



## Elderly & living alone in rural Mississippi

**Wanda Lott Collins**  
Associate Professor,  
Kent School of Social Work  
University of Louisville



**T**oo often, older persons have been characterized as burdensome to society and especially to their families. According to a U.S. Census Bureau report commissioned by the National Institute on Aging (NIA), the population aged 65 and older is expected to double in size within the next 25 years. The report indicates, “By 2030, almost 1 out of every 5 Americans (some 72 million people) will be 65 years or older. The age group 85 and older is now the fastest growing segment of the U.S. population” (National Institute on Aging, 2005, p.1). Likewise, “Projections suggest that by 2030 the composition of the older population will be 72 percent non-Hispanic White, 11 percent Hispanic, 10 percent Black, and 5 percent Asian (U.S. Census, 2005, p. 6). The societal challenge to meet the physical, mental, spiritual and social needs of older adults underscores the need for family life professionals to understand factors that affect aging and living well.

The purpose of this article is to share positive viewpoints about the utilization of resources, social supports and self-empowerment for older adults seeking to live in their own homes. Special attention will be given to congregational supports as the author suggests implications for social workers, clergy and others human services professionals. The author is an adult daughter and also social work educator participating in long-distance caregiving. Living 500 miles from an aging parent, the author grapples with the question: How can one best help a parent at a distance? From this author’s experience, family and support networks, participation in church and religious activities, and utilization of medical and preventative services enhanced the elderly parent’s general well-being and independence.

Although these types of support activities are not exhaustive, they are germane to aging well.

### FAMILY AND SUPPORT NETWORKS

A strong network of family, other kin and friends (informal supports), in addition to sources of emotional support from the wider-community, neighbors or church members (external supports), has long been recognized as important to the health and well-being of elderly adults (Barker, Morrow, & Mittenness, 1998; Choi & Wodarski, 1996; Clare, 1997; ). Studies show that strong social supports have a positive effect on seniors and enable them to maintain productive, meaningful and satisfying lives, which enhance functional independence (Cleak & Howe, 2003; Finchum, 2005; Gustavson & Lee, 2004; Li, Edwards, & Morrow-Howell, 2004). Research findings provide evidence that supportive social environments are important to an older adult's sense of security and general well-being (Li, et al., 2004; Ross & Mirowsky, 2002; Yeh & Lo, 2004). "Physical closeness and a sense of community can promote positive social networks and research should be mindful of the potentially important role played by local neighborhoods in shaping the social ties of older adults" (Krause, cited in Cleak, et al., 2000, p. 21).

On the one hand, it is well documented that one of the major consequences of increased longevity is that, as people grow older, they are more likely to experience social isolation (Barker, et al., 1998; Cleak & Howe, 2003). On the other hand, loneliness, lack of emotional support and lack of companionship or social support can leave older adults vulnerable to heart and other health problems. For example, Sorkin, Rook, and Lu (2002) found from their survey of 180 men and women ranging in age from 58 to 90 that

having just one person for emotional support seemed enough to reduce the risk of heart disease. But, the healthy effects of social support required relationships with multiple individuals. In other words, greater loneliness was found to be associated with an increased probability of having a coronary condition, as were low levels of emotional support and companionship. Yet another study shows that having close friends and staying in close contact with family members offers a protective effect against the damaging effects of Alzheimer's disease (Bennett, Schneider, Tang, Arnold, & Wilson, 2006).

Using data from a semi-longitudinal qualitative study of 45 older African Americans, researchers explored informal social support among women and men aged 65 and older in an inner city (Barker et al., 1998). In this study, the researchers found that African Americans' informal support networks compensate for the various forms of social and economic marginalization. This is a likely result from African Americans' experience with exclusion from formal services and institutions throughout their lifetime (Barker et al., 1998). The study highlights that preferred sources of assistance were spouses, children, siblings, other relatives or friends who constituted a ready and available resource of support. Moreover, adult daughters were key figures in their elderly parents' social support networks.

