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by
Sylvia Cicily Claire Lawson
In Memory Of My Parents

Eunice E. Earle
(1899 - 1983)

Stanford A. Earle
(1884 - 1959)

and My Sister

Rowena E. Earle Mitchell
(1920 - 1980)
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OLD AGE AND CAREGIVING IN A BLACK COMMUNITY

By

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Currently existing formal and informal support systems necessary for providing a better quality of life for noninstitutionalized elderly persons, especially those who are poor and Black, may be inadequate. This research employs a conceptual framework and methodology designed to examine knowledgeability, accessibility, and use of services among noninstitutionalized elderly Black persons. The social and cultural situations of Black elderly persons are examined to assess whether these elements determine and or contribute to their participation in, and knowledge about, available formal sources of assistance for instrumental activities of daily living (IADLs). The analytical model differentiates elderly persons who are users from non users of formal services and assesses their knowledgeability regarding formal and informal
services which are in place to assist them with various IADL functions.

Information was gathered, over a period of approximately twelve months, on a convenience sample of 71 elderly persons in an all black community in central Florida, using in-depth interviews and participant observation. This approach provides process data rather than the typical snapshot supplied through one-shot survey interviews. The nature of the design of the study allowed for the cross-checking and rechecking of what people say and do, increasing the reliability and accuracy of the data.

The data gathered by this research do not support assumptions about kinship patterns of informal caregiving that place great emphasis on the role of the black extended family. A large proportion of the elderly studied were living alone. The findings suggest that black elderly persons have limited awareness of the various services available through government agencies to assist them with their IADL functions. They instead utilize informal agency sources of help or do without needed services. The informal system of caregiving in this community also appears to fall short of providing the assistance needed by black elderly persons.
CHAPTER ONE
INTRODUCTION

Caregiving in its simplest form refers to care provided to someone who, because of physical or other limitations, is unable to perform certain functions unassisted. The concept of caregiving to the elderly is well defined by Horowitz (1985), as care provided to persons over the age of 65 with some degree of physical, mental, or emotional impairment which limits independence and necessitates ongoing assistance. This is the concept of caregiving used in the present research.

Insufficient caregiving for functionally disabled elderly persons in the community has become a serious social problem in American society. The responsibility of caring for persons 65 years of age and over, which has been for centuries primarily the responsibility of the family, one segment of the informal support system, has now become a joint venture between the state (the formal system) and the family. The informal support system consists of all unpaid help provided by family, friends, neighbors, or others who are not part of a group formally organized to provide long-term care assistance (Branch and Jette, 1983). Formal support on the other hand, refers to organized care provided
by government or voluntary organizations or agencies that exist to provide long-term care services to the noninstitutionalized impaired elderly (Branch and Jette, 1983). Once responsibility shifts to or involves the state, there are social as well as moral obligations to be addressed. The question becomes: are those who are in need receiving the care needed to lead a reasonably satisfactory level of daily living? Where the formal system of caregiving falls short, the burden shifts to the informal system to give needed support. Where the informal system falls short, governmental assistance is needed.

This research focuses on the informal system of caregiving to elderly black persons in need. The literature on black families has continued to expound on the primary role played by these families in taking care of their elderly relatives in the extended family setting. The general consensus is that the informal system is especially strong in the black community. The question is: to what extent is this image of elderly care in the black community accurate? That is: are black families still playing the role of caregivers to their elderly relatives in these final decades of the twentieth century? In spite of the consensus in the literature, there has been very little empirical research on the role of the extended family and other informal caregiving for black elderly persons. Although the gerontological literature is replete with studies concerned with caregiving
for the elderly, there is very little research on caregiving for black elderly persons. This research takes a careful, in-depth, qualitative approach to locating and describing the state of care, informal and formal, provided for elderly persons in one black community. To the knowledge of the researcher this is the first study to do so. The purpose is to contribute to our knowledge of how needy elderly persons are cared for in the black community.

This study, then, is an attempt to help fill some of the gaps in research on elderly black persons. The problem is mainly one of supports for this population of persons. Black elderly persons in need of assistance are more likely than white elderly persons to be in residence in the community than in institutions. The general question that needs to be answered is: what are the systems in the community that do or do not provide care for black elderly persons who are in need? The systems that are available for providing care to elderly black people fall into two distinct but interrelated categories of the formal and the informal caregiving systems. The major part of the study was conducted through visits, observations and interviews concentrated on the informal system mainly during the year the researcher spent in residence in Eatonville, historically, an all black community in Florida. Data were also gathered on the formal system through interviews with government officials, published data, and record archives.
As noted, the central reason for embarking on a study such as this is to see to what extent black family traditions, and community traditions have an impact on caregiving to elderly persons. Is the traditional view of the importance of the extended black family myth or reality? It is possible to obtain answers to this question in a variety of ways, but the researcher opted to conduct the study in Eatonville for several reasons. It was felt that a predominantly black community would present a more homogeneous group of elderly persons. Also, it was believed that black traditions and social support systems would be most viable and visible in a community which had a long-standing identity as an autonomous community rather than being just a semblage of neighborhoods. Eatonville was selected because it closely fit the model of a community which was nearly all black with some historical identity as a separate community of black citizens.

Answers to the above questions have implications for policy makers. A study such as this should also have implications for the discipline of sociology, especially to the fields of social gerontology and medical sociology, since black elderly persons and their need for health and other care as a group represents a source of potential research interest and constitutes a segment that has received very little study. However, the focus is primarily applied and descriptive social research addressing the physical, social,
mental, and financial welfare of noninstitutionalized black elderly persons, (aged 65 years and over). There is little theoretical development in the literature on which to build, and neither testing nor construction of theory is a goal of this research. Rather, the goal of this research is to provide a description of the informal and formal care given to black elderly persons based on their perceptions and descriptions and on the researcher's own observations. The notion of caregiving having been introduced, an overview of the elderly in America will be presented.

*America's Elderly: An Overview*

There are today approximately twenty-seven million persons aged 65 and over in the United States, comprising 12 percent of our population (U.S. Bureau of the Census, 1984). This translates into approximately one in nine Americans who are aged 65 years and over. Older persons today are categorized as falling into three groups: the young-old, 65 to 74; the old-old, 75 to 84; and the oldest-old who are those aged 85 years and over. Demographic shifts are evident due to the rapid graying of America in the decades of the 1970s and the 1980s as well as projections for the 1990s and well into the twenty-first century. The trend is toward a progressively older society. By the year 2030, when the core of the baby boom generation reaches retirement age, the projection is that over one in five Americans will be aged 65 or older (U.S. Bureau of the Census, 1984). It is also
estimated by the Census Bureau that the very old, those 85 and older, will increase from 2.7 million today to 8.6 million in 2030 and 16 million in 2050. These shifts have forced the polity into the realization that there is need for the creation of more support systems to care for these elderly persons.

The proportion of people who are elderly varies by race, ethnicity, and sex. People aged 65 and over make up 12 percent of all whites, 8 percent of blacks, 6 percent of Asians, and 5 percent each of the Hispanic and American Indian populations (Hess, 1986). Despite the goal of the 1965 Older Americans Act to enable the aged to maintain independence and to improve the quality of their lives, the practice of institutionalizing functionally impaired older people continues unabated (Olson, 1982). The problem is not so much with current numbers of persons institutionalized, but with the rate of institutionalization. This is, a 2 percent rate of institutionalization in 1910 amounted to 80,000 persons, whereas the 1980 rate (at 5.0 percent institutionalized) translates to over one million elderly persons living in institutions, a better than tenfold increase (Olson, 1982). If the rate of institutionalization continues to increase as the population ages, then by the early twenty-first century the numbers of persons in such care will grow still further. Despite increases in the rate of institutionalization, there still remains a large
percentage of elderly persons (95 percent to 98 percent) who are not institutionalized at any given time. Blacks make up 11.69 percent of the United States (US) population. That is 26,488,218 persons (U.S. Bureau of the Census 1980). Of the population of black persons in the United States, approximately 2.2 million are over the age of 65 years. Elderly black people have many problems that elderly white people do not have. This situation is referred to by some as double and triple jeopardy (Jackson, Kolody, and Wood, 1982; Kart, 1985). That is, they have the problem not only of being elderly, but complicating this are the features of being black and, for the majority, of being poor. Black females have quadruple jeopardy, that is, of being old, black, poor, and female.

Because of the uniqueness of their situation, blacks should be studied separately as a subgroup of the elderly population who have special needs and who need special attention from researchers. As early as 1968, Billingsley pointed out that, even though the black family system is one institution in a complex of various American institutions, the black family cannot be totally understood or interpreted from a general (white) analytical framework. The limits of using a general analytical framework have been evidenced through various studies. Areas such as poverty and kinship patterns are very important in any study relating to black
families. The same does not hold for the general U.S. population.

Poverty is suffered by large numbers of elderly black people today; in 1981, 39 percent of elderly blacks lived below the poverty level (U.S. Bureau of the Census, 1981). The systematic racial discrimination tolerated in the United States during the early decades of this century resulted in a lack of education for this cohort of individuals leading to lack of professional qualifications for the majority and hence the impossibility of procuring high-paying jobs. This led to marginal occupations and dependence on social services agencies throughout the life of many blacks, and gave them little access to private pensions. In the case of black elderly people, this helps to explain the fact that few of them are found in retirement villages, retirement condominiums or such. Institutionalized racism exacerbates the economic situation. Most blacks still feel uncomfortable in white dominated communities.

Kinship patterns among blacks also contribute to the preference that blacks have for remaining at home to the end of their days. It has been claimed and it is generally acknowledged that the black kinship network is more extensive and cohesive than kinship bonds among the white population (Staples, 1981). Research shows that for blacks the kinship network serves its members most effectively as a functional mutual aid system (Mindel, 1986). Numerous studies have
shown the positive effects of kinship networks among blacks, but there are others that have found relatively few differences by race among elderly people in participation with family and kin (Heiss, 1975).

Most black elderly people have experienced extended family arrangements. The offspring of black elderly persons have traditionally felt responsible for their care and welfare, whether they be parents, grandparents, or other blood relatives. Even close family friends are oftentimes afforded the same treatment as family in black communities; sometimes such persons are termed "fictive kin."

Blacks have always been known to be religious. Churches and friendly societies all cater to elderly black persons, filling the gaps left void by government. Out of these informal institutions have sprung such organizations as Dorcas Societies and similar groups which have taken care of clothing the poor. Black elderly women especially, while benefiting from these organizations, also contribute a great deal to them in terms of service. They voluntarily do sewing and craft as means of helping each other.

The survival pattern for whites has always been better than that of non-whites. However, the difference in life expectancy at birth for whites which was 15.9 years higher in 1900-1902 than it was for blacks had, by 1982, decreased to a 4.9 year difference for females, and a 6.6 year difference for males (U.S. Department of Health and Human Sciences,
National Center for Health Statistics, Monthly Vital Statistics Report, 1983). In 1983 life expectancy at birth for white males and white females in America was 72 years and 79 years respectively, while for black males and black females it was 65 years and 74 years, respectively (U.S. Department of Health and Human Services: Report of the Secretary's Task Force on Black and Minority Health, 1985). The lower life expectancy of blacks has been attributed to their generally lower socio-economic status in the United States (Butler and Lewis, 1983).

It has, however, been found that reversal occurs at a certain age. At that age which has been termed the "crossover point," blacks begin to show a greater survival rate than whites (Cornely, 1970; Heiss, 1975; U.S. Dept. of Health and Human Services, 1985). In 1976 the crossover was found to occur at age 65 for men and 72 for women. This "crossover" was first reported in 1968 (Heiss, 1975), but the explanation for it was unclear and it was attributed to the "survival of the strongest." This is still used to explain this phenomenon (Manton, 1982; Markides, 1983). Although blacks comprise about 11.69 percent of the total population in the United States, black people make up only 8 percent of the older age group. Black older women outlive black older men. The ratio of black women per 100 black men increased from 115 in 1960 to 131 in 1970 and black females make up
56.7 percent of the total black aged population (Butler and Lewis, 1983).

**Marital Status**

The majority of men over 65 years in the United States, even those aged 75 and older, are married (79.8 percent in 1983), and living with their wife. In contrast, the majority of women over 65 are not currently married (U.S. Bureau of the Census, 1984a). Several factors contribute to the probability that an older man will have a wife with whom he will be living. One well known factor is that men typically marry women who are younger than themselves while society still discourages women from marrying men who are younger than they are. This difference is exacerbated by the lower life expectancy of males. Another factor is that the remarriage rates of older men are higher compared to women (U.S. Department of Health and Human Services Survey 1983b:7). In 1980, among nonmarried persons aged 65 and over, men remarried at nine times the rate of women. The result of this situation is that most older women are widows. There are at least three times as many widows as widowers to be found in the U.S. (Hess, 1986).

Among black elderly persons whether male or female, a lower percentage are married both in the young-old period and in the old-old period when compared to white elderly persons. Substantially more black elderly persons are widowed and divorced than are white elderly persons (Mindel, 1986). For
black women, aged 75 years and over, 78 percent are reported as widowed in 1983 (U.S. Bureau of the Census, 1984). The shorter life expectancy of black men is an important contributory factor, leaving a black woman widowed much earlier than a white woman.

**Health Status**

As people get older their resistance to new diseases declines. Verbrugge (1986) states that chronic diseases developed earlier in life tend to deteriorate, and although acute conditions are less frequent in older persons, the recovery period for them is longer. "Health status refers to measures of illness, injury, and symptoms, including people's own evaluations of their health, interview reports of health problems, and data from medical examinations" (Verbrugge, 1986:182). Closely associated with, or linked to, health status is "health behaviors." It is common knowledge among health care professionals that health behaviors impact very strongly on health status. "Health behaviors refer to all curative and preventive actions, relating to short-term disability ('restricted activity'), long-term disability ('functional limitations'), use of health services, and use of medications" (Verbrugge, 1986:182). Culture plays a major role in any analysis of health behaviors in that "cultural patterns and typical ways of life give substance to the manner in which illness is perceived, expressed, and reacted to" (Mechanic, 1978:55).
There are some health problems which are common companions to old age. These are heart disease, cancer, cerebrovascular disease and hypertension. Heart disease has been identified as the principal cause of death among the elderly and accounts for a great deal of morbidity, disablement, and inactivity in older people (Kart, 1985). The incidence of cancer increases with age; hence, older people should be encouraged to have periodic preventive medical examinations. Cerebrovascular disease which manifests itself as a stroke is the result of impaired brain tissue. Cerebral thrombosis is a main cause of stroke in the elderly. Kart (1985) notes that as many as one in four older people have hypertension, or high blood pressure. Other prevalent elderly-related health problems, which are bothersome though less life-threatening, are arthritis, digestive disorders, foot and skin problems, and chronic respiratory symptoms (Verbrugge, 1986). Other health problems associated with aging are the decline of sensory (vision, hearing, balance) and mental faculties and the weakening of bones and muscles. A popular manifestation of bone weakening is osteoporosis especially in elderly females.

Elderly black persons demonstrate different configurations regarding certain chronic diseases. There is a higher incidence of hypertension among elderly black persons. The incidence of diabetes is also reported to be higher in elderly black persons. The same is true for
certain types of cancers (lung, esophagus, prostate, stomach, cervix, uterus, multiple myeloma, pancreas and larynx). In fact, it is reported that blacks have the highest overall age-adjusted cancer rates (for both incidence and mortality) of any U. S. population group (Report of the Secretary's Task Force on Black and Minority Health, 1986a, 1986b).

Health data confirm that older men are more seriously ill than older women, but the data also indicate that older women are more frequently ill than men. "Data on subjective perceptions of health status, acute and chronic conditions, and disability for acute and chronic conditions support this conclusion" (Verbrugge, 1986:185).

When the health problems of elderly persons are analyzed according to gender, older women are found to have more acute and more chronic conditions; they are bothered more by their chronic conditions, but these diseases are seldom life-threatening. Older men have higher rates of life-threatening conditions, which lead to employment restrictions and earlier death. Attitudes and behavior toward illness may be very important in explaining sex differentials in short-term disability, limitations and death among older people (Verbrugge, 1986).

The overall level of health of America's aged has not changed greatly since 1970: "while there are proportionately more chronically ill very old people, the younger aged are reported to be in better health than in the past" (Hess,
Nine-tenths of the elderly describe their health as fair or better compared with other people their age (U.S. Bureau of the Census, 1983), and over half report no limits on any major activity because of health considerations. By age 85 years and over these figures shift, with half reporting themselves unable to carry out a major activity because of poor health. In 1980, as in 1965, four of five older people reported having at least one chronic condition, although in most cases this did not interfere with major activities (Hess, 1986).

Health status plays a major role in caregiving for elderly persons. It is a key determinant in their living arrangements.

**Living Arrangements**

The 95 to 98 percent of America's older people who are not institutionalized live in the community, and most live in their own households. Seventy-one percent of all persons over 65 own their own home (Woodward, 1986). Those who do not live in their own homes have a variety of housing arrangements available to them depending on their health and economic status.

Living arrangements of older people has been classified as living alone (complete independent living), living with non-relatives, living with a spouse, living with other relatives, and not living in a household (Shanas, 1962; Wilson, 1977). A variety of factors impinge upon and
determine which of the five arrangements will be selected by or for individual elderly persons. These factors include marital status, sex, functional impairments, race, income, health status (both mental and physical), and attitudes.

The vast majority, approximately 95 percent, of all aged persons, live independently in the community, either by themselves or, more often, with a spouse, family, or friends. Butler and Lewis (1983) report that of every ten older Americans, seven live in families. Approximately one fourth live alone or with nonrelatives. This situation differs for men and women. Women are three times more likely to live alone or with nonrelatives.

The frequent statement that most older black people live in extended families is only a myth. Studies have shown that "50.2 percent of black persons over the age of 60 years lived alone or with only one other person, relative or nonrelative, while 16 percent were found to live entirely alone" (Butler and Lewis, 1983:27). There is also evidence that 11 of every 100 older blacks have no living relatives, compared to 6 of 100 whites (Butler and Lewis, 1983). Data contrasting men and women show that half of all black older men live with their wives. But again, because of a longer life span, only one fifth of black older women live with their husbands (Butler and Lewis, 1983).
Housing Alternatives

In the United States, residences available to the elderly are Adult Foster Homes, Adult Congregate Living Facilities (ACLFs) or Congregate Housing, Senior Citizens Lodge and Home Care, and Granny Flats. There are also personal care boarding homes, commercial boarding homes, congregate care homes, congregate care, life care or continuous care, retirement villages, and shared living.

The old are anything but homogeneous. These people lead vastly different lives depending upon their situation. Living arrangements of men over 65 differ markedly from those of women. Similarly, the living arrangements of people with children differ from those of persons without children. Grouping together all older people would therefore only obscure these important differences. Differences in marital status are responsible for many of the differences in the living arrangements of men and women, black and white.

The most recent data on marital status of elderly women reflect a most striking change in living arrangements of any age or sex group over the past two decades: the decline in older women who live with other relatives (from 19 to 10 percent between 1965 and 1981) and the commensurate rise in the proportion living alone (from 31 to 40 percent during the same period). The major contributory factor to this shift is economics, giving older women more independence today than they had two decades ago. More older women are now able to
afford independent residences and maintain their own automobiles. In some cases this is due to the liberalization of Social Security benefits and the introduction of Medicare in 1965 (Hess, 1986).

With the concept of shared housing (not only intra- but also intergender) becoming more popular, in the future we might expect to see more widows and widowers who are not married living together in the same household. In 1983 there were about 120,000 households in which a nonmarried couple, one of whom was 65 and over, lived together (U.S. Bureau of the Census, 1983d).

State of Health

The state of health of the elderly plays a major role in deciding their living arrangements. The greater the number of chronic ailments that older persons have, the less the likelihood of their living alone. This situation is compounded if the impairments result from severe impairments of vision or mobility. Increased frailty and incapacity can necessitate that an older person not living with a spouse, and who has grown children, change his or her living arrangements. That is, he or she may move in with one of his or her children. The physical condition of the very sick older person forces him or her to be much more dependent upon family members not only for physical care but for companionship and social activities.
In the absence of children, an older person may move in with a relative, or have a relative move in with him or her. In situations such as these, they mutually decide who should be head of the household.

Sometimes elderly dependent parents move from one section of the country to another to share a child's home, paying something towards the rent. If their health is fairly good, some are able to help with babysitting while their children go to work. Some are also able to help with housework.

**Visitation by Family and Friends**

One important aspect of an older person's life is receiving visits from relatives and friends; older people therefore prefer to live near at least one child. This allows them to see their children often. Visiting their children or receiving visits from them contributes to the life satisfaction of older persons. This is further enhanced if there are grandchildren present. Some may see their children as often as once per week while others receive visits only on special holidays such as Christmas, Easter and Thanksgiving. Family anniversaries may also merit visits especially from those who live far away.

Most older people are long-time residents in the areas in which they live and are able either to visit or receive visits from neighbors. However, an older person may sometimes find that he or she has outlived most of those who
once were visiting neighbors. Visits from relatives, other than children, also play a major role especially for those older persons who do not have children. Other people such as clergymen, church visitation groups, and welfare workers may form a part of the visiting group. A survey carried out about three decades ago demonstrated that in general, persons without living children appear to be the most isolated group in the aged population (Shanas, 1962).

Today there is expected to be less isolation as we find that elderly persons can choose the type of living arrangement which best contributes to a reduction in isolation and hence enhances their life satisfaction. The myth of the isolated elderly no longer has strong support (Aldous, 1987). The Older Americans Council plans various activities, and provides meals-on-wheels delivered by volunteers. These volunteers play a double role. As they deliver meals they also use this time to visit. To reduce loneliness experienced by some elderly persons, there is day care designed especially for the elderly and there is low cost congregate living which moves the older person from living alone to living with others. Those who are more affluent may move into retirement villages where activities are designed to keep them from being lonely and bored.

**Racial Constraints**

Living arrangements may differ according to race. More older blacks than whites do not live with their spouses.
This has been attributed to the greater economic pressures on black families, including unemployment and public welfare laws that encourage black men to leave home early in life. The lower socioeconomic status of the majority of black elderly persons also militates against them living in expensive retirement facilities.

It has often been posited that black elderly persons live in extended families. Thus, isolation has never been seen to be a problem with black elderly people. Shifts have been seen however, in the living arrangements of elderly blacks. An examination of multigenerational households in the U.S. population found that a major change had occurred suggesting that elderly people who might have lived with their kin have gradually shifted to living alone (Mindel, 1979). This is an indication that black elderly persons are more similar to whites than previously supposed in that among the black elderly there is almost as great a tendency for them to live alone as there is among whites (Mindel, 1986). Cantor et al. (1979) found that a larger number of black elderly women were likely to report themselves as heads of households than was the case among white families. They contend that this sharing of limited resources suggests a positively adaptive method of meeting the pressures of poverty and unemployment within a functional family system. Mindel (1986) observes that among black Americans there is a
greater likelihood that an elderly female will be a head of household.

Older people want to continue to live in their own homes as long as possible irrespective of their race and whether or not they have children. The common belief that older people in the United States are isolated either physically or socially has not been proven. On the contrary Shanas (1962) concluded from a survey that when older people had children they generally lived close to at least one of them. Furthermore, older people see their children often. Even children who live at a distance apparently try to see their parents on major holidays and other special occasions. While marital status, health status and gender play a major role in determining the living arrangements of older people today, because of the available social supports, most older persons can fit into one form or another of living arrangement and avoid institutionalization.

**Geographic Distribution**

Older people, both black and white, live most frequently in central parts of cities and in rural locations. The residence patterns of older black persons show a somewhat different configuration than that of older people as a whole. Three-fifths still reside in the South, many in rural areas, but because of the large numbers that moved to urban areas in the black rural-to-urban migrations of the early 1900s, older black persons are now also concentrated in central cities,
primarily in those areas with the worst housing. By 1970, one of two older blacks lived in central city locations. In 1980 black elderly remained heavily concentrated (68 percent) in the central core of older cities (Hess, 1986). Many are trapped there under the dual influence of economic hardship and a continuing racism that tends to preserve the suburban areas for whites.

**Standards of Housing**

It has been estimated that up to 30 percent of older persons in the U.S live in substandard housing largely as a result of outright poverty or marginal income. Many of these have become substandard as the costs of maintenance, utilities, and property taxes have so skyrocketed that upkeep and needed improvements have become impossible for many elderly homeowners. Government subsidies for maintenance have been a great help recently because most elderly people live on fixed incomes. Those who do not live in their own homes either live alone, with relatives or friends or in retirement facilities. Some older people live in public housing, "often seen by them as a highly desirable resource in view of the wretched alternatives available. Many are so poor that they cannot even afford public housing and some of these are forced to reside in single room occupancy (SROs) hotels embedded in a fierce environment peopled by petty thieves, pimps, prostitutes, addicts, and hustlers" (Stephens, 1976).
Income of the Elderly

Poverty, like substandard housing, is typically associated with old age. People who are poor all their lives can expect to become poorer in their old age and elderly blacks are especially plagued by poverty. In fact, it is reported that the rate of poverty among older blacks is twice that of older whites. "In 1984 the median income for black males over the age of 65 was $6,163 compared to $10,890 for white males. For black females the 1984 median income was $4,345, while for white females the figure was $6,309" (Johnson, 1988:101). Blacks have often been employed in the service industry and in seasonal jobs. In the competitive sphere of job situations one could say that they are at the bottom of the heap. Many blacks have few work skills, and discriminatory hiring practices common throughout the society render some virtually unemployable. Jobs generate only sporadic and minimal income. Carp's (1972) study of the occupational characteristics of the aged slum dweller show that

retirement--usually from menial jobs that provided no security, tenure, or fringe benefits--has not been an event that occurred on a given day, but was rather the culmination of increasingly frequent and lengthy periods of time during which these individuals were unable to obtain employment. (Carp, 1972:57)

These observations fittingly describe many blacks. It has been noted that some find more or less steady conventional jobs in low-paying, low-skill services, working as waiters,
dishwashers and cleanup helpers. These are jobs with abysmally low pay scales, little security, and poor working conditions. All of these contribute to their dependency on Social Security and Welfare. The economic status of elderly persons dictates their living arrangements to a great degree. It is also a determinant of caregiving and plays a major role in health status, health beliefs and education.

Plan of Research

To reiterate, the purpose of the study is to examine the level and type of caregiving of elderly persons in a black community. It was assumed that by going into the community and studying it through interviews and observations, other questions and issues that affect black elderly people would surface. The intention was to explore the use of formal and informal networks in order to test whether friends, kin, church, and neighbors provide a pivotal resource for responding to the needs of elderly persons in the community.

In order to examine caregiving of black elderly persons, this research concentrates on the age group 65 years and older taking care in some instances to compare and contrast the care-giving network as it affects the young-old, those 65 to 74 years of age; the old-old, those 75 to 84 years; and the oldest-old, those who are 85 years and over. The research methodology employed is based on the view that data needed to understand caregiving at this stage of our
knowledge are best gathered through qualitative research. Certain information can only be garnered from field research.

Chapter Two addresses black families and black elderly persons in the United States. An analysis of black families is germane to the study of black elderly persons and a review of previous research on black elderly persons is in turn necessary for studying a group of black elderly persons in a particular community. It is necessary to have as clear as possible an understanding of this racial group before attempting an assessment of its elderly subgroup. This chapter also analyzes the demographic characteristics of black families and black elderly persons. The aim is to bring into focus changes concerning the diversity of black family patterns and the theories that are used to study today's black Americans. The major demographic areas addressed are (1) family composition, (2) marriage and divorce and (3) education, employment and income. Black elderly persons are analyzed in terms of health problems and kinship in addition to the general demographic patterns.

Chapter Three presents a review of caregiving by formal and informal support systems. The chapter begins with a brief introduction which is followed by an overview of caregivers and caregiving including the literature, the formal support system, the informal support system,
impairments of elderly persons, activities of daily living (ADLs), instrumental activities of daily living (IADLs), support systems for elderly black persons, and caregiver stress and burden. The chapter ends with an analysis of caregiving and black elderly persons followed by a brief summary.

Chapter Four contains a description of the methodology used and the setting in which the field research took place. Data were gathered from a convenience sample of 71 elderly persons and/or their primary caregiver where this was necessary.

The findings from the field research are presented in descriptive form in Chapter Five supported by a quantitative analysis of forty independent variables. A description of the elderly people of Eatonville as well as their caregiving networks is included. Family, impairments and caregiving are addressed. Vignettes are utilized to demonstrate the various ways in which the elderly persons of Eatonville access and utilize formal and informal support systems either separately or combined.

Chapter Six contains conclusions and implications. The potential impact of this study lies in its assessment of how factors relating to caregiving affect the well being of black elderly persons. It is hoped that local, state, and national programs designed for older persons will eventually shift an emphasis from support for the institutionalized to support
for the elderly person living at home, paying special attention to black elderly people. Such a shift will influence the life satisfaction and wellbeing of older black persons in positive ways.
Of all social institutions, the family is perhaps the most basic (Tischler et al., 1983). Sociologists view institutions as systems of social norms and norms are society's rules of conduct for its members (Leslie, 1979). The family can be studied either as an institution or as a social group. Leslie (1979:22) points out that

when the family is viewed as a social institution, the norms governing family forms and functions are emphasized. [However], when one focuses upon the family as a social group, attention is directed more toward its internal functioning than toward its relationships with other aspects of the society.

Definition of Family

It is difficult to find a definition of family general enough to cover the family as it exists in all societies, but a generally accepted typology of families includes the concepts of nuclear family and extended family. A family has traditionally been defined as a married couple or group of adult kin who cooperate and divide labor along sex lines, rear children, and share a common dwelling place. A variety of family forms have emerged to challenge this definition. Examples of these are single-parent families, cohabiting families, blended families, families without children, and
gay and lesbian families (Strong and DeVault, 1989). Strong and DeVault (1989) propose a contemporary definition which, in order to include these diverse forms, would define the family as one or more adults related by blood, marriage, or affiliation who cooperate economically, share a common dwelling place, and may rear children.

The classical definition of family, of which we now see variations is that given by Peter Murdock (1965) in his book *Social Structure*. Murdock's definition states that

the family is a social group characterized by common residence, economic cooperation, and reproduction, and consists of a male and female adult and their offsprings or adopted children. (Murdock, 1965:1).

Murdock used husband/wife and therefore implied legal marriage. He later distinguished marriage and the family. Murdock's definition really speaks about the structure of the family, and implies the makeup of a family. He refers to a nucleus of individuals. His nuclear family is approximately the same as Levi Strauss's conjugal relationships. While nuclear stresses the husband-wife relationship, extended family is used to imply parent-child relationship applying to a type of family which usually comprises three generations, that is, man, spouse, their children, their children's spouses (especially sons), and their children living either in the same household or very near to each other with some cooperative domestic arrangement. Extended family is the same as consanguine, implying blood relatives. The nuclear
family tends to be a small unit, whereas the extended family is a larger unit. The nuclear family, because of its size, is more applicable to living in modern societies and the extended family to living in more traditional societies. Authority structure differs in the different family systems. The nuclear unit tends to be patriarchal, implying that authority is vested in the male. It is, however, sometimes matriarchal.

Functions of the family are central to life, culture, and society. Functions of the family were long seen as providing a source of intimate relationships, acting as a unit of economic cooperation, producing and socializing children, and assigning status and social roles to individuals. It is contended, however, that while these are the basic functions that families are "supposed" to fulfill, families do not necessarily have to fulfill them all. Strong and DeVault (1989) suggest that technology, industrialization, mobility, and other factors are altering the way the family performs its functions today. The question as to whether every family performs these basic functions leads to the debate over the universality of the family. The United States with its numerous ethnic and racial groups supplies various family forms which could be studied cross-culturally. To this end, the present review of black families in the United States addresses black people as a sub-group of the society and discusses family forms of
blacks, that is, residence, forms of marriage, authority structure, and functions of black families. The area of kin relationship will also be addressed since kinship is germane to any study of black families and black elderly persons in particular.

Black Families

Knowledge of black families must form the basis for studying any segment of black communities since the family is intricately tied to the society. A diversity of black family patterns exists in the United States and it is maintained that different family forms prevail at different class and income levels throughout the American society. This has led to the conclusion that the black family is itself a fiction (Glick, 1988). Hence, this study will analyze 'black families' rather than 'the black family.'

Family forms of blacks can be analyzed in terms of residence, forms of marriage, authority structure, functions of black families and kin. In this analysis of black families three major demographic areas are addressed. These are family composition; marriage and divorce; and education, employment, and income. The strengths of black families is also addressed.

Studies of black families date as far back as the early 1900s and can be found in the works of W. E. DuBois (1969), Franklyn Frazier (1932), Melville Herskovits (1930, 1941), and Drake and Cayton (1962). Others such as John Dollard
conducted community studies in the South in the 1930s, focusing on the prevailing caste system and its effect on social life. Hylan Lewis (1955) carried out a community study among blacks in a North Carolina town. Virginia Young (1970) conducted research among southern black populations. Molly Dougherty (1978) carried out research among black girls and described how they developed into women in a rural black community in North Central Florida. Very little research on blacks was carried out in the 1940s and the 1950s.

