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Activities That Promote Wellness for Older Adults in Rural Communities

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Abstract: Growing interest in healthier aging coincides with the comprehensive whole person wellness model that includes physical, emotional, spiritual, intellectual, occupational, and social dimensions. The study reported here examined current activities for older adults in rural community centers via a mail survey sent to the directors of Oklahoma community centers. To follow up, site visits to the centers and interviews with the directors were conducted. Findings indicated that 16% of the centers offered activities for all six dimensions and that older adults generated many activities. To accommodate activities in a rural community center, programs for these diverse activities must be addressed.

Introduction

Older adults are the fastest growing U.S. population sector. Growing interest in healthier aging coincides with the comprehensive whole person wellness model. This model includes six dimensions: physical, emotional, spiritual, intellectual, occupational, and social. Positive outcomes for older adults include more than physical independence. They include the ability to function and remain active in the individual's setting of choice. In this context, community centers play an important role in how older adults interact in the community around them.

Research suggests that communities are not always designed to provide for older adults' needs to remain active and socially connected (Kochera & Bright, 2006). However, community centers that integrate the six dimensions of wellness will maintain a healthier older adult segment. Therefore, providing programs that are attractive to and serve older adults will foster additional opportunities for wellness.

The elderly should be a priority for the Cooperative Extension Service now and in the future. People in the U.S. today can anticipate living beyond 70, continuing to enjoy an extended and productive life. If social and psychological wellness is to accompany physical vitality in old age, we need to recognize education's potential contributions toward wellness (Weber & Johnson, 1989). Therefore, what are the implications for

Extension and its efforts to strengthen the wellness of older adults? How can Extension determine and then respond to the needs and interests of older people in rural communities?

The purpose of the study reported here was to examine community centers' current activities that contribute to the six dimensions of wellness for rural older adults. Knowing the current status provides information to integrate activities that promote wellness for older adults within rural community centers, and this information can be applied in Extension programming.

Six Dimensions of Wellness Model

As the size of the older population increases, health care experts debate whether older Americans will live longer and healthier or live longer but experience periods of chronic illness and disability. Proponents of the live longer and healthier model cite research that indicates older people have increased knowledge and awareness about the importance of health management (Montague & Stanley, 1998).

The desire for optimal health as we age, to be functionally able for as long as possible, has older adults embracing the concepts of wellness as a leading model of health management. This model incorporates a holistic perspective that integrates the six dimensions of wellness (Montague & Stanley, 1998). For the purpose of the study, the definition by Bill Hettler, Executive Director of the National Wellness Institute in 1979, has been selected as the working definition of wellness. Each dimension is explained more thoroughly below.

Physical wellness: recognizes the need for regular physical activity. Physical development encourages learning about diet and nutrition, while discouraging the use of tobacco, drugs, and excessive alcohol consumption.

Emotional wellness: recognizes awareness and acceptance of one's feelings. The ability to form interdependent relationships with others based upon mutual commitment, trust, and respect is a critical component of emotional wellness.

Spiritual wellness: recognizes our search for meaning and purpose in our human existence. Wellness is characterized by a peaceful harmony between internal personal feelings and emotions through life and measuring those against the value system that one adopts.

Intellectual wellness: recognizes one's creative stimulating mental activities. A well person expands their knowledge and skills throughout their life.

Occupational wellness: recognizes personal satisfaction and enrichment in one's life through work. The ability to contribute to one's work that is personally rewarding is a key element of occupational wellness.

Social wellness: encourages contributing to one's environment and community. Social wellness supports making healthy living choices, initiating better communication with others, and building a better world for everyone.

Rural Community Centers

As Americans age, community-minded organizations and individuals must closely scrutinize how communities are structured and how healthcare and social service systems respond to the needs of older Americans. Establishment and promotion of senior citizen centers has been an integral part of the Older

Americans Act of 1965, which enabled the federal Administration on Aging, as well as state units on Aging and local Area Agencies on Aging, to plan, implement, and monitor the development of services and support for the nation's aging population (Turner, 2003).

Senior centers are community facilities for the organization and delivery of a broad spectrum of services, including health, mental health, social, nutrition, and educational services and recreational activities for older individuals (Turner, 2003). Some centers serve as focal points to provide information and assistance services and to house their services in the same location (collocation) used by other providers of services to seniors.

Centers are especially critical in rural states like Oklahoma, where 57% of the population lives outside urban areas. In rural communities, the absence of other senior services often leaves senior centers as the only service, information, and referral point for seniors. Specific factors that should be examined include whether current systems meet the demands of rural citizens, which demands the systems meet, and how these systems meet current demands while preparing for the massive growth of older adults expected in the future (Beverly, Mcatee, Costello, Chernoff, & Casteel, 2005). Rural senior centers need to have all the necessary tools to serve their communities in the future.

