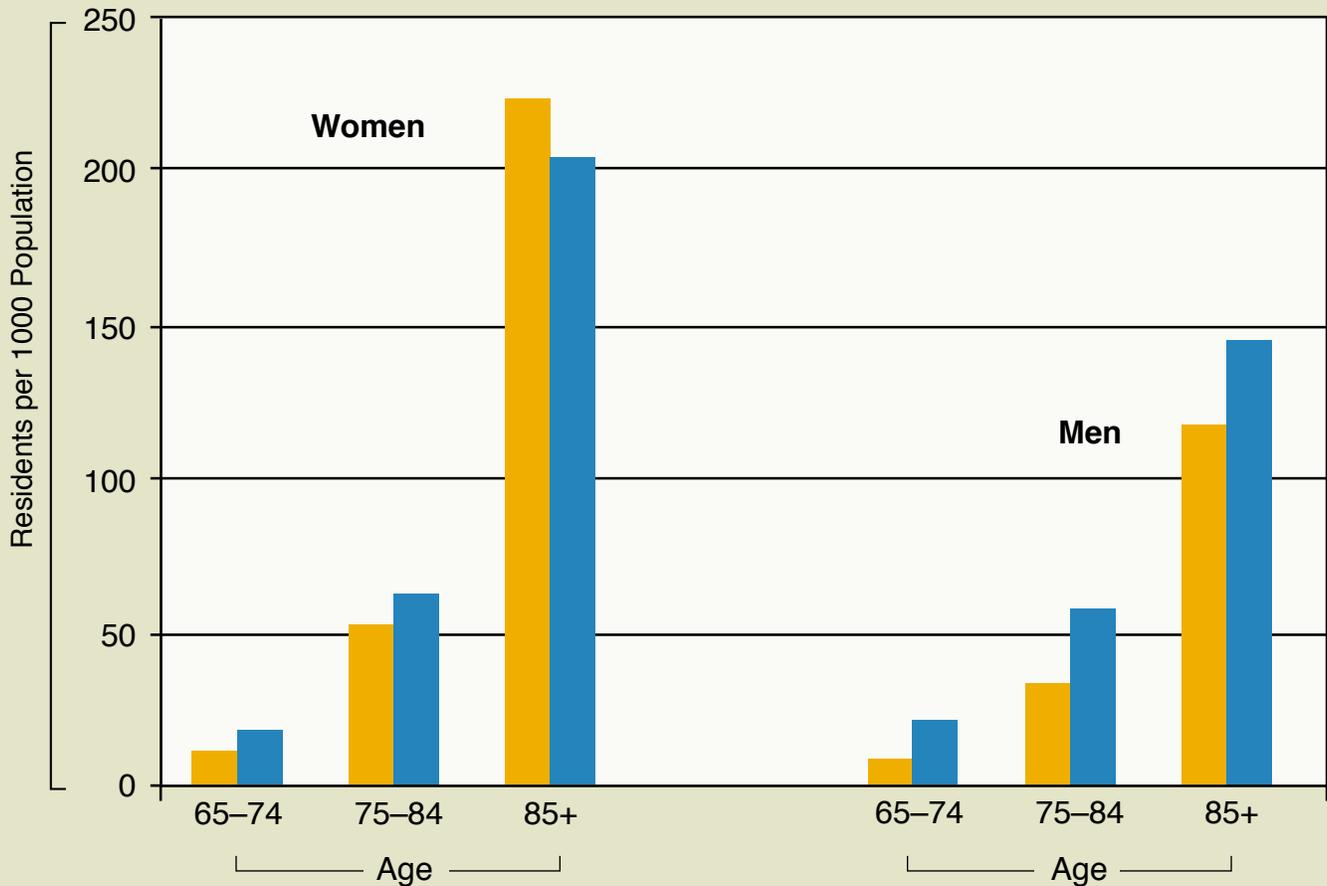
Though hospice care is an important long-term care resource, few studies have examined the use of hospice care by ethnic older adults in the United States. African Americans and other ethnic older adults are less likely

(ACCESS & UTILIZATION CONT'D)

Fig. 3

**Nursing Home Residents Comparison:
Black and White Older Adults**

■ = Black
■ = White



© 2010 VJ Periyakoil, MD <http://geriatrics.stanford.edu>

(ACCESS & UTILIZATION CONT'D)

“ Investigators concluded that family-based oral communication rather than written documents appear to be particularly important to this group. ”

to use hospice care. Some authors suggest that cultural stigma associated with accepting hospice care outside of the home and/or lack of knowledge about palliative care services contribute to under-utilization of the services.

Barriers to Use of Hospice Care

African Americans older adults may be ambivalent and mistrustful of hospice programs which require them to forego curative treatments. Inadequate hospice related services in poor urban communities may also interfere with African American older adults receiving hospice care. Haas et al. (2007) suggest that minority communities may have an inadequate medical infrastructure to provide hospice care.

For example, the pharmacies in those neighborhoods may not stock sufficient quantities of opioids needed for the severe pain of terminal illness. Hospice workers may be less willing to go into minority neighborhoods and hospice services are less likely to be located in these communities.

Advance Directives

Advance directives are a controversial, important issue in long term care of African American older adults. This population is much less likely to have advanced directives. African American older adults who remember the Tuskegee experiment and other examples of historical mistreatment in health care are concerned that they will receive inadequate and inferior medical care if they complete advanced directives.

For many older adults, signing an advance directive exacerbates their mistrust and makes them worried that their medical and spiritual needs will be dismissed by

health care providers. African Americans approaching end-of-life tend to rely on trusted family members, friends or clergy to speak for them regarding medical decisions. Investigators concluded that family-based oral communication rather than written documents appear to be particularly important to this group (Welch et al., 2005).

Institutional factors may contribute to ethnic differences in use of advance directives. Several investigators suggest that future research should explore:

1. The type and amount of staff training practitioners need to provide information about advance directives to African American older adults and their families
2. Administrative attitudes about advance directives
3. Whether staff deal differently with White and African American individuals in the presentation of advance directive options (Troyer, 2006).

Role of Church and Religion

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

The value of religion, reading religious materials, listening to religious programs, prayer and other forms of non-organized religious participation are part of the fabric in the life and culture of older African Americans.

(ACCESS & UTILIZATION CONT'D)

Studies done in the early 1990s indicate that while the church is a significant contributor to feelings of well-being in elderly Blacks, the family network is viewed as more supportive than the church network (Walls, 1991).

Later reviews of the literature suggest that churches provide significant amounts of “non-kin” support to older African Americans. Particularly in rural communities, or communities with few services, churches play a special role, often serving as the “provider” of services. Ministers and church members form part of the caregiving and “expressive” or emotional support network needed by the older adult.

The frequency of church attendance has been found to impact the amount and frequency of care received. It has been noted that for certain groups of elderly African Americans, friends and church members may be of greater importance than previously thought (Fried, 1998; Taylor, 1986).

Health Promotion

“African-American older adults are a diverse group. They can vary from an elder living in the rural South to an urban area in the Northeast. They may have been born in the northern or southern United States or (in) Jamaica or Haiti.

“Their socioeconomic and marital statuses vary as well as their work history, educational and religious backgrounds... The (current) cohort of African American older adults ... represent a group that has experienced the worst American educational and health care systems. Most have experienced segregated education and housing.

