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Caregiving and carereceiving patterns among Arab-Americans living in California and Arabs living in Israel

Pauline Marie Calderone

CAREGIVING AND CARERECEIVING PATTERNS AMONG ARAB-AMERICANS LIVING IN CALIFORNIA AND ARABS LIVING IN ISRAEL

A Project

Presented to the

Faculty of

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ABSTRACT

The increasing number of Arab elderly people, age 60 and over, in Israel and in the United States, who will be in need of care is becoming a growing social concern. The elderly can be independent, partially dependent, or totally dependent on others for their care. The current caretakers and receivers of care, on whom we will be focusing, will consist of dependent elders and their spouses, or other relatives who are taking on the responsibility of providing the care needed by their elderly relatives. These caregivers may not have the proper skills or resources to care for an elderly relative. They may be experiencing stress, which could have a negative impact on the elderly as well as the caretakers themselves. The goal of this research project is to help educate social workers, current and future caregivers, as well as the recipients of such care, around the issues which they will face when involved in the caregiving/receiving process. This research study will also focus on the cultural aspects and comparisons between elder Arab-Americans living in Southern California and elder Arabs living in Israel, who are in need of care, as well as the providers of that care. It was concluded that the study showed noticeable differences in specific areas such as, financial support, medical care, the amount of time the caregiver spends in the home, etc. These and other differences are addressed in the text.

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INTRODUCTION

Problem Statement

More families today are involved in providing some type of care or support to an elderly family member than ever before. Some of these people include those of Arabic descent living in Southern California and in Israel. This elderly population may be in need of the type of care that would prevent the institutionalization, and therefore, the ultimate isolation of a societal subgroup (i.e.), Arab-Americans and Arab-Israelis. This particular population was chosen due to the lack of research on this unique population, and the problems associated with Arab immigrants in the United States and the Arab population in Israel. The provision of social services in Israel are usually provided (to the Arab population) by Jewish workers, and by non-Arabs in the United States (Sharon & Zoabi, 1997). This issue, in and of itself, creates a stressful environment for the Arab family, where they and their elders, who are in need of services, are placed in the position of seeking help outside of their cultural value system (Lowenstein, 1995).

Elder care patterns among Arabs living in Israel and Southern California have been minimally included in professional social work journals. As one of a number of ethnic minorities in Israel, the Arabs are found to be

generally distrustful of using public health care facilities and mental health providers in Israel, because the caregivers and professionals are predominantly Jewish (Al-Haj, 1989). The potential for studying and understanding the elder care patterns and the treatment of the older Arab population has been limited due to the Arab peoples' limited use of and access to the Israeli health care and/or social service systems (Savaya, 1997). Professional social workers in Israel, therefore, have limited contact and interaction with Arab caretakers to distinguish and assess their patterns of providing care for the elderly among Arab families. According to Rivka Savaya of Tel Aviv University, in 1995, out of 123 families seeking professional mental health services, only three of those families were Arab-Israelis.

With so few caregivers receiving help, the demands of combining work and care- giving responsibilities has the potential to create high levels of stress, especially for middle aged and older care givers. As the proportion of elderly people in the United States increases, mental health professionals, employers and policy makers, have become concerned about the impact of elder care issues on the family. Thus, professionals in human service settings who manage and deliver services to elderly people and their families (at least in the United States), play a vital role in helping family members sustain their role as employees

and care providers (Braithwaite, 1996).

Knowledge about aging and family caregiving will be increasingly important to social workers working with families who are caring for an elderly family member. Caregiving is defined as assistance provided to persons who cannot perform the basic daily chores of living (Phillips, 1983). According to Mui (1992), caregiving gender has always been an important variable in the studies of family caregiving. Approximately 70-80% of care is provided by daughters, thus significant attention has been given to the study of female caregivers who provide for the needs of elderly family members (Mui, 1992). Mui also states that a small number of studies have inspected the role of male caregivers. Most studies have shown that female caregivers were consistently more likely than male caregivers to provide a higher level of overall domestic care, as well as personal care for an elderly family member (Mui, 1992). Both gender groups were found to experience emotional strain in relation to the caregiving tasks and duties pertaining to their elders (Montgomery, 1992; Young & Kahana, 1989).

Research has documented the variety of strains that employed caregivers can experience, including emotional symptoms such as depression, anxiety and stress. Some of the physical symptoms have been identified as headaches, weight changes, and physical fatigue. Increased

absenteeism, tardiness, work disruptions, excessive telephone use, and reduced productivity are some of the negative impacts on the working caregiver (Montgomery, 1992; Young & Kahana, 1989).

Problem Focus

The focus of this study is to examine the potential problems associated with elder care among family caregivers. This study will focus on Arab-American caregivers living in Southern California, and Arab caregivers living in Israel. It will also focus on the recipients of that care in both countries. The study will take place in Los Angeles County, California, and in a small Arab town in Israel which is located southeast of Tel Aviv, and has a current population of 35,000 people. The reason for this study is to find out if the care of the Arab elderly family members in Israel and in the United States causes similar or differing caregiving issues that can lead to negative outcomes. We will be taking into account the impact of culture on the caregivers and the elderly recipients of that care. The under-representation of Arab-Americans receiving services from social service agencies and medical and mental health studies was also a motive for this study. To accomplish this study, we will be using a post- positivist approach.

The findings of this study might have an impact on the

current level of education and training provided by human service agencies to caregivers of older family members of varied cultural backgrounds. If caregivers and service providers are given the opportunities to gain more knowledge and skills for caring for culturally diverse, elderly individuals, then the improvement of their care and the resources needed would hopefully increase. There may also be a reduction in the caregiver's's personal stress over the responsibility, for they would have more skill and a more knowledgeable and responsive support system. Currently, an assumption delineated from the literature review, is that most family caregivers enter the caregiving role with preconceived notions and without specific knowledge or training in the tasks of caregiving. In addition, members of the helping professions do not have specific training in the sills necessary for successful outcomes with diverse, elderly populations. A working question for this study would be whether there is a difference in the treatment of elderly people living with family members from an Arabic background in the United States, and the elderly Arab people living with family members in Israel.

