FUNCTIONAL ASSESSMENT AND COPING BEHAVIORS AMONG THE RURAL BLACK ELDERLY

By

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The problem of this research was to determine the reliability and validity of the Functional Assessment Inventory (FAI) for measuring the functionality of the rural black elderly. Additionally, the coping behaviors of the rural black elderly were examined in depth in order to assess the impact of coping behaviors upon maintenance of lifestyle in this group.

Research was conducted from 1981 to 1984 among rural elderly residents living independently in their communities in Alachua County, Florida. Fifty-four elderly persons, black and white were recruited through the snowball sampling procedure to participate in the Functional Assessment phase of the study. Subsequently, the black elderly persons

participated in an in depth examination of coping behaviors.

Determination of the reliability and validity of the Functional Assessment Inventory (FAI) were determined through a retrospective blind design. Results showed that the FAI was reliable but had low concurrent validity when compared to other measures of functionality.

The black elderly scored higher on the FAI than their white counterparts. Scores of 17 or more on the FAI are believed to indicate possible need of institutionalization and many of this sample were in this category. However, these black elderly, their FAI scores notwithstanding, were not in need of institutionalization. The high scores of the black elderly are attributable to the language of the instrument often not being understood and standardization procedures prohibit adaptation of the language to their education and culture.

The nutritional and health status of these elderly subjects was assessed through interviews, clinical examinations and biochemical measures. Coping behaviors of the black elderly subsample were examined to determine how they obtained the necessary nutrition and medical care. Coping behaviors were assessed through use of a questionnaire and by participant observation. Results showed that the black elderly have made adaptive adjustments to their cultural milieu which includes rural living, poverty and lack of transportation.

CHAPTER ONE
ANTHROPOLOGICAL INTERESTS IN GERONTOLOGICAL ISSUES

Problem and Theoretical Orientation

The focus of this study was to determine the reliability and validity of the Functional Assessment Inventory (FAI) and to ascertain functional capacities in the activities of daily living, to examine the utilization of informal social contacts as these relate to the maintenance of lifestyle, and coping behaviors of rural black elderly. Behaviors may be viewed as responses to the practical problems of life in conjunction with the person's perception of these phenomena. The survival mechanisms of the rural black elderly will be examined in the literature review which follows.

Literature Review

Rural Environment and the Elderly

The process of urbanization of American society has been rapid since the beginning of the 20th century but many elderly people continue to reside in rural areas (non-Standard Metropolitan Statistical Areas as defined by the Bureau of Census). At the present time it is estimated that

31 percent of the elderly people in this country continue to live in rural areas; they constitute 44 percent of the elderly poor but they receive only 18 percent of the federal monies designated to meet the needs of the elderly poor (Rural America Factsheet 1978). The disproportionate distribution of money for the elderly poor in this country as a whole is even more disproportionate in the South where 59 percent of the black elderly reside (Watson 1983).

The rural elderly are not only disadvantaged by the inequity of governmental services. Rural residence places constraints upon the individual in terms of the availability of health care services, access to food stores, employment opportunities and the ability to maintain social ties with family and friends. Additionally, rural living for the elderly people may place them in a uniquely vulnerable position due to their reduced physical capacities.

The incidence of poverty is reported to be greater in the rural areas than in the urban environment (Ansello 1980; Carp 1976; Hooyman 1980; McKinney and Bourque 1971). In 1976, the average monthly Social Security payment for a rural elderly person was $176 as compared to $203 for an urban elderly person (Rural America Factsheet 1978). A study that I conducted in Alachua County, Florida, in 1981, showed that incomes of less than $4,000 a year were typical for the rural elderly. This was $2,000 a year less than the incomes of their urban counterparts.

Efforts of the rural elderly to maintain community and social ties as well as to meet nutritional and health care needs may be seriously impeded by lack of transportation. It was observed by Patton (1975) that many of the rural elderly are widows who have never driven and now experience frequent transportation needs. Furthermore, problems with vision, arthritic conditions and inability to finance the cost of maintaining and operating a vehicle will prevent the older person from driving.

Research investigating the quantity and quality of family interaction comparing rural and urban elderly persons has not yielded consistent results. Heltsley and Powers (1975) suggest that the satisfaction of older persons from interactions with both their children and their peers was not affected by environmental setting (i.e. rural/urban). Hynson (1975) also found that satisfaction with family relations was not related to rural/urban residence, although he reported that the rural elderly were more satisfied than the urban elderly with their community, expressed greater general satisfaction and less fear. Matthews (1965), however, suggests that rural elderly people are becoming more isolated from social contacts and less assimilated into the larger society than their urban counterparts.

Lack of transportation may also be one reason that the elderly do not participate in Western medicine to the extent of other segments of the society. However, other studies have shown that rural elderly people perceive that doctors

are not interested in their problems and that their folkways are considered in a pejorative way by the medical establishment (Hill 1976; Murphree and Barrow 1970; Reynolds, Banks, and Murphree 1976). Other factors which may relate to this lack of utilization of medical services are poverty and lack of satisfaction regarding interactions with medical personnel.

Some researchers have also suggested that the rural elderly do not utilize services to the extent to which they are available. Such services include food stamps and Security Supplemental Income (SSI). This has been attributed to the rural elderly's intense feelings of pride and independence, as well as to their viewing these programs as welfare (Ansello 1980; Moen 1981; Steinhauer 1980). These constraints, in conjunction with incomprehensible paperwork, long waiting periods and high rates of illiteracy in this population seem to preclude this group from using programs that might provide assistance.

In summary, rural residence seems to place the elderly in a more precarious position than their urban counterparts and thus in greater need of programs and service plans designed to incorporate the differing needs and value orientation of this group.

Black Elderly

The black elderly (i.e. aged 60 or over) were 11.7 percent (26.5m) of the total U.S. population in 1980; 7.9

percent of the 65 and over age group nationally and 22 percent (N=3326) of the 60 and over age group in Alachua County (Bureau of Census 1980). Nationally, one-third of all black elderly continue to live in rural areas (Hill 1976) with a higher proportion in the South than in any other section of the country (Watson 1983). This population density presents a unique opportunity to examine the functional capacities and lifestyle of this group. However, an understanding of this group is incomplete without an awareness of the living conditions experienced by the black population as a whole.

Prior to 1910, 90 percent of all blacks lived in the South. After World War I, however, a decline in the agricultural economy of the South resulted in many blacks' moving to the North in search of industrial jobs. By 1940, the proportion of blacks living in the South was down to 77 percent, dropping to 53 percent in 1970. No change was seen in this proportion in the decade between 1970 and 1980 as more blacks began moving back into the South compared to those moving out. This reverse migration, however, did not mean a return to a rural life but to residence in the urban areas. By 1980, 85 percent of blacks lived in urban areas compared to 71 percent of whites (Reid 1982).

Return to the South, however, has not meant an increase in employment. Black unemployment remains about twice that of whites. In October, 1982, unemployment in the U.S. reached 10.4 percent, the highest point since the Depression.

It was 20.2 percent among blacks and 46.7 percent for black teenagers compared to 21.7 percent for white teenagers (Reid 1982).

In addition to disparity in employment rates, major differences were seen in median incomes during the decade of the 1970s between the black and white populations. Median incomes had increased for blacks during the 1970s to 61 percent of the median income of the whites but since that time the income gap between black and white families has widened again. In 1981, the median income for a black family was $13,266 (56 percent) compared to $23,517 for white families (Reid 1982).

As a result of widespread unemployment and lower incomes, the incidence of poverty increased in the black family. Persons below the poverty threshold as defined by the Bureau of Census in 1981 included 34 percent of all black individuals compared to 11 percent of all white persons (Reid 1982).

This economic adversity has not resulted in a decline in the fertility rate for black females. In fact, there has been a rapid growth of the black population in all the years between 1790 and 1980 and fertility rates have been higher for black females than for white females since the keeping of records was begun in 1920. While fertility rates have hovered around 1.8 births for white females since 1979, the rate has been 2.3 for black females.

At this same time, the percentage of one-parent black families has risen from 20.6 percent in 1960 to 44.1 percent in 1980. The proportion of children born to single mothers has increased from 37.6 percent for blacks in 1970 as compared to 5.7 percent for whites to 55.3 percent in blacks and 11.0 percent in whites in 1980.

The role of kin in maintaining the lifestyle of black families has been the focus of several studies. McAdoo (1979) states that "turning of one's back" on poorer family members may be a prerequisite for those blacks moving into a middle class society. Stack (1975) found that poor and working class blacks maintain close networks and are helped substantially by kin. Other studies have shown that the black family is twice as likely as the white family (14 percent versus 7 percent) to include extended family members, especially grandmothers (Reid 1982).

With this overview of the U.S. black social and economic situation, it is now possible to focus specifically on the lifestyle of the black elderly.

Robert Butler, former director of the National Institute of Aging, stated that "to be old is bad enough: to be old and not white is even more terrible" (1975, p.30). The black elderly enter the stage of old age with fewer resources than their white counterparts; possessing fewer assets, victims of a lifetime of social and economic disadvantages (Sheppard 1978) and deprived of access, availability and support services available to the rest of society (Dancy

1977). However, Gibson (1983) viewed these adversities as contributing to better coping skills in the black person during old age. She stated that the black elderly "arrive at the penultimate transition--old age--more fortified, more rehearsed, and better able to adapt to its exigencies, despite fewer economic and social resources" (p.2).

This fortification observed by Gibson may be explained by religiosity or locus of control. Antonovsky (1979) has defined locus of control as a belief that there is someone or something in control of one's life. The black elderly seem to have found this locus of control in religion. Dancy (1977) stated:

> A strong orientation toward religion and the black church is a cultural attribute which holds a great deal of importance in the lives of the black elderly. The black elderly have needed a frame of reference to enable them to cope with the oppressive forces of racial discrimination, and for many this frame of reference is religion (p.22).

Watson (1983) and Tate (1983) also found that ability to adjust to stressful situations in the lives of black elderly people was attributable to their degree of religiousness. A strong belief in an omnipotent and loving God will not get them to the grocery store but perhaps makes the inability to go more bearable. However, it is possible that the black elderly generally have better coping mechanisms since they have always had to make out with fewer resources and perhaps have different expectations.

The utilization of kinship ties to cope with old age has traditionally been described as a characteristic of the black elderly. Recent studies have found that, contrary to popular belief, the older black person is not living in an extended family setting but is living alone and is not exchanging monetary resources with other family members (Gibson 1983; Gibbs 1982). However, black elderly are more likely than their white counterparts to have young children living with them. Hill (1978) stated that two-fifths of black women over the age of 60 had children living with them compared to one-tenth of elderly white women.

Whether single or married, elderly black men and women have incomes only two-thirds those of their white counterparts. Additionally, the median income of elderly blacks is significantly lower than the level that the government has defined as providing a minimum standard of living. In 1976, the Bureau of Labor Statistics lower budget standard for a retired couple was $4,695. Only 17 percent of whites were below this level but 37 percent of the blacks were in this category (Hill 1978). In 1980, these figures had decreased to 13 percent of the white elderly but had increased to 38 percent in the black elderly population (Watson 1983). The percentages are even worse for the elderly black female living alone; 60 percent of this group are living in poverty (Chunn 1978). In my previous study of Alachua County elderly (Nickens 1981), I found that 89 percent of the black females, 73 percent of the black males, 50 percent of white

females and 23 percent of white males had incomes below the poverty level.

Poverty most likely has an impact on findings of life satisfaction in this population. The 1974 Harris Survey, conducted by the National Council on Aging, found that the elderly whites scored higher (58.2 percent) on life satisfaction scales than the black elderly (41.3 percent) (Register 1982). Phillips and Usui (1981) found statistically significant differences on scores of life satisfaction between black and white elderly. The black elderly scored an average of three-fifths of a point lower that the white elderly on a thirteen item life satisfaction scale.

In general, black elderly people express satisfaction with their life at the present time and do not perceive it as being more precarious that life at earlier times (Robertson 1981; Gibson 1983). Explanations for this phenomenon may be seen as resulting from a lifetime of unfavorable working conditions and the presence of a steady, albeit meager, income at the present time.

Another factor which may influence life satisfaction may be degree of interaction with family and friends -- relationships that could provide emotional and material support for the older person. Unfortunately, research shows that black elderly get no more satisfaction from these kinds of ties than do white people. Jackson, (1971) compared black elderly people who had been employed in both manual and nonmanual jobs with the amount of instrumental aid and

affectional relationships between these people and their offspring. She found that parents employed in nonmanual jobs (the least needy!) were most likely to receive aid and that their daughters were most likely to be the givers. These high income black elderly, however, scored lower on life satisfaction than high income whites (Jackson 1978). Jackson stated that this may be attributable to heightened expectations not fully recognized or unwillingness to accept the subordinate status of old age. Furthermore, Robertson (1981), in a study of reported frequency of interaction with kin among rural black elderly people in Missouri, found less frequent interaction than was expected. Huling (1978), in fact, states that it is a myth that blacks "take care of" their elderly even though he does concede that "a reciprocal helping" relationship is a frequent pattern.

If black families are not caring for their elderly, perhaps friends are providing important assistance. The research that has been done suggests otherwise, but data are scarce on this subject. Sterne et al. (1974) suggest that friendships of the black elderly may not involve the interpersonal intimacy and the resulting role supports necessary for sustaining morale. Studies that have examined the role of friends and family in the black population have not typically included the black elderly and hence shed little light on this question (Stack 1974; Jerome 1980; Kennedy 1980).

Whereas the role of family and friends in maintaining morale in the black elderly may have been inadequately examined, studies in the elderly population as a whole have found the role of friends to be more important in maintaining morale than the interaction with family. Bell (1981) states that "it is peer friendship, not filial relationships, that basically determine morale in old age" (p.181). Additionally, Woods and Robertson (1978) found no positive relationship between frequency of contact with their children and higher morale in elderly people. They suggest the possibility that frequent contact and assistance between elderly people and their children may be "largely ritualistic, based on obligation which is devoid of warmth and closeness" (p.369). If this is true, morale as well as treatment of the elderly may be affected.

Studies of other cultures have shown that the treatment of elderly people within a society is not necessarily the same as that received by other members of the group (Simmons 1945). Societies under stress may employ various means of dealing with members deemed unproductive (i.e. aged). A holocultural analysis of treatment using the Human Relations Area Files (HRAF) showed that 84 percent of all societies for which there were data concerning the treatment of the aged had some form of non-supportive treatment which in most cases is death-hastening. Non-supportive treatment may be found in the failure of givers to provide food, abandonment of the elderly person, and verbal insults. Furthermore, the

elderly person may sustain loss of property and be designated as undesirable members of society (eg. witches) (Glascock and Feinman 1981). When a person is considered young and intact by members of society, support for his or her existence is said to be provided. However, once the person passes into the decrepit category, support is withdrawn.

While these studies do not focus on the current cohort of black elderly people in this country, their cultural milieu may be considered as one under stress. Stresses on the young and middle-aged black person may have resulted in a reduction of assistance given to the black elderly who already receive lower Social Security checks and have reduced amounts of savings and other assets as compared to their white counterparts. Since conditions of the black society seem to qualify this group as one under stress, a closer examination of the informal social contacts, functional capacity and coping mechanisms of these black elderly is warranted.

Coping Through Social Contacts

Elderly people, like all members of society, must utilize resources other than their personal capabilities in order to handle the exigencies of life. The social contacts of families and friends can be a powerful resource in alleviating the rigors of everyday life.

The role of social contacts in the lives of older people has been shown to mitigate circumstances common to their existence (Bell 1981; Robertson 1981; Tate 1983). Various studies have shown a positive correlation between perception of health and actual health status (Linn and Linn 1980; Suchman, Phillips and Streib 1958; Maddox and Douglas 1973; Nickens and Lieberman 1982) and perception of health was shown to be improved when the person has family and friend networks that provide sympathetic support (Boyer 1980). Those elderly with fewer social contacts viewed their health more negatively than those with more contacts.

The elderly may not only benefit psychologically from social contacts but contacts may have practical benefits for them as well. These practical benefits may include economic assistance, transportation services for medical and nutritional needs, aid with activities of daily living and help with maintenance of the elderly person's home. Jonas and Wellin (1980) found that elderly women were more likely to receive assistance from personal acquaintances than elderly men. The only men who were receiving significant amounts of personal assistance were those who were married and the spouse was the source of aid. Myerhoff (1978), however, in her study of elderly Jewish women, found assistance was given to elderly men by women who had been widowed.

Assistance is usually considered to emanate from the family and family support is an acceptable cultural norm in

our society. However, many elderly people in our society have no children and must find other sources of support in old age. Johnson and Catalano (1981) found that married couples who were childless had a smaller number of outside support contacts and tended to rely on each other for all their needs. In contrast, those older people who were never married and were childless seem to have developed better strategies over their lifetime by participating to a greater extent with friends, neighbors and church activities in preparation for the possibility of dependency. Furthermore, Keith (1982) states that "acceptance from a peer does not connote dependence in the way that support from a child or an institution might" (p.202)

Proximity is important in the development of social contacts. Age segregated housing has often been referred to as a dumping ground for the elderly but Jonas and Wellin (1980) found that people living in these houses were more likely to develop strong support networks. In addition, morale was greatly increased due to the fact that they were able to reciprocate. Help was provided in terms of household chores, emotional support, personal care and errands. If proximity is important in the development of strong social contacts, then we would expect the rural elderly to have fewer strong social contacts and to have lower morale than those residing in areas of high population density.

Economics also plays a role in the development of support contacts. Old people who have resources (whether material or psychological) and have shared them usually develop strong reciprocal relationships. Older people whose resources are meager may not be able to obligate others and reciprocate (Wentowski 1981; Jackson 1971) and thus they may have reduced networks.

Adequacy of social contacts in terms of absolute numbers is difficult to ascertain. Adequacy is a function not only of quantity but also the quality of the interaction as well as the fulfillment of the person's perceived needs. Sokolovsky and Cohen (1978) found that the elderly residing in the single room occupancy hotels (SRO's) placed great value on being loners, independent and without societal intrusion into their lives. Even though their networks were small, they served the functions that the individuals desired. If perceptions of poverty (Moen 1981; Streib 1976) and health (Linn and Linn 1980; Boyer 1980) are important indicators of a person's satisfaction with his or her life, it is also possible that the individual's perception or his or her social contacts is a measure of their adequacy.

The foregoing studies have contributed much to our understanding of the role of social contacts in human life. More work is needed, however, to determine the extent to which rural black elderly people use social contacts that would enable them to maintain their way of life.

Additionally, further research should examine a person's perception of the adequacy of these social contacts.

Independent Living

One of the most frequently stated goals of all older people in this country is the desire to remain independent, especially to be able to remain in one's own home (Moen 1981). Some authors would have us believe that this is an expression of a value orientation of the larger American society. The anthropologist Francis Hsu has stated that

> the American core value . . . is self reliance, the most persistent psychological expression of which is the fear of dependence. . . . In American society the fear of dependence is so great that an individual who is not self-sufficient is an object of hostility (Hsu 1961, p.216).

Dependency may be either developmental or precipitated by crises. Examples of developmental dependencies include infancy, childhood, pregnancy and senescence. These transitional stages are viewed as time-limited periods and thus old age is a legitimate excuse for dependency only if the dependency is for a limited period of time and terminated at the proper time by death (Clark 1972). This results in a conflict of values since the diseases associated with old age tend to be chronic and result in long term-care needs.

Not all societies share this value orientation. The Ibo, for example, studied by Shelton (1965), are taught interdependency from childhood and thus dependency is mutual and is not considered negatively. The Ibo elderly can demand

care as a publicly acknowledged right without any sense of guilt (Fry 1980; Kalish 1975). Anyone refusing to give such care is ostracized by the larger society and receives no spiritual benefit from the ancestors.

The Ibo and American black society have been termed "collective" whereas the larger American society has been called "individualistic" (Jerome 1980; Stack 1974). We should expect, then, that black elderly would be treated more like Ibo than are white Americans. In other words, we would expect their needs to be met within the extended family.

Recent research, however, shows that the black elderly are living alone, many in rural settings (Gibbs 1982; Gibson 1983). Evidently, the rural to urban migration of the black population has not included a significant proportion of the black elderly. Perhaps the black population is becoming more assimilated into the mainstream of American life, i.e., becoming more individualistic and less collective. If this is true, the living conditions of the black elderly may represent a change from prior lifestyles and research is needed to determine how the black elderly are functioning in this new cultural milieu.

Methods of Determining Ability to Live Independently

If the core American value is to live independently, as has been suggested, the question of determining if a person should be institutionalized assumes greater significance.

Currently, only five percent of the elderly are in an institutional environment (principally nursing homes and homes for the aged) at any given time. However, it is estimated that one in four elderly persons will be in a nursing home at the time of his or her death (Khel 1977).

The decision to institutionalize a person has been reached utilizing various methods such as recommendation of physician or social worker, or through the use of instruments designed to measure the functional capacity of the person. I conducted a telephone survey of nursing homes in Alachua County, Florida, and found that almost all patients in one home were admitted by physician referral whereas in the remaining three homes the majority of patients were admitted by social service referrals.