Research among black populations and black families in the United States has been influenced by the sociological tradition and contributions of both Frazier (1932, 1939) and Herskovits (1930, 1941). Frazier (1939) referred to the instability of marital unions among "New World" blacks, as well as the lack of social support for the man to operate effectively in the male or father role. He emphasized a structural explanation, to replace an explanation based on African cultural survival in vogue then. He also formulated some significant generalizations about the effects of slavery upon the family life of American blacks. With respect to New World blacks, he observed that black Americans were trying to build a stable life after the almost total social disorganization of slavery and in a society which continued to be hostile and discriminatory. Frazier argued that the effects of emancipation on black families resulted in
problems affecting today's black family. Frazier (1939:81-85) wrote

mobility of the black population after emancipation was bound to create disorder and produce widespread demoralization. Promiscuity, and confusion in marital relations would be evident while marriage as a formal and legal relation was not a part of the mores of the freedmen. The severe hardship on Negro "families" after emancipation left them without any means of subsistence. Where families had developed a fair degree of organization during slavery, the male head assumed responsibility for their support.

Frazier noted that this severe hardship became a test of the strength of family ties. Two general tendencies are manifest in the fortunes of the Negro family dating the period of its adjustment to the state of freedom. For those families that had achieved a fair degree of organization during slavery, transition was easy. Authority of the father was firmly established in these families, and the woman in the role of mother and wife fit into the pattern of a patriarchal household. Roles were fairly clearcut, and the father became the chief, if not the sole breadwinner thus demonstrating that he had assumed the responsibilities of his new status. Sometimes he acquired land of his own and thereby further consolidated the common interests of the family group (Frazier, 1939). The second tendency is that the loose ties that held men and women together in a nominal marriage relation during slavery broke easily during the crisis of emancipation. When this happened, the men cut themselves loose from all family ties and followed the great body of homeless men wandering about the country in search of work and new experience. Sometimes women,
primarily those without children, did the same. (Frazier, 1939:88)

Historically emancipation locked black families into two groups, in which many today still find themselves. Most studies would have us feel that the latter group is the most dominant and some scholars' descriptions of black families have implied that their members are shiftless and uneducated.

Herskovits (1930), in his study of New World black families, noted that a close bond existed between mother and child. He also noted the peripheral status of the man or father, implying matrilocality and marginality. His conclusion was that these patterns were vestiges of African systems. Herskovits has been acclaimed as one of the first scholars to recognize similarities in African cultural patterns and those of African descendants living in the United States, the West Indies, and Brazil. It is said that one of his major contributions was a more realistic conceptualization of family life in traditional African societies, which are characterized by unity, stability, and security (Dodson, 1988).

Negative assumptions have been made about blacks in general and about black men in particular. The main ones are that they do not want to work and are disinterested in their children. Such pathological and dysfunctional views of black families, associated with the work of authors such as Daniel Patrick Moynihan (1965) in the "Moynihan Report," have elicited responses in defense of black families. One such
response comes from the writer and sociologist William Ryan. Ryan's (1976) work, *Blaming the Victim*, serves as an excellent rebuke to all those who place all the blame for the black person's ills on the black person himself. In pondering the thought processes of victim-blaming, Ryan analyzes a new ideology which he sees as very different from the open prejudice and reactionary tactics of the old days. Its adherents include what he calls "sympathetic social scientists with social consciences in good working order and liberal politicians with a genuine commitment to reform" (Ryan, 1976:7). Continuing his chastisement of this group of victim blamers, Ryan (1976:6-7) states that

they are very careful to dissociate themselves from vulgar Calvinism or crude racism and indignantly condemn any notions of innate wickedness or genetic effect. The Negro is not born inferior they shout apoplectically. Force of circumstance, they explain in reasonable tones, has made him inferior. They dismiss with self-righteous contempt any claims that the poor man in America is plainly unworthy or shiftless or enamored of idleness. They say that he is caught in the cycle of poverty. He is trained to be poor by his culture or family life, endowed by his environment.

The culture of poverty theory has also been used to analyze black families and became a part of the infrastructure of black ills. Oscar Lewis (1966) carried out studies in Puerto Rico and referred to unstable family forms, mating patterns and poverty. It was Lewis who used the term "Culture of Poverty" to imply that the poor "in time" come to represent a certain sub-culture of poverty. This "culture of poverty" syndrome has been assigned to black persons in the
United States because they are usually seen as having unstable family forms and mating patterns and as being necessarily poor. Lewis' "culture of poverty" theory as applied to black people in the United States, has, however, been rejected. Ryan (1976) draws our attention to "those who would want us to believe the myth regarding the culture of poverty, that it produces persons fated to be poor, in order to blind us to the fault of a corporation dominated economy" (Ryan, 1976:120). Ryan also addresses the myth that black families produce young men incapable of achieving equality which he observes is "designed to blind us to the pervasive racism that informs and shapes and distorts every social institution" (Ryan, 1976:120).

Attempts at demythologizing black families are to be found in the works of several other researchers including Joyce Ladner (1988), John McAdoo (1988), Harriet Pipes McAdoo (1988), and Robert Staples (1971, 1981, 1985). Staples (1985) blames the inability of black aspirations for a traditional family life and roles on structural conditions. These structural conditions are said to have the greatest impact on the black male and force him to abdicate his role as husband and father. This has had far reaching effects resulting in what Staples sees as the most significant change in black families during the last 30 years: the proliferative growth of female-headed households. He notes that "when the Moynihan report was first issued in 1965 more than three-
fourths of all black families with children were headed by a husband and wife. In 1982, however, barely one-half of all such families included parents of both sexes" (Staples, 1985:1006). This had severe consequences for black families because of disparities in family income. Households headed by black women had a median income of $7,458 in comparison with the median income of $20,586 for black married couples and $26,443 for white married couples (U.S. Bureau of the Census, 1983).

An examination of the situation of black families 20 years after the publication of the Moynihan report forces Staples to ask questions such as: "How is it that a group that regards family life as its most important source of satisfaction finds a majority of its women unmarried?," "Why does a group with more traditional sexual values than its white peers have a majority of its children born out-of-wedlock?," and "How is it that a group that places such importance on the traditional nuclear family finds a near majority of its members living in single-parent households?" (Staples, 1985:1006).

Staples sees the structural conditions of the black population as being responsible for the problems experienced by today's black families. "These conditions not only denigrate the black male but reduce the quantity and quality of black males and hence rob black females of satisfactory potential mates" (Staples, 1985:1006). Studies have shown
that 46.6 percent of the 8.8 million black men of working age were not in the labor force. Some were unemployed, some had dropped out of the labor force, some were in prison and almost 1 million were classified as "missing" because the Census Bureau said it could not locate them (Staples, 1985).

The situation is further exacerbated by the number of black males serving in the Armed Forces. Census figures (1983) report that in 1982 a significant number (415,000) of blacks were under arms. This figure represented 20 percent of all United States military personnel. It is estimated that 90 percent of these were male (Staples, 1985).

The job situation of black males in the civilian labor force contributes to enlistment as a choice. Instead of being a means to an end, the Armed Forces become an end in themselves for a large number of black males. "This results in a rate of re-enlistments for black males which is much higher than their white counterparts" (Staples, 1985:1009).

**Socio-Demographic Profile of Black Families**

Black families include a variety of family types. The majority are either families which are maintained by a married couple or those which are maintained by one parent and one or more of the parent's own young children. In 1985, 81 percent of black Families were of one or the other of these types, and the corresponding proportion for all families without regard for race was 91 percent (U.S. Bureau of the Census, 1986). Families which were not of either of
these types consist of such groups of relatives as 
grandparents and their grandchildren, brothers and sisters, 
and other relatives. A large percentage of black families 
have young children among their members. In 1985 this figure 
was 57 percent. This is a reflection of the higher birth 
rate of black women coupled with the shorter survival of 
black marriages (Glick, 1988).

Single parent families are another common form of black 
families. In 1985 these families represented 30 percent of 
all black families while the corresponding proportion for all 
families without regard for race was 11 percent (U.S. Bureau 
of the Census, 1986). Factors such as the vast increase in 
the divorce rate and a decline in mortality rate for young 
mothers have resulted in four times as many young children 
living with a divorced parent versus a widowed parent in 1985 
as did so in 1960 (Glick, 1988). Glick (1988) also notes a 
continual increase since the 1960s and up until the present 
time, in the number of young adults who are living in the 
parental home.

**Education**

Blacks are still more likely to attend racially 
imbalanced schools representing 44 percent of black children 
in the North and 20 percent in the South. They have less 
education on the whole than their white counterparts, and the 
education they receive may be inferior due to the fact that 
the schools they attend lie mainly in poor school districts.
Only 8 percent of blacks compared to 18 percent of whites have college degrees. However, blacks today have much better prospects than their parents did. Blacks have made strong gains in education. From 1968 to 1878, for example, the proportion of black children in the South attending mostly black schools dropped from 79 percent to 59 percent (Stevens, 1980). From 1970 to 1980 the proportion of black undergraduates at American colleges jumped from 7 percent to 11 percent, while black enrollment in graduate and professional schools increased from 4 percent to 6 percent (Stevens, 1980).

These educational gains have led to better-paying jobs for many blacks. For example, about 6 percent of the nation's managers and administrators are black. Today blacks hold about 10 percent of the positions in finance, real-estate, and insurance. And between 1968 and 1980 the number of blacks elected to public office in the 11 states of the deep South increased from 156 to 1813 (Henslin and Light, 1983; Rowan, 1981).

Despite such gains, however, black persons remain underrepresented in American politics; Wright (1979) notes that less than 2 percent of elected officials are black. Although black people today have better education and increased opportunities, ethnic discrimination still underlies their relative impoverishment. At all levels, whether among factory workers, managers, or supervisors,
income gaps still separate blacks and whites, and the gap always puts whites on top (Wright, 1979).

**Economics**

Although nearly one third (30.9 percent) of all black families lived in poverty in 1984, nearly the same number (29.4 percent) of black families had earnings above $25,000 (white median family income was $27,000 that year). Income varies widely among black families by family composition. While median income for all black families totaled $15,432 in 1984, it totaled $28,775 in married couple families with the wife in the labor force, but just $8,648 for female headed households (Malveaux, 1988). Whether black families experience poverty, receive public assistance, or maintain relatively high earnings, disparities between black and white families at every income level are important (U.S. Department of Commerce, 1985). It is important to emphasize the diverse composition of black families, in that black families range from single mothers who receive public assistance and raise their children against all odds, to upwardly mobile, dual-earner families with incomes above $50,000 per year (Malveaux, 1988).

**Marriage and Divorce**

"Young adult black persons have a consistent pattern of postponing marriage longer than persons of other races" (Glick, 1988:119). Statistics show that there was a sharply increasing delay of marriage between 1970 and 1985 in the
form of a rising percentage of persons in their twenties who had never married (Glick, 1988). The phenomenon called a "marriage squeeze" is held as one of the prime reasons for this delay. The marriage squeeze as experienced today makes it more difficult for women of marriageable age to find husbands in their range. Back women are reported to be especially affected by this phenomenon (Strong and DeVault, 1989).

Staples (1985) explains that the reason why a near majority of black Americans, especially women, are not married and living in traditional nuclear family units is not a result of any devaluation of marriage qua institution but rather a function of limited chances to find individuals in a restricted and small pool of potential partners who can successfully fulfill the normatively prescribed familial roles. (Staples, 1985:1005)

The divorce rate in black families is said to be the highest of all racial groups in the United States of America. One in every two black marriages is said to end in divorce. Combined data from several national surveys taken between 1973 and 1980 indicate that 37.2 percent of black males and 42.2 percent of black females who have ever been married have divorced. This is not surprising since a large percentage of blacks fall in the lower socioeconomic group and because of the strong negative correlation between socioeconomic status and divorce rates. As income levels for blacks increase, divorce rates also decrease (Raschke, 1987). It is reported that in 1985 there were 25 percent as many black divorced
persons as black married persons in the United States. Findings suggest that the proportion of divorced persons who remarry is lower among blacks than whites at each interval since divorce (U.S.Bureau of the Census, 1980; Glick, 1988). Based on findings from an earlier study conducted in 1980, Glick (1988) notes that remarriage is more likely to be followed by redivorce among black women 35 to 44 years old than among women of other races of the same age.

Both cultural and structural explanations have been used to explain black family forms. However, neither cultural nor structural explanations by themselves can adequately account for existing black family forms; both are needed. For example, cultural explanations require knowledge of the African family system, and the American plantation system, and its patterns of mating. It was in the plantation system that the weakening of the male role began as well as the attempt to de-emphasize any form of family unit. Economic production was the prime objective of the American plantation system, but it was not encouraged within the context of the "family life." This led to unstable relations between managers and workers and among workers. This instability could contribute to the claim that black marriages are less stable (Heiss, 1975). It was only after emancipation that the ex-slaves attempted to introduce some stability into their family units.
Living Arrangements of Children

Some of the sharpest differences between the family life of blacks and other races can be found in the living arrangements of young children. For example, of all children under 18 in 1985, 15 percent were black but 35 percent of those living with a lone mother were black. The most extreme contrast is found among children living with a mother who had never been married—two of every three (67 percent) of these children in 1985 had a black mother. In fact, as many black children were living with a never-married parent as with a divorced or separated parent (26 percent and 24 percent, respectively).

Nearly all of the racial differences that can be demonstrated from data present a picture of much greater family disorganization in the living arrangements of black children than of other young children. Even though there was about a one-third downturn between 1980 and 1985 in the proportion of black children living with a separated or widowed mother, there was a doubling of the proportion with a never-married mother (from 13 percent to 25 percent).

The rapid growth in the number of young children living with a never-married mother is closely related to the sharp upturn in the proportion of births occurring to unmarried mothers. Vital statistics reveal that the proportion of births to unmarried mothers rose from 35 percent in 1970 to 59 percent in 1984 for black births and from "only" 6 percent to 21 percent for all races. Although the rate of increase for black births to unmarried mothers was not as great as that for all races, the level is still close to three times as high as that for all races (59 percent versus 21 percent). As
recently as 1960, there were more young children living with a widowed parent than with a divorced parent, but now four times as many live with a divorced parent as with a widowed parent. This shift resulted from both a declining mortality rate for young mothers and a vast increase in the divorce rate. (Glick, 1988:114)

Glick observes that a continuing larger proportion of black than other children under 18 live apart from either parent. According to the 1980 census, these children represented 4.5 percent of the children of all races and 11 percent of black children. A significant proportion of those children who were living apart from their parents were residing with relatives, and the rest were living with foster parents or in institutions. Living with their grandparents was the most frequent form of living arrangement for those children who were living with relatives (about two-thirds). It is hypothesized that in these circumstances, many of the mothers being younger, better educated, and more employable must have left their children in the care of older relatives while they moved elsewhere to increase their opportunities to earn a living (Glick, 1988).

Young Adults Leaving Home

The departure of young adults from their parental home generally occurs during their late teens or their twenties and is a critical period for all concerned. Glick and Lin (1986) report that up until 1970 approximately 32 percent of the black population 18 to 29 years old were still living in their parental homes or had returned to live there. By 1970,
however, the trend had turned upward and has continued to rise. In that year, the authors note that the figure had risen to 40 percent, and by 1984 it stood at 46 percent, well above the 36 percent for those of all races in 1984. This recent phenomenon of late departure from (or return to) the parental home has also been characteristic of young adults of all races. Factors which are said to contribute to this include relatively high rates of unemployment, divorce, and unmarried parenthood, as well as to more young adults delaying marriage while they attend tertiary institutions to further their education (Glick and Lin, 1986).

Conceptualization of Black Families

Early research among black populations and black families in the United States has been influenced by the sociological tradition and contributions of both Frazier and Herskovits. Earlier works such as those of Frazier have, however, been criticized because of their cultural ethnocentric approach. Dodson (1988) looks at contrasting approaches to the study of black families and compares the cultural ethnocentric approach to the cultural relativity approach. She notes that the pathological and dysfunctional view of black families has been primarily related to the cultural ethnocentric approach associated with the work of E. Franklin Frazier (1939) and Daniel P. Moynihan (1965). Dodson (1988) sees the works of these scholars as having culminated in the implementation of social policies
predicated on the assumption that the black family is unstable, disorganized, and unable to provide its members with the social and psychological support and development needed to assimilate fully into American society. Dodson observes that studies which concentrated on the dysfunctional and disorganized aspects of black family life have deduced that the typical black family is fatherless, on welfare, thriftless, and overpopulated with illegitimate children. Inevitably they have recommended economic reforms for "saving" black families from their own pathology (Dodson, 1988).

Opposing the cultural ethnocentric approach are those scholars who tend to focus on the strengths of black families rather than their weaknesses, having in most instances traced the origins of these cultural differences back to black Americans' African cultural heritage. The cultural relativity school begins with the assumption that black American culture and family patterns possess a degree of cultural integrity that is neither related to nor modeled on white American norms (Dodson, 1988). Dodson sees the cultural relativistic view as having been developed primarily as a reaction to the deficit view. Proponents of this view maintain that the black family is a functional entity. Dodson observes that this conceptualization is designed to challenge the theories and social policies emanating from the ethnocentric approach. However, she is aware of the common
assumptions underlying the theoretical and empirical arguments of the two schools. That is, that black and white families are qualitatively different culturally. She notes, however, that this assumption is not shared by all students of black family life. Proponents of the cultural relativity view include Andrew Billingsley (1968), Robert Hill (1972), Wade Nobles (1974), and Virginia Young (1970). The consensus among these scholars is that black Americans' cultural orientation encourages family patterns that are instrumental in combating the oppressive racial conditions of American society. There is, however, a variation in their individual assessment of the degree to which African culture influenced the culture of black Americans (Dodson, 1988). In examining the American black family, proponents of cultural relativism in North America point out that slavery did not totally destroy the traditional African base of black family functioning (Dodson, 1988). Dodson cites the works of Blassingame (1972), Nobles (1974), and Turnbull (1976).

Research has also found that black families are not disorganized or dysfunctional. Young (1970) observed patterns of high illegitimacy rates and frequent marital dissolutions usually associated with disorganization. However, these patterns were interpreted by the researcher as natural to the emotional underpinnings of the family system and thus, functional. The central position of the female in the domestic organization is thought to be related to the
restrictions on black male participation in the economic and political institutions of the wider society throughout the Western Hemisphere (Dougherty, 1978; Scanzoni, 1971). Historically, family theorists have argued that family structure and achievement interact with one another (Parsons and Bales, 1955). While that may have some validity for certain ethnic groups in America, none of those groups share the history and current social conditions of the black population in the United States (Staples, 1985). According to Staples (1985) "the peculiar history of black Americans, combined with structural conditions inimical to family formation and maintenance, have precipitated a crisis in the black family." Staples' observations have been supported by others (Coner-Edwards and Spurlock, 1988).

**Kinship and the Extended Family**

Strong kinship bonds is one of five characteristics which have been isolated as being functional for the survival of black families and is identified as one of the strengths of black families (Hill, 1972). Nobles (1974, 1988) has indicated that the black community is oriented primarily toward extended families, in that most black family structures involve a system of kinship ties. This idea has been supported by Billingsley (1968), Hayes and Mendel (1973), Hill (1972), and Stack (1974). Blacks are known to have higher fertility rates and larger families than whites.
This renders them more likely to live in multigenerational households.

At this point it may be useful to define the extended family. The most famous definition is that given by George Murdock (1965:2):

An extended family consists of two or more nuclear families affiliated through an extension of the parent-child relationship rather than of the husband-wife relationship; that is, by joining the nuclear family of a married adult to that of his parents. It embraces, typically, an older man, his wife or wives, his unmarried children, his married sons, and the wives and children of the latter. Three generations, including the nuclear families of father and sons, live under a single roof or in a cluster of adjacent dwellings.

The extended family system is assumed to provide support for family members, either as assistance for protection or for mobility. It is argued that the extended family in the black community consists not only of conjugal and blood relatives, but of nonrelatives as well. Additionally, the prevalence of extended families, as compared with nuclear families, is held as another cultural pattern which distinguishes whites and blacks. Dodson (1988) argues, however, that the extent to which such families are characteristic of the black community has not been adequately substantiated.

Numerous studies have shown the positive effects of kinship networks among blacks, but there are others that have found relatively few differences by race among elderly people in participation with family and kin (Heiss, 1975). In
addition, some maintain that black people have fewer relatives to call on in an emergency (Heiss, 1975). Kinship patterns among blacks are much debated and kinship is linked to the extended family. Cowgill (1972) in his earlier work went to great lengths to show how the elderly in developing countries were not as dependent on their governments as those in developed countries because of kinship patterns. This theory has been extended to apply to black elderly persons in the United States. Some have charged that patterns of kin relations sometimes produce frustration and unhappiness, but Heiss (1975), addressing this charge states that there is little evidence to support this. Heiss concludes that people who live in extended households are not significantly less satisfied than those who live in nuclear homes (Heiss, 1975). Heiss observes that this holds for several different kinds of multigenerational homes.

Harriette Pipes McAdoo (1988) in an empirical examination of upward mobility and extended-family interactions in black families, examined whether involvement within the extended-family support network was a help or a hindrance to upward mobility. Theories related to the value of support networks as a coping strategy of poverty and not of culture were directly addressed. The findings indicated that the education and achievement of the individuals were often impossible without the support of the extended family, and that the reciprocal extended family-help patterns
transcended economic groups and continued to be practiced even when families had moved from poverty to the middle-income level. McAdoo concluded that the continuation of the extended-family support system reflects continued cultural patterns and is a factor in countering the vulnerability of the black middle class. Both factors are operational within all of the mobility patterns.

The kin support network because it involves cultural patterns created and retained from earlier times that are still functional and supportive of black family life is as essential now as it was in earlier generations. (McAdoo, 1988:166)

Hayes and Mendel (1973) demonstrated that the extended family is a more prominent structure for black families and that blacks differ from whites in intensity and extent of family interaction. Based on their study of midwestern urban families they concluded that, with the exception of parents, blacks interact with more of their kin than do whites. Black families also receive more help from kin and have a greater number and more diversified types of relatives living with them than do whites.

Dubey (1971) examined the relationship between self-alienation and extended family. He concluded that subjects with a high degree of powerlessness were significantly more oriented toward the extended family. Dubey's study has been credited with raising the question of whether the extended family is used as a buffer between oppression of the dominant society and the unmet needs of the family (Dodson, 1988).
Stack (1974) proposed that the extended family is, in part, a strategy for meeting physical, emotional, and economic needs of black families, and involves a reciprocal network of sharing to counter the lack of economic resources. Kinship and the extended family are said to play important roles in the lives of black elderly persons.

**Black Elderly Persons**

The number of elderly Americans who are black continues to increase at a faster rate than the other segments of the black population. In 1980, elderly black persons age 65 years and over constituted almost 8 percent of the black population, that is about 2.1 million. Moreover, 7.5 percent of the elderly or 157,000, were 85 years and older. The "cross-over" phenomenon experienced by blacks who manage to survive to 75 years of age has been used to explain the tendency for this group of black people to disproportionately outnumber others 75 years and older (Cornely, 1970). Elderly black people were the fastest growing segment of their population group in the decade of the seventies, increasing 34 percent. During this period the increase for the total black population was only 16 percent (Johnson, 1988).

Because black Americans have had limited access to supportive social services, elderly black persons have relied a great deal on the supportive resources of their families, and families in turn have relied on elderly relatives (Dancy, 1977). Research has shown that the larger black extended
family is highly integrated, is not based on female dominance, and provides important resources for the survival and social mobility of its members (Mindel, 1986).

In recent years, considerable new work has been done examining the nature of the black extended kin support system and its ability to care for its members (Aschenbrenner, 1973; Hill, 1971; Martin and Martin, 1978; Mindel, 1980; Stack, 1974; Staples, 1981). With respect to black elderly persons, this support system often becomes crucial, considering that in many cases formal governmental support systems are not always sufficient. A common theme which runs through much of the discussion of the black family is the important function of the black family as a social and psychological refuge for individual members (Mindel, 1986).

Elderly persons tend to be an important element in the structure of black family systems. In fact Wylie (1971) argued that the elderly are more apt to be included in the black family structure than in white families. Cantor, Rosenthal, and Wilker (1979) found that elderly black women continued to carry out instrumental and effective familial roles far beyond the period customary among whites. They argue that elderly black women were more highly involved in a mutual assistance system among and between family members.

It was mentioned earlier that elderly black persons experienced what has been described as triple-jeopardy and elderly black women quadruple-jeopardy because of their
position in the American social arrangement. Black elderly persons experience great hardships because they are subject to racist stereotypes, and the often impoverished quality of their lives reflects this (Dancy, 1977). The socioeconomic status and position of blacks within the United States must be addressed in considering issues affecting the care of elderly black Americans (Bennett, 1982; Johnson, 1988). Johnson (1988) makes reference to the covert and overt aspects of various forms of racism which have been instrumental in determining both the status and position of the black elderly. "The engineered human degradation and oppression of racism have taken their toll on the current population of black elderly, and will influence the well-being and quality of life of all black Americans for the foreseeable future" (Johnson, 1988). Any study of black elderly persons in the United States must demonstrate an understanding of the difference in demographic facts, history, culture, and life style as against the majority group.

*Marital and Living Arrangements*

Among black elderly persons, a lower percentage are married both in the young-old, and in the old-old period than are white elderly. This holds for both male and female (Johnson, 1988). There is also statistical evidence that substantially more black elderly are widowed and divorced than are white elderly. The marital status of black elderly
persons in 1980 was as follows: 56.9 percent of the men were married, 22.1 percent were widowed, 14.7 percent were divorced or separated, and 6.5 percent were single, never married; for the women 25.0 percent were married, 57.7 percent were widowed, 11.6 percent were divorced or separated, and 5.6 percent were single, never married (Johnson, 1988). Since women outlive men, they also tend to be without a mate.

Many elderly black persons live alone. It has been noted that this tendency is almost as great among elderly black persons as it is among whites. Black elderly persons often take other relatives into their homes. It has been noted (Hill, 1972) that four times as many families headed by black elderly couples take younger relatives into their households than do white elderly couples. Hill also reports that families headed by black elderly females take in the highest proportion (48 percent) of children. Another important observation is that "a higher proportion of white than black female headed families had elderly members living with them" (Hill, 1972:6).

Housing

Stokesberry (1985) argues that in the area of economic issues, and other issues, there is not a great deal of difference in the need for services for all elderly persons in terms of quality, quantity, and accessibility. However, being a minority member exacerbates the problem all elderly
have in reference to their need for appropriate, affordable, and adequate housing. Black elderly persons like their white counterparts experience housing problems. Those who do not own their own home, must resort to renting (sometimes subsidized by government) or living in elderly hotels (SROs). Although there are Adult Congregate Living Facilities (ACLF's), not too many black elderly persons reside in them. The literature supports the claim that most black elderly persons reside at home.

**Health Status**

"The health status of elderly black people is poorer than that of elderly white people" (Aiken, 1982:179). Elderly black persons demonstrate different configurations regarding certain chronic diseases. A Report of the Secretary's Task Force on Black and Minority Health reports a higher incidence of hypertension among elderly black persons. The incidence of diabetes is also reported to be higher in elderly black persons, and the same is true for certain types of cancers (U.S. Department of Health and Human Services, 1985). It is reported that major chronic diseases which are aggravated by dietary excesses are said to be in excess prevalence among minority groups. For example, hypertension and diabetes are prevalent among black Americans (U.S. Department of Health and Human Services, 1985). Dietary intake is influenced by socioeconomic status. Nutrient intakes are higher at higher levels of disposable income (in
the low to middle income range), with the exception of carbohydrate intake, which decreases with decreasing income.

Black elderly persons continue to suffer from the lack of adequate health care services. The majority receive health care through Medicaid funding. It has been and continues to be a problem for black elderly persons to find physicians who will agree to accept the Medicaid reimbursement. Neighborhoods and geographic location play a major role in this situation (Stokesberry, 1985). The cost of medical care and the availability and accessibility of such care place difficulties in the paths of black elderly persons. Studies have implicated structural, social, and psychological factors in health utilization behavior.

In terms of availability and accessibility, the conceptual framework generated by Andersen and Newman (1973) and Aday and Andersen (1978) with regard to health services finds application in, and contributes greatly to, understanding these phenomena. Three groups of variables are identified in this conceptual framework: (1) predisposing factors which are social-structural variables (for example, race, religion, ethnicity) as well as family attitudes and health beliefs that may affect the recognition that health services are needed; (2) enabling factors which include individual characteristics or circumstances, such as available family income and accessibility of service, that might hinder or accelerate use of a health service; and
finally (3) need factors which include subjective perceptions and judgments about the seriousness of symptoms, the level of physical disability or psychological impairment, and an individual's response to illness. With regard to black elderly persons their educational level (a predisposing factor) and their income and insurance coverage as well as accessibility of health services (enabling factors) are important predictors of their use of health services. This model finds easy application to the availability, accessibility, and use of formal services by elderly black persons.

Economic Status

Black elderly persons have generally earned less than their white counterparts throughout their lifespan. The types of income that those over 65 have available to them are significantly different for the black and the white population. The three major sources of income for elderly black persons, whether they were living alone or in a family situation, were, in order, Social Security, earnings from employment, and Supplemental Security Income (SSI). For the white elderly who were living alone, the three sources of income were Social Security, dividends, and pension incomes; and for white elderly who were living in a family situation the three main sources of income were Social Security, dividends, and earnings from outside the home (Stokesberry, 1985).
Separating the men and the women, Stokesberry (1985) points out that 39 percent of black women receive SSI in addition to Social Security and income from continued employment after age 60 or 65. Among the black males, 27 percent were receiving SSI, indicating that their Social Security payments obviously were so low that they were also entitled to the SSI. For white males, only 12 percent were receiving SSI and only 11 percent of white female elderly were receiving SSI.

At the end of the decade of the 1970s, approximately one out of three black elderly persons lived below the poverty level (Stokesberry, 1985). Drawing from the data of Hill (1978), Stokesberry observes that "even with a dramatic reduction in the proportion of black elderly persons living in poverty during the seventies (50 to 36 percent), at the end of that decade the numbers of black elderly persons below the poverty level was still three times that of the white elderly" (Stokesberry, 1985:32). The disparity in the poverty level of black elderly persons continued to be an area of concern in the 1980s. Johnson (1988) reports the number of black elderly persons living below the poverty level as being two times that of whites in the 1980s. Johnson (1988) reports a decline from 39.1 percent in 1983 to 33 percent in 1986 representing a figure of well over 700,000 black elderly persons aged 65 and over. Although this shows some improvement in the economic situation of black elderly
persons from the 1970s to the 1980s, such a disparate situation is still an indictment on a country which is one of the richest in the world.

Stokesberry (1985) refers to the existence of blacks whose income from Social Security, SSI and private pensions may not meet the basic needs for food, shelter, and health care. This is compounded by the fact that the lack of training and skills to continue employment after retirement, if that is a financial necessity, or to re-enter the workforce is a special problem for these persons (Stokesberry, 1985).

Elderly black persons largely represent that pool of elderly persons who, in the days when they had membership in the labor force, were saddled with the lowest paying and dirtiest jobs. Their numbers include a few retired school teachers, retired owners of small businesses, or former government employees, but these represent only a very small proportion of today's elderly black persons. The majority worked in manual labor, and domestic service jobs. These jobs did not offer benefits and were not covered by Social Security. As a result, many black elderly persons now receive minimum Social Security which cannot cover everyday living expenses. Black elderly persons are thus likely to remain employed after retirement age due to inadequate or nonexistent retirement income.
Although there does not seem to be a difference in the proportion of elderly blacks and whites who re-enter the work-force after they reach 65, elderly black males in this situation have a much higher unemployment rate than do elderly white males (Stokesberry, 1985). Of note, too, is the fact that the unemployment level for black females is lower than it is for white females.

The economic disparity in the black American community can be seen at all levels and in all types of families. Black family median income was 56 percent of white family income in 1984. This difference in income was also found among the elderly who have generally earned less throughout their life span. In 1984 the median income for black males over the age of 65 was $6,163 compared to $10,890 for white males. For black females the 1984 median income was $4,345. For white females the figure was $6,309 (Johnson, 1988).

Religion

In considering the unique aspects of the black cultural experience it is imperative that one be attuned to the religious experience of black elderly persons. Hill (1972) lists strong religious orientation as one of the strengths of black families, which function for their survival, development, and stability.