Literature Review

Mistreatment of the elderly is among the nation's most rapidly increasing problem. In 1986, the United States

experienced 117,000 reported cases of elder mistreatment. By 1991, that number rose 94% to 735,000 cases of domestic abuse and 842,000 cases of self-neglect by elders which were report to Adult Protective Agencies (Tatara, 1993). Experts estimate that the United States will see 4.1 million cases of elder mistreatment by caregivers, and projects 7.2 million cases in a decade (Help Expose, 1997). The National Center on Elder Abuse reported that one in ten elderly individuals will fall victim to domestic elder mistreatment and neglect (The Elder Abuse Question, 1997). It is estimated that only one in fourteen cases of abuse and neglect get reported (Help Expose, 1997).

California's share of elder abuse cases in 1985 was reported at 41,585, but by 1998, the number had increased to 225,000 cases in (The Elder Abuse Question, 1998). Los Angeles County's Adult Protective Services programs experienced a 150% increase in abuse reports between 1990 and 1995, or an average of 230 cases monthly (The Elder Abuse Question, 1996). Over 50% of the reported cases of elder mistreatment are substantiated by the investigating agencies (Elder Abuse and Violence, 1994).

Nationwide, over 10 million families are providing long term care to related elders. The mean age of these caregivers is 50. Almost 1/3 of them hold down jobs, seven out of ten are married, and 75% of the caregivers live with the person for whom they are providing care. In

California, senior citizens currently represent 4.5% of the population. In 1990, there were 3.1 million people over the age of 60, and by the year 2020, over 16% of California's population will be 60 years of age or older (Rosengrant, 1994).

Elder mistreatment, in most states, is broadly classified in four categories: physical abuse, sexual abuse, emotional neglect, and financial exploitation (Elder Abuse and Violence, 1994). The Los Angeles Times (1996) categorized elder mistreatment as 45% physical, 18% mental, 17% self-neglect, 15% financial, and %5 other abuse (Elder Abuse Numbers Grow, 1996). According to Tatar (1994), females constitute about 2/3 of the victims of elder abuse. Individuals age 60 and over make up 78% of Los Angeles County's elder abuse cases (Elder Abuse and Violence, 1994). Comparative figures of Israel's elder mistreatment were not available to the student researchers.

Little research has been conducted on the race and ethnicity of today's mistreated elders and their perpetrators (Elderly Abuse and Violence, 1994). However, projections of the baby boomers show that by the year 2050, about 9.5 million African-Americans, 6.1 million Latino-Americans and 2.8 million other ethnic minorities will represent about 47.3% of the elderly population in America. Three particular groups (Cubans, Puerto Ricans and Mexicans) were shown to have less income, are less equipped

financially, will have more health problems and concerns as they grow older, and as they reach their senior years (Cornman & Kingson, 1996). The social system that this population draws upon, tends to be one sided and filled with interpersonal conflicts, thus having a negative effect upon the elderly (Krause & Borawski-Clark, 1995).

There are many theories on the cause of elder mistreatment. Isolation and a lack of social support systems are just two of the causes of elder mistreatment. Tatara (1994) writes of four causal theories of domestic elder mistreatment: Stress of the Caregiver, Impairment of the Dependent Elder, The Cycle of Violence, and Personal Problems of the Caregivers. The Stress of the Caregivers theory holds that both internal as well as external factors create stress and frustration that can lead to mistreatment. Internal factors consist of employment problems, emotional problems or decreased coping mechanisms. External factors consist of physical problems, financial limitations, or family circumstances. The Impairment of the Dependent Elder theory suggests that a caregiver's stress increases with the level of care and the elder's physical constraints. Consequently, the increased dependency on the caregiver leads to mistreatment. The Cycle of Violence theory states that violence is a learned behavior and that abuse is multi-generational and an established norm. Some perpetrators were mistreated as

children, and some of the time this mistreatment was at the hands of the individuals for whom they are now caring. As adults, these caregivers turn to violence to cope with stress. Finally, the Personal Problems of the Caregivers theory suggests that the abusers suffer from a variety of emotional, psychological and dependency problems, and are often dependent upon the elderly person for whom they are to be providing care. These individuals transfer their feelings of inadequacy onto the elderly victim (Elder Abuse and Violence, 1994).

Perpetrators of domestic violence against the elderly are most often family members. Adult children of the elderly represent 34% of abusers, and spouses represent 18%; other relatives constitute 15%, professional caretakers make up 11% and other individuals who are not related comprise 12%, and 10% of perpetrators were unidentified (Elder Abuse Arresting, 1997). Abusers of the elderly, in some instances, are involved with drugs or alcohol and may be dependent upon the victim (The Elder Abuse Question, 1996). Many perpetrators are in a caregiving position and are experiencing caregiver burnout (Caregiver Burnout, 1992).

Elder mistreatment effects a wide range of individuals beyond the victims. Health care professionals reveal that desperation and depression are experienced by caregivers (Caregiver Burnout, 1992). Caregivers provide exhaustive

services to the elderly by locating and arranging for the delivery of need services (Cornman & Kingson, 1996). The Daughter Trap, a book about elder caregiving, states that approximately 87% of female caregivers are in the workplace. Brody, et al, 1987, found that quitting their jobs is a choice that women make when they find themselves overburdened by multiple roles. The cost is particularly high for women. It comes at the expense of their loss of employment, wages, health care benefits and future retirement benefits (Moen & Forest, 1995). Businesses acknowledge the negative impact that caregiving has on its employees. TransAmerican Life Companies conducted a study on the cost of elder care, and discovered that the average cost to the company, as a result of employee elder care, was $2,500 per month for each worker with elder care responsibilities. This cost was a result of attendance, personal telephone calls, and lower productivity, etc. (Franklin, et al. 1994).

Elder mistreatment affects the victim in a variety of ways. It is estimated that 15% of Los Angeles County's senior citizens are impacted by financial and physical mistreatment (Caregiver Burnout, 1992). The cost of not addressing the issue of elder mistreatment comes at the expense of the victim's physical and emotional well-being. It is expected that more than 50% of middle aged women will be in a caregiving position during their lifetime (Himes,

1994). As this phenomenon occurs, the number of individuals experiencing emotional and financial strains will become increasingly problematic. Furthermore, employers will suffer as absenteeism and employee turnover increases. It's estimated that by the year 2040, some 11.4 million elderly will require caregiving in their homes (Corman & Kingson, 1996). Based on the current rate of elder mistreatment, we can expect that one in ten of these individuals will be subject to some form of mistreatment (The Elder Abuse Question, 1996). Without addressing this problem, the number of elder mistreatment cases will continue to rise. Preventive measures are certain to be more cost effective than crisis intervention.

