CHURCH ATTENDANCE, SOCIAL ISOLATION AND LONELINESS IN OLDER AFRICAN AMERICAN ADULTS DURING COVID-19

by

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ABSTRACT

As the number of older and aging adults continues to grow in the United States, it is important to understand the process of aging and the obstacles associated with growing in age. Two social factors linked with aging are social isolation and loneliness, especially during the global COVID-19 pandemic. Since COVID-19, social isolation and loneliness have been of greater focus due to regulations. This qualitative research study analyzed the impacts of social isolation and loneliness on older African American adults' overall health by using semi-structured interviews to explore their lived experiences. This study focused on the associations between social isolation, loneliness, and reported health-related issues in older adults during the COVID-19 pandemic. It was found that older African American adults' who reported social isolation, also reported poorer perceived overall health and health practices. Stress and anxiety during COVID-19 were found to be consistently reported by all participants. The use of technology was found to be a buffer to loneliness, as all participants engaging in social connectedness, whether or in-person or virtually, report having valuable relationships. This study adds to existing research related to the lived experiences of older African Americans, during the COVID-19 pandemic. By understanding the significance of social comradeship and connectedness, individuals are anticipated to be more likely to make deliberate decisions and intentional strides to avoid social isolation. By identifying social isolation in older adults, interventions can be implemented by organizations such as medical offices and churches to reduce and/or eliminate social isolation by encouraging older adults to engage in social activities virtually or in person. Local and federal policymakers could also be influenced to create programs that allow older adults the capability to easily and affordably access or retain technological devices.

Keywords: older adults, African Americans, loneliness, social isolation, health, well-being

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Dedication

To anyone who has a dream, follow it. To anyone who has a goal, work towards it. To anyone who feels unworthy, you are worth it. To anyone who feels incompetent, you are capable. To anyone who is uncertain, do it! This study is dedicated to you.

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CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

Because of many global advances and the increase in longevity, adults are living longer today than they have in previous years, resulting in more cases of social isolation, loneliness, and decreased cognitive and physical health conditions. This contributes to the growing number of older adults in America (Bureau, 2021). According to the United States Census Bureau, older adults (adults 65 years of age or older) are predicted to outnumber children in the United States for the first time in history by the year 2030 (Bureau, 2019). As adults continue to age, the aging process for many older adults includes various undesirable factors. Older adults are at higher risk of mental, physical, emotional, and social changes that they were not faced with in the past. Social isolation and loneliness are aspects of aging that have been identified to negatively impact a number of older adults. On top of this, COVID-19 has presented the world with mandates of social distancing that adds an additional barrier against older adults. Many studies have measured social isolation and loneliness in older adults and their findings show that social isolation and loneliness are associated with a number of health-related issues (Hakulinen et al., 2019). Minimal research has been conducted to examine social isolation and loneliness amongst older adults during the COVID-19 pandemic, specifically older African American adults within the church. However, the research available suggests that social distancing is not only a factor associated with ageing, but is increased by virtual worship during the COVID-19 pandemic (Parish, 2020). Because of the recent social changes and social restrictions that have impacted the way individuals commune and gather for worship, many congregations have been prevented from gathering (Bryson et al., 2020). This research study will highlight and qualitatively explore

social isolation, loneliness, and overall health of older African American adults that attend church virtually and in-person.

The objectives of this research study are to identify and compare social isolation, loneliness, and quality of health in African American older adults who are attending church virtually and are no longer gathering in-person at church due to the COVID-19 pandemic and older adults that are attending church in-person. This research hopes to show the benefits of social connectedness and social interactions in older African American adults by examining and measuring social isolation and loneliness in older adults and their overall health and wellbeing.

Background

Many older adults face increased obstacles associated with ageing. These challenges associated with ageing include physical, cognitive, and social challenges. Older adults experience social isolation at alarming rates, which has been associated with a number of physical health consequences. In the United States, there are almost 1 million new diagnoses of heart failure every year (Manemann et al., 2018). Individuals who suffer with heart failure are at increased risk of having a poor quality of life. In addition to this, psychological factors such as social isolation have been linked to various physical ailments. Manemann and colleagues (2018) decided to analyze the relationship between social isolation and heart failure. Research finds that older adults who reported moderate or high levels of perceived social isolation also had reported heart failure. In addition to this, research also shows that higher social isolation was associated with higher hospitalizations, doctor visits, and higher risk of overall death (Manemann et al., 2018).

The Bible gives us confirmation that God disapproves of social isolation. As we explore the Bible and apply its content to our lives, God expresses the benefits that we have when we come together.

> Two are better than one, because they have a good return for their labor: If either of them falls down, one can help the other up. But pity anyone who falls and has no one to help them up. Also, if two lie down together, they will keep warm. But how can one keep warm alone? Though one may be overpowered, two can defend themselves. A cord of three strands is not quickly broken. (*New International Version*, 1978, Ecclesiastes 4:9-12).

God encourages us not to neglect our elders and take care of them as they age, "Do not cast me away when I am old; do not forsake me when my strength is gone" (*New International Version*, 1978, Psalm 71:9). Because of this, we will work to improve their lives through engagement and social interactions, "For where two or three gather in my name, there am I with them" (*New International Version*, 1978, Matthew 18:20). By connecting with older adults that are experiencing social isolation, we are able to do the work of the Lord by spreading love and keeping God in the midst of all of our activities and research.

Problem Statement

In attempts to remain healthy and safe during the COVID-19 pandemic, many individuals have resorted to virtual experiences of contact, limiting if not depleting in-person interactions. As individuals age, the number of older adults in the United States is rapidly increasing. As the number of older adults is growing, there are more ageing adults over the age of 65 than in previous years. The United States Census Bureau predicts that by 2030, older adults will outnumber children for the first time in record (Bureau, 2019). The ageing process is

accompanied with various obstacles. Some social barriers associated with ageing are social isolation and loneliness. During the COVID-pandemic, people have experienced an added barrier and increased encouragement to distance themselves and isolate socially. In addition to the social changes related to COVID-19, African American older adults have had to experience multiple social barriers as they are less likely to have in-home internet services, which has been a main source of communication during the pandemic (Chatters et al., 2020). Social isolation and loneliness have been linked to various physical conditions, cognitive issues, and higher mortality rates. Social isolation and loneliness has been linked to increased hospitalizations, cardiovascular disease and depression (Manemann et al., 2018). Previous research studies have studied older adults but little research has been found that has been conducted focusing on older African American adults' experiences during the COVID-19 pandemic. The problem is that COVID-19 has prevented a number of older adults from gathering in-person at church and has limited many individuals to virtual experiences rather than in-person social interactions, resulting in increased social isolation and loneliness amongst older adults (Bryson et al., 2020).

Purpose of the Study

The purpose of this qualitative research is to examine the experiences of older African American church going adults during the COVID-19 pandemic. This research will explore the experiences of older adults' social isolation as it relates to their church attendance, their perceived loneliness, and their perceived overall health and well-being.

Research Questions

This research study intends to answer the following questions:

Research Question 1: "How do older African American adults describe their lived experiences and perceived quality of relationships?"

Research Question 2: “How do older African American adults describe their lived experiences and perceived health?”

Research Question 3: “How do older African American adults who attend in-person church describe their level of loneliness?”

Research Question 4: “How do older African American adults who attend church virtually describe their level of loneliness?”

Theoretical Foundations of the Study

Social isolation and loneliness has been studied for many decades and found to be prevalent in various populations, especially in older adults. Perlman and Peplau’s (1998) research defines loneliness as the unpleasant experience of one’s social relationships, whether in quality or quantity. Perlman and Peplau (1998) suggest that loneliness is not a modern world condition, but is an issue that has been dated back to the prehistoric period. Many Greek mythologies and writings have been interpreted to reflect many ideas of loneliness and isolation. Greek philosophers such as Aristotle, Sarte, and Descartes have all written contributions that reflected social isolation and loneliness. Researchers generally observe that individuals who describe their loneliness, describe with terms that depict their feelings in a negative light (Perlman & Peplau, 1998). Perlman and Peplau (1982) share on three dimensions of loneliness: the nature of loneliness, the abnormality and/or normality of loneliness, the positive or negative experiences of loneliness, and the causes of loneliness. Many studies trace loneliness back to infanthood, where humans desire the need for intimacy, to include Bowlby’s Attachment Theory (Cherry, 2022). This theory is illustrated by the discontentment of an infant left alone in a crib, crying for the intimacy of their parents. However, Bowlby’s attachment theory not only applies to children and parents, but also relationships with adults and their discontentment and anguish

when being physically separated. Bowlby defined attachment as "a psychological connectedness between human beings" (Cherry, 2022). Children that do not receive intimacy from their parents often have difficulty forming and maintaining friendships as they grow older, which results in a continuum of loneliness (Perlman & Peplau, 1982). Perlman, Peplau, and colleagues suggests that loneliness is felt and intensified by which ways it is perceived. This perception is formed by the inconsistency between one's desired and actual experience of loneliness.

Baumeister and Leary (1995) suggests that as humans, we all have the need for belonging to a group of others. This belongingness is proposed to be innate and evident in all humans, despite their ethnicity, gender, or socioeconomic status. This research suggests that the lives of human beings are most fulfilled by their relationships, quality of their relationships, and interactions with others. Baumeister and Leary's theory of belongingness tells us that humans have a natural desire for belonging. Not only do individuals desire to belong to a group, but they are also most satisfied when these interactions are pleasant and frequent and when these interactions are with familiar people that they feel cared for by. Interactions with strangers and infrequent interactions with others do not result in the same satisfactions as the interactions mentioned in Baumeister and Leary's "The Need to Belong." This belonging not only makes one have a sense of fulfillment but has positive effects on their physical and cognitive well-being (Baumeister & Leary, 1995).

Many theories have been used throughout the years of research. However, Grounded Theory is a form of research that works to develop new and innovative theories, developed by Glaser and Strauss in 1967. This type of research works to explore theories that have not been explored before or has little to no knowledge on the topic. The Grounded Theory approach is a qualitive research methods theory that generally examines social issues, generalizations and

relationships. This research type analyses words and makes meaning of the experiences of individuals (Khan, 2014).

Research shows that humans have an innate desire for belongingness and fulfilling relationships. However, it is not always possible for one to receive a sense of belongingness and have physical connectedness during the COVID-19 pandemic, as these natural desires have been discouraged in attempts to keep people safe and healthy. Though the need for these things are understood, the experiences of social isolation and loneliness have been increased during COVID-19 (Gaeta & Brydges, 2020). However, these experiences can be better understood through the use of grounded theory approach.

Definition of Terms

The following is a list of definitions of terms that are used in this study.

Social Isolation **–** The objective absence or paucity of contacts and interactions between a person and a social network (Gardiner et al., 2016)

Loneliness – A subjective feeling state of being alone, separated or apart from others, and has been conceptualized as an imbalance between desired social contacts and actual social contacts (Gardiner et al., 2016)

Older Adults – anyone 65 years or older (Centers for Disease Control and Prevention, 2021)

Health and Wellbeing – state of complete physical, mental and social well-being (World Health Organization, 2022).

Church goer- A church-goer is one who goes to church, especially one who does so regularly (Full Gospel Holy Temple, 2019).

Assumptions and Limitations of the Study

Potential limitations of this research study include population sample, self-report, form of data collection. Limitations of this research study include being able to reach the severely socially isolated and impoverished individuals whom may not have computer or internet access, as this is how participants will be contacted and educated on study. This is limiting of initial contact and communication regarding participation, resulting in non-representation of those that do not have internet nor technological capabilities. The research population includes older African American adults that are affiliated with church by virtual or in-person attendance. Because this research population is not a random sample, this aspect of research is limiting as its results may not be generalizable. Although retrieving data via self-report can measure for things that cannot be seen and are subjective, honesty and truthfulness of beliefs and feelings can be reported inaccurately, exaggerated or understated.

Assumptions of this research project is that participants will be honest when disclosing their age and their status at it relates to not having any known conditions nor diagnoses that impede memory and/or recall. It is also assumed that participants will answer questions honestly and deliver truth about their church attendance, attitudes towards their relationships and feelings regarding their overall health.

Significance of the Study

The number of older adults is continuing to rise (Bureau, 2019). Along with ageing comes a number of health, social, and cognitive difficulties. Social isolation and loneliness continue to impact the lives of many older adults. Along with the typical barriers associated with social isolation and loneliness, COVID-19 has created countless social barriers, including

mandated social distancing and encouragement not to commune in large groups or in close proximity. Attending church and being able to gather in religious settings has comforted many older adults and reduced their physical isolation, affording them the opportunity to gather and fellowship (Chatters et al., 2020). However, because of COVID-19, many churches have resorted to virtual services and discontinued in-person service (Qian & Jiang, 2020). These actions and precautions taken in attempts to reduce COVID-19 have led to an increase social isolation, which has been linked to decreased health and well-being (Hammig, 2019). The findings of this study hope to highlight the prevalence of social isolation and loneliness amongst older adults during the COVID-19 pandemic as it relates to church attendance or the absence thereof, based on individuals' subjective feelings and beliefs. In addition to social isolation and loneliness, it will highlight the perceived health and well-being of older adults that are attending church virtually and in-person. By focusing on older adults within the church, this research will account for the experiences of a particular population of older adults during the COVID-19 pandemic, how they perceive their loneliness and overall health and well-being. These research findings hope to highlight the effects that COVID-19 have increased in the lives of older adults. By reducing social isolation and loneliness in older adults, this study will lead to increased overall and health and wellbeing in older adults.

Summary

The number of American older adults is rapidly increasing as babyboomers are growing in age and life expectancy of adults is rising. Because of this, there are more adults over the age of 60 in the US than in previous years. Because there are so many older and ageing adults, as well as the overall increase of longevity, it is important to identify and understand the obstacles that they face. Social isolation and loneliness are known to be associated with the ageing process

and many older adults experience these social deficits. By identifying loneliness as an experience that older adults face, especially with adverse effects, it is possible to implement interventions to lessen these instances. Past research explains individual's needs for social connectedness, belonging, and intimacy. Perlman & Peplau (1998) identify loneliness as a social issue that individuals have had to face since prehistoric times. Popular Greek philosophers have written of the experiences of social isolation and loneliness, as do researchers and writers today. Most experiences of social isolation and loneliness are associated with negative feelings, especially in older adults. Although many people experience social isolation and loneliness as adults, the need for this interpersonal intimacy starts at birth, as reflected by Bowlby's Attachment Theory. Though the needs and desires are innate, they have been reduced during the COVID-19 pandemic, in attempts to maintain health and safety. Research has shown that there are various cognitive and physical effects of social isolation and loneliness. In addition to research, the Bible discourages us to isolate ourselves, encouraging people to fellowship and worship together. However, the COVID-19 pandemic has prevented many from doing so. Because of measures taken during the pandemic in efforts to maintain healthy, negative effects of social isolation and loneliness have been exacerbated by the COVID-19 pandemic, as individuals have been encouraged to social distance and stay in their residences. This research will show the benefits of social engagement as it relates to loneliness, perceived health and church attendance amongst older African American adults. By exploring individual experiences of loneliness and perceived health, we can work towards reducing the levels of social isolation and loneliness in older adults by better understanding effects of church attendance during COVID-19.