A strong orientation toward religion and the black church is a cultural attribute which holds a great deal of importance in the lives of black elderly persons. Dancy
(1977) states that "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." "Historically," he states, religion and the black church have played a vital role in the survival and advancement of blacks. The black church is an independent institution which blacks control in their communities. It is the one black institution which has remained relatively free from white authority. (Dancy, 1977: 22-24)

Black churches include such traditional black Protestant denominations as the Baptists and Methodists, as well as varied Pentecostal or fundamentalist religious groups.

In the black church there are points of uniqueness (culturally and experientially) that differ from the mainline churches of the dominant society. An example is worship through celebration. The black elderly have within the black church the freedom to express themselves as the Spirit dictates. The black church is a place of affirmation, rejoicing, and recognition. Historically, these churches have provided for the elderly a place where they can feel like somebody and be somebody. The church's role as the provider of opportunities for many poor black elderly persons to gain an understanding of the world beyond their city and state through missionary groups and church related trips has been observed. (Dancy, 1977:23)

Dancy sees the religious experience of the black elderly especially those from the low-income group, as contributing to the value they place on life.

In the face of life's many trials--ageism, racism, the normal changes of sixty and more years, the uprooting from the rural South to the urban North or West--the black elderly have often found solace, strength and assurance in the black church. In society at large they have experienced rejection, but in the church they have found acceptance and freedom. The black church has provided them an
avenue of release—"that soon we'll be done with the troubles of the world," as the spiritual puts it—and an avenue of rejoicing and renewal. Self-understanding is shaped by many factors. American society has not helped to instill racial pride in black people. Such pride and affirmation have had to come from within, and from the supportive encouragement of other black persons and of the black church which refused to accept the idea that black people were inferior. Through the church, black elderly persons were reminded that they possessed dignity and that such dignity would endure in spite of all that men could do to them. (Dancy, 1977:23)

Many black elderly persons would not have much to keep them going if they did not have the black church. It is important therefore, that anyone embarking on a study of black elderly persons and black communities have an understanding of the dynamics of the black church and the influence that religion has on black elderly persons. The church is described as a channel through which a large segment of the black elderly can be reached, and the black church continues to be a source of communication with the outside world for many black people in the United States.

Historically, the black church has been a strong social force among black elderly persons. Dancy (1977) observes that "when vital social services were not available to its parishioners, the black church provided the needed counsel, the services, and the framework of meaning. The black church has always been an organizing force" he notes and "a service center for its members" (Dancy, 1977:24). A challenge facing those who are interested in the problems of black elderly persons in terms of social supports, as advocates, is to
change the societal system which fails to meet the clients' needs. In this effort, the cooperation and support of black pastors and congregations can be enlisted. By mobilizing in this fashion, these persons and the church can move beyond their daily piecemeal supportive efforts (Dancy, 1977).

Whatever the task, there is powerful potential for reform when the black church is considered a part of the informal network system as it affects black elderly persons. The role of the church in an aging society is becoming more visible. This does not only apply to the black church, but other churches and synagogues are being called on to develop a wide range of activities to enhance the spiritual, emotional, and physical well-being of older persons (Sheehan, Wilson and Marella, 1988). It is obvious then, that something which black churches have been doing for their elderly persons for a very long time is now being recognized and courted for the rest of the elderly population.

Kinship Relations and Family Support

No analysis of black elderly persons would be effective or complete without some observations about the kinship system and the role it plays in the lives of black people. There is a growing body of literature on black families describing the components of the kinship system. Literature on the kinship interaction among black families as well as the system of mutual aid and support that persists and exists within black families is also on the increase (Mindel, 1986).
Discussions of kinship in the United States usually cover three areas, affectional attachments, interaction, and mutual assistance (Mindel, 1986).

It appears from the research that for blacks the kinship network serves its members most effectively as a functional mutual aid system. Numerous studies have shown that black relatives help each other with financial aid, child care, advice, and other supports to a rather extensive degree (Aschenbrenner, 1975; Hill, 1971; Martin and Martin, 1978; Shimkin et al., 1978; Stack, 1974). Strong kinship bonds is one of the attributes of black families. A sense of cohesiveness is a strength of black families and elderly persons are often the focal point of that cohesiveness. (Dancy, 1977).

One consequence of discrimination is that it has caused black people to depend on each other and to distrust the dominant society which would not accord them respect. The desire for dignity and freedom from oppression helps account for the black elderly person's reliance on the strong family bond. Family members recognize and value black elderly persons, because they have survived and surmounted many obstacles which the dominant culture has strewn in their path. In turn, the family frequently provides needed emotional support and understanding. (Dancy, 1977:20-22)

Summary

In this chapter black families have been examined in terms of social, economic, and demographic factors. Various theoretical approaches used to study black families in America have been analyzed. The strengths and weaknesses of black families have been discussed and a profile of black
elderly persons has been presented. Of importance is how black elderly persons have coped considering their position in the society. The role of the black church as it continues to respond to the needs of its elderly members has been examined. Caregiving as it relates to black elderly persons continues to be dependent on the informal support system which includes, family, church and kinship networks. It has been shown that studying black families from the cultural relativistic approach can have positive effects by dispelling some of the myths long held about these families. It could also reduce the tendency of stereotyping these families and so prove effective in countering the cultural ethnocentric school which has for years underpinned some of the wrongs that have been meted out to black Americans by some researchers. The caring nature that is inherent in black families has enabled them over the years to take care of and nurture their elderly relatives. This characteristic is also responsible to some extent for the manner in which elderly relatives of black families have also always supported the younger members of their families.
CHAPTER THREE
CAREGIVING

A Review of the Literature

Although there may be no theory of caregiving for the elderly, there is, within the literature, information on the concept of caregiving and since this is such a central part of this study it is important that we inform ourselves regarding its meaning. In the literature there is no clear cut or agreed upon general concept of caregiving. Although there is a rapidly growing body of literature on caregiving wherein reference is made repeatedly to the aspects of caregiving tasks, the stress and burden of caregiving (Cantor, 1983; Gubrium and Lynott, 1987), the economics associated with caregiving (Arling and McAuley, 1983), caregiver selection (Ikels, 1986), as well as the demands, risks, and costs of caregiving, family responsibility and caregiving (Gubrium, 1988; Soldo and Mylyluoma, 1983) the difficulty still lies in finding any concise conception of the term. Indeed what we have is all very much an intuitive and common sense understanding of the meaning of caregiving, and the above are examples of the common sense ordinary way in which the term caregiving is used in the literature. The concept of "caregiving" is used when older people need care
of any sort because they are chronically impaired and hence unable to perform certain functions without assistance. This care may be administered in the home or in an institution. This study is concerned with care which is administered in the home, and that is the conception of caregiving that is used. That is, a consensual, intuitive, common sense meaning of caregiving. But in order to go beyond what is in the literature I define caregiving using the following questions: First, is there a need for care? Is there impairment? Is there helplessness? and is there a need for assistance? The search for answers to these questions directs the researcher into looking at programs such as Social Security, Medicare and Medicaid and other such features (these constitute the formal system), and family members and friends (these constitute the informal system).

Why are findings on such things as Social Security, hospitals, food stamps, family members, friends and neighbors, important to such an investigation? The answer lies in the fact that the concept can be subdivided into two types of caregiving: formal and informal. Both systems together make up one caregiving network.

The term caregiving has been used in the gerontological literature as an umbrella term to cover a wide variety of support services for elderly persons. The concept will be defined here in terms of its application and utility. A caregiving equation could be defined as follows: Formal +
Informal Assistance = Caregiving. Why is there a need for formal and informal assistance? There is a time in the lives of many human beings when they are unable to do things for themselves and unable to supply all the support they need to manage effectively. For example a person who is impaired mentally, physically, and/or economically needs assistance from one or both systems. Hence, we can logically say that caregiving is taking place if the needed assistance is forthcoming and does not cause a strain for the care receiver, or causes very little strain, while taking place. The concept of Caregiving usually connotes a care equation and caregiving can take place when the care receiver is in an institutionalized or noninstitutionalized setting.

Caregivers and Caregiving

Many older people are able to cope by themselves, but a large number get to the point where they need care. This places them in the category of care receivers. Those who administer the care are known as caregivers and the product administered is known in the gerontological literature as caregiving.

Older people not only have to cope with the physical problems indigenous to their population, but they also have to cope with stressful life events such as death of a spouse, loss of financial benefits when they are no longer able to work, and loneliness (Shivers and Fait, 1980). Shivers and Fait (1980) also note that "if any generalization can be made
about the aging process, it is the increasing vulnerability of the organism to environmental stress, disease, and continuing loss of functional ability of organs and systems" (Shivers and Fait, 1980:19).

In a survey conducted by the American Association of Retired Persons, the major events causing the need for care were found to include major illness, hospitalization, death of a spouse, retirement, and being laid off or fired (American Association of Retired Persons, 1986). This survey also found that the kinds of help provided by caregivers range from financial support and managing finances to household chores, personal care, ambulation, transportation, administration of medication, companionship, making or receiving phone calls, and arranging outside help ((American Association of Retired Persons, 1986). Caregiving, then, refers to care provided to an elderly person with some degree of physical, mental, or emotional impairment which limits independence and necessitates ongoing assistance (Horowitz, 1985).

The organization of society today determines that people receive support from agencies of government (the formal system) or from family, kin, and neighbors (the informal system). The elderly recipient of care may benefit from both formal and informal support systems.

Care receivers are often plagued by various chronic illnesses that limit their abilities to care for themselves.
Care receivers, on average, suffer from four medical problems from among a list of over 20. These include high blood pressure, arthritis, vision problems, heart problems, depression, circulatory problems, hearing problems, memory loss, sleep disorders, dizziness, respiratory problems, diabetes, stroke, constipation, bone fracture (especially of the femur), cancer, elimination problems, diarrhea, and Alzheimer's disease (American Association of Retired Persons, 1986). The AARP study also reports that the health conditions most frequently experienced by older care receivers were high blood pressure, arthritis, vision problems, heart problems, depression, and circulation problems (American Association of Retired Persons, 1986).

The Formal Support System

Government, through bureaucracies at local, state and federal levels, is committed to providing financial support in the form of Social Security to the elderly. Through Medicare and Medicaid, government also provides a portion of the payment for the health care for the elderly. In a series of reports compiled by the Social Security Administration, public social-welfare expenditures are defined as cash benefits, services, and administrative costs of all programs operating under public laws that are of direct benefit to individuals and families. The programs included are those for income maintenance (social insurance and public aid) and
The Informal Support System

Caregiving needs to be assessed in the same way as any other social organization. Once the formal segment has carried out its role, everything that remains is expected to be undertaken by the informal system.

Informal caregivers are usually spouses, children, and relatives in that order. The process of caretaker selection appears to follow rules that transcend cultural differences. Certain demographic groups have a greater likelihood of being caregivers than others. Results of the survey conducted by the American Association of Retired Persons (1986) indicated that the probability or likelihood of being a caregiver is greater for females than it is for males, and the likelihood of having caregiving responsibilities is greater for females who are older, and widowed (American Association of Retired Persons, 1986). This finds support in the caregiving literature where many researchers note that filial caregiving connotes daughters and that this has implications for the role of women in our society.

Researchers have been able to detect the underlying dynamic that leads to caretaker selection (Ikels, 1986). The factors found to be involved in the selection of caretakers fall under three headings: Demographic Imperatives, Antecedent Events, and Situational Factors. Demographic Imperatives listed the caretaker as being the only child, the only child of preferred sex, and the only proximate child.
Antecedent Events incorporate those such as gradual emergence, explained by the dependent child or children who were still at home when widowhood occurred. These children are said to be slated early on for the caretaking role and gradually assume it. Situational Factors such as least inconvenience and greatest motivation are also used in the selection of a candidate for the role of caretaker (Ikels, 1986). All things being equal, in most cultures the child with the least obligations and the greatest motivation will undertake the role of caretaker.

Most caregivers provide several different supports simultaneously. The average caregiver provides approximately four supports to the person being cared for (American Association of Retired Persons, 1986). This places heavy burdens on them, since a large proportion also hold full time jobs. The majority of employee caregivers care for aged relatives who live in their own home, some near the caregiver and some quite far away. Some caregivers share housing with the older person, while some of the care receivers may live in a nursing home near or far from the caregiver (American Association of Retired Persons, 1986).

Some subgroups of the elderly population are known to place more faith in the informal support system and hence receive most of their support from this system. Black elderly persons are among those who, for reasons that have
been given some support in the literature, place heavy
dependence on the informal support system.

**Impairments of the Elderly**

The process of aging begins with conception and
continues until death. Unless some catastrophic event causes
early death, most people tend to follow an aging cycle that
terminates at or about the beginning or the middle of the
seventh decade. Only a few people live into their nineties,
and a tiny proportion go on to be centenarians. According to
the 1980 Census there were 32,000 persons aged 100 or older
in the United States, two-thirds of whom were women. Many
factors contribute to longevity. This can be the result of
genetic foundation, nutrition, environment, physical
capacity, lack of stress, or a combination of these. Many of
those attaining long life can expect to be plagued by some
kind of impairment either mental or physical. Some elderly
experience minimum impairment while others suffer terribly.

To impair is generally defined as "to make worse, to
lessen in quality, quantity, value, excellence or strength;
to deteriorate" (New Webster Dictionary of the English
Illustrated Medical Dictionary (1985:218), defines impairment
as "damage resulting from injury or disease," and mental
impairment as "intellectual defect as manifested by
psychologic tests and diminished effectiveness (social and
vocational)."
When considering impairments in the elderly one should concentrate on those that cause the greatest handicaps, since certain impairments of elderly persons are more devastating than others. Hearing, visual, and mental impairment are of particular concern and demand special emphasis. When we are dealing with areas such as living arrangements for the elderly, we are faced with an even greater problem; that of functional impairment. Those who are functionally impaired are those who have trouble in mobility or transportation, personal care, basic housekeeping activities, and self-management, i.e., taking medication, using the telephone (Verbrugge, 1986).

"Hearing loss is more common than visual loss among elderly persons, although both are found to increase with age" (Butler and Lewis, 1983:108). Although most persons past 60 years of age retain hearing sufficient for normal living, the elderly individual is three times more likely to display a significant loss of hearing than is a younger person, and older males have greater hearing loss than do older females (Shivers and Fait, 1980). Statistics from the National Health and Nutrition Examination Survey (HANES I) of 1971 indicate that the ratio of hearing loss for persons less than 17 years of age as opposed to that for persons of 65 years and over increases from 3.5 per 1,000 persons to 133 per 1,000. About 19 percent of individuals age 45 to 54 as compared to 75 percent in the 70- to 79-year-old age group
report a hearing loss. It has also been reported that 23 percent of elderly persons 65 to 70 years of age and 40 percent of those age 75 and above reported that they had hearing impairments that were somewhat handicapping (The National Health and Nutrition Examination Survey, 1971).

Hearing is crucial to mental health in old age; hence hearing loss has been known to contribute to depression among the elderly. Butler and Lewis (1983:109) note that "hearing impaired persons receive much less empathy than visually impaired persons and are more subject to depression, demoralization, and psychotic symptoms." It is estimated that in the United States there are 5.5 million elderly persons (over the age of 65) with hearing defects (Butler and Lewis, 1983).

**Visual Impairment**

Visual impairment presents its own problems for the elderly. Nearly half of the legally blind population in the United States is 65 years of age or older (Butler and Lewis, 1983). Macular degeneration, cataracts, glaucoma, and diabetic retinopathy are the four most common causes of visual impairment in the older age group (Butler and Lewis, 1983). Visual impairment can be devastating in terms of both psychological isolation and physical immobilization. Visual impairment can result in accidents in old age. By affecting driving, the outcome can be loss of one's drivers license, thus increasing dependency on others for transportation.
Visual impairment can also be responsible for accidents in the home such as physical injury and the misreading of labels on medications and on household products. All of this impedes the visually impaired person from living alone.

**Mental Impairment**

Chronic conditions among elderly persons include those of a psychopathological nature. The elderly are more likely than younger persons to develop mental manifestations of their physical problems. According to Pfeiffer (1977), approximately 15 percent of the elderly population in the United States suffer from significant, substantial, or at least moderate psychopathological conditions. It is also estimated that between 70 and 80 percent of elderly nursing home patients suffer from moderately severe mental disorders (Whanger, 1973). Kart (1985) reports that organic brain syndromes, depressive disorders, schizophrenia, and alcohol disorders are listed among the specified diagnoses accounting for the highest rates of patient-care episodes in outpatient psychiatric services for old people in the United States in 1971. He cautions however, that for many reasons these figures may not be as authentic as we could be led to believe. Kart (1985) cites several factors that are conceptual and methodological in nature which contribute to this probable incorrect documentation. He notes that the epidemiology of psychopathological conditions is beset by conceptual and methodological problems. Diagnosing schizophrenia or depression is often difficult even under careful conditions of
assessments. Diagnoses are not made under strict experimental conditions. There is a substantial degree of subjectivity involved, complicated by the fact that different doctors use different definitions and criteria and vary widely in their competence and in their understanding of aging processes. (Kart, 1985:182)

Changes in the environment have also been said to be a causal factor in the early mental change shown by elderly persons (Libow, 1973). Research shows that many cognitive problems in old people may result from adverse drug reactions (Lipton and Lee, 1978). Iatrogenic brain disorders are not uncommon. Doctors unwittingly produce reversible and often unrecognized irreversible brain disorders. Tranquilizers and hypnotics are said to be the most likely causes of such conditions, but steroids used for arthritis can cause organic brain disorders as well as hypomania or depression or both (Butler and Lewis, 1983). Despite the difficulties involved in determining the degree and extent to which psychopathological conditions are distributed among the elderly, there is no doubt that some elderly people are mentally impaired, hence requiring care that is usually very demanding on the caregiver.

The mental health evaluation in its simplest sense is a method of looking at the problems of older people, arriving at decisions as to what is wrong, and concluding what can be done to try to alleviate or eliminate these problems. Evaluators use historical data from the person's past; current medical, psychiatric, and social examinations; and their own personal interactions with the individual to get a
many sided and, one hopes, coherent picture of what is happening (Butler and Lewis, 1983). Knowledge of the racial, cultural, and ethnic backgrounds of these elderly persons during the process of evaluation is germane to the evaluation process.

Decisions made on the basis of the mental health evaluation should be aimed at the well-being of the older person, not only via medical and professional treatment, but through social supports. Knowledge of the resources available for treatment purposes should be uppermost in the mind of the therapist; also it is important to know of the older person's own emotional and physical capabilities, the assets in his or her family and social structure, and the kind of services and support available in the community (Butler and Lewis, 1983:165). Treatment goals should be reasonable and reachable and when decisions are made not only must the margin of error be small and aimed at the well-being of the elderly person, but care should be taken that presentation of the decision should be in language which can be understood by the older person's family and friends as well as by the older person (Butler and Lewis, 1983). This will provide them with a basis for assessing the mental health care offered them and will know what to expect and how to best participate actively in evaluation and treatment (Butler and Lewis, 1983).
Depression appears to be the most common functional psychiatric disorder in the later years. Depression can vary in duration and degree; it may be triggered by loss of a loved one or by the onset of a physical disease (Impallomeni and Antonini, 1980; Kart, 1985). Depression often results from adjustment reactions. It can be triggered by fear. The fears of elderly persons are many and justified. Elderly persons fear being alone, they fear being attacked, and they fear the loss of loved ones. Kart (1985) observes that the complexity of their emotionality can result in increased blood pressure (increased heart rate) stemming from their physical problems and these in turn can result in depression. Today's elderly person grew up in the 1920s, a period when people were termed mad, crazy, and so on if they acted even slightly strange; hence their fears are justified. A depressed individual may show any combination of psychological and physiological manifestations. Diagnosis is difficult and treatment is problematic. Drug therapies are popular for the elderly since they are viewed by many professionals as poor candidates for the psychotherapies (Kart, 1985:183).

Suicidal thoughts often accompany depression. Suicide rates are very high among the elderly. According to the U.S. Public Health Service, in 1975 these were between 43 percent and 62 percent higher than they were for the total population. The elderly accounted for 16.3 percent of all
the suicides in the United States in 1975 (U.S. Department of Health, Education, and Welfare, 1977). An examination of suicide rates by sex and race for 1979 revealed that aged white males show the highest suicide rate of any group, 39.2 per 100,000 population. Their rate is three times that of aged black males (12.9), more than five times that of aged white females (7.3 per 100,000 population), and about sixteen times that of aged black females (2.5 per 100,000 population) (U.S. Bureau of the Census, 1982–83). Elderly females in the United States have among the lowest suicide rates in the world.

Paranoia and hypochondriasis are two additional functional disorders common to elderly persons. Paranoia is a delusional state, usually persecutory in nature. It often involves attributing motivations to other people that they simply do not have (Kart, 1985:184). Paranoia is reported to be more common in individuals who suffer from sensory defects such as hearing loss (Eisdorfer, 1960; Houston and Royse, 1954). Some paranoia may result from changes in life situation. Paranoid reactions of the elderly person are usually directed at the spouse or adult children or persons working in the home (home help). There is a lot of misinterpretation and misunderstanding in such situations. Paranoia could contribute to the degree of stress which caregivers and others experience. The older person usually accuses others (Pfeiffer, 1977), and isolation can result by
virtue of their behavior, this in turn can lead to depression.

Hypochondriasis is an overconcern for one's health, usually accompanied by delusions about physical dysfunction and/or disease. The disorder presents problems in treatment since hypochondriacs are not predisposed to psychological explanations of their condition. Telling the patient that nothing is really wrong is rarely effective (Kart, 1985). Elderly people and their relatives fear Alzheimer's disease. They also fear cancer, especially cancer of the colon, and so they use laxatives to prevent constipation. Butler and Lewis (1983:298) note that bowel complaints, especially constipation, in both mental disorders (for example, depression) and physical conditions, are frequent and provoke anxiety in older people.

The distinction is made between organic brain syndromes (OBS) and organic mental disorders (OMD) (American Psychiatric Association, 1980). Organic brain syndrome refers to a group of psychological or behavioral signs and symptoms without reference to etiology. Organic mental disorder designates a particular OBS in which the etiology is known or presumed (American Psychiatric Association, 1980). OBS can be grouped into six categories, the most common of which are delirium, dementia, and intoxication and withdrawal. It is believed that as many as half of those elderly persons with mental disorders have OBS (Redick et
al., 1973); the prevalence rate of OBS appears to increase with age (Redick et al., 1973), although onset usually occurs in the seventh to ninth decades and is more common in women than in men (Fann et al., 1976).

Kart (1985) observes that primary degenerative dementia of the Alzheimer type may be the single most common OBS. According to the DSM-III, between 2 and 4 percent of the entire population over the age of 65 may have this dementia. Alzheimer's disease has an "insidious onset and gradually progressive course" (American Psychiatric Association, 1980). "It brings a multifaceted loss of intellectual abilities, including memory, judgement, and abstract thought, as well as changes in personality and behavior. The clinical picture may be clouded by the presence of depression, delusions, or (more rarely) delirium" (Kart, 1985:184). Some conditions may manifest themselves as something else, leading to misdiagnosis, for example, senility. There are times when there is misdiagnosis of this condition and some use the term pseudosenility to refer to such conditions (Libow, 1973). Causes of pseudosenility, Libow notes, include drug reactions (and the elderly are usually taking more than four types of drugs at any single time), malnutrition (another problem of older people), and fever. When these conditions are treated, the senility often vanishes (Libow, 1973).

Older persons need a lot of support to help them overcome the feelings of worthlessness and depression that
often assail them. Opportunities to encourage them must be grasped by all those responsible including social workers, family, relatives and friends. Emphasis must be placed on the positive values of their greater understanding of life, experience, and wisdom. Too often those around them tend to ignore, deny or denigrate these values. The older person given this kind of support, "can be helped to withstand the onslaught of his or her various incapacities, build up self-esteem, accept more easily the change in his or her status, and see him— or herself as being a worthwhile person despite incapacities" (Field, 1972:169). The importance of the supportive role cannot be overemphasized. The mental health of the older person can be ameliorated, and some problems can be diminished if there is adequate support. There are times when nothing can be done regarding the disease, but anxieties can be reduced or removed. Those close to the older person also need support, especially if they are the primary caregivers. The stress burden can be relieved in most cases if others are supportive in crisis situations.

The problems associated with audio, visual, and mental impairments of older people will always be with us and most times will be cause for anxiety for both the older person and his or her loved ones. Irrespective of the situation there are different supportive roles to be played by the formal and the informal network. If these roles are played with consideration and empathy many of the problems, especially
those stemming from anxiety, can be minimized and older persons can be helped to live out their last days with dignity, self-respect, and a sense of self-worth. It is imperative that mentally impaired elderly persons not live on their own, since there is the likelihood of them harming themselves. Drug compliance is particularly unreliable in these persons and there is also an higher than average risk of self-poisoning (Impallomeni and Antonini, 1980).

Activities of Daily Living

Some measures of impairment focus on the older persons functional capacity to perform certain tasks. Functionally impaired persons are those who are unable to perform the tasks or activities of daily living (ADL) without the assistance of other persons. Functional impairments result from chronic diseases such as arthritis and others that restrict the elderly and cause physical limitations. The activities of daily living usually evaluated by researchers include bathing and dressing, combing one's hair, making one's bed and being able to perform simple domestic chores like preparing a meal, feeding oneself, toileting and transferring (from bed to chair or commode and vice versa, or from one part of the house to another (American Association of Retired Persons, 1986). Older persons, who are not institutionalized, and who fall into the category of ADL-limited, usually qualify for programs such as Community Care for the Elderly (CCE). In some states this program is
state-funded. Functionally impaired elderly usually depend on family, friends, or agencies for their primary and/or secondary support.

Impairments not only restrict the elderly physically, but can and do result in other problems for them. For example, failure or noncompliance in the taking of medications, is a major factor in determining response to any therapeutic regimen requiring self-administration. Impaired hearing or sight can often result in errors in the intake of drugs. To complicate this further a large proportion of elderly persons especially minority elderly persons are unable to read, which leads to further confusion.

Instrumental Activities of Daily Living

Both black and white older people are said to be much more likely to utilize informal rather than formal agency sources of help for the main instrumental activities of daily living (IADLs). But the black aged are generally much less likely to know of various sources of assistance irrespective of whether they are presently in need of services or were to develop a future need (Trevino-Richard and Krain, 1987). The main IADLs assessed are (1) the need for help with yardwork; (2) the need for help getting to places farther than walking distance; (3) the ability to prepare one's own meals; (4) the ability to manage one's own finances, and the ability to administer one's own medications.
Impairments in whatever form, auditory, visual, functional, or mental, usually severely handicap older persons not only physically but socially. The degree and type of impairment determines how, where, or with whom elderly persons live. Depression and other diagnosable mental states can be the result of certain physical impairments which produce isolation and loneliness. The nature and extent of an older person's impairment also determines that person's ability to perform the activities of daily living, and is instrumental to the accomplishment of their daily living tasks.

Support Systems for Elderly Black Persons

A topical issue today is the use of and knowledgeability about formal and informal sources of assistance by older black persons for a variety of health and social needs that many of them experience. Generally, most of the formal services available to older adults are provided through the Area Agencies on Aging (AAoA) as mandated by the Older Americans Act of 1965. The purpose of the Act was to make a comprehensive and coordinated range of social services available to older persons through the partnership of older citizens, community agencies, and state and local governments (Kutza, 1981). The Act, amended in 1967, 1969, 1973, 1975, and 1978, authorizes funds for four activities. The first and probably the most important is "for the establishment of state and substate agencies, which are to plan and coordinate
Services to the elderly within a geographical area" (Title 111). 'Services' are very broadly defined to include health, continuing education, welfare, recreation, homemaker services, counseling and referral, transportation, housing, supportive services, as well as nutrition services and multipurpose senior centers (Kutza, 1981).

It is important that these agencies understand the patterns of need among persons of different race or ethnic backgrounds as well as the general level of knowledge of these persons concerning the sources that are available to them. Accordingly, critical issues in aging network research include measuring how much assistance is provided by the formal and informal network to those in need of help, determining whether there is a need to supplement the informal network, and assessing whether those in need of help are aware of the programs available to assist them (Trevino-Richard and Krain, 1987). The research findings of Richard and Krain suggest that differences between black and white aged are minimal in regard to the general needs for services and the numbers that gain access to agency services. Dancy, (1977) however, observes that

Elderly blacks have learned, over a lifetime of bitter experience, that they should not expect a high level of service from public agencies. As a result they have developed certain styles of coping with the dominant society and its agencies, styles which have enabled them to survive and even deal realistically with indifferent agencies. However, they create a barrier which the concerned practitioner will need to break down in order to
serve the elderly black client effectively.  
(Dancy, 1977:30)

Black people have tended to be underinformed regarding services available from the formal system and hence have depended on the informal system for support. This may be more by design than by accident and what Dancy (1977) attributes to "the consequence of a painful history of inequality, rejection, and ejection" (Dancy, 1977:30). Dancy notes that in the past, blacks could be put out of a public agency for asking too many questions about their rights.

Blacks have constantly been accused of depressing the social system and especially of exploiting the welfare system. Black elderly persons seem to have accepted their situation and are unwilling, more than unable, to appeal to the formal system for fear of being rebuffed. This coupled with the conspiracy to keep them uninformed about the services or benefits to which they are entitled has forced them into greater dependence on the informal support system. Their geographic location (most reside in the rural areas and in Southern States where formal services may be less adequately funded) also contribute to this behavior.

There is evidence that the availability of formal support services in rural areas is significantly lower. Nelson (1980) notes that the availability of day care, homemaker, and foster care services, as well as the number of acute care hospital beds is substantially less in rural settings.
Dancy (1977) observes that few meaningful and needed services are located in the communities in which black elderly people live and too frequently they must travel considerable distances to obtain a particular service. Availability of transportation may be a determinant in whether they make these trips or not.

Elderly black persons have designed their own coping mechanism for dealing with the low service delivery expectation. Strategies include appearing to agree with practitioners and other authorities when in fact they do not understand and avoiding the system. Closely related to avoidance is withdrawal (either physically or psychologically) from hostile and demeaning encounters or situations which are not sensitive or supportive to them (Dancy, 1977). Dancy notes that the cost of such behavior is the loss of benefits and services to which they are entitled. He, however, sees a payoff in this behavior since the technique has strengthened blacks who assumed greater independence and pride by relying on their own resources (Dancy, 1977).

**Caregiver Stress and Burden**

**Caregiver Stress**

Caregiver stress is one of the pathologies of caregiving. This applies to both the caregiver with an outside job and the one at home. For the working caregiver, there may be interference with his or her work
responsibilities. Some may lose time from work because of the crises that may occur. Many may lose sleep or suffer extreme tiredness and anxiety, especially if their economic situation militates against them being able to afford home help where the care receiver is terribly impaired (American Association of Retired Persons, 1986). They, therefore, suffer emotional and mental strain.

The formal support system can help to alleviate situations such as these by providing counseling services for these persons, as well as respite care for those for whom they care. The caregiver should be able to call upon other members of the family for help. In the absence of other family members or relatives, neighbors may be able to provide assistance. Government should provide support systems that will complement the caregiver. It has been found (Quadagno et al., 1987) that the provision of formal services can relieve the stress of daily caregiving but has little to offer regarding relieving the subjective feelings of burden felt by caregivers constrained by the caregiving role.

**Felt Burden**

Caregiver burden is especially significant when the care receiver is mentally impaired in some way. Caring for someone who is stricken with Alzheimer's disease is one example of this situation. Gubrium and Lynott (1987) considered three components of the Alzheimer's disease care equation. One component relates to felt burden and is the
caregiver's response to caring for the impaired elderly person, which is usually conceived as the strain resulting from the stresses of the burden of care. Felt burden is assessed by distinguishing the impairment's impact on the quality of the caregiver's daily life from its impact on the caregiver's emotions (Gubrium and Lynott, 1987). To this effect, certain questions are posed to the caregiver necessitating responses leading to a determination of whether caregiving responsibilities resulted in sleep difficulties for the caregiver or led to the caregiver's social isolation. In determining this the authors suggest that "a common item tapping the impact of the care receiver's impairment on the caregiver's emotional life would be the degree to which the impairment and caregiving experience was depressing for the caregiver" (Gubrium and Lynott, 1987:274).

Several researchers have developed and administered measures of felt burden (Zarit et al., 1980; Robinson, 1983; Poulshock and Deimling, 1984). For Poulshock and Deimling (1984), burden is broadly identified with the emotional costs of embarrassment and overload, disruption of the daily routine, and financial and health deterioration. Their method of assessing burden was to have caregivers evaluate the burden they felt in response to four separate indicators of impairment. With regard to the patient's ADL impairment, caregivers were required to rate related caregiving tasks according to whether these tasks were tiring, difficult, or
upsetting. Poulshock and Deimling (1984:238) conclude that the concept of burden should be used to refer to the subjective perceptions of caregivers related to the degree of problems experienced in relation to elders' specific impairments.