Elder abuse programs are in their early stages of development since elder mistreatment became an issue in the United States in 1984, the year that the Adult Abuse Registry was formed. By 1987, Title III of the Older Americans Act allowed for funding of educational programs at the state and county level. In 1990, Congress appropriated 2.9 billion dollars toward the prevention of elder mistreatment. Programs formed under the Older Americans Act, whose focus was on social policy and prevention, included the Administration on Aging (AOA:, the National Aging Resource Center on Elder Abuse (NARCEA), and the National Center on Elder Abuse (NCEA). Additionally, in 1990, the government established the Elder Abuse Task

Force of the U.S. Department of Health and Human Services. This department's focus is on the reduction of domestic violence. Funding has been allocated to the states through the Social Service Block Grant (SSBG). In 1992, collaborative efforts were addressed when the Older Americans Act was amended under Title VII and the Vulnerable Elder Rights Protection Act was integrated to improve the actions of the elder abuse prevention and ombudsman programs. Between 1985 and 1989, California allocated funding to five counties to implement pilot programs called Adult Protective Services. The Area Agencies on Aging are also a part of the federal government's and California's commitment to addressing issues of elder abuse (The Elder Abuse Question, 1996).

The United States, Canada, India, Hong Kong and other countries, with possibly the exception of the United Kingdom, are devoted to assisting the elderly (Podnieds, 1992). Podnieds conducted a study to identify, for the first time in Canada at a national level, the prevalence and circumstances of abuse of the elderly in Canada. The four major categories were material abuse, chronic verbal abuse, physical violence and neglect. The study found that 40% per 1,000 elderly recently experienced some serious forms of maltreatment in their homes at the hands of a partner, relative or significant other. Cross tabulations were used to identify risk factors and to provide profiles

of the abuse victims and the circumstances of their maltreatment. With an elderly population in Canada estimated at 2,679,585, the results of this study imply an estimate between 83,625 and 132,181 abused and neglected elders in Canada nationwide. Material abuse emerged as the most widespread form of maltreatment, with a prevalence rate between 19 and 33 victims per thousand. Chronic verbal aggression was the next most prevalent, affecting from 8 to 18 persons per thousand. The rate for physical violence was 3 to 9 cases per thousand (Podnieds, 1992).

On the other hand, the United Kingdom, according to a study conducted by Alison Brammer (1996), does not have any terminology that is equal to our term for elder abuse. The reason for this is that England proclaimed that elder abuse does no exist in their country. This is one reason why elder abuse is hardly recognized by English Law. The one instance where English Law applies to elder abuse is disorganized, difficult to understand and not easily accessible. That is, the law is "....less accessible than the child protection law contained in the Children's Act of 1989." Due to the fact that no legislation is written that will protect the elderly population, the Law Commission is using the Child Protection Laws as a reference point for the elderly. However, there are some who do not believe that this is an effective manner in which to deal with the problem because of the apparent social and legal

inconsistencies which exist between the two least powerful groups of English citizens, the children and the aged (Broomier, Alison, 1996).

Shah, Vidian, and Vagi (1995), confirmed that elder abuse also exists in the country of India. These researchers report that in India it is difficult to categorize any specific abuse. Financial, physical, and psychological abuse, as well as neglect and abandonment are inter-linked in this particular cultural climate. In New Delhi, more than 50% of the crimes committed against elderly citizens involve family members because of inheritance problems. The aged, at times, threaten to disinherit their children, according to a criminal lawyer in New Delhi, who prompts children to hire killers, force their parents to hand over property or abandon them in old age homes. Subjection of senior family members to the psychological trauma of implicating them as insane, in order to gain financial control of their assets is another crime common in many cities across India (Shah, Vidian & Vase, 1995).

According to the study by Shah, Viedon, and Vasi, persons hailing from differing income groups, as well as elderly women in India, are considered at special risk of abuse. Elderly belonging to the lower socioeconomic strata largely fell into the unorganized sector of Indian society. This is coupled with a marked absence of any personal

financial security due to a lifetime of poverty. These factors contribute to creating a total dependency of the aged on their young relatives and family member. This dependency, according to Shah, Viedon and Vasi, sharply curtails the decision-making power of elderly persons within their respective family units. As a result, they are exposed to psychological and sociological stress and pressures that give them feelings of rejection and worthlessness. This study also found that the senior family members in India were susceptible to abuse in the form of abandonment, neglect, and coercion to perform domestic chores. Abuse of elderly women is not only a major problem in India, but it cuts across all age groups and exists at all levels. The impact of old age on Indian women is different from than on older men because of the differences in their status and role in society. Like the case of Arabs in Israel, elder abuse has received very little attention in India, and so there are no specific policies, programs, or services in this area. This study did reveal that the media in India has become more aware of the problem of elder abuse and neglect. The films, dramas, and newspaper articles are now playing an active role in reporting cases and sensitizing both the general public as well as the elderly themselves, regarding the needs, problems, and rights of the aged (Shah, Vasi & Viedon, 1995).

Khan (1995) clarifies that the elderly are no longer

respected by most people living in Hong Kong. This study suggests that the family, the primary social support system for many elderly persons, has been weakened in recent years. Also, the crowded conditions of Hong Kong have amplified the problem. The small size of public housing, for example, has directly or indirectly discouraged young couples from living with their aged parents. As young couples with children move to the suburbs outside of Hong Kong, many elderly people are left behind in the deteriorating residential areas of the city centers. The prolonged life expectancy in Hong Kong has called for more and better services for elderly people living in the community. Unfortunately, these services are not readily available, as 88% of the elderly people in Hong Kong are forced to stay with their families or relatives. In addition, a number of elderly people are abandoned each month in Hong Kong hospitals. This problem is related to the fact that most children of elderly persons are not able to financially afford to support their aging parents. Current social welfare policy in Hong Kong emphasizes the importance of family in assuming the greatest share of responsibility for the care of the elderly.

