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Brenda Crawley
University of Kansas

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BRENDA CRAWLEY,

The University of Kansas
School of Social Welfare

Predicting resources for one's later years is risky and evokes feelings of vulnerability. Findings from a study of older blacks reveal that while race and culture may predispose clients to prefer certain resources, such as spouses and children, others realistically expect kin and friends to care for them. The heterogeneous nature of the black elderly suggests an open posture be maintained in assessing support resources for those who face short– or long– term care needs.

Predicting resources for one's later years is frequently risky and can evoke feelings of vulnerability. The most common means for engaging in predictive behavior for one's later years is through pre-retirement and retirement planning (Butler and Lewis 1977; Shank 1985; Atchley 1976; Meier 1975). The usual areas of such planning include finances, housing, and leisure. To a lesser extent persons may plan for education, post retirement work, and relationships.

The riskiest predictions occur in projecting one's human support resources in old age. Whereas an individual may engage in financial planning by obtaining stocks, bonds, and CD's or purchase retirement property, it is not within an in-

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dividual's control to purchase or guarantee another's length of life or willingness to provide support services. Nonetheless, individuals do place strong emphasis on who they anticipate will be available to assist with their care in the later years. Elderly minorities particularly may feel the need to predict such resources because they have frequently been deprived of access to participation in society's more formal social service systems (Taylor 1985; Chatters, Taylor and Jackson 1986).

Humans are anticipatory creatures. Social scientists have documented how individuals plan their behaviors and lives around desired outcomes (Epstein 1979; Cline and Richards 1960). Not only is prediction practiced but some research has demonstrated that persons can be fairly accurate in their predictions of interpersonal relationships and the behavior of others (Epstein 1979). Young persons plan for a college education in anticipation of the rewards of a satisfying career and higher lifetime earnings. Couples plan for the addition of children to their family unit. This event broadens beyond the purview of the potential parents to an ever-widening sphere of individuals which includes potential grandparents, aunts, uncles, nieces, nephews, and cousins. Each anticipates the meaning and presence of the new person to her or his life. Each allocates a measure of emotional and perhaps even monetary resources to be used for the future event. As mentioned, persons are expected to project years into the future to determine financial, health, and social conditions (Shank 1985). Whether a person anticipates turning to informal or formal support systems is influenced by use of, access to, and availability of such systems.

Use of Formal or Informal Support Systems

Certain groups of aged use formal support resources more readily than do other aged groups. The urban elderly have been found more likely to use formal support systems than rural aged (Nelson 1980; Goodfellow 1983). White elderly, in contrast to hispanic or black elderly, have been shown to turn more frequently to formal support systems.

Reasons for use or non-use varies along the dimensions of accessibility, social status, health, awareness, availability, stress, existence of other support systems, and value systems (Moen 1978).

Conventional wisdom suggests that race is a causal explanation in the use of informal support sources by elderly blacks. Multran found that variables such as health, marital status, number of young persons in the household, and socioeconomic factors were able to account for almost two-thirds of the difference in elderly black and white parents receiving support from their families (1985). She concluded, however, that her data did not disprove that race, as expressed in values about giving and receiving help, could be a viable explanation for the fact that more black elderly rely on informal resources.

This would be consistent with the results found by Taylor (1985), Jacquelyn Jackson (1979), and Hobart Jackson (1981). These and others suggest that decades of socioeconomic deprivation and the mutual experience of oppression have forged survival alliances between the generations and within black families (Jackson 1985; Ford 1981; Wentowski 1981). For example, while the black elderly may have little or no income to contribute to their younger relatives, they offer babysitting, chore, and meal preparation services. In return, young families offer their elders shelter, food, and emotional-psychological support.

Lack of Opportunity

In light of recent changes resulting from the civil rights movement, it is sometimes forgotten or overlooked that today's aged blacks are life-long victims of discrimination and racist practices. The impact of the 1960s and early 1970s has more significantly reverberated to younger members of minority groups. Hobart C. Jackson, the late chairman and founder of the National Caucus of the Black Aged, said the following:

> Elderly Blacks bring to their older years a lifetime of economic and social indignities, a lifetime of struggle to get and keep a

> job (more often than not at unskilled labor), a lifetime of overcrowded and substandard housing in slum neighborhoods, of inadequate medical care, of unequal opportunity for education, and the social and cultural activities that nourish the spirit. Added to this third-class citizenship is a lifetime of watching their children and grandchildren learn the high price that must be paid for just being Black in America (1981, p. 85).

They have not received "equal protection under the law" nor "equality in the medical and support services that should be available to them."

Black aged cannot always count on formal systems of services. It has been cited that some aged blacks have been denied benefits or caused considerable difficulty in obtaining financial support (Jackson 1979). Black elderly have been found to constitute the lowest portion of nursing home residents. One reason cited for their underrepresentation includes mistrust of professional caregivers. Additionally, maintenance of a strong tradition of home care of older members by black families, the impact of institutional barriers such as discrimination and racism, and cost constraints play a role. It has also been found that black families' inclusion of their aged members have been supported and strengthened by informal support systems such as the church, social organizations, and kinship networks. These extra-familial sources provide social and emotional incentives for maintaining the tradition.