Assessment by physician has been acknowledged to be "disorganized and primitive" at the present time (Khel 1977, p.121). Physicians may employ several means of evaluation such as functional capacity and psychological assessments. Functional capacity covers activities of daily living such as feeding, bathing and grooming. Psychosocial assessment deals with the persons ability to interact with others (i.e. family members, peers, professional caretakers). Both are considered pertinent to the person's ability to function within his or her environment but one is not necessarily more important than the other. A person with impaired functional capacity may be able to mitigate these circumstances by utilization of family resources and social resources.

However, these psychosocial assets may be overlooked by the physician.

Efforts to provide a broader spectrum of information, including both functional and psychosocial information, have resulted in the development of instruments designed to quantify these factors to a greater degree. One of the most widely used instruments designed for this purpose is the Functional Assessment Inventory (FAI).

The FAI is a shortened version of the Older Americans Research and Service Center Instrument (OARS). The FAI has undergone a systematic reduction of questionnaire items, some rearrangement of items and the addition of a few new items. The instrument evaluates five domains: social resources, economic resources, mental health, physical health and activities of daily living. From the responses, the interviewer makes a judgment of the functional status in each domain along a six-point scale where 1=excellent functioning and 6=totally impaired (Pfeiffer, Johnson and Chiofolo 1981).

A major problem with the use of instruments such as the FAI is the lack of studies determining their reliability and validity. The OARS instrument, as well as the derived FAI, are used widely for the purpose of clinical assessment, population surveys, program evaluation, personnel training and planning provision of social, economic, medical and dietary services (Fillenbaum and Smyer 1981). In spite of their extensive use, the reliability and validity of these

instruments has not been determined for use in different population segments of the U.S.

A recent effort to determine the reliability and validity of OARS was conducted at the Center for the Study of Aging and Human Development at Duke University by Gerda Fillenbaum and Michael Smyer (1981). The study used a comparatively small sample size (N=33). Ratings based on professional assessment provided the standard against which the scores were measured. Spearman's rank order correlations were highest for activities of daily living (.89) and lowest for mental health (.67). Validation of the OARS instrument is supported by its ability to discriminate among elderly community-based residents in general. No work, however, has been published as to the ability of the instrument to effectively discern group heterogeneity among ambulatory, community-based elderly. Studies of the OARS instrument were conducted for test-retest reliability by researchers at Duke University. However, no independent investigators have examined the reliability and validity of the OARS instrument or the shorter FAI.

Pfeiffer (who developed the FAI), Johnson and Chiofolo (1981) administered the FAI to 58 elderly persons in a rural Florida county. They stated: "rapid, reliable and valid assessment of the functional status of elderly persons is a prerequisite for the efficient provision of appropriate types of services" (p.433). Their conclusions, however, do not declare that the instrument is either reliable or valid.

They conclude that "the findings suggest potential for the widespread use of the shorter Functional Assessment Inventory for determining the type, level, and appropriateness of services for the elderly" (p.433). It should be noted that the study included only one black and two Hispanic elderly people and therefore limits any conclusions which might be made concerning its applicability in ethnically heterogeneous populations.

Training sessions in the use of OARS and FAI stress that the language of the instrument must not be changed but that the items must be asked as written. Coyle (1981) found this to be a problem when administering OARS to a rural black elderly sample residing in Louisiana. She found it necessary to use a black research assistant to translate the terminology of the instrument to the older people. Without this interpreter she states that "many interviews could not have been completed" (p.3).

In conclusion, it seems that serious problems exist in these methods of determining the ability of the older person to maintain an independent life. The most serious of these problems is the failure to include a cross-cultural perspective. Since this determination is of such critical importance to older persons, greater care should be given to making certain that the final recommendation as to their ultimate mode of life is a correct one. Furthermore, elderly Americans are an extremely diverse group with heritages

originating in many ethnic groups. Therefore, the possibility of racial and ethnic differences, as well as location of residence, may result in varying concepts of functionality that should be included in any final recommendation. Perhaps the utilization of support from family, friends and service agencies will be different among groups. If this is the case, the use of any one instrument to ascertain ability to maintain lifestyles is questionable.

CHAPTER TWO
STATEMENT OF THE PROBLEM

Problem Formulation

Poor economic and social conditions have placed the rural black elderly in a disadvantaged situation. Specifically, these people have less access to congregate meal sites, shopping areas, and medical and government services. Their income levels, in most instances, are low because they had little or no Social Security paying employment before retirement. Furthermore, the cultural emphasis on independence among many of this age group prevents them from requesting help from persons or agencies that might be willing to assist them. Finally, as younger members of the black family have moved to urban areas in search of employment, the older black people are typically left without the support of extended family networks to alleviate their needs during this period of life.

The focus of this study was to determine the ability of the rural black elderly to maintain their independent lifestyle. Two methods were used to assess their functionality. The reliability and validity of the Functional Assessment Inventory (FAI) as a tool for assessing the

functionality of the black elderly was examined. Twenty elderly white persons were included for comparative purposes. The FAI is a formal approach of assessing functionality and a less formal approach--coping behaviors--was also included in this research. Coping behaviors were investigated to determine how they functioned to maintain the lifestyle of rural black elderly people residing in Alachua County, Florida. Specifically, the areas of social resources, economic resources, mental health, physical health and activities of daily living were related to social support. Particular emphasis was also given to the role of social contacts in assisting the older person in obtaining nutritional requirements and medical care.

The assumption investigated was that extensive reliance on kin (either real or fictive) found by researchers who studied younger black families (Jerome 1980; Kennedy 1980; Stack 1974), would not apply to the rural black elderly. It was theorized that black families were under increasing stresses as compared to other segments of American society and that black elderly people would be receiving little, if any, support from their families.

Specific Aims

The specific aims of this study were as follows:

1. To determine the reliability and validity of the Functional Assessment Inventory (FAI) in the

domains of social resources, economic resources, mental health, physical health and activities of daily living in the rural black elderly population and the usefulness of this instrument in describing the coping behaviors of the rural black elderly;

2. To determine the roles of family and friends in the procurement of nutritional requirements and medical care.

Particular questions asked, along with the related hypotheses, were as follows:

1. Is the FAI a valid and reliable instrument to assess the functional capacity of the elderly black person? It was hypothesized that cultural differences would limit the usefulness of this instrument among different elderly populations.
2. With whom do the rural black elderly interact? It was hypothesized that the rural black elderly would be interacting with friends more than with family members.
3. How do the rural black elderly perceive the quality of their life? It was hypothesized that regardless of the number of informal social contacts, the rural black elderly would view their life positively.
4. Do the informal social contacts of this population contribute positively or negatively to the maintenance of their lifestyle? It was hypothesized

that social contacts would function both positively and negatively.

5. To what extent do informal social contacts function to assist the rural black elderly in activities of daily living? It was hypothesized that these contacts would not contribute significantly to activities of daily living.

6. Are the coping mechanisms used by the black elderly adaptive or maladaptive in maintaining their independence? It was hypothesized that coping behaviors would function adaptively.

CHAPTER THREE
METHODOLOGY

Sample Selection

A non-random sample of 54 rural, black and white, male and female elderly persons over the age of 60 participated in this study. Coping behaviors were examined in greater depth for black (N=27) subjects. Participants in this research had previously participated in a multiphasic screening and evaluation project that I coordinated in 1981. Subjects were selected through a snowball sampling technique with contacts being made at nutrition meal sites, in church groups and through community leaders. From this larger sample, which included both rural and urban elderly persons, 54 rural elderly who were living independently within the rural areas of the county and were aged 60 or over, agreed to participate in this study. Thirty four were black and 20 were white.

Geographic Location

Alachua County is located in North Central Florida. This area includes 16 counties, all of which are predominantly rural in character. This area has not experienced the large influx of retirees commonly associated with Florida's retirement communities found in the southern areas of the state. However, the number of elderly people in this area is increasing. In 1950, 8.3 percent of the population of North Central Florida were aged 65 or over. This percentage has increased to 16.5 percent of the population in 1980 (District III Area Agency on Aging 1984).

Elderly persons in this area more frequently reside in rural areas (i.e. towns of less than 2500 in population). Fully 64 percent of the elderly live in these rural areas. Even those elderly persons who live in the urban centers have cultural orientations that are characteristically rural.

The great majority of the elderly in this area are Caucasian (89 percent). Within the non-Caucasian population, most are black, with those of "other" races (mainly Spanish in origin) comprising only one percent of the older population (U.S. Bureau of the Census 1982). Alachua County has 15,226 white persons over the age of 60 and 3,326 black persons within this age range.

Due to the rural nature of this area, public transportation is very limited, or in some instances, non-existent. When public transportation is available, the increasing

costs of taxis and buses prohibits their use by many of the elderly people.

Measurement of Functional Capacity

The Functional Assessment Inventory (FAI) was administered to each person as a measure of his or her functional capacity. The assessment was conducted in the individuals home without the aid of informants.

The FAI is an abbreviated version of the OARS Multidimensional Functional Assessment Questionnaire and was developed by a multi-disciplinary team at Duke University and refined by Eric Pfeiffer, M.D., presently director of the Suncoast Gerontology Center at the University of South Florida. The FAI has 11 distinct sections:

1. Short Portable Mental Status Questionnaire (SPMSQ) which is used to assess the presence of organic brain syndrome and as a basis for determining whether the subject can complete the questionnaire;
2. Socio-demographic background information including race, sex, age, etc.;
3. Social resources information including quality and quantity of relationships with friends and family;
4. Economic resources information including occupation, income and other resources;
5. Mental health information including two subjective scales measuring life satisfaction and self esteem

as well as a 15-item Short Psychiatric Evaluation Schedule (SPES) indicating level of functional psychiatric symptomatology;

6. Information on physical health including the presence of physical disorders and the extent of participation in physical activities;
7. Activities of daily living including information on the performance of instrumental and bodily care tasks that permit individuals to live independently;
8. Information on social and medical services used by the subject in previous months and services they believe they need;
9. An informant interview to be used when the subject is unable to complete the questionnaire;
10. An interviewer assessment of data reliability;
11. A series of five scales on which the interviewer rates the impairment on a 6-point scale where 1 = excellent function and 6 = total impairment (Pfeiffer, Johnson and Chiofolo 1981; Pfeiffer 1975; Pfeiffer 1976).

The Cumulative Impairment Score (CIS) is obtained by adding the scores from each of the domains (social, economic, physical, mental and activities of daily living). A CIS of greater than or equal to 17 is considered to be the score at which the person is possibly in need of institutionalization (Beverly Burton, personal communication,

Suncoast Gerontology Center, University of South Florida). I was trained in the administration and scoring of the FAI at the Suncoast Gerontology Center at the University of South Florida.

Determination of Reliability and Validity of the FAI

Two methods were used to determine reliability of the FAI. In the first method, the test-retest, 10 randomly selected subjects answered FAI questions a second time, approximately four weeks after the initial test. Correlations were obtained between the total scores of the first test and the total score of the second test through the use of the Statistical Analysis System (SAS) Pearson's product-moment correlation statistic. Also, correlations were similarly obtained within test domains. In the second method, the internal consistency was analyzed by correlating items of each domain with the domain score.

Concurrent validity was determined by use of Spearman's Rank Order correlations between item scores on the FAI and responses to similar data elements reported in the multiphasic data base. Additionally, t-tests were calculated to examine the relationship between mean scores in each domain, the CIS and the SPMSQ by race and sex.

The multiphasic data base included data obtained from an interview schedule, assessment of health status by a physician, determination of immune functioning, biochemical

assessment of blood constituents and standard urinalysis. The interview schedule required approximately three hours to administer. Information was obtained from the interview schedule on the social, economic, mental and physical attributes of the subject, 24-hour recall data on dietary intake, and a food frequency questionnaire.

Material Lifestyles of the Rural Black Elderly

The material lifestyle of the subject was determined through the use of a checklist which included items related to home ownership, age of home, construction materials, physical condition, heating and cooling capabilities, kitchen facilities, miscellaneous items and subjective assessment of the overall inhabitableness of the home (See Appendix B).

Coping Nutritionally

Determination of nutritional practices was assessed through the use of a food frequency questionnaire (See Appendix A). The food frequency was obtained with the aid of food models from the National Dairy Council. These models were laminated onto heavy paper, hole-punched and placed in notebook form to facilitate ease of data collection. The person was asked if a particular food item was eaten daily, weekly, monthly, during the year, or never.

Methods of food procurement were obtained through the use of a questionnaire. Questions were asked concerning the types of stores that the person most frequently used to obtain food; frequency of receiving food from family, friends, or other sources during the week; their course of action should they need groceries at unscheduled times; how they got to the grocery store on their last visit; and amount of food that they either grow or raise for their own consumption (See Appendix C).

Coping Medically

Each person in the sample participated in a clinical assessment of their health status. The clinic was conducted with the assistance of physicians and trained medical personnel from Shands Teaching Hospital in Gainesville, Florida. Transportation to and from the clinic was provided. The health assessment and the transportation were given without charge to the subjects.

Clinical assessment of health included blood pressures, both sitting and standing; a SMAC-25 Profile and a Complete Blood Count from fasting blood samples; a medical history interview eliciting information concerning the presence of diseases such as coronary heart disease and arthritis; and an assessment of the immune status of each subject. Analysis of the SMAC-25 and CBC was conducted by the Smith-Kline Laboratories in Tampa, Florida. The SMAC-25

Profile evaluates amounts of blood constituents such as glucose, iron, cholesterol, triglycerides, etc. A CBC calculates the number of white blood cells, red blood cells, hemoglobin and hematocrit levels. Immune functioning was determined through the use of four antigens (Candida, mumps, purified protein derivative (PPD), and trichophyton). These antigens were injected intradermally on the volar surface of the forearm with one-tenth ml. of each antigen. A circle was made around each site with a skin marker and the subject was asked not to wash these areas until a reading could be done from 48 to 72 hours later.

Medical coping behaviors were assessed through the use of a questionnaire (See Appendix C). Questions include when a doctor was last visited; how the subjects got there; their choice of actions when they became ill, including the use of home remedies, prayer, treatment by neighbors or friends, use of prescription or over-the-counter drugs and visit to a doctor; and whether they had unmet medical needs at the present time.

Participant Observation

Participant observation is perhaps the one method most traditionally associated with anthropologists. Typically, this involves "moving in" on the subjects and observing their daily lives. This method is best conducted

within demarcated populations and this has been the situation in the majority of studies of elderly people in this country. The elderly who live in single room occupancy hotels (Sokolovsky and Cohen 1978); those who live in old age communities (Wellin and Boyer 1979); elderly who attend senior citizens centers (Myerhoff 1978); and other bounded areas (Clark and Anderson 1967; Keith 1982) have been the focus of research relating to aging.

Moving in on subjects is more difficult when the persons of interest are living independently and even more difficult when they live in rural areas without a central location for meeting together. These were the conditions encountered in this research. In order to compensate for these constraints, I have worked among this group for four years; visiting in their homes, attending nutrition meal sites, counseling family problems, becoming acquainted with local shopping and medical facilities frequented by the group and visiting their churches.

Photography

Photography has served a dual purpose in this research. First, the camera has provided a visual documemtation of the material lifestyle of the subjects. But second, and perhaps more importantly, it has provided a way whereby I was able to show my appreciation to the subjects

for what must often have seemed my interminable questions. All subjects were given copies of all pictures made of them and their surroundings.

CHAPTER FOUR
THE COMMUNITIES AND THE BLACK ELDERLY

The Research Communities

The population of Alachua County is concentrated in the city of Gainesville. However, there are several rural outlying communities with populations varying from 1000 to 4000 persons. Five of these rural communities, Archer, Alachua, Hawthorne, High Springs and Waldo, were the sites of this study. The following data relating to these selected towns were obtained from the U.S. Bureau of the Census (1980), from the residents and from the respective city halls.

Archer is located 12 miles southwest of Gainesville and has a population of 1,230. Of this number, 39 percent (N=481) are black and 60 percent (N=749) are white. Farming is the main source of employment. There is one physician in the town, one small grocery store and a convenience store. There is no nutrition meal site available in Archer for the elderly residents.

Alachua is located 16 miles northwest of Gainesville, and can be reached by way of a major four-lane highway. Alachua has a population of 3,561. Forty-seven percent

(N=1,679) are black and 52 percent (N=1,872) are white. Until recently the town had a large meat packing plant, but now is an agricultural town with numerous large and small outlying farms. Alachua has one physician and one small grocery as well as a few convenience stores. The town has a nutrition meal site which served noon meals to approximately 25 (predominantly black) elderly persons.

Hawthorne is located approximately 25 miles southeast of Gainesville. The town has a population of 1,303; 58 percent (N=762) are black and 41 percent (N=539) are white. Hawthorne has the largest percentage of black population of any town in Alachua County. Early industry included a turpentine factory, and several of the older residents are former employees. Hawthorne lies at the crossroads of several state routes for agricultural transport. The town has one dentist, one physician, several small groceries, and a nutrition meal program serving approximately 35 elderly persons.

High Springs is located approximately 25 miles northwest of Gainesville and is nine miles from Alachua. The towns are linked by the same major highway. High Springs has a population of 2,491. Of this number, 68 percent (N=1,717) are white and 30 percent (N=756) are black. Much of the elderly population are made up of middle-class retirees from the railroad and the federal government. The town has a medical clinic, one large grocery store, several smaller markets, and a nutrition meal site where approximately 30

elderly persons eat their noon meal from one to five days a week.

Waldo is located 15 miles northeast of Gainesville and is accessed by a major four-lane highway. The town has a population of 993 with 22 percent (N=226) black residents and 76 percent (N=539) white residents. This percentage of black residents is one of the lowest among the rural towns of the county. There are no physicians practicing in Waldo and all the grocery stores are small minute market types. There is a nutrition meal site available to approximately 25 of the elderly residents.

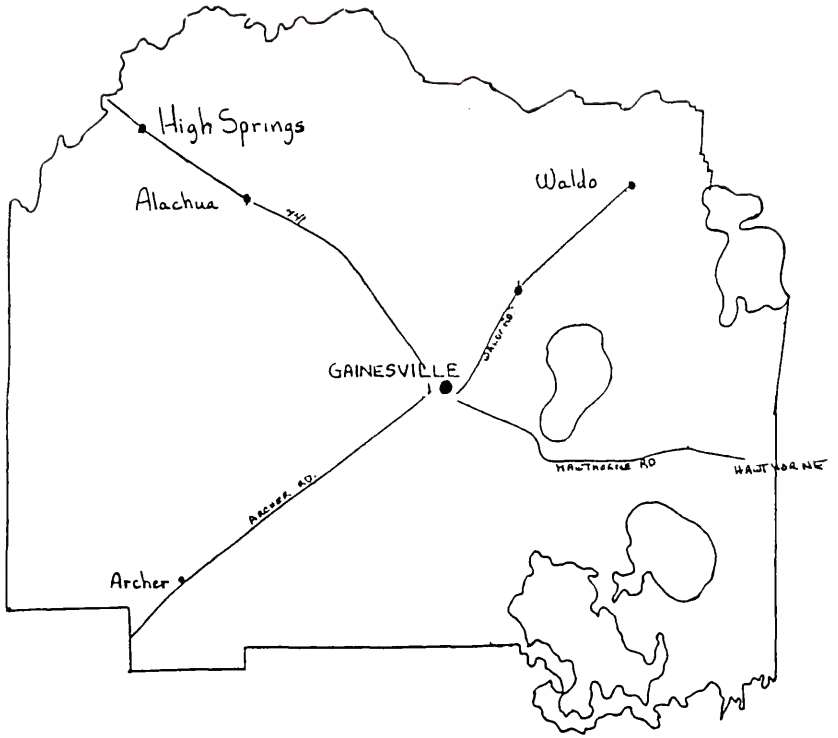
Case Studies

The Black Elderly in Archer

Six of the subjects who participated in this study resided in Archer. All, however, live outside the boundaries of the town. Five live on unpaved roads. Four of the six subjects are included in the case studies. These four are representative of the unreported cases and it is my belief that the inclusion of the others would not contribute significantly to the case studies.

Two males in this study seemed to have given much thought to conditions and constraints of life and I have termed them my "philosophers." One of these subjects is Mr. J who lives on a dirt road outside of Archer. He owns 160 acres of farm land and the farm has provided him with a

Map Of Alachua County, Florida


High Springs
Alachua
441
Waldo
GAINESVILLE
HAWTHORNE RD
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ARCHER RD.

source of income but he found it necessary to supplement that income by driving a schoolbus for many years. I once asked him how he came to own such a large parcel of land and he told me that "land did'nt cost so much back in those days." Furthermore, he stated that as acreage that "joined mine" became available that he would buy these and that over a period of time the amount had built up. Although he is 82 years of age, he is still driving his car and is a very active man.