CHAPTER 2: LITERATURE REVIEW

Introduction

COVID-19 has impacted many individuals directly and indirectly, especially African American older adults, as they have had to experience "new norms" as it relates to every day life. Numerous African American older adults have relied on the church over the years as a place of comfort and belonging, dating back to slavery. However, because of COVID-19, the accessibility of the church and its members has been reduced, if not eliminated for many. Mandates by government officials were ordered in attempts to reduce the spread of COVID-19 and many public places shutdown, encouraging people to isolate socially by maintaining physical distance and cease public and private commune. During the COVID-19 pandemic, the church has not been an exception for these rules. For many years, African Americans have depended on "The Black Church", as it has filled the role of a safe place that provided them with social bonds, emotional counsel and quality relationships. During the COVID-19 pandemic, for the first time in the lives of some African Americans, their new "norms" no longer consisted of attending church in-person, isolating them socially. Social isolation and loneliness have been linked to a number of health issues to include physical, cognitive, and emotional well-being. This review highlights the impacts of COVID-19, the health effects of social isolation and loneliness in African American older adults, and the implementation of virtual church attendance during the COVID-19 pandemic.

Description of Search Strategy

A comprehensive literature search was conducted for this Grounded Theory research study. While constructing my research project, multiple online databases were used to explore literature. These online databases included APA PsycNet, PLOS One, Google Scholar, and

Liberty University's doctoral digital commons to lookup relevant literature. Advanced search options were able to be used to search literature by selecting specific range of dates, article type, and research discipline. Key terms used within these databases were social isolation, loneliness, health, older adults, adults, COVID-19, church, church attendance, the black church, health effects, and well-being. The Holy Bible was browsed using the OpenBible website, which allows the searcher to search using passage, keyword, and/or topic.

Review of Literature

COVID-19

In January 2020, the World Health Organization declared a global health crisis known as COVID-19, a type of Coronavirus, originating from bats, pigs, and birds (Velevan & Meyer, 2020). COVID-19 is a virus that was first discovered in December 2019. Within weeks, it had traveled across the world. As the virus first received recognition, not much was known other than that is was highly contagious and spreading rapidly. Since then, much has been discovered about the COVID-19 virus. COVID-19 is caused by the Severe Acute Respiratory Syndrome (SARS) and generally has symptoms of a common cold or flu that disturbs one's head and chest. Although this virus mainly attacks the respiratory system, other systems and organs can be affected too (Centers for Disease Control and Prevention, 2022). COVID-19 infects humans' lower and upper respiratory system and results in a number of moderate to severe flu-like symptoms. Moderate symptoms consist of headache, fever, loss of taste and muscle aches, while more severe symptoms consist of dry cough, respiratory failure, and death (Dzieciatkowski et al., 2020). COVID-19 is highly contagious, as it spreads through droplets propelled by talking, laughing, coughing, or sneezing. As the genetics of the virus has changed, many variants of the virus have been discovered, some which have been more severe than others. The Delta variant

and the Omicron variant have spread throughout the world, originating in India and South Africa. Though both variants had similar symptoms, the Delta variant's symptoms seemed to be more severe. However, the Omicron variant was more contagious but less severe in symptoms, resembling a common cold. Most symptoms of this virus become evident within two days to two weeks (CDC, 2022).

In order to protect oneself and others from the COVID-19 virus, the Centers for Disease Control and Prevention suggested various methods to prevent the spread of COVID-19. These prevention methods included: wearing a mask, maintaining 6 feet distance from others, avoiding large crowds and poorly ventilated spaces, maintaining up-to-date vaccines, and washing hands frequently. Mask wearing requirements became popular in many public facilities, having to have one worn to enter buildings or ride public modes of transportation. Individuals that did not comply with mask mandates could potentially be refused service, as the mask were implemented to protect heavily populated areas or spaces that may be constrained such as a city bus or an airplane. Social distancing was encouraged by suggesting that individuals not leave their homes and if they did leave their homes, to maintain at least 6 feet of physical distance from others. As the COVID-19 virus continued to spread, testing for the virus was encouraged. Many health professionals encouraged testing if one had any cold-like symptoms, a result of the uncertainty of contraction of COVID-19 and the fear of spreading it to others. Testing for the COVID-19 virus could be done at local healthcare facilities and various at-home, self-administered tests became available at local drugstores. Those that test positive for COVID-19 are at increased risk of social isolation and loneliness as they are promoted to quarantine at home. Those that live with others, even confine themselves to a single room in a home, not having contact with others

within the home. Though the time period of quarantine was altered to 14 days to 5 days, isolation from others was still recommended (CDC, 2022).

Though individuals of all ages have succumbed to COVID-19, the span between onset of virus and death are shorter in older adults over any other age group (Wang et al., 2020). Although the COVID-19 virus did not discriminate, as people of all ages and races were becoming infected, some groups of individuals were at a higher risk of having severe and/or fatal symptoms. Older adults, pregnant women, and people with a pre-existing health condition were at greater risk of more acute symptoms. Older adults continue to be an at-risk population for COVID-19 and severe symptoms, which is why they were passionately encouraged to isolate and maintain distance from others during the COVID-19 pandemic, in attempts at remaining well. Older adults that became infected with COVID-19 were more likely to be hospitalized, require rigorous care, and/or depend on a ventilator to assist with breathing. The vaccination was heavily promoted amongst older adults as it was shown to reduce their likelihood of hospitalization and death related to COVID-19 (CDC, 2022).

COVID-19 has negatively affected millions of people rather directly or indirectly and employed increased social isolation, loneliness, fear, anxiety, and depression (Parlapani et al., 2020). Older adults have experienced a significant increase in social isolation and loneliness, as a result of diminished physical supports and in-person interactions due to the pandemic. Though individuals were fearful of contracting COVID-19 and becoming physically ill, the chances of experiencing depression, anxiety, and negative feelings were ranked higher (Bland et al., 2021).

Social Isolation

Social isolation is typically referred to as one's actual social interactions and social contacts. This can be measured by the presence or lack of social interactions. Social isolation is

generally recorded by self-reports of social characteristics and therefore varies from person to person. In research, social isolation has generally been studied as an objective measure. These people and interactions can be personal or public. In the field of social science and psychology, social isolation is referred to as the lack of actual connectedness and withdrawal from others. Many factors can contribute to one's chance of becoming lonely or socially isolated, including a person having no children, death of a spouse, retirement, living in rural areas, no transportation, or physical mobility issues (Xie et al., 2020).

Social isolation effects individuals of all ages. However, the elderly is more at risk of social isolation for various reasons such as widowhood, lack of mobility, poor health, losing friends and family, and retirement. Social isolation increases as age increases, as older adults have reported smaller social networks and many older adults report living alone (Seyfzadeh et al., 2019). Older adults participating in social events and activities has been linked to improved mental and physical health. However, this has been obstructed by closings of buildings and cancellations of social programs for older adults, which afforded older adults the opportunity to create and cultivate friendships and social relationships (Seyfzadeh et al., 2019).

Older adults have many health and social barriers that continue to increase with age. Xie et al. (2020) informs that older adults have had to experience a "triple jeopardy" during the COVID-19 pandemic. These consists of higher risks of developing serious health conditions, more likely to experience social isolation and loneliness and less likely to maintain support and information by using the internet. Before COVID-19, many older adults suffered from social isolation. This has been increased as older adults have been encouraged to social distance because of their greater risk of mortality associated with contracting the COVID-19 virus. During the COVID-19 pandemic, the transition to virtual means of communicating has been

necessary in order to maintain relationships, contacts, and communications during implemented social distancing and stay at home orders. Poscia and colleagues (2018) analyzed the efficacy of interventions used to reduce social isolation and loneliness in older adults. A systematic review of online databases was conducted. The effects of interventions on social health, specifically loneliness and social isolation was observed. All participants were 65 years or older. Interventions consisted of various social supports, social activities, and social technologies. Results show that group activities posed significant changes in loneliness for older adults. Results also found that older adults that live in city-dwellings had significantly less levels of loneliness. On average, participants self-reported improved social health following engagement in social interventions (Poscia et al., 2018). Though this form of communication and interaction has become widespread, many older adults still suffer as they have not embraced the use of many technological advances as compared to younger adults and children. Although many older adults have not adopted newer technological habits, some of them have. However, most of them report that they need assistance setting up and operating devices. This has been extremely difficult if not impossible during the COVID-19 pandemic, as older adults that live alone are encouraged not to leave their homes nor having non-residential guests visit. Xie et al. (2020) suggests that older adults should be encouraged to physically distance, not social distance. This encourages older adults to distance themselves with space but not with communication. Xie and colleagues even suggest a focus on emphasizing the social component of tools used to communicate. This can be achieved by assisting older adults maintain social relationships that they had before the COVID-19, although that relationship may be limited to digital communications. However, because some older adults report being technologically unskilled, this may not be possible for some older adults.

Social isolation continues to be an issue that older adults face. This becomes problematic as the geriatric population is growing worldwide (Parlapani et al., 2020). Research shows that 1 in 4 older adults experience loneliness in older age (Cudjoe & Kotwal, 2020). The term social distancing has been rejected by healthcare professionals, as they feel that individuals, especially older adults, should not distance themselves socially but rather physically. The issue then becomes maintaining social connectedness while keeping physical distance. This physical distancing is indeed important to maintain health and safety during the COVID-19 pandemic. However, those older adults that are accustomed to daily in-home or public interactions from friends or healthcare professionals may struggle to maintain these connections. Telehealth has provided older adults the opportunity to maintain contact with healthcare physicians from the comfort of their homes without having to come in contact with anyone outside the home. This allows physicians and clinicians to assess loneliness and depression that may be associated with social isolation (Cudjoe & Kotwal, 2020). Telehealth allows older adults to communicate, discuss, and even engage in counsel as they are confined to their personal dwellings. Social isolation has been a concern for older adults and the concern is continuing to grow for healthcare professionals as they see the damaging effects of social isolation, especially during the COVID-19 pandemic and continues to be a concern as older adults, on average, report being unfamiliar with technology and technological devices (Cudjoe & Kotwal, 2020).

Loneliness

Loneliness is an issue that has damaging effects on older adults' physical, mental, and cognitive health (Hammig, 2019). As the older population continues to grow, social concerns are of important focus regarding this group (Parlapani et al., 2020). This has been heightened and identified as an indirect effect of the COVID-19 pandemic. Generally, researchers and

professionals agree that loneliness is the perceived discrepancy between desired and actual social relationships. Loneliness is often given from a personal perspective and is measured typically by how one feels. For instance, in a number of instances it is measured by simply asking someone "do you feel lonely?" and they will respond with a "yes" or "no" although it can be described more complexly. In clinical studies, loneliness is generally referred to as one's satisfaction or dissatisfaction with their social relationships. This satisfaction and/ or dissatisfaction is based on the quality of one's relationship. For example, a person can have many close relationships with people that they see daily but be unsatisfied with the quality of the relationship because of disagreeableness, causing the person to feel lonely. The quote "feeling alone in a room full of people" best summarizes this feeling. On the other hand, a person can have one or only a few relationships and not having feelings of loneliness because they are pleased with the quality and dynamics of the relationship. For instance, if one wishes to have a large group of friends and they have one or two friends, they may feel lonely. This loneliness may also be felt if one wishes to have close friendships but feels that their connections are superficial, this may result in one feeling lonely. Loneliness varies from person-to-person because each person had different expectation and standards for their social relationships. Some research uses the terms social isolation and loneliness interchangeably. However, most agree that social isolation is an objective concept and loneliness is subjective (Dahlberg, 2021). Research reports an increase in loneliness of older adults during the COVID-19 pandemic. During the COVID-19 pandemic, research shows that older adults experienced more emotional loneliness as compared to social loneliness. This means that older adults had negative feelings towards the loss of emotional connections rather than physical connections. This is thought to be because of the expectancy of social physical interactions was reduced (Dahlberg, 2021). Communities and cultures that are

more collectivistic may experience more loneliness during the pandemic as distancing rules and mandates have been put into place, as they are used to gathering frequently and spending time with others. On the other hand, those of an individualistic culture are less likely to feel increased feelings of loneliness, desiring less social interactions (Dahlberg, 2021). Parlapani and colleagues report that loneliness has been associated with older adults with irregular social interactions, whose social needs are not being cared for, and those living alone. Among older adults, loneliness is associated with increased depression, poor sleep quality, decreased cognitive functioning and cardiovascular disease (Parlapani et al., 2020).

Loneliness and social isolation have been unprecedently increased during the COVID-19 pandemic. Research shows that loneliness and social isolation result in various negative consequences such as increased mortality and depression (Krendl & Perry, 2020). Because social isolation and loneliness are known to effect older adults negatively, Krendl and Perry (2020) work to determine if these were heightened during the pandemic, along with increased depression. Longitudinal studies show that loneliness is a predictor of depression. However, depression is not a predictor of loneliness. Quality of social relationships seem to be a consistent factor that is associated with loneliness. The closer one feels to the people that they have formed relationships with, less loneliness is reported versus those who do not feel close to others. Though COVID-19 was first discovered in the United States in 2020, many older adults are still taking precautions and limiting their social interactions by staying home. Krendl and Perry (2020) were able to identify the prevalence of older adult's discontentment of their social lives during COVID-19, as nearly 80% of their study participants reported a decline in the quality of their social lives. A large number of older adults also reported that during the COVID-19 pandemic, they have spent less time with the people they care for. Those these individuals

reported decreased in-person contact with others and unsatisfaction with the quality of their social lives, they reported that much communication had been done, mostly virtually. Telephone or virtual contacts were reported to be made daily. Results of this study proved that increased loneliness during COVID-19 was positively associated with increased depression during this time. This highlighted the negative emotional and mental effects of COVID-19 on older adults (Krendl & Perry, 2020).