However, theoretical welfare policy provides almost no support for this care, giving the role of caretaker to adult sons and daughters. A major step, according to Kwan in working with causes of abuse, would be to acknowledge

the family's contribution to the care of the elderly person and to provide services that support and enhance the caregiving role. Other needed services in Hong Kong include home nursing care, home health aides, home delivered meals, home care and transportation. Kwan finally suggests that the government service planners and community advocates for the aged in Hong Kong need to advance a national policy on the elder abuse issue.

In Israel, during the 1980's, an examination of the issues of violence in the family was initiated. During the last decade, the aging of the Arab-Israeli population has become a focus of public attention. Not only has the number of Arabs living in Israel grown, but the number of aged Arabs, age 65 and older, have grown to slightly more than 5% of the Arab population in 1990 (Lowenstein, 1994). A study was conducted to assess the living conditions of elderly Arabs living in Israel. One hundred and twenty-eight professional agencies in northern Israel were asked to report about all cases of elder maltreatment that they came across in the previous 18 months (Sharon & Zoabi, 1997). The findings revealed that Arab elders in Israel have a 2.5% rate of abuse as opposed to a 6.5% rate in the United States in 1994 (Elder Abuse and Violence, 1994). The profile of the maltreated Arab elderly individual was similar to that of Western countries, and the majority of the victims were female (Sharon & Zoabi, 1997). Sixty

percent of these females were widowed and half of them lived alone, while the other half shared their home with other families or in-laws, particularly daughters-in-law. In addition, the majority of the alleged victims of maltreatment were physically impaired. The alleged perpetrators of the abuse were highly represented by sons and daughters-in-law (Sharon & Zoabi, 1997).

In 1995, Dr. Lowenstein, a professor of Social Work at the University of Haifa, Israel, examined the outcome of the care of the elderly in Israel, and found that the elderly Arabs are living longer due to better health care. However, the burden of care on the families is increasing, according to Dr. Lowenstein. The overall dependency rate in Israel is higher than the average found in other developed countries, for it is estimated that close to 31% of the Arab elderly in Israel are living with their daughters (Lowenstein, 1996). Dr. Lowenstein also discovered that, due to a strong sense of family ties, as well as cultural traditions, several religious and cultural groups were against the institutionalization of their elderly parents or relatives. She also found that Arab minorities had a tendency to deal with family problems within the family. The author also stated that there was an under-use of social services among the Arab-Israeli population because of the negative attitudes they hold regarding the use of such services.

Savaya (1996) discovered that there is a strong cultural interdiction among Arabs disclosing family problems to outsiders. In such a culture, disclosing family affairs is considered shameful and unacceptable. There is a negative attitude among Arabs towards seeking help from social and psychological services (Savaya, 1996). Arabs living in Israel, however, might seek another family member if they need help. Arab families who seek professional help outside of the family are seen as failures and might be viewed as bringing shame to the family. The Arab culture has arbitrators and mediators within the family who are utilized when the families need to resolve their problems. On the other hand, they would refuse this type of service from a non family member. Another issue which is viewed as a failure of the family is when the family places an elderly member in a residential setting. This type of behavior towards the Arab elderly is viewed an admission of the family as not having fulfilled their role. Placing an elderly member in a facility is considered to be a shameful act. Finally, the author points out that Arab-Israelis would feel as if they violated a trust if they sought help from a Jewish service provider. The Arab population is extremely distrustful of Jewish service providers. As a result, it has been found that only .05% of the Arabs in Israel use the country's mental health services (Savaya, 1996).

Because of the political situation between the Arabs and the Israelis, Arabs living inside of Israel are caught between their identity and loyalty as Arabs, and their identity and loyalty as citizens of Israel. With many Arabs living near or below the poverty line, this must be a dilemma for them. These people may have the need to seek help, yet they choose to remain in their particular situation as a sign of loyalty to their Arab culture. As a result of their culturally loyalty then, it is difficult to research the living conditions of elder Arab-Israelis. They have a strong distrust of the system, highly value family secrecy, and the under-reporting of elder maltreatment is flagrant (Lowenstein, 1993).

The United States is known as a culture that values the individual, while the Arab culture values the collective. The United States then, believes that each individual has the right to privacy, the right to make their own decisions, as well as to be emotionally independent. Members of the Arab culture hold a firm conviction that their orientation is that of a collectivist one. The Arab population, then, bases their identity on the social system to which they belong and to those institutions, organizations and clams to which they are emotionally tied (Bud, Essayed-Elkhouly, 1998).

The Arab family is described as the material structure (body) of the unit, and the Qur'an (Koran) is considered to

be the sacred text (soul) of Islam. Islam, the religious faith of Muslims and many Arabs, focuses on the unity of the whole family and considers all Muslims to be as brothers and sisters who belong to the same family unit. Within the family, men have certain duties with regard to their wives and children. The wives, basically, are told how to care for their husbands. All the children are expected to bestow honor upon their mothers. The children are raised in order to continue with the legacy of customs and traditions of the family. Children of Arab descent are advised to remain in close familial contact, and individualism and separateness are discouraged. As a matter of fact, families are encouraged to be the source of support for all family members, and the likelihood of an Arab family member seeking professional help for personal problems is extremely low. Both father and mother ". . . are expected to contribute to the support and maintenance of the family unit according to traditional codes of family and honor and are responsible for the rearing of children" (Nuha, Abudabbeh, 1996).

Western influences, industrialization, war, conflict and urbanization have placed a great deal of pressure on the Arab family. The family, however, is still the primary support system for all Arabs. Because of these pressures, role changes are taking place in Arab families. The older father, who was originally the dominant figure in the

households of the paternalistic Arab society, are now more dependent on the State of Israel and their offspring. The older Arabs were depended upon to provide the family with knowledge, economic security and wisdom. Elderly Arabs have always lived in close proximity to their children. Often times they would all live together in the same household, similar to that of an American extended family, such as we had when the United States was an agrarian society (Nuha, Abudabbeh, 1996).

Unfortunately, the number of Arab elders living with their children has decreased. In addition, these same Arab elders, (approximately 2/3 of them), receive help from their children and grandchildren with regard to their activities of daily living (Sharon & Zoabi, 1997). Also, one unfortunate result of these changes is that the elderly Arab residents of the small villages adhere to their traditional values and religious beliefs which thus prevents them from asking for or accepting help from service providers (Sharon & Zoabi, 1997).