**Caregiving and the Black Elderly**

Caregiving as it affects black elderly persons is just as problematic as it is for the rest of the elderly population. Black elderly persons, however, have to cope with special caregiving problems. Most black elderly persons are at home and it is reported that even at the oldest-old age level, 85 years and over, only 12 percent of elderly black persons live in institutions (Johnson, 1988). It is also observed that the lower income levels in the black American middle-class (as compared to the majority group), the continued escalation of the cost of living, mobility of family members and significant others, fixed income dependence, and other economic factors will make it increasingly difficult for middle-class black Americans to take care of their own (Johnson, 1988).

It is important that care giving and care receiving be studied in terms of the situational factors impacting on blacks throughout their lives. Inadequate health care, insufficient food, poor housing, and no luxuries are a continuation of a lifelong condition.
The stress and burden of caregiving and care receiving fall heavily upon black elderly persons. They not only are care receivers but in many instances are themselves caregivers. When they are in the role of caregivers, it is not usually a spouse, but other family members such as grandchildren and other relatives who are the major care receivers. The care receivers could also be neighbors or friends. This is especially evident when the black elderly person is female. Elderly black women have been found to have a larger social network than their white counterparts (Mindel, 1986). It has also been found that for blacks the formal support system provided substantially more basic maintenance services than it did for whites. These services included financial aid, food, and living quarters. The informal support system tended to provide home and personal care services which included checking, supervision, meals, nursing care, and homemaker services. In addition to the division of labor between the formal and informal support systems, it was found that the differences between black and white elderly persons, once the effects of social class were removed, were not especially great (Mindel, 1986).

Research findings concerning the support system of black elderly persons show that to a somewhat greater degree the informal family and kinship group of black elderly persons provides and sees to it that the elderly are helped. In addition, it has been observed (Hill, 1972; Mindel, 1986)
that many black elderly persons, are a main source of support for younger members within their families. In this sense, the support system is a system of mutual exchange of aid. It is important to recognize the reciprocal nature of the exchange system within black families since examinations that include only the one-way delivery of aid to black elderly persons may mask the true nature of the support system by not reflecting the support the elderly give to other family members (Mindel, 1986).

A family's strengths lie in those characteristics that enable it to respond to the particular needs of household members and to the demands society places upon the family. The empirically based analysis of McAdoo (1978) suggests that the primary criterion of black family strength, whether caring for the elderly or raising children, is the kinship network. This network does not always have positive effects on the black elderly since the value placed on the family by older blacks makes them vulnerable to exploitation and abuse.

Elderly black people have problems accessing the formal network, hence their heavy reliance on the informal network. This is due to illiteracy and ignorance in many cases, but there is also suspicion of government agencies based on past experiences with institutional racism resulting in their being denied equal access to the services and material resources needed to function satisfactorily. Although black elderly people are known to be a resilient group with sturdy
coping strategies, Stokesberry (1985) sees the need for the development of a network of benefit advocate programs to assist low income black elderly in obtaining benefits and services to which they are entitled.

**Summary**

In this chapter, the caregiving function has been discussed. Formal support, informal support, hearing, visual, and mental impairments, functional impairment, and stress/burden have been identified as germane to the caregiving function. Caregiving and the black experience have been given special attention since the degree of caregiver strain has been linked to demographic factors such as race and socioeconomic position (Cantor, 1983). It is not clear whether there is, to some extent, an interrelationship between all the caregiving components. The next chapter will address the methodology utilized to study caregiving of black elderly persons in the town of Eatonville, Florida. The aim is to determine where, how, and with whom elderly persons in that community live, and who takes care of them.
CHAPTER FOUR
METHODOLOGY AND RESEARCH SETTING

Methodology

This study focuses on black elderly persons living in the "all-black" community of Eatonville, in Orange County, Central Florida. The research is primarily field-based. The data were gathered from in-depth interviews and participant observation. The method of study is intended to be what Eckert (1983) has described as a systematic and holistic process of discovery which, at its best, should be ecologically sensitive, considering the older individual in his or her primary groups, functional locale, and community. (Eckert, 1983:470)

Eckert (1983) notes that this approach provides process data rather than the typical snapshot supplied through one-shot mail surveys or interviews. The nature of the design of the study allows cross-checking and rechecking what people say and do, thus increasing the reliability and accuracy of the data. In the interview, people may state that they perform certain roles. Participant observation may support or refute this information. This use of multiple methods and strategies serves to alleviate the weaknesses inherent in any single design. The investigator is sensitized to the perceptions and feelings of the population being studied,
thus reducing the likelihood of making erroneous assumptions and conclusions about the group, as may occur when adopting an "etic perspective" a priori.

The term etic perspective applies to the conceptualization of a community from the point of view of the "outsider." Eckert (1983) contends that outsiders (typically researchers, planners, or service providers) define community on the basis of some set of conceptual divisions dictated by political, social, or scientific objectives. Such definitions of community, he asserts, tend to be couched in the language of objectivity and precision, divorced from the culturally specific meanings and implications present in any naturally occurring situation. Insiders' definitions of community, on the other hand, are based on the set of perceptions and models residents themselves hold. This demonstrates that the differences between insiders' and outsiders' perceptions can be quite distinct. (Eckert, 1983:471)

In this study both perceptions are taken into account. Although it is not a true community study, it, however, requires the same treatment as one would for a community study.

The research method that is utilized in this study is not new. It is very similar to what anthropologists refer to as ethnography. Several researchers have transposed ethnographic research techniques to the study of American towns and communities. One of the pioneers in this method of research was W. Lloyd Warner (1963) in his study of a New England city, Yankee City. Begun in 1930, Warner's ambitious
and extensive study produced several volumes of rich data on the industrial and social structure of a major U.S. city. Warner's research had far reaching influence by stimulating holistic studies of communities within the United States (Whyte, 1943; Gans, 1962) and abroad (Arensberg, 1964; Arensberg and Kimball, 1940).

A study of community life in the state of New York, *Small Town in Mass Society* by Vidich and Bensman (1958), utilized anthropological techniques to understand a small town in a regional and national context. The study views the community as a limited and finite universe in which one can examine in detail some major issues of modern American society. The community is viewed as a stage on which major issues and problems typical of the society are played out (Vidich and Bensman, 1958).

Other researchers have opted to study clearly demarcated communities within larger urban contexts. "They build on ideas developed by 'Chicago School' sociologists who depicted the 'city' as consisting of 'natural areas' or subareas (slums, ethnic and residential neighborhoods) in dynamic relationship and with more or less unique values and behaviors attached to them" (Eckert, 1983:456). Ware's (1935) study of Greenwich Village, Whyte's (1943) ethnography of an Italian slum, and Gans' (1962, 1967) studies of both urban and suburban enclaves are examples of this method.
The methods employed in this research are derived from participant-observation developed from anthropologists to study relatively small, isolated, and homogeneous peasant communities (Eckert, 1983). The community studied here satisfies most of the requirements for such a study. The population does not exceed 3,000, it is racially homogeneous, though not too isolated, and not a peasant community. There is extended residence in the community. As described by Eckert (1983), and in keeping with this method, there have been meticulous observations (census taking, map making, minute behavioral descriptions), casual and serendipitous observations, informal and formal intensive interviewing, and first hand participation in as many life events as possible. It is typical of the researcher in most cases to enter the field alone and not as a member of a research team. This was done in the present study.

The method of research discussed above has had some influence on the study of old age. Numerous ethnographic accounts of the daily life of older persons have emerged in the past two decades focusing on persons living in urban hotels (Eckert, 1980; Stephens, 1976; Siegal, 1978; Teski, 1979), retirement communities (Jacobs, 1974; Johnson, 1971), senior centers (Hazan, 1980; Myerhoff, 1978), adult congregate living facilities (Bear, 1988; Benedict, 1976; Carp, 1976; Tibbitts, 1976), apartments (Hochschild, 1973), senior high rises (Jacobs, 1975; Ross, 1977), and nursing
homes (Gubrium, 1975; Kayser-Jones, 1981). The studies mentioned above attempt to describe life holistically within bounded microenvironments and/or local neighborhoods in that they assess how older persons experience their life on the ground, that is, how older persons who having been used to a different way of life, adjust and adapt to the social and physical environments in which they find themselves (Eckert, 1983).

The methods of participant observation to studies of what is termed "life in well defined and bounded social niches" (Eckert, 1983:457), although being extremely well suited to answering the problems posed, display certain serious shortcomings. One serious shortcoming which has been noted in some of these studies concerns the representativeness and generalizability of findings to other settings (Eckert, 1983). To demonstrate this Eckert notes that studies which focus on one senior citizen center, one hotel or one apartment building may produce rich insights, yet are severely limited in what they can tell us about life beyond those settings. Hence, in cases where no sound sampling strategy was employed regarding who was interviewed within the setting, even description of the setting itself must be questioned. Further limitations involve the lack of connection between life within a selected type of living environment and the larger contexts of city and state politics, social organization, economics and history. (Eckert, 1983:457)

To the extent that the study such as the one which has been undertaken in this research, addresses issues difficult
to study in bounded environments the contribution to
gerontological research will increase (Eckert, 1983).

The Research Setting

The town of Eatonville in Orange County in Central
Florida was the setting for the research. The field research
was carried out from January to December 1989. The idea of
conducting field research in such a setting evolved out of an
interest in the living arrangements of those black elderly
persons who were not institutionalized. Such a study it was
thought would afford the researcher an opportunity to observe
black families and kinship patterns.

The Town of Eatonville was settled as early as 1880 by
small groups of blacks who had drifted into the area from
further north as well as from the black portion of the soon
to be incorporated Town of Fort Maitland. On August 18,
1887, 27 registered voters met in the public hall of the Town
of Eatonville in Orange County, Florida, to vote on the
question as to whether or not to incorporate their community.
They were all residents of the area within the proposed
Town's boundaries. Their meeting was historically
significant because all 27 were blacks and the municipality
which they unanimously voted to incorporate that day became
the first incorporated all-black community in the United
States (Town of Eatonville, FL). This all-black community
was an outgrowth of the white municipality of Maitland which
had been incorporated three years earlier in 1884. It
appears that the all white community of Maitland found the blacks and the area they inhabited to be somewhat "unsightly" and wanted them to move to another area. It was at this time that one Josiah Eaton, who had helped establish Maitland, offered to sell the blacks a rather large parcel of land one mile to the west of Maitland. The land was bought by Joseph Clarke, who would be the first mayor of Eatonville. Clarke in turn sold the land within the bounds of Eatonville (named after Josiah Eaton) to any blacks who wished to settle there. The population of Eatonville continued to increase throughout the late 1800s and early 1900s. Today, Eatonville is a city of almost 2,800 people, bounded on the north and east by Maitland and on the south by the city of Winter Park. It is situated such that its main street provides the connecting link between U.S. Highway 17 and U.S. 441. The city has grown to the north and south of this main street. Eatonville is approximately 6 miles east of Orlando.

The town is administered by a mayor with a small staff of 28 persons. The mayor works part-time while the rest of the staff are employed on a full-time basis. The administration is carried out at the Town Hall, which is the only government administrative building in the town. The City Council consists of six elected officials the mayor, vice-mayor, and four councilors.

The elderly citizens of Eatonville enjoy several unique facilities provided by both the municipality and the county.
The reason for selecting Eatonville for a study of black elderly people, is its uniqueness in being an all-black community, administered by blacks, and the only one of its kind in the state of Florida. It was hypothesized that this would afford a certain homogeneity and a regulated environment. In such an environment one would expect to find less objection to senior citizens because of their race, whether it be to residential proximity or to demands on the system. Similarly, it was hypothesized that socio-cultural constraints would be less likely to exist due to the racial composition of the town, and hence would not impinge on supports for the elderly. Absence of zoning limitations means that there would always be opportunities for making elderly housing available and not subject to zoning curtailment. One would expect to find victimization either nonexistent or lessened; hence, there would be no need to consider ways of devictimizing the elderly of this community.

Being black, although from another culture, the author did not have to embark on an anthropological study of black culture. The people of the West Indies, from which the author comes, share a common heritage with black Americans, being in large part descendants of Africans who were brought to the New World as slaves.

Preparation for the research involved the gathering of demographic data and making numerous telephone calls both to the County Administration and that of the town. Introductory
telephone calls were made and letters of introduction were sent to the mayor and administrators of the town. Information was also gained from several persons who were known to have knowledge about the town.

Visits to neighboring nursing homes revealed that most of Eatonville's elderly were living at home. Two nursing homes were visited, both located in Winter Park. The first one, DePugh, is about 10 minutes' drive from Eatonville. Its residents are mainly black and it has a 40-bed capacity. Thirty-seven of these beds were occupied on the day the researcher visited but only one occupant was from Eatonville. The second nursing home, Parklake, is situated on the border between Eatonville and Winter Park. Of its 170 residents only 14 were black, and of this number, only one was from Eatonville. Winter Park is a predominantly white middle to upper-middle class town. A third institution visited was the only Adult Congregate Living Facility (ACLF) in Eatonville. This facility is privately owned by a local couple. The husband acts as Director and the wife as Resident Manager. The facility has 24 beds, but only 3 are designated for senior citizens' occupancy. Referrals are from the Health and Rehabilitative Service's (HRS) office in Orlando. Senior citizens from this facility participate in the daily activities of the Senior Citizens Class at the Wymore Education Center which is basically a county Nutrition site. On the day that the center was visited, only one of the
allocated senior citizens' beds was occupied. The occupant was a lady just over 65 years old and very active. This lady was born in Eatonville but had left for several years, returning about 10 years ago.

**Demographic Profile**

Demographic information is germane to any study of this kind and is of exceptional import for comparative purposes. The demographic profile of a community includes the population, and the educational, occupational, and economic features of the area.

The Town of Eatonville lies in Orange County, approximately 6 miles East of Orlando a major tourist center with major medical, educational, and county facilities. It extends over approximately 2 square miles, after annexation. The population of Eatonville in 1980 was 2,185 (Table 4.1). This increased to 2,576 in 1985 and by 1988 had grown to an estimated 2,668 (1989 Florida Statistical Abstract). Of Eatonville's 1980 population only 48 were nonblack. Of this number, 30 were white, 16 were of Spanish origin (11 Mexican and 5 others not Cuban or Puerto Rican), one was Japanese and one Hawaiian (Table 4.2).

Males make up 47.2 percent of Eatonville's population, females the remaining 52.8 percent (Table 4.1). There are 661 households (Table 4.3) averaging 3.36 persons per household. This is considered fairly high for the State of
Table 4-1: Population Figures--Eatonville--1980

<table>
<thead>
<tr>
<th>Total</th>
<th>Males</th>
<th>Females</th>
<th>Black</th>
<th>White</th>
<th>Spanish Origin</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2185</td>
<td>1032</td>
<td>1153</td>
<td>2137</td>
<td>30</td>
<td>16 *</td>
<td>2 **</td>
</tr>
<tr>
<td>%</td>
<td>47.2</td>
<td>52.8</td>
<td>97.8</td>
<td>1.4</td>
<td>0.73</td>
<td>0.09</td>
</tr>
</tbody>
</table>

* Not Cuban or Puerto Rican   ** Japanese = 1, Hawaiian = 1

Source: Bureau of Economic and Business Research, College of Business Administration, University of Florida, Gainesville, Florida, 1986.

Table 4-2: Age Distribution--Eatonville--1980

<table>
<thead>
<tr>
<th></th>
<th>&lt;5 years</th>
<th>5-17</th>
<th>18-64</th>
<th>65+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All races</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td>9.98</td>
<td>27.88</td>
<td>54.83</td>
<td>7.32</td>
<td>101</td>
</tr>
<tr>
<td>Blacks</td>
<td>216</td>
<td>603</td>
<td>1170</td>
<td>159</td>
<td>2137</td>
</tr>
<tr>
<td>%</td>
<td>9.89</td>
<td>27.60</td>
<td>54.74</td>
<td>7.28</td>
<td>97.80</td>
</tr>
<tr>
<td>Whites</td>
<td>1</td>
<td>3</td>
<td>26</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>%</td>
<td>0.05</td>
<td>0.14</td>
<td>1.19</td>
<td>0.00</td>
<td>1.38</td>
</tr>
</tbody>
</table>

Source: Bureau of Economic and Business Research, College of Business Administration, University of Florida, Gainesville, Florida, 1986.

Table 4-3: Number of Households--Eatonville--1980

<table>
<thead>
<tr>
<th></th>
<th>Black</th>
<th>White</th>
<th>Spanish</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>634</td>
<td>15</td>
<td>7</td>
<td>5</td>
<td></td>
<td>661</td>
</tr>
</tbody>
</table>

Source: Bureau of Economic and Business Research, College of Business Administration, University of Florida, Gainesville, Florida, 1986.
Florida, since the state and county averages were 2.55 and 2.67 respectively (Table 4.4).

In 1960, 62 percent of Eatonville’s population (1358) were aged 18 years of age and over, and 7.3 percent (160) fell in the age group 65 years and over (Table 4.2). All persons in the 65 and over age group except one are black (Bureau of Economic and Business Research, 1986).

<table>
<thead>
<tr>
<th>State of Florida</th>
<th>Orange County</th>
<th>Eatonville</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.55</td>
<td>2.67</td>
<td>2.36</td>
</tr>
</tbody>
</table>

Source: Bureau of Economic and Business Research, College of Business Administration, University of Florida, Gainesville, Florida, 1986.

Education

The majority of the adult residents of Eatonville have not been educated beyond the elementary level. They therefore work in areas such as custodials, contracting, construction, and trade. About 15 percent to 20 percent are professionals and para-professionals for example, teachers and aides teaching in schools (Eatonville’s Economic Specialist interview, 1986).
College of Business Administration, University of Florida, 1986).

**Economics**

In 1985, the average per capita income for the people of the town was $7,036 compared to $11,315 for Orange County and $11,271 for the State of Florida (Bureau of Economic and Business Research, College of Business Administration, University of Florida, 1986). Although, the job market has been improved through development ventures, especially for school leavers, most of the labor force of Eatonville works outside of the town making it a dormitory town for the large tourist centers nearby. About 10 years ago decision makers in Eatonville decided to become part of the economic world to prepare for the economic boom, based on neighboring towns such as Orlando and Altamonte Springs. In order to effect this, the town applied for and received a $4.1 million grant to install infrastructure: pave all the streets, put in sewer lines, build a water plant, and put in sidewalks. Eatonville is the only town in Orange County that is completely paved and watered, and this has led to several companies moving into the town. The city could no longer depend on residential property taxes for support, because the average household assessment was less than $25,000. With Florida's $25,000 homestead exemption, enacted in 1980 (Statutes Number 196), the city government received little or no money from property tax. The city therefore saw the need to concentrate
efforts on developing a commercial district in Eatonville. Two years after effecting this they had more than doubled their tax revenue by attracting commerce and industry into the town. The increase in industry and commerce has meant more jobs and more people working in the town itself. This has also meant more money through taxes for the municipality.

Having examined the demographic profile, the remainder of this section will be directed to other features of the community including politics, housing, religion, and recreation. Extreme care has been taken to plan the city, since it is surrounded on three sides by other towns and hence much more annexation is not envisaged because very little land is available. A tour of the small town reveals beautifully kept houses and yards, spin-offs of the grant received earlier by the town. Large stores and shops are conspicuously absent, but the close proximity of larger towns takes care of this aspect of the needs of the residents: They do not have to go extremely long distances to shop.

Businesses owned and operated by citizens of Eatonville include the Tiger Gas Station, Vereen's Cabinet Shop, and Eatonville Diversified Corporation which includes a funeral home and commercial building. There are also Sims' Plant Nursery, Johnson's Lawn Mower Repair Shop, and Ellis' Welding and Metal. There is a Town Hall which is the administrative center for the municipality. There are no hotels, and only a single motel in the town. There are two night clubs, Mr. B's
and the Rainbow Bar, Grill and Entertainment Complex which is one of the landmarks of the town (Otey, 1989). Mr. B's is very formal with a rigid dress code. It is described as being "as fine as any night club in Central Florida" (Otey, 1989:35-6). "Mr. B's is also a classic entertainment spot for special parties, weddings, club meetings, conventions, and reunions" (Otey, 1989:36). The Rainbow club is more like a bar where some of the men of the town spend most of their day. Another meeting place is Duncan's coffee shop where the older men meet for coffee and social interaction. The town boasts a beautiful community center: the Denton Johnson Community Center, which acts as a central venue for clinics and food distribution among other functions. There is a single restaurant and there are two small grocery shops. There is a kindergarten and day nursery, one large elementary school and one high school which is also a vocational center. The high school and vocational center make up the Wymore Education Career Center. There is a large auditorium--The Hungerford Memorial Auditorium--where major civic functions are held. There is a post office in the town but no mail carriers; hence, the residents who can afford it rent boxes in the post office. Residents are, however, able to purchase stamps and do all their mailing at the Eatonville Post Office. Those who cannot afford to pay for mail box rental have their mail sent to the Maitland or Orlando Zip Codes, and these are delivered to their residences.
Politics

As noted earlier, the Mayor is the chief executive of the town. Included in the city staff is the Police Department (one chief of police and five officers) and a Fire Department of three persons. The Mayor and Council members are elected officials.

Housing

Most of Eatonville's residents own their homes. Eatonville is about 95 percent owner occupied. The mayor of Eatonville told the researcher "the people who are living in their homes will do so until they die, then these homes will be passed on to the next generation. This has been going on for years because they are a close-knit community." There are three sets of low income apartments in Eatonville. These are West Community Apartments, Oakpark apartments, and Kennedy apartments. These were built under Section 8 of the Housing and Community Development Act of 1974 (Economic Specialist, 1986). Under this Section of the Act, rent supplements were replaced by a new but basically similar plan, the program for leased housing. None of these residences are specifically designed for or allocated to senior citizens.

Religion

Religion, plays a major role in the lives of the majority of the people of Eatonville. The black church is an integral part of the community's existence, although it does
not seem to dominate the lives of all the people. There are 10 churches in the town. The major ones are St. Lawrence African Methodist Episcopal, Macedonia Missionary Baptist, Mt. Carmel Baptist, Open Door Baptist, Church of God and Christ, Healing Crusade Mission, Revival Center, and Church of God by Faith. All residents are able to worship in a church that is within walking distance. The oldest church is the St. Lawrence African Methodist Episcopal Church; however, the largest is the Macedonia Missionary Baptist Church. Churches in the community provide a range of activities not only for their members but for the community at large.

Recreation

The people of Eatonville do not suffer from a lack of recreation. The small size does not deter the municipality from providing recreation for its residents. There is a community swimming pool, tennis courts, and softball fields. In 1985 the council appointed a Recreation Committee to develop a comprehensive recreation program for the elderly as well as for the youth. The program was completed by the end of Summer 1986 and implemented early that Fall. Other recreation programs are carried out as cooperative efforts among the schools, the community and the churches. The municipality hosts various programs for its citizenry. These include parades such as the one held annually to commemorate the birthday of the late Reverend Dr. Martin Luther King, Jr., roasts, and beauty pageants.
The town of Eatonville with its many lakes is strategically located. This location, however, could be a contributor to the town's backward development. The close proximity of other townships, which makes all their support systems available to the people of Eatonville, contributes to the lack of its development. The result is that the town lacks several supports such as a clinic, a bank, a pharmacy and a mail carrier. There are very few jobs for young people, and this may be a contributing factor to Eatonville's drug problem which has escalated over the past 2 years. The residents of Eatonville do not complain much, but older residents do find it very difficult to carry on daily life because they have to go out of the town for almost everything except church attendance. The commercial park, which was expected to boost the job offerings for young people, was a disappointment in that there were not many jobs offered. The clientele of a major wholesale store located in the Park is mainly persons from the neighboring white communities who can afford to purchase in bulk. The residents of the town do not benefit from this enterprize.

One major influence on the Town of Eatonville's development is Florida's Interstate Highway 4 (Figure 4-1). This highway traverses the state from Daytona on the east coast to Tampa on the west coast. The highway, built in 1964-65, passes through the center of Eatonville on its way north to Orlando. Although there is no highway entrance or exit
Figure 4-1: Schematic Representation of the Place of the town of Eatonville in the East Orlando Community
ramp at Eatonville, Interstate-4 gave the town a new exposure (Otey, 1989).

The year 1987 witnessed the celebrating of the centennial of the Town of Eatonville. At this time tribute was paid to its founding fathers and to those citizens who had contributed to its growth and development through the years.

**Caregiving in Eatonville**

The care given to elderly persons in the Town of Eatonville was found to be effected by seven different methods utilizing both the formal and the informal support systems. Most senior citizens were dependent to some extent upon a person (or persons) for assistance. Dependence is defined here "as the extent to which the means necessary for survival are not directly available to the individual through his or her own efforts, but must, to some extent, be obtained from others" (Clark, 1972:263). Clark speaks of six types of dependency that seem to be distinguishable in terms of cultural meanings and behavioral dynamics. These are (1) Socioeconomic dependency, (2) Developmental or transitional dependency, (3) Dependency of crisis, (4) Dependency of non-reciprocal roles, (5) Neurotic dependency, and (6) Dependency as a culturally-conditioned character trait (Clark, 1972:264). Although Americans place a great deal of emphasis on individuality and freedom, Clark (1972:263) noted that this particular imperative, when applied to the case of the
aged, forces many elderly people in our society to make an unhappy choice between denial on the one hand and self-recrimination on the other.

Presentation of the findings includes in part a quantitative analysis based on a sample of 71 elderly persons. However, vignettes are used to highlight the use of services in Eatonville by its elderly residents. The persons dominating these vignettes are not being treated as simple respondents in a survey but are being treated as informants in the anthropological sense about the system and the town. The vignettes describe illustrative cases of the levels of dependency and the types of formal and informal support networks of elderly persons in Eatonville. In each vignette there is a given level of dependence and a given type of support each receives.

The researcher believes vignettes to be a useful medium through which to illustrate topics such as caregiving networks in studies employing the type of methodology as is done here. They appear to be one of the means which best illustrates to the reader how individuals and their kin come together to make up a community as well as the intertwining of these individuals with their community.

**Sample for Interviews and Quantitative Analysis**

A convenience sample of seventy-nine (n = 79) elderly black persons was taken representing approximately 50 percent of the total black elderly population of the community which
is estimated as 159. The resultant data, however, is based on a sample of 71 persons (n = 71). Eight (n = 8) of the original sample had to be excluded because, although they lived on the periphery of the town and participated in its social life, they did not fall within the official city limits of Eatonville. Boundary changes resulted in this situation. It is not clear whether these boundary changes were effected after the 1980 census. A total number of 115 persons representing older persons, caregivers, church and community leaders, political leaders and county agency personnel were polled.

Obtaining the sample was not straightforward. No directory of elderly persons existed. The snowball sampling procedure was employed. In this procedure the researcher chooses one or more informants which may generate information about other persons which leads the observer to contact one of these others as a second informant, who in turn directs him or her to a third informant and so on until there is an extensive chain of contacts (McCall and Simmons, 1969). The researcher first visited two of six elderly ladies who had been contacted during a pilot study which she had conducted in the summer of 1986. From them were obtained the names of six others. Following this a visit was paid to the Town Hall, from which there was a possibility of obtaining a listing of senior citizens. This visit proved futile. Twenty registration slips were left with the clerk to be
completed by senior citizens who visited the town hall to pay their water bills. The next agency that was targeted was the Senior Citizens' Center at the Wymore Career and Vocational School. A short list consisting of ten persons was obtained from the director of the center. This list, together with the names that had previously been obtained, served as the catalyst. Only names and telephone numbers were available, no addresses. The researcher also met with six senior citizens who were in attendance at the center on the day of the visit. Appointments were made to visit with them in their homes. These visits proved useful not only for obtaining personal information but also for obtaining information about other senior citizens in the town with whom these persons were acquainted. Of note is the observation that most senior citizens in the community keep an updated telephone listing of several other senior citizens. This list is their main mechanism for communicating with each other and it proved very useful since names and telephone numbers could be obtained. This procedure was repeated at each visit until a comprehensive telephone listing of a large number of the senior citizens in the town was made. This snowball sampling technique was the method used to obtain the majority of subjects for this study. The remainder of the sample was selected through contacts made at the county surplus food distribution center.
Introductory telephone calls were made to these persons explaining the project and requesting a visit. Most were amenable while some were a bit skeptical. For those who did not respond positively, a short visit to the home became necessary. After explaining the reason for the visit, there was very little problem arranging future visits. Telephone networking as practiced by many senior citizens in the town, played a major role since those that were visited called others and told them about the researcher and the research. This helped tremendously. During the 12-month period of the research multiple visits were paid to each respondent. Quota sampling method was used to sample government and community officials. With this method of sampling, the observer is aware of certain formal categories of organization members and determines beforehand that he/she will interview and observe at least a few persons from each of these categories (McCall and Simmons, 1979). The categories sampled were county officials, officers of the Area Agency on Aging and the Older Americans Council, members of the Town Council and administration, nurses, clergymen, teachers, police, firemen, community workers, philanthropists, and local businessmen.

**Measurement of Variables**

Although the study is primarily qualitative, 18 major independent variables were measured quantitatively. These include socio-economic status, health status, living
arrangements, and kinship patterns based on family and friends.

Questions centered around ownership patterns of dwelling units, number of health problems, marital status, disability, household size, living arrangements, and economic status. The ability to perform the Activities of Daily Living (ADLs), the Instrumental Activities of Daily Living (IADLs), sources of income, and the use of leisure time were also examined. When elderly persons were physically or mentally unable to respond to the interview \((n = 1)\), or participate in the discussions, data from their closest other were used.

**Operationalizing the Major Variables**

In order to assess the care given to the elderly persons of Eatonville, 18 major variables utilizing the following 40 independent indicators are analyzed.

**Age of Respondent**

Respondent age is an interval variable ranging from 65 to 93.

**Gender of Respondent**

Respondent gender is a dichotomous variable coded one when the respondent elderly person is female.

**Marital Status**

Marital status of the respondent is coded 0-4. This nominal variable is coded zero if the respondent has never been married, one if the respondent is married, two if the
respondent is separated, three if the respondent is divorced and four if the respondent is widowed.

**Residential Status**

This variable has these dimensions:

- **Born in Eatonville** is a dichotomous variable coded one when the respondent was born in Eatonville.
- **State of birth** is a dichotomous variable coded one when the respondent was born in Florida.
- **Years in Eatonville** is an interval variable ranging from 2 to 86.

**Living Arrangements**

Two variables deal with this aspect of life.

- **Ownership of the dwelling unit** is a dichotomous variable coded one for own.
- **Number in household** is a continuous variable ranging from 1 to 7 including the respondent.

**Disability**

Disability of elderly persons is an indicator of the need for both formal and informal caregiving. For the purposes of this study, respondents were labeled disabled if they were blind, wheelchair-bound or bedridden. Disabled is a dichotomous variable coded one for yes.

**Health Status**

Five variables determine the health status of respondents. Hypertension, diabetes and arthritis were selected for special treatment since they are the most
common forms of chronic diseases affecting black elderly persons.

**Number of health problems.** Number of health problems is a continuous variable ranging from 0 to 7.

**Hypertension.** Hypertension is a dichotomous variable coded one for yes.

**Diabetes.** Diabetes is a dichotomous variable coded one for yes.

**Arthritis.** Arthritis is a dichotomous variable coded one for yes.

**Other.** All other ailments that the respondent reported are recorded under other. Other is a dichotomous variable coded one for yes. This variable is used to determine impairment of the respondent. Respondents ailments are recorded in terms of numbers and severity based upon self reports and researcher observations.

**Number of ADL Tasks**

For the purpose of this research, activities of daily living were dressing, bathing, feeding, toileting, and transferring, e.g., from bed to chair or commode and vice versa, or from one part of the house to another. An interval variable was created ranging from one to five representing the number of ADL tasks which the respondent was able to perform unassisted.
Number of IADL Tasks

Seven instrumental tasks were used. These were grocery shopping, managing finances, housework, yardwork, meal preparation, transportation, and administering medications. Number of IADL tasks is a continuous variable ranging from zero to seven. Again the number recorded was the number of tasks that the respondent was able to perform without assistance.

Socio-Economic Status

Occupation and income were used as measures of socio-economic status.

Occupation. Occupation is measured using the Hollingshead Occupation Scale coding from one to nine. Homemakers were not originally included in the occupation scale. In this study they were coded four because that coding included practical nurses, foremen, restaurant managers, machinists, storekeepers, and decorators which are occupations with similar manual skill requirements and prestige. Eatonville is a low income community and hence if these ladies worked outside of the home they would be expected to hold positions equivalent to those listed.

Income. The income of elderly persons is usually derived from various sources. Income based on dependence on the respondents' children or other relatives indicated a sometimes unstable source of income, necessitating caregiving in one form or another, formal or informal. Income based on
Social Security could indicate financial hardships as well. Income based on Social Security and/or pension was an indication that the respondent's former occupation fell into a category above service industry or seasonal work. Four indicators representing the main sources of household income are used. These are Social Security (SS), Supplemental Security Income (SSI), pension, and holding a current job. These are the sources reported by the elderly respondents.