Methods

Directors of community centers were surveyed to examine current activities of the six dimensions of wellness for older adults in rural community centers. Follow-up site visits to community centers and interviews with the directors of the centers were conducted.

The population of the study was rural community centers. A convenience sample was obtained from the directory of Oklahoma community centers. Data was collected via a mail survey sent to the directors of these centers. The survey questionnaire began with an explanation of each of the six dimensions of wellness and then was comprised of open-ended questions. To obtain a high response rate, an initial mailing, followed by a second mailing after 2 weeks, and a third reminder mailing to complete the survey were sent.

For the analysis of data, lengthy answers were reduced and sorted into specific response categories through a coding process. Descriptive statistics were employed to summarize the data, focusing on frequency and percentage of activities offered in community centers. To gain additional information about activities and services offered, follow-up site visits to community centers and interviews with the directors were conducted and content analysis was performed.

Results and Discussion

The questionnaire was sent to 259 community center directors; 90 returned their questionnaires, which provided a response rate of 34.7%. Findings indicated that 16% of the centers offered activities for all six dimensions. Activities addressed, in decreasing order, were social, physical, spiritual, intellectual, occupational, and emotional needs.

Activities for the social dimension were offered in 87% of the centers. Respondents indicated that games, such as bingo, dominos, cards, and puzzles, and parties/gatherings for family and friends were frequent social activities aimed at creating and maintaining healthy relationships.

Activities for the physical dimension were offered in 85% of the centers. Activities for the physical dimension were the most diverse, consisting of a variety of individual and group exercises focused on muscle strength and endurance, flexibility, coordination, and balance. The most frequent activity was the use of

exercise equipment such as treadmills. Other exercise included walking, dancing, video exercise, aerobics, and bicycling.

Spiritual activities were offered in 61% of community centers. These activities were more personal than others and included prayers for meals and bible reading. Activities for the intellectual dimension were offered in 55% of community centers. The most frequent activity was participating in education programs (computers, word seek, storytelling, autobiographies, trips, library, and training). Activities that contribute to occupational and emotional wellness were less frequently identified. Occupational activities were offered in 37% of community centers, while activities for the emotional dimension were offered in only 31% of centers.

It was also observed that not only does each dimension contribute to overall wellness, but that individual dimensions interact with one another. For example, in addition to games serving the social dimension, they also serve as intellectual activities that encourage individuals to expand knowledge and skill, occupational activities that promote positive attitudes toward personal and professional development, and emotional activities that help seniors maintain confidence in managing their physical and emotional health.

Site visits to community centers and interviews with directors of the centers were conducted to gain additional information. Approximately 25-100 older adults use centers in their communities, depending on population size. The average age of the user is approximately 75. Transportation to the center is typically by the user, though many carpools within their community and some larger centers will pick up residents in a small minivan, etc.

Many of the centers serve as a meal site, providing an average of 25-30 meals per day onsite and a varying number of meals delivered within the community. The centers receive financial support from the Department of Human Services, which is administered through the Area Agencies on Aging. Directors are typically hired into their positions by the centers. Many do not have formal training as a center director; the role is considered more of a volunteer position in the community. Many of the smaller centers do not have additional staff, such as a secretary or other support staff.

Activities in the centers vary due to the type of older adults using the facility, and many of the activities are generated by the users of the centers. Even with the community centers' established programs in place, older adults will augment these with interests of their own as needed. As many of the centers serve as a meal site, most do not currently provide established programs for wellness of rural older adults. For example, activities for the social dimension were most frequently and diversely offered, but the activities were often not professionally organized activities. Instead, the activities included conversing with friends, church groups, and other social activities.

Researchers observed the need for educational opportunities for rural older adults for better, fuller, more productive lives. It is ironic that stereotypes of older rural adults often represent symptoms of significant and treatable illnesses, such as depression, that lead to an imbalance in their emotional wellness. Instead of relying on a single isolated response from the community center, Cooperative Extension can develop widespread programs to address emotional wellness in rural communities, such as programs for detecting depression and improving mental health.

Conclusion

The comprehensive whole person wellness model that includes wellness dimensions needs to be addressed fully in rural community centers for older adults. Activities for the occupational and emotional dimensions were offered less frequently in community centers, while activities for the social dimension were most frequently and diversely offered. Additionally, many of the activities were generated by users of the

community centers.

Extension educational materials can be developed to educate community centers on the whole person wellness model, as well as on occupational and emotional wellness programs. The programs developed by Extension will be helpful for directors and staffs in rural community centers who might be limited by time and resources. In pursuit of a more efficient use of limited resources to meet the growing demand, diverse programs that can contribute to several dimensions of wellness should be investigated. Also, the programs should address diverse needs, which include individual and small or large group activities. The whole person model can be achieved through diverse activities for each dimension. Therefore, Cooperative Extension can make a significant impact on improving wellness initiatives in this country by developing extensive programs to accommodate activities in rural community centers.

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