Mr. Miles is an example of an elderly African American man living alone with strong informal and external support networks. At 79 years of age, this retiree has been a widower for six years. He lives in a two-bedroom brick home in a quiet rural neighborhood. Predominately African American, his neighborhood is mixed with career couples, elementary age to teenage children and other retirees. Mr. Miles is the father of five children (i.e., three daughters and two sons).

---

... one of the major consequences of increased longevity is that, as people grow older, they are more likely to experience social isolation.

---

His second oldest child, an adult daughter, lives within four miles of his home. His other four children live in two different states. Mr. Miles's oldest child, an adult daughter, lives 500 miles away. He identifies her as his primary contact for legal, medical and some day-to-day caregiving decisions. Occasionally, he also depends on his youngest son as an additional long-distance supporter regarding various issues related to his aging.

Although he has health challenges with diabetes, high blood pressure, asthma and



Baylor Photography

heart disease, he manages fairly well on his own. He is very independent and prefers to help himself whenever possible. However, he involves family and non-family members as a part of his self-care plan, on an as-needed basis.

Mr. Miles has ensured that all legal and medical documents are in his oldest daughter's name. In addition, he repeatedly tells his physician and other community members (e.g., banker, funeral director and friends) that she is in charge of his affairs. Because of the close community networks, various individuals will call or stop by to visit Mr. Miles

if he has not been seen recently. Several of these individuals also have his children's phone numbers should they need to be called in an emergency. Interestingly, a restaurant owner phoned him on a Saturday morning because he did not show up the day before to eat breakfast. Mr. Miles was elated with the attention and informed the owner that his family was visiting and that they had cooked for him.

He communicates with his female companion via phone during the morning and evening. Sometimes they visit at each other's home. His second oldest daughter visits sporadically since her job and family responsibilities are demanding. The youngest son phones once a week and the oldest daughter generally phones him long distance about three times during the week. This is her way of monitoring his day-to-day activities and following his daily routine. Because of their close bond, he is comfortable listening to her advice when it is needed. In addition, his other children, grandchildren, a sister, several church members and people in his neighborhood also call at various times throughout the week. Religious activities also connect him spiritually, serve as an extended family and provide a resource for him to cope with the deaths of family and friends.

Mr. Miles's situation illustrates that family and friends are of primary importance and that they provide a valuable source of assistance. It also shows that informal and external social supports are the foundation for increased psychosocial health and autonomy for older adults living alone (Potts, 1997). For that reason, if senior citizens are to avoid social isolation and grow old in their communities, they will require the emotional, physical and social support networks of family, friends and the wider community.

#### **PARTICIPATION IN CHURCH AND RELIGIOUS ACTIVITIES**

The Black church represents the strongest and most ingrained institution in the

African American community and serves as a bedrock to bring many African Americans together across demographic and socioeconomic lines. Several researchers report that the Black church fulfills many functions of social organization, such as education, social welfare, civic duties and business enterprises, and serves as an outlet for social expression, a vehicle for social protest and a refuge from racism and discrimination (Becker, Gates & Newsome, 2004; McRae, Carey, & Anderson-Scott, 1998; Walls, 1992). One group of researchers states, “The Black church, by virtue of its role as a social support network, embodies group norms, values, role models, self-revelations (emotional outlet and respite from the burdens of everyday living and crisis events), and learning experiences for its members and those in surrounding communities” (McRae et al., 1998, p. 779).

There is also evidence that church attendance, prayer and other forms of religious participation appear to contribute to quality of life, feelings of well-being, and facing adversity among elderly African Americans (Roff et al., 2006; Wallace & Bergeman, 2002; Walls, 1992). Black (1999) found in a study of elderly African American women living in poverty that their relationship with God allowed them to take a positive view in interpreting the circumstances of their lives. Their reliance on God engendered self-esteem and empowered them to keep despair at bay.

