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Social organization in an evolving senior center

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SOCIAL ORGANIZATION IN AN EVOLVING SENIOR CENTER

by

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DISSERTATION

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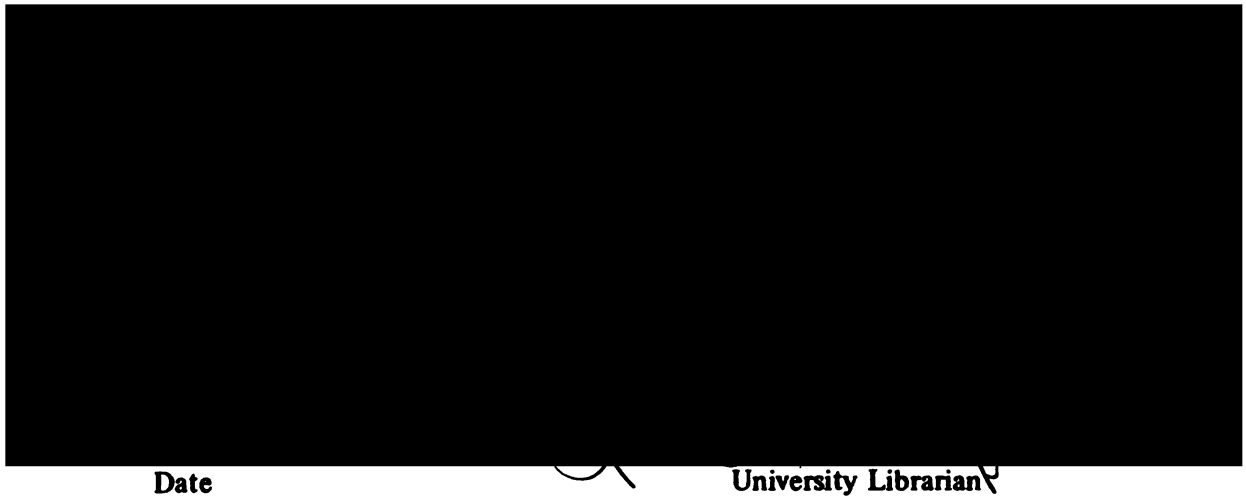

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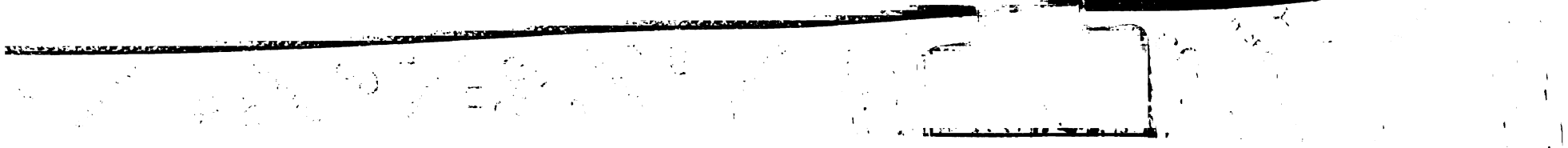

DISSERTATION ABSTRACT

This study focuses on the use of social and health services in a predominantly Black community located in a West Coast metropolitan area. Specifically, the opening of a senior center for an elderly population provided an opportunity to explore this population's participation in the activities, games, classes and programs offered through this social service. Additionally, the social and political forces, which created and influenced the structure of the senior center are presented and the impact of these forces on the organization of services and activities within the senior center are examined.

Major findings from this study include the following: The implementation of services for the elderly was a consequence of politicl activism by minority community members. Underfinancing characterized the senior center and hampered the staff's efforts to meet the aged's needs. A spontaneous or "unexpected" community based on helping and sharing among the elderly, staff, and visitors, arose to help somewhat offset the lack of adequate funding. Finally, among the aged clientele, differential participation and use of the Center's services, activities and programs was related to physical and mental health, familial support and socio-demographic resources.

Recommendations based on the study findings are directed to the agency funding the senior center as well as to the broader audience of policy and social health planners to effect better and more productive use of the senior center.

Conceptually, this study is cast in the social anthropological tradition as the study attempts to understand why do people behave the way they do. In this context, this study relies upon the theoretical orientations of social organization as conceived by Firth (1961) and Barth (1966) and structural-functionalism as perceived by Mair (1965) and Radcliff-Brown (1965).

DEDICATION

This work is dedicated to the elderly participants and staff at the senior center who have diligently struggled to maintain the only elderly service in their community and make it successful.

ACKNOWLEDGEMENTS

There are many people who have provided assistance, either through words or deeds or both, in the completion of this dissertation. Although I cannot begin to individually thank all of those people, there are a few whose advice or cooperation was indispensable. Ms. Adrian Baker introduced me to and guided me through the vagaries of providing services to the elderly in general and minority aged in particular. She, the other staff members, and all of the elderly at the senior center wholeheartedly welcomed me into their midst and for this I am eternally grateful.

To Dr. Colleen Johnson and Dr. Charlotte Weaver, I owe a special thank you for providing advice, critical comments, and timely encouragement. I am indebted also to Dr. Christie Kiefer, Dr. Reynaldo Maduro, Dr. Margaret Mckenzie, and Dr. John Ogbu for their counseling and participation.

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CHAPTER I: RESEARCH PROBLEM

PURPOSES OF THE RESEARCH

The purposes of this research are: 1) to examine the structure of community sponsored social and health services and resources and their delivery to Black elderly population; 2) to explore the participation patterns of elderly users in a recently opened community social service, a senior center; and 3) to associate these participation patterns to the overlapping relationships between formally and informally arranged social supports.

Interest in this study originated with an interview with the Director of the Family Health Center, a community mental health sponsored service "providing counseling and psychological assistance to troubled families". During the interview the Director expressed disappointment about two related matters: 1) that the service was greatly underutilized, especially by Blacks; and 2) that so few community residents knew about the service.

In fact, the range of roles aged Blacks occupy within families has not been substantially or accurately documented (See Chapter II) and in designing a counseling service for a predominantly Black community, policy-planners may have based their decision on inaccurate information about Black families.

However, the Family Health Center had an age limitation for users of its services (serving those between the age of 5 and 22). The creation and implementation of mental health counseling was concentrated on adolescent and young adults instead of the elderly. This situation was perhaps due to the common assumption that mental health services, including personal and family counseling, are provided by extended family members in Black families (Aschenbrenner 1975; Martin and Martin 1978, Shimkin, Shimkin and Frate, 1975) in Black families.

This report addresses what information exists about Afro-American use and participation in health and social services. Because of a lack of reliable research findings about the availability of social and health services, the legal acts which mandate the delivery of such services are critically examined as are the consequenses of such service delivery to a minority population. Specifically, this report focuses on the participation of a group of elderly Black individuals as they interact in a senior center.

RESEARCH PROBLEMS AND QUESTIONS

Confusion envelopes research studies about the use of social and health services by Black aged individuals. Older Black people are often considered as a homogeneous group, set off from the rest of society by a single

in confusion, and the decision-making process is based on a series of myths or stereotypes such as "Blacks maintain their elderly at home" and "Black family kin would squeeze blood out of a turnip to aid their elderly members". Confusion also envelopes research about Afro-American social support systems as well as research about the nature, function, and structure of Black families. Out of the many conceivable approaches to the study of Black family life, two have been made salient, the "social pathology" and the "Africanity" model (See Chapter II).

Lost in this confusion is research about the family and its capacity to give support to its elderly members, as well as research about the quality of assistance from governmental and voluntary agencies. Community support strategies are as plagued by misinformation and stereotypes as are family support models and both require testing and validation. The opening of a drop-in center for the aged during the fall of 1977 was viewed as an opportunity to begin testing the validity of such stereotypes.

There is a need to study services aimed at Blacks because they are a rarity in predominantly Black communities like the Pacific Sea Side (a pseudonym), City and County of St. Rose. The decision to open a senior center in Pacific Sea Side (P.S.S.) was made by a

non-P.S.S. community advisory board. Blacks in the P.S.S., and Asians migrating to the Moonrise District had lodged a complaint about the lack of services (especially for the aged) located within the two respective districts in the early 1970's. As a result of their political efforts, at least the Moonrise District now contains the following services for seniors: Home evaluation; Geriatric Screening; Retired Seniors Volunteer Programs; Telephone Reassurance; and Psychiatric Day Care Center.

My interest in the senior center focused on two major problems. The first was to better understand how and when social and health services are utilized in low to middle income neighborhoods with large racial/ethnic populations. The second was to assess the quality of the actual services delivered.

The opening of the Center represented an opportunity to explore the responses and attitudes of potential users over a short period of time to find out who makes use of what particular services and the benefits the users get from those services. Specifically, the reality of stereotypes explaining Afro-American underutilization of services could be tested. The major questions are: Do "Blacks maintain their elderly at home" (a frequently cited explanation of underutilization), or is it that such services are either not generally available or are inappropriately

designed and presented to them? What is the nature of the interface between formally arranged social and health services and the more informally organized assistance offered by family and friends? Is the relationship between family members and the assistance they provide to their elderly members based on cultural expectations or a sense of duty, or is it a rational aid system with the aged taking part in the exchanging of gifts and services as well?

The second problem concerned the quality of care Black elderly individuals receive. Observations of an emergency psychiatric clinical setting revealed how elderly patients were regarded and, in turn, treated differently from non-elderly patients. That is, the younger clientele elicited immediate treatment while the elderly got delayed and received a minimal treatment response. When the variables race and age are combined, the issue of "double jeopardy" or multiple hazards is raised (Jackson 1970; National Council on Aging, 1972; National Urban League, 1964). These descriptions refer to the cumulative negative effects of being old, a minority, and poor, on the frequently cited indicators of quality of life such as health, life satisfaction and housing.

Those who are minority and aged, like other older people in industrial societies, experience the devaluation of old age which is found in modern societies (Cowgill and Holmes, 1972). Rose (1965a, b) posits a "subculture of the aged" where regardless of ethnic background, the aging individual is exposed to a variety of influences which cut across racial lines and may mediate or level differences in patterns of aging (Hirsch and Kent, 1969). Nevertheless, it has been demonstrated that minority aged bear additional economic, social and psychological hardships (Dowd and Bengston, 1978).

Further investigation is required into the extent to which minority groups are subjected to the debilitating effects of these "multiple hazards". What is needed is an examination which goes beyond a survey approach such as Dowd and Bengtson's (1978) work in Southern California. Also critical to the research process is detailed information to compliment the survey data collected on the minority aged populations in Southern California. While this data documents the economic, social and psychological hardships which accompany double jeopardy, how are these hardships manifested in a setting such as a senior center characterized by low financing? Given poor financing, how do those who must administer social services programs construct and offer services for minority and

elderly clientele? What are the structural manifestations of institutions' adaptive responses to poor financing? What were the effects of economic constraints on the relationships between elderly and staff and elderly and elderly? Moreover, what are the outcomes reflected in participation patterns and attitudes of the elderly using the senior center? What covert or latent forms of social organization, if any, evolved as a response to economic constraints?

The senior center offered an opportunity to study, for example, what life is like for individuals using the Center and how they adapt their lives to accommodate and adjust to a new setting. I was also able to assess the psychological, familial and social strengths these individuals possess. In other words, what is the relationship between the community services intended for the aged and the needs and capabilities of the elderly using the Center?

THEORETICAL ORIENTATION

The implementation of a specific service for the aged in a low income community in St. Rose presented an opportunity to study (1) the evolving participation patterns of an elderly population, and (2) the adaptive strategies both users and staff developed to cope with the structural constraint of economics within a senior center. This study represents a classical social

anthropological approach and relies on the theoretical concepts of social structure (Radcliffe-Brown, 1940, 1965), social organization (Firth, 1954, 1961, 1965), and latent and manifest functions (Merton, 1964). An examination of the adaptive strategies of individuals and the motivations behind these strategies derives from the concepts of the individual as a self-interested actor (Barth, 1966), and social networks (Barnes, 1954, 1966; Boissevain, 1968; Bott, 1957).

SCOPE AND LIMITATIONS

It is a premise of this study that many problems or aging transcent ethnicity and are generally common across groups to the point that social policy, programs, and theory acquire a more universal application. Many experiences shared by and common to individuals of the study population lend a uniqueness to this group as do the tribulations this population experienced in the course of the Center's evaluation. But the lack of other detailed descriptive studies about elderly Black populations make it difficult to determine how unique or typical this study population may be.

Ethnicity is viewed as an important construct of social differentiation, bonding group members on the bases of shared cultural experiences, perceptions, and values. This study addresses ethnic and subcultureal variations within the population of aged U.S. citizens.

Responses to these questions were collected through participant observation and interviews with a group of 18 - 25 elderly Black individuals attending a senior drop-in center. It is therefore an intensive descriptive study of a situation, rather than a survey of conditions and outcomes.

This drop-in center was unique when contrasted with other senior centers located throughout the P.S.S., and differs from other centers in this and other cities as well. First, it was open five days a week as opposed to the two day a week schedule of the other centers. Second, it offered a range of social and health services in addition to the arts and crafts and exercise classes which characterized the other centers. Third, the drop-in center eventually evolved its own ideology, a process not seen in other senior centers.

ORGANIZATIONAL FRAMEWORK

Chapter I as the introductory chapter presents the research study, problems, questions and setting. Chapter II reviews the literature on social and health service policy and utilization by specific populations within the United States, and specifically focuses on the Black population. Chapter II begins with an assessment of the Community Mental Health Act (CMH) of 1966, as an example of a service organization formally created to meet the needs of all U.S. citizens. Some of the

consequences of ignoring socio-demographic differences (e.g., age, sex, race) are explored and some barriers to health and social services delivery are noted. The responses of the aged in general to these barriers are next examined vis-a-vis different environments (e.g., age-segregated, age integrated, family). When the variable of race is added as a barrier to health care, the literature on utilization and participation is seen to be even more scarce. What little literature there is about the Black aged's use of health and social services has been obscured by researchers studying the family context of the aged, a point dealt with in detail in Chapter II.

Chapter III delineates the methodological techniques used in the collection of data to complete this study; describes the socio-demographic features of the study population; and introduces the two key informants selected for intensive observation and interviewing. A discussion of the fieldwork process is included in this section with emphasis on gaining entry to the study site and establishing rapport with the study population. Chapter III also describes the community from which the study population is drawn. This chapter closes with an examination of the two different locations which have housed the Senior Center.

Chapter IV presents and examines the social organization which evolved within the Senior Center. This evolution occurred consequent to the efforts of staff, volunteers, and the elderly to make the Center a place where people could meet, interact and enjoy themselves. All of these participants brought with them their expectations and "ideal" conceptions of what types of behavior, activities, and services were vital to the Center if the needs of the participants were to be met. A structural-functional approach is used to analyize the role of staff and volunteers, as well as the elderly who received these services. Again, it should be remembered that planning was minimal.

The major focus of Chapter V is who uses and participates in the activities and services offered by the Center. The elderly population participation in this study is divided into three groups of high, medium and low users/participants. These categories are based on an assessment of socio-economic status, family organization, and physical and mental well-being.

Chapter VI, the final chapter, contains the summary, study conclusions, and a set of recommendations directed to the funding agency.

CHAPTER II: BACKGROUND AND LITERATURE REVIEW

INTRODUCTION

In Chapter II the literature relevant to the study question is reviewed. The review begins with a brief comment on the theoretical orientations on which this study is based. There follows a discussion of the Community Mental Health Act (CMH) of 1964 which sought to provide health services for all citizens. The CMH Act specifies the obligations of a formally structured agency in providing services in the vital areas of health care delivery and social support. This act also recognizes the need for assessing the impact ethnic group membership has on the accessibility of health and social services. Unfortunately, old age as a critical variable impacting the delivery of services was not taken into consideration. In light of the importance of this variable, also reviewed is the general literature on the social environment of the aged. Specifically addressed are the issues of the environment of the family, age-segregated versus age-integrated environments, social networks, and the role of the aged as community builders.

As this study focuses on a specific ethnic minority population, there follows a discussion of the scant data on the utilization and participation of Black aged in social and health services in predominantly low-income communities. Finally, Chapter II examines two conceptual approaches used in studying the Afro-American family: the social pathological and "Africanism" perspectives. As will be apparent, this examination identifies how the aged are excluded from consideration in the research of Black family studies.

SOCIAL ORGANIZATION AND SOCIAL STRUCTURE

This study of elderly Black individuals interacting and participating in a drop-in Senior Center derives its theoretical foundation from a desire to understand the social organization of aged persons and based on the myraid social conditions which direct human behavior. Firth (1961) distinguishes three complementary concepts necessary to the study of social relations, the "structural, functional and organizational aspects." Firth defines these aspects thus:

> "by the structural aspects of social relations we mean the principles on which their form depends; by the functional aspect we mean the way in which they serve given ends; by the organizational aspects we mean the directional activity which maintains their form and serves their ends" (Firth, 1961:28).

Structural principles, upon which the form of social relations depends, include for example, economics, ideology, objectives and social relationships (Firth, 1961:29). Social function stresses the relation between a social action and the system of which the action is part. The principles of organization is a necessary complement to the analysis of the structural aspect of social action as it permits an examination of how the forms of basic social relations are capable of variation (Firth, 1961:35). Indeed, Firth sought the study of variation largely ignored in static formulations of social structural analysis. Variations or modifications in the existing structural principles are generated by individuals reaching decisions and making choices. It is through the decision-making and choice selection that the static nature of a social system is offset or made dynamic. This study records the variables which influenced decision-making in the Center. Stressed throughout this chapter are the structural effects, i.e., the adaptations both the seniors and staff made to the funding agency's rather ambitious goals and limited budgets with which to work.

Traditionally, anthropologists within the subdiscipline of social anthropology have focused on the "structural-functional approach". This approach is most concerned with questions of what are the existing

patterns of social relations and how are these patterns maintained (Radcliff-Brown, 1965). Functionalists view the patterned relationships of social structure as serving the ultimate purpose of contributing to the maintenance of society as a whole. Also important is what is expected of the individual within the system of social patterns (Mair, 1965).

> "It means that we think of <u>society</u>, not the culture, as an orderly arrangement of parts and that our business is to detect and explain this order" (1965, 1974:10). (Author's emphasis).

Structural-functionalism portrays society as an enduring system of groups maintained in equilibrium by the functioning of such elements as roles, statuses, positions, beliefs, values, norms and relationships. Essentially, a structural-functional analysis of a social system maps out the form and content of patterned relationships within a society. Briefly, a group's social structure consists of persons participating in social interactions which function to maintian equilibrium.

Critics of this approach object that the structural-functional approach is descriptive and lacks explanatory power, is circuitous in its logic, and causes social relationships to be viewed statically with the actors knowing what to expect of one another (Barth, 1966, Boissevain, 1974; Firth, 1961). However, the

structural-functional approach allows the identification of, for example, enduring rules, roles, role behavior, and other structural features of social group. Moreover, this approach is useful for analyzing forces that structure the socail interactions of daily life which occur in any field of social relations. These static descriptions of formal social relations are vital as data bases for an understanding of a people as well as for policy formation.

SOCIAL AND HEALTH SERVICES AND THE CMH MOVEMENT

As conceived by Congress and the National Institute on Mental Health, the objective of the original Community Mental Health Act of 1964 was to provide "adequate and comprehensive" services for all, including ethnic-minority groups, the aged, the chronically ill, school drop-outs, the handicapped, and alcoholics. The organization and structure of Community Mental Health or CMH centers as well as their objectives and operating principles are summarized by Harris (1978), Levenson (1972), and Levenson and Brown (1968). Each CMH center assumes responsibility for a specific geographic population, labelling these populations "catchment areas." Each CMH center was expected to serve a minimum of 75,000 but not more than 200,000 persons, and to offer a minimum of five services. Four of these services were to be "direct" clinical activities: in-

patient care, out-patient care, partial hospitalization (day care), and 24-hour emergency service. The fifth service is "indirect" and oriented toward prevention with a focus on community education and consultation service. Harris (1978) succintly identifies the philosophy and characteristics of CMH centers. These include: a focus on positive mental health and prevention; continuity of care; emphasis on crisis resolution and adaptation; emphasis on services available within the community; access to these services; and a stress on patterns of services within these centers.