“They were more likely to receive substandard health care when they were younger, which now impacts their current health status. Many have worked for years in high-risk jobs under dangerous conditions, which contributed to the development of multiple chronic illnesses and poor overall health at relatively young ages” (Brangman, 1995).

When exploring outcomes and quality of care, it is important to note that African Americans tend to emphasize the “process” of care (Fongwa, 2001). Consistent with what is reported anecdotally, African Americans are at risk of under-utilization of preventive services.

In a large epidemiological study of cancer prevention services among men and women age 70 and over in the Piedmont area of North Carolina, the Black respondents reported significantly lower use of Pap testing, clinical breast examination, mammography, rectal examinations, and fecal occult blood testing.

When levels of education, income, and insurance coverage were controlled for, however, the racial differences in cancer prevention services were no longer significant (Hegarty et al., 2000).

(ACCESS & UTILIZATION CONT'D)

Three Tips for Improving Health Care of African American Older Adults



African American older adults may rely on varied resources to gain medical education and to take care of themselves. This includes traditional health care providers, but because of cultural and religious beliefs they may rely on less traditional providers or on input from clergy or other African American folk remedies (Fahie, 1998). Provision of health care to older African Americans must give consideration to culture and tradition, with the acknowledgement that social and kinship networks, community, extended family, and the church are all significant players in the health care and support service system.

The following are three tips for improving health care in the African American older adult community:

- 1 Increasing frequency of office or clinic visits can significantly impact prevention in this population and improve outcomes (Wright et al., 2000).
- 2 Identification of unique points of access to health care and supportive services will differ by community, but must be the focus of the contemporary health care provider who is serving African American older adults.
- 3 Community leaders, church older adults, and other “communicators” should be incorporated in Advisory Boards and be involved in health care planning for the community.

It is only through cultural awareness and sensitivity that improved access to and utilization of health care services, positive health behaviors and successful outcomes will be attained, not only for African American older adults, but for all racial and ethnic groups.

Photo © iStockphoto.com/Monkey Business Images/Catherine Yeulet

INSTRUCTIONAL STRATEGIES

Projects and Assignments

1. Visit a local nursing home or personal care home for Black older adults for a pre-arranged question and answer session featuring Black older adults (men and women, preferably) talking about the history of their health and health care.
2. Participant observations through grand rounds and/or case conferences can also be useful ways of developing and reinforcing insights into conceptions of illness and treatment approaches.
3. Invitations to a traditional medicine practitioner to make a classroom presentation and/or visit his/her office to discuss his/her conceptions of illness, treatment and health.
4. Observe a case conference of an interdisciplinary team meeting with a focus on an older Black patient.
5. Assigned readings, lecture, and discussion can be augmented with the following assignments:
 - a. downloading the latest data on life expectancy and mortality rates for older adults from different ethnic populations from web sites (e.g., Trends in Health and Aging at www.nchs.gov) and making comparisons
 - b. interviewing African American older adults on the help they give and receive, or other specific topics (See Interview Strategies: http://geriatrics.stanford.edu/culturemed/interview_strategies.html)
 - c. presenting the results of the interviews in class to compare and discuss
 - d. similarities and differences, group projects that address individual disease risks, such as diabetes
 - e. a field trip to a historical museum (e.g., Carver Museum in Tuskegee, Alabama) on African American History to see film, pictorial displays and other objects pertinent to the health history of Blacks
 - f. film and video, such as “Old Black and Alive” produced by the National Center on Black Aged, Washington, D.C.,
 - g. problem-posing discussions

(INSTRUCTIONAL STRATEGIES CONT'D)**Case Study 1: Mr. S**

Mr. S is a 72-year-old retired African American man who lives with his 70-year-old common-law wife in a small, two-bedroom apartment in a public housing development. He is the primary caregiver for Mrs. S who is exhibiting cognitive deficits and behavioral changes consistent with a progressive degenerative neurological process.

History of Present Illness

Mr. S and his family noticed for several months that Mrs. S was experiencing increasing memory deficits, coordination difficulties and personality changes. During her work as a beautician, she was finding it difficult to hold the curling iron and remember how to “put chemicals into people’s hair.” After she retired, she became uncharacteristically irritable and angry and demonstrated more memory difficulties. Initially the family attributed her difficulties to her longstanding hypertension which they called her “pressure.” When she was finally brought to her doctor, Mr. S was told that her blood pressure was very high, that she had suffered a stroke and had Alzheimer’s disease.

Psychiatric History and Previous Treatment

Mr. S had never previously sought psychiatric treatment.

Social and Developmental History

Mr. S was originally born in Ohio but moved to Boston at an early age. He is a World War II veteran and a retired construction worker. He and Mrs. S have known each other socially for many years. Their courtship began after his divorce from his first wife and the death of Mrs. S’s previous husband. They have been together for the past forty years.

Course and Outcome

Mr. S reports that he must assist his wife with the most basic self-care activities including bathing, eating,

and using the bathroom. Mr. S describes an average day, “...she gets up in the morning, and then I

make her go to the bathroom so she can relieve herself. After that, is to make her get up and get in the tub. She won’t get in the tub. I have to reach down and take one foot, take it up and set it in the tub. After I do that, then she’ll take the other foot and go in. If I don’t do that, she isn’t going to get in the tub. She can wash herself...But I do that because I can get it done quicker than what she would get it done.” Because she is often incontinent, she wears diapers and must be changed regularly. She does not do any chores around the house. She never goes outside alone.

He also notes that his frustration and sense of confinement associated with caregiving has been further aggravated by the inefficient and inadequate formal services available in his area. “Well, I’m like, you might say, I’m locked in jail. And the only outlet that I have is when she goes to Kit Clark. But now we’ve been having trouble with The Ride. They put her on standby.”

Though Mrs. S is supposed to be transported to an adult day health program each day, often “The Ride” does not come at all. An additional obstacle is that Mrs. S’s eligibility for these services seems to be in doubt due to changing rules and regulations that restrict eligibility.

Diagnostic Formulation

DSM-IV	
Axis I	300.4 Dysthymic Disorder
Axis II	No diagnosis
Axis III	No diagnosis
Axis IV	Problems with caring for his wife who has dementia Problems with primary support group (critical of wife’s children)
Axis V	GAF=58 (Current)

Cultural Identity

Mr. S was born in Ohio but moved to Boston at a very young age.

(INSTRUCTIONAL STRATEGIES CONT'D)**Language**

Mr. S can speak, read and write English.

Involvement with Culture of Origin

Mr. S lives with his common-law African American wife. He has frequent but conflictive contact with his wife's children. He often criticizes her children for "messing around out there in the streets that dope and stuff."

He notes that several of her children are fighting addictions and "trying to get their lives together."

He notes that only two of her children and grandchildren visit regularly. He strongly feels that love, care and attention from the family play an important role in what it means to age well. "I still believe that, if you have love and care around you, even when you're sick, that you can live longer, progress longer or whatever. But you have to have that love and care."

Cultural Explanations for the Illness**Predominant idioms of distress and local illness categories:**

Mr. S describes his wife's illness in terms of changes in behavior and loss of ability to manage activities of daily living. He describes her apathy and social withdrawal by using the analogy of someone who when greatly upset or shocked by something reacts by becoming mute. He maintains that though she does not speak she can understand everything going on around her. He still holds out hope that one day she may "snap out of it" and become her old self again.