The research findings relative to the importance of the Black church and religious participation in the lives of elderly African Americans are reflected in Mr. Miles’s weekly involvement with his church. Mr. Miles attends a Baptist congregation, four miles from his home, which is comprised of 40 families and their kinship network. He served faithfully as an usher for 12 years before retiring his post because of advancing age. Church

attendance, reading religious materials, listening to sermons and uplifting songs of praise feed the hunger of Mr. Miles’s spirit. His undaunted belief in God’s providential care inspires his hope in the goodness of people in spite of dark events in the world.

The rural church plays a special role in Mr. Miles’s life because of social activities that involve shopping trips, visitation to other churches, diabetes education and full-course meals following some evening worship services. During the illness and subsequent death of his wife, the church provided an emotional support network that nurtured and sustained him with in-home visitation and frequent telephone calls. These visits and calls helped him to benefit from the company of others and reduced feelings of loneliness and depression. Some members shared their fond memories of his wife, which allowed Mr. Miles to openly talk about his sadness and to express his feelings. A few of the deacons offered prayers for spiritual strength via phone and in the home. For Mr. Miles, religious participation and involvement with his church family provide him a positive coping strategy, a resource for solving problems and a catalyst for affirming his need for psychological and spiritual support.

#### **UTILIZATION OF MEDICAL AND PREVENTIVE SERVICES**

A person’s health condition is a major predictor of quality and length of life. Research findings about the delivery of preventive services indicate that racial minorities are less likely than Whites to receive a variety of health care services. Even though rural Americans are predominately White, more than 90% of the African American rural population resides in the south (National Advisory Committee on Rural Health and Human Services [NACRHHS], 2004, p. 4). Many researchers agree that access to pre-

---

**If senior citizens are to avoid social isolation and grow old in their communities, they will require emotional, physical and social support networks.**

---

ventive services can improve or prevent the outcomes of many diseases (Chen, Diamont, Pourat, & Kagawa-Singer, 2005; Higgs, Bayne, & Murphy, 2001; NACRHHS, 2004; Probst, Moore, Glover, & Samuels, 2004). Other research studies have indicated that the unavailability of resources and transportation in rural areas are ongoing barriers to access for rural populations (Kienzie, 2001). Rural residents, when compared to their urban counterparts, are more likely to experience geographic isolation, transportation difficulties, limited access to emergency specialty care services, reduced health care resources, and disparities in meeting their basic health care needs (Chen et al., 2005; Higgs et al., 2001; NACRHHS, 2004; Probst et al., 2004). Therefore, the growing awareness of the issue of health disparities within health care settings is a concern relative to preventive health services to elderly African Americans.

In accessing health care settings, rural ethnic elders generally experience gaps in health insurance coverage or reduced access to private insurance. Consider Mr. Miles's situation. He has private health insurance that pays for hospitalization care and medications. However, the cost of prescriptions to manage chronic illnesses such as diabetes, hypertension and asthma is challenging on a fixed income. Although his prescriptions were covered through his private insurance, the high cost of medicine with end-of-year reimbursement became financially stifling. To defray prescription costs, his oldest daughter pays for his participation in a Medicare Part D prescription drug program that qualifies him for low or reduced copayments for each prescription. The prescription drug plan lessens the financial hardship in purchasing his monthly medications. As a veteran, he supplements six-month check-ups through the Veterans Administration (VA) and receives cardiovascular monitoring from a cardiologist. Both

---

Rural ethnic elders  
generally experience  
gaps in health  
insurance coverage  
or reduced access to  
private insurance.

---

health care providers are 112 miles from his home. He also utilizes VA services for glaucoma screening, muscular-skeletal conditions and other preventive care screenings. For seasonal colds, sinus flare-ups, vaccinations, diabetes screening or transitory illnesses, he schedules appointments with a physician in his community. Although the community physician is responsive to Mr. Miles's health needs, the physician's crisis and illness model of health care flounders in areas of prevention and wellness.