This is also true of elderly Arab-Americans. When Arab-Israelis reach old age, they may come to live with their children in the United States. It is important to the members of the Arab culture to be seen as capable of taking care of its own family, regardless of the problems or the need. Otherwise, the family may feel shame and embarrassment.

Therefore, providing service to the elderly Arab-American immigrant population becomes a need that must be met by those who are sensitive to the Arab culture. There is a lack of research done on how the Arab elderly are being specifically cared for by their families, both in the past as well as in the present. This may be a result of the secrecy on the part of the Arab family unit and on the lack of commitment on the part of professionals to address the issues of care of the elderly family members of cultures with which we are not familiar.

Few studies to date have been conducted on Arabs living in the United States (Hofstede, 1983). Arab-Americans form one of the largest and most neglected minority group in the United States (Kulwicki, 19991). The numbers of Arab-Americans living in the United States constitute about 6% of the population (Swanson, 1989). According to Sengstock (1992), the lack of knowledge about the needs of the elderly Arab-American population has major consequences on the individual in need of service as well as the service providers. The common concern raised by the author in her studies on elderly care for Arab-Americans is that doctors, nurses, social workers, etc., are not only unaware of the needs of this population, but they are also unaware of what cultural issues may be interfering with the implementation of services. Sengstong (1992) discussed that many of the close-knit Arab-American families feel a strong

sense of responsibility for each other and have a strong tradition of providing assistance for the elderly family member. Swanson (1989) points out that elderly Arab-Americans tend to be from rural areas where the use of the English language is limited. This poses a dilemma for professionals who are asked to serve these individuals. The author stated that the language barrier is but one factor for not seeking outside help, but she also pointed out that the primary reason for the lack of use of services was the conflict of being caught between being loyal to family and culture and the challenge of becoming Americanized. The second generation of Arab-Americans, who are the primary caregivers to the elderly family members, are usually adjusted to the American way of life. Swanson (1989) stated that these caregivers are facing a challenge of being caught between conflicting expectations from aging parents and those of the American culture.

Kulwicki (1991) provides important information about the issues related to health care among Arab-Americans. She was able to identify some important findings related to elderly care for Arab-Americans. A major difficulty between the professionals and this population was language, as stated earlier. Many of the Arab-Americans, especially the old, old generation, have extremely limited or nonexistent English skills. It has also been pointed out that the attitudes of Arab-Americans towards using professional or

nonprofessional assistance for solving the problems of family members is still viewed as being a disloyal act to the family as a unit, and to the Arab culture as a whole.

Summary Statement of Literature Review

Through the evaluation of elder care customs and practices in Israel, Hong Kong, India, Canada, England and the United States, and the rising incidents of elder abuse and neglect in domestic settings, a common problem was found. In essence, there is a lack of effective public and social programs and policies to aid the caregivers of elderly family members. This problem is especially troublesome in the Arab communities in Israel where a distrustful relationship has developed between the Arab minority and the Jewish majority, the Israeli government and health care facilities, and Jewish social service agencies. The lack of sufficient data and evidence to chronicle this distinctive problem encountered by elderly Arabs in Israel, complicates finding an appropriate solution to address these issues.

Based on the review of the literature, the potential problem of elder abuse and neglect among Arabs in Israel can be seriously considered (at least in this present study) a potentially growing one because of the common factors associated with the same problem in other countries. The sons and daughters of Arabs in Israel, like

the sons and daughters in Canada, Hong Kong, India, England and the United States, can also be considered to be under increasing socioeconomic pressures and feel burdened by the cultural "requirements" to care for the elderly members of their families.

Purpose and Design of the Study

The purpose of the proposed study is to explore the needs of Arab-American and Arab-Israeli caregivers of elderly relatives, as well as the needs of those family members receiving the care. We will also attempt to explain the differences and/or similarities of the caregiving process and its participants by examining the acculturation, assimilation, biculturalism and deculturation of Arab-Americans and Arab-Israelis. The investigation will be exploratory in nature and is concerned with the generation of ideas and information rather than testing an hypothesis. This investigation will use a grounded theory or post positivist paradigm. This paradigm was chosen because of a lack of or no previous research on the subject. The design will be interactive and acknowledges that the interactions themselves may influence or even change the responses of the participants. However, influence on or even the change of the participants' responses will have the advantage that the design will facilitate the exchange of information,

generate new information and learning, and will, hopefully, promote further investigation.

We chose the post positivist paradigm over other paradigms such as critical theory or constructivist paradigms because these two other paradigms might go into the research approach with a preconceived idea about the issue of receiving care of an elderly person by a family member with regard to a specific culture. This may influence the result of the findings. The design will use a random sampling technique. In this post positivist study, we will be asking the participants to answer questions which can be answered by the use of a Likeart scale. This will give the participants a guideline on ways in which the questions can be answered, without necessarily putting rigid constraints on them, such as with a yes or no answering requirement. We intend to obtain a sample of Arab-Americans and Arab Israelis by randomly selecting possible participants from an Arabic telephone directory in both study areas. Those selected must be a family of Arabic descent who is currently providing for the daily care of an elderly family member, as well as those who are receiving the care. (Originally, the design contained twenty caregivers and twenty elderly recipients of care for each of the two countries. However, the student researchers were only able to locate ten caregivers and recipients of care in Southern California who were willing

to participate in the study.) The focus of the research was on Arab-Americans living in Los Angeles County, California and Arabs living in a small Arab town southeast of Tel Aviv, Israel. This sample was selected because we believed it to be representative of the population being studied. Also, the number of participants were limited due to the time constraints on the student researchers.

Questionnaires and information sheets were given to all families who were eligible to participate in the study and were chosen for such. The information given detailed the purpose of the study and how the study would be conducted, as well as the roles of each of the participants. The participants were also informed that the gathered data would be kept confidential and that their identities would be protected and not revealed in any way. The informed consents were given to each participant in Arabic and English in order to insure that the participants would understand the details of the study and what was expected of them.