Mr. S also describes his personal experience of Alzheimer's disease in terms of criminality, loss and confinement. Mr. S characterizes Alzheimer's as a villain and portrays himself as the helpless victim. When asked what Alzheimer means to him, Mr. S replies "I don't know. That's pretty hard. To me, Alzheimer's [has] robbed me out of a lot, doing the things I want to do with her." He reflects how the rigors of caregiving have resulted in the loss of a satisfying relationship and have tragically and forcefully altered the trajectory of their relationship.

“ I don't know. That's pretty hard. To me, Alzheimer's [has] robbed me out of a lot, doing the things I want to do with her. ”

Meaning and severity of symptoms in relation to cultural norms

Early in the course of the illness, Mrs. S's behavioral and personality changes were interpreted by Mr. S and other family members as the result of hypertension. Other authors have noted that among lay populations "hypertension" is caused by difficult life situations and may cause changes in behavior. One might hypothesize that Mr. S's cultural perspective on "hypertension" may have influenced his interpretation of the early symptoms of dementia.

Mr. S interprets Mrs. S's incontinence, social withdrawal and need for significant assistance with self-care activities as the result of her willful resistance rather than "loss" of ability. He does not blame her or feel resentful but directs his anger at her children whom he feels neglect her.

Perceived Causes and Explanatory Models

Over the course of several interviews, Mr. S articulated two seemingly different and contradictory explanatory models of his wife's illness. He used the professional label Alzheimer's disease when referring to his wife's condition and seemed to understand the traditional biomedical formulation of his wife's deficits.

(INSTRUCTIONAL STRATEGIES CONT'D)

However he spoke much more passionately about his belief that her illness was based on the failings of her family. Her children were guilty of two major offenses:

1. Their drug use led to her increased worry and anxiety.
2. Their ongoing emotional neglect of their mother contributed to her decline. He strongly believed that the illness was directly related to her anxiety and repressed emotional distress over her children's illicit drug use.

Help Seeking Experiences and Plans

Mr. S has attempted to utilize formal services to relieve the burden of caregiving and provide socialization for his wife.

Cultural Factors Related to Psychosocial Environment and Levels of Functioning**Social Stressors**

Mr. S has very emotionally charged relationships with his wife's children. He strongly feels that her children's drug addiction and emotional neglect have deeply affected his wife's emotional well being. "I don't think she can take it. It was not only that she worried about her children but that she kept everything inside her." Mr. S believes that if "she had opened up and let this stuff out, maybe this (dementia) never would have happened".

Mr. S also feels morally outraged by her children's apparent lack of concern and support for their mother's condition. "She gave all her love to her children. And down inside of me I think it's damn time for them to turn around and start giving something back to her... that's all she wants, is to be around her children...She's got grandchildren she don't even know."

Social Supports

Mr. S notes that only two of her children visit regularly and he has ambivalent feelings about the effect of their visits. He often feels "teed off" about their visits because when she is around her grandchildren, Mrs. S is a

different woman altogether. She becomes "almost like her old self". He strongly feels that an important part of successful aging is to have the love, care and attention from family. "I still believe in, if you have love and care around you, even when you are sick, that you can live longer, progress longer or whatever. But you got to have that love and care."

During the course of the interview, he voiced his complaints quite forcefully and clearly in the presence of the children. His public criticism may have been intended to invoke shame on the part of the children and perhaps to change their behavior. In his everyday life Mr. S spends most of his time involved with caregiving for his wife and he has become increasingly socially isolated.

Cultural Elements of the Clinician-Patient Relationship

Throughout the interview, Mr. S was able to speak and communicate clearly to the interviewers. At one point his pointed criticisms seemed displaced on to the interviewer who was a member of the same generation as his wife's neglectful, selfish children.

Overall Cultural Assessment

This case illustrates the complexity of the psychological experience of caregiving for an elderly African American man. Though he is aware of the Western biomedical model for dementia, he firmly believes that his wife's illness is just as likely a result of suppressed emotional distress stemming from her concerns about her irresponsible and selfish children.

He is convinced that her condition would remit if her children were more attentive to her and terminated their substance abuse. His assessment of the relationship between anxiety and his wife's cognitive deficits and behavioral difficulties are reminiscent of a folk illness called "worriation." Worriation is lay term used among poor African Americans to denote a condition of emotional distress that results in cognitive symptoms (difficulties in concentration, attention and memory),

(INSTRUCTIONAL STRATEGIES CONT'D)

motor restlessness, fatigue and other somatic complaints (e.g. headache).

Mr. S's experience of dementia focuses on the psychological and social factors, and may serve several purposes. His explanatory model preserves the possibility for improvement or cure and allows social factors to be integrated into the illness in a useful manner. It presumes that if his wife's children are more attentive and emotionally available to her, her illness will improve. Finally his psychosocial model allows Mr. S and his family to exert some control over the course of the illness.

Case Study 2: Mrs. P

Mrs. P, a 65-year-old African American wife and mother of five, had a stroke that resulted in residual right sided paralysis. After the acute phase, Mrs. P returned home. Her geriatric nurse practitioner (GNP) understood that this was probably going to be a chronic condition.

Mrs. P's oldest child, Dee, aged 26, was married and had two children. She wanted her mom to help with parenting skills, but Dee knew that such help might not be possible because repeated strokes are common. After much prayer and many teary days and nights, Dee asked Mrs. P's GNP for help.

Without a doubt, Dee was going through her own anticipatory grief work. Dee believed the GNP might help her mom and family, especially her dad, through some role changes. Mr. P had only been the wage earner. He did not know how to pay the bills, cook, clean, or do laundry.

**Possible Questions to ask Mrs. P:
The LEARN Model**

The LEARN Model encourages Geriatric Nurse Practitioners (GNPs) to use open-ended questions in a conversational approach.

As one builds a culturally appropriate exchange between ethnic older adults and families, a direct "complete the questionnaire" style of communication would be ill-advised. The following are a few questions one might want to ask in a conversational style interview.

- What do you think led to the change in your condition?
- How have you managed the condition or illness so far?
- How can we work together to deal with this condition or illness?
- What traditional cultural approaches have you used thus far?
- What should we aim for in our new action plan?
- What is the best time to begin a new action plan?

*Adopted from Anticipatory Grief and Chronicity,
Lewis et al., 2004*

STUDENT EVALUATION

Objective Questions

Health status information in this module lends itself to objective questions to evaluate students' retention of the information.

Essay Questions

Essay questions can be used to evaluate their understanding of the sources and limitations of the data.

Group Projects, Reports and Exams

Group projects, individual written and oral reports, short essay exams, and multiple choice tests can also be used in the evaluation of student performance.

Case Studies

The cases in the Instructional Strategies Section can be used as take home or essay questions.

Sample Questions

Some other examples of pre-/post-test questions are given below.

1. To the best of your knowledge describe the health care of Black older adults during the antebellum period of the United States. How did slavers differ in their care of older disabled slaves? In what way did slaves care for each other?
2. To what extent did health care for Black older adults improve after the Civil War? What were the indicators of improvement or the lack thereof?
3. Describe twentieth century developments in the health and health care of older Blacks.
4. Write a brief definition of the following terms:
 - Natural illness
 - Occult illness
 - Spiritual illness
5. Describe the problem of misdiagnosis and the nature of cultural bias in medical practices as it applies to older adults from African American backgrounds. How can biases be minimized in health professional practices?
6. How does the role of the church and religion affect health and health care for African American older adults?
7. Name three conditions for which older African American are at increased risk; name two for which they are at less risk than other older Americans.