**Social Security.** Social Security is a dichotomous variable coded one when the respondent is a recipient of Social Security.

**Supplemental Security Income.** The Supplementary Security Income (SSI) program is a federal program enacted by Congress as a part of the Social Security Amendments of 1972, to guarantee that the annual income of an older or disabled person would not fall below a minimum level. Eligibility for SSI benefits is based on a categorical requirement and on limits on income and resources (Kutza, 1981:39). Supplemental Security Income is a dichotomous variable coded one when the respondent is a recipient of SSI.

**Pension.** Pension is a dichotomous variable coded one for respondents who benefit from a pension. This includes Veterans Pension.

**Current job.** Current job is a dichotomous variable coded one for respondents who were currently working. This
applied to those holding part-time as well as full-time positions.

Family

Respondent's family is comprised of three indicators which are the living children, grandchildren, and siblings of the respondent.

**Number of children.** Number of children is an interval variable ranging from 0 to 11.

**Number of grandchildren.** Number of grandchildren is an interval variable ranging from 0 to 22.

**Number of siblings.** Number of siblings is an interval variable ranging from 0 to 8.

Care Receiver

Respondents who were care receivers were those who were receiving assistance with at least one ADL and two IADLs. Care receiver is a dichotomous variable coded one when the respondent is a care receiver.

Caregiver

Some respondents are caregivers. They administer unpaid assistance primarily to relatives, but some administer care to neighbors and friends. Caregiver is a dichotomous variable coded one for those respondents who in some way are caregivers.

Formal Support

Formal support is constructed by summing positive responses to the use of six indicators. These are Medicare,
Medicaid, Surplus Food, Food Stamps, Day Care, and Others. Thus, it has a theoretical range of 0 to 6.

**Medicare.** Medicare began in 1966 as a federally financed health-insurance program for persons aged 65 and over, and in 1972 it extended benefits to the disabled and persons suffering from end-stage renal disease. Medicare consists of two parts, the Hospital Insurance Program (Part A) and the Supplementary Medical Insurance Program (Part B). Hospital Insurance helps pay for hospital care and for posthospital care in so-called extended care facilities or through home health programs. The Supplemental Medical Insurance Program is a voluntary program in which almost everyone aged 65 or over may enroll. Part B helps pay for physicians' services and outpatient services. To be eligible to receive Medicare Part A benefits, an individual must be (1) aged 65 or over and receiving or entitled to Social Security or Railroad Retirement benefits as an insured worker, or be a dependent or survivor of an insured worker; (2) disabled and eligible for Social Security or Railroad Retirement benefits for 24 or more consecutive months. To be eligible to receive Medicare Part B benefits, an individual must pay a monthly premium and be entitled to Medicare Hospital Insurance, or be aged 65 or over and a citizen and resident of the United States. Benefits under Medicare are subject to certain copayment and deductible provisions.
Medicare is a dichotomous variable coded one for beneficiaries.

Medicaid. Medicaid is a Medical Assistance Program authorized under provision of Title XIX of the Social Security Act, as amended. Unlike Medicare, Medicaid is not a health-insurance program. Instead, it is a federal-state program of medical assistance for the needy and for certain other low-income persons who are aged, blind, disabled, or members of families with dependent children. Benefits under the Medicaid program are medical-care services for which full or partial payment is made directly to the providers of services on behalf of eligible beneficiaries (Kutza, 1981:40-43). Medicaid is a dichotomous variable coded one for beneficiaries.

Surplus food. Surplus food is a dichotomous variable coded one for recipients of this benefit.

Food stamps. For a household to be eligible for food-stamps benefits, its income after deduction must fall below the poverty line annually set by the Office of Management and Budget. Each month an eligible household receives an allotment of stamps, the number determined by the amount it would cost to purchase a "Thrifty Food Plan" (as determined by the Department of Agriculture for various Family sizes) less 30 percent of the household's net income after deductions (Kutza, 1981:48). Food stamps is a dichotomous variable coded one for yes.
**Day care.** Day care is a dichotomous variable coded one for yes.

**Other.** Elderly persons are recipients of other formal supports. These include rental subsidy, utility supplement, chore/home repair services, home nursing services, homemaker services, home-delivered meals, and shopping assistance. Other is a dichotomous variable coded one for yes.

**Informal Support**

This major independent variable was constructed using the indicators spouse, children, family, church, neighbors and friends. It is based on the support the respondent receives from each of these groups that make up the informal network. It is not a measure of the quantity or quality of support received but whether or not respondents benefit from some kind of assistance from each group. The range of this variable is from zero to five.

**Spouse.** Spouse is a dichotomous variable coded one for yes.

**Children.** Children is a dichotomous variable coded one for yes.

**Family.** Family is a dichotomous variable coded one for yes.

**Church.** This is a dichotomous variable coded one for yes.

**Neighbors and/or friends.** Neighbors and/or friends is a dichotomous variable coded one for yes.
Agency Awareness

Although there are formal agencies such as Area Agencies on Aging which exist for the sole purpose of serving elderly persons who are not institutionalized, one common observation is that those who are in need of help often lack knowledge regarding these sources of help. They therefore do not know where to go to get help. Some elderly persons may be in receipt of help from one agency but are ignorant of the existence of other agencies which are in place to provide other supports such as home-delivered meals. The variable Agency Awareness includes other agency awareness and meal awareness.

Other agency awareness. This variable summarized responses to questions posed by the researcher, complaints made by respondents, as well as on observations made by the researcher. Other agency awareness is coded two for high awareness, one for medium awareness, and zero for low awareness.

Meal awareness. Many elderly persons, especially those living alone are in need of home-delivered meals. Although this is a service provided by the formal support system, many are unaware of its existence. Meal awareness is a subjective coding based upon the respondent's knowledgeability regarding this service. Meal awareness is coded two for high, one for medium, and zero for low.
Indication for the Need for More Help

Elderly persons are recipients of assistance from both the formal and the informal network systems. Many however do not receive as much help as is necessary to reduce fear and anxiety. The need for more help was assessed based on two factors. The respondents' statements and the observations of the researcher. More help needed is a dichotomous variable coded one for yes.

Summary

The setting and methodology have been presented in this chapter. In order to address the care of black elderly persons and in an attempt to reveal inter-relationships of the formal and informal support systems and the black family, the community selected is small, that is less than 3,000 population and is predominantly black. In order to generate the data surrounding the phenomenon of black elderly caregiving, a methodology is employed to facilitate observation of persons, objects and events, time and locales. Quota sampling was the procedure used to sample county officials, and local and church leaders, while snowball sampling procedures were used to sample the elderly population of the community.

Research questions focused on the role of the family as service agent, as well as on knowledgeability about, use of, and access to formal services. Forty independent indicators were isolated for quantitative descriptive analysis, thereby
integrating field interviews with structured data collection. Kinship patterns were determined based on an overall assessment of family relations and on the literature which states that low-income families usually have stronger kinship ties than middle-income families; Eatonville is primarily a low-income community. The historical demographic, political residential, social, and religious components have been addressed. A pilot study conducted by the researcher in Eatonville in 1986 was beneficial to the larger study. Chapter Five presents the major findings from the data. One of the outcomes of the interviews is the construction of Vignettes. These vignettes are presented in Chapter five and are used as a means of presenting the qualitative analysis.
CHAPTER FIVE
FINDINGS AND DISCUSSIONS

There are several interrelated purposes of this study. The overall purpose is to examine caregiving for frail black elderly persons in the Town of Eatonville, Florida. Within this general purpose, the researcher is first concerned with the role of the extended family in caring for functionally disabled elderly persons in an all-black community. Second, the researcher will examine the role of friendship, church and other informal groups in providing care. Third, the role that the formal caregiving system, governmental and publicly funded, plays will be explored. Fourth, the researcher will be concerned with the interrelations between the formal and informal caregiving and support systems in the Town of Eatonville.

In pursuing these purposes, several questions are raised. First, does the elderly person need help, and if so, does he or she know sources of help, that is, is there awareness of formal and informal sources? Second, if there is a helper, is the primary helper provided by a formal agency? And, is there need for more help? Third, do people know where to go to get help (agency or nonagency)? A final
set of questions asks whether the fact that formal services are available but are not being utilized is explained by the ignorance of their existence, preference, culture, or problems with access? Do the people in this community perceive a lack of access to the formal services system? And are their needs adequately met?

One example of care given to an elderly black person is Mrs. Brown. She is an 86-year-old widow who lives alone with her 38-year-old daughter in a large and attractive house. The house is beautifully furnished and Mrs. Brown's living room is resplendent with trophies which were awarded to her son who was a professional athlete. Mrs. Brown is not allowed to do anything at home. Her daughter who holds a full-time job does everything for her and drives her when she has to go out. Mrs. Brown attends the senior citizens daycare center everyday. She has been doing this since its inception. In 1989 the center was transferred from Eatonville (a black community with a black program director) to Winter Park (a predominantly white community with a white program director). Mrs. Brown described her experience with the move, and noted that, although the folks were white, "they were O.K." She mentioned that they still did some of the activities that they did at the former center. "There are no problems," she said. "We sing and all that. You know 'white people' they'll do anything you tell them to." Mrs.
Brown is disenchanted with the local municipality. She states

I no longer attend the public meetings. I am not happy with how they are run. People are not allowed to get up and say what they want. You have to speak through another person, and I don't agree with that. I know what I want to say and how I want to say it. So if I can't say it myself I don't bother to go to the meetings.

Mrs. Brown was referring to a ruling by the Town Council regarding town meetings. The ruling was that if there was a group idea to be brought to the council then one person should be given the responsibility as spokesperson for that group. The case of Mrs. Brown's caregiving is not typical of what takes place in Eatonville. Life is not as uncomplicated for all its elderly citizens. Culture plays a significant role in the giving and receiving of care in this community. Culture as it involves kinship patterns is very evident. There is a great deal of dependency upon friends and neighbors. This is especially evident with those elderly persons who are living on their own.

Ignorance of available formal supports for elderly persons has very often resulted in family members experiencing more than their share of the stress and burden which accompany taking care of an elderly relative. This is especially acute when that elderly relative is frail and suffers from Alzheimer's disease. Many relatives of Alzheimer's disease patients are reluctant to institutionalize their loved ones.
Based upon findings from a study, Cantor (1983) reported that spouses report the greatest degree of physical and financial strain, and that the extent of impact on the everyday life of the caregiver appeared to be clearly related to the closeness of the kinship bond and was most severe in the case of spouses who lived in the same house as the Alzheimer's patient. It is not uncommon for family members to give up their jobs to care for the ill relative (Clark and Rakowski, 1983). The situation of many of the respondents to this study appear to fit these criteria.

The findings of this study are presented in two ways. First, vignettes are utilized to summarize the qualitative findings, and second, a quantitative descriptive analysis is presented and discussed. Vignettes are not case studies in the true sense, and in this research they are used to study and indicate the range of dependency and type of support used by elderly residents of Eatonville (Figure 5-1). Six Vignettes are presented.

**Vignette #1**

Mr. Duffus* is 76 years old, married, and suffers from Alzheimer's disease. He lives alone with his 59-year-old wife who takes care of him on a full-time basis. Mr. Duffus who is in an advanced stage of his disease was unable to respond to any questions so his wife provided the researcher with all of the information. In 1980, when Mr. Duffus'

*Pseudonyms are used throughout this text.*
condition worsened, Mrs. Duffus had to quit her full-time job as a nurse's aide in a hospital in order to stay home and take care of him. It is not uncommon for family members to give up their jobs to care for the ill relative (Clark and Rakowski, 1983). Mr. Duffus' other ailments include a chronic heart condition, fluid in his lungs, a history of spinal meningitis 27 years ago, and prostate surgery. He is incontinent and has to be watched all the time. He is unable to go to the bathroom by himself and has to use a bed pan. Mrs. Duffus reports that Mr. Duffus is incapable of using the bedpan or urinal without supervision. His doctor gave them a prescription for a commode chair, but he is unable to use it. His doctor and Mrs. Duffus had hoped that this would have relieved Mrs. Duffus by removing one of her burdensome tasks, that of supervising the visits that Mr. Duffus makes to the bathroom.

Mrs. Duffus assists her husband with all ADLs except feeding himself, but even this, she states, has to be supervised. He was in a semicoma for about 6 months and has had to learn to walk again. Mrs. Duffus has to work at least 2 days per week doing domestic work in order to supplement their only income which is from Social Security. She reports that they could not cope financially if she did not work. The only other support they receive is in the form of surplus food which is distributed every 2 months and does not include
the basic food requirements. The package consists of raisins, butter (which is salted), honey, and cornmeal.

Although this man is not bedbound, or wheelchair bound, he is homebound, spends most of his time sitting on their enclosed porch and stares vaguely all the time, while mumbling incoherently. All the doors of the house, in which they live alone, have to be kept locked at all times. The porch is, however, quite airy and so he gets a lot of fresh air and the neighbors can see him when his wife has to go out.

Mr. Duffus is left alone at home when his wife goes to work and the neighbors keep an eye on him. This appears to be dangerous since, if there were a fire or if he should fall, there could be serious repercussions. The researcher visited the house several times while on rounds and got no response from a knock on the door. Once Mr. Duffus was observed sitting on the porch, and the other times the researcher was aware that he was inside the house but was unable to respond. The neighbors reported that they had seen him moving around in the house earlier. This is the extent of the support that the Duffus' receive from their neighbors.

The couple have two sons and two daughters ranging in ages from 37 to 40 years. One daughter who lives 1 mile away checks on them regularly but is unable to offer any assistance at respite for her mother because she has to take
care of her own family. They also have three granddaughters residing in Orlando, 4 miles away. Nothing was said about the other children. None of the children or grandchildren offer any financial assistance.

Mrs. Duffus is a very pleasant lady, who takes very good care of her husband but her stress burden is obvious. She performs all the IADLs including doing the yardwork. Mrs. Duffus reports that she is not "one hundred percent" well. She is hypertensive and, although the disease has been controlled, she sometimes feels very tired. Mr. Duffus is currently on medication for his heart condition, his respiratory condition, and his hypertension. His wife has to administer the medication at all times. He visits his doctor by appointment, and she drives him to these appointments. Her main concern is having to leave him on his own whenever she goes to work or goes out. She also complained that there was no one who could take over if she were ill or had to go away for a few days.

Mrs. Duffus was not aware of any source of formal support that she could receive. She did not know about respite services and home help. She spoke uncomplainingly of physical and mental burn out, although she "[does] not object to taking care of him." Her concern for him was similar to that shown by a mother for a child. She sometimes takes him for walks so that "he can get out a little." They have an attractive home with a well kept yard. Mrs. Duffus complains
of some backache and of sometimes feeling very tired. The stress burden compounded by the physical burden is one of the major concerns for caregivers. More could be done for this couple in the form of assistance but knowledge about available formal services is lacking. It was evident that if the knowledge was there, some of these services could definitely have been accessed.

Three problems can be identified in this household, in which there is an elderly male care-receiver. There is a financial problem which forces Mrs. Duffus to go out of the household to work while taking care of her husband full-time, and this despite the fact that the nature of his illness demands full-time care. The second is the health of Mrs. Duffus, the caregiver. Based upon findings from a study, Cantor (1983) reported that spouses report the greatest degree of physical and financial strain, and that the extent of impact on the everyday life of the caregiver appeared to be clearly related to the closeness of the kinship bond and was most severe in the case of spouses who lived in the same house as the Alzheimer's patient. One can expect Mrs. Duffus' health to deteriorate if she does not get some help soon. The problem lies not only with her physical health, but also with her mental health.

A third problem is the lack of family support, that is, some person or persons on whom Mrs. Duffus can call to relieve her. In the absence of this informal support the
answer to their problems lies in the formal support system. They need financial assistance. This could be in the form of food stamps to supplement their Social Security. If they received this, Mrs. Duffus would not have to go out of the home to work. Mrs. Duffus, although a fit looking lady, complains that she has to do a lot of lifting. Fortunately she is a well built lady and he is a small frail man. The assistance of a home health nurse even once per week would be a great help to Mrs. Duffus. The stress burden which is evident could be alleviated by Mrs. Duffus being able to attend an Alzheimer's support group.

It was evident that family physicians are not doing their job properly in the case of this patient. It is the physicians duty to be familiar with the types of assistance available to families with frail and functionally disabled elderly persons at home, and advise their relatives accordingly. Respite care is very badly needed. It should be possible for Mrs. Duffus to leave her husband in a facility for short periods of time while she enjoys a break. The cost of this service should be the responsibility of the formal system. Another service that would be of help is day care. Mrs. Duffus would then be spared the guilt and worry when she has to leave Mr. Duffus at home alone.

Alzheimer's disease is known to last from 2 to 20 years; it leads to permanent disability, and eventually to death. There is no cure for the disease, which can be mild,
moderate, or severe. Persons with Alzheimer's disease need constant supervision (Doty and Caranasos, 1987). The family should learn about the disease and what to expect. Mrs. Duffus seemed to be quite conversant with her husband's illness and was trying to cope as best as she could. Although many relatives of Alzheimer's disease patients are reluctant to institutionalize their loved ones, the existence and/or accessibility of an Alzheimer's support group would be of great help to Mrs. Duffus. It was obvious that if Mrs. Duffus knew of the existence of these services, and if they were accessible, she would avail herself of them. Unfortunately, none of these services are available in the community.

Mr. Duffus is an example of dependency mainly on the informal support system. This dependence however, can be attributed to a lack of knowledge of formal support systems that are in place to assist him and his caregiver spouse.

Vignette #2

Mr. Noble is a heavy-set 220 pound, 76-year-old male who lives with his wife in their three-bedroom house. He has been retired for 25 years. His medical ailments are hypertension and congestive heart failure. He has a problem walking about the house without the assistance of a stroller or a stick. He owns crutches that he uses from time to time, depending on the condition of his legs. His hearing is impaired and he uses a hearing aid. Recently he has been
attempting to walk around the house without the aid of the stroller. He used to go for short walks out on the street but has given this up since his most recent illness 6 months ago when he was diagnosed with congestive heart failure. He utilizes both the formal and the informal support systems. He depends upon the paramedics at the local fire department in the event that he should fall. His wife, who is a slender 69-year-old lady, is not able to lift him by herself. He has an emergency response button which is activated at the fire station. The couple report a response time of less than 5 minutes from the paramedics. The small size of the town is also an advantage since it does not take more than 10 minutes from one end of the town to the other. Mr. Noble dresses himself but needs assistance with his bath. He prepares his own lunch whenever his wife goes to work. She does so 1 or 2 days per week, doing housework, to supplement the family income which is from Social Security. They receive Medicaid for assistance with medical expenses. He spends most of his time reading, sitting in one place since he cannot move about too much. His wife performs all but one of the IADLs. Mr. Noble is able to administer his own medication without assistance.

Mrs. Noble has her own health problems although she is not incapacitated by them. She is hypertensive, suffers from arthritis, and has had a bilateral mastectomy and radiation
therapy for breast cancer. She is on medication for her hypertension.

Mr. Noble depends on the formal and the informal systems approximately equally. The Nobles are knowledgeable about how to access the formal support system and hence utilize the services provided by this system to complement the informal system. From this we learn that if elderly persons are aware of the services which are available, then they are likely to utilize these services.

**Vignette #3**

Mrs. Barton is an 89-year-old widow who lives alone and is confined to a wheelchair. She has been living at her current residence, a two-bedroom apartment in a low income complex about 3-1/2 years. She pays rent of $285 per month and does not receive a rent subsidy. Mrs. Barton formerly resided with her 75-year-old niece in an adjoining community for 3 years. It was this niece who had persuaded her to move to Florida to live with her when her doctor recommended that she move to California from New Jersey where she lived for over 49 years with her husband. She was a certified foster parent, and for 35 years fostered more than 80 children for the State Board of New Jersey. She also raised four other children, two of whom were her nieces and one her only son. Her husband died in 1980 and her health started to deteriorate after that.
Mrs. Barton has a medical history of three strokes, gastric ulcers, gall bladder surgery, nephrectomy (removal of one kidney, in 1949), arthritis, osteoporosis, and being involved in an automobile accident in which she suffered a broken collar bone. She has severe problems with her hips as a result of her arthritis and osteoporosis. She has not been able to drive since the automobile accident and finds it difficult to get into or out of automobiles. Mrs. Barton, like several others in the community, chews snuff. She also spends several dollars each week on mail offers which appear fraudulent. These offers usually request that a certain amount of money be sent and in return the sender would receive some article or articles. It was not always definite that the sender would receive something in return. Mrs. Barton tells a sad tale about her care receiving:

Her niece had promised to take care of her in return for which Mrs. Barton spent a lot of money to repair the niece's house, refurbish it with new awnings, install a new cooker with hood, and buy a new washing machine. She had a new front screen door installed and pays for all the landscaping each month. In total, Mrs. Barton reports that she has spent in excess of $3,000 on her niece's property. She sold two houses and brought all the cash with her to Florida and her niece knew of this. She continued to give her niece a lot of money to spend on the house. When her niece felt that her money was running out, she evicted her. Mrs. Barton had nowhere to go and rode around in a taxi for an entire day after being told by the nursing home to which she had a referral that they could not accommodate her. Eventually the taxi driver feeling some compassion for her, took her to the only motel in the town and she stayed there for 3 months. Meals-on-wheels provided her with meals and the management was very kind to her. She met a lady while at the motel who proved to be a good
friend and who helped her with her laundry and transportation. It was from this motel that Mrs. Barton moved into the apartment in which she now resides.

Mrs. Barton is very knowledgeable about the various formal support services. This is reflected in her utilization of these services. She keeps all emergency and other telephone numbers within arm's reach. She has been confined to her wheelchair for 8 years. She uses a stroller sometimes and also owns a pair of crutches. She has not used the crutches for a long time. She fell once and so "she is now scared of using them." She has an emergency response buzzer which is activated at the Fire department and alerts the paramedics, who respond immediately, usually within 3 minutes. This was substantiated by the Chief of Fire Services who told the researcher of "a false alarm at this lady's apartment one morning, when she had accidentally bumped the buzzer and was not aware of this." This gentleman was not aware that the researcher knew this lady. Mrs. Barton was the second elderly person in whose home the researcher encountered this emergency alert buzzer, although there were several frail elderly persons living alone who demonstrated a need for these emergency buttons. Response to these alerts is one service provided by the Municipality, but many of the town's elderly persons are not aware of its existence.

Mrs. Barton takes care of all her ADLs but has a problem with washing her feet. A nurse visits once per week and
washes her feet on those visits. A cleaning lady from homemakers comes in on Thursdays. She receives meals-on-wheels because her doctor advised against her sitting in the wheelchair in front of the cooker to prepare her meals. Someone from homemakers comes in to pay her bills and her physician makes house calls. When the researcher visited her in October 1989, she reported that her doctor had not been in to see her that month and that when she called his office, his nurse informed her that he no longer made house calls. She was upset, since he had not informed her of this change. Formerly, a nurse from home nursing services visited her to take her blood pressure, but "she no longer comes either." The Older Americans Council "sends a van to collect her to go to the clinic, but she has stopped going because the current driver of the van refuses to come inside the apartment to get her in her wheelchair to take her to the hospital." Mrs. Barton reports that the driver claims that she is not supposed to enter the residence. She observes that the previous driver used to be more helpful and caring while the current driver is very inattentive. She attributes this to the fact that the previous driver was a black male, who probably empathized, stating that he would wish the same treatment for his mother should she find herself in this situation. The current driver is a white female.

Mrs. Barton uses physician's services, home nursing services, homemaker services, home chore services,
transportation services and meals-on-wheels. She is a good example of someone who relies almost exclusively on formal support services, and has been victimized by her informal support system. She receives Social Security, widows insurance, and receives Medicare health insurance. She used to receive $10 in food stamps but has ceased doing so since she experienced difficulty "getting them." She reports that she would have to pay someone $2 to go and get the Food Stamps and sometimes she could find no one to do so, so she now forgoes this service. Mrs. Barton claims that she should have received a widow's pension from the firm that her husband had worked for, for more than 22 years. She claims that lawyers, who had made promises to get this pension from the company, just "took all her money" without results.

Mrs. Barton also reports problems with her bank account, stating that her bank notified her that some person, or persons, had withdrawn over $1,000 from her account. She was informed after the fact; she had "not authorized anyone to do this and had not signed any checks for that amount." She notes that she had left all of her documents at her niece's house when she was evicted and thinks that this is the explanation. She also notes that she received phone calls from her bank, informing her that her niece wanted information about her account. She has now asked the bank not to give information or money to any unauthorized person or persons. Mrs. Barton is very alert, her home is very neat
and clean, and she takes care of herself on the days when she has no help. She performs all her ADLs and utilizes her telephone fully. She, however, complains of hearing problems which started about 6 months ago. She takes care of all her finances, administers her own medication, and prepares some meals. That is the limit of her IADL performance. A neighbor, another elderly lady, helps her with her shopping, and the children in the neighborhood come daily and put out her trash. She reports that she likes this arrangement with the children, since if anything happened to her they would be the first to know and could alert someone. She speaks of the cooperation of the lady who manages the apartments, and the help that another lady used to give her but no longer does.

Mrs. Barton is very happy with her current living arrangements. She "used to pay her niece $225 per month for a tiny room" and now she has "a nice comfortable apartment" all to herself. She sounds almost grateful to her niece for having evicted her, since she now "has peace of mind and is more relaxed" than she was when living with her niece.

Mrs. Barton has one son, who resides in Philadelphia, and one granddaughter. She has two nieces living within a 3-mile radius. She reported that when she first moved into her apartment, her nephew moved in with her. About 6 months after he moved in she had to ask him to leave because he was a drug user, and he used to have his drug-using friends "crowding her residence." She reports that she was always
very scared because she knew what drug addicts could and would do to obtain money to support their habit. She reports that he died about 5 months ago from a heart attack. Noninstitutionalized frail elderly persons depend on both the formal and the informal support network for services which will enable them to remain in their own homes. The type of support system most utilized depends upon factors such as living arrangements, available familial support, available community services, and available formal support services. Those elderly persons who have no relatives or close friends will be found to depend more on the formal support network for assistance in these situations. In these cases formal care is a substitute for the informal care that does not exist. It has been found that users of formal services are more likely to be female, older, former housewives, widows, and that they usually live alone (Chappell, 1985; Shanas, 1979). Mrs. Barton is one such elderly person who fits into the description of those elderly persons who is almost totally reliant on formal services for their well-being. Mrs. Barton, who does not receive many visitors, and spends a lot of time in her house is an example of how the formal support system can assist persons to live comfortably and dignified lives in their own homes. She was excited that soon she would be having house guests. She was looking forward to the visit of her son at Thanksgiving and
that of her granddaughter at Christmas. Mrs. Barton is almost totally dependent on the formal system.

**Vignette #4**

Although there are those elderly persons who are not intimidated with the Formal Support Network, some elderly persons are fearful of utilizing these services. Several factors account for this behavior, but culture seems to play an important role. Mr. Hines is one such frail elderly person. Mr. Hines is an example of an individual who is almost totally independent but who receives some assistance from the informal care system.

Mr. Hines is an 86-year-old widower who lives by himself in his own house. Mr. Hines used to be a chef. He moved to Eatonville 27 years ago. Mr. Hines has no children. He has no siblings or relatives living in the area. He has no family doctor, makes no visits to the doctor or to the clinic. He is the only respondent encountered by the researcher who did not have a family physician. He is in very poor health and is badly in need of medical assistance. He has no form of transportation and cannot help himself. The house in which Mr. Hines lives is dirty, smells bad, and it is very dark. He has a single light which is in the kitchen. There are no outside lights and no room lights. He had a space heater going in the hallway. Everywhere, the room was untidy and seemed overcrowded with junk.

The researcher visited Mr. Hines early one Saturday evening. She wanted to locate his house since several persons in the town had told her about the help that a local philanthropist had given to Mr. Hines. This gentleman had reroofed Mr. Hines' entire house and when he was interviewed by the researcher the next day, he told her that his crew had also cleaned out a section of the house and had also cleaned the yard. This philanthropist also told the researcher that he was the only person whom Mr. Hines would allow to do anything to his house.
Mr. Hines was ill when the researcher visited, and had not left his house for several days. He had no food in the house and had not eaten. He was very much in need of care. The researcher questioned his neighbors, who reported that they used to assist him. One neighbor claimed that her son used to clean the yard, and that she used to assist him with his laundry. She had to stop doing the laundry because the clothes were usually so dirty and smelly when she received them, that she could no longer take them to her house where she also had her small grandchildren. Her son had also stopped cleaning the yard and running errands because of Mr. Hines' behavior.

The neighbors seemed to have stopped their caring for several reasons. The main one was that Mr. Hines refused to seek medical help or the assistance of the Health and Rehabilitation Service or the County health service because he claimed that his house would be taken away from him, and he could not allow this to happen. The consensus among Mr. Hines' neighbors was that he belonged in a nursing home. Mr. Hines did not agree, however, since he was convinced that he would lose his house to the government. The researcher was accompanied by one of his neighbors to the store to purchase food for Mr. Hines. At a seminar, which the researcher had organized with the cooperation of one of the local churches for local church leaders and elderly persons the following Monday, the researcher called upon members of the community to help this gentleman. When the researcher returned to the community 2 weeks later, she was informed by this neighbor that Mr. Hines had been placed in a nursing home, because
there was just no one to take care of him, and he was incapable of doing it himself.

Prior to being institutionalized, Mr. Hines was totally dependent on the informal system even though his situation required the opposite. His could be an example where culture plays a major role and dominates his behavior. He does not even appear to have any friends.

**Vignette #5**

In many instances elderly persons in a community receive most of their assistance from persons in the community who are unrelated to them. These persons, who are termed "affiliated family," are unrelated persons who take on roles similar to those of relatives, joining in work or recreation (Strong and DeVault, 1989). Mrs. Gooden is a beneficiary of the affiliated family.

Mrs. Gooden is a 93-year-old widow who lives alone in her own house. Mrs. Gooden formerly owned the lot of land adjacent to her house along with the one her house is on, but she had to sell it to raise funds to pay her hospital bills. She has resided in Eatonville for 73 years. She has been married three times and widowed as many times. She has no children. She has brothers and sisters, also nieces and nephews whom she helped to rear and to whom she refers as "her" children. Mrs. Gooden is hypertensive and is on medication for her hypertension. She visits her doctor regularly. She also has problems with her legs, probably the result of arthritis. Mrs. Gooden has worked as a maid for "white folks." She has also been a seamstress. Most of her life however, was spent as a hairdresser. She had her own hairdressing salon at her house. Mrs. Gooden gets around her house with very little assistance.
Mrs. Gooden performs all her ADLs and one IADL—that of administering her own medication. She receives no assistance from her relatives. However, she has friends who come in and bathe her and help her get dressed sometimes. She has a hairstylist who comes every two weeks to take care of her hair. She combs it herself daily. She does all her ‘small’ laundry. After being in hospital once, she recuperated in a small nursing home owned by a lady who has since become a good friend. This lady continued to take care of Mrs. Gooden’s laundry for her a long time after her discharge from the nursing home. Recently this lady has had some problems with arthritis in her hands and can no longer do the laundry. Different people come to clean her house. She does a little each day herself.

There was a lady, Miss Chambers, whom Mrs. Gooden claims lived with her for a long time; yet she never paid rent, nor offered to help with the utilities, or garbage bills. It was “this” lady, whom Mrs. Gooden had learned to love, who “turned her back on her” at the end, and who was responsible for Mrs. Gooden nearly losing her home. When Mrs. Gooden was hospitalized six years ago, Miss Chambers did not get all her mail to her. Among these were the tax notices for her property. These notices had to be signed and returned to the collector of taxes. The next thing that Mrs. Gooden knew, she was about to be evicted from her home because her tax debt had been sold to someone. This person was kind enough to call her and apprise her about the situation. Mrs. Gooden with no relatives or friends to help her was distraught. Two ladies in the community, who knew Mrs. Gooden only as a member of the community, heard about her plight and took up the challenge to save Mrs. Gooden’s home. They contacted six churches in the community and asked for financial help so that they could pay off Mrs. Gooden’s tax debt thus enabling
Baptist Church—along with Mrs. Binns and Mrs. Sinclair, to discuss the problem since both caretakers agree that some legal advice is needed. "Those churches that do not want to be involved will be given the opportunity to say whether or not they want to remain in the will. Those that agree to remain in the will must come together and retain a lawyer to do the necessary legal work to avoid any problems in case anything should happen to Mrs. Gooden." Mrs. Binns stated that at a previous meeting some good suggestions had been made about the future of the "little" house. It was suggested that it should be kept "working for the community." A board of directors could be set up, and it could be used for purposes such as temporary residence for a homeless family or for families who had lost their home through a fire or whose home was being repaired, or it could be used for some youth activities. The churches would support it. No one would receive any money from it.