Availability of Support Resources

Black social scientists using a national probability sample of elderly black Americans found that among black elderly couples spouses relied heavily on each other, never married individuals were more likely to select friends and neighbors, and elderly blacks with children chose them as helpers second only to spouses (Chatters, Taylor and Jackson 1986). As with Wolf, et al.'s findings, distance and frequency of contact played a key role in the selection of children as helpers (1983). An additional finding of Chatters, et al.'s research was that black elderly in the south operated in a "larger

helper network" inclusive of not only spouses and children but siblings, friends, and neighbors (1986). The black elderly experience of helper selection was based on marital status, socioeconomic level, helper availability, and perceived as well as preferred helper availability (Taylor 1985; Multran 1985).

Data and Methods

Data for the present study were obtained on 165 blacks sixty years of age and older in conjunction with a 1985 Gerontological Society of America summer research fellow project in Omaha. Respondents were randomly selected from census tracts which identified "saturation areas" of blacks aged sixty years and older. Face-to-face interviews were conducted by trained interviewers.

Sample Characteristics

Of the 165 respondents, 28.5 percent were male and 71.5 percent were female. Approximately 50 percent of blacks had annual incomes of less than $5,000. Almost 30 percent fell within the range of $5,000 to $7,499. Very few had incomes in excess of $10,000. This sample is in line with the national picture of about 50 percent of elderly blacks being in or near poverty. As would be expected, more females (56.7%) than males (28.8%) were well below the poverty line.

Blacks in the sample closely resemble the age categories in the 1980 census data. According to census figures for Omaha, "young old" (60 to 64 years of age) constitute 29.0 percent; "old" (65 to 74 years of age) constitute 44.0 percent; and the "old old" (75 years of age and older) make up 27.0 percent of older blacks. Also, following the national picture, black females were more likely to be widowed than were males. The patterns were as follows: females - married 25.4 percent (30); never married 25 percent (3); widowed 58.8 percent (69); separated or divorced 12.7 percent (15); other .8 percent (1); for males respectively - 47.8 percent (22); 4.3 percent (2); 30.4 percent (14); 17.4 percent (8); 0 percent. Finally, one third of the sample indicated their health was fair. Approximately one half rated their health more positively than

fair. In descending order, 27.3 percent rated good, 12.7 percent rated very good, and 6.1 percent used the excellent rating. At the other end of the continuum, 15.8 percent experience their health as poor, while less than five percent view theirs as very poor.

Expected Support Sources During Illness

This analysis focused on identifying respondents' perceptions of resources for care should long- or short-term illness occur, and the identification of the expected helper. Interviewers asked the following questions:

Short-Term

If you were sick for several weeks, do you have a family member, friend or neighbor who could take care of you?

Is that person your spouse, another family member, a friend or neighbor, or someone else?

Long-Term

In the future, if serious illness should require extensive care for you, in what one place would you want to receive that care? Would you want to be cared for in your own home with your spouse or family, in a nursing home, in a son's or daughter's home, in an apartment complex where health care is provided, in some other setting?

Findings

Regarding long-term illness: two thirds of the sample preferred care in their own home with spouse or family, 16.2 percent in an apartment complex where health care is provided, 8.8 percent in nursing home and 4.7 percent in their children's home; and 3.4 percent selected the other category. When analyzed for differences by sex the most interesting finding is that not one male preferred living in his children's home. The remainder of choices are shown in Table 1.

Additional analysis by age, marital status and income reveal several patterns. 1. Regardless of age, care was preferred in one's home with a spouse or family members. Among older respondents, i.e., ages 70 and above, the second most preferred source (over one-fifth) was an apartment.

TABLE 1

AGED BLACK RESPONDENTS' PREFERRED CARE ARRANGEMENTS BY SEX

	Males		Females	
	%	N	%	N
In home with spouse and family	74.4	(32)	62.8	(67)
In nursing home	9.3	(4)	8.6	(9)
In son's or daughter's home	0	(0)	6.7	(7)
In apartment complex with health care	11.6	(5)	18.1	(19)
Other	4.7	(2)	2.9	(3)
Total	100.0%	(43)	99.1%*	(105)

*Due to rounding error.