Mr. J and his wife have been married for 62 years, a fact in which he takes great pride. He stated that he had "never been separated." His wife was ill in 1981 when I first met this family and she has continued in this situation to the present time. Her activities are mainly confined to sitting in the house with occasional walks outside. As a result of her illness, Mr. J does all the cooking for the two of them. On my first visit, Mr. J told me that he would like to eat out more in restaurants but that his wife did not want to eat out. This was a statement that I had never heard a man make before and after further questioning, he revealed that he was doing all the cooking for himself and his wife.

The concept of family seems very important to Mr. J and on each of my visits to this home, I met both children and grandchildren. He has 13 children, three of whom live within the county. One grandchild lives in a house adjacent to Mr. J and often drops in and out of his grandparents

home. On my first visit with Mr. J and his wife, this grandson would not leave as long as I was there but after that initial visit, I only saw him occasionally. I suppose I had met with his approval and he believed his grandparents were safe in my company. Although Mr. J's daughters live outside the county, there are three who live in surrounding counties and alternate coming on weekends to do cooking and cleaning for Mr. J and his wife. He speaks very proudly of his children and gave me the name of all his eight daughters. Interestingly, he did not give me the names of his sons. Four of his daughters have obtained college degrees. He stated that "it seems like my kids appreciate their raising."

Growing and preserving food is still an important part of Mr. J's life although he stated that most of the food that he grows now is given away to neighbors and to his family. He stated that he could not get his wife to eat the vegetables anymore and that he "just don't want anymore." He is currently growing corn, mustard greens, and peas. He cans pears from several trees located in the yard. He raises both beef and pork for consumption but will not eat the pork himself. He stated that the "pork is against my pressure."

Religious faith is a very important part of Mr. J's life. He is an elder in a local black congregation and his conversation is always interspersed with references to his faith. He stated that he prayed often for health and "for

this family that love will continue to exist." He still attends church meetings twice a week.

Although Mr. J is 82 years old, he appears to be in very good health. He says that he has pains in his joints and back but that these are "due to me, it's time to have pains and I'll just have to adjust." When asked about his health problems in 1981, Mr. J said that he had heart disease, high blood pressure and arthritis. When asked again in 1982 and 1983, he stated that he had high blood pressure and arthritis but made no mention of heart problems.

Mr. J seems to have given much thought to the situations of life that he has encountered. For instance, in discussing race relations between blacks and whites, as he has experienced during his lifetime, he stated that "hit weren't right." The educational system was one of those things that was not right. He stated that the school buses that he drove were always ones that had been discarded by the white schools. He recalled one school superintendent who had stated that no black children would ever ride on a new school bus as long as he was the superintendent. Additionally, he stated that all the textbooks used by the black chilren were books that had been discarded by the white schools.

Mr. J was the first person to tell me that "schools were different then." When I asked him what he meant by that statement he told me that the rural black schools were

only open for two to three months out of the year. Furthermore, he recalled one time when the school was only open for six weeks before they ran out of money to operate the school and had to close for the year.

Another subject from the Archer area was Mrs. M, a 76 year old woman who has been a widow for the past 17 years. She was the only person from this area who lived on a paved road and her home was located approximately one and one-half miles from the town of Archer.

The living conditions of Mrs. M are rather dire. The home in which she lives is co-owned with her four sisters and two brothers. It is located on approximately five acres and was inherited from her parents. The house is a wooden shack that has large cracks in the walls making it impossible to either heat or cool. When I visited with her in the winter time, we would huddle around a small woodburning heater located in the front room of her house. In the summertime, we sat outside under the trees to escape the oppressive heat inside. When I asked her how she kept warm in the winter, she stated that "I just sets around this stove." Water for the home is obtained from a well in the rear of the house. An outhouse is located near the well.

The house is not only in bad physical condition but is so filled with various items as to make it difficult to navigate through the house. Fabric and cloths seem to be all over the interior. Several scrap quilts were draped over two chairs in the front room. A cloth covers a small

corner table where the television set is located. Furthermore, Mrs. M always had on several layers of clothing regardless of the time of year. The kitchen walls are covered with various sizes of pots and pans and the kitchen counters are likewise covered with utensils as well as cleaning aids and food. The door into the house enters the kitchen and a narrow walkway leads into the front room. Two small bedrooms are located adjacent to the kitchen and the front room.

Mrs. M has four sisters and two brothers who reside in the area. In fact, one brother who is totally blind lives with Mrs. M. In addition to her siblings, Mrs. M has two children, a son and a daughter. She stated that the son lives "all different places." Her daughter lives next door in a very nice mobile home. I have never seen this daughter although I have met two of Mrs. M's sisters as well as her brother who lives with her.

Assistance from family members is very minimal for Mrs. M. When I first met Mrs. M her daughter owned a late model car but Mrs. M stated that she had to hire someone to take her grocery shopping or to medical appointments. I have observed her walking the distance from a grocery store in Archer to her home. On subsequent visits, the daughter no longer had a car. I asked Mrs. M about this apparent absence of assistance from her daughter and she explains this by stating that "she has her own kids to care for. She can't help me that much." Mrs. M seems to have lost trust

in other people. She stated that "I don't trust nobody since my mother died."

The economic situation for Mrs. M is also severe. Both she and her husband spent their working lives as farmers and had not paid into the Social Security system. She now receives the minimum amount of income from Security Supplemental Income (SSI) and she stated that she is "just barely scraping by."

Sufficient acreage is available to Mrs. M to grow a substantial garden but she is not doing this. She stated that "I ain't able anymore." She is, however, growing a small amount of food although she does not preserve any for later use. She was growing "greens" and this included both mustard and collards. Black-eyed peas, acre peas and tomatoes were also grown. She stated that she did not eat pork because "pork don't agree with me."

The lifestyle of Mrs. M appears to be harsh but her health seems to be quite good for a woman of her age. She is very active, chopping the wood for her woodburning stove and walking the mile and a half to the grocery store. She stated that she had "high pressure and arthritis." Additionally, she stated that she had "kidney probems" but I was unable to determine exactly what she meant by this and how it affected her activity. Her blood chemistry revealed a low hemoglobin level.

The physical appearance of Mrs. M is very striking due to the presence of a large golf-ball size growth directly in

the middle of her forehead. I questioned her about the possibility of the growth being some form of malignancy but she informed me that the growth had been there for many years and had never created any problems for her. However, I imagine that if there had been sufficient economic resources available she would have had the unsightly growth removed.

The living conditions of Mrs. M were so severe that one might expect her to have a low morale but this was not the case. She said that she "hardly ever worries" and that she considers her life to be "pretty good." She was cheerful on all my visits and seemed delighted to have someone take an interest in her life.

Unlike Mrs. M, another Archer resident, Mrs. L does not live under such adverse conditions. Mrs. L was born in the Archer area. Her father had owned 170 acres at one time but at the time of his death, the acreage had been redued to 80. Ten acres were given to each of seven children and to his wife. Mrs. L was married at the time of this inheritance and she sold her ten acres to help pay for 40 acres "across the road." She stated that land was "cheap back then (1920s), about $5 a acre, but that $5 was hard to get". Cotton was the cash crop and none of the black farmers had any kind of mechanical equipment to assist in harvesting. Peas and peanuts were also grown but mainly for personal consumption. Mrs. L is currently considering deeding the land to her children so that she could get more

help from the government. Her Social Security check is low enough to enable her to receive SSI monies but she cannot do this as long as she has the 40 acres. Her husband has been dead for 18 years; she has nine living children and is currently 73 years old.

Mrs. L lives in a small white frame house that she and her husband built before they had any children. An addition was added to the rear of the house several years later. The house is raised off the ground with open space visible underneath. It is in need of some repair. The steps leading into the house are ramshackled and the screen door needs replacing. The interior also is in need of repairs. The main source of heat is a fireplace in the living room but the fireplace does not produce enough heat to even heat this room. Two pictures are prominently displayed over the fireplace. One is a picture of Martin Luther King, Jr. with his family and the other is a picture of John F. Kennedy. Numerous pictures of family members are displayed on small side tables.

Extensive numbers of family members live around Mrs. L. One brother, a sister and two daughters live "just down the road" and one son (aged 28) and one grandson (aged 19) live in the house with her. Mrs. L had ten children in all but only nine are currently living; six reside within the county. She states that the son who lives with her is a major source of help. He cooks when she "doesn't feel like it", fishes and maintains a large garden. However, she

describes the grandson as "lazy" and of "no help." Although the son lives with Mrs. L, she states that she is closer to her younger daughter. On almost all my visits, this daughter either called her mother or came by to visit and on one occasion brought Mrs. L a pot of chicken and rice for her dinner.

One of the things that Mrs. L regrets about her life is that she never learned to drive. She stated that her husband told her that she would "get killed if you get out on that road" and he would not let her learn. She stated that she wished she had learned anyway because when she wanted to go somewhere "all I would have to do would be to get in the car and take off."

Gardening is an important part of Mrs. L's life. She maintains a small garden plot near the house where she grows "all kinds of greens", onions and tomatoes. Her son maintains a large garden farther down a dirt road and away from the house. Peas, corn, okra, potatoes and beans are grown on this plot. Mrs. L stated that she does not tend to this larger garden because she is no longer able to care for a plot of that size. She does preserve food from the garden as well as fruits from pear and peach trees found in the yard. Chickens roam freely around her yard and she sells eggs from these chickens. She speaks proudly about her "yeller" eggs and says that she sometimes sell these to her neighbors when they want to make "real good cakes like at Thanksgiving and Christmas time." She stated that she

does not eat pork anymore because her doctor had told her that pork was not good for her.

In contrast to Mrs. L who had many family members living around her, Mrs. E had no family members in the area. Her husband had been a preacher but he had died in 1936 leaving her a widow at the age of 39. She is presently 89 years old and she never remarried. Although she had been married for many years prior to her husbands death, Mrs. E never had a child. "Just weren't none for me. If the Lord had intended me to have 'em, I would've" she stated. She does not recall having any "female" problems. Although she had no children of her own she stated that "I had other peoples children." In addition to the absence of spouse and children, all of Mrs. E's brothers and sisters were dead.

Life has not been as severe for Mrs. E as for some of the other subjects but she does share life characterized by poverty similar to others in these case studies. After her husbands death, Mrs E found employment with a county judge. This employment lasted for 40 years. She not only cleaned and cooked but she also took care of the judge's children. These are the childern whom she refers to when she discusses having other peoples children. The judge is now dead but the judges wife and his children continue to check on Mrs. E and she calls on them when she needs help. Just prior to my last visit, Mrs. E stated that she had to ask them to help her pay a heating bill and they did. Furthermore, they provide Mrs. E with assistance in getting to the grocery

store and doctors appointments. The judge's family is white. Mrs. E's income at this time would allow her to qualify for SSI monies but she stated that she had never tried to get these monies. She stated that "I don't need welfare."

Although at the present time, Mrs. E is crippled with arthritis, she still maintains her sense of independence. "People need to do for themselves, that's what they ought to do," she stated. Her knees are very enlarged from the arthritis and she must use a cane in order to walk but she said that "I prays a lot and asks the Lord to help me and He does." She also had high blood pressure.

The Black Elderly In Alachua

Four of the black elderly subjects in this study live in the town of Alachua and unlike the subjects in Archer, all of these subjects live in the town rather than the outlying areas. All live on paved streets in a section of town inhabited only by blacks and I have included all of them in the case studies.

Mr. M is a 70 year old man who lives alone in a rented house. He and his wife have been divorced for seven years and although they had seven children, Mr. M does not know where they are. He stated that he does not believe they are living in the county and he has not seen them for several years. The only relative that he admits to having a close relationship with is an aunt in Sanford and he stated that this aunt would "take care of me if I need help." He appears to be about six feet tall and would probably weigh

about 170 pounds. He moved to the Alachua area in 1931 "to work."

The house where Mr. M lives has been condemned by the town and on my last visit with him, he was looking for another place to live. This was causing him some problems because most of the available places required more rent than he felt he could pay. His current home is already caving in on one side and I was most uncomfortable on my visits there as I kept wondering when the side we were sitting in might also collapse. He has no way of cooking in the house other than an old hotplate that he stated he used "just to heat up a few things." A gas room heater is his only source of heat and this is totally inadequate in the collapsing house. Furniture is very sparse with a couple of straight chairs in the room that serves as both sitting room and bedroom. The only other rooms are a kitchen and a tiny bathroom. All homes within the city limits are required to have indoor plumbing but there is no hot water in the house.

I first met Mr. M at the congregate meal site in Alachua where he eats a noon meal five days a week. Even though surrounded by people at the meal site, Mr. M always manages to sit out on a bench by himself, apparently watching what is going on around him but never participating. I observed this behavior on each visit that I made to the meal site. He comes about an hour before the meal, sits on the bench without interacting with the others

and leaves immediately after the meal. He is not an unfriendly man and seemed to enjoy talking with me once he found that I was interested in his life and experiences.

Tools are a part of Mr. M's attire. Sometimes wrenches would be protruding from a pocket and sometimes screwdrivers or various other tools were visible. This was possibly a carryover from his working days when he was a construction worker, mainly building houses. His reason for carrying the tools now was that "I might need them. You just don't know."

Mr. M was shot in the head 18 years ago when he "got into it with some of the boys." A concave spot is visible on his forehead where the shot entered. He is totally blind in his right eye due to the gunshot wound. Furthermore, The shooting ended his working life and he has had epileptic seizures since that time. He is taking medication for this condition. He states that the only other health problem that "troubles" him is arthritis in his legs and on each visit with him, complaints about pains in his legs increased. Although a doctor is available in Alachua, Mr. M hires someone to bring him into Gainesville when he needs to see a doctor. He said that he had recently seen the doctor and had to pay him $25 for the visit. After paying the doctor this amount, he stated that "I can't buy the medicine. Guess I'll have to wait till I get my next check."

There were very few people in this study who stated that alcohol consumption had been a problem to them but Mr. M was one of those. He stated that his doctor had told him to "quit that drinking or I wasn't going to live." He stated that he has not drunk any alcoholic beverages in six years now.

Due to the fact that Mr. M lives in the town area, grocery stores are within walking distance to him but he is limited to only those items that he can carry in his arms. He stated that once a month a friend would come by and take him to the store so that he could buy more groceries. When I asked him who this friend was, he could only remember "James. I can't think of his last name." He did say, however, that this person would not take any money from him for this service.

Whereas Mr. M had few interactions with family or friends, this was not the situation of Mrs. B. When I first met Mrs. B she was living alone within the black district of Alachua. However, on subsequent visits she had moved in with a grandaughter due to her declining health status and even though her health seemed much improved on my last visit, she continued to live with her grandaughter. Mrs. B has been a widow for 18 years and has four children, two of whom live in the county. I met her daughter on one occasion but the daughter appeared to be intoxiacted and was uncommunicative. In contrast, the grandaughter seemed very interested in her grandmother's health and asked many

questions about ways to improve her nutritional status and her health in general.

The home where Mrs. B is now living with her granddaughter is located in a public housing project and appears very unkempt. The walls are very dirty and in need of paint and the house smelled of urine. Two small children scamper around the house and are the likely source of the smell. Both children are part of the family, belonging to the grandaughter and a niece.

Health seems to have been a particular problem to Mrs. B for several years. On my first visit with her she stated that "I'm very happy now cause when you've got your health, you've got everything." She said that she had previously been ill with ulcers and heart disease but that these had all cleared up now and she was feeling fine. Six months later she was so ill that I really did not see how she could survive. At that time she told me that she "hurt all over." She stated that she had arthritis, heart trouble, ulcers, hiatal hernia, cancer and anemia. Furthermore, she stated that she did not have enough money to buy all the medicine that had been prescribed and when I asked her what she considered to be her greatest problem, she very quickly responded "money." On my last visit to Mrs. B, I found her health much improved and she was caring for those same two small children that I had first encountered in her house.

Severe illnesses had been such a part of Mrs. B's life for the past several years and I thought she might be able

to give me some insight into how she reacted to the onset of these health problems. "I pray hard," was her primary reaction. She stated that she did not use any home remedies anymore because "the doctors say not to use those old home remedies like we used to."

The inability to remain active was a particular concern to Mrs. B. "I was raised on a farm--raised to doing something. This don't seem right to just sit here" she stated.

I am sure that every researcher has subjects that are considered absolutely unforgetable and the following lady from Alachua was one of those persons to me. Mrs. G is an 80 year old woman with a toothless, perpetual smile. She has been a widow "for so many years I can't remember." Even when her husband was alive, he was evidently not the ideal husband. "He didn't help me none. He spent all his money on other women," she stated.

The marital union did, however, result in the birth of two children; a son and a daughter. The son died while in the Navy but his daughter, Mrs. G's grandaughter, lives in Alachua and Mrs. G lives with this grandaughter. Mrs. G first told me that her daughter was in Chattahoochee at the state mental hospital and she had no idea if she was still alive. On a later visit she told me that she did not know where her daughter was living.

The grandaughter is the major caregiver and the level of care seems total. For instance Mrs. G stated that she

had no idea about how much money she received every month because her grandaughter "gets my check and takes care of all my money." A great-grandson "gives me a few dollars along." Mrs. G lives with her grandaughter and the grandaughter takes care of all the grocery shopping and takes Mrs. G to any doctor's appointments that she may have.

The housing condition for Mrs. G is better than for many of my other subjects. The house is owned by her grandaughter and is constructed of concrete block with no major visible defects. The yard is large enough to have a small garden where various greens, onions, and a small amount of corn are grown during the summer months. Mrs. G eats her noon meals at the congregate meal site in Alachua but says that "I don't eat pork."

The past continues to be a major focus in the present for Mrs. G. On all my visits with this lady, she recounted her early life experiences and the story was always the same. Her story is one of abuse, first from her grandmother and mother and later from her husband. She says that her grandmother was "a slavery time lady who wouldn't let you open your mouth." Mrs. G seems to make some connection between the slavery status of her grandmother and the treatment given to her as a grandaughter. Mrs. G seems to feel that the "meanness" of her grandmother was related to her status as a "slavery lady" but Mrs. G has trouble in elucidating exacting what she means by these statements. Many of my inferences were drawn from the expression on her

face and the tone of her voice when she discussed the situation.

The living situation with her mother was no better than that what she experienced with her grandmother. Mrs. G stated that her mother was "a street walker and she wouldn't let me go to school." Her mother was not around for long periods of time during which Mrs. G was left with her grandmother. Mrs. G recalls that a family wanted to take her and send her to school but her mother would not allow them. She also says that she remembers many nights of sleeping out in fields and woods trying to hide from her mother or grandmother but always being found and brought back. She states "my mama never telled me right from wrong."

An early marriage did not improve the living conditions of Mrs. G. She states that her husband "beat me" and "ran off with other women." Mrs. G was forced to make her own way by cooking for other people and hoeing in their fields.

These kinds of living experiences could very reasonably result in a negative personality but this is not the situation with Mrs. G. She is always smiling, visiting with all the people at the meal site, talking with neighbors and seemingly enjoying life immensely. Her present life, when compared to her past, is probably better than anything she ever expected and she says that her life is now "good."

The health status of Mrs. G is exceptionally good for a person of her age. She states that she has hypertension but none was found when her blood pressure was taken and she

is not taking any medication for hypertension. Furthermore she states that she has diabetes which she is controlling by diet and no "out-of-range" values were found for blood glucose levels. She also stated that she had arthritis in 1981 but on other visits stated that she did not have this condition. She had no response to the four antigens when her immune functioning was checked in 1981.

The final subject living in Alachua is Mrs. H. She is a very thin, frail appearing woman of 72. Her husband died six years ago and she has lived alone since that time. Her home is a small four-room wood frame house and as in so many of the instances in this study, the home is very cluttered. An exercise bike is found in one corner of the living room but Mrs. H says that she does not use it very often. The bike was given to her by her son.

Mrs. H has two children, both sons. One son lives within the county but the other son is not living in the state. I have never met the son who lives in the county but according to Mrs. H he is very actively involved in her life. For instance, this is the son who bought her the exercise bike and she says that he also comes and mows her yard whenever it needs mowing. She has no grandchildren or other family members living near her but pictures of her children and grandchildren are found on the walls and the tables in the house.

The physical and mental condition of Mrs. H has declined radically over ther years that I have known her. A

major problem would appear to be her total disinterest in eating. She attends the congregate meal site for her noon meals five days a week but even there she tends not to eat, simply nibbling at the food. I have wondered if perhaps this refusal to eat was an unconscious way of committing suicide. I discussed her refusal to eat with the meal site manager and we decided upon a plan to see if we could get Mrs. H to eat. The plan called for enlisting the assistance of other meal site participants and giving Mrs. H an extra amount of attention and letting her know that we were going to be checking up on her to see that she was eating. The plan has only been moderately successful. When she sees me, she usually begins the conversation with "I have eaten ...." but she continues to decline. She does appear to enjoy the extra attention from her friends at the meal site.