REFERENCES

- Adams, V. H., III, & Jackson, J. S. (2000). The contribution of hope to the quality of life among aging African Americans: 1980-1992. *International Journal of Aging and Human Development*, 50(4), 279-295.
- Adebimpe, V. R. (1981). Overview: White norms and psychiatric diagnosis of black patients. *American Journal of Psychiatry*, 138(3), 279-285.
- Adebimpe VR, Hedlund J., Cho DW et al (1982). "Symptomatology of depression in black and white patients." *J Natl Med Assoc* 74: 185-190.
- Administration on Aging. (2000, 2004). Achieving cultural competence: A guidebook for providers of services to older Americans and their families. www.AoA.gov
- Administration on Aging. (2006). A Statistical Profile of Black Older Americans Aged 65+. www.AoA.gov
- Alexander GE, Furley M., Grady CL et. al. (1997). "Association of premorbid intellectual function with cerebral metabolism in Alzheimer's disease: implications for the cognitive reserve hypothesis." *Am J Psychiatry* 154: 165-172.
- Arth, M. (1968). Ideals and behavior: A comment on the Ibo respect patterns. *The Gerontologist*, 8(4), 242-244.
- Baker, F M. (1996). Issues in assessing dementia in African American older adults. In Yeo, G. & Gallagher-Thompson, D. *Ethnicity and the Dementias*. Washington DC: Taylor & Francis.
- Baker, F. (2000). "Further Reflections on Race, Psychiatric Diagnosis and Mental Health Care Utilization in Older Persons." *Am J Geriatr Psychiatry* 8: 297-300.
- Blackhall LJ, Frank G., Murphy ST et al. (1999). "Ethnicity and attitudes towards life sustaining technology." *Soc Sci Med* 48: 1779-1789.
- Blazer DG, Hybels C., Simonsick EM et al. (2000). "Marked differences in antidepressant use by race in an elderly community sample. 1986-1996." *Am J Psychiatry* 157(17): 1089-1094.
- Bowles, J., Brooks, T., Hayes-Reams, P., Butts, T., Myers, H., Allen, W., & Kington, R. S. (2000, February). Frailty, family, and church support among urban African American elderly. *Journal of Health Care for the Poor and Underserved*, 11(1), 87-99.
- Brangman, S. (1995). African American Elders: Implications for Health Care Providers. *Clinics in Geriatric Medicine*, 11(1), 15-23.
- Brown, J. (1855). *Slave life in Georgia: A narrative of the life, sufferings, and escape of John Brown, a fugitive slave, now in England*. [Edited by L. A. Chamerouzow.] London: Anti-slavery Society.
- Brown, W. (1847). *Narrative of William W. Brown, a fugitive slave*. Boston: The Anti-Slavery Office
- Caralis, P, Davis B, Wright K, & Marcial E. (1993). The influence of ethnicity and race on attitudes toward advance directives, life-prolonging treatments, and euthanasia. *Journal of Clinical Ethics*, 4:155-165
- Clavon, A. M. (1986). *The black elderly*. *Journal of Gerontological Nursing*, 12(5), 6-12.
- Cox, C., & Monk, A. (1996). Strain among caregivers: comparing the experiences of African American and Hispanic caregivers of Alzheimer's relatives. *Int J Aging Hum Dev*, 43(2), 93-105.
- de Albuquerque, K. (1981). Folk medicine in the South Carolina Sea Islands. *Review of Afro-American Issues and Culture*, 2(2), 44-47.
- Dilworth-Anderson, P., Williams, I. C., & Gibson, B. E. (2002). Issues of race, ethnicity, and culture in caregiving research: a 20-year review (1980-2000). *Gerontologist*, 42(2), 237-272..

(REFERENCES CONT'D)

- Douglass, F. (1855). *My bondage and my freedom* (pp. 35-40, 45-49, 69-70, 114). New York: Miller, Orton and Mulligan.
- Duster, T. (2007). Medicalisation of race. *Lancet*, 369(9562), 702-704.
- Eleazer, G. P., Hornung, C. A., Egbert, C. B., Egbert, J. R., Eng, C., Hedgepeth, J., et al. (1996). The relationship between ethnicity and advance directives in a frail older population. *J Am Geriatr Soc*, 44(8), 938-943.
- Fahie, V. P. (1998, Spring). Utilization of folk/family remedies by community-residing African American older adults. *Journal of Cultural Diversity*, 5(1), 19-22.
- Ferdinand, K. C. (2003). Recommendations for the management of special populations: racial and ethnic populations. *Am J Hypertens*, 16(11 Pt 2), 50S-54S.
- Fisher, W. (1969). Physicians and slavery in the antebellum Southern Medical Journal. In A. Meier & E. Rudwick (Eds.), *The making of Black America: Essays in Negro life and history* (pp. 153-164). New York: Atheneum.
- Fongwa, M. N. (2001, January). Exploring quality of care for African Americans. *Journal of Nursing Care Quality*, 15(2), 27-49; quiz 74-75.
- Frazier, E. F. (1957). *The Negro in the United States*. New York: Macmillan
- Fried, S. B., & Mehrotra, C. M. (1998). *Aging and diversity: An active learning experience*. Washington, DC: Taylor & Francis.
- Froehlich, T. E., Bogardus, S. T., & Inouye, S. (2001) Dementia and race: Are there differences between African Americans and Caucasians? *Journal of the American Geriatric Society*, 49, 477-484.
- Gallagher-Thompson, D., Hargrave, R., Hinton, L., Arean, P., Iwamasa, G., & Zeiss, L. M. (2003). Interventions for a multicultural society. In D. W. Coon, D. Gallagher-Thompson & L. W. Thompson (Eds.), *Innovative interventions to reduce dementia caregiver distress: a clinical guide*. (pp. 50-73). New York: Springer..
- Garrett, J. M., Harris, R. P., Norburn, J. K., Patrick, D. L., & Danis, M. (1993). Life-sustaining treatments during terminal illness: who wants what? *J Gen Intern Med*, 8(7), 361-368.
- Gaskin D, Briesacher B., Limcangco, Brigantti B (2006). "Exploring Racial and Ethnic Disparities in Prescription Drug Spending and Use Among Medicare Beneficiaries." *Am J Geriatric Pharmacotherapy* 4: 96-III.
- Genovese, E. D. (1974). *Roll Jordan roll: The world the slaves made*. New York: Pantheon Books. [See especially pp. 519-523.]
- Greiner K, Perera S., Ahluwalia J (2003). "Hospice Usage by Minorities in the Last Year of Life: Results" *J Am Geriatric Society* 51: 970-978.
- Haley, W. E., Gitlin, L. N., Wisniewski, S. R., Mahoney, D. F., Coon, D. W., Winter, L., et al. (2004). Well-being, appraisal, and coping in African-American and Caucasian dementia caregivers: findings from the REACH study. *Aging Ment Health*, 8(4), 316-329.
- Haley W. E, Roth D., Coletton MI et al (1996). "Appraisal, coping and social support as mediators of well-being in black and white family caregivers of patients with Alzheimer's disease." *J Consult Clin Psychol* 64: 121-129.
- Hand, W. D. (1980). *Magical medicine: The folklore component of medicine in the folk belief, custom, and ritual of the people of Europe and America*. Berkeley and Los Angeles, CA: University of California Press.
- Hargrave, R. (2006a). "Caregivers of African American Elderly with Dementia: A Review and Analysis." *Annals of Long-Term Care* 14(10): 36-40.