The CMH Act of 1964 did more than just provide funds for construction and staffing of centers. It created an array of social programs which promised to alleviate poverty and make health services more accessible. However, the CMH movement has been criticized and challenged for its ambitiousness (Kirk and Therrim, 1975), and its insensitivity to research studies documenting ethnic and cultural diversity in United States society (Cobb, 1972; Harris, 1978; Macht, 1975; Sue, 1977; Warner, 1977).

The recognition of this diversity was necessary in order to establish the most responsive services possible for these populations. However, a review of the literature suggests that this goal was largely ignored by the psychiatric professionals who were treating ethnic-minorities. For example, Yamamoto and his

colleagues (1968) did a follow-up study of Blacks (n=149), Chicanos (n=53) and Asians (n=5) selected for treatment in a Southern California clinic. These authors found that these populations rarely used their therapists, generally felt their therapists were prejudiced, and were more likely to be prematurely discharged or seen for minimal supportive psychotherapy. These findings held true for the working class whites used as a controlled population for this study. Similar results have been reported by Gross et.al., (1969) who studied the effects of race and sex on diagnosis and dispositions made by the clinical staff. That is, as the sociocultural distance between clinical staff members and their patients increased, diagnosis became less accurate, and dispositions more non-specific, and specific symptoms lumped into broader psychiatric categories. Other evidence documenting that ethnic-minorities are not receiving appropriate treatment is provided by Adams, (1950), Brayboy, (1971), Calnec, (1970), Davis et.al., (1974), Grier, (1967), Gross, et.al., (1960), Jones and Sequall, (1975), Shapiro and Pinsker, (1973), Smith and Gundlach, (1974), Sue and McKinney, (1975).

In summary, although the CMH Act of 1963 mandated the delivery of at least mental health services to meet

services largely ignored ethnic and sub-cultural variations in the delivery of services to these populations. It has been shown that the tendency to avoid using services on the part of people whose needs show them to be in need of such services is associated with socio-cultural differences between providers and consumers. To understand the influence of socio-cultural differences between providers and clients, the general subject of service delivery needs to be studied in-depth.

RESEARCH IN THE SOCIAL ENVIRONMENT OF THE ELDERLY

An examination of the social environment of the aged entails looking at the aged in the context of the family, age-segregated versus age-integrated environments, social networks, and the role of the aged in the community building process. Social scientists have documented the preference for nuclear family type structures in the United States. The dyad of husband-wife constitutes the primary unit in old age (Riley and Foner, 1968; Streib, 1970). These authors provide evidence for the early exit of children today, thus exposing this dyad to a loss of valuable resources. Studies of marital adjustment indicate that satisfaction with marriage increases with age (Rollins and Feldman, 1978), suggesting that other factors being equal, marital adjustment is a primary source of support.

marital adjustment is a primary source of support. Death or declining health of the spouse/caretaker mark the weakpoint of this arrangement.

Research on families of old people have challanged the notion that the aged or post-parental couple are socially isolated and receive no help from their children (Bork, 1967; Faulkner, 1975; Jackson, 1971a, b, 1972a, b; Shanas, 1967, 1973; Smith, 1965; Sussman and Burchinal, 1962; Troll, 1971). These authors demonstrate that a modified extended kin structure exists to incorporate the older members of the family. Lopata (1978) describes the types of support that bond the family together into a viable unit as economic, social, service and emotional. Whether family members can or will supply these types of supports to their elders is questioned by Brody (1978), Lopata (1978), Maddox (1977), and Treas (1975). These investigators indicate that the capabilities of families to deal with disabled members will be and is affected by the decline in family size, increasing cost of medical care, and the increasing number of women in the labor pool.

Related to the problem of defining and describing a family is the variety of family forms in contemporary United States society which vary by social class and ethnicity. Investigators researching ethnic-minority families have illustrated that kinship structures differ

both qualitatively and quantitatively in the incorporation of elderly members into the family (Faulkner, 1975; Jackson 1971b; Johnson and Johnson, 1978; Shimkin et.al., 1975). Shimkin and his colleagues (1975), in a report on family systems in Black societies, indicate that the extended structure is the norm among Blacks and is found in urban as well as rural settings. It has also been demonstrated that class, attitudes and beliefs, and the helping patterns that emerge among families with older members also differ (Jackson, 1971b; Shanas, 1967; Shimkin et.al., 1975; Sussman and Burchinal, 1962). Jackson (1972b), for example, reports that elderly members in Black families are viewed as having unconditional and legitimate claims for help, and extended kin will "squeeze blood from a turnip" to provide assistance (1972b:26).

A slightly different perspective is reported from the researchers who find higher morale and higher satisfaction to be characteristics of age-segregated environments (Blau, 1973; Cantor, 1975; Carp, 1966, 1967, 1969; Cowgill, 1978; Ehrlich, 1973; Rosow, 1967; 1970; Wood and Robertson, 1978). These investigators provide evidence that although the elderly see their children frequently, they appear to be better off with peers. Blau (1978), Rosow (1967), and Wood and Robertson (1978) have demonstrated that for the elderly whose networks are dominated by age peers, there is greater morale and

higher satisfaction from social contacts, and greater preference for friends. Rather than see the argument reduced to an age-segregated versus age-integrated level, more studies are needed which take into account and examine the ways in which variations in the life situation of the older person affect adaptation to them.

The adaptive and coping methods used by the aged in specific environments are identified in studies of the elderly as being "community builders" (Angrosino, 1976; Bryne, 1974; Hochschild, 1973; Jacobs, 1974; Johnson, 1971; Ross, 1974a, b). Specifically, studies by Bryne (1974), Hochschild (1973), Johnson (1971), and Ross (1974), demonstrate how effective the aged are in creating their own environments to meet their own needs, and the role the elderly play in the community building process whether the environment is age-segregated or age-integrated. Ross (1974), for example, in a study of a French retirement residence tested three hypothesis about the social organization regarding the relationship between the internal social organization of the embedded community and the social organization of its external context. What Ross found was simple enough -- "life goes on" with the retirement residence being neither a reflection of the outside world nor a reaction against it. Consequently, regardless of the environmental barriers imposed by society, the aged appear to have maintained their ability to adapt and change their life

space to meet their daily needs. What is obvious is that there is a variety of options open to the elderly, and that generally speaking, these options are obscured by presentations of the aged as "frail and vulnerable."

Additional support for the aged as community builders comes from studies on the aged's social and personal network systems. Developed in the 1950's, network analysis helped to examine the importance of informal and interpersonal relationships in describing and analyzing forms of social organization (See Barnes, 1954; Bott, 1957; Boissevain, 1968; Mitchell, 1969a,b). Mitchell (1969) defines network analysis as a "specific set of persons with the additional property that characteristics of these linkages as a whole may be used to interpret the social behavior of the person involved".

Students using this methodological approach have demonstrated that social networks in United States urban areas constitute a significant element in combating the depersonalized effects of the elderly's isolation caused by urbanization and associated social disorganization (Lopata, 1975; Sokolovsky et.al., 1978; Stack, 1974; Sussman and Burchinal, 1962). Thus, the application of network analysis in the study of the aged provided investigators with a tool for looking at everyday social life from the perspective of social actors. Net-

work analysis allows for a social reality which continues to regard the aged as contributing and functioning members in the daily life within a social world or group. The popular notion of the aged as "frail" and "vulnerable" obscures their role as active participants in community life, and more specifically, the aged's utilization of community services. Evidence of this obscurity is seen in the following review of the Black aged's participation in and use of community services.

THE BLACK AGED: SOCIAL PARTICIPATION & UTILIZATION OF COMMUNITY SERVICES

Social participation is defined here as "the activity with other people that contributes to one's social relationships which he comes to depend on for emotional support and responsiveness and which maintain him in many subtle ways" (Lehr and Rudinger, 1969). Lehr and Rudinger's definition recognizes the contributions to an aged individual's social support system made by family, friends, and neighbors as well as local, state and federal agencies. Rubenstein (1971) initiated a national survey study to test his hypothesis that household situations are different for a national sample of Black and White ethnic sub-populations. Moreover, he proposes that Black elderly were supposed to be more likely to live alone or in a household situation without spouse and that White elderly were more likely to live with a spouse as a couple, or in a household

situation with a spouse. Rubenstein also correlated types of living arrangements with morale or well-being in old age; thus , since Black elderly were hypothesized to live alone or without spouse, they were expected to have a lower state of morale and well-being. However, Rubenstein did not support his hypothesis that Black elderly are to be found more alone due to higher rates of widowhood, divorce and separation. He found that Black elderly "are not as limited in their opportunity for participation in their household as are the White elderly" (Rubenstein, 1971:185).

More recent works on social participation among the Black aged (Kent and Hirsch, 1973; Williams, 1981), suggest that aged Blacks are more likely to belong to a church group and social and recreational associations than aged Whites. They also are more likely to join ethnic organizations and senior citizens clubs (Kent and Hirsch, 1973). Through the analytic technique of regression analysis, Clemente and his colleagues (1975) substantiated this hypothesis and noted that part of the difference is due to the greater participation of Blacks in church-related groups. These studies indicate that the social participation of the Black aged ranges from church, social and recreational associations (including senior citizens clubs), to family, kin and friends. It is with this range of elderly participation in mind that the familial system of Afro-Americans is now examined.

AFRO-AMERICAN* AGED: THEIR FAMILY CONTEXT

In this study the family is viewed as a front-line mutual aid, emotional and natural support system for aging individuals (Jackson, 1971a,b). It is also a premise of this study that it is the familial system which provides the major roles for the aged in later life. The nature of these roles, whether or not they are expressive (e.g., being regarded as a bread winner) is obscured by research derived from data about Black family lifestyles, as well as a paucity of data concerning types of roles which grandparental and elderly persons evolve and occupy within a family setting. The following literature review documents the obscurity enveloping Black family life. The review is divided into two sections. The first section presents two dominant and opposing approaches to the study of Black family life in our society. These are the "pathological" and the "Africanism" perspectives. The second section contains a discussion of what literature exists about the Black family and the treatment of its aged members.

PERSPECTIVES ABOUT AFRO-AMERICAN FAMILY LIFE

As a result of the recent involvement of Black social scientists in the field of Afro-American family studies (Staples, 1971, 1974; Willie, 1976), the

literature on Black family life is characterized by two opposing schools of thought. The first, labeled the pathological, treats Black family life from the perspective of social problems and social disorganization and pinpoints female-headed families as the perpetrator of social and economic ills within Black communities (Frazier, 1939; Kardiner and Ovessey, 1951; Moynihan, 1965). The second perspective concentrates on positive cultural and psycho-social factors or "Africanisms" and focuses on available strengths within their families, as well as the variations that exist in Black family structure and organization (Billingsley, 1969; Hill, 1972; Staples, 1981; Willie, 1976).

Studies investigating the family life of Afro-Americans in our society have been criticized for their profound emphasis on a "pathological" social disorganization perspective. Examples of these works include such authors as Drake and Cayton (1945), Frazier (1939), Kardiner and Ovessey (1951) and Myrdal (1944). Proponents of this view maintain that the African heritage disappeared with incarceration. In their view, upon arrival to America, Africans became "Negroes" (Spanish for Blacks) whose personality and culture were forever to bear the scars of slavery.

The oppression of slavery was postulated to be so overbearing in its effect that it reduced <u>all</u> African

descendants to a caste state and a child-like status resulting in the evolution of a "Sambo mentality" (Elkins, 1959) among the general New World African population. The inability of the slave population to care for itself meant, to those who held this view, a permanent dependency of the African population upon the resources and goodwill of the ruling class in the United States. Traditional African family practices were never allowed to naturally evolve on a large scale. Africans, while they aged biologically, were never allowed to mature to old age socially.

In summary, the pathological perspective and its use in studies on Black families has been criticized for its heavy emphasis on social disorganization. Martin and Martin (1978), two researchers studying the Black extended kinship system, characterize this approach:

> "proponents of this perspective emphasize Black family instability and deviant, maladaptive characteristics which they consider to be inherent in or acquired by Black families" (Martin and Martin, 1978:103).

Those who would employ the pathological approach eliminate from their analysis careful consideration of positive adaptations to the economic system, legal constrictions, the demands of a new environment, and overt and covert racism. Given this perspective it is

easy to understand how social aspects of aging among Blacks are almost totally omitted by these researchers. In many respects, aged Blacks are blameless victims of the same inequalities suffered by aged Whites, and in many respects their survival in the face of multiple hazards strongly contradicts the "pathology" model.

In contrast to the view that African culture did not survive the impact of slavery, proponents of the strength-resiliency perspective (Billingsley, 1963; Ladner, 1971; Hill, 1972) focus on "Africanism" which emphasizes significant features of African culture carried over into the New World (e.g., Herskovits, 1941). Billingsley (1958) posits that surviving African traits in New World Africans account for the resiliency and viability of Black families and the delineated types of family forms (nuclear, extended, denuded). Following a discussion of these family forms he notes that,

> "...the range and variety does not suggest, as some commentaries hold, that the Negro family is falling apart, but rather that these families are fully capable of surviving by adapting to the historical and contemporary social and economic conditions facing the Negro people" (Billingsley,1958:21).

Reflecting this positive perspective in the study of Afro-American family life, Hill (1971) delineates what he considers five major family strengths: high religious orientation, strong kinship bonds, strong work

orientation, high achievement orientation, and adaptability of family roles. Other researchers working in the area of Afro-American life and who also reflect this positive approach include Willie (1970), Staples (1971), Stack (1974), Gutmann (1977), and Aschenbrenner (1976).

The establishment of the strength-resiliency perspective has resulted in an increased concern with extended family relations. With the notable exception of Frazier (1939), no work in the area of Afro-American family systems focuses on the extended family until the late 1960's (Billingsley, 1968). The role of the extended kinship system among Afro-American and/or Black families has been used as the point of departure for a pair of comparatively recent works: Shimkin, Shimkin and Frate (1975), and Martin and Martin (1978).

The strength and viability of the extended family system is portrayed in the ethnographic works of Stack (1974) and Aschenbrenner (1975). Aschenbrenner found large social networks surrounding Black families which were characterized by high interaction and interdependence among kin. Her work among Black families of all classes in Chicago suggests that the Black family is extended in character. Although often showing a bilateral tendency, family extensions are more frequently oriented towards the maternal side (Aschenbrenner, 1975:3). Stack's work, on the other

hand, concentrated specifically on strategies Black kinship networks have developed in surviving in "The Flats", the poorest section of a Black community in a Midwestern city. The adaptive strategies identified by Stack include: patterns of coresidence kinship-based exchanged networks linking multiple domestic units, elastic household boundaries, life long bonds to three-generation households, social controls against the formation of marriages that could endanger the network of kin, the domestic authority of women, and limitations on the role of the husband or male friend within a woman's kin network (Stack, 1974:124).

While these studies (Billingsley, 1968; Aschenbrenner, 1975; Martin and Martin, 1978; Shimkin, Shimkin and Frate, 1975; Stack, 1974) discuss the importance of elderly persons in the kin system, it is the case that the aged and the subject of aging continue to be a peripheral concern. For example, although Martin and Martin (1978) indicate that a concomitant of extended kin systems is a "dominant family figure" who typically is older, this key individual has yet to be a direct focus of a research study within an Afro-American family context.

In summary, social disorganization within the Afro-American family unit is a reality, and not to be denied

as an important factor affecting the delivery of critically necessary support services to the elderly population. The implications of social disorganization have been well documented for Black communities (e.g., Frazier, 1939). That is to say, studies using the "social pathology" approach failed to discern, regardless of age level, assumed adaptative strategies evolving within the social organization of Afro-American communities.

Later researchers (Stack, 1974; Aschenbrenner, 1975; Staples, 1971, e.g.) using a different approach ("Africanism" or "positiveness") documented such suddenly appearing "unique" adaptive strategies as exchange networks among multi-generational domestic units and the domestic authority of women (Stack, 1974).

The importance of the Africanisms perspective is that it offers concrete examples of the ways families at poverty or near poverty status modify and adapt family and domestic units to meet the demands of their environments. The range of responses these units have developed and evolved open the way for the study of the conditions under which they function or fail to meet the needs of their elderly units. The role that family and domestic units play in the delivery of support services to the elderly and, in turn, the contributions the elderly make to the family or domestic unit is open to study and documentation. This study provides some

documentation of both these latter issues, as the study focuses on the relationship between the elderly and their contributions to the domestic unit.

AFRO-AMERICAN FAMILIES AND THEIR ELDERLY MEMBERS

Except for large-scale surveys, the aged or grandparental member(s) of Afro-American families are largely ignored in most of the family studies' literature (Dowd and Bengston, 1978). Similarly, the greater portion of gerontological literature is equally devoid of studies examining the role shifts that take place with aging and the status the elderly occupy in the family unit. The importance of examining the role of the elder member(s) within the larger family structure derives from our need to know more about the unit's supportive capacity toward its older member(s) in order to locate alternatives to the present social policies guiding the delivery of health and social services for the elderly. These policies are premised on assumptions about the "American" family system without regard to cultural variability (Sussman, 1976:223).

Research in the area of subcultural variation and specifically about differing supportive involvement of kin network are reported from Mexican-Americans (Moore, 1971; Leonard; 1967); Japanese-Americans (Johnson, 1977; Kiefer, 1974); Italian-Americans (Johnson, 1976, 1978);

and Afro-Americans (Bourg, 1975; Cantor, 1975; Faulkner, 1975; Jackson, 1970, 1971a,b, 1972; Lopata, 1973, 1975; Rubenstein, 1971).

This literature basically shows that expectations of help, health perceptions and definitions of illness, physical and geographical proximity of family members, interactional frequency, and economic and mutual interdependency all acquire different meanings from a subcultural and ethnic-minority point of view.

Results from studying subcultural family units are important for the measurement of kin structure and reflect as well dimensions of an institution basic to a study of Afro-American elderly -- that of the extended family. Of the few studies on Afro-American family life that include a focus on the elderly members, several "norms" prescribing kin support for aged members in such families are identified (Jackson, 1971a, b, 1972; Lopata, 1973).

Jackson (1971a,b) documents how the families of low-income urban Black elderly adapt supportive service roles when society fails to provide adequate education, employment, income, and housing for the aged, their children and their children's children. Additionally, Jackson (1971b) demonstrates that although most of the parental subjects received some economic assistance from

children, middle-class parents were more likely than lower-class parents to receive this type of assistance. Similarly, in a review of the literature about the family in later life, Troll (1971) reflects this notion in concluding that middle-class parents and children are more likely to exchange money, while the working class exchange services and sociability.

In addition to the works of Jackson (1971a, b; 1972) other investigators have shown that the extended family is capable and does provide psycho-social support and economic aid to its elderly members (Bernard, 1966; Billingsley, 1968; Shimkin, Shimkin and Frate, 1975). Bernard (1966) essentially maintains that the function of the Black extended family is to provide a supportive aid and sociability for the elementary family units. Billingsley (1968) contends, further, that the active extended family of Blacks is an example of the Black family's ability to structurally adapt to various socio-economic environments, and that the extended family network functions as a stabilizer for the Black community.

In their review of the literature on Afro-American family systems, Shimkin, Shimkin and Frate (1975) generalize the conclusion that the extended family is the primary kinship form among Blacks and is found in urban as well as rural environments. They state:

> "A widespread and functionally important institution of Black society in the United States is a bilateral descent group; with extensions to various kinds of fictive relatives, which is called "family"....."

Significantly, it is only when the extended family is examined as the operational unity of family functioning that the role of the elderly members can be appreciated. Unfortunately, Afro-American family studies have only tangentially touched on this aspect of Black family life. Shimkin and colleagues address this in their description of the elderly members' role as being central to the larger family unit:

> Characteristically, this family (extended) is centered, perceptually and in terms of action incentives, on its representatives of the oldest living generation, who are symbols of unity, objects of respect and moral authority, sources of fosterage and objects of care for all members. (Shimkin, Shimkin and Frate, 1975).

The high status accorded the aged in Black societies certainly indicates that the Black extended family is prepared to commit whatever resources they have available to help their elderly members. Whether or not extended family members will actually do so remains to be empirically tested.

Therefore, the study findings on minority and subculture groups, and specifically Blacks, show significant variations in the areas of family structure, kin support systems, and the role of the elderly within the family unit. However, we need more extensive documentation of these variations which go beyond more social contact. Specifically, additional research is required that will document the role shift that accompanies the change of status to that of the "aged person" for different social class and cultural groupings. This need for a better understanding of the role of the minority elderly within the family and the larger community is basic to the conceptualization of cost-effective social and health services that are culturally appropriate and acceptable to these populations.