Diet may also have been an important factor in the mental condition of Mrs. H. She had the highest score (i.e. greatest mental impairment) on the Short Psychiatric Evaluation Schedule of any of the subjects in this research. Her health problems do not seem severe enough to be causing her this degree of mental anguish. She says that she does have arthritis and heart trouble but there are no extreme outward manifestations to these problems. Rather, she seems to have lost the will and vigor to live.

The Black Elderly in Hawthorne

Six subjects live in Hawthorne; four males and two females. Four are included in these case studies. They are not confined to any particular area of the town but all live within the boundaries of the town. I originally met these people at the congregate meal site where they meet for lunch everyday.

Mr. T is a small, sprightly man who is 82 years of age. He lives alone, his wife having died almost two years ago. His home is a small wood frame home with a living room, kitchen, two bedrooms, a bathroom and a small back porch where he keeps his washing machine and prepares his herbal medicines. The house is surrounded by a small yard with a fence around the area. Unlike many other elderly people in this sample, Mr. T's home is not cluttered. Furthermore, he maintains his home immaculately clean. He owns his home.

Although Mr. T lives alone, he is surrounded by family members. A sister lives on one side of him and a brother on the other. I never had the opportunity to meet the sister but I have met the brother and he is much younger that Mr. T. In addition to the siblings, Mr. T has one daughter and she lives in the town also. The daughter has several children and these children are often in and out of Mr. T's house. Mr. T says that this daughter will "look after me when I need help but she can't do too much 'cause she's got children of her own to look after." He says that this

daughter does come over and do his laundry and that she also does his grocery shopping for him.

Transportation for Mr. T does not only consist of that provided by his daughter because Mr. T is an avid bicycle rider. The bike provides him transportation to the congregate meal site five days a week and he says that the last time he went to see his doctor that he rode the bike.

Religious faith is an important part of Mr. T's life. On one visit to his house he showed me where he kept his Bible located under his mattress. "It's all to me. Reading this book would help anybody. If it wasn't for the Lord I wouldn't be here this long."

In addition to help from the Lord, Mr. T also uses the natural resources around him to help maintain his health. He takes frequent walks into the woods that are near his home to search for the roots and plants that he uses for his medicines. These plants and roots include rabbit tobacco, snake root, wild garlic and asafetida. These plants and roots are prepared in various ways and preserved in old whiskey bottles.

Self-treatment has not always resulted in the best interest of Mr. T. When he was a young man, "back in the 20s," Mr. T was involved in an automobile accident that broke the humerus bone in his left arm. Mr. T attempted to set the bone himself and put the arm in a sling. The treatment did not work and as a reult of that treatment, Mr. T's upper arm gives the appearance of having been tied

into a knot. It is grossly deformed but Mr. T has learned to manipulate and use his arm to an amazing extent. I asked him why he had not sought medical help and he stated that his friends tried to talk him into this course of action also but that "I was just too hard-headed."

Health is not a major concern to Mr. T at this time. He has some arthritis which causes him some pain in his legs and he says that he has high blood pressure. However, he says that "high pressure" is not a problem as long as he drinks a cup a day of an elixir that he prepares from wild garlic roots preserved in vinegar.

Mr. T and Mr. R are close friends. Like Mr. T, Mr. R is also an avid bicycle rider and they eat their noon meal together at the congregate meal site. Mr. R is a very tall, thin man who is 69 years old.

Mr. R lives in a small five-room wood frame house located on a dirt road near the city limits of this rural community. A fence surrounds the yard and serves to hold the chickens that wander loose within the confines of the fence. There is no grass in the yard.

Extensive family members are also found around Mr. R but he is not so happy with his family connections. Mr. R married his present wife during his more mature years and they have three teenage sons from this union living at home with them. Additionally, his wife has two daughters from a previous marriage living with them and each of these daughters have several small children.

The daughters from his wife's previous marriage are a major cause of dissension between Mr. R and his wife. Mr. R once called me and asked me to come and visit his wife. When I asked what seemed to be the problem, he stated "she needs a talking to. Those girls are giving her hush-mouth money but I ain't getting none." It seems that the daughters were giving their mother a minimal amount of money all along but none to Mr. R and he felt that he should be given something to compensate for their presence. Mr. R's wife said that she expected that the daughters would be moving out in the near future. However, the daughters were still there two years later and the strain between Mr. R and his wife seemed to have increased. On my last visit, he stated that "I hope I don't kill nobody."

Mr. R has worked at various kinds of jobs over his life. He stated that he was "raised on a farm" and his first employment was on a chicken farm. From this, he went to a job with a pulpwood company and finally to a job with a concrete company. Working with a concrete company has had two major impacts on Mr. R's life. First of all, the job resulted in a larger Social Security check than that of many of the other subjects in this research and, according to Mr. R, the job "ruined my nerves." He frequently appears agitated and when asked to evaluate his mental health, he stated that his nerves were "poor" and "worse" than they had been in prior years.

At the beginning of this chapter I stated that there were two men among the subjects that I have referred to as "philosophers" and Mr. J from Archer was one of those men. The other "philosopher" is Mr. H and he lives within the city limits of Hawthorne. Mr. H is 77 years old and has lived with his daughter--his only child--for the past eight years since the death of his wife. He speaks very proudly of his daughter whom he says is "college educated."

Mr. H, like Mr. J, has not only experienced life but has tried to determine why life has been as it has. One day after Mr. H had described some of his experiences in a segregated society, I commented to him that I was amazed at his acceptance of me--a white female researcher--and I asked him why he felt that he could talk with me. "White women have given my people more help than any one else. Why, they're even more better than our own people are to us," he explained. This "better" characteristic was only ascribed to the white female, however, and not to the white male. He went on to explain that "we're still having troubles from the white man."

When comparing the totality of life now to what it was in previous times, Mr. H states, "living now is like being in heaven. The young folks don't like to hear us old folks talk like this. They think it's slave talk. But Missy, you just don't know where we've been."

The health of Mr. H has declined significantly over the past few years. On my first visit with him, he was a

robust, vigorous person who enjoyed putting puzzles together. However, on my next visit a year later, Mr. H appeared to be distressed over his health. "I don't know what's wrong with me but I know somethings wrong," he stated. He said he had been to see his doctor but "he didn't reveal any serious problem to me." His failing health was obvious on preceeding visits as he continually lost weight and said that "seems like nothing don't taste good." His doctor finally told him that he has inoperable cancer and although this was hard to accept, he seems less distressed now that he knows exactly what is wrong with him. "I'm prepared to meet my Maker," he stated.

Not all of my subjects living in Hawthorne are males. Two are females and Mrs. V is one of those. She is 82 years old and she lives alone in what she calls a "government rebuilt house." All of her family members have died; her brothers and sisters, her husband, and one child who was born dead.

Mrs. V and her husband bought their small home "a long time ago." Her husband was a "turpentine man" and she worked "in the fields and in a laundry." The house was renovated several years ago with the aid of federal monies. It is in very good condition and is well kept both inside and out.

Social contacts are minimal for Mrs. V with most of her contacts coming from the congregate meal site where she has her noon lunch five days a week. "I ain't got many friends.

People ain't like they used to be," she stated. The main social contact outside the congregate meal site is a "godchild" who, according to Mrs. V would "give me some help if I needed it." This godchild provided the transportation for Mrs. V's last visit to the doctor but she charged Mrs. V $10 for the trip. Mrs. V uses the Older American's Council (OAC) for one trip to the grocery store every month but at other times she must walk to a small store that is within walking distance. I asked her if she had ever thought about what she would do if she became ill and had to have some assistance and she responded that "I'll have to leave that up to the Lord."

Mrs. V not only has few social contacts; she also has meager economic resources. Her work in the fields and in the laundry has resulted in a very small amount of income from Social Security but she is also receiveing a small amount of money from Security Supplemental Income (SSI). At one time she had received food stamps but has now decided that "it's too much trouble. I'd rather do without. It weren't much anyway."

Outwardly, Mrs. V appears to be a very happy woman. She always has a smile and apparently gets along well with her counterparts at the meal site. However, happiness was not expressed when I asked her about the quality of her life. During the years that I have known Mrs. V she has consistently rated her life in general, her emotional health and her physical health as poor. Furthermore, she says that

she worries a lot. "I,m always so tired that I can't do anything," she stated. She is taking medication for a heart problem and for high blood pressure but she expresses no faith in the medical establishment. " 'Bout the best thing you can do is talk to the Lord 'cause He's the only one can heal you," she stated.

The Black Elderly in High Springs

Six of the elderly people who have participated in this research live in High Springs; four females and two males. With the lone exception of one man, all live "across the tracks," both literally and figuratively, in an area known as "the quarters." Only black persons live here. The streets are mainly unpaved and the area appears blighted. There are several "juke joints" in the area. Three of these subjects are included in the case studies.

The oldest person in this study is Mrs. D who is 94 years old. She is affectionately called "Grandmother D" by her friends at the congregate meal site. She has been a widow for over 20 years

Mrs. D lives in a home that must have been beautiful at one time but now is on the verge of disintegration. The house is an old two story frame house with a porch across the front. The steps leading into the house are now rickety and the porch has many loose or missing boards. There are cracks in the walls and several windows have broken windowpanes. A small gas heater is located in the living room area and a free-standing kerosene heater is located in

Mrs. D's bedroom. On one particularly cold day when I was visiting with Mrs. D, she tried to light the kerosene heater but she did not know how and we had to continue our visit in a very cold room. There is no hot water available in the house. This home, as so many others in which I have visited, seems to be exploding with items that it surely took a lifetime to collect. Mrs. D sleeps in a in a bed that is literally piled high with quilts and covers.

Social contacts are minimal for Mrs. D at this time of her life due to her age and physical health. She has outlived all four of her children. She shares her house with a grandson and grandaughter but I have never seen them there. She explains that they are working during the day but that they are there during the evening. Her declining health prevents her from participating in the congregate meal program anymore but friends from the meal site bring her a lunch everyday and stop in to visit with her for a while. The friends from the meal site have expressed their concern to me over the refusal of Mrs. D to eat all the food that they bring her but she says that she only wants the milk " 'cause I don't have much of an appetite anymore." These daily contacts keep Mrs. D informed of the personal and social activities of her friends and she seems to enjoy these daily visits.

Obtaining food presents no problem to Mrs. D. Her noon meals are brought to her and her grandaughter does the grocery shopping and preparing of the evening meal. When I

asked Mrs. D about gardening she stated "Lordy child, I miss my garden. I don't fool with it anymore, ain't able to do it."

The physical health of Mrs. D has declined rapidly over the years that I have known her. She did not respond to the four antigens when her immune functioning was checked in 1981. At that time, however, she was participating in the meal site program everyday and she was able to come to Gainesville for the medical checkup. However, on each subsequent visit, she was no longer able to leave her house. Her only physical complaint was about the arthritis in her knees. The knees are very swollen and make it difficult, if not impossible, to climb the steps that lead in and out of her house. She is not taking any medications.

Faith appears to be the major source of comfort to Mrs. D at this time. All conversation, regardless of the topic, somehow evolves back to this faith. She states, "I don't use those home remedies anymore. I pray, and the Lord's done blessed me." When I asked her about her activites everyday, she stated "I'm serving my God." After one visit, I asked her if I might return the next week to see her and she replied, "surely child that would be fine but if I don't get to see you here, I'll see you in heaven."

Perhaps Mrs. D's faith accounts for the optimistic outlook that she has although life could not have been easy for her. She worked in the fields as a child and later after her marriage, she continued this activity along with

her husband. As a result, she had no Social Security benefits when she became too old to work. She receives a small amount each month from Security Supplemental Income (SSI) and she gives most of this to the grandchildren in return for her care. These problems, however, do not seem to bother her. When I asked her about her satisfaction with life, she responded, "I'm perfectly satisfied. The Lord's looking out for me. If He likes me, I guess I'm 'sposed to like myself and I sure do."

Although life has been difficult for all these elderly people, few live in circumstances as dire as those of Mr. C. He is an 85 year old man who appears to be several years younger. He has been separtated from his wife for about three years and has one son by this wife. Mr. C states that this son is "bout 20 years old. He lives with his mama and I don't never see him."

The house where Mr. C lives is delapidated to the point of being almost uninhabitable. He pays $55 a month for rent of the house. The area around the house is grown up in weeds and bushes which make getting into the house somewhat difficult. A door that is swinging on it's hinges leads into a small screened porch. Inside, the house has a living room, bedroom kitchen and a bathroom. All the floors are bare wood. In the living room, there is an old couch, a straight-back chair and a small kerosene heater. The house always feels cold in the winter and there is no method of cooling during the summer.

The health status of Mr. C seems to have improved during the years that I have known him. My first visit with Mr. C lasted for about three hours. After this visit, I arranged for him to come into Gainesville for a medical examination. He came to the clinic with several other black elderly persons, all of whom he was acquainted with. I met him at the door of the clinic and much to my surprise, he draped his arms around me and began crying. My first assumption was that he was in a strange area and that his crying was most likely a fear reaction. He could not seem to tell me what was wrong but I happened to look down at his feet and saw that his feet were swollen to several times their normal size. I asked if he was hurting and he could only nod his head affirmatively. After getting him seated in a chair and elevating his feet, the physicians assistant took his blood pressure and found it to be over 200 systolic and 100 dystolic. The clinic physician checked him and found him to be in congestive heart failure. A call was made to Mr. C's doctor in High Springs and the clinic physician explained Mr. C's condition to his doctor.

The doctor's reaction was one of anger. He stated that he could not get Mr. C to keep his appointments or to take his medication and that he simply had no more patience with Mr. C. In actuality, however, Mr. C had no way to get to the doctor's office and had not told anyone of his need. Furthermore, transportation to a pharmacy and paying for medications presented Mr. C with seemingly insurmountable

obstacles. Once these needs became known, his friends at the meal site began taking him to the doctor and the pharmacy whenever he needed to go. On my last visit, there was very little swelling in his feet and he said he was taking his medication.

The mental outlook of Mr. C seems incongruous with his total life. I asked him if he had a friend or someone that he could talk to when he had troubles. "I don't have no troubles," he replied. At another time he stated, "I'm happy all the time." When I asked him what he would do if he became too ill to care for himself, he explained that his next door neighbor would take care of him. However, this neighbor is a young woman with several small children and it seems unrealistic to me that she would take on the care of this man. Overall, at this time, he seems to be coping adequately in meeting his needs mainly due to the efforts of friends at the meal site, but if his needs increase, it is doubtful that he could maintain his independent lifestyle.

All of the subjects discussed up until this point either are presently or have in the past, been married. The following subject, Ms. O, has never been married. According to Ms. O, "I've had lots of boyfriends. I just never married 'em." Ms. O is 66 years old and lives alone in a house belonging to a friend. She pays no rent because she says "I take care of this house for the lady who owns it."

Although Ms. O never married or had any children of her own, more children are found around Ms. O's home than any of the other subjects. The reason is popsicles. Ms. O gets up every morning and freezes a batch of popsicles. The children, both black and white, come every day after school and quietly knock on her door and tell her what flavor they would like. She gets the popsicle out of the freezer; they give her a dime and then they leave. The whole exchange is characterized by quietness but many smiles. I have never seen the children behave rowdy and Ms. O looks forward to these afternoon exchanges. She says that she makes a little money in this way but mostly she simply enjoys having the children drop by. She states, "Somedays I don't feel like making popsicles or selling 'em. Then I close the curtains and shut the door and play like I'm not here." These times are the exception however, and from 10 to 15 children may stop by on any afternoon.

Another distinguishing characteristic of Ms. O is that she is currently employed. She cleans an office building five afternoons a week. The office building is within walking distance but I have noted that Ms. O can and does walk rather long distances. Although Ms. O uses several methods to improve her financial status, her income is still less than $300 a month. She states, "I have barely enough to just get by on."

The major health problem of Ms. O is diabetes which she seems unable to bring under control. The normal range for

glucose level in the blood is from 70 to 110 mg/dl but Ms. O's blood glucose level was 361 mg/dl when she came to the clinic for a checkup. Even though the blood glucose level was very high, her doctor did not change the amount of medication that she was receiving. She takes three pills a day for the diabetes, one pill "to improve my circulation," and a pill to control high blood pressure. Ms. O eats her noon meals at the congregate meal site and no special diets are available there for people who need them.

Life in general is not as severe as that of other of the subjects but Ms. O does not perceive of the qualtiy of her life as being as good as some of the other people have. Scores greater than six on the Short Psychiatric Evaluation Schedule (SPES) section of the Functional Assessment Inventory (FAI) are considered by its developers to be pathological. Ms. O scored seven on the SPES but I believe this score is more related to her diabetic state than to her mental state. I have spent many hours with Ms. O and found her to be a very pleasant and cheerful person to be around. She rates her satisfaction with life in general as only fair but this may be a more reasonable assessment than many of the others that the black elderly subjects in this study have expressed.

The Black Elderly In Waldo

Five subjects live in the small town of Waldo. Instead of considering them separately, as I have the other subjects, I will discuss them together. I have chosen to do

this because they share so many similarities. They are Mrs. L, aged 82; Mrs. E, aged 77; Mrs. A, aged 81; Mrs. G, aged 83; and Mrs. M, aged 81.

These five women live very near each other and are very good friends. Mrs. E, the youngest of the group, is the only one who owns and drives a car and she provides transportation to the grocery store and to doctors appointments for the other women. I asked her if she did not consider this to be burdensome but she explained, "it gives me more time to visit." Adequate visiting time does not appear to me to be a problem because on visits to any of these women, one or more of the others were likely to drop in for a chat. Mrs. E is the only one of the group who is still married but her husband has been ill for several years.

None of these women ever had a living child. Mrs. E stated that she was told by her doctor that she had a "crooked womb" and was therefore unable to conceive but she states that "I raised a niece." Mrs. L had "one baby born dead. Something went wrong with my womb." The other ladies apparently had not considered a reason for this problem. Mrs. A stated that "it just weren't meant to be" and Mrs. M said that "I guess I should've asked a doctor but I didn't."

All of these women own their homes with the exception of Mrs. G and she rents a home owned by Mrs. M. The homes appear to be in adequate condition although Mrs. A says that termites are eating the house and she has no money for

repairs. She inherited the house from her parents and she keeps the house very neat, both inside and out. The rental home of Mrs. G is in poorer condition than the other homes. There are broken windowpanes, broken boards on the porch and cracks between the boards in the walls. A hot water heater was only recently added to the house and she, as so many others in this study, keeps her house totally cluttered. Mrs. L and Mrs. A apparently demand more privacy that the other women because their homes are enclosed by fences.

Religion is also very important to these women. Mrs. M states, "I be praying all the time. I ask the Lord to strenghten me." "I rely on prayer. It gets me through," states Mrs. E.

I had heard so many of my subjects discuss the importance of religion in their lives that I began to assume a common morality for all my subjects and this mistake was brought to my awareness by Mrs. G. One day as we were discussing her inability to have children, I asked her how long she was married to her husband. She replied, "Oh, 'bout two years." I suggested that perhaps this might explain why she had no children. A large smile came over her face as she patiently explained to me, "honey, I might not have been married long but I shore had plenty of boy-friends. In fact, I'm still looking for one but those men down there at the meal site ain't no good." I was well reminded to not take too much for granted with my elderly subjects.

Only one of these women is growing any food although all stated that growing a garden was a part of their past that they missed. The general concensus seems to be that as expressed by Mrs. L when she states, "I'm not able to garden anymore." Mrs. G, however, continues to grow various "greens" and she grows these both within her yard and in a discarded bathroom commode which sits in her front yard. Mrs. L provides the women with transportation to the grocery once a week. All the women with the exception of Mrs. L, eat their noon meal at the congregate meal site. Mrs. L states that she eats at home in order to be with her husband.

Another interesting similarity between these women was that three of these women only had vision in one eye and the other eye was damaged. Mrs. G lost the ability to see in one eye due to glaucoma and she has limited vision in the other eye from the same problem. Mrs. M was accidently burned as a child and this accident resulted in the loss of vision in one eye. She has a cataract that is limiting her vision in the other eye. Mrs. L lost one eye "in a fight" and she also has a cataract resulting in reduced vision in her other eye.

Generalizations

The black elderly people in this sample share many similar characteristics. They live in rural areas and many

have no or few family members still living in the area. Most are poor and have low educational levels. Very few have personal transportation and therefore must rely on others to get them to the grocery stores and medical appointments.

Coping with adversity has been a way of life for these people. They grew up in a segregated society in which the black person had very little opportunity for advancement. The development of survival strategies had to be learned at a very early age and these strategies are now sustaining them during their old age. Stoicism appears to be a major part of their adaptive strategy. I was frequently told that I should not worry about them because their perception was that they would be fine, regardless of the circumstances. The mental outlook of these people is overwhelming optimistic and I always left their presence with an upbeat feeling.

These elderly people were using many resources to assist them in maintaining their independence. Families and friends were the source of much of their assistance but in the absence of these resources, these older people used formal service agencies, creative transportation sources such as bicycles, or they were willing to walk significant distances to obtain their needs. They have much to offer us in learning to cope during adversity and these skills may yet be needed by all people in our society.