As adults are ageing, more individuals are moving into senior living communities and/ or retirement communities. By studying this population, Morlett Paredes et al. (2020) was able to understand loneliness amongst older adults that are not socially isolated, rather than just in those who live in isolation or lack mobility and social connectedness. Much research has been conducted to analyze social isolation and loneliness in older adults that are ill or live in residential settings. However, little research has been conducted to identify loneliness and social isolation in older adults who live independently in senior living communities. By using a population that is not socially isolated, it is convenient to study subjective loneliness in these older adults not resulting from isolation. Interviews were conducted to gather information. Findings showed that loss is a predictor of loneliness. These losses consisted of losing spouses, friends, and/or family members. Another predictor was feelings of sadness and emptiness. Participants disclosed that they cope with loneliness by accepting their age and seeking companionship, in attempts to reduce or alleviate loneliness. This research study contributes to minimal research conducted using independent living older adults in community settings. This study also identified coping mechanisms used by participants against loneliness, rather than just identifying loneliness. This research identified potential predictors of loneliness and coping skills used to potentially combat loneliness (Morlett Paredes et al., 2020).

Effects of Social Isolation and Loneliness

Social isolation and loneliness are concerns that negatively influence individuals of all ages (Hamza et al., (2021). However, social isolation and loneliness are especially prevalent in older adults and are caused by a number of factors and although older adults are more vulnerable to social isolation and loneliness, research finds that older male adults report more feelings of loneliness, specifically older White men (Finlay & Kobayashi (2018). Gyasi (2019) identified potential risks for social isolation such as widowhood, retirement, and lack of physical mobility (Gyasi, 2019). Typically, social isolation is defined objectively, measuring the number of social relationship or lack thereof. Loneliness is generally defined subjectively, referring to one's dissatisfaction of their social relationships (Gale, 2017). Because of the COVID-19 pandemic, Banerjee (2020) anticipated a study that would contribute to the reduction of social isolation and loneliness during the global pandemic. The aim of this research study is to investigate individuals' feelings, as they relate to social distancing during the COVID-19 pandemic, gauging people's levels of loneliness. This research also aims to analyze the relationship between social isolation, loneliness, and mortality. This study consisted of 12,954 participants that were at least 20 years of age. Data was collected using the National Health and Nutrition Examination Survey and one-question surveys. Findings show that during the COVID-19 pandemic, the term "loneliness" has been searched in increased levels, as compared to pre-COVID-19. Results also show that loneliness and mortality are significantly related (Banerjee et al., 2020). These results accentuate the prevalence of loneliness, especially during COVID-19 and by focusing on the predominance its hopes are to have an influence on the numbers of loneliness throughout the US (Banjeree, 2020). As the number of ageing and older adults continued to increase, the number of older adults that live alone is continuing to increase, ultimately largely increasing the number of

individuals who experience social isolation and loneliness (Hammig, 2019). Hammig (2019) found that recurrent feelings of social isolation and loneliness significantly increased with age. Although being socially isolated does not always result in one being lonely, it is a good predictor. The aim of this research study was to focus on social isolation and the rate at which it was reported in relation to multiple health conditions. Social isolation, health status, health behaviors, and health services were assessed by using telephone interviewing. Data was statistically analyzed by using bivariate and multivariate regression analyses (Hämmig, 2019). Results find that increased reports of social isolation is positively associated with increased various health risks. One strength of this study is that the study was conducted and made generalizable by considering all age groups. Therefore, it would be easy to apply the results of this study to the overall population, considering all ages of people (Hammig, 2019).

Beller & Wagner (2018) highlighted the interaction between social isolation and loneliness, and investigate their effects on mortality. Typically, researchers combine the two terms social isolation and loneliness and look at their prevalence and impacts as a single entity. However, this study analyzed each independently. The participants included in this study were of German descent and at least a qualifying participant age of 60 years old. Participants were randomly selected using the German Ageing Survey. This research was conducted as a longitudinal study. The de Jong-Gierveld Loneliness Scale was used to objectively measure loneliness and social isolation was measured using a series of questions to measure social demographics. Official death records were used to assess mortality rates. The results find that increased reports of social isolation and loneliness consequence in higher rates of mortality. Holt-Lunstad (2018) highlights the effects that social isolation and loneliness have on longevity and its influence of premature mortality. This research conducts a meta-analysis, 148

independent studies were conducted, using over 300,000 participants. These studies found that a 50% reduction in premature mortality was associated with higher levels of social connectedness. The second meta-analysis was conducted, using 3.4 million participants. These results show that loneliness and social isolation have a significant effect on mortality. Risk factors associated with social isolation and loneliness were identified, age being a contributing factor. Although, individuals of all ages are affected by social isolation and loneliness, older adults are at greater risk because of considerations like widowhood, retirement, and health issues resulting in lack of mobility (Holt-Lunstad, 2018). Tanskanen & Anttila's (2016) also found associations between social isolation, loneliness, and mortality. Participants included in this research study consists of Finnish adults. The Living Conditions Survey of Finland and Statistics Finland were used to collect data. The Berkman Syme Social Network Index was used to measure social isolation and loneliness was measure by a single question. Findings show that social isolation and loneliness are more frequent in older adults and younger children. Social isolation was significantly associated with mortality. In addition to these results, women who were most educated tend to report higher levels of loneliness. Furthermore, Beller & Wagner (2018) suggests that loneliness is highly associated with mental health risks, while social isolation is more closely linked to cognitive and physical decline (Beller & Wagner, 2018). Social isolation and loneliness are not subject to only impacting older American adults, but adults throughout the world, having factors other than age controlled for (Jang et al., 2021.) Jang et al.'s (2021) research also shows that social isolation and loneliness are positively associated with cognitive impairment in older Korean immigrants (Jang et al., 2021). Though these findings show results of older adults, it is not specific to my population of interest, older African American adults.

Much research has shown negative consequences associated with social isolation. Tanskanen and Anttila's (2016) research theorized that any degree of social isolation is linked to greater mortality rates. Data was collected using the Living Conditions Survey of Finland and Statistics Finland. Mortality rates were obtained through Statistics Finland. Social isolation was assessed using the Berkman Syme Social Network Index, which gauges for various types of social connectedness and relationships. Loneliness was assessed by a single question, reporting if they ever felt lonely. Data was analyzed using the Cox Regression analyses. The results found that social isolation was more prevalent in younger children and older aged adults. These findings show that individuals, regardless of social isolation severity, put mortality at risk. Results find that women and individuals with higher education levels reported higher levels of loneliness. In addition to this, individuals who reported more levels of social isolation too reported less levels of physical activity, which is linked to various physical health issues (Tanskanen & Anttila, 2016). However, because this research is specific to the Finland community, it is not generalizable and may not be applicable to African Americans. Therefore, there is a need for this current research study as it will be specific to older African American adults.

Previous research has examined the relationship between social isolation, loneliness, and cognitive impairment (Jang et al., 2021). However, little to no research studies highlight the individuals' perceived significance between them. Jang et al., (2021) worked to examine the relationships between social isolation, loneliness, and cognitive impairment. Data and participants were collected using the Study of Older Korean Americans. They then completed a survey and social isolation was measured using the Lubben Social Network Scale, where questions were answered using a 6-point scale. The UCLA Loneliness Scale was used to

measure loneliness. Cognitive impairment was measure objectively using the Mini Mental Status Exam and measure subjectively by having participants rate their overall perceived cognitive functioning. All participants were at least 60 years of age. Results found that higher levels of social isolation and higher levels of loneliness are positively associated with higher levels of cognitive impairment (Jang et al., 2021).

Previous research identifies social isolation and loneliness as obstacles presented as individuals age. These negative consequences of ageing are known to influence older adult's overall mental and physical well-being (Chawla et al., 2021). This study works to highlight older adults' personal experiences of social isolation, loneliness, and overall well-being. By doing this, we are better able to understand and create interventions that specifically fit the needs of older adults in the United States. By knowing exactly what they lack, desire, and prefer socially, it is likely that social isolation and loneliness will be reduced in their lives, ultimately resulting in improved overall health and reduced reports and experiences of social isolation and loneliness.

Along with cognitive and physical decline, research studies psychological consequences of social isolation and loneliness. Best et al. worked to detect factors associated with psychological distress during the COVID-19 pandemic, showing that social cohesion was associated with increased overall psychological wellbeing. In addition to these results, findings show that social distancing, due to COVID-19, results in increased psychological distress, including stress, panic, and depression (Best et al., 2021). Loades and colleagues (2020) also identified potential risks factors on mental health caused by social isolation in children and adolescents. This study consisted of 51,576 participants, children and adolescents primarily from the United States, China, Australia and Europe. Articles included analyzed the negative

effects of loneliness and the effects of loneliness on mental and physical health. Results found that loneliness has a significant influence on depressive symptoms. According to this review's results, social isolation and loneliness are positively associated with anxiety and social anxiety in children and adolescents (Loades et al., 2020). Santini et al.'s (2016) research study determined the effects of social relationship's quality and loneliness on mental health. Data was collected using The Irish Longitudinal Study on Ageing. The sample used was nationally representative, making the results easily generalizable for the population. Two waves of data were collected, the first being those who did not suffer from dementia, providing self-reported survey answers. The second wave included those knowingly suffering with dementia and were assisted typically a close family member. Data was collected via face-to-face interviewing. The Center for Epidemiologic Studies Depression index was used to measure depression and anxiety. Anxiety was assessed using The Hospital Anxiety and Depression Scale. The Berkman-Syme Social Network Index and The UCLA Loneliness Scale were used to measure social networks, isolation and loneliness. Various variables were controlled for. Results showed women to be more socially isolated, as compared to men. Additionally, perceived social network quality, social isolation, and loneliness were significantly associated with depressive symptoms (Santini et al., 2016).

The purpose of Bu et al.'s (2020) study is to investigate the association between social isolation, loneliness, and fall risks amongst older adults. This research study was conducted as a longitudinal study, using participants age 50 years and/or older. For data collection purposes, self-report and hospital documentation was used to measure the amount of falls experienced in older adults. The UCLA Loneliness scale was used to measure loneliness. A two-question questionnaire was used to measure social isolation. A regression analysis was used to

statistically process data, finding that increased reports of social isolation and loneliness in older adults resulted in increased reports of falls (Bu et al., 202). Gale et al.'s (2017) research also consisted of older adults at least 50 years of and utilized The UCLA Loneliness scale to measure loneliness, a point scale was used to measure social isolation, and a frailty index was used to measure frailty in older adults. Gale (2017) defined frailty as one's inability to maintain homeostasis including decreased strength, physical activity and increased exhaustion. Results show that increased social isolation and loneliness were both associated with increased frailty. However, the change of frailty in older adults was changed by social isolation, but not loneliness (Gale et al., 2017).

Positive social relationships and satisfaction in relationships has been linked to a number of benefits. However, just as this has been shown, dissatisfied and poor relationships have been linked to negative health effects, including depression. Ge et al. (2017) worked to examine the association between social isolation, loneliness, and depressive symptoms in adults. Many studies have been conducted and defined and measured social isolation. However, very few, if any, highlight the individual risks of social isolation, making it impossible to determine which particular risks contribute to depression and depressive symptoms. Participant recruitment was led by mailing participation invitations via mail. After participation agreements were received, face-to-face interviews were conducted at the participants' homes. Social isolation and loneliness were measured using the Lubben Social Network Scale and the UCLA Loneliness scale. A Spearman's correlation revealed a large overlap of individuals reporting social isolation, also reporting feeling lonely. Results show that loneliness is a significant risk factor of depressive symptoms (Ge et al., 2017). Gyasi (2019) focuses on the older Ghanian population and their struggles with many psychological and cognitive challenges as they age. Participants

used in this study were all 50 years or older. An Aging, Health, Psychological Wellbeing and Health-Seeking Behavior Study as used for data collection. Social isolation was assessed via face-to-face. Loneliness was assessed via the use of the UCLA Loneliness Scale. Kessler's Psychological Distress Scale was used to measure mental health and psychological strain. A Pearson's Correlation was used to determine social isolation and loneliness has a significant association with psychological distress. It is suggested that satisfactory social networks and social relationships may slow down the onset and progression of mental health problems. Findings of this research indicate that loneliness is a significant predictor of psychological distress. In addition, Gyasi (2019) reports that older adults that live in heavily populated neighborhoods experienced less social isolation and less reports of poor mental health (Gyasi, 2019). These negative consequences of social isolation and loneliness not only effect older adults but has effects on individuals of all ages. Hamza et al., (2021) works to investigate the effects of social isolation, due to social distancing mandates of COVID-19 on college students' mental health. The participants included in this study consisted of 733 undergraduate students. Participant qualification included only individuals whom had previously taken an on campus mental health survey. This sample set of students were then asked to complete a follow-up survey. Only those who agreed to take the follow-up survey were included in the study. The College Students' Recent Life Experiences Inventory was used to measure individuals' levels of stress. There levels of social support were measured using the Multidimensional Scale of Perceived Social Support. Stress and depression were measured using the Perceived Stress Scale and a revised version of Epidemiologic Studies Depression Scale. Results found that undergraduate students that reported more social isolation also reported more mental health problems. Smith et al. (2020) found the same to be true, specifically during the COVID-19

pandemic (Smith et al., 2020). Recruitment was conducted via contact through email and/ or social media websites. Social isolation was assessed using The Friendship Scale. Other measurements instruments used were The Depression Anxiety and Stress Scale, The Valuing Questionnaire, and the World Health Organization Well Being Index. Statistical analyses were conducted using Pearson's Correlation and regression analyses. Results show that increased reports of social isolation result in higher levels of poor mental health.