In conclusion, there continues to be a lack of articulation and communication between conclusions derived from these studies and how (or whether) these conclusions are interpreted and acted upon by service providers. Biegel and Sherman (1979) indicate, for example, that health services are "parachuted" into minority communities and operate with few, if any, linkages to the informal community support systems. Zambrana and his colleagues (1979) examined the use of health services among a group of Puerto Rican elderly in East Harlem and concluded that a gap exists between the

health service delivery system and the ethnic group's socio-cultural factors and patterns which have significant impact on the use of such services.

Apparently, cost-effective delivery of social and health services to minority and ethnic (including "White" ethnics, see Guttman, 1979) communities continue as antithetical conceptualizations.

CHAPTER III

RESEARCH SETTING AND METHODS OF INVESTIGATION

DATA COLLECTION METHODS

This anthropological investigation combines ethnographic and survey methods to study an elderly population as they use and participate in a senior drop-in center located in a low-income community. Ethnographic research emphasizes the participant-observer method which allows for in-depth description of a group's behavior pattern. The richness of the ethnographic description reveals as well, behavioral variance within the groups studied, motivations behind behavior, and the predominant values, norms and beliefs of its members. The participant-observer method consists of intensive, daily contact with the research participants as they go about their daily life activities. The researcher's constant presence over a long period of time is thought to minimize the effects of being observed. That is, although the study population is initially aware of the researcher as an intruder, his or her continous presence is enough to overcome this shortcoming. The researcher-observer simultaneously experiences the life of those he studies as much as possible while building a cumulative body of data concerning the study population.

Included within the participant-observer method is information gathered through constant and continual informal interviewing. Informal interviewing and data collection about the Center's social organization occurred in varied contexts including: daily staff meetings; preparing hot meals in the kitchen; participating in games; transporting staff and elderly about; attending community meetings; and, unfortunately, funerals. These specific settings are noted for the different types of data yielded.

For example, when meal preparations were underway, the kitchen constituted an excellent location to acquire the latest gossip about new relationships, new romances, family related information, or data about conflicts between individuals or family members. The daily staff meetings provided information about new participants at the Center as well as data updating the emotional, physiological, and sociological status of the other participants.

It was through attending community meetings that the efforts of the Center's staff to work closely with other community voluntary organizations, were revealed. One result of these efforts was a joint sponsorship, between the Center and a voluntary organization, of a para transit system whose expressed purpose was to primarily provide supplementary transportation for the aged within the P.S.S.

Key Informants

The ethnographic method also relies upon key informant(s) or intensive interviewing of an individual who is well-grounded in the knowledge base of a community. Key informants are cultural representatives who are articulate and with whom the researcher is able to form alliances and friendship bonds sufficient to support intensive interviewing. Eventually two key informants were selected for closer observation and in-depth interviewing as example of the elderly's participation in and use of the different activities and service within the Center. A brief description of these key individuals, Mother January and Mother March, follows.

Mother January is 90 and currently widowed having outlived two husbands who have left her property and homes. She has recently converted this property to cash and in addition to this money, her other source of income includes social security. She has not let the deaths of her former husbands discourage her and she is actively seeking a third husband. She presently enjoys the company of a younger gentleman (age 76) who on occasion will come to the Center with guitar in hand to entertain Mother January.

Mother January has five living offspring (3 daughters, 2 sons) and numerous grandchildren. She resides with and pays rent to one of her daughters, who

is married, with five children. Mother January and all of her family members remain close. Either of her two sons will provide transportation when she requests it, as she frequently does. Mother January's health is excellent and she continues as an active church member, attending all the different church related programs.

For example, when extra funds are needed in the Church, it is Mother January that the minister calls on to organize and head fund-raising campaigns. But Mother January's sense of religious brotherhood extends beyond church boundaries. For until the day he died, she also contributed to and cared for the needs of one of her ex-son-in-laws who had suffered a debilitating stroke which left him partially paralyzed. Despite her daughter taking another husband, Mother January's devotion and caring for her "ex"-son-in-law never ceased.

Mother March is 87 and also widowed. She too enjoys the company of the opposide sex but is not actively seeking another mate. Mother March's income sources include retirement monies from her teaching vocation, social security and funds generated through private enterprise. She makes quilts for a convalescent hospital which reimburses her for her efforts. She also managed to sell one or two quilts at the Center.

Mother March lives alone in a large two bedroom apartment in the Lake Sea Side Towers. The Towers is

not advertised as an age-segregated facility buts its population is approximately ninety percent over 65. Mother March's only offspring (a daughter) resides in Texas, but a niece and son-in-law look after her financial and legal affairs. They, along with Mother March's many friends, also see to her transportation needs. Although Mother March has experienced "stomach problems", her health allows her to be mobile and she continues to be active and independent in her daily life. Mothers January and March both reside in neighborhoods located within Pacific Sea Side. (P.S.S. community is described in the last section of this Chapter.)

As a means of cross-checking information gathered from observations as well as that gained from the key informants, a structured questionaire was administered to staff and elderly individuals who agreed to participate in this study. The questionaire was adapted from a previously proposed five state study of aged Black persons in the Deep South. The interview guide elicited detailed socio-demographic and educational background, income, present and previous occupations, current housing and living arrangements, available support personal and information concerning interdependency -- past history of family supports, filial values, kinship behavior and reciprocity, marital relationships, and social network characteristics. Socio-demographic information provides a contextual and historical under-

standing of the neighborhood and community in which the senior center and its elderly population are geographically located.

Finally, other related background information included data collected from previously completed ethnographic studies of the community in which the elderly participants resided, archival information concerning the neighborhood from public, state and federal libraries, and demographic data from private and non-private corporations.

THE FIELDWORK PROCESS

Gaining Entry

Entry into the daily activities and routine at the senior center was through its director. A previous research assignment required an interview with this person in her capacity as the head of the Senior Block Information and Referral Service located in the Moonrise District, City and County of Saint Rose. She had discussed with her supervisors the possibility of a community service for the elderly to be located within Pacific Sea Side. She recalled my teaching experience in an Ethnic Studies Department and contacted me in regard to offering a history class for the participants at the senior center. She was also aware of my research interest in gerontology and this interest became a point

of negotiation as we both sought resolution to our mutual interest. When the senior center opened in the spring of 1977, the researcher's role as teacher was formally recognized by other staff and clientele.

This teacher's role was maintained throughout the duration of my fieldwork in the senior center from 1978-1980. In between the start and finish of the study, the fieldwork plan included the researcher being in attendance and participating in the activities at least three days a week, from 9 a.m. until 4:00 p.m. when the seniors went home. Transportation for some of the seniors was often a problem and this meant helping other staff members provide rides for those who needed them.

While it was convenient for the seniors to have a ready made response ("He's the teacher") to the often asked question, "who is he?", the adoption of the teacher's role was not without its drawbacks. This was evident when it came time five months into the fieldwork to present the research project and inform the elderly of the need to interview or ask questions about their current as well as past life styles. The response and of course, consent to participate, depended on two factors 1) who was around when the study plan was announced -- an act which was systematically repeated as the months went by, and 2) establishing rapport. The

problem of rapport was related to age and status differences between a group of basically elderly females, and a young constantly intruding male "teacher", who on occasion was referred to as "just a baby to me." In most Black communities, babies are to be seen and not heard. Through the first 16 months of the study, the question, "Teacher, what you want to know that for" required explanation.

The initial and ongoing contact with the elderly population was through the Center. Although initially intended as a site where seniors could drop-in as they felt the need to, outreach work was conducted to ascertain the health status of the elderly and to inform them of the Center's services and activities. The Center's staff has achieved a modicum of stability with respect to its constituency. Twenty to twenty-five seniors attended and participated in the Center's programs daily. (Detailed description of the Center's programs, follow in Chapters III, IV, and V). The program included the traditional arts and crafts and sing-along periods, free hot lunches, legal and tax services, and a mini-vegetable market, for example. The quality as well as variety of the Center's activities could swell the client population from its base of 25 to numbers as high as 50 to 55 (My notes indicate 53 different individuals passed through the Center on one particular mini-vegetable market day).

passed through the Center on one particular mini-vegetable market day).

Establishing Rapport

The process of establishing rapport occurred primarily through the omni-present domino game. Two of the most dominant elderly females were avid players and it did not take one long to figure out when to lose and when to win for gaining rapport. The domino game often exceeded the working hours of the Center, and would continue either in the home or apartment of either of these two individuals. The two individuals were both to become key informants. Rapport was successfully accomplished when I received a telephone call at 5:30 a.m. from Mother March asking if I could take her to a friend's house to pick up some "strings" (used in making quilts). She had been awake since 4:30 a.m. and wanted to know how soon I could get there. Many of the remainder of the study population, while not so aggresive as Mother March, were also interested in such "services".

STUDY POPULATION

The study population consists of those persons age 55 years and over who used the Center frequently enough to be observed or interviewed. The use of age 55 rather than 65, the standard in gerontology, is in keeping with the works of others studying minority aging, which takes

into account the lower life expectancy and the earlier onset of old age.

Observational data were collected on 28 seniors who consistently attended the Center, with ethnicity not a selection criterion. Interview data were collected from 16 of the 21 Black seniors attending the Center on a regular basis. Of the five who were observed but not interviewed, two had had psychological impairments and confusion; two died before they could be interviewed; and one individual refused to participate in the study.

Table 3-1 summarizes the socio-demographic characteristics of the 16 Black elderly interviewed by age, sex, marital status, living situation, number of children, whether they rent or own their home and their economic status. Each of these variables are discussed below.

TABLE 3-1: Study Population by age decade, sex, marital status, living situation, number of children, rent vs. own home, and economic status

Decade	Sex	Single/ Married	Living Sitation	Number of Children	Renter Home Owner	Economic Status
(N = 5) 1890 - 1899						
1891 (90)	F	Widowed	Da. & Da.'s Husband	3F 2M	Renter	SS1, SSI2
1891 (90)	F	Married	Family w/step niece	4F 2M	Renter	SSI
1894 (87)	F	Widowed	Alone	1F	Renter	R3, SS
1897 (84)	F	Widowed	Da. & Da.'s Husband	1F	Renter	SSI
1899 (82)	M	Married	Lives with wife		Home Owner	SSI
(N = 4) 1901 - 1901						
1901 (80)	F	Widowed	Alone until sickness Skilled nursing home	1F	Home Owner	SSI
1902 (79)	F	Widowed	Daughter	6F	Renter	HP4, SSI
1906 (75)	F	Widowed	Brother & Bro.'s wife	1M	Renter	SS, R
1906 (75)	F	Widowed	Alone	2F 1M	Home Owner	SS, HP
(N = 6) 1910 - 1919						
1911 (68)	M	Divorced	Ex-mother-in-law/Son	1F 1M	Home Owner	SSI
1911 (68)	F	Widowed	Alone	1F 1M	Renter	SS, R
1911 (68)	F	Widowed	Alone	3F 1M	Home Owner	SSI
1912 (67)	F	Widowed	Niece/Niece's husband	3F 1M	Renter	SSI
1918 (63)	F	Widowed	Cousin/board & care	1M	Renter	D5, SSI
1919 (62)	F	Divorced	Daughter	1F	Renter	D, SSI
(N = 1) 1920 - 1929						
1926 (55)	M	Widowed	Sis/Sis's hus./Mother	1F	Renter	S, SSI

TABLE 3-1 (CON'T)

LEGEND:

1 Social Security
2 Supplementary Security Income
3 Retirement
4 Husband's Pension
5 Disability

DA = Daughter
Sis = Sister
Hus = Husband
Bro = Brother

AGE - DECADE AND SEX

There is no doubt of the skewing factor favoring the very old (mean = 74.7 years of age) as visitors to the Center. It may be as the Director claims, that the skewing is attributed to the high employment rates of 55 to 65 year old aged. Or, the number of "very old" at the Center may be explained by a desire on behalf of offspring or other family members to get their elderly members out of the house and into social interactions with other aged individuals.

With respect to sex, it is obvious that females easily outnumber their sexual counterparts at the Center. Explanations for this phenomenon have to be extended beyond the proverbial "women outlive males at all age categories." A personal survey of one of the neighborhoods in P.S.S. revealed a number of very old males who were still working (as janitors in elementary schools or as maintenance in laundry mats), or congregated in small masses at any one of four barber shops. On the other hand, it may be a truism that Black males do not either have time for luxury items like senior centers, or do not stop "running the street" until they die. Or, it may be that these men are married or attached to younger women who look after them.

MARITAL STATUS

With one exception, all of the female study participants are widows. This "fact" does not represent the desire or efforts of these ladies however. For example, it has been noted that both Mother January and Mother March may have lost two husbands but are still in the market for another husband. Nor does the classification "widow" reveal that Mother August recently and suddenly lost her husband to death and that she has not yet adjusted to widowhood. Indeed, a general attitude characterizing the female study population is that if the males were available, most of the women would remarry.

The two unmarried (divorced or widowed) males apparently shall remain so as a result of irreverseable physical disabilities. The sensitive nature of one of these disabilities and the need for anonymity prevents discussion of this case. The other male (son-in-law of Mother January) suffered a stroke and is partially paralyzed.

LIVING ARRANGEMENTS

The living arrangements of this study population range from the single-person household to the convalescent home. If the living situation of the Black elderly can be characterized at all, it would have to be

the pattern of living with family. That is, the majority (62.5%) of this elderly population resides either with offspring, siblings, or other related family members (N = 8).

Five or 31.3 percent of these aged individuals lived alone at some point during this study. One such individual was eventually committed to a skilled nursing care facility. Of those elderly residing with family, six lived in a three generation familial situation. This practice, for this study population, is dominant for those elderly who reside withh family members. The economic viability of this practice is, of course, open to debate (Jackson, 1968; Lopata, 1975). Other living arrangements observed include residence with other siblings or with fictive family.

NUMBER OF CHILDREN

The term "children" in this study means those who are the product of marriage, those acquired through remarriage, and those who are either adopted or viewed as fictive kin. With respect to the study population, two patterns are worth brief mention. The first pertains to the small number of offspring produced by individuals in the study population (Mean - 2.4 children per family). The limited number of offspring and the low income status of most of these families indicates a limitation of availability of resources and support. What may be

operating to offset the consequences of fewer children is increased educational levels and better occupational opportunities with higher wages.

The second pattern related to adopted and/or fictive family relations. It is a pattern which seemingly has been used in Black families since the disruptive period of slavery, and which precedes the entry of Africans in large numbers into the United States (Benett, 1962). The use of fictive kin terms by this population is in keeping with that tradition. Thus, Mother February Page 90) indicated she lived with her "daughter" but further questioning revealed that she had no natural children of her own while she was married. Instead, she elected to help raise the six offspring her ex-husband brought with him to the marriage state. Mother February lives with her step-daughter and her husband and children.

Another step-daughter flew Mother February to Arizona last summer, but she was home three months later complaining of daughters who wanted to make baby-sitters out of their mothers. Mother February who raised her husband's step-children "as though they were her own daughters" expects them to behave as such. She is not greatly dismayed when they attempt to exploit her as baby-sitter. That too, she expects. Mother January (age 90) introduces a young thirteen year old female who is

white as her daughter and does not draw even an eye-blink. Mother February is the only individual in the study population who was without natural children of her own.

RENTERS AND HOMEOWNERS

Most respondants rent rather than own their homes. Five individuals indicated they were homeowners. Eleven of the elderly said they were paying rent and this includes the one individual residing in a board and care home. In the case of those paying rent, further probing indicated that in eight of these cases the rent was being paid directly to a younger family member. Of the five seniors who listed themselves as homeowners, three were receiving payments from one of their offspring and their married mates where the latter resided with his/her elderly parent.

Two of the seniors, now paying rent to their respective offspring, recently owned their own houses. Mother July (age 75) was living with her son in Southern City until her house burned down. Mrs. July's brother raised questions about payments for the house for which Mrs. July was still sending money to her son. When her brother did not receive a satisfactory response to his questions from the son, he flew to Lousiana, packed his sister's bags and brought her back to California to live with him and his wife.

ECONOMIC STATUS

All of the elderly individuals in this study rely heavily upon Federal income maintenance programs - principally the Retirement and Survivors Insurance program (also know as Social Security), and the Supplemental Income (SSI) program, both being administered by the Social Security Administration (SSA). Within this study population there is only one individual (female, age 68 years old) who is presently employed and continues to receive earned income which is also supplemented by Social Security (SS), Supplementary Security Insurance (SSI) and a retirement pension. Table 3-1 also reveals there are only three other individuals (ages 90, 87 and 75 years of age) who had worked long enough to pay into social security and then be eligible for its benefits when they retired or reached age 65. One individual was receiving social security from her husband's pension. Easily, the majority of these individuals (N = 10) were dependent on SSI as their primary source of financial support. Additional sources of income support available from pension plans and/or life insurance policies was information not obtained.

RESEARCH SETTING:
THE PACIFIC SEA SIDE COMMUNITY (P.S.S.)

RESIDENCY, ETHNICITY AND RACE

The P.S.S. community is bounded by a freeway to its east and south and two major thoroughfares to its north and west. Seventy-six percent of the neighborhood is residential while ninety-five percent of the homes are single family dwellings. Commercial land use in the P.S.S. is only five percent. Industrial land use is only one percent (Table 3.2).

With respect to ethnicity and race, P.S.S. is a multi-cultural community with Blacks comprising a large majority (63 percent) of the population (Table 3-6).

TABLE 3-2 LAND USE: P.S.S.
Source: CORO Foundation 1977

Uses of Land	Residential	Commerical	Industrial	Other
%	76	5	1	18

Housing	Owner Occupied	Renter Occupied	Vacant	Total
Number	4,224	1,467	176	5,867
%	72	25	3	100

Housing Condition	Poor Condition	Total Units
Number	99	6,232

%	1.6

TABLE: 3-3: FAMILY TYPES AND INCOME: P.S.S.
Source: United States Census 1970

	Total Families	Male Headed	Female Headed
Number	4,496	3,732	764
%	100	83	17

TABLE 3-4: FAMILY TYPES AND INCOME: P.S.S.
Source: United States Census 1970

Marital Status:

Total Persons over 14 years of age	Single	Married	Widowed	Divorced
4,573	3,869	8,013	1,105	829
100%	28%	58%	8%	6%

TABLE 3-5: OCCUPATIONS: P.S.S.
Source: United States Census 1970

Occupation All Workers	Managerial Professionals	Skilled	Semi & Unskilled
7,729	1,082	4,251	2,396
100%	14%	55%	31%

TABLE 3-5: OCCUPATIONS: P.S.S. (Con't)
Source: United States Census 1970

Getting to Work	Auto	Bus	Walk	Work at home	Other
7,468	4,107	1,866	244	75	1,195
100%	55%	25%	3%	1%	16%

TABLE 3-6: P.S.S. POPULATION BY RACE
Source: CORO Foundation 1977

Black	Chinese	Filipino	Latin	White	Other
63%	1%	3%	17%	22%	1%

In summary, P.S.S. has a population of 17,619 with the majority of these persons living in 4,496 family units. The primary family type is the nuclear family and the majority of residents are Black (Table 3-3).

OCCUPATIONS

P.S.S. is primarily a working-class neighborhood, with only fourteen percent of its residents (N = 7,729) working in the managerial or professional occupation (N = 1,082) (Table 3-4). A large proportion of the population is low income; forty-six percent of Sea Side families had incomes of less than $10,000 in 1970 (Table 3-4).

RELIGION, GOODS AND SERVICES

From a religious perspective the P.S.S. community reflects its multi-cultural population. The range and variety of religious services available include Baptist, Catholic, Methodist, Presbyterian, Episcopal, Jewish, Seventh-Day Adventist, Lutheran and other separate denominations. Baptist churches are visible and predominant throughout P.S.S.

Goods and services such as large food centers (QFI, Inc. and Safeway), drug and general merchandise store lie adjacent to the P.S.S. community. More typical and interspersed throughout the Sea Side are the "mom and pop" corner stores.