CHAPTER FIVE
RESULTS

The Functional Assessment Inventory

The purpose of this study was twofold. First, to determine if the widely used Functional Assessment Inventory (FAI) was reliable and valid for use within a black elderly sample, and second, to examine the lifestyle and coping mechanisms of the black elderly. The first section addresses the issue of reliability and validity of the Functional Assessment Inventory (FAI).

The FAI is a modification of the older version of the Older Americans Research and Service Center Instrument (OARS). Modifications included a systematic reduction of questionnaire items, some rearrangement and the addition of some new items. The instrument evalutes the social resources, economic resources, mental health, physical health and activities of daily living (ADL) of the individual. From the responses, the interviewer makes an evaluation of each domain along a continuum where 1 = "excellent" and 6 = "totally impaired." The scores of each domain are summed to provide an overall cumulative impairment score (CIS). These total scores are then used to

assess the needs of the subject and develop a plan to meet these needs. The plan may recommend assistance from various service agencies or institutionalization may be recommended if the CIS is 17 or higher.

Sociodemographic Data

The sample consisted of fifty-four rural Alachua County residents: 14 black males; 5 white males; 20 black females and 15 white females. The white elderly were included for comparative purposes. All subjects had participated in an earlier (1981) research project that evaluated their health and nutritional status. Selection was made through a snowball sampling technique. Their socioeconomic characteristics are summarized in Table I.

The average age of the subjects was 75. White males and females had an average age of 74 and black males and females had an average age of 76.

Educational attainment was low for all subgroups with the possible exception of the white females. Eighty six percent (N=12) of the black males, 74 percent (N=15) of black females, 60 percent (N=3) of the white males, and 13 percent (N=2) of the white females had not attended high school at all.

The majority of these subjects were either life-long residents or had lived in the area for more than five years. All of the white males (N=5) had lived here five

years or longer. Furthermore, 93 percent (N=13) of the black males, 90 percent (N=18) of the black females and 74 percent (N=11) of the white females were longterm residents in the area.

The females in this sample were more likely to be widowed than were the men. Eighty seven percent (N=13) of the white females and 84 percent (N=17) of the black females were widows. However, only 6 of 14 black males and 2 of 5 white males were widowers.

Low incomes were characteristic of all the subjects but were more frequently found in the black rather than the white subsample. Black females had the lowest incomes with 83 percent (N=17) having incomes either below the poverty level or classified at "near poverty". Near poverty is defined as income between the poverty level and 125 percent of poverty (Longino 1983). Fifty five percent (N=9) of the black males and 51 percent (N=9) of the white females had incomes below the poverty level but no white males had incomes at this low level.

Home ownership was high for this group. Eighty percent (N=4) of the white males; 50 percent (N=10) of the black females; 40 percent (N=6) of the white females and 36 percent (N=5) of the black males owned their homes. More information about the physical condition of the homes of the black elderly is presented in a later section.

Table I. Sample Characteristics.

	Black Males (N=14) Avg. Age 76.2		White Males (N=5) Avg. Age 73.6	
	N	%	N	%
Education:				
1. 0-4 yrs.	9	64	1	20
2. 5-8 yrs.	3	22	2	40
3. High School (Incomplete)	1	7		
4. High School (Complete)				
5. Trade School				
6. 1-3 yrs. College	1	7		
7. 4 yrs. College			1	20
8. Post Graduate			1	20
Length of Residence:				
1. Seasonal				
2. Less than 5 yrs.	1	7		
3. 5 yrs. or more	13	93	5	100
Marital Status :				
1. Married	3	21	2	40
2. Widowed	6	43	2	40
3. Divorced	1	7		
4. Separated	4	28	1	20
5. Never Married				
Income:				
1. 0-$999				
2. $1,000-$1,999				
3. $2,000-$2,999				
4. $3,000-$4,999	9	55		
5. $5,000-$6,999	3	27	3	60
6. $7,000-$9,999	2	18	2	40
7. $10,000-$14,999				
Own Home:				
1. Yes	5	36	1	80
0. No	9	64	4	20

Table I--extended.

	Black Females (N=20) Avg. Age 76.9		White Females (N=15) Avg. Age 73.6	
	N	%	N	%
	9	43		
	6	31	2	13
			4	27
	4	21	6	40
			2	13
			1	6
	1	5		
	2	10	4	26
	18	90	11	74
	1	5	2	13
	17	85	13	87
	1	5		
	1	5		
	4	7		
	13	76	9	51
	2	12	2	16
	1	5	3	25
			1	8
	10	50	6	40
	10	50	9	60

Reliability of the FAI

Measures of reliability showed that the FAI was a reliable instrument. Specifically, the test-retest measure of reliability was conducted within a time interval of four weeks. Correlations between responses of the two tests revealed that the instrument was reliable at the $p < 0.01$ level of probability. Eighty four percent of the scores of each domain were the same and 100 percent of the scores were within one point. Results are summarized in Table II.

Additionally, examination of the inter-item measures of reliability revealed high correlations between total CIS scores and each of the five domain scores. The inter-item test for reliability was highest for the mental health domain and high values were also found for the physical health, economic and social domain in descending order. The value for activities of daily living had the lowest reliability of the domain items, and that was .65. Spearman correlations of the inter-item reliabilities are shown in Table III.

Validity of the FAI

Validity of the FAI was assessed by conducting a Spearman's Rank Order test for correlation between items on the FAI and the large data base already in existence for this group. Correlations were evaluated between individual

Table II. Test-Retest Scores.

	Case 1		Case 2		Case 3		Case 4		Case 5	
	Test-	Ret.	Test-	Ret.	Test-	Ret.	Test-	Ret.	Test-	Ret.
Soc.*	4	4	2	2	2	2	4	4	2	3
Eco.*	4	4	4	4	3	3	4	4	4	4
Ment.*	4	5	3	2	3	3	4	5	4	4
Phys.*	4	4	3	3	3	3	4	4	3	3
ADL*	3	3	2	2	2	2	4	3	3	4
CIS *	19	20	14	13	13	13	19	20	16	18

	Case 6		Case 7		Case 8		Case 9		Case 10	
	Test-	Ret.	Test-	Ret.	Test-	Ret.	Test-	Ret.	Test-	Ret.
Soc.	2	2	2	2	2	3	2	2	3	4
Eco.	3	3	3	3	4	4	4	4	4	4
Ment.	2	2	2	2	3	3	2	3	3	3
Phys.	4	4	4	4	4	4	3	3	3	3
ADL	4	4	2	2	2	2	3	3	3	3
CIS	15	15	13	13	15	16	14	15	16	17

* Soc.=Social; Eco.=Economic; Ment.=Mental; Phys.=Physical; ADL=Activities of Daily Living; CIS=Cumulative Impairment Score.

Table III. Inter-Item Reliability Spearman Correlations.

Domains # of Items	Social 9	Economic 16	Mental 7	Physical 14	ADL** 17
CIS**	.74*	.75*	.80*	.79*	.64*

* $p < 0.001$
** ADL=Activities of Daily Living
CIS=Cumulative Impairment Score

items on the FAI and comparable items in the multiphasic data base as well as total scores in each domain of the FAI and individual items in the multiphasic data base.

A high correlation was found with similarly phrased questions. For example, questions of total income revealed correlations of $p < 0.001$ when responses between the data bases were compared. However, when total scores for the domains were correlated with related individual items in the multiphasic data base, correlations were often not significant. Results for total FAI scores and individual items in the large data base are summarized in Table IV.

Comparisons by Race and Sex

The mean values for the six domains and the SPMSQ were compared by race and sex. Comparisons were made between white and black females; black males and black females; black males and white females; white males and black females; white males and white females; and white males and black males. A t-test was used to determine significance between the means of these groups. These values are summarized in Tables V and VI.

Statistically significant differences were found for race and sex comparisons. White females and males had better scores in all categories. However, due to the small number of white males, along with an unusually high CIS score for

Table IV. Spearman's Rank Correlations of FAI Domain Scores and Multiphasic Data Base Items.

FAI	Multiphasic Data Base	r	Sig.
Social	Number of meals/week eaten with family	.33	p<0.01
	Number of friends		n.s.
	Number of meals/week eaten with friends		n.s.
	Extent of family involvement		n.s.
Economic	Use of food stamps	-.57	p<0.0001
	Income	-.48	p<0.001
	Number of meals/week eaten with family	.26	p<0.05
	Income from SSI	.48	p<0.03
Mental	Zung's Depression Scale		n.s
	Holmes Stress Scale		n.s.
Physical	Ease of movement	.34	p<0.01
	Diabetes (verbal assessment)	-.33	p<0.01
	Glucose (biochemical assessment)	.35	p<0.01
	LDH (lactic dehydrogenase)	.29	p<0.03
	Level of activity		n.s.
	High blood pressure		n.s.
	Low hemoglobin levels		n.s.
	Cancer		n.s.
	Heart disease		n.s.
	Creatinine, serum		n.s
	SGPT (serum alanine transaminase)		n.s.
	Arthritis		n.s.
CIS*	Income	-.36	p<0.01
	Low triceps skinfold	-.26	p<0.05
	BUN (blood urea nitrogen)		n.s.
	Self assessed health status		n.s
	All items related to social involvement		n.s
	All items related to mental status		n.s.
	All items related to ADL		n.s.
SPMSQ*	Income	-.47	p<0.001
	Low triceps skinfold	-.38	p<0.01
	Education level		n.s.
	Age and birthday		n.s.

* CIS=Cumulative Impairment Score
SPMSQ=Short Portable Mental Status Questionnaire

one of the men, drawing conclusions from the mean scores for this group is unfounded.

Results show that white females scored better than the other groups in five out of the seven categories (i.e. SPMSQ, social, mental, physical and CIS). Furthermore, they were tied with white males in the economic domain and there were no significant difference in means of ADL between white males and females. Additionally, scores between black females and black males are very similar.

Comparisons between the races revealed significant differences. The means of white females and black females showed statistical differences in four of the six domains as well as the SPMSQ. No significant differences were found in the social and mental domains. Additionally, comparisons of white females and black males revealed significant differences in four of the six domains and the SPMSQ and no statistically significant differences in the social and physical domain.

In summary, results showed the FAI to be a reliable instrument. Concurrent validity, however, was low in social, physical and mental domains , CIS and SPMSQ. The magnitude of differences between the races exceeded the differences between the sexes with the black elderly scoring higher in the majority of the domains.

Table V. Mean FAI Scores By Race and Sex.

	Black Female (N=20)	Black Male (N=14)	White Female (N=15)	White Male (N=5)
SPMSQ	2.8	2.6	0.4	1.6
Social	2.5	2.6	2.0	3.0
Economic	3.5	3.5	2.8	2.8
Mental	2.8	3.0	2.3	3.6
Physical	3.4	3.2	2.6	3.4
ADL	2.8	2.8	2.1	2.0
CIS	15.0	15.0	11.4	14.8

Table VI. Comparisons By Race and Sex: t-test Values.

	WF/BF*		BM/BF		BM/WF	
	t-test	Sig.	t-test	Sig.	t-test	Sig.
SPMSQ	4.5	p<.001	.25	n.s.	5.2	p<.001
Social	1.5	n.s.	.38	n.s.	1.8	n.s.
Economic	2.4	p<.05	.17	n.s.	2.6	p<.01
Mental	1.8	n.s.	.42	n.s.	2.2	p<.05
Physical	2.7	p<.01	.60	n.s.	1.9	n.s.
ADL	2.6	p<.01	.05	n.s.	2.2	p<.05
CIS	3.8	p<.001	.09	n.s.	3.2	p<.01

	WM/BF		WM/WF		WM/BM	
	t-test	Sig.	t-test	Sig.	t-test	Sig.
SPMSQ	1.2	n.s.	1.7	n.s.	1.1	n.s.
Social	1.1	n.s.	2.1	p<.05	.86	n.s.
Economic	1.4	n.s.	.0	n.s.	1.6	n.s.
Mental	1.7	n.s.	2.9	p<.01	1.4	n.s.
Physical	.0	n.s.	2.0	n.s.	.4	n.s.
ADL	1.9	n.s.	.2	n.s.	1.6	n.s.

*BM= Black male WM= White male
BF= Black female WF= White female

Coping Behaviors

Sample Characterisitcs

Attrition due to medical reasons, resulted in the loss of seven black subjects reducing the sample size to 27; 8 males and 19 females. The average age for this group was 77.5. Sixteen were widowed, four were separated, three were married and three were divorced, and one person was never married. Ten women in the group had no living children and interestingly, nine reported that they never had a living child. Fifteen of these black elderly had no chilren living in the county. Results are summarized in Table VII.

FAI Domains

An exmaination of the social domain of this elderly sample revealed an optimistic outlook concerning the quality and quantity of their social interactions. Twenty-one of the 27 subjects stated that they had someone that they could trust and confide in. Furthermore, 18 of the subjects stated that there was someone who would take care of them indefinitely or as long as needed. Eight subjects felt that they could only count on assistance for a short period of time and one person said that she could only depend on help now and then. When asked who this person was and their relationship to the subject, eight persons said that it

Table VII. Black Elderly Sample.

Sex:	N	%
Male	8	29.6
Female	19	70.3
Average Age 77.5		
Marital Status:		
Married	3	11.1
Widowed	16	59.3
Divorced	3	11.1
Separated	4	14.8
Never Married	1	3.7
Number of Living Children:		
None	10	37.0
One	5	18.5
Two	4	14.8
Three	3	11.1
Four	2	7.4
Seven	1	3.7
Nine	1	3.7
Thirteen	1	3.7
Number of Respondents With Children in County:		
None	15	55.5
One	6	22.2
Two	2	7.4
Three	3	11.1
Six	1	3.7

would be a friend and 18 stated that it would be a family member. Fifteen of those family members who were listed as sources of assistance were female. The remaining three who were males included a son, a son-in-law and a brother.

The economic domain revealed that the majority of these subjects were living in poverty. Only six of the subjects had incomes greater than $400/month. The highest and lowest incomes in the sample were $813 and $222, respectively. However, 14 of the subjects owned their homes.

Responses to items found in the mental domain indicated the presence of mental problems in a significant number of this sample. The Short Psychiatric Evaluation Schedule (SPES) includes 15 items that indicates the level of functional psychiatric symptomatology. A score of four or five is indicative of borderline mental problems and five persons in this sample were within this category. Scores between six and nine are said to be indicative of a pathological state and again, five persons in this sample had scores in this range. Scores between 10 and 12 are believed to be indicative of need for institutionalization and two persons in this sample had scores in this range.

The persons subjective assessment of their mental health was also indicative of problems in many of the subjects. Eighteen of the subjects stated that they never worried but nine stated that they worried either fairly often or very often. Eleven rated their mental health as either fair or poor and 16 stated that their mental health

was good. Ten subjects stated that they considered their lives in general to be either fair or poor and 17 stated that their lives were good.

These subjects considered their physical health to be worse than their mental health. Sixteen stated that their physical health was either fair or poor whereas 11 subjects stated that they were in good health.

Activities of daily living were not perceived to be a major problem in this sample. Twenty-one subjects had average or better scores in this domain, with only six persons having scores (four or greater) indicating impairment in activities of daily living.

In summary, the majority of these black elderly subjects considered their social contacts to be adequate and few problems were encountered in the performance of activites of daily living. However, problems were found to exist in the economic domain and in the domains of mental health and physical health

Material Style of Life

Home ownership, poverty not withstanding, was a characteristic of this sample. Fully 48 percent of the group stated that they owned their homes. The construction material most frequently used in the homes (55 percent) was wood. Concrete blocks accounted for 33 percent and a combination

of these materials for 11 percent of the homes. Material lifestyle data are summarized in Table VIII.

The physical condition of many of these homes, however, was substandard. The average age of the houses was 48 years. Broken windowpanes were found in 26 percent (N=7) of the homes. Leaking roofs were a problem in 11 percent (N=3). Seventy percent (N=19) of the homes needed paint on the outside and 74 percent (N=20) needed painting on the inside. Cracks were seen in the walls of 33 percent (N=9) and broken boards on porches were found in the same percentage of the homes. Screen doors were in need of repair in 44 percent (N=12). However, screens were found to be present on windows in 93 percent (N=25). Rickety steps were found in 33 percent (N=9) of the homes. After completing a checklist of the physical condition of the house, I evaluated the houses as being either excellent, in need of minor repair, adequate, in need of major repairs or as totally uninhabitable. Two of the homes were evaluated as being excellent, three in need of minor repairs, twelve as adequate, four in need of major repair and six as being uninhabitable.

The homes were most frequently heated by room heaters. This method of heating was found in 89 percent (N=24) of the homes. Other methods of heating included fireplaces in 7 percent (N=2) and central heat in 15 percent (N=4) of the homes.

Table VIII. Material Lifestyle of the Black Elderly.

	Yes		No	
	%	N	%	N
Physical Condition of Home:				
Broken Windowpanes	25.9	7	74.0	20
Leaking Roof	11.1	3	88.8	24
Needs Paint Outside	70.3	19	29.6	8
Needs Paint Inside	74.0	20	25.9	7
Cracks in Walls	33.3	9	66.6	18
Broken Boards on Porch	33.3	9	66.6	18
Screem Doors Need Repair	44.4	12	55.5	15
Screens on Windows	92.5	25	7.4	2
Rickety Steps	33.3	9	66.6	18
Heat:				
Fireplace	7.4	2	92.5	25
Room Heaters	88.8	24	11.1	3
Central Heat	14.8	4	85.1	23
No Heat			100.0	27
Cooling:				
Air Conditioner	18.5	5	81.4	22
Fan	77.7	21	22.2	6
No Cooling			100.0	27
Kitchen Facilities:				
Stove	100.0	27		
Hotplate			100.0	27
Refrigerator	96.2	26	3.7	1
Freezer	44.4	12	55.5	15
Hot Water	85.1	23	14.8	4
Miscellaneous:				
Electricity	100.0	27		
Indoor Plumbing	96.2	26	3.7	1
Television	92.5	25	7.4	2
Radio	92.5	25	7.4	2
Telephone	70.3	19	29.6	8
Washer	51.8	14	48.1	13
Dryer	14.8	4	85.1	23
Pets:				
Dog(s)	18.5	5	81.4	22
Cat(s)	14.8	4	85.1	23

Evaluation of Home:	N	%
Excellent	2	7.4
Needs Minor Repairs	3	11.1
Adequate	12	44.4
Needs Major Repairs	4	14.8
Uninhabitable	6	22.2

Cooling, like heating, was most frequently accomplished by room units rather than central units. Fans provided the source of cooling for 78 percent (N=21) of the sample, whereas air conditioning was found in only 18 percent (N=5) of the homes.

Overall, kitchens seemed to have adequate appliances. All persons in the sample had a stove. Refrigerators were found in all the kitchens except one and hot water was found in 85 percent (N=23) of the homes.

Other household apppliances and amenities were found in the majority of homes. Televisions and radios were found in 93 percent (N=25) of the homes; telephones in 70 percent (N=19); and washers in 52 percent (N=14). However, clothes dryers were found in only 15 percent (N=4).

Most often these elderly people did not have pets. Only 19 percent (N=5) of the people stated that they had a dog and and 15 percent (N=4) had a cat. No person had both a dog and a cat, and no other animals were found to be pets except for a fish found in one household.

Coping Nutritionally

Diets were assessed through the use of a food frequency survey. Results revealed a diet low in variety. Table IX summarizes the foods consumed by 50 percent or more of the total sample on a daily, weekly, or never consumed basis.

Very few items (N=4) were consumed on a daily basis. Specifically, only butter and sugar, usually used to flavor foods and drinks were consumed by greater than 50 percent of the sample on a daily basis.

Likewise, few foods were consumed regularly on a weekly basis. Items that were chosen are consistent with a diet that is characteristic of Southern cuisine (Todhunter et al., 1974) but is more restricted in variety.

The breads of choice were cornbread and biscuits. Interestingly, toast or loaf bread in any form was not included in the weekly diet and dinner rolls were rejected by a majority of the sample.

Protein sources were consumed on a weekly basis in the form of chicken, which 66 percent of the people stated that they ate every week, and hamburger, eaten weekly by 56 percent of the subjects.

The vegetables most frequently chosen were greens and mashed potatoes. The category "greens" included turnip greens, mustard, collards, spinach, etc. Sixty-three percent of the sample said they ate greens every week. The same percent said that they ate mashed potatoes on a weekly basis. In contrast, field peas, often characterized as a favorite food of rural Southerners, was consumed weekly by only 41 percent of the subjects.

The only fruit consumed weekly by a majority of these subjects was in the form of a fruit salad. Exact contents of

these fruit salads are not known and they may or may not be rich as a source of vitamin C.

Desserts were not frequently consumed by this group. However, among those desserts consumed, jello and cookies seem to be the most popular desserts. Cookies were consumed weekly by 70 percent of the sample and jello was consumed by 63 percent of the group.