Although older adults that experience depression and engage in little physical activity, are at increased risk of heart attack and stroke, so are older adults that experience social isolation and loneliness. Hakulinen et al.'s (2019) study's aim is to analyze the relationship between social isolation, loneliness, stroke, myocardial infarction, and mortality. The study was conducted as an experimental design consisted of 479,054 participants between 40 and 69 years of age. Data was collected by surveying, physical vital measurements, and biological testing. Participants excluded from the study were those having a history of stroke or myocardial infarction. Results found that social isolation and loneliness were associated with a number of chronic illnesses, putting older adults at 30% greater risks of cardiovascular issues. Consequently, results found that higher reports of loneliness were associated with higher reports of stroke. In addition to this, Manemann et al.'s (2018) also found that one-quarter of adults that reported perceived social isolation also reported having heart failure. In addition to this, social isolation was also linked to more hospitalizations, doctor visits, and deaths. Because of these findings, it is likely that future research and implementations will be used to reduce the rates of social isolation, ultimately reducing the number of reports of heart failure. One major benefit of this research is that it uses a population representative sample, making its findings generalizable for most people (Manemann et al., 2018). Novak et al., (2020) used a longitudinal study and

found that there was a significant correlation between loneliness and cardiovascular mortality in Swedish women. The study sample used was highly representative of the overall population, making these findings highly generalizable for older adults (Mannemanm et al., 2018). Older and ageing adults are faced with various cognitive, physical, and mental health challenges associated with age. A number of these challenges cannot be controlled for. However, it is likely to control for different aspects of decline if we can identify risks factors for them (Valtorta et al., 2018). Valtorta et al.'s (2018) findings pose that participants who reported feeling lonely were at an increased risk of cardiovascular disease (Valtorta et al., 2018). By identifying loneliness as a potential risk factor for cardiovascular disease, researchers can now work towards interventions used to decrease feelings of loneliness. By doing so, they are too reducing the risk of cardiovascular disease in older adults.

Social isolation and loneliness negatively influence older adults in a number of ways that one may not consider, including decreased physical activity and inconsistent sleep patterns, one of the most popular complaints of the geriatric population. These complaints consist of lack of sleep, too much sleep and poor quality of sleep. The purpose of this research study is to identify the effects of social isolation and loneliness on quality of sleep. (Yu et al., 2017). Schrempft et al. (2019) analyzed the impact that social isolation and loneliness have on one's level of physical activity. Participants in this study included those that were between the ages of 50 and 81 years old. This research study included 267 participants. Social isolation and loneliness were measured using a 4-point and 3-point scale. An accelerometer was used to measure physical activities. Statistical analyses were run using T-tests and Pearson's Correlation. Results found that during the waking hours of those who report social isolation and loneliness, there was little no physical activity, as opposed to those that did not report social isolation and loneliness

(Schrempft et al., 2019). Yu et al., (2017) identifies sleep as top complaint of older adults. Participants included in this study are older adults 60 years old or older. The Pittsburg Sleep Quality Index was used to measure sleep quality. A questionnaire was used to measure social isolation. Loneliness was measured by a single question, reporting if one feels lonely or does not feel lonely. Research was conducted as a longitudinal analysis. The results of this study show that individuals who reported increased levels of social isolation and loneliness also reported increased levels of poor quality of sleep.

Many older adults suffer from social isolation and/or loneliness (Hwang et al., 2018). Hwang and colleagues (2018) studied the impacts of the Walk 'n' Talk program, a community exercise and social program, as it relates to social isolation and loneliness. Hwang and colleagues hoped to find positive outcomes of community and program engagement. It is theorized that physical activity in later life may result in a decrease in social isolation and loneliness for older adults. It is thought that physical activities also combat a number of physical and mental concerns, as well as influence overall mortality. Participants' experiences of loneliness and social isolation were analyzed using interview questions in order to get an in-depth personal account of each individual. Participants were asked about their personal social isolation and loneliness since being engaged in the Walk 'n' Talk community exercise program as well as their feelings towards the program itself. Analyses were conducted to gauge participants' perception of loneliness, reasons for loneliness, and strengths and benefits of the Walk 'n' Talk program. Results found that participants report to be happier, are interested in continuing the program or a program that is similar, like the personalities of the volunteers, and state that they experience less depression when at the program rather than home by themselves. The Walk 'n' Talk program, a program that encouraged interpersonal interaction, appeared to aid

older adults in more than one way. Not only was social isolation and loneliness decreased but physical health was improved and health education was gained (Hwang et al., 2018). In attempts to better comprehend the individual experiences of older adults, interviews are used to access social isolation and loneliness. Finlay & Kobayashi (2018) use semi-structured interviews is to identify personal and neighborhood influences that influence social isolation and loneliness in older adults that live in the Minneapolis metropolitan area. These semi-structured interviews assessed neighborhood characteristics, demographics, living situations and daily social interactions. Results found that safe spaces, sense of community, and services/amenities was associated with feelings of loneliness in older Minneapolis adults. Homes and living quarters that were considered stable and comforting were considered to be safe spaces. Communities, particularly the downtown Minneapolis area, linked social scenes and multigenerational population to social isolation and loneliness. Services and amenities such as available parks, churches, and/or movie theaters were linked to social isolation and loneliness (Finlay & Kobayashi, 2018). Though these studies show the experiences of social isolation and loneliness in older adults, the research is limiting as it is not generalizable. Limitations of this study include the non-variety of program types. This research study only studied one program, Walk 'n' Talk. This can be problematic, as all programs do not have the same structure, activities, and staff, which can render a difference in results (Hwang et al., 2018). Finlay & Kobayashi's research poses the same limitations as this study's sample was limited to only Minneapolis residents, its findings may not be generalizable.

"The Black Church"

Organized Black religious settings can be dated back to slavery in America. Many social and religious associations of slaves were despised by slave owners, as they saw it as a potential

threat and did not encourage nor accept slaves involving themselves. As church did not look as it is commonly viewed today, the earliest associations of organized Black religion were prayer meetings amongst slaves. Religious practices such as prayer meetings were often monitored closely by slave owners, as they feared the slaves were praying against the owners and/or making plans for escape. Because of this fear, some slaves were forbidden to attend religious gatherings and sometimes forbidden to pray at all. Slaves and indentured servants not only attended prayer meetings together, but they also attended meetings led by their masters, typically encouraging them to be submissive to their masters. During this time, Christian masters were using the Bible manipulatively and slaves and indentured servants found these teachings and preaching style to be intolerable. Slaves then took the risk of further abuse or being killed, by sneaking away to worship God and pray amongst themselves (Raboteau, 1992).

Gates' literature "The Black Church: This Is Our Story, This Is Our Song" (2022) educates on the importance of religion throughout the history of African Americans. The term "The Black Church" has been used for many years in order to capture all African American religions. As there is not one physical building and not one single religion, the term The Black Church has been used to umbrella them all. For hundreds of years, The Black Church has been a place where African Americans can worship, pray, and express themselves. The Black church served and still serves as a pillar in the African American community where individuals developed cultural literacy to include ways of dressing, styles of singing and playing music. Dating back to slavery, The Black Church was a place of refuge and comfort from the institutions that were created to keep them oppressed by their slave masters. African Americans used religion and created their own styles of worship and interpretations of the same Christian religion that was manipulated to keep them subservient. The survival and prospering of African

Americans can be solely connected to The Black Church, as they developed and utilized spiritual, political and social tools that would benefit them and their descendants for years to come (Gates, 2022).

During the Civil Rights era, The Black Church blossomed, as many African Americans were able to congregate, worship, and discuss the pressures of society. Not only were they able to find comfort in Biblical scripture, they were able to depend on each other and vent to others that had similar feelings and experiences. The Black Church was founded on support, likeness, and connectedness of African Americans. This became a place where political leaders of the time could deliver encouraging and passionate messages to the African American community. During an era where African Americans were not afforded the same opportunities and justices as other Americans, The Black Church provided a place for emotional and spiritual counsel, economic assistance, and social inclusion. Even today, as compared to other ethnicities, 80% of African Americans report that religion and the church play an important role in their lives (Avent & Cashwell, 2015)

One of the unanticipated consequences of social distancing is the increase in social isolation and loneliness amongst older African American adults, isolating them from friends, family, and healthcare aids (Chatters et al., 2020). Digital and virtual alternatives of gathering have been implemented during the COVID-19 pandemic. However, not all have access to devices and/or internet to engage with streaming and social media platforms such as Facebook, Zoom, Skype, or Doxy. The effects of the "double jeopardy" of age and race have been seen during the pandemic as Blacks are less likely to have in-home internet services, as compared to Whites, and older Blacks over the age of 65 are less likely to have in-home internet services as opposed to Blacks under the age of 65 years. Because of this, it has been difficult for older

Blacks to stay connected, especially to virtual church during the pandemic. Blacks, as compared to any other racial group, have the highest report of religious involvement and many of these individuals have attended church in-person for the majority of their lives (Chatters et al., 2020).

Being that COVID-19 has resulted in many in-person church events being disrupted, a number of older Blacks have had to adjust to new social norms and routines, as well as go without seeing and interacting with close friends and church members. Church attendance has not only shifted to a digital platform during COVID-19, many church members have been affected by the virus and many Blacks have lost their life to the illness, taking membership numbers down and resulting in a loss of members, family, and friends. In attempts to reduce disparities, churches have moved services to digital platforms and some have resulted in moving service from indoors to outdoors. Although having church service outdoors allows those who may not have computer and internet capabilities to join service, there are social distancing protocols followed and some people even attend the service without leaving out of their vehicles. Though there are various options and alternatives to in-person worship, they are still without much or any face-to-face interaction, resulting in increased social isolation and loneliness in older African American adults (Chatters et al., 2020).

Church During COVID-19

Social isolation has become a larger concern as the population of older adults is steadily rising and COVID-19 has implemented many new "norms" that require older adults to limit physical contact (Seyfzadeh et al., 2019). COVID-19 has impacted the way that people live, the way people shop, work, and worship, discouraging face-to-face contact with anyone that does not live within one home. The COVID-19 pandemic has forced many Christians to recreate the "norm" as it relates to church. Many beliefs and traditions have remained constant over the

years within the church. However, during the pandemic, many changes and unconventional ways of worship were implemented. Changes that many thought were temporary have shifted to long-term, if not permanent shifts (Pillay, 2020). COVID-19 has implemented many changes and obstacles for social interaction and social connectedness. During COVID-19 there have been mandated and encouraged lockdowns of church and other religious buildings, preventing individuals from coming together in public buildings (Bryson et al., 2020). As COVID-19 spread through much of the world in early 2020, many churches were forced to close their doors and implement lockdowns for public and private gatherings in an attempt to reduce the spread, resulting in digital interactions. By communicating digitally, the church is able to reach more people and with only the click of a button (Pillay, 2020).

Though technology has benefits to a large number of people, many people older adults are reluctant or unfamiliar with many technological devices and internet capacities. The internet and digital communication has been shown to reduce the feelings loneliness during COVID-19, allowing individuals to create and maintain contacts with loved ones and associates. However, this has been problematic during the COVID-19 pandemic as many older adults are confined to their homes and places of residence without access, understanding, or aid to assist with technology. Therefore, older adults may have technological devices in their home but not be skilled a how to use them. Conversely, older adults may understand how to use technological devices but may not have access to them in the home. Because of these reasons, older adults are more at risk of feeling excluded from their social lives and from the digital world as well (Chatters et al., 2020).

Research has shown that spirituality and religiosity have been buffers that have reduced the negative effects of COVID-19. Luchetti et al.'s 2020 study investigates the effects of

spirituality and religiosity on mental health issues caused by social isolation due to COVID-19. This is a timely and unique study, as its research focuses on modern and every day challenges of a disease that the whole world has been forced to face. Because of limited face-to-face contact, recruitment was conducted using online methods such as emailing and social media contact, which provided questionnaires that were available for 3-4 days. Questionnaires measured one's level of social isolation, spiritual, and religious values. Statistical analyses of data used descriptive statistics, logistic regression models and confidence intervals. Findings of this study found that the implementation of spirituality and religiosity resulted in decreased reports of negative feelings such as fear and/ or worry caused by the COVID-19 pandemic (Luchetti et al., 2020).

Many liturgical dwellings have transitioned to virtual worship via radio, social media, and television in attempts to maintain a normalcy as it relates to worship and public gathering for liturgical purposes (Parish, 2020). Noone et al. (2020) presents the influence that social isolation and loneliness has had on older adults during the COVID-19 pandemic. The purpose of this study is to determine the effects of video calls on social isolation and loneliness in adults over age 65. Results found that after periods of three and six months, there was little evidence that video calls reduced feelings of loneliness. However, after a period of 12 months, studies show small effects that video calls have on the reduction of loneliness and depression (Noone et al., 2020). Therefore, although virtual streaming systems were able to bridge the gap during the COVID-19 pandemic, it only made minimal influences on the perceived quality of interactions.

The transition to virtual church during the COVID-19 pandemic has been limiting, as some individuals are unable to attend digitally due to lack of finances and resources. Over the years African American older adults have had to battle the double-jeopardy of ageism and

racism, which has affected the ways in which they have had to adjust to the vicissitudes of COVID-19 (Chatters et al., 2020). Chatters and colleagues (2020) explore the obstacles that Black older adults face and how their mental health has suffered during the COVID-19 pandemic. Research suggests that social isolation and loneliness of older Blacks has been protected by interacting with others, engaging with social supports (Chatters et al., 2020). However, this has been difficult to do during the COVID-19 pandemic, while attempting to stay safe and reduce the spread of the virus.

Biblical Foundations of the Study

Biblical theories can fill many gaps on this research topic by focusing on the importance of what God tells us to be true. Our lives are ultimately molded by the quantity and quality of our interactions with those around us. Copan (2016) focuses specifically on one's thoughts, feelings, body, and will, and how these aspects shape one's social being. In the book "Changing your Mind: The Bible, the Brain, and Spiritual Growth", the importance of relationships, love, physical touch, acceptance, and healing are all highlighted.

Copan's (2016) reading, "Changing your Mind: The Bible, the Brain, and Spiritual Growth", provided a clear knowledge of what God wants for people, in relational contexts. By having a socially connected foundation, many of the risks and factors associated with social isolation and loneliness will be reduced, if not eliminated (Copan, 2016). By loving and caring for one another as God does for us, we are accountable and responsible for the well-being of our fellow man

> My command is this: Love each other as I have loved you. Greater love has no one than this: to lay down one's life for one's friends. You are my friends if you

> do what I command. I no longer call you servants, because a servant does not know his master's business. Instead, I have called you friends, for everything that I learned from my Father I have made known to you. (*New International Version*, 1978, John 15:12-15).