MEDICAL AND HEALTH SERVICES

Medical and health services also lie adjacent to the P.S.S. Although they are within a ten to twenty minute driving range, factors such as discrimination, social distance and finances create barriers to their accessibility (cf. Shiloh and Sclavan, 1974). That is, variables such as race and class occupy an important position in the delivery of medical, health and social services. The more ethnic and class similarity there are between provider and consumer, the more accessible delivery becomes (Guttman, 1979).

Because of race, language and other cultural differences, the majority of P.S.S. community residents must rely either on private physicians out of the area or on the emergency services at major medical facilities such as the St. Rose General Medical Center (public), Wilheim Hospital (private) or the St. Rose General Medical University Complex. The average distance a resident must travel to the nearest health care facility is six miles and requires from sixty to ninety minutes by bus.

The major health problems of P.S.S. residents reflects the age distribution and occupational distribution within this community. A 1981 public health department survey indicated there is a high infant death rate -- one census tract (#213) had a rate of twenty-nine deaths per 1000 live births compared to the city-wide rate of fourteen deaths per 1000 live births. There is a high rate of low-birth-weight per 1000 live births; e.g., in 1976 P.S.S. had a low birth-weight rate of 164.2 per 1000, compared to the overall P.S.S. area rate of 81.0 per 1000. Also there is an increasing rate of teenage pregnancy, a high rate of drug abuse, and a high rate of high blood pressure.

PUBLIC TRANSPORTATION

Readily accessible throughout the Sea Side is public transportation, although automobiles remain the primary mode of transportation (Table 3-5). The St. Rose Municipal Transit System has lines on all the major thoroughfares which border this District. However, comparison of public transportation available in the St. Rose supervisorial districts by the CORO Foundation in 1977 revealed that P.S.S. is very near the bottom of the list with respect to the services provided by the St. Rose Municipal Transit System (i.e., the actual number of seats that travel through the district). A twenty to thirty minute wait between buses is not an uncommon complaint voiced by this community's residents.

In summary, a brief socio-demographic description of the P.S.S. community has been provided as a backdrop for an examination of a senior center recently opened. The community was shown to be primarily a blue-collar, working-class, residential neighborhood. The P.S.S. contains a multi-cultural population with Blacks comprising over sixty percent (63%) of the total P.S.S. population. The community has an elderly (over 60) population of fourteen percent (14%) as well as a high percent of individuals seventeen and under (32%). The type of health problems endemic to P.S.S. reflect age categories. There are many home bound elderly. For

example, the 1980 census figures for non-institutionalized elderly Blacks listed 902 such individuals out of a total population of 28,923 for the City of St. Rose. There is a high infant death rate and a high low-birth-weight rate. P.S.S. is characterized by a lack of health and medical service.

THE P.S.S. SENIOR CENTER - PAST AND PRESENT

PAST

The high percentage of residential houses and the low percentage of industrial type facilities combined to limit the availability of potential locations for the Center. The drop-in Center was initially located in Traveler's Baptist Church (TBC) constructed in 1951. According to the director, having the Center situated in the Church appeared to be a good practice, as the Church is allegedly the most stable institution in Afro-American communities and the Church is centrally located in the neighborhood. By being situated in the Church, the Center also would benefit from foot traffic as well as from its ample space. More importantly, the rent was within the range set by the St. Rose Council of Churches. The Church benefited from this arrangement as well, for not only was rent to be paid, but the facility itself was to be used daily, an action Church Board Members desired.

The complete building was given over to the Director and her staff of three (an assistant director, a social worker and a senior service aide). The Church facilities included the upstairs, which housed a large kitchen and an office with a huge work storage area. The downstairs area contained an alcove, restrooms, the sanctuary with its ever present pews, (twelve each and evenly divided on both sides of the sanctuary), two pianos, the choir-loft a step above and behind the pastor's podium, the pastor's office, and a storage space where additional tables and folding metal chairs were located. The sanctuary's ceiling was a good sixty feet or better above the floor.

After six months at the Church, problems with the physical plant from the perspective of the seniors and the staff became evident. For example, the distance between the floor and ceiling and between the alcove and the choir-loft presented a problem as the sanctuary was never warm enough for anyone, particularly the seniors. Compounding the lack of adequate warmth downstairs was the fact that the heating system was located upstairs in the storage area set off from the staff's office. They would quickly get warm and turn off the heater believing it was warm downstairs. The attire the seniors wore was appropriate for a cold weather climate; large bulky full-length overcoats, which permitted the

wearing of one or two wool sweaters underneath. Most of the ladies would also wear knitted wool caps atop their heads which were pulled low enough to cover their ears. The males would also wear hats but would take them off upon setting foot through the Church doors.

But it was not only the open space in the sanctuary which made for a cold and unfriendly environment. The decor of most Churches leaves a lot to be desired with their long and slender stately windows and their ominous religious bearing. Traveler's Church is no exception. The fear of being sacreligious by the Center's participants also contributed to a seemingly cold environment. This fear among seniors and staff prevented them from hanging anything on the walls. A radio set was given to the seniors but it was never played loudly for fear that such behavior might also be misinterpreted. The Center's staff was constantly kept off balance as well by irregularly scheduled Church activities. Never knowing what would transpire between the evening work and the next morning, few items except tables and chairs would be left out. Art and craft pieces were frequently found broken or missing, and resetting looms or unknotting strings were a daily chore.

A related problem was the location of the staff's office and the kitchen (where staff frequently congregated to chat informally), both of which were upstairs above the sanctuary. In the thirteen months the Center was located at the Church, only one of the elderly females (89 plus) ever climbed the stairs. Two males (age 63 and 62) were constantly up and down serving as "go-fors" between seniors and staff. The location of the staff's office functioned as a barrier limiting social interaction and activities between staff and seniors.

Mobility within the Center by the aged was restricted due to the lack of adequate warmth, and the location of the stationary wooden pews. Few seniors objected to sitting on the pews as these were somewhat warmer. The permanent placement of the pews greatly limited the amount of available floor space for social interaction and the structured activities. Although the entire sanctuary was open for use to the seniors, the pews' location in the center of the Church sanctuary reduced the useable space to either the front or rear of the pews. Typically arts, crafts, classes, and game-playing occurred at the tables situated in front of the pews, while dining occurred at tables located behind the pews.

In summary, naturally inhibiting Church barriers functioned to retard not only social relations within the Center, but these barriers also restricted the range of services and activities the Center could offer as well. Moreover, the Center did not get the foot traffic as its Director initially believed. Many of these same elderly related that they would be afraid to play cards or dominoes in such an environment.

PRESENT

It was a real relief thirteen months later when the director announced that the Center would be relocated diagionally across the street at the old arcade building. From a cosmetologist at the neighborhood beauty salon, it was discovered that the new site of the Center had once housed a penny arcade on the first level, and a doctor's office on the upper level. The "Arcade", as it is coloquially referred to, is an elongated "U" shaped building running north and south. At the time of this writing the Center had been operating in the arcade location for approximately eighteen months, occupying almost the entire lower level. On the lower level, facing south is a separate realty office, and then, the core of the Senior Center -- the sitting and dining rooms. Initially, these were two separate rooms but they are now commonly connected

by a recently constructed doorway. In addition to being much smaller (16 x 12, and 24 x 12 respectively), both rooms are warm in marked contrast to the Church. The warm atmosphere as well as the pride of the Center emanates from the numerous art works produced by the seniors which are displayed on the walls. These artifacts include such things as knitted baby shoes and mittens, decopages, art pieces, photographs, and quilts.

All the rooms have individual wall heaters. The wall heaters, the small sized rooms, low ceilings, and the carpeted floors in the sitting room all make this new setting warm and comfortable. Completing the decor of the sitting room are a couch (which typically seats three sleeping bodies), several "prized" padded chairs, three folding metal chairs (for the incontinent"), a coffee table with a floral arrangement and health education materials arrayed across it, a bottled water container, a large work table, two desks and accompanying metal chairs for staff members.

The dining room is carpetless. Four 16-foot tables take up most of the floor space. Two of the tables run north and south while the other two sit perpendicular to the first two and run east and west. Along the common wall to the sitting room is a folding card table, on which sits a coffee urn and coffee pot -- one holding

coffee, the other hot water for tea. Sugar cubes, cream, and plenty of napkins round out the remaining articles on the table. Along the east wall of this room are three steam servers which keep the "hot meals" warm. These steamers are usually turned on about 9:30 a.m. and are well heated by the time the "Meals on Wheels" arrive between 10:30 and 11:00 a.m. Utensils for serving meals, along with those for setting the tables (napkins, plastic forks, spoons, knives, and cups), sit on a table next to the servers. A closet is the remaining item along this wall. It holds the bingo paraphanalia as well as the necessary brooms, mops, and mop bucket. Above the servers is located a bulletin board on which is usually posted the daily menu. The dining room also serves other purposes such as a classroom (especially for the films that are shown), market place (for the once a week mini-vegetable mart), and smoking area. The two skylights in the ceiling of this room allow sufficient ventilation for smoking.

Across the corridor of the arcade, centered between the beauty salon and an old dress making shop is the arts and crafts room. Three randomly placed tables with their concomitant folding chairs, a radio, and a storage table comprise the furnishings in this room. Laying on the storage table are the looms and various threads used for weaving. The arts-crafts room also serves as the conference room for the different "group process"

meetings, exercise and music classes. This room is also carpeted making it easy to heat, and its walls are adorned with the art work of the seniors.

It is within these three rooms that the Center's participants come together to talk, work, or gossip. They conduct their social interactions and develop friendships and networks. These evolving friendships and networks are infringed upon by the funding agency's prescriptions and the director's ideology which constitute key determinants in the formation of the Center's social organization is described in the next chapter.

CHAPTER IV:

SOCIAL ORGANIZATION IN THE EVOLVING SENIOR CENTER

INTRODUCTION

Chapter Three characterizes the Pacific Sea Side (or P.S.S.) neighborhood as having a predominantly Black (60%) population which consists of blue collar workers the majority of which own their won homes and cars and have skilled professional jobs. It was also seen that the neighborhood contains few community social and health services, especially those intended for the aged. What few services do exist for the aged population are characterized by restricted operating hours and reduced services (see Chapter I). Whether or not these qualities are typical of in the delivery of social and health services to minority communities in general remains to be seen. It must not be assumed that the type of services delivered to the aged function to meet the goals or objectives as set by the funding agency. What will be seen in the following pages, is that the achievement of these aims was greatly hampered by limited financing received from the funding agency, which had the effect of creating a gap between the funding agency's goals and what was realistic with respect to the delivery of services to the P.S.S.'s elderly population.

Chapter four focuses on the Senior Center's evolving social organization, the "systematic ordering of social relations by acts of choice and decision" (Firth 1961:40). The Center's social organization is examined in light of the structural variables which influenced the myraid relationships taking place within the Center.

This chapter is divided into four sections. The first section delineates the Center's objectives and goals and contrasts the influence of these goals on the structuring of services with the officially defined responsibilities of the staff positions assigned to the Center. The intent of this analysis is to show how these goals and objectives were met through formal and informal structured activities and services within the Center. Section two explores the aged population's desire and efforts to remain independent through examples of social activities, specifically dominoes and the functions these activities fulfilled.

Section three assess the role of economics and politics in the structuring of the Center and the Center's social organization. Finally, section four examines the informal social relationships and interactions which evolved coterminously with the formal activities offered by the Center.

THE CENTER: OBJECTIVES, ORGANIZATION AND STRUCTURE

From 1978 - 1981, the Senior Center's social structure was to gain its formal or manifest form from the structure imposed by the funding agency. The funding agency, in order to develop a comprehensive and coordinated delivery system needed by the aged in San Francisco prescribed the personnel positions, their role content, and their statuses vis-a-vis each other and the funding agency. The functions served by this social form were mandated in the goals and activities which held for all senior centers in thier delivery of services to the elderly.

ROLES AND STATUS OF THE P.S.S. SENIOR CENTER

As mandated by the St. Rose Commission on Aging (hereafter the funding agency), the funding agency overseeing the delivery of services to the elderly, the Pacific Sea Side Senior Center was to open its doors with the following staff positions; a full-time director, a full-time assistant director/social worker, a nutritionist (6 hours daily) and an escort aide (4 hours daily). At the top of the status hierarchy is the director whose primary responsibilities are to administer and direct the Senior Center. This person's duties include: setting the operating hours for the

Center; contracting for consultative services such as psychiatric assistance; maintaining records for attendance (staff and elderly); budget affairs and personnel; arranging for the types of activities and services mandated by the funding agency such as field trips and classes; information and referral services for legal, financial, and health needs; maintain relations with other aging agencies (see SFMPSS, 1982); and, of course, hire and fire personnel. Within the latitude allowed by the structural mandates imposed by the funding agency, the individual in the director's position held sufficient power to shape the Center according to his or her own ideology. A later section describes in more detail the director's influence in the structuring of the purposeful activities and work.

The other staff positions mandated were a social worker, a nutritionist, and an escort aide. The social worker position carried the status of being the assistant director. This position was characterized by the following responsibilities: to conduct initial screening for all elderly using the Center; to maintain and update all files and records on the Center's users; to make referrals to legal, mental health or social service agencies; to make home visits for evaluation of home-bound seniors, and to monitor medications. The nutritionist's duties are narrower than those of the social worker. This individual plans the weekly menus

The nutritionist's duties are narrower than those of the social worker. This individual plans the weekly menus after consulting with the elderly participants; prepares the meals and with the assistance of other staff members (the director and assistant director, etc.), serves the food, and keeps the kitchen clean.

Inadequate salary and low hours doomed the nutritionist position to failure, and eventually the individual was dismissed and the functions transferred to other staff members. The major reasons explaining this failure include the fact that the position was not only part-time, but the pay was inadequate as well. Also this individual was unable to consult with the elderly participants at the Center. Repeated offenses by the nutritionist included an overcompensation in reducing the amount of sugar and salts in preparing foods, the omission of pork dishes and the constant removing of the outer skin whenever fried chicken was served. From the elderly's perspective, this skin was the best part of the meat.

In analyzing the failure of this position, several factors require attention. Although the main reason for the failure of this position was structural, i.e., inadequate pay, the individual occupying this position repeatedly "didn't do right" according to the elderly

consultation about the weekly menu was to occur. Although she did consult with the elderly, the nutritionist did not implement the wishes of the aged participants and they complained. The director interceded but to no avail. The nutritionist was fired and cooking chores were assumed by the other staff members until an agreement was made with "Meals on Wheels" to deliver meals to the Center. The nutritionist's lack of raport with the elderly was debilitating as the insufficient pay and both had untoward effects on the delivery of services.

The escort aide's position met with better success. The duties of the escort aide included accompanying the elderly who needed or requested assistance for shopping, recreational outings, medical appointments and the like. The funding agency prohibited staff members from using their own cars to provide rides for the elderly during working hours due to liability concerns. Transportation was to be either by public carrier or a privately sponsored paratransit organization. Although public transportation is available in the P.S.S., the buses do not always run on time and cannot heed the expressed needs of its elderly clientele. The Center's staff contracted with a privately run paratransit organization but numerous complaints from the elderly about late buses or buses that did not arrive, or rude and uncivil drivers, quickly caused the staff to terminate the

contract. The result of limited transportation seriously hindered the escort aide in fulfilling her position responsibilities. Subsequently the director and her assistant successfully wrote a proposal creating a paratransit unit within the community sponsored jointly by the P.S.S. - Community Association (P.S.S. - CA) and the Center. The P.S.S. - CA is a voluntary association comprised of community residents whose goal is to maintain a neighborhood of which all residents can be proud.

MANDATED GOALS AND ACTIVITIES OF SENIOR CENTERS

The Center's objectives as determined by the funding agency were put forth in a report outlining the health and social services available to the elderly throughout the entire city by the St Rose Multi-Purpose Senior Services Project (SFMPSS). This report defined the goals of the senior centers as "places where older people can socialize, express and share their common concerns, and find services which assist them to maintain an independent lifestyle" (SFMPSS, 1982). These very exemplary objectives must be regarded as an example of generalized goals which are not directly tied to the operationalized goals and methods for evaluating their effect and outcome on the delivery of services and activities at the Center.

Firth (1961) noted that to analyze a field of social relations in terms of only structural determinants as roles, positions, or status is to omit the process of social change and how variations to existing rules are created. What follows, therefore, is an examination of the P.S.S. Senior Center's goals, as it is determined not only by the formal attributes of the director's position, but set by the personal attributes of the individual as well. If, as Firth asserts, the key to the modification of social structure is decision-making, then it follows that an individual reaching decisions will make them on the basis of previous experiences and other attributes such as occupational history, cultural ideology, attitudes toward aging and the aged, as well as knowledge of community or neighborhood resources. It is in this light that the director's position is briefly examined.

Both the P.S.S. community and specifically its elderly population were fortunate. The individual hired to fill the director's position, Miss Cook (a pseudonym), came to the position with practical experience and training in the aging field. Her educational background includes a bachelor and masters of art in social work. Before assuming the director's position at the Center, Miss Cook was director of the Senior Block Information and Referral Services, and had

worked part-time as a social work assistant for a residential care home program. Moreover, she had developed a yearly health fair, with service providers dealing only with health problems related to the elderly. It was to be a combination of occupational and personal attributes which the director possessed that played a significant part in determining the scope of services and activities the Center was to offer. Indeed, Miss Cook's previous occupational experiences, her understanding of the needs of seniors, her knowledge of other existing community resources and services were all important in structuring the goals of the Center.

Miss Cook's primary consideration in designing services for the aged focused on "structural activities." In the following report she provides rationale for this overriding concerns:

> I chose to have planned activities because I usually try to put myself in the other person's position, regardless of age, because if I was going someplace, what would I go for? I would certainly want to go for communication with other people and socialization. But I'd like something going on at that time. So we looked at the community services that could be provided free to the elderly, then we contracted with different people and asked them if they could come in to the Center to provide these services. So that the Center became structured, rather than non-structured.

That is, in keeping with the general goals put forth by the Senior Services Project, the P.S.S. Senior Center objectives were pragmatically grounded on what

the older people said they desired as well as the director's experience gained from previous occupational positions. The Center's objectives as determined by the director were to include: communication and socialization, the reduction of social isolation, social and health services, and referral services for housing, legal and financial needs. Activities such as congregate noontime meals, bingo and recreational outings functioned to reduce the degree of social isolation some of the elderly experienced. Classes on health and hygiene, stress reduction, high blood pressure or hypertension were offered to address the health needs of the elderly population. The director also arranged for an accountant, a lawyer, and an individual from the housing authority office to come to the Center once a month and give advice to those elderly requiring help in these areas. Other classes included current events, conversational Spanish, music (group singing), exercise, reminiscense class, arts and crafts, and Black history.

ECONOMICS, POLITICS AND SOCIAL ORGANIZATION

The opening of the P.S.S. Senior Center in 1978 represented the delivery of a fulltime service for the first time in the Sea Side community. The existence of the Center resulted from community action for the development of such services, with participation in the

planning of these services by minority communities (Chinese and Black). Previous to the Center's existence, services or programs for the aged in P.S.S. were offered sporadically. The coordinator of these services operated them four days a week at two alternate sites in the community. The limited activities that resulted from the infrequent days and hours consisted of exercise classes, arts and crafts, music and singalong sessions, and congregate meals. These constitute mainly recreational activities and not the range of social, legal and health services needed by seniors. In addition, these services were conducted in churches which volunteered their facilities, an obvious cost-effective mechanism.

The fragmented nature and the location of these services prevented access to and coordination with other community programs and organizations (cf. Guttmann, 1979) such as the legal assistance program or the information and referral services. Informal conversations with elderly users of these fragmented services revealed that many participants "happened upon" it while walking about the neighborhood. A few elderly initially believed that these services were intended for "the crazies" because so many of these individuals were frequently at these sites. It may be that the funding agency was attempting to serve as much of P.S.S.

as possible, as these churches were at opposite ends of the P.S.S. community boundaries (one service being located in the southwest corner and the other being situated in the northwest corner). But the overall effect of the agency's efforts were being misinterpreted by P.S.S. residents. The outcome was a further underuse of what few services existed within the P.S.S. This underutilization may have supported or functioned to justify additional financial and service reductions from the agency's perspective.

Coordinating these services and facilities was the responsibility of one fulltime staff position. This individual was to oversee the daily operation at each of these separate locations as well as the management of such services located outside the P.S.S. A cadre of consultants (especially mental health related personnel) functioned as a supporting unit for this individual and at the behest of the funding agency, but the core of services for the elderly were provided by individuals of all ages and races who volunteered their time, energy and effort.