Mrs. Binns, who works for the municipality, reports that the police check on Mrs. Gooden's home every night because she has been there by herself for years. This supports information supplied to the researcher by the Chief of Police regarding services provided for elderly persons in Eatonville.

Mrs. Sinclair, the second caregiver, is married and works part-time. The nature of her work enables her to
assist Mrs. Gooden during the day whenever there is need. 
She speaks of having "adopted" Mrs. Gooden. She does 
for her out of the kindness of her heart, not for any reward. 
She has known Mrs. Gooden for several years. As an elderly 
person, "her heart goes out to her." She states 

It seems people no longer have time to help out 
others, so two years ago I took Mrs. Gooden on as a 
project. I take care of all her business since she 
is in her 94th year. She has sisters and brothers 
and nieces and nephews. She also has relatives 
living here in town including a brother who goes 
around every now and then, but no one does anything 
for her.

Mrs. Sinclair does all of Mrs. Gooden's shopping and 
most of her laundry. While Mrs. Sinclair's mother was 
staying with her last year, someone else took care of Mrs. 
Gooden's laundry, but now that her "mom" is no longer with 
her she has started once more to take care of the laundry. 
Every now and then, she transports her to the doctor, "but 
there are taxi cabs which Medicaid supplies to take these 
elderly people to their doctors and other appointments."

About 3 weeks ago Mrs. Sinclair drove Mrs. Gooden to get her 
glasses. She also does all her banking for her. With 
reference to the problems that Mrs. Gooden had experienced 
with her house, Mrs. Sinclair's response was 

Mrs. Gooden had failed to sign and return the 
document for her homestead exemption. A card is 
sent each year, and if this is not signed and 
returned to the collector of taxes by April, there 
is an announcement in the newspaper and people 
start watching for this with the intention of 
purchasing the certificates towards ownership of 
the property. The tax office then sends a notice 
of reminder. This is the office in Orlando and has
nothing to do with the Eatonville Town Hall. If there is still no response, the certificate is sold to anyone who wants to purchase it. This person then sends a notice to the homeowner that if the taxes are not paid he or she would purchase the property.

When Mrs. Sinclair and Mrs. Binns, the co-caregiver, heard about the situation, they approached the churches in the community and they all came up with the money so that "Mrs. Gooden would not lose her home."

Mrs. Sinclair supervised the assessment made for repairs to be done to Mrs. Gooden's house by meals-on-wheels, a division of the Older Americans Council and the Department of Community Affairs, when they came to evaluate the amount of work that needed to be done. This involved the replacement of windows and doors. Mrs. Gooden had experienced problems from persons who had tried to break into her house, having the knowledge that she was old and lived alone. She also lived in a section of town that was experiencing tremendous problems with those involved with crack cocaine. There was also work to be done to repair a leak in the kitchen. Mrs. Sinclair contacted the department that has responsibility for this. She was happy that all of this work would be done at no cost to Mrs. Gooden. Mrs. Sinclair visits Mrs. Gooden once or twice per week. She is concerned that Mrs. Gooden is on her own.

She needs someone to stay with her but we have not been able to find the right person. She (Mrs. Gooden) would like to have a couple living in with her. She has two bedrooms. She doesn't go to church anymore since she has a bladder problem.
She really wants to attend church, but it just is not convenient.

Mrs. Sinclair had another elderly lady whom she used to assist with going to the grocery store and shopping, etc. She had "to give it up" as it proved to be too burdensome; she found it hard to cope. She also has to give some assistance with transportation to her 83-year-old mother-in-law. She worries about being unable to do what she would like to do "for these senior citizens" but "there is just too much. I have been trying to get others from my church to help out, especially the younger people, who could go around and see what assistance they could give to help out the elderly in the community."

Mrs. Sinclair is a kind person whose children are all grown. She lives with her husband who has a night job. She is employed as a school-crossing guard and works part-time at a laundromat which is owned by her sister-in-law. She is a Deaconess in her church and is also the church recording secretary. Close friends of Mrs. Sinclair report that for several years Mrs. Sinclair would not learn to drive. Because she did not have a driver's license, she had to rely on her friends for transportation. They persuaded her to learn although she was at an advanced age, and she did. Mrs. Sinclair admits all of this, and in her sweet way remarked, "Now that I can drive myself I can help several others, especially senior citizens, by providing them with transportation."
Mrs. Gooden depends on both the formal and the informal systems. Her main dependence is, however, on the informal system in the form of "affiliated family" or "fictive kin." She demonstrates medium awareness of the formal support system. She has had house repairs through the formal system and enjoys meals-on-wheels.

Vignette #6

Mrs. Hammond is an 86-year-old widow. She is the oldest living native resident of the community. She lives in her own home. It used to belong to her parents, along with the lot alongside it. She gave this lot to her stepdaughter, who sold it. This has upset Mrs. Hammond very much. Mrs. Hammond states that it is traditional that family-owned land in Eatonville be handed down so that families will always be neighbors. This was evident with several homes that were visited by the researcher. The neighbors were related. They were either siblings or otherwise related. Mrs. Hammond's neighbor, on the other side, is a cousin. Widowed for several years, Mrs. Hammond used to share her home with her only son until his death in 1987. He was her only child and she still grieves for him. For approximately 2 years now, Mrs. Hammond has had a lodger who is also a senior citizen. She has a lodger "because she cannot live alone anymore." Mrs. Hammond, without realizing it, is practicing a simple form of shared housing which benefits both herself and her lodger (Streib et al., 1984).
Despite her health problems, Mrs. Hammond is an active person who until 1 year ago still drove her car. She stopped driving because of problems with gout in her legs and the loss of sight in one eye. Mrs. Hammond is hypertensive and suffers from arthritis. Her arthritis, she reports, is her main problem. She is on medication for arthritis, hypertension, and gout. Some years ago she fell and hurt her hip but never had it treated. She uses ace bandages because of the swelling that she experiences in her legs. She has slight hearing problems. She has had surgery on her left eye for cataracts and now sees very well with that eye. However, she lost her sight in her right eye because of glaucoma. She visits the eye clinic in Altamonte Springs where she has been going for some time, and where she had her eye surgery performed. In February of this year, Mrs. Hammond had surgery for breast cancer. During her recuperation at home, a nurse visited her daily to give her a bath, etc. At that time too, her niece, who lives in the community, took a 2-week vacation to take care of her. Mrs. Hammond performs all of her ADLs and all IADLs excepting her yard work with which she gets some assistance from her nephew when he is well enough. He too is a senior citizen, and he suffers from chronic respiratory disease. Mrs. Hammond reports that she exercises in her bed in the mornings before getting up. She also takes walks along her street daily, but she has a little problem walking and has to be careful not to fall. She
Mrs. Hammond used to be a beautician. In her early years she "held jobs such as housekeeper and companion to a writer." She receives Social Security, and Medicare. Her Social Security income is her only income. She subsidizes this with the small amount she receives from rent. Because of her meager income, she has to prioritize her expenditures. Sometimes she cannot fill her prescriptions "because the medications are so expensive." After paying her water bill and her utility bills she has very little left over for food and transportation. She showed the researcher four bottles of medication and tells her how much she has to spend per month.

Mrs. Hammond has several relatives living in the community. However, she is most dependent on her 75-year-old stepdaughter who has a car and helps her out with transportation. Her stepdaughter, whom she raised, sometimes takes her to church. But since Mrs. Hammond has started attending the early church services, she either walks or a friend takes her. Mrs. Hammond's stepdaughter worries a lot about her and, whenever Mrs. Hammond is ill, she has her move
her to retain her home. This they were able to achieve, and Mrs. Gooden is very grateful.

Thanks to the generosity of the people in her community, Mrs. Gooden was saved from eviction from her home. Mrs. Gooden, in a gesture of gratitude, has willed her house and property to these six churches. She was advised by Miss Chambers to remove the churches from her will, but this she refused to do. Mrs. Gooden reports that Miss Chambers told her that she had a lawyer who could remove the churches from her will since she had too many people in her will. Mrs. Gooden refused to comply with Miss Chambers' advice.

Mrs. Gooden's two caregivers, Mrs. Binns and Mrs. Sinclair, are happy to be assisting her. They are not related to her and are not even close family friends. They are what some refer to as "fictive kin." They speak about Mrs. Gooden with reverence and compassion. The two ladies divide the assistance that is needed between them. Mrs. Binns holds an office position, and so she handles all the "paper" work. She reports that Mrs. Sinclair takes care of the day-to-day necessities. Mrs. Binns has been "involved" with Mrs. Gooden for about 3 years. She reports that Mrs. Gooden has no relatives who have come forward to assist her. Mrs. Binns documented the request of Mrs. Gooden and has sent a copy to all the churches involved.

The Tuesday following the Sunday on which the researcher interviewed Mrs. Binns, there was to be a meeting with the pastor of the town's largest church—Macedonia Missionary
in with her. Mrs. Hammond reports that "that worked before she felt that her age no longer allowed her to move into someone else's house." She prefers to be "in her own home whenever she is ill."

Her stepdaughter also has the problem of being a caregiver to a very old aunt who is nearing 100 years of age, and for whom she is totally responsible. She does all her shopping, etc., and actually performs most of her IADLS. This stepdaughter is very stressed from having the responsibility for these two older relatives. Mrs. Hammond reports that this is the reason why "she withholds information about her health from her stepdaughter." She feels that her stepdaughter has too much to cope with. This stepdaughter is widowed, hypertensive, has a history of respiratory disease, and has problems with her knees. She has had complete knee replacements and her problems have recently recurred, forcing her into hospital for more surgery.

Prior to her breast surgery, Mrs. Hammond attended the senior citizens daycare center every day. She always drove herself. When she stopped driving she was picked up by the bus that was available for the center. Now, "I just do not feel up to it" she states. It was at the center that the researcher first met Mrs. Hammond 3 years ago. She has been a participant at the center since its inception. She is an active member of three social clubs, including the Key Chain...
Club, which is a charity club having a maximum membership of 25. These members are "all Christian women," she states, and everyone cares for each other. There is a long waiting list of potential members. The annual membership subscription is $10. The meetings are held in the Winter Park Women's Club building, and the Key Chain Club pays an annual fee of $200 to the women's club for use of its facilities. The three clubs to which Mrs. Hammond belongs are mainly charity clubs dedicated to doing charity work in their community. The members are all black women. These clubs are not, however, in the geographical district of Eatonville but are in nearby Winter Park.

Mrs. Hammond started the Black Beautician's Club in 1946 and was its president for 14 years. This group disbanded in the 1970s. Mrs. Hammond has a display of trophies which she received from state conventions, and the local municipality. Mrs. Hammond is transported to club meetings by friends who take her shopping after meetings. Sometimes they even go to visit other elderly residents who are known to be ailing. This assistance with transportation means a lot to Mrs. Hammond.

Mrs. Hammond is replete with history of the community. She knows all the older members of the community and their families. She was able to tell the researcher where the founding fathers of Eatonville were buried, at the corner of West and Eaton Streets. This is a small "burial ground"
which is not obvious as such because the graves are unmarked and there are no tombstones and no signs. The younger generation is not aware of its existence and, some years ago, it was divided in half, and houses now stand on a section of it. This, Mrs. Hammond notes, was due to a lack of knowledge because most of the then political administration were not even aware of its significance. However, when the town council recently tried to use the other section as a playground Mrs. Hammond says that she objected and had to attend a council meeting to have this revoked.

Mrs. Hammond receives a small amount of support from both the formal and the informal systems. She however does not like to "trouble anyone" and so tries to live an independent life. Mrs. Hammond worries about her dependency. This worry could be explained in terms of nonreciprocal roles.

The above vignettes present the qualitative analysis of the findings of the research which was primarily based on in-depth interviews conducted by the researcher. These vignettes are employed to illustrate how some of the elderly persons in the community of Eatonville utilize support services. The findings indicate that elderly persons who reside in the Town of Eatonville receive care from both the formal and the informal support networks. The level of dependence is on a continuum from none to completely dependent (Figure 5-1). From these vignettes, it can be
Figure 5-1: Diagram showing the combinations of level of dependence and type of support described in each of the six vignettes of elderly persons in the community.
deduced that elderly black persons are a non-homogeneous group. Nearly all research on elderly persons, generally, and caregiving, specifically, treat the elderly as a homogeneous group despite the fact that the literature shows that differences should exist. The vignettes presented support the theories that elderly persons, and especially black elderly persons, are not a homogeneous group. Having presented the Vignettes as a way of capturing the essence of the qualitative data, we now turn to the kind of information that was gained from the quantitative analysis of the interviews.

Quantitative Descriptive Analysis

Table 5-1 delineates characteristics of all 71 respondents in the sample of elderly persons. Of the respondents, 35.2 percent (n=25) are males and 64.8 percent (n=46) are females. In terms of age, and in keeping with current usage in the gerontological literature, the sample is made up of the old, 56.3 percent (n=40), the old-old 32.4 percent (n=23), and the oldest-old 11.27 percent (n=8). The average age is 74.6 years, and 43.7 percent (n=31) are 75 years or older. If the "cross-over" phenomenon is applied, then of those who are 75 years old, many will probably live for another 10 or 15 years. The findings from this research will be analyzed under three major headings. These are (1) family, (2) impairments, and (3) caregiving.
Table 5-1: Characteristics of Eatonville's Black Elderly Sample

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Table 5-1—continued

<table>
<thead>
<tr>
<th>Characteristics</th>
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<tr>
<td>CARE RECEIVER</td>
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<tr>
<td>CAREGIVER</td>
<td>30</td>
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<tr>
<td>FORMAL SUPPORT:</td>
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<tr>
<td>Medicare</td>
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<td>Medicaid</td>
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<td>Food Stamps</td>
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<td>Day Care</td>
<td>16</td>
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<tr>
<td>Other</td>
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<td>23.9</td>
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<tr>
<td>Spouse</td>
<td>11</td>
<td>15.5</td>
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<tr>
<td>Children</td>
<td>23</td>
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<td>36.6</td>
</tr>
<tr>
<td>Neighbors and Friends</td>
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<td>OTHER AGENCY AWARENESS:</td>
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<td>14.1</td>
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<tr>
<td>MEAL AWARENESS:</td>
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<td></td>
</tr>
<tr>
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<td>27</td>
<td>38.0</td>
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<tr>
<td>Medium</td>
<td>28</td>
<td>39.4</td>
</tr>
<tr>
<td>Low</td>
<td>16</td>
<td>22.5</td>
</tr>
<tr>
<td>MORE HELP NEEDED</td>
<td>23</td>
<td>32.4</td>
</tr>
<tr>
<td>NEED HELP</td>
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<td>45.1</td>
</tr>
<tr>
<td>FORMAL SUPPORT:</td>
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<td></td>
</tr>
<tr>
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</tr>
<tr>
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<td>35</td>
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<td>INFORMAL SUPPORT:</td>
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<td>26.8</td>
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<td>23</td>
<td>32.4</td>
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<td>11</td>
<td>15.5</td>
</tr>
<tr>
<td>Four</td>
<td>5</td>
<td>7.0</td>
</tr>
<tr>
<td>Five</td>
<td>1</td>
<td>1.4</td>
</tr>
</tbody>
</table>
Family

The family plays a critical role in providing informal support for its elderly members. This, however, is not the total extent of the family's involvement in caregiving for elderly persons, in that family members who are a major source of assistance for impaired elders are likely to influence the elders' use of formal services (Bass and Noelker, 1987). The support that families give to their elderly relatives is examined, and the findings are presented under the headings of offspring (children and grandchildren) and living siblings, migration, economics, occupation and work, income source, and marital and living arrangements. Information regarding the place of birth was also found to be useful since in many instances this determined proximity of family members which in turn influenced the frequency of visits to frail elderly persons.

Children, grandchildren and siblings

Sixty-nine of the 71 in the sample reported having from 0 to 11 children (Table 5-2). (There were two who furnished no information.) The average number of living children based upon the 69 who reported is 3.2. These children are reported to be living as far away as California and as close as Orlando. Some were even residents of Eatonville who lived within walking distance of their parents.

The number of grandchildren reported ranged from 0 to 22. Forty were not able to report how many grandchildren
Table 5-2: Summary Table of Elderly Sample by Offspring and Siblings

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER OF LIVING CHILDREN:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>11</td>
<td>15.9</td>
</tr>
<tr>
<td>One</td>
<td>16</td>
<td>23.2</td>
</tr>
<tr>
<td>Two</td>
<td>11</td>
<td>15.9</td>
</tr>
<tr>
<td>Three</td>
<td>8</td>
<td>11.6</td>
</tr>
<tr>
<td>Four</td>
<td>6</td>
<td>8.7</td>
</tr>
<tr>
<td>Five</td>
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<td>1.4</td>
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<td>Six</td>
<td>3</td>
<td>4.3</td>
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<tr>
<td>Seven</td>
<td>3</td>
<td>4.3</td>
</tr>
<tr>
<td>Eight</td>
<td>4</td>
<td>5.8</td>
</tr>
<tr>
<td>Nine</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>Ten</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Eleven</td>
<td>3</td>
<td>4.3</td>
</tr>
<tr>
<td>Unreported</td>
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<td>2.9</td>
</tr>
<tr>
<td>NUMBER OF GRANDCHILDREN:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>16</td>
<td>51.6*</td>
</tr>
<tr>
<td>One</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td>Two</td>
<td>3</td>
<td>9.7</td>
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<tr>
<td>Three</td>
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<td>9.7</td>
</tr>
<tr>
<td>Six</td>
<td>1</td>
<td>3.2</td>
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<tr>
<td>Nine</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>Ten</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>Twenty-one</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td>Twenty-two</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td>NUMBER OF SIBLINGS ALIVE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>37</td>
<td>52.1</td>
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<td>Six</td>
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<td>1.4</td>
</tr>
<tr>
<td>Eight</td>
<td>1</td>
<td>1.4</td>
</tr>
</tbody>
</table>

*This could be the result of loss of contact with children.
they had because their children had either moved away or had not kept in touch with them. One gentleman reported that his wife had left him over 40 years ago taking the children with her, and that he had not seen them since. He, however, reported that one child calls him on the phone quite frequently. Another male reported a similar situation. Even those who had reported none seemed uncertain of the validity of their statements because of similar situations. They had lost touch with children who were living in other states, long distances away, and so they were not aware of the number of the grandchildren they had. The average number of grandchildren based upon the 31 who reported is 4.13. Some respondents have children and grandchildren forming a part of their households.

The number of siblings documented in Table 5-2 represents living siblings. A total of 52.1 percent (n=37) reported no living siblings. The remaining 47.9 percent (n=34) reported a number of siblings ranging from one to eight. The average number of living siblings is 1.15. Using averages in this situation is only an exercise. Based upon the ages of the respondents, it is expected that most of their siblings would be deceased. The averages were obtained purely to estimate some kinship relations regarding caregiving. Siblings usually form a good support group in most instances and in some instances are providing various
types of support to some of the elderly persons in Eatonville.

One such case is a recently widowed male, Mr. Foster, whose younger sister helps him with meal preparation and house cleaning. Mr. Foster suffers from chronic respiratory problems. His 86-year-old aunt also gives him assistance in meal preparation. When he is well he assists his aunt by cleaning her yard and sometimes driving her to the store.

Another person, Mrs. James, is alone most of the time. She has an adopted grandson who is a drug addict and is unreliable as a housemate. She relies upon her sister who lives about one mile away, mainly for moral support. Mrs. James' husband suffers from Alzheimer's disease and resides in a nursing home in nearby Winter Park.

There are several other cases: Mrs. Downer, a divorcee, has a sister who lives across the road from her, and who spends a lot of time with her. The sister of Mr. Hewan, who is a bilateral amputee and wheelchair-bound, takes care of him on a full-time basis. He is separated and she is divorced. Others report siblings in other parts of Florida with whom they keep in touch, while others report regular telephone conversations with siblings who reside in other states.

Migration

Only 7 percent (n=5) of those in the elderly sample was born in the Town of Eatonville; 49.3 percent or (n=35) of the
respondents were born in the state of Florida. The majority of those not born in Florida, 39.4 percent (n=28) were born in Georgia. Of the remaining 8 persons in the sample, 2 each were born in Alabama and Virginia, and 1 each in Jamaica, West Indies, Mississippi, New York, and Pennsylvania. Among those from other states who had migrated to Eatonville in the early years, some had relatives who had visited this all black community and had spoken highly of Hungerford school; consequently, they had moved to Eatonville, because they wanted their children to receive a good education in a nonsegregated school. I found that most of the relatives of these elderly persons were living some distance away and were not able to visit as often as their elderly relatives would wish. Some of these elderly persons have been instrumental in having their relatives relocate to Eatonville or to other parts of Florida. This was the method used to bring Mrs. Thane and her family to Eatonville.

Mrs. Thane, who is 84 years old and was born in Georgia, has resided in Eatonville for 58 years. She tells of the circumstances that led her and her family to move there. She states that both of her parents had moved to Eatonville in the early years of its founding. After her husband visited them by himself, he decided to make it his home. He returned to Georgia for her and their seven children. She tells of how impressed her husband was with everything here: the low cost of land, the schools and the fact that it was an
all-black community. She had to work very hard to assist her husband with the children and to enable them to get a good education. Today, all her children are either professionals or paraprofessionals. Mrs. Thane continues to work in nearby Winter Park as evening companion to an elderly white lady who is not allowed to be on her own. She is also an avid gardener growing her own vegetables which she sometimes sells.

Other residents had fallen in love and married Floridians who settled in Eatonville after their parents purchased land there.

Occupation and work

The position of Eatonville, surrounded by the white dominated communities of Maitland and Winter Park has meant that many of its residents, most of whom were found to be either blue collar or service workers (Table 5-3), would be assured work in the homes of white families as maids and gardeners. Others would find work in Daytona Beach and Orlando. Some worked on roads while others were truck drivers.

Findings regarding previous or current occupation revealed that only one person fell into the higher executive classification (Table 5-3). This was the mayor of the town, who was also the president of the largest private organization in the town, Eatonville Diversified. Two people (2.8 percent) were administrators and lesser professionals,
Table 5-3: Current and/or Previous Occupation

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>SCORE</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher executives...Mayor</td>
<td>9</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Administrators and lesser professionals</td>
<td>8</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td>Minor professionals Managers, small business</td>
<td>7</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Semiprofessionals</td>
<td>6</td>
<td>8</td>
<td>11.3</td>
</tr>
<tr>
<td>Clerical &amp; sales workers</td>
<td>5</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td>Skilled manual, small business, homemakers</td>
<td>4</td>
<td>12</td>
<td>16.9</td>
</tr>
<tr>
<td>Semi-skilled</td>
<td>3</td>
<td>17</td>
<td>23.9</td>
</tr>
<tr>
<td>Unskilled score</td>
<td>2</td>
<td>13</td>
<td>18.3</td>
</tr>
<tr>
<td>Menial service</td>
<td>1</td>
<td>15</td>
<td>21.1</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
<td>99.9</td>
<td></td>
</tr>
</tbody>
</table>

Classifications are based on the Hollingshead Occupational Scale
while 23.9 percent (n=17) were semi-skilled, 18.3 percent (n=13) were unskilled and 16.9 percent were skilled manual workers or owned small businesses.

**Income source**

Most of these elderly persons were dependent on Social Security alone as their source of income. Of the total 94.4 percent (n=67) were receiving Social Security, and for 43.7 percent (n=31) Social Security was their only source of income. Only 25.4 percent (n=18) were receiving any form of pension. Income from a combination of Social Security and Pension was available to 16.9 percent (n=12). Of the total, 12.7 percent (n=9) were receiving SSI and only 1.4 percent (n=1) had this benefit as the only source of income. Seven percent (n=5) were receiving both Social Security and SSI, while one person had income from a combination of Social Security, SSI, and a Veteran's benefit from her husband who was institutionalized. Nearly one-third 29.6 percent (n=21) were currently working to enhance household income. The majority were doing housework 1 or 2 days per week. This number included two ladies who were over 80 years old. Two single-person households were receiving rental supplements, one was receiving an energy supplement, and two persons who were raising young children were receiving AFDC as well as Social Security. One of these was a widow with a young orphaned grandson attending school, and the other a couple with twin great grandchildren.
From the above data, and based on observation, except for one elderly lady, persons receiving SSI were only those whose Social Security payments were so low that they were also entitled to SSI. One isolated case was found where one respondent was receiving SSI only. The explanation for this was that there was a problem in establishing her date of birth. No documentation of her date of birth can be located, hence she cannot receive Social Security. She has lived in Eatonville 54 of her 68 years and has attended schools in the State of Florida only.

The majority of black persons, who today are elderly, were employed in low paying jobs while they were full time in the labor force. The result of this is that they are still as poor today as they were then. They subsist on small Social Security incomes which is inadequate for their everyday expenses. One way that government could alleviate their economic situation is to supplement this income with SSI for everyone found in this situation. However, very few of them qualify for this grant. The fact that more of Eatonville's elderly population are not eligible for SSI could be attributed to home ownership, since many of them own houses (it was pointed out earlier that many inherited modest homes) and are therefore ruled ineligible by virtue of the value of these homes. The small numbers receiving a pension is an added indication that not only were these jobs low-paying but they were not tenured. The data in Table 5-3 show
that most (63.4 percent) had an occupation classification of 3 or less indicating that they were either semi-skilled (23.9 percent, n=17), unskilled (18.3 percent, n=13) or performing menial service (21.1 percent, n=15). As noted earlier, the majority worked in homes in nearby affluent towns.

Education, or the lack of it, was a large contributor to the economic situation of these elderly persons. Most had been educated to the elementary school level only, and only one elderly male was found to be functionally illiterate. This gentleman had, however, been employed as a truck driver most of his life.

Although the economic situation of these elderly persons forced them to live relatively simple lives it was found that except for two persons, all were visiting their physicians regularly. Most of these visits were for treatment for some form of chronic disease. They were benefitting from some form of health insurance in the form of medicare or medicaid, but they had to pay for their medications and some were taking several different pills. Many were unable to afford to pay for these medications on their small Social Security income. Mrs. Hammond explained her predicament in these terms: "I do not always fill my prescription. I first pay my utility bills and all others, then I purchase my groceries and if there is anything left over I will have the prescription filled." This was echoed throughout the community.
Marital and living arrangements

Findings regarding marital and living arrangements are presented in Table 5-4 and discussed under (1) home and landownership and (2) household composition. Of the 71 elderly persons studied 39.4 percent (n=28) are married, and 46.5 percent (n=33) are widowed (Table 5-4). There is an equal number of those who are divorced and separated, that is 5.6 percent (n=4) of each category. Only 2.8 percent (n=2) have never been married. A breakdown of those who are married (Table 5-4) reveals that there were 13 females and 15 males, that is, approximately an equal number of both sexes are married. Of those who are widowed, however, 81.8 percent (n=27) are females. The proportion of those living alone (35.2 percent, n=25) reveals that 76 percent (n=19) are widowed and that, of the widowed living alone, 78.9 percent (n=15) are female.

Home and land ownership

Home ownership is an important feature of the residents of Eatonville. 77.5 percent (n=55) own their own homes and less than a quarter (22.5 percent, n=16) are renters of their residence. Of those who are renters, 37.5 percent (n=6) live in low-income housing, one person lives in an ACLF, and one is a lodger with another elderly person who is widowed, (an arrangement which could be classified as 'share a home') in the gerontological literature. One person lives in a house rented from her son, and one lives in a granny flat for which
Table 5-4: Summary Table of Marital, Residence and Household Status

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
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<tr>
<td><strong>MARITAL STATUS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>28</td>
<td>39.4</td>
</tr>
<tr>
<td>Widowed</td>
<td>33</td>
<td>46.5</td>
</tr>
<tr>
<td>Divorced</td>
<td>4</td>
<td>5.6</td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
<td>5.6</td>
</tr>
<tr>
<td>Never Married</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td><strong>PLACE OF BIRTH:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Born in Eatonville</td>
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<td>7.0</td>
</tr>
<tr>
<td>Born in Florida</td>
<td>35</td>
<td>49.3</td>
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<tr>
<td><strong>HOME OWNERSHIP:</strong></td>
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<td></td>
</tr>
<tr>
<td>Own</td>
<td>55</td>
<td>77.5</td>
</tr>
<tr>
<td>Rent</td>
<td>16</td>
<td>22.5</td>
</tr>
<tr>
<td><strong>NUMBER IN HOUSEHOLD:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>25</td>
<td>35.2</td>
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<tr>
<td>Two</td>
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<td>35.2</td>
</tr>
<tr>
<td>Three</td>
<td>8</td>
<td>11.3</td>
</tr>
<tr>
<td>Four</td>
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<td>11.3</td>
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<tr>
<td>Five</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td>Six</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Seven</td>
<td>3</td>
<td>4.2</td>
</tr>
</tbody>
</table>

Average No. in Household = 2.07
she pays rent to her daughter. In addition, two females, one widowed and one divorced, and both aged 76 years, live alone as do two males, one of them receiving a rental subsidy for the house which he rents. The one male who owns his own home lives in a trailer in his backyard while renting out his three-bedroom house on the same premises. He is recently widowed, and found the house too large for a single male.

Black ownership of all the land in Eatonville was found to be very important to its residents. Those who purchased land in the early days had obtained double lots and even today some of these double lots are visible. Some have given the second lot to their children who have built houses on them resulting in siblings and children often found to be neighbors. Those who sold the second lots traditionally did so to relatives or other black persons. One 86-year-old respondent who was born in Eatonville complained bitterly when she discovered that her stepdaughter had sold the land she had given to her to someone outside of the family. She felt that it should have been handed down to a relative, or if it had to be sold it should have been sold to a relative. It is also not unusual to see cousins as neighbors, based upon how the people of Eatonville feel about their property. As the Mayor remarked when he was asked by the researcher about retirement facilities for elderly persons: "This is a closeknit community, people take care of one another, and
those who own houses remain in them until they die, then they pass them on to family members" (Interview, May 1986).

**Household composition**

Information regarding who shares the home with an elderly person or with elderly couples is found to be important when considering caregiving or carereceiving. Are the elderly persons the primary residents or are they the secondary residents, that is, did they move into the household of a child or other relative or did a child or other relative move into the home of the elderly person?

There was only one situation found where an elderly person had moved in with an adult child. This elderly person was Mrs. Hewan. She is 95 years old and has been widowed for 10 years. She formerly resided in an ACLF in Winter Park along with her husband. Upon the death of her husband she moved to Eatonville to live with her adult daughter and grandson.

When the residences were classified into households by the researcher, the 71 elderly persons studied were found to reside in 57 homes but there were 58 households according to economic arrangement. This is because one elderly male resides in the residence of another elderly person but only as a paying lodger. They operate separate household accounts. For the purposes of computing various statistics only 57 households will be used for analysis since household finances in terms of actual dollars are not included in the study.
Of the 57 elderly households, 43.9 percent (n=25) represent elderly persons who are living alone. It was found that 35.2 percent of the sample lived alone, and that 72 percent (n=18) of these are females.

Fourteen percent (n=8) of the households were made up of married couples living by themselves. In six of these households, both spouses were over 65 years old, but in the other two, the husbands were over 65 years while the wives were younger women, both in their fifties, who spend most of their time taking care of their elderly husbands. One of these husbands is in an advanced stage of Alzheimer's disease, while the other is disabled and suffers severe attacks of seizures. The wife of the elderly male who suffers from seizures is herself disabled according to HRS standards since she suffers from chronic respiratory disease and is unable to perform most of the Instrumental Activities of Daily Living.

Of these elderly persons 12.3 percent (n=7) had others besides spouses in their households and 29.9 percent (n=17) had others living in their homes but had no spouses. All of the households which included others other than spouses were female headed. Relatives living with these elderly persons were mainly grandchildren and great grandchildren for whom these elderly persons had assumed total responsibility. This is a situation which is pervasive throughout black households in the United States and represents what has been termed
"informal adoption" (Hill, 1972). The importance of the informal adoption network among black families has been functional in that it has been found to solidify and tighten kinship bonds since many black women are reluctant to put their children up for adoption. It has been suggested also, that "when they are formally placed, black children are more likely than white children to be adopted by relatives" (Hill, 1972:7).

A breakdown of the families of elderly persons found in Eatonville by household composition, revealed a departure from what is found in the gerontological literature regarding living arrangements. The situation is usually that the older person moves in with a younger member of the family, in most instances a child. The opposite situation of younger relatives moving in with the elderly person was found, which led the researcher to abandon classical models of elderly living arrangements and instead develop a 14 category classification model. This seemed to find application in and to better describe the situation which obtains in Eatonville. The researcher embarked upon this exercise because she was interested in seeing who was taking care of whom in these elderly households.