God encourages us to care for one another just as He cares for us. When we are hurting, God comforts us. When we are confused and unsure of what direction to take in life, He guides us with the Holy Spirit. When we are friendless, God is a friend to us, "One who has unreliable friends soon comes to ruin, but there is a friend who sticks closer than a brother. (*New International Version,* 1978, Proverbs 18:24) Therefore, it is important for us to lend the same grace to others. Because social isolation and loneliness is an issue within the elderly population, as researchers, we are required to fill the gap and get better understanding of how to help our fellow man. By conducting research and better understanding the feelings and beliefs of others, we are more equipped to help them and extend care and love in action.

> When the Son of Man comes in his glory, and all the angels with him, he will sit on his glorious throne. All the nations will be gathered before him, and he will separate the people one from another as a shepherd separates the sheep from the goats. He will put the sheep on his right and the goats on his left. "Then the King will say to those on his right, 'Come, you who are blessed by my Father; take your inheritance, the kingdom prepared for you since the creation of the world. For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison

> and you came to visit me.' "Then the righteous will answer him, 'Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? When did we see you a stranger and invite you in, or needing clothes and clothe you? When did we see you sick or in prison and go to visit you?' "The King will reply, 'Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me. (*New International Version*, 1978, Matthew 25: 31-40)

Social isolation is a social concern that must be closely monitored in younger, middle-aged and older adults. The mental and physical health consequences not only affect us day-to-day, but have long term effects that can contribute to premature mortality. Remember, "How good and pleasant it is when God's people live together in unity!" (*New International Version*, 1978, Psalm 133:1). I find it safe to say that "everyone needs somebody", in agreeance with Copan (2016) and in agreeance with God. Very early on, in the first book of the bible, it tells us "The LORD God said, "It is not good for the man to be alone. I will make a helper suitable for him" (*New International Version*, 1978, Genesis 2:18). In the verses following, Adam encountered many different creatures, but "…no suitable helper was found" (*New International Version*, 1978, Genesis 2:20)

Human beings need one another and God is not shy about letting us know that. God lets us know very early in the Bible that he doesn't want nor encourage us to be isolated and by ourselves. In Genesis 2:18, this is the first time that God talks about something not being good, this lets us know how important it is Him. There are many reasons why we need one another and

the Bible highlights them individually. Procreation, companionship, and worshipping are all reasons that we need one each other and cannot make it alone.

In the previously mentioned scripture, Adam cannot procreate with a partner, as the Bible encourages us to do

> God blessed them and said to them, "Be fruitful and increase in number; fill the earth and subdue it. Rule over the fish in the sea and the birds in the sky and over every living creature that moves on the ground. (*New International Version*, 1978, Genesis 1:28)

Without man and woman, we would not be able to multiply, which would ultimately cause an end to humankind. God created man and woman to procreate, as man and man cannot and woman and woman cannot. However, there is still a need for companionship that we get from one another. Companionship is another benefit offered to us by being amongst others,

> Two are better than one, because they have a good return for their labor: If either of them falls down, one can help the other up. But pity anyone who falls and has no one to help them up. Also, if two lie down together, they will keep warm. But how can one keep warm alone? Though one may be overpowered, two can defend themselves. A cord of three strands is not quickly broken. (*New International Version*, 1978, Ecclesiastes 4:9-12).

Being that American culture is very much so "me" oriented, as opposed to "us" oriented, we are accustomed to doing things on our own and often encouraged to do things independently. However, this mindset can prevent us for experiencing what God has for us. In addition to these

things, as Christians it is important that we stay connected for worshipping the Lord. Though prayer and worship can be done privately, there are also benefits of corporate worship and prayer. The bible validates this point by stating "For where two or three gather in my name, there am I with them" (*New International Version*, 1978, Matthew 18:20)

Summary

Over the past 2 years, American have been presented with unparalleled events, illnesses, practices and various variants all associated with COVID-19. COVID-19, a type of Coronavirus that is discovered to originate from a variety of species, is a virus that attacks individuals' lower and upper respiratory systems. This virus presents itself in cold and flu-like symptoms and is highly contagious. COVID-19 is most commonly spread through droplets released from the body while talking, laughing, coughing, and/or sneezing. Because of its high contagiousness, the Centers for Disease Control and Prevention encourages individuals to wear facial coverings, be vigilant about public spaces, maintain 6-feet of physical social distance, and isolate in their homes. Although COVID-19 attacks people of all populations, the geriatric population is consider an at risk population, making them more susceptible to the virus, more likely to be hospitalized and/or require a ventilator to aid with breathing, and more likely to succumb to the illness. During the COVID-19 pandemic, older adults have and continue to face many health, physical, and social challenges

Many individuals use the terms social isolation and loneliness are used interchangeably. However, social isolation refers to the quantity of actual interpersonal interactions and relationships one has. Loneliness, on the other hand, refers to the quality and satisfaction and. Or lack thereof satisfaction associated to these relationships. Although the Bible encourages us to

maintain connectedness with one another, social isolation and loneliness continue to be a common issue amongst older adults, especially over the past two years. This distance and loneliness has been shown to result in cardiovascular complications, increased depression, anxiety, cognitive decline in older adults, as well as overall mortality. As the number of ageing older adults continues to rise, issues associated with ageing such as loneliness and social isolation will continue to be a problem for countless Americans.

Social isolation and loneliness has become more prevalent and more of an issue over the past two years, as COVID-19 has created unprecedented social times for many people, particularly African Americans. For many years, African Americans have relied on "The Black Church" to provide them emotional and social support. This social reliance started during slavery, as slaves first create their own way to worship God aside from what the slave masters manipulatively taught them and allowed them to do. The Black Church has been a pillar in the African American community since that time, becoming popular and widespread during the Civil Rights era, serving as a judgment free place where individuals could discuss and inform on political and societal issues. Churches and liturgical buildings that were previously attended for African Americans to find comfort and companionship have been closed and transitioned from face-to-face gatherings to virtual services and digital gatherings, which unfortunately do not have the same benefits of in-person interactions. These unprecedented times have left African American older adults having to discover "new norms" and alternative ways of worships and socializing, transitioning from face-to-face to virtual interactions.

CHAPTER 3: RESEARCH METHOD

Overview

This Chapter conceptualizes the methods that were used to conduct research. The main objective of this study is to qualitatively analyze the impacts of social isolation (specifically church attendance) and loneliness on African American older adults' overall health. Data was collected using open-ended interview questions. By collecting data and analyzing subjectively, while structuring interventions, one is better able to use participants' experiences and perceptions to provide specifically what may be requested or lacked in the lives of older adults. For example, many older adults may like the idea of engaging in social activities from the comfort of their home rather than traveling to attend programs or activities, especially if they live in a rural area and are no longer able to drive. For this reason, it was determined that data collection would best be conducted by interviews to get a clear understanding of the experiences of older adults and how they may have been affected during COVID-19 by transitioning to virtual church attendance or remaining in-person during the COVID-19 pandemic. Participants were adults aged 65 years and/or older, who were recruited using an interactive Facebook polling system. Interviews were conducted telephonically and audio recorded. Participant responses were transcribed and coded using NVivo transcription software. Research was conducted using the Grounded Theory approach, as a way to get specific data as it relates to each individual's experiences.

Research Questions

RQ 1: "How do older African American adults describe their lived experiences and perceived quality of relationships?"

RQ 2: "How do older African American adults describe their lived experiences and perceived health?"

RQ 3: “How do older African American adults who attend in-person church describe their level of loneliness?”

RQ 4: “How do older African American adults who attend church virtually describe their level of loneliness?”

Research Design

A qualitative grounded theory approach was used for this research project, as a content analysis of interviews was used to examine to social isolation, loneliness, and perceived overall health of older African American adults. This theory was chosen because it is used to formulate and develop a new theory as it relates to collected data (Chun Tie et al., 2019). Though there has been research and theories to explain social isolation and loneliness in older adults, there are no available theories to include older African American adults during COVID-19, as their isolation is accounted for by their attendance of church virtually or in-person. The Grounded Theory was founded on collecting data, organizing data, and examining data. This is a systematic method of research that requires extensive data analysis used to develop theories. Founders of this theory suggests that all collected data is meaningful and can be analyzed, forming new theories (Charmaz & Belgrave, 2018). Interviews were used to obtain a personalized, in-depth understanding of the attitudes and feelings of older adults. This approach was used to understand the experiences and beliefs of older African American adults’ social lives, social relationships, perceived relationship quality and overall health. Grounded Theory was created by two sociologists, Barney Glaser and Anselm Strauss, in the 1960s. At the time, quantitative research was thought to have been more valid as it relates to truth about people. This design proved to be a contemporary valid systematic research method. Grounded Theory design is a research design used to formulate theories from collected data (Chun Tie et al., 2019).

Grounded Theory was the chosen qualitative research method approach over all other methods because of its unique characteristics. Grounded Theory's findings solely rely on the information gathered during the research and interview process that are the most current and adequate feelings and beliefs of the participants, rather than relying on past documents and interviews. As this research study did not use the analysis of past documents, participant observation, nor focus groups, it is the most applicable approach as opposed to a case study, ethnography, historical, or phenomenological approach. Grounded Theory approach best fits this research study as it uses data to formulate a new theory, as opposed to using developed theories to explain, understand, and deal with social issues.

Participants

Participants in the study consisted of 20 African American older adults, 65 years of age and older, and attend church virtually or in-person. Based on previous research studies, it is determined that this number of participants will reach the point of saturation for this study. However, I am open to more participants if the point of saturation is not reached. Participants' locality or church denomination was not a considering factor for participation. Participants were recruited using a Facebook. Of the 20 participants included in this study, participants consisted of both male and female participants. Inclusion criteria was for participants to be African American and at least 65 years of age, attending church virtually or in-person. Participants were excluded from the study if they reported any diagnoses that impeded on memory, cognitive functioning and/or recall such as, but not limited to, Alzheimer's Disease, Mild Cognitive Impairment, or Vascular Dementia. The researcher conducting this study was a doctoral student from the Social Psychology department at Liberty University.

Two types of sampling techniques were used for this research study, convenience sampling and purposive criterion sampling. Convenience sampling is a popular type of nonrandom sampling. Convenience sampling typically uses a sample population that is easily accessible, within close geographical proximity and willing to participate in the study (Etikan, 2016). Convenience sampling was used, selecting participants from local churches and church members of local pastors that are currently conducting online virtual church services. Purposive criterion sampling wase used to select participants, including only individuals that are of particular interest relevant to the study (Andrade, 2020). Purposive sampling includes using individuals that are specific to your research topic and will provide important information based on the research study (Campbell et al., 2020). The inclusion criterion needed for participation was for participants to be African American and at least 65 years of age, having no known diagnosis or illness that impedes memory and/or recall.

Study Procedures

This study was conducted using a grounded theory approach. Data was collected using telephonic interviewing. Interviewing was conducted by using open ended, semi-structured interview questions. Social isolation was identified as the presence and/or absence of in-person church attendance. Loneliness as then identified as the perceived feeling of satisfaction with social interactions and/or lack thereof. Health related issues were examined as the qualitative report of health-related issues. The examiner recruited individuals using interactive polls on social media, Facebook. This poll recruited older individuals by screening for age and church attendance by selecting if they attended church virtually or in-person. The poll read "Are you an African American adult 65 years of age or older and attend church virtually or in-person?" Participants were able to vote by selecting "yes" or "no." Recruitment (Appendix A)

and informed consent documentation (Appendix B) were then be sent to individuals. Participants provided informed consent, sent via email. Inclusion criteria for the study was participants' willingness to engage in a telephonic interview, having no known diagnosis of dementia or any other illness that may impede memory, cognitive functioning, identifying as African American, being at least 65 years old and attending church virtually or in-person. Individuals that reported dementia or any other illness that may impede cognitive functioning, memory, or recall were excluded from the study after reporting illness. Individuals that were not at least 65 years old and do not identify as African American will be excluded from this study. The researcher communicated with participants in their most preferred form of communication, via telephone or Facebook audio messaging capabilities to collect data and gather information about church attendance/ social isolation, loneliness, and health-related issues of older adults. The qualitative research method, Grounded Theory Study was used to analyze data. Semi-structured interviews were used to collect data. Interview questions were structured to avoid using direct terms such as "isolation" and "loneliness", as some may have a negative viewpoint towards these words (Wong et al., 2017). Instead of using specific terms, individuals were asked to explain their personal experiences of in-person and virtual church attendance. Interview prompts (Appendix C) consisted of questions to include, "Are you currently attending church virtually or in-person?", "Could you tell me more about your church experience since COVID-19?, "How is your health in general? Is it very good, good, fair, sometimes good and sometimes poor, or poor?" Participants were then asked to explain their perceived quality of health. Interviews wereconducted, and transcripts were examined for themes and keywords presented in responses using NVivo transcription software.

Ethical Considerations

The risks involved in this study were minimal, which means they were equal to the risks individuals would encounter in everyday life. As needed or requested, participants were provided with contact information of local grief and outpatient therapists. The records of this study were kept private. Research records were stored securely on a password locked computer, and only the researcher will have access to the records. Participant responses were collected and used anonymously. Participant responses were kept confidential through the use of pseudonyms chosen by the researcher. Data was stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted. Interviews were audio recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher had access to recordings obtained during this study. Participants were not be compensated for participating in this study. Participation in this study was voluntary. Participants' decision whether or not to participate does not affect current or future relations with Liberty University. Individuals that choose to participate were free to not answer any question or withdraw at any time without affecting those relationships. If anyone chose to withdraw from the study, they were expected to contact the researcher by telephone or email. Upon a participants' withdrawal, data collected from you will be destroyed immediately and will not be included in this study.