In brief, the delivery of services for the aged in the P.S.S. before the Senior Center were of a sporadic and limited nature. They were never destined to address the problems of participation of public services nor the problems Blacks experiences in gaining access to these

services. As will become apparent in the following pages, the fulltime services the Center provided were also remiss.

Shortages and limitations imposed by inadequate funding characterized the Center. The annual budget for the Center was $23,000.00. Such a small budget made it impossible to adequately staff the Center given the funding agency's scale for staff positions within the Center in 1978: Director, $18,000 $23,000.00; Assistant Director/Social Worker. $14,000 $19,000; Nutritionist, $11,000; Escort Aide, $9,000.00. At the minimum, the start up budget for staff positions alone required $52,000 to $66,000 dollars. The Center's director faced an insolvable problem of staffing the Center with a fulltime director and two aides with only $23,000.00 dollars. Needless to say, there was no money for activities such as arts and crafts and other provisions such as coffee and tea. The salaries offered are noncompetitive, many professionals accepting these positions would not be able to earn a liveable wage. The City and County of St. Rose in conjunction with the Commission on Aging determined where, when, and how services for the aged were to be delivered. Minority input was seen to have the effect of creating the delivery of an elderly service on a fulltime basis to the P.S.S. community.

The Senior Center's creation was a direct outgrowth of political manuvering by the community residents. Unfortunately, these well-intentioned individuals did not address the financial bases for the Center's survival. Success and survival of the Center was left to the discretion of its director. Her knowledge and previous experience in the aging field made her aware of existing services and alterative voluntary helping agencies. For example, she sought and received help in the area of activity classes from Pacific Heights Community College. The college pays its instructors on an hourly bases for teaching a range of activity classes at different sites like the Senior Center. The classes at the Center included crocheting, current events, music (Gospel), Black history, small item repair, health education, stress and loss, and a class on death and dying. The instructor for the health education course was paid for by the Public Health Department.

Similar to the health care course offered by the public health nurse, all of the physical and mental health services originated from sources outside the P.S.S. community. The health care course was sporadically offered, depending on the nurse's time and energy. Her primary objectives were high blood pressure testing and preventive health education. These services were conducted on a monthly basis. The other health services were less frequent and their delivery depended

on the volunteer branch of health educational institutions, such as the Community Health Education Program of the St. Rose Medical University. Under the auspices of this program, two of their dental students came to the Center and provided dental and denture examinations on two separate occasions. Although infrequent, these dental services identified the dental health care needs of each senior. The results of these examinations were given to this population as well as to the Center's staff. Since there was no follow-up dental service or continuity of care however, the direct benefits to the participants are questionable.

Insufficient funding also undermined attempts to provide services in podiatry and psychiatry which were contracted for by the Center and the city-wide funding agency. Similarily, underfinancing of the Center limited the types and range of activities and services arranged with volunteer agencies like the community college as well as with other health and social agencies which reside outside the P.S.S. community. As the effects of state manipulated cutbacks in the property tax base of the City were instituted, courses offered to the Center by the Pacific Heights Community College were no longer funded. Following these cuts, the remaining classes at the Center included music, current events, and a film class. Reductions also occurred among

staff. Lost at one point were the Assistant Director/Social Worker as well as the Escort Aide positions, leaving just the director to staff the Center.

When the initial underfinancing in combined with further budget reductions and the elimination of staff positions, the ability of the Center to meet the needs of the elderly stated within the Center's objectives was no longer possible. These reductions occurred immediately following the Center's relocation to the arcade building. Until the director successfully lobbyed the Council of Churches for more help, she either relied upon volunteers or operated the Center alone. (The longest the director was without paid professional help was three weeks). The Center continued to offer courses staffed by Pacific Heights Community College, but legal aide, information and referral and counseling services for the elderly were curtailed. As a result, the effect of budget and staff reductions became manifested at the structural level of the Center.

Property tax cutbacks and their impact notwithstanding, it is important however to see the effects of underfinancing manifested among the social relations and interactions of the Center's participants as they respond and adjust to these economic and politically derived constraints. The following section

will describe the latent functions the Center was able to meet as a result of the development of a "spontaneous community" (Hoschschild, 1973) within the Center. At the heart of this community lie the social relations as they occur within the Center. Social relations and the determination of the Center's aged population to remain independent and autonomous are respectively explored in the following sections.

SOCIAL RELATIONS, INTERACTIONS AND SOCIAL ORGANIZATION

Social relations and interactions between the Center's participants are influenced by the objectives and goals as delineated by the director of the Senior Center; within the concomitant duties and responsibilities of staff positions; and within the controlling influences of such variables as politics and economics. The relations and interactions between staff and elderly and elderly and elderly, for example, are an equally important constituent comprising of Senior Center's social organization. The evolving interactions and relationships constitute the dynamic or processional compliment to the inherent static structural roles and positions.

In a recent article exploring the utility of locally based social networks, Evans and Northwood

relationships constitute the dynamic or processional compliment to the inherent static structural roles and positions.

In a recent article exploring the utility of locally based social networks, Evans and Northwood (1978) present what they call a" mutual aid investment theory." The theory attempts to explain why people become involved in natural helping networks and, at the same time, incorporate a workable methodology which allows researchers or planners to identify the network structures formed at the interpersonal level (i.e., the dyads, triads, their combinations, and the qualities of network size, density, intensity and heterogeneity). Basic concepts of the theory are "mutual aid" by which is meant social and helping activities as collective; and "mutual aid network" which consists of individuals in these types of activities.

The mutual aid theory is used to organize the types of caring and sharing behavioral interactions taking place among the Center's participants, and to explore the latent functions which are met through this sharing and caring behavior. Sharing and caring behaviors are defined as items or actions which were exchanged repeatedly in the Center, gift giving, recognition services, and affection. These behaviors functioned to transcend social differences, so that an alliance bond

Sharing and Caring

One very noticeable method this elderly population used to establish new relationships was through the giving or exchange of gifts.

EXAMPLE 1 Observational Notes

> Mother January (89, Black) and I are playing dominoes. The bus has just arrived and is unloading its passengers, one of which is Mr. Tuesday (88, Asian). He comes in, walks over to our table and hands Mother January a bottle of white rose oil for her ailing knees (arthritis). In his best English, he tells her not to get any of it in her eyes. She thanks him and replies she will be careful in using the oil.

Previous to this exchange, Mother January and Mr. Tuesday were cordial with one another, but their mutual likeing for conversation was restricted by a language barrier. Following this exchange, Mother January made it a point to invite Mr. Tuesday to play dominoes whenever a game was to begin. Mr. Tuesday was always accompanied to the Center by his wife, who spoke no English. Thus, Mr. Tuesday was reluctant to leave her working by herself for too lengthy a period.

EXAMPLE 2 Observational Notes

> Mother January got hungry while playing dominoes with Mother March, Ms. December and myself. She pulled out a sandwich (hamburger patty stuffed between two apricot halves which in turn were stuffed between two heels of the breadloaf) and offered it to myself, Ms. December and suprisingly Mother March. Even more surprising, Mother March accepted half of the sandwich. Ms. Rose (age 72, Black) immediately asked Mother January if she wanted coffee with her sandwich, which Ms. Rose got for her when Mother January replied "yes". The sandwich spent, Mother January pulled out another which she also shared with Mother March. The latter apparently got thirsty, for she called over Ms. Rose and asked her to get a glass of water. Without comment or second thought, Ms. Rose got the water for Mother March.

Although Mother January and Mother March were not new to each other, their periodic spats with each other constantly disrupted their "friendship". Prior to this food sharing event their relationship had suffered an almost mortal blow as a result of a shouting match over who cheated the most while playing dominoes. Both are very strong-willed, independently spirited persons. These two were constantly at one another about cheating during dominoes, cards or other competitive events. Both were articulate during classes such as contemporary events and conversational Spanish. It was always fascinating to see them in situations where they were either compelled to cooperate (brunches, funerals) or in interactions just between the two of them such as in the cited example (#2).

EXAMPLE 3 Observational Notes

> Ms. December (age 63) is still going on about how Ms. September (age 68) had brought her a bag full of clothing to the Center which Ms. September no longer wears. Ms. December is especially boastful about a housecoat which was included in the lot. This happened yesterday. Ms. September is at work today.

Ms. September's altruism reflects her religious bearing and training. She is thankful for her job as a salesperson, and her sharing what she has with others she sees as an expression of the gratitude she feels. Whenever Ms. September comes to the Center she and Ms. December hold conversations. Ms. September is aware that Ms. December recently moved to a board and care home to escape an uncomfortable living arrangement.

EXAMPLE 4 Observational Notes

> Ms. Pansy just informed Mr. Thursday, one of the community college teachers, that she bought him a present, had he seen it yet? One of the staff had hung it on the wall not knowing who it belonged to. The present was a picture of a very beautiful African woman.

The exchange of gifts or sharing of items such as food had the effect of reducing differences in the areas of age (Example 4), sex (Examples 1 and 4), race or

ethnicity (Example 1), language (Example 1) and socio-ecomomic (SES) differences (Examples 2 and 3) for the participants in the Center. This method was vital in the reduction of tension as well.

Recognition Services

The exchange of gifts or sharing and caring in general was not unilateral. Staff and even visitors to the Center frequently demonstrated affection for the elderly. Birthdays for example, were always celebrated by either special luncheons, signed cards, cakes and presents, and sometimes by all of these. The particular combination honoring an individual's birthday depended on such aspects as the individual's popularity, family system, socioeconomic status, and other existing natural support groups, for example.

Beyond these qualities, the recognition of an individual by others, specifically those visiting or at the Center for a temporary span of time, was capricious or idiosyncratic. For example, the director arranged for a group of high school students to complete their eligibility for summer work-study programs by working at the Center. A young lady from this group struck up an intimate relationship with Mother March and once the latter's birthday arrived, the young lady baked a cake

and arranged a birthday party at the Center. This friendship lasted until the death of Mother March six months later.

Affection

As a result of a desire for company, the elderly females daily attending the Center fortuitously devised an interesting method of becoming acquainted and establishing new relationships. This method entailed different individuals making the short but treacherous walk to the grocery store located across the street from the Center. There was no predetermined pattern to who would make the trip to the store. In one day as many as eight trips could be made with each trip to the store consisting of a new duo. Females making the trip to the store, most frequently made the trip in pairs, with the trydic unit being the next most common group. A solitary female going to the store was rare.

Equally rare was an elderly male accompanying an elderly female to the store. Two factors operate to support this observation: 1) males are a rarity at the center; 2) for the males who did attend the Center, they are either much younger and more mobile, or they are physically handicapped sufficiently enough to hinder their mobility. The younger more mobile males were willing partners in making trips to the store for others

who either could not or did not want to make the trip. Indeed, being a "go-for" functioned as a means to bridge sexual and racial barriers, establishing new relationships or cementing old ones. Caring and sharing behavior among males in an interactional context was more verbally manifested as the following example illustrates.

EXAMPLE 5 Observational Notes

> Mr. Friday (age 55) and I have this typical male relationship. Either he or I will come in (to the Center) and greet the other in a "dozens" (see Abrahams, 1964) fashion: Mr. Friday: "Hey turkey! How's my turkey. Where have you been?" Observer: "Turkey! How somebody with a big old chicken butt like yours is going to call someone a turkey?" Mr. Friday: "Ah come on turkey and let me whip you at a game of dominoes real quick". Observer: "It's all right with me. I've been looking for a chump to beat today."

These playful verbal exchanges also occurred in addition, across racial, sexual and age levels. Again the limited number of males (especially Black elderly males) attending the Center may operate to prohibit a more accurate range of behavioral responses. But, other manifestations of caring behavior among males included the traditional handshaking (and its situationally determined variations) and infrequently, hugging. Obviously, given socialization practices, the women were more likely to hug than the men. The women were also more likely to call on the telephone to check on their

friends at the Center or to chat with them before arriving or after leaving the Center. A day's absence from the Center would result in at least one phone call from another concerned elderly participant. These processes construed by this aged population are similar to the processes identified in the works of S. Johnson (1971), Byrne (1974), Hochschild (1973), and Ross (1974a,b). Other expressions of concern took the form of, for example, Mother March persistantly chiding Ms. December about the latter's cigarette habit. Mother March felt that money spent on cigarettes was "banking money". Mother April was very good about constantly asking Sister October, who is incontinent, if she needed to go to the restroom. Ms. December also was on the alert to Sister October's special need.

In summary, the Center itself acquired a very special character based on a desire of all its participants to be cared for and care for others. This expression of concern was initially begun by the elderly participants through gift-giving to show staff that they appreciated their efforts to provide services, activities and provisions. Staff response to gift-giving manifested itself through special meals for birthdays or non-business hour trips to the symphony or museums for example. The outcome of the exchange of gifts was seen to be an unanticipated or "unexpected community" constructed by the elderly participants with

the staff being recruited into the aged participant's primary or "natural helping" network (Evans and Northwood, 1978). That is, the staff and other visitors to the Center were incorporated into the spontaneous development of kin-based relations, where ethnic or racial, sexual, age and socio-economic barriers were either transcended or broken down. At the heart of this behavior exist the need to structure an environment in which not only needs are met and fulfilled, but where strangers can meet, interact without fear, and establish new and meaningful relationships. The construction of the personal community within the Center was spontaneous, but certainly not suprising in light of the elderly participants' attempt to remain self-sufficient. This trait is explored as a final determinant influencing the Center's social organization.

SELF SUFFICIENCY AND HELPING AS DETERMINANTS OF SOCIAL ORGANIZATION

Independence, within the United States society is a core value to which all citizens are exposed consciously or subconsciously. The aged population in this study show the effects of both birth and socialization in the United States. They were taught to be independently functioning, relatively autonomous individuals. Dependency as a value is something to fear and loathe at the same time, whether it is of a psychological or

physical nature. Needless to say, the fear of moving from an independent existence to a dependent state is a dominating theme, not only these participants, but most other older people as well.

Independence in the Center is expressed in the ability of the individual to do for him or herself, and be in a position to do for others. The criteria establishing grades of self-sufficiency include such behaviorial items as physcial mobility, accessibility to private transportation, and relative financial freedom. Indicators of being in a position to help others obviously include sharing, giving and gift exchange.

Self-Sufficiency

The following recorded conversation demonstrates, more disjunctively than constructively, a desire for self-sufficiency as an attitude (and value) prevasively held by the aged at the Center.

EXAMPLE 10 Observational Notes

The efforts of two staff members to walk Mother May (80) to the bathroom amidst her rapidly deteriorating physical condition solicited the following comments from a group of elderly observers:

Mother February: "If I get to the place like that (i.e., similar to the physical condition of Mother May), I'll have to stay home. As long as I can, I'm going to do by myself".

Ms. Lily: "I'd rather stay at home than have people carry me around ... Everytime we have a birthday we get that much closer."

Ms. June: "She used to walk in here so happy."

Mother April: "Yes, but she still needs to get out (away from Laguna Honda, a convalescent hospital) every now and them. Any of us can wind up like that. I'm still able to walk and I'm thankful for that".

Mr. Friday stated while playing dominoes one day, that when he gets to be that "old" (age 80 or so) he wants to stay at home. At the same time, he recognizes that such a desire required interdependency as well. A necessary ingredient for his wish fulfillment he realizes, is either an offspring yet residing at home or other family members who can lend a hand. It was interesting that despite visiting the Center on almost a daily basis, and being aware of its services and activities, Mr. Friday did not make mention of using an agency as part of a support system.

This last point requires emphasizing for its points to a shortcoming in the implentation and distribution of community services which can have a drastic impact on social relations at several levels: elderly - elderly; elderly - staff; elderly - family relations. For

example, following the death of Mr. August the question of what kind of therapeutic help would be best for Mrs. August created a great degree of stress among the August's three offspring. Their lack of information about services for the elderly in general and their being unaware of the Center in their mother's neighborhood only magnified the stress the family suffered. As a result Mrs. August's children felt they had to do more for their mother to the point that she began to feel constrained. During an interview, she spoke of her children's good intentions but at the same time she silently resents her children constantly asking if they can do things for her:

> "...When they bother to ask at all. Sometimes it's hard for me not to tell them that I may have lost a husband and a leg but I haven't lost my mind or the rest of my body."

The self-sufficiency which Mother August struggles to maintain is demonstrated at the Center in a number of ways. The most ritualistic method these elderly individuals have established are the daily trips to the grocery store (see the previous section). Seemingly, there exists an element of mastery as well as mystique or adventure in making this trip. Beyond the physical skills vital to a demonstration of mobility, going to the store required crossing Randolph Avenue, an undertaking ardous for all ages. The avenue is a wide one

because of the street car tracks running down its middle. Its width is conducive to automobile racing. Repeated complaints from community residents eventually resulted in the placement of stop signs on a per block basis, but this step had had only a minimum effect. Crossing Randolph to get to the store remains an adventure.

The self-sufficiency of this elderly population is also of interest to the director. From a cultural and experiential view point she was profoundly struck by the attitudinal differences between the elderly White population she worked with in the Moonrise District, and the self-sufficiency exhibited through caring and sharing among the Black aged at the Center. As the following interview data shows, the major difference was the Black aged's independent stance on "paying their own way".

> "Another thing about elderly Whites, when I worked in the Moonrise, they exposed a commonly held attitude of `get what you can'. They felt they had worked all their lives and payed into the (social security) system and they were entitled to this. In contrast, Black aged have a mind set which goes `I don't want you to know I need, so I'm not going to come in here (the Center) begging'. And it's like with the congregate meal, I had to go over and over again telling them that they do not have to contribute, that if they have money, it's a donation, but it is not required that they pay for their meal. But, like Mother January, she will get up and make sure that everyone puts in their money because it's like `pay-up' and it's hard to get the concept over to them because they are seniors and are entitled to this. You'd never see that in white senior centers. I mean, if they didn't have to they wouldn't pay, and they'd keep going".

Other demonstrations of self-sufficiency included Mother January (age 89) intrusively arranging for a ride with one of her sons so that she and Mother February (also age 89) would be sure to make it on time to their church's Wednesday morning prayer session. Mother April (age 84), on the other hand, waits on no one. If she has to be someplace she walks. Mother March (age 87) is more industrious. She earns income by making and selling quilts to a convalescent home in Vallejo, California. First she arranges for her many friends to help her by cutting and accumulating "strings" (strips of material essential to quilt making). Then she will call (at 5:30 a.m.) and arrange a ride for the gathering of these materials and for the delivery of the quilts. She often exchanges her products for services rendered.

Helping, Sharing and Caring

As manifested among the Center's population, helping took the form of sharing, giving, and gift exchanges. These acts were remarkable for their depth as well as their breadth.

EXAMPLE 11 Observational Notes

> Mrs. Rye who infrequently gave Mother March a ride to the Center and probably other places, came in late this morning with a bag full of sewing thread

and gave it to Mother March. Mrs. Rye states she had purchased the thread during an after - Christmas sale and felt at least it would get used this way.

EXAMPLE 12 Observational Notes

Mother January and Ms. Lily are concerned about the van driver eating so poorly, so they have been taking turns buying him lunches for the past couple days.

While these examples reflect the sharing, helping and caring patterns only among the aged, this is not to say that they did not occur between the staff and elderly. The development of reciprocal behavior among staff was addressed in previous sections of this chapter. Staff was likely to show their concern or feeling for the elderly through the celebration of birthdays or other special days. It was not uncommon for staff members on their days off to visit their elderly friends, take them to the symphony, fishing, or shopping if the need be, to play dominoes, whist, or just sit and talk.

Instead of being clients who received services, the Black elderly insisted upon reciprocity and a two-way exchange. The elderly were likely to reciprocate with gifts. Gift giving included items the aged could make at home such as knitted pieces, paintings or drawings, quilts, baked goods, books, cards, and the like. For both staff and the aged the gifts and services exchange cemented a relationship which went far beyond a client -

service provider relationship, namely friendship, care and concern.

The outcome of these activities must be assessed pragmatically, particularly with reference to the informal functions they fulfilled in the Center.