The questionnaire contained a list of general questions and/or topics that we intended to address in the qualitative study. We would be asking the elders' caretakers if they faced any problems in the area of their caretaking responsibilities. The Arab-Americans would be asked if living in America had changed their ideas or methods of caretaking their elderly family members. The

Arab-Israelis would be asked the same types of questions with the exception of an American cultural impact. The family members who received care from their relatives would be asked questions pertaining to their ideas of what they needed in terms of care, if it has been provided in the way that they want it to be, and to rate the quality of their care.

The questionnaire with a five point Likeart scale would allow for structure, yet have enough flexibility to give the respondents choices which would closely match a more rigid questionnaire, thereby giving the student researchers as accurate a picture as possible. The study, which took place in Israel, was conducted by a professional and an assistant who were willing to aid the student researchers in the steps associated with accurate data collection. The Arab-Israeli interviewers followed the same steps as those that were taken by the student research team in the United States. We were hoping that we would be able to provide information on elderly caregiving and receiving care by a family member that would then, in turn, motivate additional work in this area.

Data Collection

The data were collected through the completion of a questionnaire (see appendix) which was provided to the participants. Both student researchers were available

throughout the data collection process in Southern California. Because of the location of the Arab-Israeli participants, the research students elicited assistance from Dr. Khaliad Abu-Alhaja, Professor at the University of Wisconsin. Dr. Abu-Alhaja was conducting his own research at the University of Jerusalem at the same time that the research students needed someone to carry out the Israeli data collection. He was willing to assist the student research team, and he worked closely with Dr. Tariq Al-Dolani as his research assistant. Dr. Al-Dolani also translated the questionnaires into Arabic. The data collection in Southern California was gathered from the participants by the student researchers in order to insure that the process would result in accuracy of the findings. It took each participant in both Israel and California approximately twenty minutes to complete the questionnaire.

Participants for the study were randomly selected from the Arabic telephone directory in both countries. The participation of those selected was strictly voluntary. The participants were divided into two groups. The Arab-American group resided in southern California and the second group resided in Israel. The two groups' participants were then identified as caregiver (of an elderly family member living in the home) or as receiver of care (by a family member). The questionnaire was made

available to both groups in Arabic and in English. This was done intentionally in order to improve communication, avoid misunderstanding, and remain culturally sensitive. In this way, we as student researchers, were able to provide the participants with a questionnaire which gave them the choice as to which language the preferred. After our brief introduction of the research project itself, as well as the debriefing statement, the questionnaires were first read to the participants in order to minimize and/or correct any technical problems the participants may have had with regard to the wording of the questions. Shortly after the participants indicated that they understood the questionnaire, they were handed to them by the researchers.

The introduction for both groups included instructions on how to complete the questionnaire, a statement regarding anonymity, and a statement regarding the purpose of the study. The participants were also provided with a list of available mental health professionals in their area. The list was provided in order to inform the participants of resources that would be willing to help them with any issues or concerns that may have arisen as a result of participating in the research study. Information on how to obtain the results of the study was also provided to the two groups.

Protection of Human Subjects

In lieu of having participants sign their names to an agreement of participation in the research, they were asked only to mark an 'x' in the space provided. Participants were asked to identify their gender, age, and ethnicity for statistical purposes only.

Participants were informed that their participation in the project was strictly voluntary and that they could withdraw from the study, if they so elected, at anytime during their participation. They were also informed that they could withdraw from the research project without giving any type of explanation or reason to the student researchers for said withdrawal. The study was approved by the Institutional Review Board of California State University, San Bernardino.

The research students spoke with Arab counseling professionals in southern California regarding the study. They, in turn, agreed to provide psychological services, if needed, on a sliding fee scale to the participants who may have become desirous to seek help, clarification or guidance on issues that may have surfaced as a result of the interviews.

It is important to note that all participants were given a code number in order to match questionnaires with the code. This system was used to insure that each questionnaire would be analyzed based on responses only.

The code was also used to guarantee that they were cared for if psychological intervention was deemed necessary.

Efforts were made to maintain cultural sensitivity toward both groups. Special attention was given to the wording of the research questions, which, we believe, were written in such a way that they were free of any type of cultural biases, assumptions, preconceived notions or judgements.

Demographics

The ages of the Arab-American caregivers in the United States ranged from 22 to 44 with a mean age of 30.5. As far as the caregivers in Israel, their ages ranged from 19 to 45, with a mean age of 26.12. Arab-Israeli carereceivers ranged in age from 49 to 74, with a mean age of 59.9 years. As for the carereceivers in the United States, the Arab-Americans' ages had a range of 55 to 81 years of age, with a mean age of 60.3. The gender of caregivers in both countries was regarded as an important statistic since the majority of caregivers tend to be middle-aged females. Out of the 30 participants, it was noted that 21 of the caregivers were female, that is, 67.9% of the caregivers in both groups were female, with only nine male caregivers, 32.1% of the sample population. Occupation and/or current work status was not seen as an important demographic area of

concern for this particular study at this time. However, in retrospect, whether or not the caretaker was working, (especially in the United States where a large percentage of women work out of the home) is an important issue in and of itself, and certainly a cultural one. Complete demographic data may be found in Appendix E.

With regard to the number and ethnicity of participants, 33% of the participants were Arab-American and living in southern California; the remaining 67% were Arab-Israeli and resided in Israel.

Implications for Social Work

Results of this study may lay the foundation for future research since this is the first of its kind to be conducted to the best of the researchers' knowledge. Even though the Arab population in the United States represents approximately 6% of the total U.S. population, we need to keep in mind that this is one of the most neglected populations of all. It would be worthwhile to gain a more thorough understanding of this population in order for social workers to become familiarized with the culture and to be able to assess accurately the needs of the population. There is much stereotyping of the Arab population, both in the United States and in Israel. It would be very useful to know how people of Arab descent interact with each other as well as how they interact with people outside of their

culture. Thus, we need more cross-cultural studies of Arabs. This is particularly important when it comes to their needs and the needs of the elderly people for whom they provide care. Because the Arab culture regards caring for their elders as a family responsibility, many will not ask for help or support when caring for their elderly family members. It would benefit both the caregivers and carereceivers if more social workers and social work organizations developed an inquisitive but sensitive approach toward the Arab population in order for their needs to be properly assessed. Social workers need to know more about the Arab population. Only then can we begin to meet those needs via culturally acceptable interventions.