Instrumentation and Measurement

Data was collected via telephonic interviews. Charmaz and Belgrave (2018) highlight the benefits of using open-ended interview questions, as it provides opportunity for solicited and potential important unsolicited data (Charmaz & Belgrave, 2018). These interviews were recorded and later transcribed using NVivo. The research manually took notes during the

interview, documenting key phrases and terms used by each participant. Participant interviews were used to analyze older African Americans' way of attending church (virtually or in-person), their attitudes about the quality of their social relationships, and their feelings towards their overall health. Open ended interview questions were used to include "Are you currently attending church in-person or virtually?", "How would you describe the quality of your social relationships since the COVID-19 pandemic?", and "how would you describe your overall health since the COVID-19 pandemic?" To combat responses such as "good" and/or "okay", I will ask participants to explain how that looks for them. For example, "How does having good health look for you?" The recordings within this study were kept private. Research records were stored securely on a personal, password protected computer, and only the researcher will have access to the records. Participant responses were anonymous. Participant responses were kept confidential through the use of pseudonyms. Data was stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted. Interviews were audio recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

Data Analysis

Participants' interview responses were transcribed manually and transcribed with the use of NVivo software. As Grounded Theory was the research design approach, open coding was conducted as a way to identify important words and phrases. This initial step of coding allowed the researcher to become familiar with data from interview transcriptions and develop unbiased codes. This requires a breakdown of qualitative data, allowing the researcher to later compare and contrast words, phrases, and experiences of the participants provided through words. Next, axial coding was used to organize codes. While being transcribed, relevant statements and words

were gathered to create categories. Axial coding includes identifying similarities between codes and grouping them with like codes, thus forming categories. Lastly, selective coding was used to make relationship between all categories by developing a central theme. Themes were then created from all categories, forming an overarching theory (Chun Tie et al., 2019). By carefully and engagingly dissecting data, I was able to create codes and make meanings of words and terms used in the presentation of participants' experiences.

Delimitations, Assumptions, and Limitations

Delimitations

Delimitations of this study include the sample population. Participants in this study only incorporated older African American adults, at least 65 years of age, from churches in Virginia. This study was limited to analyzing older African American adults' perceived overall health, as a result of church attendance and loneliness.

Assumptions

Assumptions of this research project is that participants were honest when disclosing their age and their status at it relates to not having any known conditions nor diagnoses that impede memory and/or recall. It is also assumed that participants answered questions honestly and delivered truth about their church attendance, attitudes towards their relationships and feelings regarding their overall health.

Limitations

As opposed to previously conducted studies, this research study will use a grounded theory approach to focus on African American older adults. Although this is my preferred target population, I recognized that engagement and involvement may be an issue, as many older adults that are socially isolated and may not want to be included or participate in the study. This is

identified as a limitation as older adults that are socially isolated may not want social engagement, have social media accounts, nor feel the need or benefit of being connected socially. In addition, being that the research utilized convenience sampling rather than random sampling, the population was specific to older African Americans. Because of this, results may not be representative of the general population.

Summary

Because there are so many older and ageing adults, as well as the overall increase of longevity, it is important to identify and understand the obstacles that they face. By identifying loneliness as an experience that older adults face, especially with adverse effects, it is possible to bring awareness to the issue and decrease social isolation and encourage in-person church attendance. By exploring individual experiences of loneliness and perceived health, we can now work towards reducing the levels of social isolation and loneliness in older adults. This research shows the benefits of social engagement and in-person church attendance as it relates to loneliness and perceived health. By conducting the study qualitatively, using the Grounded Theory Approach, we are able to highlight the individual experiences of older African American adults as it relates to the research question. Grounded Theory Approach is founded on the collection, analysis, and thorough examination of data, in attempts to develop new theories. Data will be collected using semi-structured interview questions regarding one's church attendance, quality of relationships, and perceived health. This is beneficial because it analyzes the experience from the perspective of the person/people being studied. By doing this, we afforded the opportunity to analyze emotions, feelings, and beliefs that could not be measured simply by observing. The data collected in this study is kept private on a password locked computer, and confidentiality will be maintained by using pseudonyms to protect identifying participant

information such as their name. Although there are limitations to this study, it is my hope that this research study inspires older adults to engage in more in-person interactions that can improve and enhance the quality of life for older and ageing adults, using a foundation built from the personal experiences of lonely older adults. As virtual church attendance has been an alternative for many during the COVID-19 pandemic, it is imperative not to dismiss the damaging social affects these precautions have on people, particularly older African American adults. This research study ethically conducted research by using the Grounded Theory Approach via the collection of interviews, in order to collect the most accurate and applicable information provided by African American older adults as it relates to their method of church attendance, loneliness, and perceived overall health.

CHAPTER 4: RESULTS

Overview

The purpose of this qualitative research study is to analyze events and understandings experienced during the COVID-19 pandemic by church going (virtual and in-person) African Americans age 65 years and older. This qualitative research study systematically investigated the experiences of older African American, church going adults in relation to their social isolation during the COVID-19 pandemic, individual perceived loneliness, and their overall perceived health and well-being. The objectives of this research study are to identify and compare social isolation, loneliness, and quality of health in African American older adults who are attending church virtually and are no longer gathering in-person at church due to the COVID-19 pandemic and older adults that are attending church in-person. These perceptions were analyzed qualitatively using interview questions that allow individuals to express their personal lived experiences during the COVID-19 pandemic. This research hopes to highlight the benefits of social connectedness and social interactions in older African American adults by examining and measuring social isolation and loneliness in older adults and their overall health and well-being.

Descriptive Results

This research study involved 20 participants that were at least 65 years of age, African American, and attending church virtually or in-person. Participants included 13 women and 7 men. Of these 20 individuals, 14 reported attending church in-person and 6 people reported currently attending virtually. Individuals involved in this study reported not having any diagnosis that would impede memory or recall, such as Alzheimer's Disease, Dementia, or any known impairment of cognitive functioning. Participants were recruited via a Facebook poll,

where individuals were able to answer “yes” or “no” to the question, “Are you an African American adult 65 years of age or older and attend church virtually or in-person?” Individuals who selected the “no” option were automatically excluded from the research study, and no further action was taken as related to those individuals. Individuals that selected “yes” then provided contact information, including telephone number and email address, via Facebook messenger. Recruitment forms and informed consent were then sent to participants via email. Once these forms were signed/dated and returned, interview dates and times were selected. The complete data collection process took place over the duration of 4 months. Data were collected from participants using telephonic interviewing to collect experiences of social isolation and loneliness during the COVID-19 pandemic. Interviews were conducted telephonically at a location most comfortable for the participant. Pseudonyms were given to participants and were used for further processing of collected data. Interviews were audio recorded using a voice recorder. Notes were taken by the researcher during the interviews, and keywords were written down. Audio recordings of the interview were uploaded to a computer and then transcribed using NVivo software. Transcriptions were then analyzed to explore words and statements to create codes and themes. These codes and themes were then used to better understand the relationship of one’s social status during COVID-19 and the relationship to their perceived levels of loneliness and perceived overall health.

Study Findings

The findings of this study comprised of the collected data from the 20 participating individuals. The data collected supported the research questions.

RQ 1: “How do older African American adults describe their lived experiences and perceived quality of relationships?”

RQ 2: “How do older African American adults describe their lived experiences and perceived health?”

RQ 3: “How do older African American adults who attend in-person church describe their level of loneliness?”

RQ 4: “How do older African American adults who attend church virtually describe their level of loneliness?”

Results were derived from the responses to interview questions. The interview questions presented to participants were:

- “Are you currently attending church in-person or virtually?”
- “How often do you go to church per week? Has this increased, decreased, or maintained the same since COVID-19?”
- “What were you involved in, at church, before COVID-19?”/ “What are you involved in now?”
- “How many friends do you have at church?”
- “How would you describe your friendships within the church?”
- “How do you keep in touch with friends from your church during the pandemic?”
- “Do you communicate with friends from church more or less since the COVID-19 pandemic?”
- “What has life been like for you during the COVID-19 pandemic?”
- “Do you engage in at least 30 minutes of exercise per week?” Why or why not
- “Have you experienced any sicknesses in the past year?
- “When it comes to your health, what are you most concerned about?"

- "During the COVID-19 pandemic, in what ways have you experienced stress and anxiety?"
- "How often do you visit your Primary Care Physician? Has it increased or decreased since the COVID-19 pandemic, and why?
- "How would you describe your current overall health?"

Once interviews were conducted and completed, interview responses were analyzed, resulting in themes being formed from coding. Open coding, axial coding, and selective coding were used to generate themes amongst the collected data. Coding was conducted to better analyze data by dissecting participant responses and organizing codes. During the opening coding portion of the analysis, there were repeated and frequently used words and phrases that were explored and used to create themes. Themes developed from data collection and code analysis were: staying connected via technology, life during COVID-19, sicknesses during COVID-19, and COVID-19-related stress and anxiety. The themes are presented in Table 1 and supported by participant responses.

Figure 1

Theme Development

Themes	Participant Quotes
Staying Connected via Technology	"We FaceTimed each other, we did video chats, and we texted each other. And we called." "… through phone calls or Facebook." "Well, we had a church service over the phone, telephone. Then I would call them from time to time, like on birthdays and stuff like that." "Basically, phone call, just check just to say, 'Are you okay? You need anything?' Or just carrying on conversation on the phone, three way phone or whatever"

	"…having Bible study on the group video calls"
Life During COVID-19	*"*It was very isolating. It was very lonesome sometimes, and it just put a damper on my social life." *"*I think the main thing with COVID was not being able to be with your family more so anybody else. But I thank God for the ways that He allowed it so that we could communicate." "Since the COVID 19, it's been scary. It's been scary because sometimes you're scared to go... You're scared to leave home to go anywhere." "…it limited my going to different places and it limited your contact with people. You couldn't visit your neighbors like you wanted to because of the pandemic." "In general, life was hard because you didn't get to see anybody. You didn't get to see your family, your friends, your church members, or whatever. And to me, life was hard during the pandemic."
Sicknesses During COVID-19	*"Just COVID-19"* *"*I've had cancer surgery. I had a blood clot removed. I had surgery to my neck, chemotherapy, and just a bunch of tasks that I've had done and more to be done.*"* *"*I had the COVID in the past year, and I had COVID again.*"* *"*I was having issues with my gallbladder. I had to have that done. And that was basically the only illness that I had." "Well, I had COVID twice, and other than that, really no sickness."
Stress & Anxiety During COVID-19	"The only stressful part about it was that I could not get out and visit other people. And it just put a damper on your mind. Let's see, the lack of the happiness that you could have engaged in if it weren't for COVID, dealing with other people on a one-on-one basis. "The stress was the fact of being sick."

> "Having members of my family and myself in the mix of COVID"
> "you get stressed out because you couldn't be with your family and your friends. It was stressful. Basically, it was hard.

Staying Connected via Technology

After analyzing participant interview responses, having the ability to stay connected via technology was the most recurrent theme throughout participant interviews. Some of the keywords that were frequently mentioned were: Facetime, video chats, text, calls, phone calls, Facebook, group video calls, and 3-way phone calls. All 20 participants reported being able to stay connected to friends from church during the pandemic by means of telephonic or computer-driven communications. A participant given the pseudonym Pat stated, "We FaceTimed each other, we did video chats, and we texted each other, and we called. It was a great thing because we could keep up with each other even though we couldn't see each other." Another participant, Lily stated,

> "I guess I communicate more at church now than I did during the pandemic because you didn't see anyone. You just talked on the phone for a few minutes during the service. So, I had less communication during the beginning of the pandemic."

Because of social distancing implemented during the COVID-19 pandemic, alternative ways of connecting were used. Daniel stated that he "got more into the cellphone" during the COVID-19 pandemic and said,

> "in the beginning it really helped me out because I got to see my two grandkids that are growing like weeds. Bible study and church services were on the computer. Well, Bible Study is still on the computer as of today, but I do a lot of texting and phone calls too"

when sharing how he was able to use various means of telecommunicating to keep in contact with his family. All participants reported staying in contact with their friends and comrades from church via several means of technology. By having a consistent and constant means of communication, all participants reported having healthy relationships with their friends from church and described these relationships using words that reflect positivity to include: encourage, good, hug, love, family, connection, and great. One participant stated, "My friendships within the church are very good. I mean, we're on a personal basis. We share information together, and we try to keep each other's morale up spiritually and emotionally."

Life During COVID-19

Life during COVID-19, specifically the hardships of life during COVID-19, was a theme throughout participant interviews. When assessing participants' life during the pandemic, most participants reported experiencing negative feelings during this time and described their experiences using undesirable words such as: isolating, harsh, hard, uneasy, scary, scared, lonesome, lonely, damper, uncertain and tough. Jill, a cancer patient, shared how life has been during the COVID-19 pandemic and stated

> "One thing I can say is that life has been good, but it has been different. I take a lot of precautions now and I took precautions first, but now I'm always uneasy when I'm with a big group or something because you just don't know, and I'm a cancer patient so of course I wear my mask, but it still makes you feel uneasy and worried, you know? But overall, God has been making a way for me through it all and I trust that things are going to get better."

Another individual, Pat, stated

> "It was very isolating. It was very lonesome sometimes, and it just put a damper on my social life. I mean you felt very uncertain and unsure about what the next day would be or what you would hear on the news."

Lily described her life during COVID-19 by stating, "…it limited my going to different places and it limited your contact with people. You couldn't visit your neighbors like you wanted to because of the pandemic." Another participant, Lucy, stated "Since the COVID 19, it's been scary. It's been scary because sometimes you're scared to go... You're scared to leave home to go anywhere. But one thing I do do when I do go out there, stay masked up." Jane responded,

> "In general, life was hard because you didn't get to see anybody. You didn't get to see your family, your friends, your church members, or whatever. And to me, life was hard during the pandemic. Really during the pandemic it was new to everybody so of course it was sort of scary, you know? But it really really was hard for me."

when discussing her life during the COVID-19 pandemic.

Sicknesses During COVID-19

Older adults dealing with and experiencing sickness during the COVID-19 pandemic was a common trend among participant responses. Lory stated, "I was having issues with my gallbladder. I had to have that done," and "I have sleep apnea. That is a scary situation, not knowing if you're going to completely stop breathing. So it keeps you on the edge of having restless nights." Another participant, Lucy, stated, "because I've had cancer surgery. I had a blood clot removed. I had surgery to my neck, chemotherapy, and just a bunch of tasks that I've had done and more to be done" when discussing various, continuing illnesses and procedures that she has encountered during the COVID-19 pandemic. Lacy stated, "Just have a lot of

problems with my foot from my surgery that I had a year ago. That's pretty much it." Participant Brenda reported

> "This year has been full of sickness for me but God has still been good. I had a brain aneurysm in July, which kept me in and out of the hospital. That's been the biggest thing for me but it messed with my legs because I feel so weak, and I used to be on a cane for a little while, but I don't use it no more. So now I'm feeling better, but I just take one day at a time."

Along with the previously mentioned sicknesses, COVID-19 was a repeated sickness that older adults testified testing positive for and suffering during the pandemic. Out of 20 participants, 12 reported being infected with the COVID-19 virus at least once, with 3 individuals reporting being infected with the virus twice.