SOCIAL ACTIVITIES, FUNCTIONS AND SOCIAL ORGANIZATION

Social activities constitute an integral organizing principle of social life as they function convertly to bond evolving social relationships within a social setting. Social activities here, include talking, visiting and recreation. One particular activity, dominoes*, dominated over the other activities. It was enjoyed and played by staff, elderly, and infrequent visitors to the Center. Here, dominoes as an influencing factor within the Center is examined.

The informal or latent functions dominoes fulfilled were: socialization, conflict resolution, creative disruption, minimization of social differences, and recruitment. These functions are now briefly explored.

*Unfortunately, there exists no ethnographic reference about dominoes within African or other Black societies. A short file-clip from the movie "The Harder They Fall" and personal observations bring to mind a rapidly played West Indian version of the game. It is rare to be able to walk into an Afro-American household and not see a set of "bones" openly displayed. The material of these "bones" may be wood, ivory or metal. Personally engraved sets are not uncommon.

The game of dominoes had the effect of bringing together individual participants of different ages, races, sexes, socio-economic background and so on as the following example demonstrates:

EXAMPLE 13 Observational Notes

> Mr. Friday (55, Black), Mr. December (65, Black), Mr. Sunday (63, White Italian), and Ms. Daisy (age unknown, Black) are across the hall from the sitting room playing dominoes, talking. Ms. Daisy's boy, Robert (age 10), is standing and watching. Ms. Daisy leaves to go to the bathroom and Robert sits down and takes her place. During the conversation, he gets off a good one-liner about today's lunch (breaded chicken, spinach, macaroni salad, mixed fruit cup, bread and margarine, and butterscotch pudding): "They ought to post a sign on the window - If old age don't kill you, the food here will."

Usually the domino game would begin in the sitting room for two reasons: 1) the staff's desks were located toward the rear of this room and this is where people would congregate to begin the day; and 2) the first staff and seniors to arrive who were domino players would occupy the table and chairs nearest the wall heater. It was an excellent location for hearing and seeing all that transpired in the sitting room. Indeed, recorded from this strategic location was the conversation presented in Example Five regarding dependency and physical deterioration. But the attractive aspect of the game is its social quality. Because the

game is easy to learn, any individual can be invited to play. For example, Mr. Thursday is Chinese and Cantonese is his primary language. He speaks very little English, but learned dominoes through conversation. He now participates in the game with most of the other elderly. His participation in this activity is restricted as his wife has elected not to participate in this activity and thus Mr. Thursday continues as her only real interactional partner in the Center.

The game of dominoes also functioned in a social context to maintain traditional male behavioral practices for relating to one another. The game was used as a device to involve the more recalcitrant males at the Center. The few males who daily attended the Center tended to be the shy, retiring types who constantly had to be urged by staff into activities, in which they would participate for a brief period. It was not uncommon for at least three of the males to come into the Center, make their way to the couch in the heated sitting room, and proceed to fall asleep. Besides arts and crafts, dominoes was the only other activity in which these gentlemen would readily participate.

Once the game of dominoes began it was difficult to either stop the game or to get its players to relocate to another room. That is, the popularity of

the game presented problems, the most predominant of which was the disrupting effect the game had on other classes. A part of the problem must be attributed to the Center's director's mandate that all the elderly and staff participate in the regularly scheduled classes and activities, keeping in mind that only Mother March refused to willingly participate because of the class disrupted the domino game. This mandate makes sense in light of the fact that classes with high attendence taught by the instructors from the community college would be more apt to be reoffered the following semester. When all of this was explained following the disruption of a game of dominoes, Mother March, as a representative of the game's participants made known the group's feeling in stating, "I didn't come here for no classes. I come here to play dominoes." It is rather ironic that these words were spoken by an individual who had been a teacher for all of her working days.

Although the domino game disrupted other activities, the game also functioned as a device through which individuals could resolve problems or work through their differences. For instance, it was while playing dominoes that Mother March and Ms. Cook, the director, were able to resolve a problem involving miscommunication as is demonstrated in the following example.

EXAMPLE 14 Observational Notes

Mother March is still put out about being told by Ms. Cook, the director, that Mother March can't sell her quilts in the Center and take the money home. Ms. Cook feels the money should be reinvested in the Center to offset the costs of material and supplies. Mother March had sold a quilt which had been hanging on one of the walls in the sitting room, pocketing the money, and earned an admonition from Ms. Cook.

Mother March:	"What really makes me mad is for agencies to tell me what I can't do".
Ms. Cook:	"Mother March I only said that for things that are sold in the Center, the money must stay in the Center to pay for coffee, sugar, cream, cookies, and the like. I didn't say you couldn't bring things to hang on display."
Mother March:	"Well that just makes me mad cause I gave a quilt to the Center last year."
Ms. Cook:	"No, you donated a quilt to the PSSCA, which was auctioned off (for $140.00)."
Mother March:	"What? I thought I gave that quilt to the Center. Well...(and under her breath) "I'm going to take my other quilt down and take it home".

By the end of the domino game, Mother March was sufficiently mollified, as evidenced by the fact that her quilt continued to adorn the sitting room's wall, and her relationship with Ms. Cook, and more importantly, the Center, was maintained.

The interactional properties of dominoes which occurred, during the verbal exchange cited above for example may be regarded as typical and for this reason these properties are emphasized. The game had the effect of bringing would-be combatants together in a mental arena. Participation in the game reduces status and hierarchy differences among individuals (i.e., aspects of social differentiation). As was previously noted, domino participants were of different ages (10 - 89); crossed sexual boundaries; and involved individuals from different socio-economic and occupational backgrounds (lawyer, accountant, maintenance personal, etc.).

Additionally, as the game was played at the Center, there was a constant verbal bantering between participants. Observed display behavior during the game (and to return to Example #14 specifically) included posturing ("Well that just makes me mad..."); threat behavior ("...I'm going to take my other quilt down and take it home..."); and resolution (the quilt continues to adorn the Center's walls).

From the perspective of behavior modification, the game of dominoes as played by Center participants may be viewed as a culturally prescribed activity which allows for the mediation of previous, current and potential conflicts, be they negative or positive situations. The

potential conflicts, be they negative or positive. The domino game represents a behavioral system that binds the participants together and, in turn permits them to express conflictional ideations and sentiments. At the same time the game creates a mileau which bonds its participants to continued interactions.

Another function the domino game played was in the area of recruitment. It was not uncommon for a visitor to the Center to get lured into playing a game or two of dominoes. This act was most likely to occur with younger males who were delivering their parents or siblings to the Center. For instance:

EXAMPLE 15 Observational Notes

> Ms. July (age 74) and her brother (about 65 - 70) are new to the Center. Well, at least Ms. July is anyway. Her brother deposits her at the Center is more the case. Today he's remaining around somewhat longer, enticed by the domino game.

EXAMPLE 16 Observational Notes

> Mr. Tanned, the gentleman (around 80) who cares for and cleans the laudramat next door is sitting in for a couple of domino hands. He's not faring well against Mother March and Mother January.

It was not unusual for either the accountant or lawyer who had their offices upstairs above the Center, to come down periodically just to play a game or two with whomever was manning the domino table, typically

at the table had the serendiptuous effect of breaching hostilities between them.

In conclusion, this section of the text has explored the relationship between social activities, specifically the game of dominoes as an example, and the capacities within which the game functioned to influence and shape social relations in the evolving social organization of the Center. Various functions of the game were focussed on, including the game as: 1) a socializing agent; 2) a device through which social conflict gets resolved; 3) a source of creative disruption; and 4) a recruitment technique.

Other activities could have just as easily been explored and assessed. For example there were a series of structured group sessions conducted by the director which treated such themes as death, stress, and anger. The functions these sessions met were quite similar to those outlined for the domino game. The one difference was that these sessions were more likely to be therapeutic, intentionally functioning to help the elderly participants cope with emotionally ladened problems.

All of the social activities along with their informal functions exists as a direct consequence of the type of financing characterizing the Center. Certainly, for example, recruitment should be a formally recognized

Center activity. Yet its importance is relegated to a secondary status as the Center's director is compelled to adhere to the funding agency's general goals and objectives.

SUMMARY

Within the context of a recently opened Senior Center in the Pacific Sea Side community, the Center's evolving social organization was examined by a social structural analysis of the goals, roles, statuses, activities, services, relationships, and ideology of the Center's personnel. In addition, the role of such structural variables as politics and economics were explored as factors influencing the Senior Center's formation. For example, it was seen that politics was critical to the creation of the Center and in turn, the delivery of social and health services to the elderly population in the P.S.S. community. However, it was economics, or more accurately, the lack of adequate financing, which played a larger role in shaping the Center.

The lack of adequate funding for the Center compelled its Director to rely on and to deliver services which resided outside her direct control. That is, she could enlist agencies external to the P.S.S. community to bolunteer their services and personnel (e.g., Pacific Heights Community College and the

Department of Public Health) but State - mandated reductions forced those agencies to cutback their services, including those provided to the Center.

However, the Director's reliance on volunteer agencies only further emphasizes the inadequacies associated with the underfinancing of the Center. It is difficult to say whether the funding agency is consciously aware that, as a consequence, its policy of inadequate funding of services mandates more cooperation between programs like the Center and City-wide volunteer agencies. Such sophistication on behalf of the funding agency is perplexing for two reasons.

First, it must be assumed that funding agency personnel has integrated findings derived from research demonstrating the formation of viable elderly communities (see e.g., Johnson, S., 1971; Fry, 1980; Byrne, 1974; Hochschild, 1973; Ross, 1974a,b). Second, despite an awareness of the viability of elderly-oriented communities and their tremendous potential as important mechanisms of support, studies of informal care-givers (Breton, 1964; Caplan, 1974; Collins and Pancoast, 1976) indicate a lack of integration between human services and neighborhood-based networks.

For human services delivery to be effective, adequate funding of these services is a must.

Incorporating neighborhood based networks and their potential is seen as a positive addition enhancing the quality of services delivered. But these neighborhood-based networks are not to be regarded as a substitute for adequate financing.

The viability of these neighborhood-based networks is clearly demonstrated in the Center, where the aged incorporated disparate individuals into their helping network and created a spontaneous or unexpected community premised on the expression of care and concern and their need to remain self-sufficient and contributing individuals. Gift exchange, sharing, and helping others functioned to solidify relationships which transcended barriers of age, sex, class or socio-economic status, and ethnic or racial identity.

Once constructed, the spontaneous community within the Center also functioned in a complimentary fashion, offsetting some of the harshness and inadequacy of insufficient financing as well as the curtailment of services and activities. But these informal entities, whether a spontaneous community or a natural helping network, need not be romanticized or made a focus of attention obstructing the obligations ascribed to the formal agency's responsibity for delivering quality services to the aged or any other segment of our population.

Indeed, the support potentials of the elderly population in general has been called into question (Treas, 1977). More specifically, whether or not minority elderly and their helping network are in any more of a financial position to provide supplementary social and health services must be viewed with extreme caution even according to the legend that the Black family will extract "blood from a turnip" (Jackson, 1975) to see that their aged kin members are made as comfortable as possible. In Chapter V, the elderly population for this study is divided into three groups as their resources - financial, physical mobility, financies - are examined in the context of their participation in the Center's activities.

CHAPTER V: THE CENTER: PARTICIPATION & UTILIZATION

INTRODUCTION

Chapter IV described a spontaneous or unexpected community which existed along side a more traditional and formal arrangement of social roles, positions and statuses within the Pacific Sea Side (P.S.S.) Senior Center. Relationships occuring within this community are reciprocal based on an exchange of gifts and related items. Gift exchange among the aged functions to incorporate non-related individuals into their natural helping network thereby extending their accessibility to additional and alternate resources.

In this chapter, the Center participants are divided into three groups, high, medium, and low participants, and the level of participation in the Center is explored in relationship to their personal attributes, self-perception of health, familial support, social, and economic resources and related socio-demographic variables.

Table 5.1 lists the services, activities, and games which the Center offers by those who participated in these events. Table 5.2 is a rearrangement of Table 3.1. The participants have been divided into three groups based on their degree of participation in these

services and activities. The individual programs listed under the categories - services, activities, and games - were not provided on an equally frequent basis. For example, legal, administrative, and health screening were provided once a month. Programs offered once a week were more numerous including the mini-market service and almost all of the classes excluding arts and crafts. The latter class was a daily activity as were whist (a card game), dominoes, bingo, and transportation services. Information referral and home health services were provided when required.

Group One - High Participation

The individual study participants are divided into three groups on the bases of the degree of support from familial and social networks; familial and economic resources; and their bases of mental and physical health. It is postulated that the richer networks, and greater resources are associated with greater participation and involvement in the Center's activities.

Sociodemographic Attributes

Five individuals are constant participants in the Center's programs. Four of these five individuals are women. The median age of this group is 78. Three of the four women are 85 and older, two of the women are 89 while the other female is 68. The sole male in Group One

the four women are 85 and older, two of the women are 89 while the other female is 68, and the sole male in Group One is the youngest participant at the Center, 55 years old. The female participants are currently widowed. One individual (Mother February) has never married. A grade school education, six years or less, characterizes four members of Group One, although one of the "old old" holds a bachelor or arts degree in Education.

TABLE 5.1: Study Population by Groups assessing participation in services, activities, and games.

		SERVICES								ACTIVITIES											GAMES				
										Classes															
		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V		
	PARTICIPANTS																								
	Ms. February		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X
	Ms. September	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X
I	Ms. March		X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X		X	X	X
	Ms. January	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X
	Mr. Friday	X	X	X		X	X			X		X		X			X		X	X	X		X	X	X
	Ms. April			X			X	X		X	X	X	X	X			X	X	X	X				X
	Mr. Saturday			X	X	X	X	X	X	X	X			X		X	X								X
	Ms. June	X		X	X		X	X		X	X		X	X			X	X	X	X					X
II	Ms. July	X		X	X	X	X			X			X				X								X
	Ms. August	X		X	X	X	X	X		X	X	X	X	X		X	X	X	X						X
	Ms. December			X	X		X	X	X	X	X	X	X	X			X	X	X	X	X		X	X	X
	Ms. Violet		X	X	X		X	X	X	X		X	X				X	X		X		X	X	X
	Ms. May		X	X	X		X			X	X						X	X		X				X
III	Ms. Lilac	X	X	X			X	X						X		X	X		X	X			X	X
	Ms. October			X	X		X	X	X								X								
	Mr. Tuesday		X	X	X		X	X						X			X						X	X

LEGEND:

A	Legal
B	Administrative
C	Information & Referral
D	Transportation
E	Mini-Market
F	Hot Lunches
G	Health Screening
H	Home Health
I	Current Events
J	Music
K	Spanish
L	Nutrition
M	Arts and Crafts
N	Recollection
O	Home Repair
P	Films
Q	Health
R	Walk to Store
S	Talk - Gossip
T	Whist
U	Dominoes
V	Bingo

TABLE 5-2: Study Population - Groups arranged by participation and utilization

	Decade	By Sex	Single/ Married	Living Sitation	Number of Children	Renter Home Owner	Economic Status
(N = 5) 1890 = 1899							
	January 1891 (90)	F	Widowed	Daughter & Husband	3F 2M	Renter	SS, SSI
	February 1891 (90)	F	Married	Family w/step niece	4F 2M	Renter	SSI
I	September 1911 (68)	F	Widowed	Alone	1F 1M	Renter	SS, R
	Friday 1926 (55)	M	Widowed	Sister/husband,mother		Renter	SSI, D
	March 1894 (87)	F	Widowed	Alone	1F	Renter	SSI
	April 1897 (84)	F	Widowed	Lives with daughter	1F	Renter	SSI
	Saturday 1899 (82)	M	Married	Lives with wife		Home Owner	SSI
	June 1902 (79)	F	Widowed	Lives with daughter	6F	Renter	HP, SSI
II	July 1906 (75)	F	Widowed	Brother & wife	1M	Renter	SS, R
	August 1906 (75)	F	Widowed	Alone	2F 1M	Home Owner	SS, HP
	November 1912 (67)	F	Widowed	Niece & Husband	3F 1M	Renter	SSI
	December 1918 (63)	F	Widowed	Cousin/board & care	1M	Renter	D, SSI
	May 1901 (80)	F	Widowed	Alone/until sickness Skilled nursing home	1F 2M	Home Owner	SSI
	Lilac 1919 (62)	F	Divorced	Daughter	1F	Home Owner	D, SSI
III	October 1911 (68)	F	Widowed	Alone	3F 1M	Home Owner	SSI
	Tuesday 1911 (68)	M	Divorced	Ex-mother-in-law/Son	1F 1M	Renter	SSI

LEGEND: I = High Participation II = Medium Participation III = Low Participation

Social, Family and Economic Resources

The average high participant has a wealth of available social resources. All these individuals are outgoing and social. Each has five or more people that they exchange home visits with. Additionally, each person in this group also spends time on the phone daily, talking to friends or relatives. Moreover, they all stated that they have spent a day or more with someone who does not live with them. In fact, two of the "old old" (both age 89) were humorously referred to as the "bobsey twins" as they were inseparable during the daylight hours.

With respect to the social resources of this aged population at the other end of the age spectrum, the two "youngsters" in this group (female 68, male 55) provide a source of entertainment for the Center's participants as they are romantically involved with each other. Their efforts to shield this aspect of their relationship provided amusement as well. They spend a considerable amount of time playing a verbal game in which they seemingly put one other down, making themselves out to be the worst of enemies, a sham that is easily penetrated by casual observers at the Center.

Economically, and compared to the other two groups, Group One members are well off. The following case studies describe in more detail the social, economic, familial, and social resources available to Group One members.

CASE EXAMPLE I

Mother February, Mother January's twin, is the "poorest" of the group as previously noted. She is now retired from her early years of doing housework and babysitting. Her only husband was a farmer and then an unskilled worker. Mother February has no means of livelihood. She lives on SSI payments ($417 - $583 monthly; $5,000 - $6,000 annually) which luckily, must support only herself. Her largest monthly expenditure is her rent, $150. for a one-bedroom place located in a basement of a house belonging to one of her fictive daughters. Mother February like Mother January is a stout religious individual and after tithing and food costs, her monthly expenses are barely met. In an emergency, her assets and financial resources would prove insufficient.

Mother February would like food stamps if she could get them, which she cannot, as she has a savings account. Her only health or medical insurance is

Medi-Caine. Financially however, she stated that she believes that she is doing about the same as others in her age group.

Mother February's family situation appears to be unusual, and for that reason, is detailed somewhat more than others in this group. She has no natural children of her own. She lives with her fictive family which consists of her step daughter, the step daughter's husband and their two children (a boy and a girl).

Mother February's mother and father died when she was an infant and she has no awareness of either of their backgrounds, having been raised by a foster mother. Her siblings consist of one other sister who died in 1927. Literally, her fictive family is all she has. Mother February's lack of transportation limits or prevents evening visits to Mother January or her other friends, although on occasions, Mother February receives visits at home.

FOOTNOTE: To gather complete economic data on all of the individuals participating in this study was not possible. Reasons abound including a need to have accessibility to all financially contributing family and network members. This would have required the researcher to intrude upon family and friends of the aged at all hours of the day, an impossibility.

CASE EXAMPLE 2

Mother February derives status and respect from the other seniors at the Center because she is Mother January's "ace coon boon" or "number one bosom buddy". Mother January's financial situation is administered by her daughter with whom she currently resides. Like Mother February, Mother January (and her daughter) are religious tithers and receive recognition from the pastor of her church who includes her in most fund raising activities and, indeed, he acknowledges that Mother January continues to be one of the key decision-making individuals in and out of the church.

CASE EXAMPLE 3

All three of the individuals who chronologically comprise the "old old" in the Center belong to the high participant first group. The third member of this triumvirate is also addressed by the respected title of "Mother". Mother March is easily the most educated person of this elderly population. She posesses a B.A. degree in education from a southern Black university and has taught elementary and high school for thirty-seven years. Now that she is

FOOTNOTE: The reader will quickly discover an uneven quality to the biographical descriptions of the study population. This is primarily due to the ability of some of the elderly to better recall biographical material as well as articulate this data.

retired from teaching, she receives a pension from this vocation, social security payments, and in-kind contributions from her niece and son-in-law. She is currently widowed for the fourth time. Her previous husbands were farmers or blue collar workers. She lives alone in a large two bedroom apartment which rents for $250 monthly. Her niece and niece's husband administrate her financial affairs, and apparently this is an amicable relationship. Mother March says she sometimes chuckles to herself at the thought of having to go to her niece for her allowance. She feels her assets and financial resources are sufficent to meet emergencies.