Due to the alienation and isolation of this cultural group, as well as the stigma attached to them, it is extremely important for practitioners and human service agencies to begin to develop a knowledge of the Arab culture. Only then can we find ways to perform outreach services and offer those services which will hopefully meet their needs. In order for change to occur, both in the United States and in Israel, social workers must advocate for Arabs, who may be labeled as terrorists, and discriminated against as the result of the actions of a few. To prevent further discrimination, maltreatment, stereotyping, isolation and unmet needs, it is our responsibility to become cognitively aware of the Arab

population and work towards providing them and their families with services and programs that have been developed in culturally sensitive ways.

This research was intended to help develop a research direction for future social work research. By looking at the factors associated with the care of the elderly and the development of education and training programs for service providers as well as caregivers, we will then know how to deal effectively with the needs of the elderly recipients of care by a family member.

Our hope is to also help social workers develop an understanding of what can lead to elder abuse and neglect by a caregiver. Whether or not there is hidden elder abuse in the findings is questionable. Therefore, if social workers develop the understanding needed with regard to the causes of elder abuse and neglect, it will help formulate those programs and treatment strategies which will work toward providing services that will help families gain the strength and skills to promote growth, and to acquire the resources which will help us all of finding better ways of caring for the elderly, no matter from which culture they come. The desired result, then, is the prevention of elder abuse and neglect, as well the training of caregivers in order to relieve stress, and ultimately have the carereceivers obtain the quality care they deserve, and the services/training necessary to achieve that goal.

We believe that there is an answer to providing the elderly with quality care and prevent institutionalization which can lead to depression, exacerbation of preexisting conditions, the deterioration of the quality of life, isolation, loss of self-esteem, self-respect and dignity. Will we be members of the elderly population before these issues are addressed, or do we want to see something done to address these concerns now? If we are not instrumental in finding ways to provide quality care to the elderly members of our society, we may be the next group of aging individuals who will suffer the consequences of no or poor planning and organization. Planning and organization now, which addresses these issues and concerns, will have a positive effect on the aging population. If we work together today, the elderly all over the world can have a better tomorrow.

Discussion

The purpose of this study was to discern any differences between care providing for Arab-American elderly family members and Arab-Israeli elderly family members. We discovered that there were differences in the results by comparing the responses of both groups. It was discovered that because Arab-Americans had learned the language, values, social competencies and sense of identity of the American culture. However, the acculturation of

Arab-Americans did not result in assimilation, as the participants in the U.S. did not replace their native culture. If there was a noticeable difference, it is not believed to have gone any further than biculturalism, where the Arab-American population identified with both cultures. For example, the elderly family members in the United States were more likely to provide their caregivers with some financial support than were the Arab-Israeli elders. The elders in the U.S. were found to have been more willing to help their caregivers by financially contributing to their care and support.

The aim of this project was not to allow for generalizations of how members of the Arab culture provide care for their elderly family members. However, the study was partially conducted to explore whether or not Arab-Americans (due to deculturation, acculturation, assimilation or biculturalism) had changed their caregiving values. In addition, our goal was to explore the caregiving and carereceiving patterns of this particular population. Most importantly, we chose this subject because of our concern with regard to the treatment of Arabs in general, and the care provided to elderly Arab-Israelis and Arab-Americans in particular. Our intentions were to gather as much information as possible in order to facilitate improvement in providing services to the Arab/Arab elderly population in America as well as in

Israel.

It is the belief of the researchers that there is much more that needs to be examined regarding the Arab communities in both countries, for little or no attention is given to this growing population. Without a closer look, we will not be able to discern the needs of this population, let alone provide them. Thus, it is our conclusion that much more must be learned about the people of Arab heritage before we can begin to determine what their needs are and how they can best be met.

Findings and Analyses

Frequencies

In running the frequencies for the caregivers and carereceivers from both countries, the following was found: In response to the question regarding the absence of caregivers from work to provide care for their family member, it was found that 40% of caregivers do miss work some of the time to provide care; according to the carereceivers, 46% of them stated that their caregiver missed work most of the time in order to provide care. With regard to the question of the carereceivers keeping busy with daily activities, it was found that 40% believe that they are busy once in a while, 23.3% were busy some of the time, 20% are active most of the time, and 16.7% stated that they are always busy. In addition, 43.3% of the carereceivers reported that family caregivers need help

some of the time with activities of daily living. The recipients of care also stated that 26.7% of the time, someone was in the home with them twenty-four hours a day, seven days a week. It was also reported by the caregivers, that 93.6% of the time, they need help in providing care to their elderly family member. The breakdown of this response by care providers is the following: 40% need help some of the time; 33.3% need help most of the time; 20% need help always; 3.3% need help once in a while, and 3.3% never need help. The care receivers also report that their caretakers need help with their care 90% of the time (with 50% stating help is needed most of the time or always).

With regard to contributing to the cost of care, it was noted that recipients stated that they contribute to the cost of their care 76.3% of the time, with 36.7% contributing some of the time and 20% contributing most of the time; 23.3% stated that they never contribute to the cost of their care. The caregivers, on the other hand, stated that 40% of the carereceivers never contribute to the cost of their care, while 50% contribute at least once in a while. When asking a similar question with regard to whether or not one should pay for family care, receivers report that 20% of the time, they should never help, and the remaining 79.9% report that they should help at least once in a while. In comparison, caregivers report that 10% of the time recipients should never pay for care, that

43.3% believe recipients should pay once in a while; 36.7% believe that recipients should pay some of the time, and only 6.7% report that their elders should pay most of the time and 3.3% stated that they should always be paid for providing care.

The question regarding truthfulness of the carereceiver's health was answered with 36.7% reporting that they are truthful once in a while; 40% are truthful some of the time; 16.7% are never truthful, and 6.7% are truthful most of the time when reporting wellness. The care providers' responses were extremely close to the responses given by the carereceivers. The providers believe that the recipient tells the truth once in a while at least 33.3% of the time; 36.7% the truth is told some of the time, and 10% tell the truth most of the time.

As far as evaluating the response given by both groups as to recipients eating the same food as the family, the majority of providers and receivers agree that the receivers eat the same food as the caregivers, at least most of the time. Both receivers and givers of care concluded that 60% of the time, the elders ate the same food as the providers most of the time.