(REFERENCES CONT'D)

- Hargrave, R. (2006b). "Neuropsychological Assessment of Dementia in African American Older adults" in *Ethnicity and the Dementias*, 2nd ed. G. Yeo and D. Gallagher-Thompson, New York, Taylor & Francis, 33-54
- Harwood, D. and Ownby, R. (2000). "Ethnicity and Dementia." *Current Psychiatry Reports* 2000, 2:40-45.
- Harris, M. I. (2001). Racial and ethnic differences in health care access and health outcomes for adults with type 2 diabetes. *Diabetes Care*, 24(3), 454-459.
- Hegarty, V., Burchett, B M., Gold, D., & Cohen, H. J. (2000) Racial differences in use of cancer prevention services among older Americans. *Journal of the American Geriatrics Society*, 48, 735-740.
- Hinton L, Franz C., Yeo G (2005). "Conceptions of dementia in a multiethnic sample of family caregivers." *Journal of the American Geriatrics Society*, 53(8): 1405-1410.
- Hopp, F. P. & Duffy, S. (2000) Racial variations in end-of-life care. *Journal of the American Geriatric Society*, 48, 658-663.
- Hurston, Z. N. (1970). *Mules and men: Negro folktales and voodoo practices in the South*. New York: Harper and Row.
- Jennings, A. (1999). Who supports elderly African Americans in adhering to their healthcare regime. *Home Healthcare Nurse*, 17(8), 519-525.
- Jha A, Varosy P, Kanaya A. et al (2007). Differences in Medical Care and Disease Outcomes Among Black and White Women with Heart Disease. *Circulation* 108: 1089-1094.
- Johnson, C. L., & Barer, B. M. (1990). Families and networks among older inner-city blacks. *Gerontologist*, 30(6), 726-733.
- Jones B, Reams K. (2007). Adequacy of communication results from screening mamograms to African American and white women. *Am J Public Health* 97: 531-538.
- Kales H, Neighbors H., Valenstein M et al. (2005). "Effect of Race and Sex on Primary care Physicians' Diagnosis and Treatment of Late-Life Depression." *JAGS* 53: 777-784.
- Kauh J., Barwley O., Berger M et a; (2007). "Racial Disparities in Colorectal Cancer." *Current Problems in Cancer* 2007 May-June; 31 (3); 123-33.
- Kitagawa, E. M., & Hauser, P. M. (1974). *Social and economic differentials in mortality*. Cambridge, MA: Harvard University Press.
- Kramarow, E., Lentzner, H., Rooks, R., Weeks, J., & Saydah, S. (1999). *Health and aging chartbook. Health, United States, 1999*. Hyattsville, MD: National Center for Health Statistics.
- Lewis, I., & McBride, M. (2004). "Anticipatory Grief and Chronicity: Older adults and Families in Racial/Ethnic Minority Groups." *Geriatric Nursing* 25 (1): 44-7.
- Manton, K. G., Poss, S. S., & Wing, S. (1979, June). The Black/White mortality crossover: Investigation from the perspective of the components of aging. *The Gerontologist*, 19(3), 291-300.
- Manton, K. G., & Stallard, E. (1997). Health and disability differences among racial and ethnic groups. In L. G. Martin & B. Soldo (Eds.), *Racial and ethnic differences in the health of older Americans*. Washington, DC: National Academy Press.
- Mavundla, T. R. (1996). Factors leading to black elderly persons' decisions to seek institutional care in a home in the Eastern Cape. *Curationis*, 19(3), 47-50.
- McCann, J. J., Hebert, L. E., Beckett, L. A., Morris, M. C., Scherr, P. A., & Evans, D. A. (2000, December). Comparison of informal caregiving by black and white older adults in a community population. *Journal of the American Geriatric Society*, 48(12), 1612-1617.

(REFERENCES CONT'D)

- Mebane, E. W., Oman, R. F., Kroonen, L.T., & Goldstein, M.K. (1999). The influence of physician race, age, and gender on physician attitudes toward advance care directives and preferences for end-of-life decision making. *Journal of the American Geriatrics Society*, 47 579-591.
- Mehta, R. H., Marks, D., Califf, R. M., Sohn, S., Pieper, K. S., Van de Werf, F., et al. (2006). Differences in the clinical features and outcomes in African Americans and whites with myocardial infarction. *Am J Med*, 119(1), 70 e71-78..
- Miner, S. (1995). Racial differences in family support and formal service utilization among older persons: A nonrecursive model. *Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 50B(3), S143-S153.
- Mitchell, F. (1978). *Hoodoo medicine: Sea Island herbal remedies*. Berkeley, CA: Reed, Cannon and Johnson.
- Mouton, C. P. (1997). Special health considerations in African-American elders. *American Family Physician*, 55(4), 1243-1253.
- Mouton, C. P. (2000). Cultural and religious issues for African Americans. In Braun, K., Pietsch, JH, & Blanchette, PL (Eds.) *Cultural issues in end-of-life decision making*. Thousand Oaks, CA: Sage.
- Murdock, G. P. (1980). *Theories of illness: A world survey*. Pittsburgh, PA: University of Pittsburgh Press.
- Mutran, E. (1985). Intergenerational family support among blacks and whites: Response to culture or to socioeconomic differences. *Journal of Gerontology*, 40(3), 382-389.
- O'Brien, L. A., Grisso, J. A., Maislin, G., LaPann, K., Krotki, K. P., Greco, P. J., et al. (1995). Nursing home residents' preferences for life-sustaining treatments. *JAMA*, 274(22), 1775-1779.
- Perry, C. M., & Johnson, C. L. (1994). Families and support networks among African American oldest-old. *International Journal of Aging and Human Development*, 38(1), 41-50.
- Petchers, M. K., & Milligan, S. E. (1987). Social networks and social support among black urban elderly: A health care resource. *Social Work in Health Care*; 12(4), 103-117.
- Pinquart M, Sorenson S. (2005). "Ethnic differences in stressors, resources and psychological outcomes of family caregiving: A meta-analysis." *Gerontologist* 45: 90-106.
- Poussaint, A. F. (1983). The mental health status of Blacks - 1983. In J. D. Williams (Ed.), *The state of Black America*. New York: National Urban League.
- Prange, A. J., & Vitols, M. M. (1962). Cultural aspects of the relatively low incidence of depression among Southern Negroes. *The International Journal of Social Psychiatry*, 8(2), 104-112.
- Qureshi A, Suri M., Zhou J, Divani A (2006). "African American women have poor long-term survival following ischemic stroke." *Neurology* 67: 1623-1629.
- Rathore S, Foody J., Wang Y, et al. (2003). "Race, Quality of Care and Outcomes of Elderly Patients Hospitalized with Heart Failure." *JAMA* 289: 2517-2524.
- Richardson, J. (1996). *Aging and health: Black American older adults (2nd ed.)*. SGEN Working Paper # 4. Stanford, CA: Stanford Geriatric Education Center.
- Roberts, B., & Roberts, N. (1976). *Faces of South Carolina*. New York: Doubleday.
- Rollman BL, Hanusa B., Belnap B., Gardner W et al. (2002). "Race, quality of depression care, and recovery from major depression in a primary care setting." *Gen Hosp Psychiatry* 24(6): 381-390.