Based upon their composition, the households of elderly persons in Eatonville are found to be comprised of the following: (1) Single persons only; (2) husband and wife only (n=8); (3) husband, wife and adult child or children
(n=2); (4) husband, wife, adult child, and children of adult child (n=1); (5) husband, wife and grandchildren only (n=1); (6) husband, wife and great grandchildren under 15 years old (n=1); (7) widow and adult female child only (n=1), widower and adult female child only (n=1); (8) widow, adult child and grandchild (n=1); (9) widow with grandchildren only (n=4); (10) widow with great grand children only (n=1). The researcher felt that this particular arrangement needed to be isolated, in that elderly persons who have great grandchildren living with them find themselves returning to what marriage and the family theorists refer to as the youthful phase of the family life cycle, in that these children are usually of school age and place strong demands on their caregivers (Strong and DeVault, 1989). In this instance the child was a 16-year-old girl who was attending the local high school; (11) widow with grandchild/children plus greatgrandchild/children (n=3). One of these, Mrs. Walker had raised the grandchild since she was 2 years old. (12) Females alone with other than offspring (n=3). One of these ladies has a teenage niece living with her and she reports that this child has lived with her since she was a very small girl. Another elderly lady has an adopted teenaged grandson with a drug problem. He has lived with her since he was a baby. The third lady in this group has a male cousin, his wife and his son in residence. The cousin's wife is her paid caregiver. (13) Mixed households (n=1). These
households are termed mixed by the researcher because they comprise both offspring of the elderly person as well as nonrelated persons. The head of the household in this case is a divorcée. Her adult daughter, the daughter's two children and three foster children, make up the household. Only one such household was found; (14) Never married elderly person with relatives or nonrelatives (n=1). In the only situation found, this lady's home is a licensed foster home and she had one adult foster person in residence. He is retarded and has been in her care for over 15 years.

Each household had its own peculiarity. The ones that were particularly distressing were the households where elderly persons were taking care of great grandchildren (n=4) on their own. These were children attending school and the heavy responsibility that this brings with it is familiar to all. In one instance the caregivers were two elderly persons over the age of 80 years. Not only were these two elderly persons overburdened, although they loved these children and loved caring for them, but they were constantly in fear that harm might come to the children. Their greatest fear was associated with the major drug problem that the town was experiencing. They were fearful of the children being kidnapped. So paranoid were they that they would not even send the children to the store on their own. They complained bitterly about the absence of their son, the children's grandfather. They had not seen him in a very long time.
although he resided in Tampa. The parents of the children did not visit or send monetary support at any time. This is a situation which the researcher repeatedly observed throughout this study.

As mentioned earlier, 25 households had single persons only, 8 had married couples only, and 1 had two nonrelated elderly persons sharing a home. This reveals that 24 households comprised elderly persons and their offspring. Only three of these households had children of elderly respondents residing in them; hence, among the remaining 21 households several grandchildren and great grandchildren were found to be residing. The majority of these households were female headed and based upon previous experiences these respondents reported that these children would be their responsibilities until adulthood, and even beyond.

Impairments

Impairments are analyzed in terms of the Activities of Daily Living (ADLs) and the Instrumental Activities of Daily Living (IADLs).

Activities of Daily Living-ADLs

The maximum number of ADLs that each respondent in this study is expected to perform is five. Most respondents have no problem performing two or more. Only 2.8 percent (n = 2) are able to perform only one ADL. The two persons are (1) a 76 year old male who suffers from Alzheimer's disease. He is reported as being able to feed himself with some assistance.
The other is an 82-year-old male who is legally blind. He reports being able to dress himself without assistance.

Table 5-5 reports findings related to Activities of Daily Living. The column 'need help' refers to persons who are receiving some assistance but are in need of more help. It reflects instances, based on caregiver reports, where the burden of assistance for the caregiver is becoming almost unbearable. This is the case of the wife of the elderly gentleman with Alzheimer's disease. She reports that "I do not mind doing these things for him, but my back aches so, and there is no one to help." She assists her husband with all but one activity of daily living, that is, feeding, and even then she has to give him some assistance.

The persons who care for the other elderly persons who need assistance report that they need more help with these activities, especially with transferring from chair to bed or commode and vice versa. Unfortunately all but one of the five elderly persons who need assistance are living in two person households. Their spouses have the difficult task of taking care of their daily needs without assistance from the formal support system. One respondent who needs assistance with bathing, weighs over 200 pounds. He sometimes falls and his wife is unable to lift him. In these circumstances they activate his emergency buzzer which brings an immediate response from the fire station which is equipped with
### Table 5-5: Summary Table of Activities of Daily Living

<table>
<thead>
<tr>
<th>ADL</th>
<th>Number performing ADLs</th>
<th>unassisted</th>
<th>N</th>
<th>%</th>
<th>assisted</th>
<th>N</th>
<th>%</th>
<th>need help*</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>unassisted</td>
<td></td>
<td></td>
<td>assisted</td>
<td></td>
<td></td>
<td>need help*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(N=71)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td>64</td>
<td>70</td>
<td>7</td>
<td>9.9</td>
<td>7</td>
<td>9.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td>70</td>
<td>98.6</td>
<td>1</td>
<td>1.4</td>
<td>1</td>
<td>1.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding</td>
<td>69</td>
<td>97.2</td>
<td>2</td>
<td>2.8</td>
<td>2</td>
<td>2.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td>67</td>
<td>94.4</td>
<td>24</td>
<td>5.6</td>
<td>2</td>
<td>2.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transferring</td>
<td>69</td>
<td>97.2</td>
<td>2</td>
<td>2.8</td>
<td>2</td>
<td>2.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*denotes those who are assisted but need more help.

State-of-the-art equipment and has two emergency medical technicians. The one who is not in a two member household has a full-time paid caretaker. This caretaker sometimes calls upon her son or her husband to assist her with the lifting and transferring.

**Instrumental Activities of Daily Living (IADLs)**

For the purposes of this research, the maximum number of IADLs which can be performed by each elderly person is seven. Some of these activities are more problematic than others and some are more complex than the ADLs which are related more to personal self care. IADLs include grocery shopping, managing finances, housework, yardwork, meal preparation, transportation, and administering medication.
As shown in Table 5-6 only 5.6 percent (n=4) reported inability to perform any of these functions; 56.3 percent (n=40) were performing all of these functions; 18.3 percent (n=13) were able to perform 4 or less; and 81.7 percent (n=58) were performing 5 and above. Table 5-7 reports findings on the ability of respondents to perform the Instrumental Activities of Daily Living. The greatest need for help is with grocery shopping, transportation, and yardwork, with 43.7 percent reporting that they need assistance with these activities. Managing finances (26.8 percent), housework (18.3 percent) and administering medication (12.7 percent) were ranked in that order from highest to lowest. The majority of the respondents, 90.1 percent, reported the ability to prepare their own meals.

Transportation seems to be a real problem in the community. The buses are not routed through the sections of the town where the need is greatest. That is, where elderly persons without cars reside. Also, the buses are not equipped with steps which can be lowered for the elderly. Elderly persons complain of having to walk long distances to get the bus and also state that they have to do "too much climbing" to get onto the buses. Considering that they must do the bulk of their shopping, prescription filling, and so on, in nearby towns, then transportation seems to be the number one need. They also must visit physicians outside of the town. Most respondents reside in homes that have yards
Table 5-6: Summary Table of Instrumental Activities of Daily Living

<table>
<thead>
<tr>
<th>IADL</th>
<th>Unassisted</th>
<th>Assisted</th>
<th>Need help</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Grocery shopping</td>
<td>40</td>
<td>56.3</td>
<td>31</td>
</tr>
<tr>
<td>Managing finances</td>
<td>52</td>
<td>73.2</td>
<td>19</td>
</tr>
<tr>
<td>Housework</td>
<td>58</td>
<td>81.7</td>
<td>13</td>
</tr>
<tr>
<td>Yardwork</td>
<td>40</td>
<td>56.3</td>
<td>31</td>
</tr>
<tr>
<td>Meal preparation</td>
<td>64</td>
<td>90.1</td>
<td>7</td>
</tr>
<tr>
<td>Transportation</td>
<td>40</td>
<td>56.3</td>
<td>31</td>
</tr>
<tr>
<td>Admin. medication</td>
<td>62</td>
<td>87.3</td>
<td>9</td>
</tr>
</tbody>
</table>

to be kept. Yard cleaning becomes quite a chore for elderly frail persons. Some choose to give up the luxury of a large house and gardens for small apartments. Mr. Hoard, who has received several awards for best kept gardens, is one such person. This 78-year-old widower reports that he was unable to keep the yard going and so when he lost his wife a few years ago he moved into a low income apartment. But only 7 percent of these elderly persons reside in apartments. Most need help with yardwork. Mrs. Salter is an 84-year-old widow who lives alone. She reports that she paid someone to take care of her yard, but because she could not supervise him, he took her money and went off without doing the work that they had contracted to be done. It was observed that the need for
assistance with these functions increased with age. The oldest-old having the greatest need.

**Caregiving**

Elderly persons in Eatonville were found to be caregivers as well as care receivers. They received support from both the formal and the informal systems (Table 5-7). Of the 71 respondents 26 (36.6 percent) were found to be in receipt of care while 30 (42.3 percent) were givers of care. The care receivers were beneficiaries of Medicare (32.4 percent), Medicaid (70.4 percent) surplus food (18.3 percent), food stamps (5.6 percent) day care (22.5 percent) and other assistance (23.9 percent) from the formal support system. Those who were receiving support from the informal support system were receiving most of this support from neighbors and friends (62.0 percent). Assistance from the church (36.6 percent) was the next in line, while assistance from children and family at 32.4 percent and 26.8 percent ranked lower. Spouses were found to be providing the least amount of assistance; 11 persons (15.5 percent) stated that they were receiving assistance from their spouses. Although this number seemed low, it must be borne in mind that there were only eight married couples living by themselves (that is, without other relatives) and that 25 respondents lived alone.
Table 5-7: Summary Table of Caregiving Characteristics of Eatonville's Elderly Sample

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly Care receiver</td>
<td>26</td>
<td>36.6</td>
</tr>
<tr>
<td>Elderly Caregiver</td>
<td>30</td>
<td>42.3</td>
</tr>
<tr>
<td><strong>FORMAL SUPPORT:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>23</td>
<td>32.4</td>
</tr>
<tr>
<td>Medicaid</td>
<td>50</td>
<td>70.4</td>
</tr>
<tr>
<td>Surplus Food</td>
<td>13</td>
<td>18.3</td>
</tr>
<tr>
<td>Food Stamps</td>
<td>4</td>
<td>5.6</td>
</tr>
<tr>
<td>Day Care</td>
<td>16</td>
<td>22.5</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>23.9</td>
</tr>
<tr>
<td><strong>INFORMAL SUPPORT:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>11</td>
<td>15.5</td>
</tr>
<tr>
<td>Children</td>
<td>23</td>
<td>32.4</td>
</tr>
<tr>
<td>Family</td>
<td>19</td>
<td>26.8</td>
</tr>
<tr>
<td>Church</td>
<td>26</td>
<td>36.6</td>
</tr>
<tr>
<td>Neighbors and Friends</td>
<td>44</td>
<td>62.0</td>
</tr>
</tbody>
</table>
Cross Tabulations of Quantitative Data

Although participant observation was the main method of study used for this research, it seemed appropriate to supplement the qualitative findings with some quantitative data.

Means and standard deviations were calculated for internal level data (Table 5-8). Significance tests also were calculated based on the chi-square statistic for cross-tabulations of several variables which were measured empirically. The results of these tests are presented only to support the descriptive information regarding formal and informal support resulting from in-depth interviews and observation. That is, the intent is not really testing statistical significance but to describe interrelationships. Nonparametric measures of association appropriate to the level of measurement were used to assess the strength of association (Table 5-9). The use of these statistical measures is intended to serve as an aid in describing the findings and not as a precise test of hypotheses.

Cross tabulations were used to examine the relationship between (1) the need for help and the elderly respondent serving as a caregiver; (2) formal support and informal support; (3) agency awareness of formal support; (4) more help needed in terms of age and sex of the respondent,
Table 5-8: Means, Standard Deviations and Other Values of Major Variables

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>N</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
<th>MINIMUM VALUE</th>
<th>MAXIMUM VALUE</th>
<th>STD ERROR OF MEAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>71</td>
<td>74.58</td>
<td>7.26</td>
<td>65.00</td>
<td>93.00</td>
<td>0.86</td>
</tr>
<tr>
<td>Years in Eatonville</td>
<td>71</td>
<td>37.34</td>
<td>21.47</td>
<td>2.00</td>
<td>86.00</td>
<td>2.55</td>
</tr>
<tr>
<td>Number in household</td>
<td>71</td>
<td>2.28</td>
<td>1.47</td>
<td>1.00</td>
<td>7.00</td>
<td>0.17</td>
</tr>
<tr>
<td>Number of health problems</td>
<td>71</td>
<td>2.66</td>
<td>1.36</td>
<td>0.00</td>
<td>7.00</td>
<td>0.16</td>
</tr>
<tr>
<td>ADLs</td>
<td>71</td>
<td>4.79</td>
<td>0.75</td>
<td>1.00</td>
<td>5.00</td>
<td>0.09</td>
</tr>
<tr>
<td>IADLs</td>
<td>71</td>
<td>5.65</td>
<td>2.19</td>
<td>0.00</td>
<td>7.00</td>
<td>0.26</td>
</tr>
<tr>
<td>Number of children</td>
<td>69</td>
<td>3.23</td>
<td>3.13</td>
<td>0.00</td>
<td>11.00</td>
<td>0.38</td>
</tr>
<tr>
<td>Number of grandchildren</td>
<td>31</td>
<td>4.13</td>
<td>7.26</td>
<td>0.00</td>
<td>22.00</td>
<td>1.30</td>
</tr>
<tr>
<td>Number of siblings</td>
<td>71</td>
<td>1.5</td>
<td>1.75</td>
<td>0.00</td>
<td>8.00</td>
<td>0.21</td>
</tr>
<tr>
<td>Formal Support</td>
<td>71</td>
<td>1.73</td>
<td>1.03</td>
<td>0.00</td>
<td>5.00</td>
<td>0.12</td>
</tr>
<tr>
<td>Informal Support</td>
<td>71</td>
<td>1.73</td>
<td>1.21</td>
<td>0.00</td>
<td>5.00</td>
<td>0.14</td>
</tr>
</tbody>
</table>
Table 5-9: Results of Tests of Significance and Measures of Association

<table>
<thead>
<tr>
<th>Variables</th>
<th>Chi-square Statistic</th>
<th>P-value</th>
<th>Measures of Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=71</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need help x caregiver</td>
<td>0.223</td>
<td>0.223</td>
<td>Kendall's Tau-B = -0.144</td>
</tr>
<tr>
<td>Formal Support x Informal Support</td>
<td>0.181</td>
<td>0.181</td>
<td>Gamma = 0.298</td>
</tr>
<tr>
<td>Agency Awareness x Formal Support</td>
<td>0.383</td>
<td>0.383</td>
<td>Gamma=0.124</td>
</tr>
<tr>
<td>More help needed x Age</td>
<td>0.267</td>
<td>0.267</td>
<td>Pearson Correlation=0.249</td>
</tr>
<tr>
<td>More help needed x Sex</td>
<td>0.958</td>
<td>0.958</td>
<td>Kendall's Tau-B = 0.006</td>
</tr>
<tr>
<td>More help needed x disabled</td>
<td>0.259</td>
<td>0.259</td>
<td>Kendall's Tau-B = 0.134</td>
</tr>
<tr>
<td>More help needed x Formal Support</td>
<td>0.145</td>
<td>0.145</td>
<td>Pearson corrln. = 0.134</td>
</tr>
<tr>
<td>More help needed x Number of health problems</td>
<td>0.309</td>
<td>0.309</td>
<td>Kendall's Tau-B = 0.252</td>
</tr>
<tr>
<td>More help needed x informal Support</td>
<td>0.084</td>
<td>0.084</td>
<td>Kendall's Tau-B = 0.193</td>
</tr>
<tr>
<td>More help needed x Other agency awareness</td>
<td>0.002*</td>
<td>0.002*</td>
<td>Pearson corrln. = -0.3551</td>
</tr>
</tbody>
</table>

* denotes significance at the p = .05 level
disability of the respondent, formal support, number of health problems and informal support.

Need help by caregiver

The relationship between the need for help and serving as a caregiver was examined; only a weak negative association was found that suggests that elderly persons who were caregivers were not significantly more or less likely to need care than those who were not caregivers. Thus, knowing whether or not these elderly persons are caregivers, did not help determine whether or not they are in need of help. The case of Mrs. Bernard illustrates this empirical finding.

Mrs. Bernard is the stepdaughter of Mrs. Hammond. She is 75 years old, is hypertensive, has a chest problem, and has had complete knee replacement. She, however, not only assists her stepmother, Mrs. Hammond, but has sole responsibility and is the primary caregiver for an aunt who is over 90 years old, is very frail, and was recently hospitalized for major surgery. This old aunt was finally placed in a nursing home. Mrs. Bernard recently had some problems with her knee and was admitted to the hospital for further surgery. One suggestion of her physicians was that she reduce the amount of driving that she does in order to take pressure off her knee. She is worried however, since she does all the shopping and errands especially for her elderly aunt.
Mrs. Bernard definitely needs help, especially to assist her in taking care of her aunt and stepmother. Her stepmother helps herself 90 percent of the time and only needs help with transportation. If the situation arises, as in recuperation from a hospital stay (this has been the experience more than once), Mrs. Bernard's stepmother moves into Mrs. Bernard's home to facilitate her stepdaughter not only with caregiving but to reduce the caregiver stress which comes from worry when she remains in her own home. The stepmother reports that Mrs. Bernard worries a lot even when she has no reason to.

**Formal support by informal support**

Formal support includes Medicare, Medicaid, surplus food, day care, Food Stamps and such supports as rental subsidy, home delivered meals, utility subsidy, house repairs, home health care, homemaker services and chore services.

Informal support includes assistance from children, spouse, church, neighbors and friends, and family. Only a weak to moderate positive correlation was found between the use of informal supports and the use of formal supports. Gamma = 0.298. This finding suggests that persons in need of help may have been using both forms of support and were not substituting one for the other as will be demonstrated in the vignettes which follow.
Agency awareness by formal support

It does not appear that knowledge of support systems dictated the use of formal support. Only a weak association was found between agency awareness and the use of formal support systems. That is, although one or two persons were high on awareness, they did not seem to appear to access the services. A test of association yielded a Gamma = 0.124, showing that there was only a weak correlation between the use of formal services and respondents' awareness of other agencies. This supports the theory that black elderly persons are reluctant to use the formal support system even if they are aware of its existence. This could be due to (1) fear of rebuffs on the part of the potential receiver, (2) insensitivity of those responsible for distribution of these services, and (3) physical problems with accessing services.

One example of this problem was the difficulty that some persons experienced in collecting the food stamps awarded to them. This led them to forego the food stamps rather than deal with the problem of collecting them. Mrs. Barton who is wheelchair-bound and lives alone reported that she had to pay someone $2 to collect $10 in food stamps, but before this she had to find someone to do it. This demonstrates that older people need methods designed to enable them to access these supports with the least possible difficulty.
More help needed by age

Age was not found to determine the need for more help. No difference was noted between, the old, the old-old, and the oldest-old. Measures of Association revealed only a moderate correlation between being older and stating that more help is needed (Tau - C = .243). No difference was noted between, the old, the old-old, and the oldest-old.

More help needed by sex

Almost exactly the same proportion of males and females stated that they needed more help. Of 25 males (32 percent, n=8) and of 46 females (33 percent, n=15) reported the need for more help. This demonstrated that there is no correlation between gender and the need for more help.

More help needed by disabled status

There are 8 disabled persons in the sample. Of these four (50 percent) reported that they needed more help. Only 30 percent of the non-disabled said that they needed more help. Because of the small number of disabled persons, only a weak and nonsignificant correlation was observed between the 'disabled' variable and the need for more help.

A better understanding of this can be obtained from the situations of the four persons indicating a need for more help. There are three males and one female.

The first male is in an advanced stage of Alzheimer's disease. His wife who is his only caregiver has to work 2 days per week to supplement their small Social Security
income. While she is away at work however he is left alone at home. This indicates a need for help with home sitting or finances. An increase in financial help would mean that his wife would not have to work. On the other hand, working these days is probably good for her mental health and could be a respite from the stress and burden she experiences taking care of an Alzheimer's patient all day, every day.

Help is also needed with respite care. This would relieve his wife who reports that she would like to visit her relatives in Georgia but is prevented from doing so since she cannot take her sick husband along with her and she has no one to come into the home and stay with him if she has to go away. The wife, who responded to all queries regarding her husband, was ignorant of any services which could assist her in terms of respite care, or home help.

The second male is 84 years old and blind. He lives with his 83-year-old wife and two twin great grandchildren, aged 11 years (a boy and a girl). These elderly people receive no assistance from the parents of the children or from any other relatives. These relatives "do not even visit or call on the telephone," states his wife. This elderly couple last saw their son, who lives in Tampa and is the grandfather of the twins, when he came back to Eatonville to bury his wife 3 years ago. The son's children live in Orlando and Tampa but they never visit nor call. Since losing his sight, the couple have been without transportation
in their home. They rely totally on friends to take them shopping and to go to the bank. But, "people are not so helpful today," states the wife. "They are afraid of being sued if they have an accident since their cars are not registered as public transportation."

This household is badly in need of help with transportation. With the added responsibility of two young children who attend school and a blind husband, the wife of this frail elderly gentleman is greatly in need for some kind of help with household chores. She also spends some time in the yard cleaning it, indicating a need for help with yard work. There is also financial need. This household receives $59 in food stamps for Aid to Families with Dependent Children (AFDC). Their expenses include Taxes (1988)—$148 (they receive homestead exemption); house insurance—$350; car insurance—$350 (their car is an antique); tag—$11.

This couple is in need of someone to advise them. It would appear that they should get rid of a car which just sits in their carport. It is highly unlikely because of their ages and their health status, that either of them will ever be able to drive it and they cannot afford a chauffeur. The only justification for keeping a vehicle which they are not using and which is costing them $361 annually would be that they were waiting until their great grandchildren attain the age when they can obtain a driver's license.
The third male is 76 years old, suffers from seizures, and lives with his 55-year-old wife who is disabled according to HRS standards. She suffers from chronic respiratory problems, is arthritic and hypertensive. She has had to stay at home for several years to take care of her husband on a full-time basis. This couple live by themselves. They receive some assistance with household chores from the formal support system, but the wife does all the cooking and house tidying in between visits by the cleaner. They have eight living children. Their oldest daughter lives in Hawaii. The child who resides closest to them is a daughter who works and lives about 2 miles away. She visits regularly and takes care of their laundry and all of their shopping. She can be reached by telephone should they need her during the day. She also has to take time off from work whenever they have to visit the doctor.

The chief complaint of this couple is that caregiving is a burden for their daughter. They could be more independent if transportation was provided to take them shopping and to the doctor. They also wished that they could receive some assistance with their laundry. They are unaware that these services exist, and that all that is necessary is to apply to the appropriate agencies. This couple also need counseling regarding their health care. The researcher observed that the husband smokes. The space in their living room where they seem to spend most of their waking hours is limited and
all the doors and windows are kept closed. This is definitely harmful for his wife who is "asthmatic, rests very badly at nights," and reports that "she has to sleep during the day to make up for this." Another observation by the researcher was that both husband and wife chewed snuff.

The only female is 70 years old, has a history of strokes, and is paraplegic. She spends one half of her day in a wheelchair and the other half in bed. Her only child, a son, resides in New York City. He manages all her affairs from that distance. She has a paid female caregiver who is also an in-law. This caregiver, along with her husband and son, lives in the house with this feeble impaired elderly lady. Prior to this arrangement 3 years ago, this elderly lady had lived alone since the death of her husband in 1981. She received all her assistance from neighbors and friends. Her neighbor, an 86-year-old lady who lives across the road, was her main help. During that period, she received meals-on-wheels but was unable to manage. Although she now has someone to take care of her on a full-time basis, this lady still demonstrates that she is in need of a great deal of care.

The caregiver is unsupervised, a situation which needs remediying since this lady is not receiving the care she deserves or needs. Although she owns a nice big house, she is kept locked away in a rear bedroom. She does not receive fresh air or sunlight, although Eatonville enjoys good
climate with a lot of sunshine. Friends and neighbors complain about her condition. She keeps her money in her bed along with everything else. Most of the time she cannot locate items and the researcher observed her searching through the bed clothes whenever she needs her comb, or a letter, or her money. It would appear that her relatives, who, she reports, do not pay rent, use her home as a cheap means of living while they do not reciprocate by giving her the assistance she needs.

Some distant relatives, who live in the community, and who formerly assisted this lady, have now refused to do so. They state that her son is the one who stands to inherit everything, although he is not there to assist and does not visit regularly. These relatives living nearby and able to assist perceive no possible gain from doing so, because of the son's likely inheritance.

**More help needed by formal support**

Some respondents were found to be receiving some form of formal support but indicated that this was inadequate and that, in order to cope, they needed more support. Of interest, those who said that they needed more help were those who were receiving formal support in the form of either Medicare or Medicaid as their primary support. In some instances this was the extent of formal support that they received, besides their meager Social Security. In most instances this was not a true indication of formal assistance
since all elderly persons received one or the other since Title XIX of the Social Security Act entitled some of them to Medicaid and Title XVIII entitled all to Medicare. In essence, then, all were receiving medical services. Of the 23 who reported a need for more help, the need appeared to be for other formal supports such as day care (only 1 was receiving day care), home help, house repairs, transportation, food stamps (n=2 receiving), surplus food (n=3), and utility subsidy.

The findings suggest that those who were using more formal supports were unlikely to say that they needed more help. Measures of association (Kendall's Tau-B = 0.274.) showed a weak trend for those using more formal supports to also be likely to say that they needed more help.

**More help needed by number of health problems**

A maximum number of seven health problems was reported. The three most common chronic health problems reported were hypertension, diabetes, and arthritis. Health problems were broken down into those who had zero to three and those who had in excess of three. Seventy-nine percent reported zero to three health problems, and 21 percent reported more than three health problems. Only one respondent reported seven health problems. Only 2.8 percent (n=2) reported no health problems. Data on the frequency of the three most chronic health problems of elderly persons mentioned above.
Of the three chronic health problems, only one person reported suffering from all three, 36.6 percent (n=26) reported two, 40.8 percent (n=29) reported suffering from one, and 21.1 percent (n=15) reported none. Hypertension ranked highest among the three chronic diseases with 61.9 percent of the sample (n=44) reported diagnosed hypertensives, arthritis ranked second with 43.7 percent (n=31) diagnosed arthritics, and diabetes ranked third with 11.3 percent (n=8) diagnosed diabetics. In addition, 84.5 percent (n=60) reported that they suffered from other health problems, which included cancer (n=12: 9 females and 3 males), stroke (n=5), seizures (n=1), chronic respiratory disease (CRD) (n=4), cardiovascular disease (n=20), glaucoma (n=7), cataracts (n=11), legally blind status (n=1), hearing impaired status (n=9), neurological problems (n=2), Alzheimer's disease (n=2), early signs of dementia (n=1), blood disease (n=2), gastro-intestinal disease (n=2), genitourinary disease (n=4) [3 of these suffered from incontinence], Parkinson's disease (n=1), and one person reported diagnosed with low blood pressure (LBP).

The variable More Help Needed is a dichotomous variable eliciting a yes/no response. Only one person reported seven health problems, and the response to Need More Help was yes. Of those reporting six health problems, 50 percent (n=2) responded yes; of those reporting five health problems, 66.67 percent (n=2) responded yes, of those reporting four health
problems, 44.44 percent (n=4) responded yes, of those reporting three health problems, 31.82 percent (n=7) responded yes, of those with two health problems, 33.33 percent (n=7) responded yes, and of those who reported only one health problem, 9.09 percent (n=1) responded yes. The Measure of Association, (Kendall's Tau-B = 0.252) showed a moderate trend for persons with more health problems to state that they needed more help.

These results indicate a moderately positive correlation between the number of health problems one has and stating that more help is needed. Thus, it appears that those with the most health problems (1) use more formal support services; (2) use more informal support services; and (3) feel that they still need more help.

Table 5-10 was constructed by combining the number of health problems. When this was done, of those reporting 4 to 7 health problems (n=15), 53 percent (n=8) indicated that they needed more help, but only 27 percent (n=15) of those reporting 0-3 health problems (n=56) indicated that more help was needed. This suggested that those with more health problems were in need of more help.

It was observed earlier that Hypertension ranked highest among the chronic health problems. Seventy-five percent of those who were hypertensive are females (n=33) representing 46.48 percent of the entire sample. Except for one lady, they are all under the care of a physician and on medication
Table 5-10: Degree of Help Needed Based on the Number of Health Problems

<table>
<thead>
<tr>
<th>More help needed</th>
<th>Number of health problems</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-3</td>
<td>4-7</td>
<td>total</td>
</tr>
<tr>
<td>No</td>
<td>31 (73%)</td>
<td>7 (47%)</td>
<td>38</td>
</tr>
<tr>
<td>Yes</td>
<td>15 (27%)</td>
<td>8 (53%)</td>
<td>23</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>56 (100%)</strong></td>
<td><strong>15 (100%)</strong></td>
<td><strong>71</strong></td>
</tr>
</tbody>
</table>

for control of their disease. They visit their physicians on the average every 2 months. Their major complaint had nothing to do with the disease but was about the cost of the medications prescribed by physicians, yet the researcher found none with a generic drug.

Arthritis ranked second among chronic health problems. Although 43.7 percent of the sample (n=31) reported that they suffered from arthritis, there was no evidence of crippling due to the disease. Most reported that their doctors prescribed pain pills. Some, however, used home remedies for its treatment. Remedies reported included such as green rubbing alcohol shaken with banana skins until it took on a black coloration, kerosene oil to which salt had been added and shaken until it dissolved. Both of these were used for rubbing the joints or affected areas. Others used various off the shelf externally applied medications.
Diabetes ranked third among the chronic health problems with 11.3 percent (n=8) reporting being diagnosed with this disease. They were all on medication for its control and were visiting their doctor at least once every 2 months.

More help needed by informal support

Five mechanisms of Informal Support were studied. Knowledge of these supports was necessary in order to enable the researcher to determine the role that kinship played in the support of these elderly persons. Quantity of supports was not what was being analyzed but rather the types of supports. Hence, they were not a continuous variable, but each was analyzed separately for its own merit. The informal supports that were analyzed are (1) Children, (2) Spouse, (3) Church, (4) Neighbors/friends, and (5) Family (Table 5-1).

The majority, 32 percent (n=23), were found to be receiving spousal support. Of these 39.13 percent (n=9) said that they needed more help. Only 26.75 percent (n=19) reported receiving some support from their children. Of these, 36.8 percent (n=7) reported that they needed more help.

Only a weak association between the two variables was found (Kendall's Tau-B = 0.193), indicating a weak tendency for those using more informal support to state that they needed more help. This could be explained by assuming that the more one uses these services the more one comes to be
aware of what services are available or it may be a function of need.

When the informal supports were grouped into two categories (1) Relatives = spouse + children + family and (2) Community = church + neighbors/friends, it was found (Table 5-11) that 37 percent of those who were receiving support from relatives indicated a need for more help while only 25 percent of those receiving support from the community indicated this need. This suggested that relatives were not giving the support that was expected of them from the literature and from their elderly relatives.

Table 5-11: The Need for More Help Based on Type of Informal Support Received

<table>
<thead>
<tr>
<th>Need More Help</th>
<th>Relatives</th>
<th></th>
<th>Community</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
<td>37</td>
<td>7</td>
<td>25</td>
<td>23</td>
</tr>
<tr>
<td>No</td>
<td>27</td>
<td>63</td>
<td>21</td>
<td>75</td>
<td>48</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>100</td>
<td>28</td>
<td>100</td>
<td>71</td>
</tr>
</tbody>
</table>

Similarly, when the community was broken down into (1) church and (2) neighbors/friends (Table 5-12), 55 percent of those who were receiving support from the church said that they needed more help while only 20 percent of those whose main support was from their neighbors and friends indicated
Table 5-12: The Need for More Help Based on Type of Community Support Received

<table>
<thead>
<tr>
<th>More Help Needed</th>
<th>Church</th>
<th>Neighbors/friends</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>45</td>
<td>4</td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>55</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>100</td>
<td>5</td>
</tr>
</tbody>
</table>

that they needed more support. This could suggest either that the church needs to play a greater role in the support of its elderly, or perhaps that only those in the worst circumstances turn to the church for help. Pastors of churches in the community when interviewed, did not deny that the church needs to play a greater role in providing care for elderly members. The findings suggest that there is more faith in the support that these elderly persons receive from the community than in the support received from relatives. The general comment was made that "children and grandchildren only came around when they wanted something." This was also the general theme about help from children. There were reports of children borrowing money from their elderly relatives. There was also a report of elderly relatives obtaining second mortgages on their homes to lend to grandchildren. These loans were never repaid. One elderly
lady even reported that her daughter would snatch her money from her hand.