Mr. Miles is particularly interested in improving his medical condition and takes great care to play an active role toward ensuring his health. To promote his nutritional needs, his sister supplies him with multivitamins, minerals and iron tablets that are shipped monthly. Special meals are prepared and packaged in servings of two and stored in the freezer when his oldest daughter visits on holidays or during the summer months. The second oldest daughter brings him cooked meals or his favorite foods on occasion. When he is not eating at home, Mr. Miles enjoys dining at various restaurants or fast food

places with his friends or female companion. Since Mr. Miles is on a fixed income, his youngest son mails a small amount of money monthly to cover a portion of the cost for his outside meals. These outings nourish him physically and socially by providing him with outside stimulation, fun and camaraderie. Addressing his nutritional needs in these ways minimizes concerns about him eating properly or becoming malnourished.

A different concern for elderly rural residents is limited transportation to obtain medical care. Findings from the National Advisory Committee on Rural Health and Human Services (2004) show that 57% of rural residents do not own a car and are thereby dependent on family members, friends and neighbors for transportation. Thus, the lack of transportation options increases the isolation of rural elderly persons. Mr. Miles



can still drive but limits himself to his community. He has a list of friends and church members who will volunteer to drive him out-of-town and to medical appointments that are more than 50 miles from his home. With the upkeep of his late-model car, financial resources to purchase gas and a modest courtesy fee, he is able to recruit people to drive him during the summer months so he can visit his out-of-state children for three or four days.

A preventive strategy relative to his emotional health is to encourage his desire to take care of two cats. The family also cheers him on for the pride he shows in pruning, repotting and maintaining several plants that were his wife's favorites. Having responsibility for the cats and plants gives him bragging rights and may help to reduce loneliness and depression, and to improve his general sense of well-being.

#### **IMPLICATIONS FOR FAMILY AND COMMUNITY MINISTRIES**

Service providers, community ministries and clergy may find these observations about social support networks, quality of life and access to health care providers useful in working with elderly rural populations. On a direct practice level, programs that serve the elderly could provide assistance with keeping connections to kin, friends and social supports that contribute positively to older adults' identity and self-worth. Inquiry about the frequency of contacts, help with updating an address book or phone log, classes on using the Internet to send e-mails or recruiting volunteers to address mail are examples of valuable services for elderly persons.

As more seniors live alone, and fewer caregivers are available, agencies and ministries should be intent on developing policies and programs that focus on seniors achieving continued independence and sustained quality of life. This should be an intentional strategy since the ability to achieve the goals of independence and quality of life can be hindered when rural elderly face declining health. Because elderly persons generally experience multiple chronic health problems,

the health implications related to inadequate access to health insurance, medicine and preventive services are serious concerns for rural African American elders. One approach might include connecting this population with personal care assistance in their later years, advocating reimbursement for in-home support or improving volunteer programs (Gustavson & Lee, 2004).

Health care practitioners, social workers, clergy and other helping professionals involved with rural African American elders must acknowledge that rural residents have many challenges that can impact receipt of social services and access to health care providers. Attaining good access to care requires: (1) understanding the person, not just the body, in a crisis or disease state; (2) partnering with family members, as appropriate, when discussing health care needs and entry into the health care system; and (3) focusing on the aging process through education, wellness and prevention that will allow older adults to maintain their independence, dignity and sense of control.

#### **REFERENCES**

- Barker, J. C., Morrow, J., & Mitteness, L. S. (1998). Gender, informal social support networks, and elderly urban African Americans. *Journal of Aging Studies*, 12 (2), 199-222.
- Becker, G., Gates, R. J. & Newsome, E. (2004). Self-care among chronically ill African Americans: Culture, health disparities, and health insurance status. *American Journal of Public Health*, 94 (12), 2066-2073.
- Bennett, D. A., Schneider, J. A., Tang, Y., Arnold, S. E., & Wilson, R. S. (2006). The effects of social networks on the relation between Alzheimer's disease pathology and level of cognitive function in old people: A longitudinal cohort study. *Lancet Neurology*, 5 (5), 406-412.
- Chen, J. Y., Diamant, A., Pourat, N., & Kagawa-Singer, M. (2005). Racial/ethnic disparities in the use of preventive services among the elderly. *American*