Stress and Anxiety During COVID-19

Stress and Anxiety During COVID-19 was a theme that was found during the data analysis process. Stress and anxiety during the COVID-19 pandemic were reported by all participants during the interviewing process. Participants reported financial stressors during the COVID-19 pandemic and said, "To me, my biggest stress and anxiety is dealing with my workman's comps, filling out applications and stuff like that," and

> "…and the anxiety of not knowing that I was going to be financially stable to take care of the things that I needed taken care of, to maintain your life. And also, I guess, again, just to be able to maintain, basically, was a stressful situation."

Participants also reported stress and anxiety concerning their health and the health of their family members. Albert stated,

> "Stress and anxiety has been pretty heavy during COVID. It's been so much to try to process because you really didn't know how to feel. I mean, I felt stress about my wife's health and you really feel anxious when you go anywhere with people because you're thinking 'am I going to catch COVID?' It's just been so much stress for me, I'm constantly praying for my grandkids' safety because this world is getting worse and worse."

Participant responses reflected consistent stress and anxiety that was COVID-19 related and non-COVID-19 related. However, 18 of 20 or 90% of participants reported stress and anxiety that was related to COVID-19.

Findings

This data collection process and data analysis highlighted key findings reported by older African American adults. Of 20 total participants, six reported attending church virtually, and 14 reported attending church in-person. Sixteen of the 20 total participants reported spending at least 30 minutes each week engaging in exercise. Of the 16 participants that reported engaging in at least 30 minutes of exercise each week, 13 reported in-person church attendance and 3 reported virtual attendance.

Weekly church attendance varied in range across responses. However, across all participants, church attendance was no less than 1 time each week and no more than 3 times each week. Individuals share a range of church involvement to include church services, Bible Study, Sunday School, as well as ministry meetings and events. Individuals who attend church in-person attend church, on average, 1.9 times each week. Individuals who attend church virtually, on average, had a reported attendance of 1.5 times each week.

All participants reported being seen by their Primary Care Physician at least once a year and no more than 4 times a year. Five out of six participants that attend church virtually reported visiting their Primary Care Physician every 3 months. One of the six virtual church attendees reported annual Primary Care Physician attendance. Of the 14 participants that reported in-person church attendance, 1 of 14 reported visiting their Primary Care Physician every 3 months, 2 of 14 participants reported visiting their Primary Care Physician every 6 months, and 11 of 14 reported visiting their Primary Care Physician annually.

Participant responses exhibit the frequency of sickness of older church-going adults over the past year. Of the total 20 participating older adults, 16 individuals report being sick at least once in the past year, ranging from 1-6 times in the past year. Four individuals report no sickness in the past year. Older adults that attend church in-person reported being sick, on average, 0.9 times in the past year. Old adults that reported attending church virtually reported being sick, on average, 2.7 times in the past year. Of the reported sicknesses, 12 participants reported having COVID-19 throughout the pandemic, and three participants reported having COVID-19 twice. These significant findings are reflected in Table 1.

Table 1
Participant Responses

Participant	**Virtual/ In-person**	**Exercise At Least 30 mins per week**	**Church Per Week**	**PCP Attendance**	**Sickness in Past Year**
Pat	In-person	YES	3	Annually	1
Lily	In-person	YES	1	Every 3 months	1
Jane	In-person	YES	2	Annually	2

Lucy	Virtual	YES	2	Every 3 months	6
Lacey	Virtual	NO	2	Every 3 months	3
Lory	In-person	YES	3	Every 6 months	2
Jinny	Virtual	YES	1	Annually	2
Albert	In-person	YES	3	Annually	1
Daniel	In-person	YES	3	Annually	0
Kenny	In-person	YES	2	Annually	0
Rhonda	In-person	YES	2	Annually	1
Jill	In-person	YES	1	Annually	0
Mary	Virtual	YES	2	Every 3 months	1
Linda	Virtual	NO	1	Every 3 months	2
Robert	In-person	YES	1	Annually	1
Rick	In-person	NO	1	Annually	1
Tim	In-person	YES	1	Every 6 months	1
Kimberly	In-person	YES	1	Annually	0
Brenda	Virtual	NO	1	Every 3 months	2
David	In-person	YES	2	Annually	1

Summary

This chapter presented all participant demographics and relevant findings of interview and research questions. Visual representations of collected data was also presented. By collecting and analyzing participants' interview responses, key findings were highlighted, and themes were created to produce an arrangement of categorized data. Four themes were created to include: staying connected via technology, life during COVID-19, sicknesses during COVID-19, and stress/anxiety during COVID-19. This qualitative research study identified and analytically compared social isolation, loneliness, and quality of health in African American older adults who are attending church virtually and in-person. Various aspects of perceived health, stress, anxiety, and relationships during COVID-19 were explored. Findings present

participant responses and thematic similarities and differences between in-person and virtual church attendees.

CHAPTER 5: DISCUSSION

Overview

Because of the COVID-19 pandemic and precautions taken to reduce the spread of the virus, many practices and social norms have been altered. In attempts to reduce the spread of COVID-19, a number of public places were shutdown to include restaurants, movie theaters, state buildings, and churches. During the COVID-19 pandemic, many churches transitioned to virtual options for viewing and attending church. The purpose of this research study is to qualitatively examine the lived experiences of older African American adults during the COVID-19 pandemic. As opposed to many historic research studies, this research analyzes social isolation and loneliness as two separate entities as opposed to measuring simultaneously. Social isolation was measured by one's current status of church attendance, and loneliness was measured by one's perceived quality of relationships. This qualitative research study explored older African Americans' levels of perceived loneliness, social isolation, and overall health who attend church virtually or in-person. The findings of this research study highlight patterns and themes of data, collected using semi-structured interviews. This chapter will present and discuss findings, along with meanings of findings, limitations, biblical foundations, and implications for future research.

Summary of Findings

The research findings of this qualitative study were derived from semi-structured, audio-recorded interviews, prompting dialogue related to individual experiences during the COVID-19 pandemic. These interviews were analyzed, and through the data analysis process, four main themes were created. The themes formulated from the data were: staying connected via

technology, life during COVID-19, sicknesses during COVID-19, and stress/anxiety during COVID-19.

Participants consisted of 20 individuals, men, and women who attended church virtually or in-person. All participants report church attendance at least one time per week, in-person attendees reporting 1.9 times on average and virtual attendees reporting 1.5 times each week. Participants shared that although they may have initially attended church virtually at the beginning of the COVID-19 pandemic, they have since transitioned to in-person. All participants reported in-person church attendance prior to COVID-19. Of the total participants, 14 reported currently attending church in-person and 6 reported attending church virtually.

Older African American adults' social connectedness was initially gauged by their current method of attending church. Social connectedness was assessed by asking the question "How do you keep in touch with friends from your church during the pandemic?" All participants reported maintaining contact during the COVID-19 pandemic by means of technology including, but not limited to, Facetime, video calls, text, phone calls, and Facebook.

Life during COVID-19 was described by older adults using words that reflected negative feelings. Words that appeared repeatedly when analyzing transcriptions were "isolating, harsh, hard, uneasy, scary, scared, lonesome, lonely, damper, uncertain, and tough." Participants shared the many changes that were brought on by COVID-19 and how these changes impacted their lives. These changes included social distancing, limiting social interactions, and wearing a face mask while in public in attempts to reduce the spread of COVID-19. Many responses reflected the difficulties of COVID-19, specially socially distancing and not safely having the opportunity to maintain face-to-face contact.

Sicknesses during the COVID-19 pandemic was another highlighted theme in participants' responses. Participants reported a variety of medical concerns and sickness during the COVID-19 pandemic, including the COVID-19 virus. Twelve of 20 participants reported being infected with the COVID-19 virus at least once. Nine of 12, or 75% of participants that reported being infected with the COVID-19 virus, reported in-person church attendance. Three of these 12 individuals reported having COVID-19 at least twice. 2/3, or approximately 67% of participants that reported being infected with the COVID-19 virus twice, also reported virtual church attendance. Sicknesses were also gauged by how often participants frequent their Primary Care Physician. Participants that currently attend church in-person, reported less frequent visits to their Primary Care Physician. Eleven of 14 in-person attendees reported annual visits. Two of 14 reported visiting their Primary Care Physician once every six months. One out of 14 in-person attendees reported visiting their Primary Care Physician once every three months. Participants that currently attend church virtually reported increased Primary Care Physician visits. One out of six reported annual attendance, while five of six participants reported attending once every three months.

Regular exercise routines, at least 30 minutes a week was reported by 16 of 20 participants. Of the 16 individuals who reported weekly exercise, 13 reported in-person church attendance. However, only 3 of 16 participants that reported at least 30 minutes of weekly exercise also reported virtual church attendance.

The data analysis process found stress and anxiety to be common amongst responses, as some form of stress and/or anxiety was reported by all participants of this study. Stress and anxiety was stated to be mostly directly or indirectly related to COVID-19. Participants reported stress that was related to finances, health of themselves, health of their families, and anxiety

related to the future as it relates to COVID-19. Financial stressors were stated but not frequently mentioned, as all participants are at least 65 years old and many are retired. Many older adults reported stress and anxiety that was caused by the uncertainty and constant worrying about the safety and health of themselves and their loved one. A common stressor and concern amongst various responses was the social disconnected from family and friends. Being away from their children, grandchildren, extended family and friends was reported to cause anxiety and worry amongst many older adults.

Discussion of Findings

Findings, throughout this section, will be highlighted and compared to previous research. Research findings' meanings will be explored, along with their likeness and variations as contrasted to previous research indications. These findings and their relations to biblical foundations previously discussed in Chapter 2 will also be presented.

Staying Connected via Technology

Religion, as it relates to attending an organized institution of faith, has been a pillar in the African American community for many years. African American older adults have been found to have the higher levels of religious involvement as compared to individuals younger and outside of their race (Chatters et al., 2020). With this dedication to religion and church affiliation, comes relationships and friendships within the church. Because of the COVID-19 pandemic, the dynamics of church and friendships within the church has shifted. Many older African American church-going adults have had to find new and innovative ways of maintaining relationships during the pandemic.

Technology was found to be a constant amongst participant responses when sharing how they were able to maintain relationships with friends from church during the COVID-19

pandemic. All participants reported communication being preserved with friends from church by using telephone and/or internet driven means to include Facetime, Facebook, text, phone calls, and group video apps. Although church participation and involvement were maintained by technology, individuals who solely attend church virtual reported less weekly church attendance/days of involvement. Findings also show that all participants reported the quality of their relationships to be healthy, using words that reflected positivity such as "encourage, good, hug, love, family, connection, and great." Previous research shows perceived social isolation to be a predictor of one's perceived level of loneliness (Seyfzadeh et al., 2019). However, this research study suggests that one's social isolation nor lack thereof does not a direct impact on one's perceived loneliness. This suggests that by communicating and interacting with others via technology, individuals do not feel alone and feel that the quality of their relationships have not decrease because of the reduction of face-to-face contact.

The use of technology not only supported participants in maintaining relationships with church members and friends but to attend services throughout the week and attend ministry meetings and church affiliated events. Church services, Bible study classes, Sunday school classes, and church affiliated ministry meetings were able to proceed digitally. Although many churches have reconvened to in-person services, many still offer virtual options as a safer alternative to worshipping in-person (Bryson et al., 2020). Because this may be society's "new normal", it is important to highlight the benefits of virtual church attendance, as well as it risks to health and overall well-being to older African American adults.

Life During COVID-19

Life during the COVID-19 pandemic was identified by all participants using words that reflect negativity to include: isolating, harsh, hard, uneasy, lonesome, and uncertain. Although

all participants reported experiencing hardships during the COVID-19 pandemic, they expressed that their relationships with friends at church had not deteriorated throughout the pandemic. This has been the importance of physically distancing rather than "social" distancing, as technology has afforded many the opportunity to maintain frequent contact. Therefore, whether individuals nurture relationships in-person or virtually, they are still fulfilling their social needs (Razai et al., 2020).

Sickness During COVID-19

African American older adults are at greater of becoming sick and have a higher rate of illnesses, as opposed to their counterparts. Race and age are two factors that place older African American adults at greater risk of having heart disease, hypertension, obesity, and diabetes. This concept of race and age contributing to health risks is referred to as "double jeopardy" (Chatters et al., 2020). Age, race, as well as social isolation are contributing factors of poor health and overall wellbeing. Social isolation has been found to be positively correlated to poor health in older adults, individuals reporting social isolation also reported poorer health conditions (Hammig, 2019). This research study shows that older adults who reported social isolation by attending church virtually, also reported more health concerns and sicknesses in the past year. In addition to more sicknesses in the past year, virtual church attendees also reported more Primary Care Physician attendance. This suggests that individuals who present social isolation also present more physical ailments and health concerns, needing more frequent medical care.

During the COVID-19 pandemic, older adults were identified as a "high risk" population, as their COVID-19 related mortality rates were greater than younger and/or middle-aged adults. This research's findings found that 12 of 20 participants were infected by the COVID-19 virus at least once, 40% of in-person attendees and 67% of virtual attendees. This finding contradicts the

theory of social isolation as a means to decrease the prevalence of the COVID-19 virus. However, this supports the theory of social isolation and poorer overall health being associated in older age. This finding leaves room for future research, as additional environmental factors could be further examined.

Virtual church-going participants in this study reported less weekly exercise as compared to in-person churchgoers. Three of six participants reported at least 30 mins of exercise per week, as 14 of 14 in-person church attendees reported at least 30 minutes of exercise each week. These findings are in alignment with Gyasi's 2019 study that identified a lack of physical mobility as a predictor of social isolation (Gyasi, 2019). Findings also show a correlation between lack of exercise and sicknesses amongst older African American adults. Individuals who reported not engaging in at least 30 minutes of exercise per week, reported an average of two sicknesses over the past year. This is a greater report of sickness as opposed to individuals who report at least 30 minutes of exercise per week, finding that these participants share an average of 1.25 sicknesses within the past year.

Stress and Anxiety During COVID-19

Stress and Anxiety During COVID-19 were highlighted as a key theme amongst participant responses, as all participants reported experiencing stress and anxiety during the pandemic. As stress and anxiety have been shown to be prevalent during the COVID-19 pandemic, religious and spiritual affiliation has been used as a coping technique to combat mental anguish and weariness (Luchetti et al., 2020). The vast majority of participants reported experiencing stress and anxiety that was related to COVID-19. Luchetti et al, (2020) suggest that stress and anxiety could be influenced by the display of COVID-19 cases and deaths presented via the local and national news and media.