Mother March has one daughter from her first marriage. The daughter (64 years old) is a college graduate, retired and currently residing in Texas with her husband. Mother March's parents were both born and reared in Texas. Her parents were both teachers. Her mother taught elementary school, and her father was a high school principal. Both parents had received training for their vocation - her mother was trained at Mary Ellen College School for Girls, and her father at Prairie View A & M where Mother March also received her degree. Both parents lived to see old age - her mother was 88 and her father 79 when they died. They produced a

total of eight children, 7 girls, and 1 boy. Of these, only one brother and one sister are still living. Mother March's brother continues to live in Texas while her sister resides in San Rafael. Mother March visits her sister twice a week and sees her brother once ever 5 years or so. With respect to family values, the siblings were taught and were expected to "pull one another up the hill", especially in the educational arena.

CASE EXAMPLE 4

The two younger members of Group One are also interesting cases although only one case example is presented. (Mr. Friday is reluctant to devulge biographical information possibly because of sensitivity about a physical disability). Ms. September works in a children's center as a house-mother. Her late husband worked as a cashier in a grocery store. Social Security, a retirement pension, and regular assistance from family members constitute her source of income. She is economically independent; lives by herself and can pay for her total rent ($275) and her food. She has health insurance. Given an emergency, she reports she would be in financial trouble. However, she views her average monthly debts as no problem. She perceives herself to be financially better off

than most of her peers. Ms. September receives periodic financial assistance from her two children (male and female now 48 and 46 respectively). However, Ms. September because she continues to work can afford modification of her expectations of family support saying: "they have got their lives to live and children to feed." Ms. September's children and grandchildren reside in Fort Worth, Texas, where she was born and reared. She cannot recall her parents place of birth, birthdates, or their age at the time of their deaths. Both parents, she recalls, "did a lot of farm work". She is one of eleven children and has one brother and two sisters still living. All three reside in Texas. They visit back and forth every year. To quote Ms. September, "I've attended a lot of funerals".

Mental and Physical Health

Given the financial and/or social well-being of this group, we would expect their sense of psychological well-being to be equally high. And indeed Mother March and Mother January both indicated that although their energy level and physical health have waned somewhat, life continues to be good. Both stated they do not feel lonely as they see enough of friends and relatives. They explained that things do not bother them and that

they do not allow worry to interfere with their sleep. As Mother March states: "I don't have to worry about anything. My niece and nephew handle everything."

Both Mother March and Mother January have stated that there is little in the world that surprises them anymore. Both admit that as they have aged, life has improved. Finances, health, health care, even old age itself, are not problematical and life at 85 and 90 respectively is worth living. Mother March probably expresses it best:

> "Oh, I'm as happy now as when I was younger. I would be happier except for the fact that I can't run all over the country like I did when I was younger. You know I've visited 31 of the 50 states in this union."

Mother February, another Group One member, stands in contrast to bother Mother January and Mother March. That is, where the latter two individuals have indicated a good degree of happiness with life as they grow older, Mother February is less contented. The cause of her discontentment is loneliness and the inability to see more of her friends especially in the evening. As a result of this unhappiness Mother February "worries a lot", "gets easily upset", and "sometimes feels that life is not worth living".

Mother February's discontentment is shared by Ms.

Mother February's discontentment is shared by Ms. September and Mr. Friday, the final two members comprising Group One. For Mr. Friday, an accident and an accompanying physical disability have left him with some "emotional scars." On the other hand, Ms. September traces her uneasiness about life to the fact that, "Honey, I'm just getting older and don't know what to do about it." Mr. Friday expresses both their contentment with life as he concludes, "No, I'm happy as I was when I was younger. But I see enough of my family and friends so that I'm satisfied (with life today)."

All of the individuals in Group One classify themselves as healthy and observations support these reports. Illness episodes which disrupt their normal, daily activities, occur rarely in this group. Only two individuals use walking canes as aides for mobility. None of them have spent any time recently in a hospital, nursing home, or rehabilitation center for physical health problems. Minor health problems, predictable for this population include high blood pressure, failing vision and hearing, arthritis, and dental related problems.

Physician visits are also intermittent. Ms. September is seeing a doctor once a month for her high blood pressure, while Mother March is on the visiting nurse's schedule, apparently for a failing kidney. The

others see a Black physician once every six months. All stated they prefer a doctor who is from the same ethnic background, but, as Mother March puts it, "I've see all racial types." For all of them, the family physician or health care specialist is six to ten miles away; twenty minutes by automobile or 45 to 60 minutes by public transportation "on a good day."

GROUP TWO - MEDIUM PARTICIPATION

As the middle group, Group II individuals have fewer network, familial and economic resources than Group I members, but more than Group III member's. Group II as a transitional group, contains some individuals who could belong to Group I. Ms. April, for example, is fiercely independant, so much so that she is a loner with few friends either within or without the Center. Ms. August on the other hand, is placed in Group II only because she is voluntarily at the center to meet new friends who will be substitutes for the husband/companion who recently died.

Sociodemographic Attributes

Eight individuals fall into the average or medium participation catagory in the Center. Of these seven are women. The median age for this group is 75. The oldest person is 84 and married, while almost all the

women are widowed. The one exception, the youngest individual in the group is divorced.

Educationally, like Group One, six years or less of grade school characterizes Group Two. The range for educational achievement within this group extends from those individuals who have at least a ninth grade education (N = 5), to those with some college education (N = 2) or who hold a bachelor or arts degree (N = 1).

Social & Family and Economic Resources

In contrast to Group One which was seen to have a wealth of social and economic resources, Group Two members are characterized by the availability of fewer friends and relatives to turn to for social and economic support. Financially, Group Two members are not as well off as Group One members. One-half (N = 4) of this group's annual income is $4,000 or less. There is only one individual in this study whose annual income is greater that $6,191, official proverty level. Of the remaining four persons, two had an annual income somewhere between four and five thousand dollars and two had an income between five and six thousand dollars yearly. Only one person indicated being covered by a health insurance program other than Medi-Care. As with Group One, no one in Group Two is receiving food stamps.

In brief, a combination of qualitative as well as quantitative differences with the social and natural helping networks characterizing Group Two members have resulted in a reduction of kin or family members, friends and neighbors who can be called on for transportation, legal and administrative assistance, and telephone conversations. The case examples which follow illustrate both qualitative and quantitative differences and the effect of these differences for the aged in Group Two.

CASE EXAMPLE 5

One would expect to find extremes in Group Two who may represent the extremes within this larger group; Ms. April is an example of the former. Ms. April has resided in the P.S.S. for 20 plus years. She is an 84 year old widow who describes herself as "a classy, sophisticated lady," and accordingly, she dresses and acts the part. She is "fiercely independent." Her education is limited to the ninth grade. Her one marriage ended with her husband's death at the age of 36, "He got shot, that's how he died". They had one child, a daughter, now 52, who has three years of college and is also currently widowed.

Ms. April was reared by her mother and her father, who were both born into slavery (1856 - 1849 respectively). Both parents were farmers and both lived to old age; her mother died in 1938 at the age of 84, and her father in 1839 at the age of 90. Ms. April's siblings, 6 brothers and 3 sisters, are all deceased. She visits her numerous cousins about once a year. They mostly reside in Kansas City, Tyler (Texas) and Los Angeles.

Ms. April indicates that most of her friends are the same age as herself, and most of these are at the Center. Indeed, her two best friends both attend the Center. Except for an incident which kept Ms. April from coming to the Center for about 5 - 6 months, she and her friends see each other daily, typically at the Center, but also at the Church to which they belong. Her daughter is her trusted confidant.

Ms. April resides with her daughter and contributes ($160.00) to the monthly mortgage. She receives SSI ($250 - $333) and retirement payments from her husband's railroad pension. She reports that her assets and financial resources are sufficient to meet emergencies as well as monthly payments for food, etc. She does not need food stamps and would

not take them if they were offered. Transportation is provided by family (daughter) and friends and the P.S.S. Van when she has to go shopping, visit friends, go to the doctor, etc.

CASE EXAMPLE 6

If there is an example of the "worst" case within Group Two, this case is representative of what could conceivablely happen to any elderly person, namely to fall sufficiently ill to be committed to a convalescent hospital. This is exactly the position Mother May (80) was confronted with when her children (two sons, one daughter) decided they could no longer provide the physical care their mother required.

Mother May is a religious woman, having been reared by parents who were both ministers all of their lives. In fact, Mother May undertook formal religious training, spending three years at a university in Southern California. As Mother May reports, "I am a minister of the Gospel. My whole life has consisted of visiting others, and spreading God's words." Mother May finds herself in the unenviable position of being dependent on others.

Her children have remained as her "constant traveling companions" and visited their mother when they can. Her oldest son religiously stops by the hospital on his way to work every morning, and on the weekends and some evenings he will bring his wife and two sons to visit as well. But Mother May expresses great disappointment in being cut off from visiting with her friends at the Center. Since her confinement at the hospital, she is permitted to visit the Center once a week. She reports she receives very few visitors at the hospital and feels "cut off."

CASE EXAMPLE 7

Mrs. August, age 75, too feels cut off. But her estrangement is caused by the death of her husband (heart attack), her "best friend, talking and traveling companion." She resided in the P.S.S. community for 23 years and almost all of her friends are about the same age as she and they visit back and forth. But, Mrs. August had established the pattern of visiting on a monthly basis, usually at Church and at family reunions.

Now that she is widowed and alone, her family of procreation has responded in an interesting way: the requests for babysitting doubled. In addition, her three offspring (two daughters, one son)

reacted by assuming that their mother now required aid in the managing of her personal and financial affairs. "I told'em I would take care of all my business, and when I need help I would let them know. They was just taking over, as though I was already so senile I couldn't do anything. But they said, no, they just wanted to help me."

Mrs. August retired from working in a clothing factory and her husband had been a construction worker. She has three years of college, while he at best had a grade school (9th grade) education. Their three children have all finished high school, and the two younger ones (daughter and son) have completed two years of college. The daughters are both married and the son is single.

Mrs. August was raised in Texas. Her mother was a housewife and her father a minister at the Bible College. Mrs. August's other siblings included 3 sisters and two brothers, three of whom are still living (one brother, two sisters). She visits her brother and sisters yearly in Michigan and Texas.

Mrs. August lives off SSI and her husband's pension. She owns the house she lives in which she believes to be worth about fifty to sixty thousand

worth about fifty to sixty thousand dollars. The monthly payments for food, mortgage, and other items, are no problem. She is one of the few individuals who is covered by private health and medical insurance such as the Blue-Cross/Blue Shield plan.

CASE EXAMPLE 8

In contrast to Ms. April and Mrs. August who have lived in the community for a lengthy period of time, Mrs. July, a 75 year-old widow has just recently moved to the neighborhood from Louisiana, which has resulted in her feeling alone and isolated. Mrs. July's cause of estrangement and unhappiness is easily traced to the family members and friends she left behind in Louisiana.

These feelings have been offset somewhat with her moving in with her younger brother (57 years old) and his wife (50 years old). Other seniors at the Center also are rapidly becoming her friends and replacing those she left behind. Both her brother and his wife work full-time.

Mrs. July is retired after having spent most of her working life as a domestic worker. Her married life was spent with one man (deceased, eleven years ago of natural causes) who worked in construction

as a building demolisher. Financially, she lives on SSI ($250 - $333 monthly) and the assistance she receives from other family members. She reports that the fixed income she receives is not enough to meet emergencies, let alone her monthly expenses. In fact, she describes the amount of money she gets to take care of her own needs as "piss poor," one of the few occasions any of the seniors in the Center resorted to the use of profanity.

The type of assistance her brother and sister-in-law provide is in response to Mrs. July's physical impairment, she has a "hip problem." She must use a cane whenever she is walking around and, on occassion, a walker. With respect to daily activities, she is incapable of doing shopping, preparing meals, or housework without help. Like a number of other elderly in this study, the needed assistance comes from other family members -- specifically in Mrs. July's case, her brother and sister-in-law. They have been Mrs. July's principal source of transportation, although the P.S.S. Van has, on occasion, returned her home. Mrs. July now accepts help from her immediate family with managing her checkbook and paying bills. Occasionally she needs help getting dressed and undressed, in taking care of her personal appearance, in getting her out of bed, and in

Ms. July was born and raised in Louisiana by her natural mother and father and a set of grandparents (whether they were paternal or maternal she could not recall). Her parents were also born in Louisiana where they spent all of their lives. The parents were agricultural workers (tenant farmers) primarily, although Mrs. July thinks her father might have been a coopersmith, as she recalls he made barrels for sugar. Mrs. July's other siblings include a sister and three brothers. Only two of her brothers are living, and they visit back and forth with one another at least twice a year. She is also anxious to get to know her peers at the Center well enough to visit them and they with her. She likes to talk although her dentures make her somewhat self-conscious. Mrs. July recognizes her inability to transport herself, either by private or public carriers, and the limitations which accompany a reliance upon others. "I would drive if I could, but with this hip, well..... But it's (life) not so bad." She notes that her hip is the only thing she would change about her life. She is pleased with the assistance she gets from her brother and sister-in-law.

CASE EXAMPLE 9

Ms. December (63) expresses a similar ambivalence about the necessity for food stamps. She lives off Social Security, which includes disability payments but not SSI. She had worked both as a domestic (a hospital "aide") and as a blue collar worker in a factory (silk block-wood presser). A job-related back injury forced her into early retirement. Her former husband worked as a plumber and then on highway construction before he was "accidentially" killed (i.e., "someone shot him on purpose"). Ms. December was in her early thirties when her husband died and she never remarried. Consequently, she has no children to call upon for help of any kind.

Ms. December does not think she is currently covered by any health plan beyond Medi-Care. Her cousin was carrying insurance on her at one time (probably life insurance) but whether it has been continued is open to question. Ms. December indicates that she would like to carry her own health insurance if she could afford it. Presently, she is only receiving $60 out of her disability check. But she is quick to note that life in general, including her financial situation, is considerably better since she is living in a board and care home. She philosophically adds: "You

live someplace - nobody's going to keep you if you don't have money."

Mental and Physical Health

Another factor, in addition to family and social networks and finances, making a difference between groups is morale or psychological outlook and well-being. Generally, Group Two members are more ambivalent about their outlook on life than are Group One members.

CASE EXAMPLE 10

Ms. December reflects this ambivalence. She does not feel that as she has gotten older, things have gotten worse, despite a drop or loss in energy level. She is not lonely much: "I'm always glad to come to the Center cause I don't have time to worry." Little things really do not bother her although she wishes she could see more of her family. She does not feel any less useful as she ages". "You're as old as you feel, and as you do. Nothin' gets old but clothes and shoes." Obviously, Ms. December has reduced the aging process to a psychological level -- "aging is a state of mind." As she sees it: "I've still got pep, I just need a 'sweet patootie' -- somebody to pat me on the back, pet me every now and then and call me their sweet patootie".

In spite of a somewhat cavalier philosphy, she rather frequently (two to three times a week) worries so much that it prevents her sleeping through the night. The worry and the unhappiness she mentions stem from her not being able to find a "sweet patootie" (a significant other). But she states she really does not have a lot to be sad for: "What's gonna be is gonna be." The only thing that truly upsets Ms. December are people who ride her because she smokes: "I get mad when I can't smoke."

CASE EXAMPLE 11

The source or reason for the psychological equivocation in the case of Mrs. August is traced to the loss of her husband eight months previously.

> My problem is worry, my husband died suddenly, and it was so hard for me to get readjusted. I depended on him for so much, and we liked to travel we went everywhere. And then, everything to be done around the house, he did it. But he died suddenly and that left me ALONE. Course, I had the children, a son, sons-in-law. But I don't know if they didn't know how to do things or they just weren't interested, or something. And that caused me to worry, and I worried so until it made me sick. And my doctor told me I had to stop worrying so much, I just prayed that God would help me. I had got so desperate, til I prayed to God to give me ....if I start worrying, give me some kind of warning, make me stop. And then when I start worrying, I get a terrible headache, and I'd say 'oh, I got to stop.' I'd go call up a friend, and all my close friends knew my conditon and they would call me up or I would call them to keep me from worrying. I'd do all right as long as I was away from home but the time I would open that door to that old rusty house ... it was terrible. Maybe someone would have a solution to my problems, ha ha ha.

At best Mrs. August is at a stage of recovering from her loss where she can now make small jokes. She is a determined woman.

Despite six visits in six months to a doctor for a thyroid problem, Mrs. August has not been sick on any one day such that she has been unable to carry on her usual activities of working around the house or attending the Center. Her family doctor is 20-30 minutes from her house by bus, but either her daughter or son-in-law transport her as she has difficulty walking due to her right leg which is non-functional. In fact, she uses a cane and artificial limb as supportive devices. Like the other study participants, she has never consumed alcoholic beverages. She rates her overall health at the present time as fair and definately better than it was five years ago.

CASE EXAMPLE 12

Ms. April has not seen a doctor during the past six months, has not been sick, has not been in the hospital, nursing home or rehabilitation center for physical health problems. Her doctor is white and she states that it doesn't matter to her what color her physician is, just so long as he has been to the best medical schools. She has no physical disabilities, her eyesight and hearing are good, and she has no physical problems or illnesses at the present time that seriously affect

or illnesses at the present time that seriously affect her health. Both her doctor (internist) and optometrist are only ten minutes away. She uses no supportive devices, does not drink, and walks for excercise. In general, she rates her overall health as good and about the same as it was five years ago. Her health status does not stand in her way of doing the things she wants to do. She indicates that she does not receive help outside the family with routine household chores such as cleaning and washing clothes, for example. An upaid family member (daughter) either helps or does these chores along with the preparation of regular meals.

CASE EXAMPLE 13

On the other hand, in addition to a hip problem, Ms. July is bothered by arthritis, high blood pressure, calcium deficiency, and potassium shortages. In the past six months she has seen a physician twice a month, but she has not spent time in a hospital or a nursing home because of her physical problems. She realizes that she is fortunate not to have physical disabilities such as total or partial paralysis, missing or non-functional limbs, or broken bones, which would prevent her from doing her usual activities such as attending the Center. Her eyesight and hearing are fair. She rates her health as fair, and definitely not as good as it was five years ago.

GROUP THREE - LOW PARTICIPATION

Group III members are characterized by a minimum, if any of familial, economic and network resources. Also, as a consequence of poor or failing health, their participation in the Center's events are greatly restricted.

Sociodemographic Attributes

Three individuals seldom participate in the Center's programs, activities, and services -- one male, Mr. Tuesday, age 68; and 2 females, Ms. Lilac and Ms. October, ages 62 and 68 respectively. The median age for Group Three is 66. The male's marital status is open to question -- his former spouse has remarried but no one is certain that the divorce was first obtained. Ms. October and Ms. Lilac are both widowed. The latter individual reported she has a high school education, while Mr. Tuesday has at least a ninth grade education and Ms. October, a fourth grade education.

Social, Family and Economic Resources

The family and social resources of this group stand in stark contrast to the first group. Where the first groups were socially outgoing, Group Three can be con-

trasted as being comprised of individuals who are currently introverted. None of these individuals stated that they knew five or more people well enough to visit with in their homes. In addition, they all indicated that they seldom if ever, talk to either friends or relatives or others on the telephone. Rarely do they spend an entire day or more with someone who does not live with them. It is the lack of friends and trusted kin which exposes Group Three members as a vulnerable population as the following case examples demonstrate.

CASE EXAMPLE 14

Ms. October is a 69 year old widow, frail of mind, suffering from lapses of memory, and body. Although she has a good record of attendance at the Center, most recently her days have been spent at home, where she is confined to bed most of the time, according to her aide. Ms. October has three daughters and one son. Two of her daughters live in St. Rose.

Ms. October reports that her children have little time for her. She has six living siblings, but they continue to reside in Louisiana where all of them were born and reared. Ms. October misses her siblings and other friends she left behind. She comes to the Center for companionship, but once there, she remains an isolate.

In fact, Ms. October went so far as to say that she does not consider the other seniors at the Center as her friends. She may feel this way because of her failing health and lack of familial involvement. Although she may not view the other seniors at the Center as her friends, they do not share a similar view. They constantly attempt to draw her into games and other activities that take place. Moreover, the other seniors are very good about remembering to ask her if she needs to go visit the bathroom as she has become incontinent.