(REFERENCES CONT'D)

- Sahyoun, N. R., Lentzner, H., Hoyert, D., & Robinson, K. N. (2001). Trends in causes of death among the elderly. *Aging Trends*(1), 1-10.
- Sachs-Ericsson N, Blazer D. (2005). "Racial Difference in Cognitive Decline in a Sample of Community Dwelling Older Adults." *Am J Geriatric Psychiatry* 13: 968-975.
- Savitt, T. (1978). *Medicine and slavery: The diseases and health care of Blacks in antebellum Virginia*. Urbana, IL: University of Illinois Press.
- Sarmeas N. (2003). "Cognitive reserve and lifestyle." *J Clin Exp Neuropsychol* 25: 625-633.
- Searight HR, Gatford J. (2005). "Cultural diversity at the end of life: Issues and guidelines for family physicians." *Am Fam Physician* 71: 515-522.
- Shadlen M, Siscovick D., Fitzpatrick A et al (2006). "Education, Cognitive Test Scores and Black-White Differences in Dementia Risk." *J Am Geriatr Soc* 54: 898-905.
- Sherkat D, Kilbourne B., Cain V et al (2007). "The impact of health service use on racial differences in mortality among the elderly." *Research on Aging* 29: 207-224.
- Siegel, J. S. (1972). Some demographic aspects of aging in the United States. In A. Ostfield & D. C. Gibson (Eds.), *Epidemiology of aging* (pp. 17-82). Washington, DC: Government Printing Office.
- Simpson, G. E. (1970). *Religious cults of the Caribbean: Trinidad, Jamaica and Haiti*. Rio Piedra: University of Puerto Rico, Institute of Caribbean Studies.
- Smith, J. L. (1881). *Autobiography of James L. Smith*. Norwich, CT: Press of the Bulletin Co.
- Snow, L. F. (1974). Folk medical beliefs and their implications for care of patients: A review based on studies among Black Americans. *Annals of Internal Medicine*, 81, 82-96.
- Spector, R. E. (2000). *Cultural diversity in health and illness (5th ed.)*. Upper Saddle River, NJ: Prentice Hall Health.
- Stamp, K. (1956). *The peculiar institution: Slavery in the antebellum South*. New York: Alfred Knopf.
- Sterritt, P. F., & Pokorny, M. E. (1998, May-June). African-American caregiving for a relative with Alzheimer's disease. *Geriatric Nursing*, 19(3), 127-128, 133-134.
- Steward, A. (1857). *Twenty-two years a slave, and forty years a freeman*. Rochester, NY: Williams Allring.
- Tallant, R. (1946). *Voodoo in New Orleans*. New York: Collier Books.
- Taylor, R. J., & Chatters, L. M. (1991). Nonorganizational religious participation among elderly black adults. *J Gerontol*, 46(2), S103-111.
- Taylor, A. (2005). "The African American Heart Failure Trial: A clinical trial update." *Am J Cardiol* 96: 44i-48i.
- Thomas, A., & Sillin, S. (1972). *Racism and psychiatry*. New York: Brunner/Mazel.
- Troyer, J. L., & McAuley, W. J. (2006). Environmental contexts of ultimate decisions: why White nursing home residents are twice as likely as African American residents to have an advance directive. *J Gerontol B Psychol Sci Soc Sci*, 61(4), S194-202.
- U.S. Department of Health and Human Services, Office of Minority Health (2001). "National Standards for Culturally and Linguistically Appropriate Services in Health Care." from www.omhrc.gov/assets/pdf/checked/finalreport.pdf.
- Viring BA, Fisher E., McBean AM et al. (2001). "Hospice use in Medicare managed care and fee-for-service systems." *Am J Manag Care* 7: 777-786.

(REFERENCES CONT'D)

- Wallace M, Weiner J., Pekmezaris R et al. (2007). "Physician Cultural Sensitivity in African American Advance Planning: A Pilot Study." *J of Palliative Medicine* 10(3): 721-727.
- Wallace SP, Levy-Storms L., Kington RS (1998). "The persistence of race and ethnicity in the use of long-term care." *J Gerontol B Psychol Sci Soc Sci* 53: S104-S112.
- Walls, C. T., & Zarit, S. H. (1991). Informal support from black churches and the well-being of elderly blacks. *Gerontologist*, 31(4), 490-495.
- Wallsten, S. S. (2000). Effects of caregiving, gender, and race on the health, mutuality, and social supports of older couples. *Journal of Aging and Health*, 12(1), 90-111.
- Watson, W. H. (1982). *Aging and social behavior: An introduction to social gerontology*. Belmont, CA: Wadsworth.
- Watson, W. H. (1983). *Stress and old age: Black aging and transplantation shock*. New Brunswick, NJ: Transaction Books. [See especially pages 1-11.]
- Watson, W. H. (1984). *Black folk medicine: The therapeutic significance of faith and trust*. New Brunswick, NJ: Transaction Books.
- Watson, W., & Maxwell, R. (1977). *Human aging and dying: a study in sociocultural gerontology*. New York: St. Martins.
- Welch L, T. J., Mor V (2005). "End-of-Life Care in Black and White: Race Matters for Medical Care of Dying Patients and their Families." *J Am Geriatr Soc* 53: 1145-1153.
- Willer, J. (1971). *The social determination of knowledge*. Englewood Cliffs, NJ: Prentice-Hall.
- Williams, D. H. (1986). The epidemiology of mental illness in Afro-Americans. *Hospital and Community Psychiatry*, 37(1), 42-49.
- Wright, P. J., Fortinsky, R. H., Covinsky, K. E., Anderson, P. A., & Landefeld, C. S. (2000). Delivery of preventive services to older black patients using neighborhood health centers. *Journal of the American Geriatrics Society*, 48(2), 124-130.
- Yeo, G. (1993). Ethnicity and nursing homes: Factors affecting use and successful components for culturally sensitive care. In C. M. Barresi & D. E. Stull (Eds.), *Ethnic elderly and long-term care*. New York: Springer.
- Yeo, G., (Ed.). (2000). *Core curriculum in ethnogeriatrics (2nd ed.)*. Stanford, CA: Stanford Geriatric Education Center. (Developed by the members of the Collaborative on Ethnogeriatric Education, supported by Bureau of Health Professions, Health Resources and Services Administration, U.S.



LINKS & RESOURCES

Department of Health & Human Services Administration on Aging

Home Page

<http://www.AoA.gov>

Statistics

http://www.aoa.gov/aoaroot/aging_statistics/index.aspx

U.S. Census Bureau

<http://www.census.gov>

National Center for Health Statistics

Home Page

<http://www.cdc.gov/>

Trends in Health and Aging

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5206a2.htm>

Statistics

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

Publications

<http://www.cdc.gov/nchs/products.htm>

Surveys and Data Collection Systems

<http://www.cdc.gov/nchs/surveys.htm>

National Cancer Institute

<http://seer.cancer.gov/>

SUGGESTED READING

Fictive Kin in African American Families

Johnson, C. L. (1999). Fictive kin among oldest old African Americans in the San Francisco Bay Area. *J Gerontol B Psychol Sci Soc Sci*, 54(6), S368-375.

Jordan-Marsh, M., & Harden, J. T. (2005). Fictive kin: friends as family supporting older adults as they age. *J Gerontol Nurs*, 31(2), 24-31; quiz 58-29.