Variety was very low in this core diet. However, when the range was extended to include those items consumed by 40 percent of the subjects, lack of variety becomes much less of a problem. Specifically, 22 additional food items were found to be eaten weekly when the range was lowered from 50 to 40 percent. These items included cabbage, scrambled eggs, sausage, saltine crackers, apples, rice, carrots, whole wheat bread, cheese, mayonnaise, coleslaw, lettuce, fried fish, grits, bananas, chocolate cake, fried eggs, green beans, hot dogs, macaroni and cheese, field peas and pudding. The inclusion of these secondary food items presented a better indication of the actual eating patterns of this sample.

Whereas few food items (N=9) were chosen on a weekly basis by 50 percent of the subjects, many items were found in the "never consumed" category. Alcoholic beverages in any form were rejected by the greatest majority of subjects. Alcohol or liquor was rejected by 93 percent of the sample; beer by 78 percent; and wine by 89 percent.

Table IX. Food Frequency.*

Food Items	Daily		Weekly		Never	
	%	N	%	N	%	N
Butter	77.7	21				
Coffee	62.9	17				
Milk	70.3	19				
Sugar	59.2	16				
Biscuits			55.5	15		
Chicken			66.6	18		
Cookies			70.3	19		
Cornbread			62.9	17		
Fruit Salad			51.8	14		
Greens			62.9	17		
Hamburger			55.5	15		
Jello			62.9	17		
Mashed Potatoes			62.9	17		
Alcoholic Drinks					92.5	25
Beer					77.7	21
Bologna					51.8	14
Chocolate Syrup					85.1	23
Cottage Cheese					59.2	16
Dinner Rolls					51.8	14
Milkshakes					59.2	16
Pancakes					51.8	14
Pizza					81.4	22
Popcorn					66.6	18
Pork Chops					51.8	14
Stewed Prunes					51.8	14
Waffles					59.2	16
Wine					88.8	24
Winter Squash					66.6	18
Yogurt					59.2	16

* > 50 percent of the Sample

Two protein sources which might have been expected to be eaten frequently but instead were found in the "never eaten" category were pork chops and bologna. Pork is often characterized as the meat of choice for Southerners but this was not found to be true in this sample. Both pork chops and bologna were never eaten by 52 percent of the sample. Only 18 percent stated that they ate bologna weekly and 15 percent stated that they ate pork chops weekly.

Several items which might be found to be consumed in younger groups, were found to be rejected in this older sample. For instance, milkshakes, yogurt and cottage cheese were not consumed by 59 percent of the sample. Pizza was not consumed by 81 percent and popcorn by 67 percent of the subjects. Flour products fared poorly with this group. Waffles were not eaten by 59 percent of the sample; pancakes and dinner rolls by 52 percent. One fruit and one vegetable was not eaten frequently by this group. Stewed prunes were not consumed by 52 percent of the sample and winter squash by 67 percent of the sample.

In summary, four items were consumed on a daily basis by 50 percent or more of the sample, nine items on a weekly basis and 16 items were said to be never eaten by this sample. Secondary food items, however, reveal a diet of greater complexity.

Methods used by the rural black elderly to obtain their food was assessed through the use of a questionnaire

(See Appendix C). Results from this questionnaire are summarized in Table X.

Even though the elderly people who were included in this sample reside in rural areas, the majority continued to shop in large retail markets rather than small markets. Fifty nine percent were shopping in large markets; 41 percent in small retail markets. No subjects stated that they shopped in convenience markets or other forms of retail outlets.

The receipt of food during the week from various sources was also characteristic of this sample. When asked if they received food from outside sources either always, sometimes or never, 30 percent stated that they always receive food, 48 percent stated that they sometimes receive food and 22 percent stated that they never receive food from outside sources. The source of most of these food receipts was the congregate meal sites where many of these elderly persons ate. Some subjects ate at the meal sites five days a week whereas others ate there sporadically.

The ability to obtain groceries independently was seriously impeded in this sample since only three people had personal transportation. When asked their choice of action if they needed to obtain groceries at unscheduled times, one person said she would simply forget it; 15 percent (N=4) said they would walk; 7 percent (N=2) said they would drive themselves; 11 percent (N=3) would hire someone; 22 percent (N=6) said that a friend would take them; 26 percent (N=7) stated that a family member would be willing to drive them;

and 15 percent (N=4) stated that they would ride on an Older American's Council (OAC) van.

Subsequent to elucidating their choice of action, each subject was asked how they went to the grocery store on their last visit. Eleven percent said they drove themselves; 15 percent had gone with a friend; 30 percent had been driven by a family member; 15 percent had walked; 11 percent had hired someone; and 18 percent had ridden on an OAC van. These modes represent the usual patterns of action.

Gardens were not providing a significant amount of food to this sample. Sixty-seven percent stated that they had no gardens and 33 percent (N=9) were growing some of their food. These gardens ranged in size from large plots for two of the subjects with the other seven gardeners growing only small amounts within the confines of their yards. Items most frequently grown were greens, tomatoes, onions, peas, and corn.

Likewise, preserving food for use at later times was not practiced to any great extent even by those who were gardening. Only 11 percent (N=3) were preserving any food at all from their gardens. The reason given for this failure to preserve food was that they were simply no longer able to engage in this activity.

Raising animals, either for consumption of the animal or for consumptioin of their byproducts, was almost

Table X. Food Procurement.

	%	N
Kind of Store Used Most Frequently:		
Small Retail	40.7	11
Large Retail	59.2	16
Receive Food From Others:		
Always	29.6	8
Sometimes	48.1	13
Never	22.2	6
Choice of Action if Food is Needed in Middle of Month:		
Forget it	3.7	1
Walk	14.8	4
Drive Self	7.4	2
Hire Someone	11.1	3
Go With a Friend	22.2	6
Ask a Family Member	25.9	7
OAC Van	14.8	4
Source of transportation to Grocery Store on Last Visit:		
Drove Self	11.1	3
Friend	14.8	4
Family	29.6	8
Walked	14.8	4
Hired Someone	11.1	3
OAC Van	18.5	5
Garden:		
Yes	33.3	9
No	66.6	18
Preserve Food From Garden:		
Yes	11.1	3
No	88.8	4
Raise Chickens:		
Yes	7.4	2
No	92.5	25
Consume Eggs From Own Chickens:		
Yes	7.4	2
No	92.5	25
Raise Pork for Consumption:		
Yes	3.7	1
No	96.2	26
Raise Beef for Consumption:		
Yes	3.7	1
No	96.2	26

nonexistent in this group. Seven percent were raising chickens and were eating eggs obtained from them. Four per cent were raising beef and pork for consumption. However, no one was obtaining either milk or butter from their cows.

Coping Medically

The health status of this group was evaluated in 1981 and again in 1982-83. Comparisons of the data sets revealed a lack of congruence concerning the health status of the subjects and their perception of their health. Data are summarized in Table XI.

The research which examined the health problems of this group in 1981 was comprehensive. Home interviews, ranging between two to three hours in duration, as well as physical and biochemical assessment by physicians, were included.

In the 1981 survey, 67 percent (N=18) of these subjects stated that they had high blood pressure. Blood pressure checks revealed that only two persons had blood pressure readings of greater than 160 systolic or 95 diastolic. In comparison, when again asking these subjects if they had high blood pressure in 1982-1983, only 48 percent (N=13) stated that they had high blood pressure. Twelve of these 13 were taking prescription drugs for high blood pressure. The other person had a prescription but had decided that she no longer needed it and therefore was not taking the drug.

Table XI. Assessment of Physical Health.

	1981 Interview		1982-1983 Interview	
	%	N	%	N
High Blood Pressure	66.6	18	48.1	13
Coronary Heart Disease	29.6	8	14.8	4
Arthritis	88.8	24	77.7	21
Diabetes	22.2	6	22.2	6
Anemia			14.8	4
	Clinical			
High Blood Pressure	7.4	2		
Lack of Immunity	18.5	5		
	Biochemical			
Low Hemoglobin (Normal=12.0-16.0 gm/dl)	11.1	3		
High Cholesterol (Normal=155-355mg/dl)	0.0	0		
High Triglycerides (Normal=30-180 mg/dl)	7.4	2		
Elevated Glucose (Normal=70-110 mg/dl)	18.5	5		

Likewise, there was no congruence between information obtained relating to the presence of coronary heart disease (CHD) and arthritis in the two data sets. Thirty percent (N=8) of the subjects stated that they had CHD in 1981 but only 15 percent (N=4) stated that they had the disease in 1982-1983. Three of these subjects were taking medication for CHD. Biochemical assessment of the blood constituents, cholesterol and triglycerides, revealed no "out of range" values for cholesterol and only two persons with elevated triglycerides.

The only chronic disease for which there was consistent agreement between the two data sets was diabetes. Twenty-two percent (N=-6) of the subjects stated that they were diabetic in both instances and elevated glucose levels were found in the blood samples of five of these people. Four subjects were taking insulin, either orally or by injection, in 1982-1983.

No questions were asked in 1981 about the presence of anemia in this sample. However, 15 percent (N=4) stated that they were anemic in 1982-1983 and blood samples taken in the 1981 survey revealed that 11 percent (N=3) of the sample were anemic.

Immune incompetence is considered to be a life-threatening situation and eighteen percent (N=5) of these subjects were found to be anergic in the 1981 survey. Even though all were still alive in 1982-1983, the health status of two of these persons had declined precipitously.

Coping behaviors associated with obtaining medical needs were similar to those utilized in procurement of nutritional needs. These coping behaviors are summarized in Table XII.

Even though experiencing the dual problems of poverty and lack of transportation, it is evident that this sample is participating in popular Western medicine to a significant extent. Fifty-two percent had visited their doctor within the last week or month and 85 percent within the last six months. I was able to verify these medical visits in 59 percent of the cases by examining the labels of prescriptions given to them by their doctors.

The ability to get to a doctor may be seriously impeded by lack of transportation but this sample seems to have circumvented that problem. Most frequently a family member takes the subject to the doctor. Twenty-two percent (N=6) stated that a family member had taken them to the doctor on their last visit. In descending order,friends and the OAC van each provided transportation to physicians 19 percent (N=5) of the time; 11.1 percent (N=3) had driven themselves; 15 percent (N=4) had hired someone; 11 percent (N=3) had walked; and one person had ridden on a bus.

The majority of these subjects felt that their medical needs were being met at the present time. When asked if they had unmet medical needs, 37 percent (N=10) said yes and 63 percent (N=17) said they had none. The major perceived unmet needs were with vision and dental problems.

Table XII. Coping With Medical Needs.

	%	N
Date of Last Visit to Doctor:		
This Week	22.2	6
This Month	29.6	8
Within Last Six Months	33.3	9
Within Last Year	3.7	1
Over a Year	11.1	3
Method of Transportation:		
Drove Self	11.1	3
Hired Someone	14.8	4
Family	22.2	6
Friend	18.5	5
Walked	11.1	3
OAC Van	18.5	5
Bus	3.7	1
Unmet Medical Needs:		
Yes	37.0	10
No	62.9	17

Priority of Action When Flu-Like Illness Occurs:	First		Second		Third	
	%	N	%	N	%	N
Pray	7.4	2	3.7	1	62.9	17
Home Remedies	18.5	5	11.1	3	0.0	0
OTC Medications	66.6	18	22.2	6	3.7	1
Call Family/Friend	3.7	1	3.7	1	0.0	0
Visit a Doctor	3.7	1	59.2	16	33.3	9

These subjects were also asked to prioritize their usual mode of actions when they become ill. Since many of these subjects may not consider themselves to be "ill" when chronic diseases are present, illness was defined in terms of catching the flu. Subjects were not prompted as to categories of answers but their responses were all found to fit within five of the seven categories listed on the questionnaire (See Appendix C).

The primary action of choice for this sample was the use of over-the-counter drugs. Sixty-seven percent (N=18) said that their first action would be to try some form of OTC drugs; 22 percent (N=6) said this would be their second choice of action; and one person said that using OTC drugs would be the third choice of action.

Home remedies accounted for the next major category for course of action. Nineteen percent (N=5) stated that the first thing they would do if getting the flu would be to use a home remedy. These home remedies were very varied and will be discused at greater length in the next chapter.

Looking at the three choices of action together, 48 percent (N=13) of this sample said that their first action would be to buy OTC drugs. If that fails, then they would visit a doctor and finally, they would enlist the aid of the Lord by praying.

Prioritizing prayer was a difficult problem for this sample. Even though only 7 percent (N=2) stated that prayer would be their first choice of action, the whole idea of

deciding where to place this in a continuum of action seemed a moot point to these subjects. One subject, when asked about the role of prayer in her life responded, "Prays? I prays all de time". Prayer was used concomitantly with other forms of therapy.

CHAPTER SIX
DISCUSSION

Reliability and Validity of the FAI

I conducted a reliability and validity study of the FAI in a heterogeneous community-based sample that included both black and white elderly persons. Although these issues have been dealt with in previous work either for the FAI (Pfeiffer 1975; Pfeiffer, Johnson and Chiofolo 1981; Cairl et al. 1983) or the parent instrument, the OARS (Fillenbaum and Smyer 1981; Pfeiffer 1976) this study makes two additional contributions by extending the range of sampled populations and by explicating the cultural bias of the instrument.

As noted both in the work of Pfeiffer (1975) and in this study, elderly black people tend to score higher than their white counterparts. Pfeiffer contends that this is more a problem of educational attainment than of other factors. However, in this study educational attainment was low for all subjects with the possible exception of some white females. It should be noted, furthermore, that black elderly people frequently stated that their school year consisted of from two to four months rather than the typical nine to ten months common to the white elderly. Educational

attainment has affected the vocabulary of this sample, but lack of education has not resulted in inability to communicate. Assessments should be conducted in a language with which the person is familiar. Many of these subjects spoke "Black English" which is a dialect of standard English.

A major problem in using this instrument among various groups is linguistic diversity. According to training in the administration of the FAI, the interviewer cannot deviate from the exact wording of the questionnaire. As a result of this restriction, many questions were not understood and resulted in erroneous responses. Examples include the use of such words as disabled, income, employed, rent subsidy, investments, trusts, annuities, extreme satisfaction or dissatisfaction, rate, inpatient, interfere, etc. Coyle (1981) also found the language of the OARS to be a barrier when administered to rural black elderly.

Another possible explanation for the disparity seen in the scores between the white and black elderly persons may be the differing lifestyles of the two groups. Consideration of variation in lifestyles is necessary when designing instruments to assess functioning. Questions must be relevant to the person who is being assessed. Many of the questions on the FAI fail to meet this criterion. For instance, many elderly in the rural areas have no phones or street addresses and nursing home residents may consider themselves to have no street address. Yet, these questions are found at the beginning of the FAI, on the SPMSQ, which

assesses the ability of the person to complete the instrument.

Specifically, the SPMSQ consists of 10 items designed to assess the mental ability of a person. Items one to three and five to eight are designed to test orientation and the subjects are allowed no aids, such as calendars or newspapers, to assist them in answering these items. All subjects in this research knew where they lived but many had problems with the date and day of the week. Knowledge of current day and date are important to the person actively involved in meetings and world events but for the person removed from these circumstances, it is perhaps more significant that they know where to obtain the information when it is needed. Few had trouble with their birthdate but some wanted to double check the family Bible for this information. Item four asks the person to give his or her phone number and if they have no phone, to give the street address. This item is to "test memory function specifically related to capacity for self care in the environment" (Pfeiffer 1975 p.435). Again, this question has greater relevance to younger age groups than to the very old. Even though they typically could not cite their phone number, all knew where to find the number and some had even copied the number on a slip of paper that they kept in their billfolds or purses. Furthermore, some of these rural elderly people had no street addresses.

The item most frequently missed on the SPMSQ was item 10. This item asks the subject to subtract three from 20 and keep subtracting three from each new number, all the way down. This item is designed to test the capacity to perform serial mental operations and is a level of abstraction that most of the subjects were not able to do correctly.

One task which posed particular linguistic and conceptual problems was related to the mental health of the individual. The task asks the person to rate their satisfaction/dissatisfaction and like of self/dislike of self by placing an arrow along a printed line between these extremes. I realized early in the research, that responses to these questions were inaccurate due to failure to understand the task. Therefore, I improvised a continuum of faces with expressions ranging from smiles to frowns and glued these to a piece of construction paper. I then asked the subjects to point to the face that best expressed their feelings about their degree of satisfaction with the things they do everyday and about their feelings of like or dislike of themselves. It is felt that this method provided more accurate information about the mental status of the subject. This was the only instance when the instrument was modified or that I deviated from the instructions for using this instrument.

In conclusion, this research shows that the FAI is reliable but with low concurrent validity and that problems exist in using this instrument within certain groups of

elderly persons. The elderly are often referred to as a heterogeneous segment of our population (Johnson and Williamson 1980; p.1) and this heterogeneity makes it very difficult to develop any instrument that will be applicable to all segments of this age group, especially an instrument that cannot be adjusted to various lifestyles and language patterns. Furthermore, as Kane and Kane (1981) have stated, not all domains can be assessed equally (p.217). For instance, impairment in the economic area is not necessarily equal to impairment in the social area for all groups. I concur with Kane and Kane (p.12) in advising the avoidance of blind faith in any measurement or scale due to the danger of misinterpretation of the data. Furthermore, these instruments, as shown in this research, are not adequate in determining coping strategies which the individual may have developed to assist them in dealing with adversities.

Surviving With No Visible Means of Support

The Living Environment

The apparent lack of informal social contacts in the black elderly sample became a concern to me in 1981, when I first met these people. Social contacts have traditionally aided the individual to live independently, and these people seemed to have so few. Their lives seem to fit that described by George Reader (1969; p.312) as persons performing

the Indian rope trick or surviving with no visible means of support. However,they were surviving and were seemingly satisfied with their life. As noted by Gordon Streib:

> The most elusive and most difficult resource to identify is the emotional or psychological health of the individual. Just as one person may have immense financial resources and lack the other three, there are some old persons who are lacking in health, financial and social resources and yet have sufficient psychological and emotional resources (1972; p.9).

Even though these subjects tended to score high on the FAI and therefore were more likely to be in need of institutionalization (according to the FAI) than their white counterparts, they were apparently surviving quite adequately. I wanted to know what resources they were utilizing that enabled them to survive. Their coping behaviors were the focus of the remainder of my research.

Data obtained from the FAI revealed that this group of elderly black subjects anticipated assistance from family members to a greater extent than any other source. Furthermore, female family members were believed to be major suppliers of assistance. Mrs. L, although living with her son, expected her daughter to be her major source of assistance.

As I noted earlier in the first chapter, the role of the extended black family in assisting members has been the focus of much research, most of which concluded that members of the black community will provide for the needs of their group. There are exceptions to these findings, most notably were those of Huling (1978) and Gibson (1983) who found

little family support provided to the elderly. The findings of Huling and Gibson were also borne out in this research; indeed the majority received little, if any support from families. Perhaps a reason for this phenomenon was the total absence of children in the majority of these females. However, through participant observation as revealed in the case studies, there was significant interaction with family members, even though these family members were not assisting these elderly persons to obtain nutritional and health care needs. An example of this was seen in the case of Mrs. H from Alachua. Her son mowed her yard, had bought her an exercise bike and was very much a part of her life even though he was not assisting her with transportation to the grocery store or for medical visits.

Reliable statistics on birth rates are extended back only to 1920 and are limited to nonwhites and whites prior to 1964. These statisitics showed that the birth rate for nonwhites (90 percent of whom were black) was higher than the birth rate of white females. Therefore, finding a lack of any living children in 47 percent (N=9) of these black females presented a paradox.

Even though an adequate explanation was not apparent to me, it was quite understandable to the women involved. The response given by Mrs. E was typical of the whole group. When I asked her if she had any idea as to why she never had a child, she replied, "if the Lord had intended me to have 'em, I would've." No one could ever remember consulting a

doctor about the problem and seemed to simply accept the situation unquestioningly. All denied having "female problems". One woman did concede that perhaps she should have seen a doctor but it did not seem the thing to do at the time.

Most likely there is a scientific explanation for why the black women had no children. One explanation could be the presence of some form of veneral disease, which resulted in few physical manifestations but may result in infertility. Another possible explanation could be poor nutritional status, and this is not an unreasaonable explanation considering the period of history when these women would have been in their childbearing years. The prevalence of malnutrition in the South during the first part of this century has been well documented (Etheridge 1972; Roe 1973). While these studies did not focus on the black population per se, it is probable that malnutrition was present to a greater extent in blacks than in whites. Malnutrition and excessively hard work may have resulted in reduced fat stores in the body. Howell (1979), in her work with the Dobe !Kung, clearly showed the relationship between body fat and the reproductive cycle. Frisch and McAuthur (1974) also found that a critical factor in starting and maintaining menstrual cycles was the possesion of a minimal amount of fat stored on the body.

Another possible explanation may be that these women are simply survivors and their more fecund cohorts may have

been victims of early mortality. It is a question which warrants further research.