- Journal of Preventive Medicine*, 29 (5), 388-395.
- Choi, N. G. & Wodarski, J. S. (1996). The relationship between social support and health status of elderly people: Does social support slow down physical and functional deterioration? *Social Work Research*, 20 (1), 52-63.
- Clare, W. G. (1997). Social networks and the prediction of elderly people at risk. *Aging & Mental Health*, 1 (4), 311-320.
- Cleak, H. & Howe, J. L. (2003). Social networks and use of social supports of minority elders in East Harlem. *Social Work in Health Care*, 38 (1), 19-38.
- Finchum, T. D. (2005). Keeping the ball in the air: Contact in long-distance friendships. *Journal of Women & Aging*, 17(3), 91-106.
- Gustavson, K., & Lee, C. D. (2004). Alone and content: Frail seniors living in their own home compared to those who live with others. *Journal of Women & Aging*, 16(3/4), 3-18.
- Higgs, Z. R., Bayne, T., & Murphy, D. (2001). Health care access: A consumer perspective. *Public Health Nursing*, 18 (1), 3-12.
- Kienzie, M. G. (2001). Coming up short: Telmedicine's promise in perspective. *Journal of Rural Health*, 17 (1), 14-15.
- Li, H., Edwards, D., & Morrow-Howell, N. (2004). Informal caregiving networks and use of formal services by inner-city African American elderly with dementia. *Families in Society*, 85(1), 55-62.
- McRae, M. B., Carey, P. M., & Anderson-Scott, R. (1998). Black churches as therapeutic systems: A group process perspective. *Health Education & Behavior*, 25 (6), 778-789.
- National Advisory Committee on Rural Health and Human Services. (2004). The 2004 report to the Secretary: Rural health and human service issues. Retrieved December 31, 2007 from [http://www.ruralhealth.ca.gov/pdf/2004\\_rural\\_report\\_secretary.pdf](http://www.ruralhealth.ca.gov/pdf/2004_rural_report_secretary.pdf)
- National Institute on Aging. (2006). Dramatic changes in U. S. aging highlighted in new census, NIH report. Retrieved July 21, 2006, from the National Institute of Aging Web site: <http://www.nia.nih.gov/NewsandEvents/PressRelease/PR2006030965PlusReport.htm>
- Potts, M. K. (1997). Social support and depression among older adults living alone: The importance of friends within and outside of a retirement community. *Social Work*, 42 (4), 348-362.
- Probst, J. C., Moore, C. G., Glover, S., & Samuels, M. E. (2004). The compounding effects of race/ethnicity and rurality on health. *American Journal of Public Health*, 94 (10), 1695-1703.
- Roff, L. L., Klemmack, D. L., Simon, C., Cho, G. W., Parker, M. W., Koenig, H. G., et al. (2006). Functional limitations and religious service attendance among African American and White older adults. *Health & Social Work*, 31 (4), 246-255.
- Sorkin, D., Rook, K. S., & Lu, J. L. (2002). Loneliness, lack of emotional support, lack of companionship, and the likelihood of having a heart condition in an elderly sample. *Annals of Behavioral Medicine*, 24 (4), 290-298.
- Yeh, S. C., & Lo, S. K. (2004). Living alone, social support, and feeling lonely among the elderly. *Social Behavior and Personality*, 32(2), 129-138.
- U. S. Census Bureau. (December, 2005). 65+ in the United States: 2005. Retrieved July 21, 2006, from the United States Census Bureau Web site: <http://www.census.gov/prod/2006pubs/p23-209.pdf>. (Census Bureau report P23-209).
- Wallace, K. A. & Bergeman, C. S. (2002). Spirituality and religiosity in a sample of African American elders: A life story approach. *Journal of Adult Development*, 9 (2), 141-154.
- Walls, C. T. (1992). The role of church and family support in the lives of older African Americans. *Generations*, 16 (3), 33-37.