Stewart, P. (2007). Who is kin? Family definition and African American families. *Journal of Human Behavior in the Social Environment*, 15(2-3), 163-181.

Taylor, R. J., Chatters, L. M., Hardison, C. B., & Riley, A. (2001). Informal social support networks and subjective well-being among African Americans. *Journal of Black Psychology*, 27(4), 439-463.

African American Age-Specific Breast Cancer Patterns

Anderson, W. F., Rosenberg, P. S., Menashe, I., Mitani, A., & Pfeiffer, R. M. (2008). Age-Related Crossover in Breast Cancer Incidence Rates Between Black and White Ethnic Groups. *Journal of the National Cancer Institute*, 100(24), 1804-1814.

Gnerlich, J. L., Deshpande, A. D., Jeffe, D. B., Sweet, A., White, N., & Margenthaler, J. A. (2009). Elevated breast cancer mortality in women younger than age 40 years compared with older women is attributed to poorer survival in early-stage disease. *J Am Coll Surg*, 208(3), 341-347.

Johnson, E. T. (2002). Breast cancer racial differences before age 40—implications for screening. *J Natl Med Assoc*, 94(3), 149-156.

Kenney, R. J., Marszalek, J. M., McNally, M. E., Nelson, B. V., Herati, A. S., & Talboy, G. E., Jr. (2008). The effects of race and age on axillary lymph node involvement in breast cancer patients at a Midwestern safety-net hospital. *Am J Surg*, 196(1), 64-69.

Krieger, N. (1990). Social class and the black/white crossover in the age-specific incidence of breast cancer: a study linking census-derived data to population-based registry records. *Am J Epidemiol*, 131(5), 804-814.

Mayberry, R. M. (1994). Age-specific patterns of association between breast cancer and risk factors in black women, ages 20 to 39 and 40 to 54. *Ann Epidemiol*, 4(3), 205-213.

Newman, L. A., & Alfonso, A. E. (1997). Age-related differences in breast cancer stage at diagnosis between black and white patients in an urban community hospital. *Ann Surg Oncol*, 4(8), 655-662.

Sarker, M., Jatoui, I., & Becher, H. (2007). Racial differences in breast cancer survival in women under age 60. *Breast Cancer Res Treat*, 106(1), 135-141.

Shavers, V. L., Harlan, L. C., & Stevens, J. L. (2003). Racial/ethnic variation in clinical presentation, treatment, and survival among breast cancer patients under age 35. *Cancer*, 97(1), 134-147.

Winchester, D. P., Osteen, R. T., & Menck, H. R. (1996). The National Cancer Data Base report on breast carcinoma characteristics and outcome in relation to age. *Cancer*, 78(8), 1838-1843.

The Tuskegee Experiment and African American Attitudes towards the Health Care System

Studies claiming a negative effect

- Eiser, A. R., & Ellis, G. (2007). Viewpoint: Cultural competence and the African American experience with health care: The case for specific content in cross-cultural education. *Acad Med*, 82(2), 176-183.
- Kennedy, B. R., Mathis, C. C., & Woods, A. K. (2007). African Americans and their distrust of the health care system: healthcare for diverse populations. *J Cult Divers*, 14(2), 56-60.
- Tullmann, D. F., & Flaskerud, J. H. (2009). Aftershocks of Tuskegee? *Issues in Mental Health Nursing*, 30(2), 131-132.

Studies showing equivocal effects

- Brandon, D. T., Isaac, L. A., & LaVeist, T. A. (2005). The legacy of Tuskegee and trust in medical care: is Tuskegee responsible for race differences in mistrust of medical care? *J Natl Med Assoc*, 97(7), 951-956.
- White, R. M. (2005). Misinformation and misbeliefs in the Tuskegee Study of Untreated Syphilis fuel mistrust in the healthcare system. *J Natl Med Assoc*, 97(11), 1566-1573.

APPENDIX A: IMPORTANT CULTURAL TERMINOLOGY

Crossover Phenomenon—Closely related to the subject of differential life expectancy, the Crossover Phenomenon refers to the fact that both Black females and males who were 80 years of age or older in 1976 had a longer life expectancy than their White female and male counterparts. Its name comes from the reversal in average life expectancy that occurs between Blacks and Whites between 80 and 85 years of age.

Fictive Kin— People that are considered ‘family’, as the result of long-standing relationships, but may not be linked directly by blood ties. These individuals may be serving as the primary care giver or even as the surrogate decision makers and may be sometimes more involved than the directly related family members.

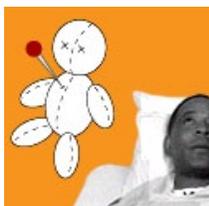


©iStockphoto.com/
Cliff Parnell



Natural Illness—Primarily induced by natural causes; conjuration may affect the physical and psychological as well as the spiritual life of the person (Mitchell, 1978). Part of some traditional African systems of thought.

Occult Illness—A result of supernatural, not physical, causes. The conjurer uses his or her powers, as well as fetishes to induce and/or ward off illness in specific individuals. Part of some traditional African systems of thought.



Spiritual Illness—A result of a willful violation of sacred beliefs or of sin, such as adultery, theft or murder (Mitchell). Like the occult, spiritual forces can affect all aspects of life, ranging from the physical to

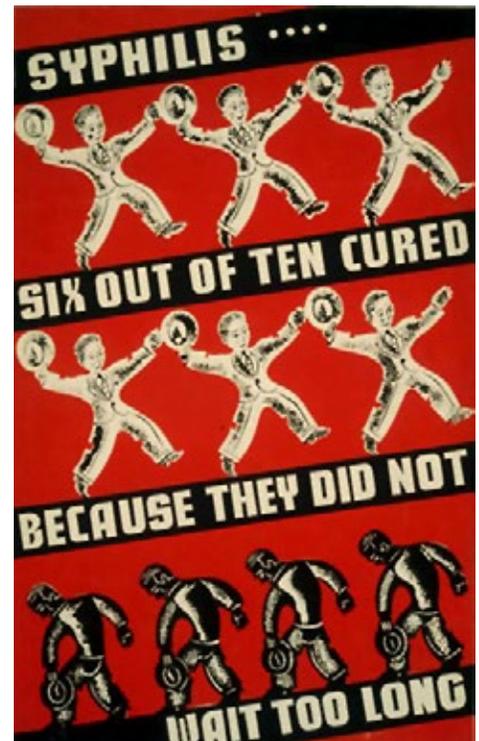
the spiritual characteristics of the person (Simpson, 1970; Willer, 1971). Part of some traditional African systems of thought.



Tuskegee Syphilis Study clinical Group. Courtesy of U.S. Government. A number of the Tuskegee Study Group clinicians. The third figure to the right, Dr. Reginald D. James, a black physician involved with public health work in Macon County, not directly involved in the study. **Source:** Wikipedia. Public Domain.

Tuskegee Experiment— In 1932, the U.S. Public Health Service began the Tuskegee Alabama Syphilis Experiment in which 599 black men with syphilis were studied. Although penicillin was discovered in the 1940s, the men were not treated until after the study ended in the 1970s.