CASE EXAMPLE 15

Unlike Ms. October, Ms. Lilac's outlook on life can be traced to her view of her a treatment of her by her children:

> I don't know what the deal is. My older daughter, D.C., every chance she gets she throws it at me (the fact that Ms.Lilac is either crazy or senile). Well, they (Social Security office) gave V.E. (a younger daughter) the first check. I don't know where either one of the checks have gone. She's got it and she is paying my bills. I say what bills? I don't have any bills as far as I know of. I don't know anything, you know, what taxes I should be paying on the house... All of them have...see, that's the thing, they want my house. They have homes. This girl has a home over there...it's right over...this street over here. She's got a house. And this other daughter's got a house. They call me up in the middle of the night and ..he (Ms. Lilac's brother) wake me and one of his daughtershad told him that I had gone coo coo. He was screaming, swearing and telling me he didn't what to hear it (i.e., about her alleged

> insanity)...But, what they are doing is going around telling people that I am coo coo. That's the thing that they are doing. I tell ya...I cry nights...I don't sleep...I don't move.

Ms. Lilac feels her family is turning against her. Her preference is to continue living with her family but given the current differences of opinion she wants to be as far away from them as possible. The causes of the differences, she indicates, stem from her belief that she is more progressive than the rest of the family. She states that her family downgrades her for her ideas and are jealous of her successes, especially the fact that she has bought two houses by herself.

Ms. Lilac is retired, having worked as a untrained hospital technician. She lives off SSI and pension monies from her old job. Her only husband worked as a coal miner in Wyoming until he died from injuries sustained in an automobile accident. Ms. Lilac and her husband sired two daughters and a son, all born in Kansas. Ms. Lilac was born and reared in Kansas as were her other siblings - five brothers (2 deceased) and one sister (deceased). Her father was an old fashion preacher who died at the age of 83, also in an automobile accident. Her mother was a housewife all her life. Ms. Lilac and her mother migrated to San Francisco five years ago, and it was here that her mother died suddenly. "I had visited her everyday while

she was in the hospital. I had missed that morning because I was visiting someone else. I got to the hospital only to be told that my mother was dead."

Until the dispute over the house Ms. Lilac owns and the onset of mental confusion, she and her older brother managed her financial, and legal affairs. Ms. Lilac's only sister was killed by another woman in a dispute over custody rights of a young child that the sister had raised for a number of years. Ms. Lilac's other two living brothers reside in the Sacramento valley. They last saw each other at a family picnic three years ago. Ms. Lilac, while adoring her brothers, at the same time has strong opinions about them which she does not hesitate to express. For example, she and her younger brother are feuding because Ms. Lilac told him he was nothing but a "hen-pecked husband," and his wife was a "liar and a thief", having taken their mother's silver.

The paranoia that Ms. Lilac exhibits about her family is not without justification as she reports it: "Everyone is against me. I don't know why .....I don't lie and bother them....And now they want to take this (house) from me. I don't understand it because they all have better jobs than I have...And now I have to go see this lawyer".

Ms. Lilac feels that her family is using the issue of senility as an excuse to relieve her of her responsibilities. She is aware of her increasing memory loss, - "I forget things. I notice it more now just like I did a few minutes ago when I couldn't remember that person's name and I think that's old age. Don't you?"

From their perspective, Ms. Lilac's family is not without cause with respect to their assessment of Ms. Lilac. In a filed court brief, the family requested conservatorship for their mother's assets based on Ms. Lilac's inability to maintain her financial affairs (i.e., keep track of her checks, credit cards; and pay her mortgage and other accounts when due), and care for herself.

> 1. The Petitioner herein purchases groceries and personal supplies weekly for the proposed conservatee. If the proposed conservatee runs out of groceries or personal supplies, she will go without food and/or supplies until the Petitioner again restocks. She does not, of her volition, supply herself with food and personal supplies.
>
> 2. The Petitioner was given eye medicine by her physician at Kaiser Hospital. She was unable to distinguish between drops for her eyes and cream used on her face, and she put cream in her eyes.
>
> 3. The proposed conservatee has eaten spoiled foods for lack of the ability to make the distinction between fresh and spoiled foods.
>
> 4. The proposed conservatee has on occasion taken public transportation,

> forgotten her destination, become confused as to her whereabouts and has to have assistance of strangers to get back home.
>
> 5. The proposed conservatee informed her physician at Kaiser Permanente Hospital that she had no immediate family or distant relatives.

Although Ms. Lilac is accused of being confused, she heeded the advice of the Center's staff and hired a lawyer to defend her person and her property from her family. The judge assigned her a lawyer as conservator based on her acknowledged confusion. But one irony amongst many related to this case again has to do with Ms. Lilac's perception of her family members:

> My oldest daughter is the worst. She is the most horrible person to be my daughter.. She's ....up here I don't think she's alright. I really don't. She'll come in just so sweet. The day she came in and bought groceries and stuff!...I'll be back tomorrow and bring some other stuff here for'? I don't eat much and there's not very many people here...Sometimes the other daughter's kids will come over and spend a little with me...She is wierd. She is wierd... She will sit back and do something and just laugh about it.

Ms. Lilac apparently has never been one to hold anything but strong opinions and by speaking her mind she is in constant conflict with her family. Ms. Lilac wishes to maintain her independency, a situation at odds with her family's plans for her.

Mental and Physical Health

Mental and Physical Health

All three members of Group Three display mental confusion in their thinking and/or suffer from physical disabilities. Ms. Lilac's mental confusion is directly related to the problems she is having with her family. One the other hand, Ms. October also shows signs of increasing mental and behavioral impairment. For example, she was able to relate that she rents a room in a private residence but forgets that it is from her niece and her husband.

Ms. October does recall that her parents reared her and five other children in Louisiana, where she was born. She remembers little else beyond the fact that her mother was a domestic worker, while her father was a common laborer, digging ditches and working in sweat-houses to earn enough money to support her family. Ms. October has six living brothers, all of whom continue to reside in Lousiana. Limited finances prevents her and her siblings from visiting one another. She last saw them three to four years ago.

Ms. October's "family" consists of her 48 year old niece and the latter's 50 year old husband. These two individuals have helped her with legal matters and the managing of her personal business and money. They also have hired a full-time aide for her to help with the routine household chores and meal preparation.

Ms. October's pessimistic view of the world is made salient by her perception of aging and old age. As she ages, for example, she believes that things keep getting worse. To her "getting worse" means a loss of energy, a lot more lonliness, more things to bother one, and more feelings of uselessness. She states that she is not as happy now as she was when she was younger. Despite having much to be sad about however, she feels that for her age life is about as she expected it to be and that it is definitely worth living.

The psychological profile of Ms. October is one that may also characterize Mr. Tuesday and Ms. Lilac. Ms. Octobers's pessimism is rather difficult to understand given the support by her family and by her "friends" at the Center. What is common for all within Group Three is relatively large physical and/or mental problems. Ms. October, for example, suffers from loss of hearing, failing eyesight, and severe arthritis which prevents her doing needlework or other craft activities and games. She first came to the Center walking without need of a cane or other assistance. Now she requires supportive help for getting around. Ms. October feels no need for medical care beyond that she currently receiving and knows that she is fortunate not to have physical disabilities such as parital paralysis, missing or non-functional limbs or broken bones.

Mr. Friday, on the other hand, suffered a stroke five years ago, which has left him partially paralyzed in both legs and the right side of his face with a concomitant speech impediment. It is the latter which inhibits Mr. Friday, and leads to his feeling socially inferior. In turn, it restricts his participation in Center activities and games. However, Mr. Friday could be easily lured into playing games he likes (especially dominoes) or into working the loom.

Mr. Friday states that he feels the need for medical care or treatment beyond that he is currently receiving, particularly for the frequent flare ups of arthritis. The arthritis is so disabling that Mr. Friday requires assistance in taking his prescribed medications. Help is provided principally by his ex-mother-in-law and ex-wife on a daily basis.

SUMMARY

In summary, by dividing the study population into categories of high, medium and low participants in assessing their participation in the Senior Center's services, activities and games, three observations about these groups emerge:

1) Serious physical impairment, mental confusion, and familial disorganization constitute significant variables which greatly influenced

the behavior and participation patterns. These variables had the effect of disrupting the social relationships between the elderly, their friends and family. Another consequence of the interplay of these variables was a reduction of participation in the Center's programs.

2) In the medium category, factors critically affecting involvement in programs and activities at the Center include the following: less severe forms of physical impairment, positive self-identity and self-assurance; recent migrations which disrupted friendships and networks; loss of mate; and total reliance on mate. These factors operating alone or in combination with one another produced residual effects among Group Two members participating in the Centers programs. For example, ill-fitted dentures worn by two individuals in Group Two prevented full-participation in group discussions and music singing classes. It was not uncommon for these individuals to hold a hand in front of their months during a conversation. In fact, a third individual who wore dentures refused to talk or sing.

In the same vein, loss of a mate or total reliance on a mate are perceived as factors strongly influencing participation. These factors make salient why Group Two is a transitional category. Individuals who have lost their mates in the recent past (Mrs. July and Mrs. August) are having to readjust or modify their behavior and actively involve themselves in the formation of new relationships. An extended family or a large social network to draw upon may operate to offset the death of a mate. At the same time, a total reliance on a mate for emotional, economic and social support leaves the remaining mate vulnerable following the death of a spouse.

3) Group One members are able to take advantage of the range of programs at the Center as a result of social, physical and psychological factors. An apparent lack of familial and social disorganization among Group One individuals resulted in a greater availability of social and familial source of supports. An increase in availability of such resources means more friends, kin and neighbors to call on for conversations, visits, and transportation, for example.

More importantly, a greater number of friends and family members increases the limits defining poverty status in this society. For those elderly individuals with intact familial and social support networks, problems with economic and legal affairs, transportation barriers, and outlook on life were seen to be somewhat more neutralized than they were for elderly persons without a supporting social network.

Dividing the elderly population into three groups helps to delineate a range for familial and social supportive group responses to problems confronting the aged. It needs to be stated that an unfortunate consequence of the current structure of service delivery to the elderly is the fact that good health, a sound mind, and tightly knitted functioning social network seem to be prerequisites for maximizing participation. Those aged persons without these qualities continue to be jeopardized less able to benefit from the services.

In conclusion the manner in which services specifically targeted for the aged were delivered placed demands upon the users of services. The demands which accompanied service utilization by the aged included good physical and mental health, access to private transportation and a well organized and functioning social and helping network. In the absence of these personal resources among aged individuals, it can be seen that this type of service delivery is underutilized by those most in need of critical social and health services.

At the same time, it should not be misconstrued that the evolution or even an on-going spontaneous community based on mutual aid can ever sufficiently function as a replacement for underfinanced services. The needs met by the spontaneous community affected only one group, those who already had social, psychological and economic resources. This group can be contrasted with the target population these aged services were designed to serve.

CHAPTER VI

SUMMARY, FINDINGS AND RECOMMENDATIONS

SUMMARY

The delivery of a social service, a senior center, to a predominantly minority community studied in order to examine the frequently raised issue, like to underutilization of health and social services by minority community members. That is, it has been suggested that (minority elderly) such as Afro-Americans, apparently regardless of age, sex, social class differences repeatedly underutilize such services. A second related explanation maintains that health and social service needs are fulfilled within the family unit.

In summary, it was seen that the delivery of this elderly service (The Center) was a consequence of political activism by minority members of the Pacific Sea Side (P.S.S) community. In fact, the Sea Side neighborhood, which was to house the Center, is an ethnically diverse but predominantly Black community. P.S.S. is a middle to low-income community, with single family dwellings making up the most frequent type of residence. Blue-collar workers dominate the occupational categories. Nuclear family households are typical statistically, although single-parent households

comprise an important trend to be watched by health and social service planners. The aged in Pacific Sea Side constitute fourteen percent of the total population.

P.S.S., in general, was a community with few health and social services directly within its boundaries. The two exceptions to the rule are both age related. These include (1) a mental health service for families with troubled youngsters (age 22 and under), and (2) part-time and truncated arts, crafts, and hot noon-time meals for the aged (age 60 and over).

Medical services were seen to abound toward the west end of Pacific Sea Side Community. But the general feeling among this study population is that these medical services are for middle and upper-income families from the Pacific Terraces and Sea Side Heights communities. The validity of this feeling needs to be tested. Indeed, despite the curiosity among service providers about the under-utilization of this service by families throughout P.S.S., no studies exist to either address this concern or to guide the construction and implementation of other services.

The opening of the P.S.S. Senior Center was a unique and ambitious undertaking. The service was unique because it represented the first and only full-time age-related service specifically in this community.

The service was ambitious in that its objective with respect to meeting its participants' needs were beyond the financial backing it received. In fact, a discrepancy was seen to result between the inadequate funding and the idealism inherent in the Center's objectives.

Underfinancing within the Center hampered the staff's efforts to provide services to meet the needs of the elderly. The staff was seen to employ previously gained knowledge and experience in designing creative alternative and solutions in response to inadequate funding. For example, although free dental exams were arranged and their results made available, no resources existed insuring follow-up or continuity of care where dentures were found to be faulty or gum disease was uncovered.

The aged participants' response to the Center was to create a spontaneous or "unexpected" community. It is difficult to say whether this community was in response to the money problems (The Director certainly made them aware of this problem), or to other factors. Certainly the aged were attempting to show their appreciation of the staff's efforts to provide services. Be that as it may, the spontaneous community was predicated on a type of family or kin-like behavior in

which the aged incorporated staff, friends and visitors into the aged's natural helping network. The evolution of this community permitted sharing and caring behavior in which gift giving, recognition of services and affection supplemented, and in some cases, even replaced services that staff offered to meet the needs of the elderly participants.

The creation of the spontaneous community also attested to the need of the elderly participants to maintain their life-long independency and self-sufficiency. Examples of self-sufficiency included the aged insisting on paying for prepaid meals as well as their desire to control their financial and legal affairs. The aged were also independent and self-reliant in their participation in the activities, services and games at the Center.

Finally, the aged were divided into high, medium and low participants based on their self-perceived physical and mental states, familial support, and socio-demographic resources. The high participants more probably used the services, activities, and events within the P.S.S., Senior Center. The high participant group were better able to overcome barriers such as transportation and lack of knowledge in using the Center's social and health services. Their familial and social support resources, health status and morale

function to offset the effects of these barriers. At the other extreme, the lack of familial and social support, or poor health and outlook on life characterize to some degree all the individuals in low participant group.

SUMMARY OF MAJOR FINDINGS

In a recent discussion of the relationship between ethnicity and aging, Bengtson (1979) noted that social policy for the elderly in the U.S. has concentrated on the white English-speaking and relatively well educated elderly. He further indicates that the design and implementation of programs and services on the whole have been tailored to the white elderly, "with the assumption being that any diverse groups would also be served by these programs" (Bengtson, 1979:13).

This research study does not claim that minority (Black) elderly have been denied many existing services or that this population has been faced with culturally insensitive programs. Instead, what seems to be a primary characteristic of service delivery to minority aged are a set of attitudes and expectations (held by service deliverers) which reflect and support Bentson's description noted above.

For example, if this community can be characterized with respect to social and health services, it would

have to be described as underserviced. From a structural point of view, the issue then becomes one of expectations, with minorities being expected to use services outside their community which has its own social structural concommitants and demands. Moreover, because most health and social services are located outside their communities, to use these services, minority group members are expected to overcome such barriers as socio-economic, cultural, educational and language differences.

Policy planners and researchers who hold this perspective only end up perpetuating what William Ryan calls the "blame the victim" game (1971). That is, social structural determinants (e.g., race, ethnicity, politics, economics, etc.) tend to be ignored in favor of tautological explanations of human behavior where study populations are "blamed" for their predicament as a result of their ascribed cutlural traits. These traits are typically described or presented as excessive cultural baggage which takes the form of language problems, different family structure, or limited education for example. From this perspective, the primary issue is not a question of underutilization of services. Instead the central concern becomes the inaccessability or lack of adequate health and social services within predominantly ethnic-minority communities.

The capability of the family system to step in and fill this void is also called into question in this study. Even for the high participant group, it was seen that at best this group economically fell at or near the limits defining poverty status in this society. For those elderly individuals with intact familial and social support networks, problems with economic and legal affairs, transportation barriers, and outlook on life seems to be somewhat more neutralized than for elderly persons without a supporting social network. Dividing the elderly participants into groups helps to delineate a range for familial and social supportive group responses to problems confronting the aged.

The family of the aged, in general, functions as the first line of defense in meeting the demands of the environment. In this study, we have seen how one individual's ex-affinal family continued to function to meet, following a disabling stroke, the physical, transportational, and emotional needs of Mr. Tuesday. We have also seen the importance of fictive and extended family functionings in the meeting of the needs of the aged.

Finally, it was found that inadequate transportation constitutes a major barrier inhibiting full participation of this study population in community social services, such as senior centers. This finding corroborates similar conclusions by the United States Commission on Civil Rights (1982:41). The Commission also found that the other barrier to full participation by minority elderly in Older American Act programs was "that minority older persons have a general feeling of not being welcome in certain groups" (U.S. Commission on Civil Rights 1982:41).

What is significant about these few findings is their indicating how much more information and knowledge is required by policy-planners and gerontologists before adequate services can be designed and implemented.

Recommendations and Discussions

The following recommendations are based on conclusions derived from research about service delivery to the elderly and potential and possible linkages to informal community support systems (see e.g., Breton, 1964; Caplan, 1974; Collins and Pancoast, 1976). Any other numbers of factors can be cited to justify these recommendations, ranging from moral issues to future demographics. Here, it only need be indicated that it is necessary to put an end to the attitude or mentality

which maintains that programs intended for minority communities can be delivered under the auspicies of a population which is "white English-speaking and relatively educated". Invaluable knowledge has been gained as a result of the brief existence of P.S.S. and not to take advantage of this data is indeed a waste of taxpayer's monies.

1) Obviously it would be nice if the P.S.S. Senior Center were funded at a level comparable to that of other full-service centers being operated by the St. Rose Commission on Aging. Services such as legal or tax assistance programs are vital to elderly individuals most of whom are on fixed incomes. Where specific services are used most likely varies by ethnic and socio-economic status.

The range of services-legal, fiscal, administrative - that are offered by the Center is admirable. But the quality and frequency of these services is questionable, especially given the few staff positions and the availability of actual contact hours staff has with the seniors. For example, it was a monumental effort on behalf of the director to give legal advice and then to attend a conservatorship hearings with Ms. Lilac (see Chapter IV).

2) The St. Rose Commission on Aging should upgrade and designate the status of the P.S.S. Senior Center as a training facility to ensure information exchange between the various sub-agencies the Commission operates. This recommendation assumes a working agreement between the Commission, the Senior Center, and the St. Rose Medical Center. The latter could contribute on an on-going basis, a cadre of rotating multi-disciplinary health care personnel interested in gerontology and geriatrics. The issue of continuity of medical and health care would be addressed.

Under the arrangement, the Center would also be granted adequate funding to provide services and programs which would stablize this vital service. Dissemination of information would also help to overcome a critical inhibiting utilization factor -- the lack of knowledge of a social service by community residents. More individuals regardless of age are using the Center and acquiring more information about the Center. Its activities and services are gradually spreading throughout the social and helping networks of P.S.S. residents. Knowledge and awareness of the Center within P.S.S. could be abetted by St. Rose by using the Center as distribution point on days the government gives away "free cheese and butter".

The Commission primarily benefits from this relationship by having a training facility located in a predominantly Black community. Moreover, they benefit by creating a more effective chain of communication between itself P.S.S. and other existing minority agencies. Again, critical to this triparitite arrangement is an exchange of information and data which focusses on commonalities as well as differences which confront ethnically diverse elderly populations.

3) Finally, given the example of Mr. Friday's ex-family (through marriage) continuing to care for his needs following a debilitating stroke, it would behoove policy-planners to heed neighborhood-based organizational and cultural networks that have the capacity to support people. Natural helping networks as manifested through the sharing and caring behavior of this elderly study population constitutes a good example of such neighborhood-based organization. It is unfortunate that service deliverers ignore or are ignorant of the potential of neighborhood-based and cultural networks as a means of overcoming personal and institutional obstacles - administrative, legal, and fiscal - to seeking and receiving help.

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