These subjects who had children did not typically have them available for support at this time. Mrs. D had outlived all her children. The children of five additional elderly persons were not living within the county, and therefore were not accessible for assistance when needed. Furthermore, it should be noted that proximity does not always result in assistance. The much reported work of Shanas (1979) in which she stated that only about 10 percent of the elderly people in this country fail to see their adult children within a month, does not consider the fact that proximity may function both positively and negatively. Mrs. M's daughter lived next door and yet she was providing no assistance to Mrs. M and Mrs. M excused this behavior by stating that "she has her own kids to look after."

Overall, however, results of this study are consistent with the literature in finding that female family members, particularly grandaughters, are providers of significant support services. Even though the concept of a black matriarchial society is often challenged today, my findings support that of other researchers in finding that if assistance is provided, the source of that help is most likely to emanate from female family members.

The two persons in the sample, a brother and sister, with the largest number of living children, were unique in several ways. They were the only persons in the sample who

owned large acres of land and furthermore they were the only persons where I saw extensive family involvement over the last three years. Children and grandchildren seemed to be constantly in and out of their homes. On the other hand, few or no children or grandchildren were observed in the homes of the remainder of the subjects although numerous visits were made.

Perhaps as McAdoo (1979) has observed, turning one's back on poorer family members may be a prerequisite to moving into the middle class. The two "philosophers" in this research had both managed to assist their children in obtaining a college education and in both instances, these children maintained close contacts with their parents. However, both Mr. J and Mr. R had greater financial resources than most of the other subjects.

It is possible that controlling a valued resource such as land affects family interaction in a positive direction. Day (1982) found that providing land for one's children and controlling land deeds and land use were important ways by which older people ensure rights to their children's labor and secure for themselves care and support in old age. Mrs. L is certainly an example of someone who has held onto her land in anticipation of leaving it to her children and her children are very much involved in the maintenance of Mrs. L's lifestyle. Both Mr. J and Mrs. L speak frequently of the importance of "having something to leave the children."

Reciprocity existed in the relationship between the landowning subjects and their families, but the elderly parents were more often the recipients rather than the givers at the present time. The elderly parents contributed foods grown in their gardens and some of the children used the land to maintain their own cows. However, the childern expected the land ultimately to be theirs.

Reciprocity did not seem to be important in the relationships of the remainder of the subjects who were relying on friends and/or family members for maintenance of their lifestyle. Mrs. E provided transportation to and from the grocery store and medical appointements to four other subjects living near her. I could not determine any way in which the four recipients were aiding her, but this seemed no problem to this woman. She stated that she enjoyed having this time to visit with them. Therefore, this intangible benefit may have been sufficient reason for providing the needed services.

Wentowski (1981) has stated that poor old people are not able to reciprocate and thus have fewer people in their networks. However, the study by Sokolovsky and Cohen (1978) and this study have shown that numbers are not that important in determining adequacy of social contacts. One good friend or family member who will assume responsibility for providing the person with resources to maintain their independence will suffice.

The educational level of this sample was very low with the exception of one woman who had a college degree. It was difficult, if not impossible, to definitely ascertain the exact educational level because, as I was told by one person, "school was different then". In trying to determine how school was different, I was told that the school year varied in duration from two to four months, depending mainly on whether their labor was needed in the fields. Furthermore, one woman stated that school would sometimes begin and then have to close within a few weeks due to lack of funds. I attempted to document this by examining school records at the local county school board office. This proved to be impossible because there were no school records kept for the rural black schools. The earliest record for a black school was a handwritten record of an "exemplary" city school, dated in 1927 and the length of the school year in this case was seven months. However, a school administrator told me that the report of my black subjects was probably correct.

Concomitant with lack of education, poverty was also characteristic of this sample. Eighty-one percent (N=22) of these people were living in poverty and three others were living in "near poverty." This did not prevent these people from expressing, what I thought, was extreme satisfaction with their life style. When questioning one man at greater length about this phenomenon, he replied, "Missy, you just don't know where we've been." When one considers their

history of racial segregation, lack of good employment possibilities, and little, if any education, then a Social Security check, however meager but regular, most likely seems better than many of their former experiences.

A maladaptive coping behavior was found to be the under utilization of programs designed to assist the elderly poor. Specifically, several persons in this study were eligible for assistance through the Security Supplemental Income program, but were not using this resource. Mrs. B from Alachua was one of those subjects and although she stated that "I don't hardly get enough money to get by on," she still has not applied for SSI. Other studies have attributed this lack of utilization to perceptions that this program is a welfare program, and tremendous amounts of pride and independence in the elderly population. Mrs. E in Archer is an axample of someone eligible for SSI and not receiving it because "I don't need welfare." Although this attitude seems to be descriptive of this sample, I believe, additionally that there is misunderstanding about these programs. Furthermore, many of these elderly persons, with their low educational attainment, were not able to fill out the necessary forms, and to keep up with the paperwork necessary to stay in these programs.

Poverty did not prevent home ownership for a large percentage of these people. Home ownership has often been referred to as the American dream, and if this is true then this sample has surely absorbed the value of the larger

culture. However, many of these homes were no more than shacks and offered these elderly people little refuge from heat and cold. In the winter time, I often huddled with these people around a wood stove and could see the outside, either through cracks in the walls or in the floors. Likewise, in the summer these small, boxlike homes seemed like sweat boxes. The condition of the homes were a source of concern to many of the people. Mrs. A in Waldo frequently told me that "termites are eating this house down and I can't do nothing about it."

Regardless of the physical condition of the homes, ownership was so highly valued that in several instances it was counterproductive for the individual. Several people in the sample were eligible for Security Supplemental Income (SSI), but would not apply because they thought (erroneously) that they would have to give up their homes in order to apply. However, I feel that other factors may also be contributing to this failure to fully utilize available social services. Fear of bureauracy, and inability to read and fill out necessary forms for these services were most likely intervening factors in their failure to apply.

Clutter seemed to be characteristic of many of the homes. Ties to the past are maintained through personal possessions and this possibly accounts for all the clutter found in these homes. One has no control over the loss of personal health, or the loss through death of family and friends, but one may keep the memorabilia collected through

the years. As Mrs. D in High Springs expained to me, "I can't get rid of my things. Makes me feel good to have 'em around."

Recent research has shown that pets may aid the elderly in several significant ways. Reported benefits include improved morale, increased self esteem, less withdrawal, and even functioning to inhibit the deterioration normally associated with the aging process (Brickel 1981; Levinson 1978). However, few of the elderly persons in this sample had pets, and when animals were present they served a more utilitarian purpose. When asked if they had pets, those persons with pets typically responded that there was an old dog or cat that stayed outside. Cats were there to catch mice, and dogs were said to be guard dogs. Mrs. M in Archer had a cat but she did not consider that cat a pet. She explained that the cat was there "to catch rats." No person had an animal living within his or her home with the exception of the person who had a fish. Pets, as such, are possibly a manifestation of more affluent living, and few of these people could afford a pet simply for the sake of having one.

Food and Food Acquisition

The most frequently eaten foods in this sample corresponds to that often described as characteristic of the rural South (Todhunter et al., 1974). This diet consists of:

chicken and hamburger, mashed potatoes and greens, cornbread and biscuits, followed by fruit and dessert. Milk was reported to be consumed daily.

The core diet contained no unexpected items, other than possibly the inclusion of milk. The problem of lactase insufficiency in the black population has been extensively studied (Harrison 1975; Simoons 1980), and found to exist in a high percentage of American blacks. The etiology was believed to be genetic in origin and symptoms consist of gastric distress, sometimes accompanied by nausea and vomiting. It should be noted, however, that the consumption of small amounts of milk at any one time, will often fail to result in these symptoms. This is most likely the situation with this sample as most of these elderly black people were receiving a cup of milk every day when they eat at congregate meal sites. Only one person, Mrs. E in Archer, stated that she could not drink milk at all due to the "stomach problems" associated with consuming the milk.

Chicken was not only the most frequently consumed source of protein, but seemed to be the preferred source of protein for the majority of these people. Furthermore, the choice of chicken seems to be very logical for this sample. Raising chickens is relatively easy for the rural person. Chickens forage for their food, requiring very little if any supplementation in order to exist and therefore are not competitive with human food sources. Additionally, an adult hen will usually lay an egg per day, and thus provide the

older person with another source of high quality protein or this egg may be sold to supplement meager incomes. Mrs. L from Archer and Mr. R from Hawthorne both sold eggs to supplement their income.

Suprisingly, gardens were providing little, if any, food supplies to these people. There is usually an association made between rural living and gardening and these people assured me that gardening had been an important part of their past but was an activity that they were no longer able to engage in. As Mrs. D in High Springs explained, "Lordy child, I miss my garden. I don't fool with it anymore, ain't able to do it."

Greens seemed to be the most consistently grown vegetable and in some instances was the only food that the elderly person was still growing. One woman, Mrs. G in Waldo, had greens growing in a small plot in her yard but she also had a discarded commode sitting in her front yard in which greens were thriving. Greens are very easy to grow, requiring no soil preparation and no hoeing or weeding. These facts, coupled with the stated preference of greens in this group, makes them a logical choice for these frail elderly to grow.

Food items categorized as never eaten may be viewed as foods rejected due to personal preferences, foods which were unfamiliar to the person, or foods which they were unable to purchase. For instance, winter squash was a food item with which most of these people are unfamiliar. Steaks and roasts

were not a part of the diet for many of these people. However, this was more a situation of being unable to buy the meat, and not a lack of preference. A typical response upon being shown a picture of a steak and asking if they were eating this item was given by Mr. T of Hawthorne. He stated "I don't never eat that. I wish I could but I can't buy that. It costs too much."

Alcoholic beverages in all forms were rejected wholeheartedly by this sample. Mrs. G from Alachua stated, "I wouldn't ever drink that stuff," and Mrs. V from Hawthorne stated, "I ain't never drunk no whiskey or beer." These rejections are comparable to those found by Bainton (1981) in a rural sample in Arizona. Bainton concluded that "two factors associated with aging-increased religiosity and decreasing health-proved to be strong deterrents to drinking (p. 215)." These findings, however, may be indicative of life-time patterns and not related to aging per se. Only six persons in this sample stated that they had been alcohol consumers in the past or were currently consuming alcohol beverages. Mr. T and Mr. R from Hawthorne and Mr. M from Alachua disavowed any consumption at this time.

The inclusion of pork chops among those food items never eaten presents an interesting confound. Pork has long been considered to be a staple of black diets dating back at least to the days of slavery (Gibbs et al., 1980), and continuing down to the present (Jerome 1980). In this study, all pork products were rejected to a significant

extent in the core diet, but sausage was found to be consumed in the secondary diet. Subjects often explained this rejection as due to the unheathfulness of pork products. As Mr. J explained, "pork is against my pressure" and Mrs. Mrs. M stated, "my doctor said to stay away from that pork." Evidently, the concern of high cholesterol levels related to the consumption of pork products was resulting in a dietary change for the black population. This needs further study to determine if this is true among other age groups within the black population.

Explanations for the rejection of other food items vary. Several of these food items may not be eaten due to lack of familiarity. These include dinner rolls, pizza, stewed prunes, waffles, winter squash and yogurt. Popcorn, although a familiar food item, was not eaten in this age group, probably because of dental problems. I can find no satisfactory explanation for the rejection of bologna and pancakes.

The core diet of these elderly people may be characterized as one of low complexity. However, variety in the diet was found with the inclusion of items consumed by 40 percent of the sample. Including this additional ten percent results in a better indication of what was actually being consumed.

The question of adequacy of nutrients and calories has not been addressed in this research. However, it should be noted that there were no subjects in this sample who were

obese. Furthermore, as noted by Posner (1979, p.10), "poverty appears to be the most important environmental determinant of inadequate nutrition among the elderly." These elderly people are therefore "at risk" for nutritional inadequacy.

The acquisition of food presents unique problems for these rural elderly. The major problems, other than poverty, were the lack of personal transportation, and living in out-of-the-way rural areas. Constraints were circumvented through the use of various coping behaviors employed by the older person.

Rural living did not prevent these subjects from shopping predominately in large retail markets. I would assume, therefore, that they would be able to purchase food for prices less than those of smaller markets. In each of the small towns that these subjects live in or around, there were markets that the subjects categorize as large. These "large" markets were not comparable in size to those that urban dwellers use. However, many of these subjects were coming into the larger metropolitan area to do their grocery shopping once a month after the arrival of their Social Security check. Sometimes the transportation was provided by friends as in the case of Mrs. E in Waldo who provided transportation for four of her elderly friends. In other instances, such as Mrs. V in Hawthorne, the OAC van provided transportaion into Gainesville for grocery shopping once a month.

Regardless of where the person shopped, arriving there meant accessing resources other than themselves. These elderly subjects have used various resources to aid them in obtaining food.

"Family members" was the most frequently stated resource used by this sample in getting to the grocery store. Seven persons stated that they would ask someone in the family if they needed to go grocery shopping. However, it should be noted that when asked how they got to the store on their last visit, eight persons had gone with family members. Perhaps this was not the desired mode of choice for one person, but was the choice most frequently available.

The family members used by these subjects were all female. Five of the elderly subjects said they would ask a grandaughter and two said they would ask daughters. In one case, the subject was living with a son but still said she would ask her daughter to take her shopping. The daughter of Mrs. B in Alachua lived near but Mrs. B relied on her grandaughter for assistance. This use of female family members to provide personal services to elderly parents was also found to be true in the urban areas studied by Lopata (1975).

Although 26 percent of these subjects stated that they would ask a family member for assistance in obtaining nutritional and medical needs, 74 percent had to find other resources. In contrast, in the FAI, 67 percent of these subjects had stated that they expected family members to

provide them with assistance when needed. It therefore seems evident that the black family is not an extensive support resource for assisting with nutritional and medical needs in this sample, contrary to their expectations. These findings are comparable to those of other researchers (Gibbs 1982; Gibson 1983; Huling 1978).

The question as to whether these findings represent a change in behavior within the black society relative to their elderly or, if the belief that the black family takes care of their own is part of our popular mythology, is unanswered in this research. Perhaps we have wanted to believe that the black elderly were being cared for within their own cultural milieu and therefore were relieved of any responsibility for them. The black elderly in this sample clearly expected their families to provide them with care when needed (FAI), but this assistance was not found when the person was asked who actually provided help when they last needed it. For whatever reason, this research and others clearly document reduced amounts of family support for the rural black elderly.

Other resources used by the black elderly in this sample include the use of friends and transportation provided by the OAC. Mrs. V in Hawthorne used the OAC van once a month for grocery shopping. Additionally, some persons felt they could rely only on themselves. Mrs. M in Archer most frequently walked to the grocery store even though the distance would have seemed prohibitive to many people. The

role of friends in assisting these elderly persons to remain independent closely parallels that of family members. The percentage of persons stating that they would ask a friend if they needed to shop is greater than the percentage who actually went with a friend on their last shopping trip. Similarly, the percentage who stated that they would ride on the OAC van is less than those who actually rode on the van for their last shopping trip. However, there was perfect congruence between those persons who either had to walk to the store or hire someone. There was no discrepancy between the ideal and the real behavior for these persons.

Health and Health Maintenance

Comparisons of the multiphasic data base, the FAI, and coping behavior data, revealed the peril of unquestioningly accepting "facts" as presented. In this study there was inconsistency in what people said was a health problem at one time and what they reported at a later date. Furthermore, no congruence was found between the person's expectations of assistance and actual assistance. The peril of self-report data has been discussed at length in the work of Bernard and Killworth (1977).

The frequent occurrence of high blood pressure in the black population has been well documented (Jackson 1978; National Center for Health Statistics 1980). The NCHS reported that black elderly were more than twice as likely

to have hypertension than their white counterparts. Therefore, there was no reason to discount the reported incidence of high blood pressure in 18 out of the 27 subjects in 1981. Data accuracy was not discounted when blood pressures were checked by medical personnel and only two subjects had elevated readings. This could have occurred because the subjects were taking medication to control the high blood pressure. An inconsistency in the 1982-1983 survey was noted when only 13 of these same subjects reported that they had high blood pressure. Since there is no cure, only control, for high blood pressure, those subjects with hypertension in 1981 had the same problem in 1982-1983 unless they have developed some cure of which I, and I believe the medical establishment, am unaware! It is possible that high blood pressure that is under control medically is not considered to be present by these people.

Hypertension was not alone in the number of chronic diseases reported to be present in 1981 but absent in 1982-1983. Coronary heart disease (CHD) and arthritis were also reported less, rather than more, in the later survey. The incidence of CHD was actually reported to be reduced by one-half in 1982-1983, and three out of 24 persons having arthritis in 1981 no longer suffered the disease in 1982-1983. A reasonable explanation for this seems to be the inaccuracies frequently found in self-reported data.

Biochemical assessments of blood constituents that may be indicative of CHD were found in few of the subjects.

There were no "out of range" values of cholesterol for any in the sample. However, the values accepted as within normal ranges by Smith-Kline Laboratories are quite high compared to other evaluators (National Academy of Sciences 1974; Haffron 1976) who suggested that values over 260mg/100ml were abnormal for this age group. If the lower threshold for high cholestrol were used, the number of subjects having abnormally high blood levels of cholesterol would only be two. Likewise, only two persons in the sample had high levels of triglycerides in their blood. It is possible that blood levels of these constituents were being maintained at low levels by the diet and/or medications taken by the sample.

The one chronic disease for which there was high correlation between the data sets was diabetes. Control of this disease is often regulated through the diet for older persons, but in this sample five out of six persons with the disease, also had "out of range" blood glucose values. Since the condition was not in a contolled state, these elderly people were most likely experiencing symptoms of the disease which constantly reminded them of its presence. Ms. O in High Springs is an example of one who seems to be unable to control her diabetic state. She is experiencing "circulation trouble in my legs" due to this disease. Meals at the congregate meal sites have undoubtably improved the nutritional status of many of these poor elderly people

but do little in helping the diabetics to control their diet.

Poverty, along with lack of understanding about diabetes, most likely accounts for the lack of control of this disease in this sample. Obesity was not a factor because there were no obese people in the sample. However, poverty and ignorance prevented these people from buying foods that should be eaten and/or drugs that should be taken. In one instance, a woman who had been prescribed medication stated that some months she would not buy the medication, but that at other times she would depending on her monetary circumstances. Needless to say, she was experiencing many symptoms of her disease and was acutely aware of its presence. Another woman in the sample was totally blind due to the disease.

Anemia is often stated to be a major problem among elderly persons (Ten States Survey 1972; HANES 1974; Lewis 1976) but was not a problem in this sample. Only three persons were found to have below normal hemoglobin values in 1981 and four persons stated that they were anemic in the 1982-1983 survey. It would seem that consumption of all those greens by these people could be considered as a very adaptive behavior.

A lack of immunity may be related to malnutrition, or caused by disease states. Five of the 22 persons in this sample were found to be lacking in appropriate immune response in 1981. Since lack of immunity is a life-threatening

situation in which the person is vulnerable for all diseases from the common cold to cancer, it might have been expected that these subjects would have not been alive in 1982-1983. This was not the case, although the health of two persons had declined to the point of death, a fact which may or may not be related to their immune status. However, the health of Mrs. B in Alachua, who was quite ill and lacking in appropriate immune response in 1981, had improved immensely in 1982-1983. I had discussed ways in which she might improve her nutritional status in 1981 and perhaps she put some of that information to use. In any case, it appeared that her nutritional status had improved, as well as her immune status.

Methods which were used by these subjects to maintain their health status or to deal with chronic problems were found to be different from those that I expected. Specifically, much of the literature states that the black elderly were not major participants in Western medicine (Special Committee on Aging 1971; Hill 1976; Jackson 1978), but these elderly black people participated extensively.

Even though the majority of this sample had seen a doctor in the last six months, a significant percentage (37 percent) of the sample stated that they had unmet medical needs. Many of the subjects stated that they were experiencing problems with vision or needed assistance with dental problems.

Modes of accessing medical assistance were very similar to those used to obtain food. Female family members had taken 22 percent of the subjects on their last visit to the doctor. Again, even though this represents the single largest category, it means that 78 percent of the sample had to find resources other than family to provide them with medical transportation. Friends and the OAC were the other most frequently used sources.

In the 1982-1983 survey, I asked the persons about the drugs that they were taking. I used the FAI checklist for perscription drugs, but additionally, I asked to see all the drugs that they were taking, both prescription and over-the-counter. These people were not taking large numbers of either prescription or over-the-counter drugs. This was attributed to their poverty, but furthermore has possibly resulted in greater longevity for the group. This needs further research.

The elderly persons in this sample demonstrated little knowledge about the drugs they were taking. Many either had no idea of what or why they were taking a particular drug or their ideas were incorrect. For instance, Mrs. A in Waldo told me that she was taking drugs for her thyroid. However, the prescription was labeled "dipyridamole". This drug is prescribed to improve circulation and is most often used for persons with coronary heart disease (Physicians Desk Reference 1982). She was taking no other drugs. Most persons,

when asked what they were taking simply described the medication rather than providing it with a name or purpose. They were either taking "a small pink pill" or one "shaped like a football" or pills of various other descriptions.