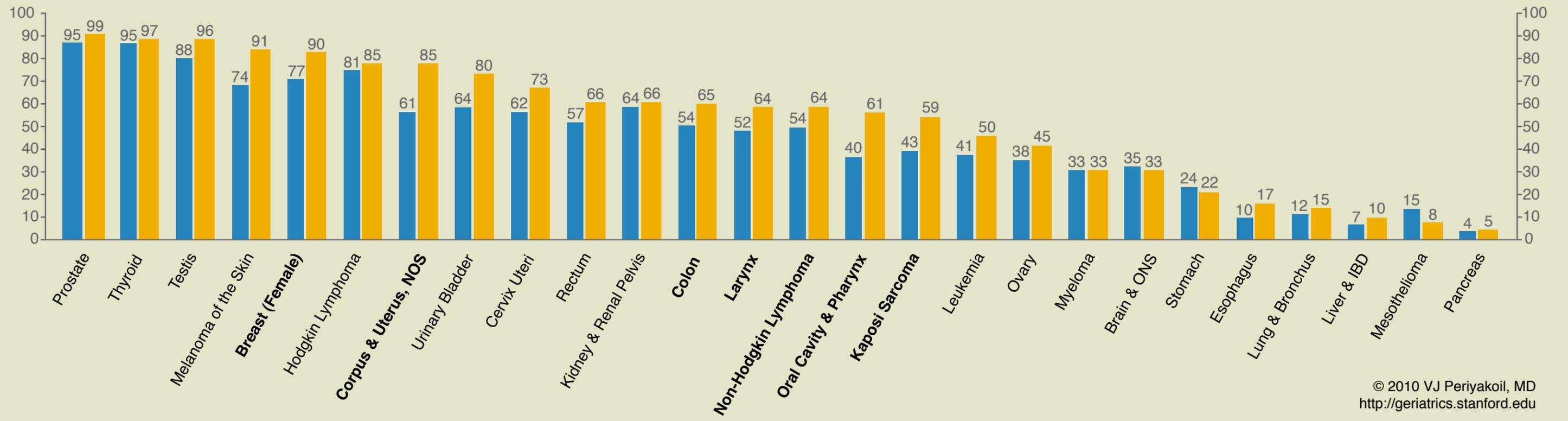
Depression-era (1930s-40s) poster promoting syphilis treatment. **Source:** Works Administration. Public Domain.



APPENDIX B: CANCER SURVIVAL RATES

Fig. 2 5-Year Relative Cancer Survival Rates SEER Program 1996–2003 (both sexes) by Race

■ = Black Patients **Big disparities are in bold**
■ = White Patients



APPENDIX C: RECENT HISTORY

Year	Periods and Events	Population (in 1000's)
Late 1800s	Chaos of Reconstruction Era in South; legal marriages, families united after emancipation; violence toward colored people, Ku Klux Klan founded, schools for freedmen burned; "Separate but Equal Doctrine" legalized inequality, Jim Crow Era began; Tuskegee Institute founded by Booker T. Washington, and other Historically Black Schools and Colleges founded; first colored graduate from West Point.	
1900–1909	National Association for the Advancement of Colored People founded by leading members of white and colored communities, including W.E.B. DuBois; initial migration of colored people from the South to the urban North.	
1910–1919	The Urban League was founded to assist migrants; WWI included 100,000 Negro soldiers who fought overseas; colored units honored for their valor; Ku Klux Klan (KKK) active; "Red summer" when GIs and others victims of bloody anti-colored rioting.	9,800
1920s	KKK claimed 5 million members; 40,000 robed Klansmen marched in Washington, DC; one million Negroes migrated from the South to the urban North; rise of arts and music, especially jazz, centered in Harlem; Marcus Garvey preached racial pride and "Back to Africa"; labor and radical political movement emerged; Brotherhood of Sleeping Car Porters affiliated with AFL.	
1930s	Depression: thousands lost jobs and sharecroppers destitute; Negro political leaders assisted in framing New Deal; poll tax, segregated schools and anti-miscegenation laws existed in South; de facto segregation in North; track star Jessie Owen won Olympic gold; Marion Anderson denied right to give concert; Social Security legislation enacted; Hitler invaded European countries; boxer Joe Lewis became an idol for Negroes.	11,800
1940s	Over a million Negro men and women served in segregated armed forces in World War II; Tuskegee Airmen fought with distinction; Executive Order 8802 banned discrimination in defense plants prompting migration to North and West; armed forces officially desegregated.	12,900

(APPENDIX C CONT'D)

**Table
3**

African Americans—Significant Dates and Periods in Recent History (cont'd)

Year	Periods and Events	Population (in 1000's)
1950s	Korean War; Brown vs. Board of Education Supreme Court ruling ended "Separate but Equal Doctrine" in education; Montgomery Bus Boycott began non-violent Civil Rights Movement; lunch counter sit-ins and civil disobedience began; Jackie Robinson first Negro baseball player in major leagues.	
1960s	March on Washington; President Kennedy assassinated; President Johnson signed Civil Rights Act and Voting Rights Act; Medicare legislation enacted; Vietnam War began; Martin Luther King, Jr. and Robert Kennedy assassinated; riots in Northern cities resulting in white backlash.	18,900
1970s	Affirmative Action implemented gradually; increasing number of elected Black officials; increasing political conservatism; TV series "Roots" taught Black history.	
1980s	Jesse Jackson ran for the nomination for President of the U.S. twice; Rainbow Coalition established; Dr. Ronald McNair died on the Space Shuttle Challenger; rise of the Black Muslims.	28,900
1990s	War with Iraq; Healthy People 2000 set goal to improve minority health; Dr. Mae Jamison was first Black female to fly in space; Rodney King beaten, African Americans riot in Los Angeles; Million Man March, Million Woman March; affirmative action legislation reversed.	30,000
2000s	Barack Obama becomes first African American President of the U.S.	

Source: Yeo, G., Hikoyeda, N., McBride, M., Chin, S.Y., Edmonds, M. & Hendrix, L. (1998). Cohort analysis as a tool in ethnogeriatrics: Historical profiles of older adults from eight ethnic populations in the United States. Stanford, CA: Stanford Geriatric Education Center.

APPENDIX D: COHORT EXPERIENCES

 Cohort Experiences—African American Older Adults			
Time Period	Experiences	Cohort Age At Experience	Current Cohort Age
1900–1920	Urban migration	Children & Adolescents	85+
	NAACP and Urban League founded	Children	75–85
	Ku Klux Klan active	not born yet	65–75
	WWI and the “Red Summer”	not born yet	55–65
1920–1940	Harlem Renaissance	Young Adults & Middle Aged	85+
	Marcus Garvey’s Back to Africa Movement	Adolescents & Young Adults	75–85
	Klan marched on Washington	Children & Adolescents	65–75
	Depression	Children	55–65
1940–1960	WWII: segregated troops; factory work in North & West	Middle Aged & Young Old	85+
	Desegregation in plants, schools, and military	Young Adults & Middle Aged	75–85
	Montgomery Bus Boycott	Adolescents & Young Adults	65–75
		Adolescents	55–65
1960–1980	Civil Rights Movement & Law	Young Old & Old	85+
	Dr. Martin L. King, Jr. led non violence then assassinated	Middle Aged & Young Old	75–85
	Affirmative Action	Young Adults & Middle Aged	65–75
	Political activism	Young Adults	55–65
1980–Present	Jesse Jackson ran for President	Old	85+
	Black Muslims	Young Old & Old	75–85
	Rodney King trial	Middle Aged & Young Old	65–75
	Million Man & Woman Marches	Middle Aged	55–65