Of the sample, 18 of 20 participants included in this study reported COVID-19 related stress and anxiety. Participants reported stress and anxiety that were ignited by worrying about the health of themselves and their family members. Many participants also reported experiencing stress and anxiety as a result of not being able to see their family members and go to places that they would generally frequent prior to the pandemic. Anxiety was also reported to be a constant amongst participants when they go into public places, worrying about when and if they'll contract the COVID-19 virus, and about the uncertainties of the future as it relates to COVID-19. Although everyone is at risk of psychological damage as a result of being physically isolated, minority groups and older adults are at higher risks. These individuals, who are considered to be more vulnerable to the negative psychological effects of social isolation, generally rely on social groups and systems that were likely halted because of COVID-19 (Usher et al., 2020). Because of this, it is imperative to resume social attendance in attempts to reduce psychological deficits to include increase stress and anxiety.

Biblical Foundations

The findings of this study are confirmed by its biblical foundations. The Bible suggests, in multiple passages, that there are benefits of the relationship and social connectedness. The research shows us some of the benefits in less Primary Care Physician attendance, more weekly exercise, greater involvement in church-affiliated events/activities, and less reported sicknesses. The Bible highlights the benefits of staying connected in the book of Ecclesiastes and states

> Two are better than one, because they have a good return for their labor: If either of them falls down, one can help the other up. But pity anyone who falls and has no one to help them up. Also, if two lie down together, they will keep warm. But how can one keep warm alone? Though one may be overpowered, two can

> defend themselves. A cord of three strands is not quickly broken. (*New International Version*, 1978, Ecclesiastes 4:9-12).

It is important for believers to not only maintain social connectedness but to maintain relationships with other believers. By attending church in-person, people are able to establish and cultivate a relationship with fellow believers of Christ.

> Oh, the joys of those who do not follow the advice of the wicked, or stand around with sinners, or join in with mockers. But they delight in the law of the LORD, meditating on it day and night. (*New International Version*, 1978, Ecclesiastes Psalms1:1-2).

This study's findings hope to highlight the experiences of older African American adults during the COVID-19 pandemic. By presenting the benefits of reducing social isolation by attending church in-person, it is anticipated that older African American adults are encouraged to resume in-person church attendance. I am hopeful that older adults we be encouraged to use technology as a means of maintaining communication and staying involved in church activities, as well as establishing and sustaining relationships within the church. The correlations between isolation and health should be considered in the lives of older adults when making day-to-day decisions, such as exercise and frequency of church attendance. It is imperative not to discard the population of older adults but to find ways to improve their lives as they age, "Do not cast me away when I am old; do not forsake me when my strength is gone" (*New International Version*, 1978, Psalm 71:9). God's requirements and teachings of the Bible should motivate individuals to live a life that is pleasing to God by staying connected with believers, even in an

unprecedented time such as the COVID-19 pandemic. "For where two or three gather in my name, there am I with them" (*New International Version*, 1978, Matthew 18:20).

Implications

Limited research has been conducted to explore the lives of older adults during the COVID-19 pandemic, as researchers and society are still working to understand the complexities of the virus and its current impact, as well as future consequences. This research study builds on existing research by sharing the lived experiences of older African Americans, specifically during the COVID-19 pandemic. By understanding the significance of social comradeship and connectedness, individuals are anticipated to be more likely to make deliberate decisions and intentional strides to avoid social isolation. The analysis of this data shows the perceived levels of loneliness and health during the unconventional times of the COVID-19 pandemic. By identifying social isolation in older adults, intervention can take place by organizations such as medical offices and churches to reduce and/or eliminate social isolation by encouraging older adults to engage in social activities virtually or in-person. Local and federal policymakers could also be influenced to create programs that afford older adults the ability to easily and affordably access or retain technological devices.

This research study's findings show the benefits of technology as it relates to loneliness, as all participants reported positive relationships and described their relationships using positive words, suggesting good quality relationships. This implies that there are benefits to technology use during the COVID-19 pandemic amongst older adults. However, by maintaining connectedness via technology, has no significant impact on one's perceived loneliness. Theoretically, this varies from a large portion of previous research which suggests that an individual's perceived loneliness is directly affected by one's social isolation.

Social connectedness maintained through means of technology are reported to be less advantageous than in-person social interactions, as related to health. Social isolation is associated with sickness, increased primary care physician attendance, and poorer exercise habits. Because of this, the use of technological communications could be supported and encouraged by all during the pandemic.

Limitations

Limitations of the research study are important to mention, as they can influence and/ or impact future research. As opposed to previously conducted studies, involving older adults, I recruited participants via social media, by using a Facebook poll. This is limiting to research as it neglects older adults that are considered "severely isolated" and do not have easily accessible internet and/or technology.

Also, this research study targeted a very specific community, using convenience sampling techniques, African American older adults that are at least 65 years old and also attend church. This can be limiting to research by reducing its generalizability to society, as this only accounts for a small percentage of the population.

Additionally, by having participants self-report their experiences, there is a greater chance to gauge subjective factors. This is beneficial as it allows the researcher to explore and understand concepts and feelings that may not be explored by close-ended and/or objective questioning. However, self-report could also result in inaccurate and/or under-exaggerated or over-exaggerated feelings and experiences, potentially skewing collected data.

Recommendations for Future Research

Although this research's conclusions were able to add significant findings to the field of study, there are recommendations to consider for future research projects. The demographics of

this research consisted of 13 women and 7 men. Therefore, it may be advantageous to distribute the sample selection of participants, as it could lead to different outcomes with gender being a variable of research. Additionally, implementing a variety of data collection techniques to include forms that may offer anonymity may be beneficial to research.

Another recommendation for future research studies is to potentially focus on a population of participants that only attend virtually, as well as participants of varying ethnicities. By changing these variables, research findings may be more generalizable for the public, and more applicable to a broad range of individuals during the COVID-19 pandemic.

Summary

Older adults are found to be a sector of the population who are most at risk of social isolation and loneliness. As social isolation and loneliness continue to be negative consequences for older adults, it has increased because of the COVID-19 pandemic. The COVID-19 pandemic has altered the way people engage in social activities, even eliminating them in the lives of many. In attempts to reduce the spread of the COVID-19 pandemic, people have had to apply techniques of physical distancing and quarantining if exposed to the virus. This research study highlights the lived experiences of African American older adults during the COVID-19 pandemic and how their health, psychological well-being and relationships were impacted by their levels of social isolation.

The lived experiences of older African American adults during COVID-19 were featured in this research study. The data collected and its analyses prove the benefits of technology and resuming social connectedness by means of in-person church attendance. All individuals involved reported technology use as a means of staying connected to the church, also reported no feelings of perceived loneliness. Positive perceptions of friendships and relationships in the

church were sustained by the use of technological devices and digital platforms during the COVID-19 pandemic. Older adults who reported attending church virtually, report more negative perceptions of overall health concerns, increased doctor attendance and decreased physical exercise. By investigating older adults during the COVID-19 pandemic, it is possible to have a better understanding of older adults' lived experiences and generate interventions to afford them meaningful and valuable lives. It is my hope that this research study inspires others to develop and utilize ways of aiding older adults and enhancing their lives by reducing social isolation and loneliness.

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APPENDIX A: RECRUITMENT FORM

Dear [Recipient]:

My name is Kinea Adkins. As a doctoral student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a Social Psychology Doctoral degree. The purpose of my research is to identify social isolation based on virtual or in-person church attendance and understand perceived loneliness and quality of health in older African American adults. This research will qualitatively collect and analyze data through semi-structured interviews in attempts to get a better understanding of subjective, personal feelings of loneliness and overall health during the COVID-19 pandemic, and if you meet my participant criteria and are interested, I would like to invite you to join my study.

Participants must be African American, attend church virtually or in-person and at least 65 years of age. Participants that meet criteria, if willing, will be asked to engage in a telephonic interview. It should take approximately 20 minutes to complete the telephonic interview process. Participation will be completely anonymous, and no personal, identifying information will be collected. Pseudonyms will be used to maintain anonymity.

Would you like to participate? [Yes] Great can we set up a time for an interview? [No] I understand. Thank you for your time. [Conclude the conversation.]

A consent document will be given to you at the time of the interview. The consent document contains additional information about my research. Because participation is anonymous, you do not need to sign and return the consent document unless you would prefer to do so.

Thank you for your time. Do you have any questions?

Sincerely,

Kinea Adkins
Doctoral Student

APPENDIX B: INFORMED CONSENT LETTER

Title of the Project: Social Isolation and Loneliness in Older African American Adults During COVID-19

Principal Investigator: Kinea Adkins, Doctoral Student, Liberty University

You are invited to participate in a research study. To participate, you must be African American, at least 65 years old and attend church virtually or in-person. Participants will be excluded from the study if they report any diagnoses that impedes on memory, cognitive functioning and/or recall such as, but not limited to, Alzheimer's Disease, Mild Cognitive Impairment, or Vascular Dementia. Taking part in this research project is voluntary. Please take time to read this entire form and ask questions before deciding whether to take part in this research.

The purpose of the study is the purpose of my research is to identify social isolation based on virtual or in-person church attendance and understand perceived loneliness and perceived quality of overall health in older African American adults.

If you agree to be in this study, I will ask you to do the following things:

> Set up a date and time for a telephonic interview. This telephonic interview will take approximately 20-35 minutes to complete. Interview will be audio recorded and transcribed for analysis. Identifying information such as name and church affiliation will not be used in order to maintain participant anonymity.

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include gaining a better understanding of subjective, personal feelings of loneliness and overall health during the COVID-19 pandemic, as it related to social isolation and church attendance.

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records. Participant responses will be anonymous. Participant responses will be kept confidential through the use of pseudonyms. Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted. Interviews will be audio recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

Participants will not be compensated for participating in this study.

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.
.
If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

The researcher conducting this study is Kinea Adkins. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at (XXX)XXX-XXX or email. You may also contact the researcher's faculty sponsor, Dr. Margaret Gopaul, at mgopaul@liberty.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.

_____

Printed Subject Name

_____

Signature & Date

APPENDIX C: INTERVIEW

Interview prompts consisted of questions to include:

“Are you currently attending church in-person or virtually?”

“How often do you go to church per week? Has this increased, decreased, or maintained the same since COVID-19?”

“What were you involved in, at church, before COVID-19?”/ “What are you involved in now?”

“How many friends do you have at church?”

“How would you describe your friendships within the church?”

“How do you keep in touch with friends from your church during the pandemic?”

“Do you communicate with friends from church more or less since the COVID-19 pandemic?”

“What has life been like for you during the COVID-19 pandemic?”

“Do you engage in at least 30 minutes of exercise per week?” Why or why not

“Have you experienced any sicknesses in the past year?

“When it comes to your health, what are you most concerned about?"

“During the COVID-19 pandemic, in what ways have you experienced stress and anxiety?”

“How often do you visit your Primary Care Physician? Has it increased or decreased since the COVID-19 pandemic, and why?

“How would you describe your current overall health?”

Optional Questions- resources will be provided upon interest/request

“Are you interested in seeking services with a local agency for grief counseling?”

“Are you interested in any face-to-face or virtual individual outpatient therapy?”

TABLE 1: THEME DEVELOPMENT

Table 1

Theme Development

Themes	Participant Quotes
Staying Connected via Technology	"We FaceTimed each other, we did video chats, and we texted each other. And we called." "… through phone calls or Facebook." "Well, we had a church service over the phone, telephone. Then I would call them from time to time, like on birthdays and stuff like that." "Basically, phone call, just check just to say, 'Are you okay? You need anything?' Or just carrying on conversation on the phone, three way phone or whatever" "…having Bible study on the group video calls"
Life During COVID-19	*"*It was very isolating. It was very lone sometimes, and it just put a damper on my social life." *"*I think the main thing with COVID was not being able to be with your family more so anybody else. But I thank God for the ways that He allowed it so that we could communicate." "Since the COVID 19, it's been scary. It's been scary because sometimes you're scared to go... You're scared to leave home to go anywhere." "…it limited my going to different places and it limited your contact with people. You couldn't visit your neighbors like you wanted to because of the pandemic." "In general, life was hard because you didn't get to see anybody. You didn't get to see your family, your friends, your church members, or whatever. And to me, life was hard during the pandemic."
Sicknesses During COVID-19	*"Just COVID-19"* *"*I've had cancer surgery. I had a blood clot removed. I had surgery to my neck, chemotherapy, and just a bunch of tasks that I've had done and more to be done.*"*

	*"*I had the COVID in the past year, and I had COVID again.*"* *"*I was having issues with my gallbladder. I had to have that done. And that was basically the only illness that I had." "Well, I had COVID twice, and other than that, really no sickness."
COVID-19 Related Stress & Anxiety	"The only stressful part about it was that I could not get out and visit other people. And it just put a damper on your mind. Let's see, the lack of the happiness that you could have engaged in if it weren't for COVID, dealing with other people on a one on one basis. "The stress was the fact of being sick." "Having members of my family and myself in the mix of COVID" "you get stressed out because you couldn't be with your family and your friends. It was stressful. Basically, it was hard.

FIGURE 1: PARTICIPANT RESPONSES

Table 1
Participant Responses

Participant	**Virtual/ In-person**	**Exercise At Least 30 mins per week**	**Church Per Week**	**PCP Attendance**	**Sickness in Past Year**
Pat	In-person	YES	3	Annually	1
Lily	In-person	YES	1	Every 3 months	1
Jane	In-person	YES	2	Annually	2
Lucy	Virtual	YES	2	Every 3 months	6
Lacey	Virtual	NO	2	Every 3 months	3
Lory	In-person	YES	3	Every 6 months	2
Jinny	Virtual	YES	1	Annually	2
Albert	In-person	YES	3	Annually	1
Daniel	In-person	YES	3	Annually	0
Kenny	In-person	YES	2	Annually	0
Rhonda	In-person	YES	2	Annually	1
Jill	In-person	YES	1	Annually	0
Mary	Virtual	YES	2	Every 3 months	1
Linda	Virtual	NO	1	Every 3 months	2
Robert	In-person	YES	1	Annually	1
Rick	In-person	NO	1	Annually	1
Tim	In-person	YES	1	Every 6 months	1
Kimberly	In-person	YES	1	Annually	0
Brenda	Virtual	NO	1	Every 3 months	2
David	In-person	YES	2	Annually	1