More help needed by other agency awareness

Agency awareness was coded on a scale of low, medium, and high awareness. Coding was purely subjective in that no particular index was used. Responses were used to document this variable. Those who responded that they had no knowledge of agencies from which they could receive help were coded low. Those who had some very limited knowledge were coded medium, while those who were knowledgeable about agency sources and the help they could receive from them (and in some instances were actually accessing this assistance) were coded high.

Twenty-three respondents (32.4 percent) reported that they needed more help. Of these 34.8 percent (n=8) were among those in the low awareness group; 39.1 percent (n=9) were from the medium awareness group; and 26.1 percent (n=6) were from the group described as being high on awareness. Significance test result P-value (0.002) indicated that there was some significance between stating that more help is needed and being aware of the agencies from which help can be received. This is quite an interesting finding. The majority of those in the medium or high agency awareness groups stated that they did not need any more help. An interpretation of this could be that these respondents were not only aware of the supports that was available to
them, but they were actually accessing these supports. However, of those demonstrating a lower agency awareness, 14 percent (n=10) the majority (n=8) stated that they needed more help.

Of those with low awareness 80 percent needed more help. Out of those with medium and high awareness those needing more help were 28 percent and 21 percent, respectively. This finding suggests that making people more aware of available support systems could reduce their need for more help since they seem to access depending upon awareness.

Discussion

The findings suggest that elderly persons of Eatonville are in need of more help. The problem seems to be one of information. Those who were aware of services appeared to be using these services. However, agencies do not appear to be disseminating the information that could help these senior citizens achieve a better feeling of well being. Although the discussion of the findings is based on a sample of 71 elderly persons, vignettes are also used to highlight the use of services in Eatonville by its elderly residents. The persons dominating these vignettes were not treated as simple respondents in a survey but as informants in the anthropological sense.

The care given to the elderly persons in Eatonville was found to be effected by six different methods utilizing both
the formal and the informal support systems. Most senior citizens were dependent to some extent upon a person (or persons) for assistance. Culturally, these elderly persons are noncomplaining. It is known that those who complain a lot and at all times receive attention. The role of the church comes into play here. An aging society has implications for religious institutions within our society. Coupled with this, the literature on black families expounds the role that the black church plays in supporting black families.

The findings suggest that the elderly people of Eatonville receive more support from neighbors and friends than they do from the church. Caregiving in a community is the responsibility of all of its institutions. Only when all of these institutions are playing their roles can the older persons in these communities expect to experience a better quality of life and live their final years in peace and happiness.

Ignorance of available formal supports for elderly persons has very often resulted in family members experiencing more than their share of the stress and burden which accompany taking care of an elderly relative. This is especially acute when that elderly relative is frail and suffers from Alzheimer's disease. Many relatives of Alzheimer's disease patients are reluctant to institutionalize their loved ones. The situation of the
respondents who make up the vignettes appear to fit all of these criteria.

Summary

The findings of this research indicate that elderly persons who reside in the Town of Eatonville receive care from both the formal and the informal support networks. The level of dependence is on a continuum from none to completely dependent. The services which are available range from informal to formal with a middle range where both of these services are "Mixed." That is, some elderly persons utilize informal services, some utilize both informal and formal in equal proportions, and some are totally dependent on the formal support system for their care.

The findings suggest however, that formal and informal support systems necessary for providing a good quality of life for noninstitutionalized elderly citizens of Eatonville are inadequate. These persons appear to have limited awareness of the various services that are available through government agencies to assist them with their IADL functions.
CHAPTER SIX
CONCLUSIONS AND IMPLICATIONS

The purpose of carrying out this study was to examine how much, and from whom, in the formal and in the informal system, caregiving was received by elderly persons in the town of Eatonville, Florida. The researcher was concerned with, and sought answers to, several questions. First, the role that extended family plays in caring for its frail elderly members was studied. Then, the roles of friendship groups, the black church, and other informal groups were examined in their provision of care to these elderly persons. Third, the roles of the formal caregiving system, as represented by government and publicly funded organizations, were explored. Finally, the researcher was concerned with the interrelationship between the familial, formal and the informal caregiving and support systems in the town of Eatonville.

These questions were raised in the hope of eliciting answers that would have an impact on the well-being of the elderly. What need did the elderly have for help? Were the elderly who needed help aware of the sources of help that are available, both formal and informal? Did they receive the
help? If it was found that help was being received, the researcher was interested in knowing whether this help was that of an informal caregiver, or whether it was provided by the formal system.

The researcher also elicited answers to questions which would reveal whether these elderly persons knew where to get help should the need arise. That is, were they knowledgeable about the formal and informal agencies that were in place to provide these services to which they were entitled. Finally, the researcher sought answers to whether there actually were formal services available, but not being utilized by these elderly persons in the community for reasons such as (1) a lack of knowledge regarding their existence, (2) a preference not to access them due to cultural reluctance, or (3) insurmountable problems with accessing these services.

Implications for Future Research

This is an exploratory study, and the findings strongly suggest that more studies of this nature are needed in order to fully assess the situation of black elderly persons throughout the nation. Studies of black elderly persons who reside in multi ethnic communities are especially needed. The dearth of such studies could be a contributory factor to the scant attention which is paid, to communities such as Eatonville, by our policy makers.

The findings were contrary to expectations based on the literature, i.e., that the extended family was in place to
take care of Eatonville's elderly population. The lack of family support experienced by these elderly persons led the researcher to conclude that the time has come for the demythologizing of the role that the black extended family system plays in taking care of its elderly members. It also led the researcher to think about future research as well as any change in direction if this project had to be done all over again. One major problem that the researcher found was that, with such a small sample, it was not possible to arrive at answers which could lead to generalization. However, through the literature and through observations made through travel, the researcher feels that what was taking place in Eatonville could be what is happening to elderly persons nationwide. If the opportunity arose for future research, the researcher believes that instead of concentrating on such a small sample, questions could be better answered if the entire elderly community is studied.

Policy Implications

Since the 1920s and 1930s the family structure has changed so much that only an idealist would wish to return to the "good old days." Architecture, family size, work patterns, migration, and lack of knowledge regarding the increased complexities of the illnesses experienced as people age all alter the role of the family in the care of older persons. Value systems in the U.S. are undergoing modification. Many younger people today have no qualms about
turning their backs on the older generation. Today's black elderly are suffering silently and lack enough socio-economic supports to make them comfortable and happy in their final years of life.

Blacks in the U.S. are described as not taking advantage of the supports and services available in the formal structure, relying instead on the informal structure for services. Speculation as to the reason why blacks may rely so heavily on family members is that they have minimal expectations for receiving effective service from social service agencies. This may especially be the case for older blacks, who have a painful history of inequality, rejection, and ejection when it comes to dealing with such agencies (Dancy, 1977). Dancy further notes that elderly blacks often lack full knowledge or understanding of the services/benefits to which they are entitled, they are cynical about promised services, and have no influence whatsoever on programs and services. Few meaningful and needed services are located in their communities.

This research suggests several problems that exist when today's black elderly persons are studied in relation to family. Change and modernization are reflected in migration of family members who would previously be found at home living with, and taking care of older members of their families. Children of aged parents after supporting their own children and families have very little left with which to
financially assist their aged parents. A common theme, which ran through the complaints of several of the respondents, was that they received little, if any, support from relatives, especially their children. It was often pointed out that the children would visit when they needed something, and that if they performed a favor for their elderly parent, they would expect something in return. There are those who contend that the family can help elderly members to access such things as home care. A finding from this research is that the family's contribution is very limited. It was also found that the formal system does not fill the gap left by the discrepancies of the informal system. It is necessary then, that both these services act in concert to take care of elderly persons. These two services are necessary as complements to each other to enable elderly persons to live out their final days as least stressful as possible.

This research attempted to examine how black elderly persons access the formal and informal support networks that are in place to benefit all elderly persons. The informal help-giving network was found to be at work, through friends, neighbors and the church. This network was found to provide a pivotal resource for these elderly black persons. Neighbors, in particular, were found to help with transportation, home care, and personal care.

For the black older person, the church has served as a focal point with the ministers or religious leaders acting as
brokers. Findings suggest, however, that the church in the community could expand its role for the benefit of its elderly members. The black church will have to assume the mandate where the formal services have failed black elderly persons. The church may have to do more to assist with transportation, medication payments, yardwork, and daily calls to senior citizens who live alone. Visitation cannot be spasmodic but has to be consistent and, if possible, must extend to providing daily respite for those caregivers who are desperately in need of reducing their stress and burden. Finally, the black church could play a larger role in disseminating information about available services for black elderly persons.

The need for help was quite obvious to the researcher, especially help with IADL functions. The informal support system could play a greater role in affecting this. These people need help, especially with yardwork, but their greatest need was for transportation. Lack of transportation is a crucial problem. Buses remain unreachable. The city government needs to play a greater role in seeing to it that some type of individualized transportation system be put into place.

Elderly persons must be put in touch with the services to which they are entitled; the fact that they have to go outside of the town for basic services exacerbates the situation. Few of Eatonville's elderly residents knew where
to go for help. Few were benefitting from the formal support services. The majority were unaware of what services existed and how to access them. The noncooperating aspects of black culture were not found to play a role in the failure to access formal services. Ignorance was the major reason for not taking advantage of available services. Rather than leaning on an insufficient informal system, the government needs to put into place easily accessible systems which will provide care for elderly persons. Crucial to this are the provisions of enough funds so that their basic necessities, food and health care, can be met.

Having examined the support system in this community, we now address some suggestions for policies which it is hoped will redress some of the inequalities to be found regarding black elderly persons not only in this community but nationwide. More day care should be provided for these elderly persons. That which currently exists is inadequate for the numbers that should be accommodated. If special programs are not feasible, existing transportation systems need to be made physically and financially accessible to these senior citizens.

If there is no extended family, elderly persons are also devoid of potential counselors. The formal system will need to fill the gap where this is concerned. There seems to be a need for professional counseling. These counselors could also serve as advocates for elderly persons. In this
capacity, these counselors could arrange for services to support statements of need and facilitate the delivery of the services necessary to meet those needs. Counselors assigned to small communities such as Eatonville could be the missing link necessary to improve the effectiveness of formal services which already exist.

The municipality of Eatonville needs to play a more pivotal role in overseeing that benefits accrue to its senior citizens. The municipality needs to be more informed and to make information on the elderly more available. There appeared to be little information regarding elderly persons. The municipality could utilize its administrative center for the collection and dissemination of information to its elderly persons. Finally, the municipality must lobby for more representation on the appropriate boards and committees in the county and in the state.

An example of how poorly this information is sometimes disseminated is the case of the hidden smoke alarms. Smoke alarms were purchased for the purpose of making them available free of cost and installation to elderly residents of the town. In the course of my research, I found the smoke alarms stored at the fire station. They remained there, unused, because the elderly persons in the community were still unaware of their existence. When this situation was called to the attention of the authorities by the researcher, the response was that a 'notice' had been placed in a local
newspaper. The town does not have its own local newspaper and so the elderly persons remained ignorant of this much needed and important service. Other avenues of information could have been used. For instance, notice slips could be included in water bills.

Black elderly persons need to be informed. They need counseling regarding guardianship. One elderly lady lost her home and is now a resident in a nursing home because she lacked the proper counseling. Another would have suffered the same fate had it not been for the assistance of the informal system through two ladies in the community. The day care center, which was a very convenient place for elderly persons of the town, and a place where they could spend a part of their day, has been transferred to a neighboring town. This has proven very difficult for those who formerly attended and some have discontinued their attendance. Elderly people need such services especially when they are living alone. Another feature of this center was the provision of one well balanced hot meal each day. Nutrition is a problem of the elderly, and this was one way of alleviating this problem.

Not only is there a need among this group to know what services are available, but they also need assistance in accessing these services in such a way that they will not feel rejected nor ejected. A common theme in black and minority literature is that elderly black persons often lack
full knowledge or understanding of the service/benefits to which they are entitled and that they are cynical about promised services. Most older black people have no influence whatsoever on programs and services, and hence very few meaningful and needed services are located in their communities. Problems arise, too, when local governments of black communities do not take the time to develop programs that will support their elderly citizens.

In the area of economics, government must play a more equitable role in order for older black persons to be able to manage financially. These are persons who start out very poor. If they are not given extra financial support, they can expect to suffer for the rest of their lives. Support is needed in the form of supplements such as rent supplements, utility supplements, day care, food stamps, surplus food, and assistance with payments for medication. Those who are willing and able to work should be assisted in finding employment to supplement their small Social Security income. It is time that there be a radical change in the percentage of older black persons who live below the poverty level.

It may be that all low income elderly persons need to receive Supplemental Security Income rather than basing this income on a means-test that excludes homeowners. What took place during the 1980s was a raising (in constant dollars) of AFDC and Food Stamp income eligibility cutoffs, thus reducing benefits for poor persons (Storey, 1982). Change in
direction for certain income security policies and substantial budget reductions during the Reagan era greatly affected low-income assistance into which category the majority of black elderly persons fall. There needs to be a reversal of the policies that resulted in this situation. What is taking place in Eatonville would appear to be a microcosm of the greater society. The major issue here is—how do we go about doing something that will result in a better life for elderly black persons across the nation?

Malnutrition is rife among older persons and is constantly addressed by dieticians concerned with the diet of elderly persons. One way to reduce malnutrition in the elderly population is for elderly persons to have easy access to shopping areas where they can purchase appropriate foods. Free rides on city buses could be offered during off-peak hours. As the price of food escalates, the real income of these older persons on fixed incomes diminishes. They are unable to purchase the appropriate kinds, quality and quantity of foods even if they receive government assistance or other supplemental income. The charge that nutrition centers impose for lunches that they provide should be removed. Many complain that they cannot afford the $1.25 daily charge for the meal and the 25 cents charge for the bus. They therefore opt to remain at home rather than attend the center. Elderly persons need to be educated about nutrition. They should be discouraged from using vitamin
supplements and should be encouraged to get their dietary vitamins from fresh fruits with skins, and from green and yellow vegetables, and to get their calcium from skimmed milk and low fat dairy products. As government continues to leave these elderly persons short of funds, it does not make sense to advise them to eat what they cannot afford.

There are other problems with the formal support system that need to be addressed. Eatonville is in dire need of a bank, a pharmacy, a health clinic, and a shopping center. These are basic amenities which would make the lives of elderly persons less stressful. Their mental health is just as important as their physical health. Programs must be put in place that will facilitate regular visits from some person or persons whether it be from the formal or the informal support system, the important thing is that it be consistent.

Primary health care and education need to play a greater role in the life of these persons. In addition to nutrition elderly persons need to be educated about medication, safety, (especially in the home), ways to gain access to the formal system, and compliance. Elderly persons alone cannot bear the blame when health care providers polymedicate and are responsible for iatrogenic diseases among the elderly. One elderly woman visited by the researcher had a large number of medicine bottles whose contents had to be taken at varied times. She did not seem to remember which ones she had taken or when. Health care providers should take all this into
consideration when prescribing more than three types of medication for elderly patients.

Today, the HIV virus is at the top of medical and health care discussions, yet we very rarely or never hear it being directed to elderly persons. The elderly need to be educated about AIDS, especially elderly men who sometimes spend time in the company of prostitutes. Blacks and minorities make up a large part of the 37 million Americans without health insurance. Medicaid has become an important source of payment for many of them. A 1982 Robert Wood Johnson survey found that 20 percent of blacks and 13 percent of Hispanics use Medicaid as their only source of health insurance. Adequate health screening must be easily accessible and not convey the derogatory impression that the older person is a welfare recipient or a second class citizen. Our society should censure those health care providers who insist on displaying a hostile paternalistic attitude when dealing with poor older persons.

It is necessary to be aware of the living arrangements and caregiving of these persons. Elderly persons must be educated about guardianship. One elderly lady in the community has been forced into a nursing home because she lost her home and all of her belongings. Nonpayment of unauthorized loans resulted in a foreclosure on her home which, unknown to her, had been used as collateral. Health education interventions should be directed at improving the
awareness of these individuals and communities about controllable risk factors associated with the causes of excess death and disability.

Due to the small sample and the homogeneous community studied, the findings of the present research are not generalizable to all formal organizations specifically designed for elderly persons, such as Area Agencies on Aging. Nevertheless, local agencies were targeted to examine the manner in which they operated to benefit these elderly persons. The findings suggest that, until recently, the agency responsible for Eatonville, the East Central Florida Regional Planning Council's Area Agency on Aging (AAoA), did not have a subcommittee with specific responsibility for minority affairs. There is now one in place, but this seems to be more in form than in substance. Nine of the 11 Area Agencies on Aging in Florida are private, nonprofit corporations under separate independent boards of directors (Stokesberry, 1985). Stokesberry (1985) observes that "if those boards of directors do not have accurate minority representation, then the special needs of that population will not have funds allocated at the time when appropriations are divided" (Stokesberry, 1985:33). Such agencies either should be public, not private, organizations, or more closely monitored by public agencies.

When I visited the local AAoA that serves Eatonville, a meeting with the person with responsibility for minority
affairs was impossible. Several attempts were made without success. When I complained, the response was that he was a "private" person. I was unable to obtain even a telephone number at which he could be reached although the newspapers carried an article lauding the fact that he exists. How can agency personnel be responsive to community needs if they are as "private" and inaccessible as this person?

In a small way I am attempting to help implement some changes in Eatonville. Since completing this research, I have paid two return visits to the town. There has been an election, and I have pledged to assist the new mayor with programs pertaining to the town's senior citizens. I am also in frequent contact with some of the elderly residents of the town to keep informed of what is taking place. One 86-year-old called to inform me about a dinner that the Town's Council had hosted on their behalf and to say that she felt my research had sown the seeds for events such as these. Churches are in contact and have invited me to attend their senior citizen's days in the near future. I had conducted a seminar at the St. Lawrence African Methodist Episcopal Church prior to ending the field research. The seminar participants who signed in were church leaders, including one retired clergyman, community leaders, and senior citizens. Booklets with information concerning caregiving for the elderly, which I had requested from the AARP, were distributed to the participants. I spoke to the group about
caregiving, what it entails and also about "Formal and Informal Supports for Elderly Persons" in a community such as theirs. This was well received and a question and answer period followed. I was thanked by those attending and was invited to hold similar seminars at other churches in the community. This activity led me to think about future research as well as any change in direction if this project had to be done all over again.

The final question which now surfaces is this: After such a study, what can be done to raise the national consciousness to the plight of black elderly persons. I feel that the key to assisting elderly black persons in their quest to live out their final days as problem-free as possible rests with good caregiving. Formal and informal caregiving for these persons is germane to their mental health, and as the year 2000 approaches, it is hoped that governments, relatives, and friends will realize the role that they need to play in their actualization.
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<tr>
<td></td>
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<td>&quot; &quot;</td>
</tr>
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<tr>
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<td>42</td>
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</tr>
<tr>
<td>Meal Awareness</td>
<td>45</td>
<td>0 = Low 1 = medium 2 = high</td>
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<tr>
<td>More help needed</td>
<td>46</td>
<td>0 = No 1 = Yes</td>
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</table>
APPENDIX B
SURVEY OF CAREGIVING RESPONSIBILITIES

The questions on this survey ask about your caregiving responsibilities—that is, any activities you do in order to take care of, or provide care for, an older family member or relative. These activities could range from shopping for another person who cannot do their own shopping to tending to a bed-bound or home-bound person. Your answers will be kept in the strictest confidence and will only be used in preparing my dissertation for my doctoral degree and possibly conference papers. If, at any time, the information is to be used for publication your permission will be sought before doing so. Please be open and candid in giving your responses.

1. What age group do you fall into?

(1) Under 30 years (5) 46 - 50 years
(2) 30 - 35 years (6) 51 - 55 years
(3) 36 - 40 years (7) 56 - 60 years
(4) 41 - 45 years (8) 61 or older

2. What is your marital status?

(1) Single
(2) Married
(3) Widowed
(4) Divorced/Separated

3. And are you...

(1) Female
(2) Male

4. Please indicate below your general job classification.

(1) Clerical/Support
(2) Management
(3) Production
(4) Technical
(5) Service/Other
5. How many children do you have living at home who are ..
(Please circle the appropriate number or numbers)

a. I have no children living at home___________

b. Number of children under age 6 ...........1 2 3 4/more

c. Number of children 6 - 18 years old.......1 2 3 4/more

d. Number of children 19 or older.............1 2 3 4/more

6. If others besides children live with you, please indicate below which people live with you. (Check all that apply)

a. ______ spouse

b. ______ father or mother

c. ______ father-or mother-in-law

d. ______ a brother or sister

e. ______ aunt or uncle

f. ______ another relative

g. ______ a friend

h. ______ other __________________________

7. How many persons aged 50 or older do you have caregiving responsibility for?

(1) ______ One  (2) ______ Two  (3) ______ Three or more

IF YOU ANSWERED "1" FOR QUESTION 7, USE "COLUMN A" FOR YOUR ANSWERS TO QUESTIONS 8 - 15. IF YOU CARE FOR TWO PEOPLE, PLACE YOUR RESPONSES FOR THE SECOND PERSON IN "COLUMN B". IF YOU CARE FOR MORE THAN TWO PEOPLE, USE COLUMNS A AND B TO RECORD YOUR RESPONSES FOR THE TWO PEOPLE WHO REQUIRE THE MOST AMOUNT OF CARE FROM YOU.

8. Where does the person for whom you have caregiving responsibility live?

COLUMN A | COLUMN B
(Person1) | (Person2)

(1) In your home......................

(2) In their own home (near yours)

(3) In their own home (a distance from yours)

(4) Other (specify)______________
9. If you indicated that a person you are caring for lives in their own home, how often do you visit with them?

(1) Never
(2) Monthly
(3) More than once a month
(4) Weekly
(5) Almost every day

10. Please provide the following information about the person(s) you are caring for.

a. Person’s age
b. Sex (M=Male F=Female)
c. Relation to you (Father, Mother)
d. How long have you been caring for the person

11. Who provides most of the care for the person(s)? (Please check only one)

COLUMNS A COLUMNS B

(1) You
(2) Your spouse
(3) Your father or mother
(4) Your children
(5) Father- or Mother-in-law
(6) Your brother or sister
(7) Brother- or sister-in-law
(8) Other relative
(9) Friend
(x) Outside paid help
(y) Other (specify)

12. Currently, which of the following problems (if any) are experienced by the person(s) you are caring for? (check all that apply).

a. Vision (Glaucoma, cataracts)
b. Hearing impairment
c. Stroke
d. High blood pressure
e. Heart problems
f. Swollen legs or ankles/circulation problems
g. Cancer
h. Diabetes
i. Drug/Alcohol abuse
j. Memory loss/disorientation
k. Depression
l. Sleep disorders
m. Constipation
n. Diarrhea
o. Uncontrollable elimination functions
p. Alzheimer's Disease
q. Arthritis
r. Bone fracture/breaks
s. Dizziness problems
t. Respiratory problems
u. Other (specify)
v. None of the above

13. Did any of the following events happen to the person(s) to cause the need for you to provide care for them? (check all that apply)
   a. Major illness/injury
   b. Hospitalization
   c. Death of spouse
   d. Retirement
   e. Laid off or fired from job
   f. Other (specify)

14. What kinds of help do you provide to the person(s)? (check all that apply)
   a. Direct financial support
   b. Manage person's finances
   c. Do household chores for person such as shopping, cooking, laundry, maintenance of living quarters
   d. Assist person with personal care (dressing, bathing, feeding, toileting etc.)
   e. Provide help moving about in the house or apartment
   f. Provide transportation
   g. Administer medications
   h. Provide companionship by personal visits or by telephone
   i. Make or receive telephone calls for person
   j. Arrange/coordinate outside help for person
   k. Other (specify)
15. How many hours per week do the following people spend in providing care for the person(s) you are caring for?
   a. You........................................... ___ hrs ___ hrs
   b. Others living within your household...................... ___ hrs ___ hrs
   c. Friends/relatives living outside your household............. ___ hrs ___ hrs
   d. Paid outside help............................... ___ hrs ___ hrs

16. For each of the categories of activities below, please indicate how often your caregiving responsibilities interfere with these activities.

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Often</th>
<th>Sometimes</th>
<th>Seldom</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
</tbody>
</table>

   a. Outside Activities (Clubs, shopping, etc) ______ ______ ______ ______

   b. Work or job ______ ______ ______ ______

   c. Other family responsibilities (spouse, children etc) ....... ______ ______ ______ ______

17. Other than help provided by you or another family member, do(es) the person(s) receive help from an outside source?
   (1) ___ Yes ___ (2) ___ No (If 'No', go to #20)

18. If 'Yes' above, which of the following kinds of help do(es) the person(s) receive? (Check all that apply.)

   Outside help used for:
   
   a. ___ Homemaking chores (cooking, laundry, etc.)
   b. ___ Repairs/maintenance to the household
   c. ___ Personal care
   d. ___ Companion services
   e. ___ Nursing services
   f. ___ Home delivered meals
   g. ___ Counseling
   h. ___ Adult day care/Senior Center
   i. ___ Transportation
   j. ___ Telephone monitoring or reassurance
   k. ___ Other (specify) ____________________
19. Which one of the following has been most helpful in providing information about outside resources available to help in providing care for the person or persons you are caring for? (Please check only one.)

(1) ___ Family physician
(2) ___ Visiting nurse or other health care professional
(3) ___ Clergy
(4) ___ Counselor/social worker
(5) ___ Employee assistance or counseling program
(6) ___ Friends/family
(7) ___ Other (specify) ____________________________
(8) ___ None of the above

20. Do you or do you not need additional assistance in order to continue providing care to the person(s)? (please check only one).

(1) ___ I do not need assistance, I can continue to provide care.
(2) ___ I need some assistance, but generally I can do it myself.
(3) ___ I need considerable assistance in order to continue.
(4) ___ Even with assistance, I may not be able to continue.

21. When were you last able to take a vacation that allowed you some time away from your caregiving responsibilities? (Please check only one).

(1) ___ Less than 6 months ago
(2) ___ Between 6-12 months ago
(3) ___ Between 13 months and 2 years ago
(4) ___ More than 2 years ago

22. How helpful would specific information on the following topics be in assisting you with your caregiving responsibilities?

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<thead>
<tr>
<th>Information on:</th>
<th>Not Very Helpful</th>
<th>Somewhat Helpful</th>
<th>Very Helpful</th>
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<td>a. Specific illnesses</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>b. Home care</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>c. Community resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Housing options</td>
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</tr>
<tr>
<td>e. How to choose a nursing home</td>
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</tr>
<tr>
<td>f. Useful tips for caregivers</td>
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</tbody>
</table>
g. Support groups for caregivers
h. Effective communications
i. Questions to ask your physician
j. Normal aging process
k. Stress management
l. Mental incapacities and aging
m. Other (specify)

23. If you work, how many days (if any) have you lost from work during the past 6 months for the following reasons. (Enter the number of days for each reason).

a. Illness(es) ..................... ______ days
b. Family emergencies .............. ______ days
c. Crisis/emergency with person(s) being cared for ............... ______ days
d. Lack of sleep ...................... ______ days
e. On-the-job accident ............... ______ days
f. Other (specify) .................... ______ days
g. ______ Check if no days lost in past 6 months

24. Is there someone with whom you can discuss your personal problems or family life issues? (Check all that apply).

a. _____ No one
b. _____ Friend/family member
c. _____ Clergy
d. _____ Counselor/Social worker
e. _____ Family physician/other health care professional
f. _____ Co-worker
g. _____ Company nurse etc.
h. _____ Other (specify)

25. During the past 6 months, have you suffered from any of the following? (Please check all that apply)

a. _____ Frequent headaches
b. _____ Weight gain or loss
c. _____ Skin disorders
d. _____ Nervousness
e. _____ Unusual drowsiness
f. _____ Inability to sleep
g. _____ Other (specify)
That completes the questionnaire. Thank you very much for your time.

The questionnaire is a modification of that prepared under the auspices of the AARP Women's initiative for The Survey of Caregiving Responsibilities.
APPENDIX C
INFORMATION SHEET
to be administered in the Town of Eatonville

1. Gender: M  F  (Please circle appropriate category).
2. What is your date of birth or your age? _______________
3. Were you born in Eatonville?......Yes_____ No_____ 
4. If you were not born in Eatonville, please indicate the State in which you were born ________________________
5. How many years have you lived in Eatonville?_________
6. Do you own or rent your dwelling unit?

    ____ own 
    ____ rent 
    ____ other  Please specify________________________

7. What is your current Marital Status?

    ____ married 
    ____ widowed 
    ____ divorced 
    ____ separated 
    ____ single/never married 

8. How many people are currently living in your household__
   How are they related to you_________________________

9. Are you physically impaired?___Yes___No. If yes, list your impairments____________________________________

10. Are you disabled?_____Yes_____No. If yes, state the nature of your disability________________________________

11. Are you able to bathe, dress, and feed yourself without assistance?____Yes ____No

12. Are you able to perform light housework?____Yes____No
13. Are you able to do your own shopping and banking, etc.?  
   ____ Yes  ____ No

14. What was or is your occupation? _______________________

15. What are your main sources of income?
   ____ Social Security  
   ____ Pension  
   ____ Children  
   ____ Other relatives  
   ____ Savings/investments  
   ____ Other - Please specify _______________________

16. How do you spend your days? ________________________________

17. What is your general attitude towards Nursing Homes?____
   ________________________________
   ________________________________
   ________________________________

18. Are you currently taking care of anyone, relative/friend
   ____ Yes  ____ No  If yes explain briefly______________
   ________________________________
   ________________________________
   ________________________________

COMMENTS:
   ________________________________
   ________________________________
   ________________________________
   ________________________________
## APPENDIX D
CHARACTERISTICS OF EATONVILLE'S ELDERLY
ACCORDING TO AGE COHORT

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<th>75-84 %</th>
<th>85+ n</th>
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**AVERAGE NUMBER OF HEALTH PROBLEMS:**

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**CHRONIC HEALTH PROBLEMS:**

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<th>Condition</th>
<th>65-74</th>
<th>65-74</th>
<th>75-84</th>
<th>75-84</th>
<th>85+</th>
<th>85+</th>
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<th>Total</th>
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<td>14</td>
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<td>41.9</td>
<td>13</td>
<td>41.9</td>
<td>5</td>
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<td>31</td>
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**FREQUENCY OF CHRONIC HEALTH PROBLEMS:**

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<th>65-74</th>
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<th>Total</th>
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<tr>
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**CAREGIVER:**

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<tr>
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**CARERECEIVER:**

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<th>Total</th>
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</thead>
<tbody>
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**MORE HELP NEEDED:**

(i.e. of those currently receiving help)

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<th>Help Needed</th>
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<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
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APPENDIX E

POSITION OF ORANGE COUNTY IN THE STATE OF FLORIDA
APPENDIX F
POSITION OF THE TOWN OF EATONVILLE
REFERENCES


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BIOGRAPHICAL SKETCH

Sylvia Cicily Claire Earle Lawson was born in Goodwill district in the Parish of St. James, Jamaica, West Indies, on January 30, 1936, as the eighth child of Eunice and Stanford Earle. Ms. Lawson has had a long career in radiation oncology technology, and teaching including the position of Clinical Supervisor in the Radiation Therapy department at Shands Hospital at the University of Florida. She earned her professional diplomas in Radiation Therapy and Diagnostic Radiography from the College of Radiographers, London (1957, 1958), and is a Fellow of the College of Radiographers, London, England. Ms. Lawson also holds the Certificate in Nuclear Medicine from The Royal Marsden Hospital and Royal Cancer Institute, London, the Further Education Teacher's Certificate from the City and Guilds, London, and the Higher Diploma in Radiation Therapy and Teachers Diploma from the College of Radiographers, London (1970). She earned a Bachelors of Science in political science from the University of the West Indies in 1978, a Master of Arts in political science from the University of Florida in 1984, and expects to earn the Doctor of Philosophy in sociology from the University of Florida in 1990.
Ms. Lawson has two children: Deirdre Mae and Peter Alwyn. Deirdre is pursuing the M.D. degree at the University of Florida, and Peter will enter Emory University School of Business Administration as a graduate student in August 1990.
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.

Lee A. Crandall, Chair
Associate Professor of Sociology

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.

Jaber F. Gubrium, Cochair
Professor of Sociology

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.

Herman Vera
Associate Professor of Sociology

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.

Ronald L. Akers
Professor of Sociology

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.

Paul R. Duncan
Associate Professor of Sociology
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.

[Signature]
William A. Kelso
Associate Professor of Political Science

This dissertation was submitted to the Graduate Faculty Department of Sociology 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.

August 1990

Dean, Graduate School