Adaptive coping behavior may possibly be seen in the small number of drugs that these people are taking. It seems that the constraints of poverty and rural living may be interacting to keep these elderly persons from using excessive amounts of over-the-counter drugs. The result is better health for the group. However, the inability to purchase prescription drugs was shown to be detrimental to the health of several of these subjects. Mr. C in High Springs had experienced severe problems due to his failure to take his prescribed medication.

Involvement with Western medicine was very evident, however, when these subjects were asked to state their course of action when an acute illness, such as the flu, occurred. Forty-eight percent stated that they would first try over-the-counter drugs and if that failed they would then see a doctor. The third course of action was prayer.

The presence of faith in the lives of these elderly subjects was pervasive, and as I have mentioned earlier, placing prayer third in their choice of action may be erroneous. Prioritizing prayer seemed to be very difficult for them because they frequently stated that prayer was a part of all their life and not just used in times of illness even though they would definitely use it at those times. I,

as an outsider who had shown an interest in their faith, was often asked if I would pray for them. Upon leaving the home of one Mrs. D in High Springs and telling her that I would see her again the next week, I was told "if I don't sees you down here, I'll sees you in heaven." The importance of religion in the black elderly population has been well documented and my findings only substantiate those of others.

The role of churches is assisting its elderly members to maintain their independence is unanswered in this research. Twenty-two of the persons in this sample stated that their faith was very important to them and 15 of these were attending church services once a week. Several others stated that they would like to attend but had no way of getting there. However, no one reported any assistance from their church. This question needs further research.

One thing that I expected to be used extensively in this sample but which was not is the use of home remedies to treat illnesses. It seemed reasonable that persons who were living in poverty and lacking personal transportation would be using home remedies to a large extent. However, only 19 percent (N=5) stated that they would use home remedies, but I was assured by almost all the sample that this was a change from their prior behavior. All could tell of home remedies that they or their parents had used in the past, but the majority seemed to think that over-the-counter drugs were better medicines than the old remedies. Mrs. B in

Alachua stated "the doctors say not to use those old home remedies like we used to."

Those persons who were using home remedies, however, seemed to have a wealth of knowledge about their environment and tremendous faith in the efficacy of its products. One eighty-two year old man, Mr. T in Hawthorne, spent a whole morning increasing my understanding of plants and herbs and their role in healing. He obtained "rabbit tobacco" from the woods near his home which he would "strip down" and boil in a kettle. After boiling for approximately 30 minutes and being allowed to cool, he added some sugar to the solution and stored it in old liquor bottles. He stated that if you would drink this as a hot drink at night it would result in a good night's sleep. He prepared "snake root" for stomach problems, and "asafetidity" for his heart. Additionally, he had preserved wild garlic in vinegar which, he said, would "keep your pressure down" if you would drink a cup a day. He was apparently in good health, and furthermore, living to be 82 is no small feat for a black man where life expectancy is approximately 64 years.

Conclusions

Test of Hypotheses

An examination of the questions and hypotheses stated at the beginning of this study will be reviewed in the

context of the results of this research. Conclusions will be drawn from the results and related to these questions and hypotheses.

The first question addressed the efficacy of the FAI in assessing the functional capacity of the black elderly person. It was hypothesized that the FAI would not be valid for assessing the functionality of the elderly among culturally diverse populations.

Reliability of the FAI was determined by using the test-retest, and by inter-item consistency methods. Both methods showed a high degree of reliability for the instrument. However, concurrent validity, determined by comparing FAI results with an indepth assessment which included self reported, biochemical and clinical data was low. Furthermore, the black elderly scored significantly higher than their white counterparts, mainly because of their inability to understand the language of the instrument. It was concluded that the FAI has high reliability, but is not valid for use in cross-cultural assessment of elderly people in its current form. Additionally, the instrument was inadequate in determining coping strategies of the black elderly. The hypothesis was supported.

The second question this study addressed was, with whom were the black elderly interacting. It was hypothesized that they would be interacting more with friends than with family.

Results showed that the black elderly were interacting more with family members than with any other single source in terms of provision of needed services. Eight persons in the sample had received assistance from family members in the form of transportation to the grocery store. Likewise, six subjects had ridden with a family member on their last medical visit. However, the difference in degree of interaction between friends and family was not statistically significant. In terms of percentages, 74 percent of these subjects stated that they would seek sources other than the family when they needed groceries or medical care. The case studies revealed that the black elderly were interacting with their families in other contexts however. The hypothesis was not supported.

The third question was related to the black elderly's perception of the quality of their life. It was hypothesized that regardless of the number of social contacts that black elderly persons would view their quality of life positively.

The black elderly persons in this sample expressed a high degree of satisfaction with their life. Specifically, 63 percent stated that their life was good. This optimistic outlook was also congruent with data from the multiphasic data base. Thus the hypothesis that the black elderly would view the adequacy of their social contacts positively was supported.

The fourth question asked if the informal social contacts of friends and family contributed positively or negatively to the maintenance of the black elderly person's lifestyle. It was hypothesized that their social contacts functioned both positively and negatively to the maintenance of their lifestyle.

Forty-eight percent of this sample stated that they would ask a family member or a friend if they needed assistance with obtaining groceries or medical care. Additionally, approximately the same percent had actually received assistance from family or friends. For these people, the social contacts with friends and family members were functioning positively. However, 52 percent of the sample found it necessary to access resources other than families and friends. Social contacts, therefore, were functioning positively for 48 percent of the sample but the remainder of the subjects seem to have not developed social contacts that would aid them in maintenance of independent living. These people, however, have developed coping strategies through other resources such as the OAC that enable them to maintain their lifestyle. The hypothesis was not supported.

The fifth question asked to what extent informal social networks functioned to assist the rural black elderly in activities of daily living. It was hypothesized that the networks would not contribute significantly to activites of daily living.

Results of this study revealed a very self-sufficient group who expressed little need of assistance in activites of daily living. Furthermore, there were few instances in which the elderly person was receiving this kind of assistance from family members or friends. The greatest apparent need was in maintenance of their homes but few subjects perceived of this as a need. Food was most often given to the subject through the Older Americans Council congregate meal program rather than from families or friends. Some subjects received food at times from family members. However, this occurred more frequently for the landowning subjects. The hypothesis was therefore supported.

The sixth question asked if the coping mechanisms used by the black elderly were either adaptive or maladaptive in maintaining their independence. It was hypothesized that coping mechanisms would be functioning adaptively for these subjects.

Results showed that the majority of coping mechanisms were adaptive but there were exceptions. Specifically, these elderly persons were consuming a diet with sufficient variety to prevent gross malnutrition. Adequate adjustments had also been made to the lack of personal transportation for the majority of these subjects, even though living in a rural area. It is also possible that adaptive medical coping behavior was seen in the small number of drugs that these people were taking. However, maladaptive behavior was found when subjects were prescribed drugs and were not taking

them. A maladaptive coping behavior was found to be the under-utilization of programs designed to assist the elderly poor.

In summary, it seems that the majority of coping behaviors used by these elderly persons were adaptive to their lifestyle. However, there were instances in which behaviors other than those being used might improve the living situation of these persons. The hypothesis was not sustained.

Summary

In summary, this research addressed the reliability and validity of the Functional Assessment Inventory and described the coping behaviors of a sample of rural black elderly. The FAI was found to be reliable but to have low concurrent validity and to have little value in determining the coping strategies of the black elderly. Coping behaviors were evaluated in terms of their adaptiveness and were found to be both adaptive and maladaptive in some instances.

Results of this study clearly indicate the problems associated with assessing the functional capacity of elderly persons. Self-report has been shown to have low validity in this elderly sample, in part because assessment interviews are not written in a terminology that is familiar to the black elderly population. Participant observation provides

a better understanding of the actual functional capacity of these people.

This study has also shown that the black elderly are not being cared for within the confines of the extended black family. Three-fourths of the rural black elderly in this sample were coping with nutritional and medical care problems by using resources other than the family.

The black elderly in this sample were predominantly meal site participants, poor and without personal transportation. These characteristics affect the quantity of social contacts that these people are able to maintain. Conclusions found in this study, therefore, should be limited to person sharing these characteeristics. In comparison, Gibbs (1979) studied black and white elderly persons in Hawthorne and found greater amounts of social interaction. However, his sample was obtained from persons actively involved in churches and most had personal transportation.

Recommendations

Due to the heterogeneity of the American elderly population, it is advisable to proceed with caution when developing single tests designed to assess the functional capacity of this group. It is extremely important to be able to speak in a language or dialect in which the person being assessed is familiar. Results of this study suggest that the

FAI should not be used in culturally diverse groups. Even though the purpose of this study did not involve the development of an assessment instrument, the results lead me to advise greater concern with ethnic diversity when assessing the needs of American elderly.

Pfeiffer, Johnson and Chiofolo (1981 p.433) have stated that "rapid, reliable and valid assessment of the functional status of elderly persons is a prerequisite for the efficient provision of appropriate types of sevice" and I concur with this need. However, I think that further research is needed to develop and validate such an assessment procedure for use with ethnically diverse populations.

Due to the constraints presented by cultural diversity, it seems reasonable to proceed with caution when using single instruments to determine the ultimate fate of American elderly. In our quest for rapidity, we may be overlooking important factors that enable elderly persons to survive adequately in their particular cultural milieu.

One important factor that seems to have been overlooked is the ability of the older person to cope with adverse situations. This is especially true for the older black person where coping with adverse situations has been a life long reality. It seem reasonable, therefore, to include coping behaviors within the framework of assessments for a more accurate determination of the ability of the older person to maintain their independence.

Participant observation, although more time consuming, provides more accurate data than survey instruments. An in-depth ethnographic study should be conducted before concluding that any individual can no longer function independently within his or her own home and community.

An additional recommendation is made relative to popular beliefs which may have no basis in reality. For many years now we have discussed the extended black family and their attribute of caring for individual members. While this may have true in the past, this research has shown that it is not true in this rural elderly sample.

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APPENDIX A

Food Frequency Questionnaire

FOOD	NEVER mark 0	DAILY mark 1	WEEKLY mark 2	
Alcoholic Drink	.	.	.	.
Apple	.	.	.	.
Applesauce	.	.	.	.
Bacon	.	.	.	.
Baked Beans & Pork	.	.	.	.
Baked Potato	.	.	.	.
Banana	.	.	.	.
Beef Stew	.	.	.	.
Beer	.	.	.	.
Beets	.	.	.	.
Biscuit	.	.	.	.
Black-eyed Peas	.	.	.	.
Boiled Potato	.	.	.	.
Bologna	.	.	.	.
Broccoli	.	.	.	.
Butter	.	.	.	.
Corn	.	.	.	.
Cantaloupe	.	.	.	.

APPENDIX A, continued

Food Frequency Questionnaire

FOOD	NEVER mark 0	DAILY mark 1	WEEKLY mark 2	
Carrots	.	.	.	.
Celery	.	.	.	.
Cheese	.	.	.	.
Chicken	.	.	.	.
Chicken Noodle Soup	.	.	.	.
Chili	.	.	.	.
Chocolate Cake	.	.	.	.
Chocolate Candy	.	.	.	.
Chocolate Syrup	.	.	.	.
Coffee	.	.	.	.
Cola	.	.	.	.
Coleslaw	.	.	.	.
Cookie	.	.	.	.
Corn on the Cob	.	.	.	.
Cornbread	.	.	.	.
Cornflakes	.	.	.	.
Cottage Cheese	.	.	.	.
Dinner Roll	.	.	.	.
French Fries	.	.	.	.
Fried Egg	.	.	.	.
Fried Fish	.	.	.	.

APPENDIX A, continued

Food Frequency Questionnaire

FOOD	NEVER mark 0	DAILY mark 1	WEEKLY mark 2	
Fruit Salad	.	.	.	.
Graham Crackers	.	.	.	.
Grapefruit	.	.	.	.
Grapes	.	.	.	.
Grits	.	.	.	.
Ham	.	.	.	.
Hamburger	.	.	.	.
Hard-cooked Egg	.	.	.	.
Hot Dog	.	.	.	.
Ice Cream	.	.	.	.
Jello	.	.	.	.
Jelly	.	.	.	.
Lettuce	.	.	.	.
Lima Beans	.	.	.	.
Macaroni & Cheese	.	.	.	.
Mashed Potatoes	.	.	.	.
Mayonnaise	.	.	.	.
Milk	.	.	.	.
Milkshake	.	.	.	.
Oatmeal	.	.	.	.
Okra	.	.	.	.

APPENDIX A, continued

Food Frequency Questionnaire

FOOD	NEVER mark 0	DAILY mark 1	WEEKLY mark 2	
Orange	.	.	.	.
Orange Juice	.	.	.	.
Pancake	.	.	.	.
Peanuts	.	.	.	.
Pear	.	.	.	.
Peas	.	.	.	.
Pie	.	.	.	.
Pineapple	.	.	.	.
Pizza	.	.	.	.
Popcorn	.	.	.	.
Pork Chop	.	.	.	.
Potato Chips	.	.	.	.
Pudding	.	.	.	.
Roast Beef	.	.	.	.
Rice	.	.	.	.
Salad Dressing	.	.	.	.
Saltine Crackers	.	.	.	.
Sausage	.	.	.	.
Scrambled Egg	.	.	.	.
Spaghetti	.	.	.	.
Steak	.	.	.	.
Stewed Prunes	.	.	.	.

APPENDIX A, continued

Food Frequency Questionnaire

FOOD	NEVER mark 0	DAILY mark 1	WEEKLY mark 2	
Strawberries	.	.	.	.
Sugar	.	.	.	.
Summer Squash	.	.	.	.
Sweet Potato	.	.	.	.
Sweet Roll	.	.	.	.
Liver	.	.	.	.
Tomato	.	.	.	.
Tomato Juice	.	.	.	.
Tossed Salad	.	.	.	.
Tuna	.	.	.	.
Cabbage	.	.	.	.
Tomato Soup	.	.	.	.
Waffles	.	.	.	.
Watermelon	.	.	.	.
White Bread	.	.	.	.
Whole Wheat Bread	.	.	.	.
Wine	.	.	.	.
Winter Squash	.	.	.	.
Yogurt	.	.	.	.
Green Beans	.	.	.	.
Greens	.	.	.	.

APPENDIX B

Material Style of Life

ID Number _____

Name _____

1. Age _____

2. Marital Status:
   1. Married _____
   2. Widowed _____
   3. Divorced _____
   4. Separated _____
   5. Never Married _____

3. Number of living children _____

4. Number of children living in Alachua County _____

5. Home:
   1. Own _____
   2. Rent _____

6. Approximate age of home _____

7. Construction Material:
   1. Wood _____
   2. Brick _____
   3. Concrete Block _____
   4. Combination of Materials _____

Physical Condition of Home:

8.	Broken Windowpanes	1. Yes _____	2. No	_____
9.	Leaking Roof	1. Yes _____	2. No	_____
10.	Needs Paint Outside	1. Yes _____	2. No	_____
11.	Needs Paint Inside	1. Yes _____	2. No	_____
12.	Cracks in Walls	1. Yes _____	2. No	_____
13.	Broken Boards on Porch	1. Yes _____	2. No	_____
14.	Screen Doors Need Repair	1. Yes _____	2. No	_____
15.	Screens on Windows	1. Yes _____	2. No	_____
16.	Rickety Steps	1. Yes _____	2. No	_____

APPENDIX B, continued

Material Style of Life

Heat:

17. Fireplace	1. Yes	_____	2. No	_____
18. Room Heaters	1. Yes	_____	2. No	_____
19. Central Heat	1. Yes	_____	2. No	_____
20. None	1. Yes	_____	2. No	_____

Cooling:

21. Air Conditioner	1. Yes	_____	2. No	_____
22. Fan	1. Yes	_____	2. No	_____
23. None	1. Yes	_____	2. No	_____

Kitchen Facilities:

24. Stove	1. Yes	_____	2. No	_____
25. Hotplate	1. Yes	_____	2. No	_____
26. Refrigerator	1. Yes	_____	2. No	_____
27. Freezer	1. Yes	_____	2. No	_____
28. Hot Water	1. Yes	_____	2. No	_____

Miscellaneous:

29. Electricity	1. Yes	_____	2. No	_____
30. Indoor Plumbing	1. Yes	_____	2. No	_____
31. Television	1. Yes	_____	2. No	_____
32. Radio	1. Yes	_____	2. No	_____
33. Telephone	1. Yes	_____	2. No	_____
34. Washer	1. Yes	_____	2. No	_____
35. Dryer	1. Yes	_____	2. No	_____

Pets:

36. Dog(s)	1. Yes	_____	2. No	_____
37. Cat(s)	1. Yes	_____	2. No	_____
38. Other(s)	1. Yes	_____	2. No	_____

39. Overall Inhabitableness of House

1. Excellent _____
2. Needs Minor Repairs _____
3. Adequate _____
4. Needs Major Repairs _____
5. Uninhabitable _____

APPENDIX C

Coping Styles of the Rural Black Elderly

Coping Nutritionally

1. Where do you usually shop for food?
   1. Small Retail _____
   2. Large Retail _____
   3. Minute Markets _____
   4. Other _____

2. Do you receive food from anyone during the week?
   1. Always _____
   2. Sometimes _____
   3. Never _____

3. If you need groceries in the middle of the month, what would be your first choice of action?
   1. Forget it and do without _____
   2. Pray about it _____
   3. Walk to the store _____
   4. Drive yourself _____
   5. Hire someone to take you _____
      Relationship: Family _____ Friend _____ Other ___
   6. Go with a friend _____
      Name of this person _____
   7. Go with someone in the family _____
      Name of this person _____
      Relationship _____
   8. OAC Van _____

4. How did you get to the grocery store the last time you went?
   1. Drove self _____
   2. Friend _____ Name _____
   3. Family _____ Name _____
   4. Walked _____
   5. Paid someone to take you _____
   6. OAC Van _____

5. Do you grow any of your own food?
   1. Garden 1. Yes _____ 2. No _____
      If yes, what vegetables do you grow?
   2. If yes to question 1, do you preserve any of these foods for later use? 1. Yes _____ 2. No _____
   3. Raise chickens to eat? 1. Yes _____ 2. No _____
   4. Eat eggs from your own chickens 1. Yes _____ 2. ____
   5. Raise pork for consumption? 1. Yes _____ 2. No _____
   6. Raise beef for consumption? 1. Yes _____ 2. No _____
   7. Consume milk from your own cows 1.Yes _____ 2. No ___
   8. Butter from own cows 1. Yes _____ 2. No _____

APPENDIX C, continued

Coping Styles of the Rural Black Elderly

Coping Medically

1. When did you last visit a doctor?
   1. This week _____
   2. This month _____
   3. Within the last six months _____
   4. Within the last year _____
   5. Over a year _____
   6. Never _____

2. Verification of visit by:
   1. Date on medication label _____
   2. Payment receipt _____
   3. Other _____
   4. Unable to verify _____

3. How did you get there?
   1. Drove self _____
   2. Hired someone _____
   3. Family member _____
      Name _____
   4. Friend _____
      Name _____
   5. Walked _____
   6. OAC Van _____
   7. Bus _____
   8. N/A _____

4. When you become ill, what is your 1st, 2nd, and 3rd, choice of action?
   1. Pray _____
   2. Home remedies _____
   3. Over-the-counter drugs _____
   4. Call a neighbor, friend or relative to treat you.
      _____
      Name _____
      Relationship _____
   5. Visit a doctor _____
   6. Borrow medicine from family or friends ___
   7. Use prescription drugs that you already have
      _____

5. Do you currently have a problem or problems that need medical attention but for which you have not sought medical help? 1. Yes _____ 2. No _____
   What are those conditions? _____

BIOGRAPHICAL SKETCH

Lois Carolyn Nickens was born in Madison, Tennessee, August 25, 1938, as the second child and first daughter of Pauline and James Clifford Hardin. Ms. Nickens attended public schools in Davidson County, Tennessee. After moving to Florida in 1959, she graduated from the Alachua County School for Practical Nurses. A career in nursing was followed at Fisherman's Hospital in Marathon, Florida and at Tallahassee Memorial Hospital in Tallahassee, Florida. While residing in Tallahassee, she pursued a degree in home economics education at Florida State University and was granted a B.S. degree in 1970. After this, she taught in Alachua County public schools and at P.K. Yonge Laboratory School on the University of Florida campus. Ms. Nickens entered graduate school in 1979 at the University of Florida, in the department of anthropology. She received a M.A. degree in 1982 and expects to receive a Ph.D. degree in 1984.

Ms. Nickens is married to Dr. John M. Nickens and they have four children: Dan, aged 29, Don, aged 27, David, aged 25, and Sheran, aged 13.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Leslie Sue Lieberman, Chairman
Associate Professor of Anthropology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

H. Russell Bernard
Professor of Anthropology

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Otto von Mering
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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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This dissertation was submitted to the Graduate Faculty of the Department of Anthropology in the College of Liberal Arts and Sciences and to the Graduate School, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

December 1984

Dean for Graduate Studies and Research