TABLE 2

LONG-TERM ILLNESS AND PREFERRED SUPPORT SYSTEMS BY INCOME STATUS

	N	Home with Spouse & Family	In Nursing Home	In Son's or Daughter's Home	In Apartment Complex	Other	Total
Income							%
0-2,499	19	52.6	5.3	5.3	31.6	5.3	100.0
2,500-4,999	42	54.8	14.3	7.1	16.7	7.1	100.0
5,000-7,499	38	68.4	7.9	5.3	15.8	2.6	100.0
7,500-9,999	17	70.6	17.6	5.9	5.9	—	100.0
10,000 & over	16	93.7	—	—	6.3	—	100.0

As can be seen, all income levels prefer to be in their homes with spouse and family. Almost one-third of the lowest income group opts for the apartment complex where health care is provided. For the remaining income groups, care outside of a son's or daughter's home is the preferred choice. complex where health care is provided. 2. The greatest variation in preferred long-term support system care arrangements was among the separated/divorced. The separated/divorced equally selected home care with family *and* independent living in an apartment complex with health care. Aside from one person who indicated other, the remainder selected nursing home care. 3. The pattern of preferred support among various income levels as shown in Table 2.

Regarding short-term illness: Four-fifths of the respondents selected assistance from spouses and other family members, 15.3 percent friends or neighbors, and 4.0 percent someone else. As with long-term illness, analysis by age, marital status and income were undertaken.

The highest expectation of non-family support occurs among those 65-69 years of age. Approximately one-fifth selected friends or neighbors. A pattern reflecting the experience of widowhood and its impact on expected support is noted by the decreasing selection of spouses as the age range drops from 60-64 years of age where 41.9 percent of respondents anticipate spouse assistance to only 8.8 percent of those 75 years of age and older expecting spouse assistance.

As would be expected from other research findings, married individuals overwhelmingly selected their spouses as the anticipated support for short-term illness (73.2 percent). Though the numbers for the never-married are too small to be statistically significant, it should be noted that the never-married expect to rely primarily on family members and friends/neighbors respectively, 50.0 percent and 25.0 percent. The same pattern exists for the widowed *and* the separated/divorced, i.e., family members and friends/neighbors respectively, 74.2 percent and 19.7 *and* 54.5 percent and 36.4 percent.

Low income ($0 to $4,999) respondents did not select

their spouses as the first line of support. They do, however, expect family members to contribute to their care—66.0 percent. Those with slightly higher incomes ($5,000 to $9,999) also preponderantly select family members for support. Those at the lower end of this range, i.e., $5,000 to $7,499, anticipate spouse assistance twice as frequently as those at the higher end—respectively, 32.3 percent and 12.5 percent, while those in the $10,000 and above brackets anticipate support by only spouses and family members.

Summary and Discussion

The overwhelming preference for spouse and family care indicates that service delivery systems must examine the total marital, family, and kinship milieu of older blacks to assess what realistically constitutes a viable support resource both for short- and long-term needs. Responses by lower income people suggest that particular attention be focused on using as broad a definition of family members as possible. Friends and neighbors must also not be overlooked as probable supports (Wentowski 1981; Cohen and Rajowski 1982). A history of use of such persons is increasingly supported by growing research data (Chatters, Taylor and Jackson 1986; Wolf, et al., 1983; Morris and Sherwood 1983-84). We do not currently know enough about the characteristics of such helpers, i.e., who they are, exact nature of the relationship, duration of the relationship, and the best way, e.g., money or nonmonetary rewards, to elicit their involvement. However, as researchers and service providers learn more about such persons, their findings will elucidate the best interventive strategies.

These findings suggest that in addition to socioeconomic variables, factors such as duration of care influence expectations as to support resources. The emphasis on independence as expressed in the desire for an apartment with health care provided suggests that service systems would be on sound footing to seek to maintain aged minorities in independent living for as long as possible. Independence is obviously desired by all aged. It should also be noted that

while not selected by many, care in a nursing home was indicated by some blacks.

In light of research which indicates the adequacy of individuals' perceptions of interpersonal behaviors and accuracy of predicting behaviors, the predictive selection of support systems by aged black respondents can represent more than wishful thinking. Rather, respondents are informing researchers and service systems of a preferred type of care. Two anecdotal responses illustrate the point.

> "If you had asked me this five years ago I would've said I expected my husband to take care of me. But he is dead now, something I couldn't have known, but you know I prefer to have my family care for me whether it's my children or sisters and brothers. I just think it's right that family help each other. Especially when you're old. No, before I go to the nursing home I'd let my kin help me." (A "young old" black female widow.)
>
> "I don't want to burden anybody. People have their lives to live. Even my husband. I don't want him to get broke down taking care of me. That's what nursing homes are for. Nobody wants to go to them but you can't ask your folks to give up everything for you." (A "young old" married black female.)

Person A is reflecting a decided preference for informal resources, whereas person B is clearly indicating that formal support is desired.

Thus, while race and culture may predispose clients to prefer certain resources, the heterogenous nature of the black elderly as a group suggests that an open posture must be maintained in assessing support resources for those who face short or long-term care needs. Because there is a traditional reliance on family members it must not be overlooked that some individuals will desire non-family resources that maintain and enhance independence. Additionally, while few individuals of any race willingly seek institutional care it may, under certain conditions, be the choice of some. Those who provide services to elderly blacks must focus on the individualization of treatment based on factors inclusive of but

also beyond race, e.g. socioeconomic status, income level, marital status, age, and treatment preference (Ford 1981).

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