Feeling welcome in the family's home was a question that was answered by 27 out of 30 carereceivers, with 3.3% never feeling welcome, 40% feeling welcome some of the time, 20% feeling welcome most of the time, and 13.3%

always feeling welcome. A similar question was asked of the caregivers which asked if they felt comfortable having an elderly family member in the home. In response, 40% reported feeling comfortable some of the time; 50% reported feeling comfortable most of the time, and 6.7% stated that they always felt comfortable with their elderly family member in the home.

Frequency of physical affection was a question posed only to the caregivers. One caregiver out of thirty chose not to answer the question. The remaining 29 caregivers reported that 50% gave affection at least most of the time while 46.7% reported giving affection once in a while or some of the time. The recipients of care responded to the question regarding being told by their caregivers that they would go to a nursing home, 40% of the recipients reported that they had been told they would go to a nursing home, at least once in a while, and 13.3% stated that they were told some of the time. The providers of care reported that 66% had told their elders that they would go to a nursing home at least once in a while to some of the time (46.7% for once in a while, and 20% for some of the time).

Whether or not prescription medication remained unfilled due to cost was asked of both groups. The receivers stated that 80% of the time prescriptions were not filled due to cost at least once in a while to some of the time (40% for each response). The providers of care

reported that 66.7% of the prescriptions were not filled at least once in a while to some of the time (with 46.7% reporting once in a while, and 20% reporting some of the time).

With regard to receivers or givers of care applying for financial or other support services the breakdown is as follows: the receivers stated that 16.7% of the time, they never applied, and 43.3% reporting that they applied once in a while. The givers reported that 23.3% of the time they never applied for services, and 46.7% applied once in a while.

In relationship to medication and services, both groups were asked if they received no or less health care due to cost. The receivers reported that 50% did not receive any or less health care due to cost at least once in a while, and 26.7% reported a lack of health care due to cost at least some of the time. The givers of care reported that 60% of their elders did not receive any or less health care due to cost
at least once in a while, and 23.3% reported that this occurred some of the time.

Providers of elderly family members were asked if they received help from outside professionals with the care of their elders. They reported that 20% never received help, 20% received help once in a while, and 30% received help some of the time. A stress related question with regard to

the care of their elders was asked of the caregivers. They reported 73.4% experience stress at least some of the time. When asking the carereceivers if they experience stress in their lives, 53.3% reported that to be the case at least some of the time. Analyses of the above data is as follows:

The following questions were asked of the carereceivers in both Israel and in California which resulted in the following:

1. Do you have activities that keep you busy during the day?

Israeli Receivers - 50% said they are not kept busy enough.

California Receivers - 80% said that they are not kept busy enough.

2. Do you think your caretakers need help to provide you with the care you want?

Israeli Receivers - 90% said that their caretakers need help, and 55% of them need help most of the time or always.

California Receivers - 40% said that their caretaker need help in providing them with the care they want.

3. Have you not seen a doctor, dentist, optometrist or other health care provider because of the expense?

Israeli Receivers - 90% reported that they are not receiving health care due to cost at least once in a while.

California Receivers - 50% reported that they are not receiving health care due to cost at least once in a while.

4. Has your family told you that you will be sent to a nursing home?

Israeli Receivers - 45% were told that they would be sent to a nursing home at least once in a while.

California Receivers - 70% were told that they would be sent to a nursing home at least once in a while.

5. Do you provide financial help to your family for the costs associated with your care?

Israeli Receivers - 25% stated that they never provide financial help, and 50% stated that they do once in a while.

California Receivers - 90% stated that they provide financial help at least once in a while.

6. Do you feel welcome in your family's home?

Israeli Receivers - Three people chose not to answer this question, while 55% stated that they feel welcome at least some of the time and 5% always feel welcome.

California Receivers - 80% reported feeling welcome some of the time to most of the time, and 30% report always feeling welcome.

7. Have you told your family not to fill your prescription because you felt it was too expensive?

Israeli Receivers - 85% do not fill prescriptions at least once in a while due to cost (45% do not fill prescriptions some of the time, and 40% do not fill prescriptions once in a while).

California Receivers - 70% do not fill prescriptions at least once in a while due to cost; (40% do not fill prescriptions once in a while, and 30% do not fill prescriptions some of the time).

8. Do you have the opportunity to go places to see and enjoy the company of people your own age and from your own culture?

Israeli Receivers - 65% stated that they socialize once in a while or sometime, and 35% reported socializing most of the time.

California Receivers - 60% reported socializing once in a while or sometime, with 20% reporting socializing most of the time, and 10% stated that they always socialize.

9. Have you ever asked for help from outside of your home?

Israeli Receivers - 20% stated that they have never asked for hep from outside of their home; 45% have asked for help outside of their home once in a while, and 15% stated that they have asked for help outside of their home most of the time.

American Receivers - 50% stated that they have asked for help some of the time; 40% have asked once in a while, and 10% have never asked for help from outside of their home.

Question asked of the caregivers and the results are as follows:

1. Has your elderly family member been unable to be seen by a dentist, doctor, optometrist or other health care provider due to the expense related to health care?

Israeli Caregivers - 70% reported that this occurs once in a while, and 30% reported that this occurs some of the time.

California Caregivers - 50% reported that this occurs at least once in a while 10% reported that this occurs some of the time.

2. Do you think that you could use extra help in caring for your elderly family member?

Israeli Caregivers - 55% stated that they need extra help most of the time or always.

California Caregivers - 50% reported that they need extra help most of the time or always.

3. Do you think that you should get paid by your elderly relatives for your caretaking services?

Israeli Caregivers - 15% reported that they should never get paid;

10% believe that they should be paid once in a while; 45% stated that they should be paid some of the time; 25% stated that they should be paid most of the time, and 5% stated that they should always be paid.

California Caregivers - 40% reported that they should never get paid; 30% reported that they should get paid once in a while; 20% reported that they should get paid some of the time, and 10% reported that they should get paid most of the time.

4. Does the elder member provide you with financial help in order to help pay for their care?

Israeli Caregivers - 15% of Arab-Israeli elders never provide financial help for their care; 65% provide financial help once in a while; 15% provide financial help some of the time, and 5% provide financial help most of the time.

California Caregivers - 100% of the Arab-American elders provide financial help to their care providers: 80% provide financial help some of the time; 10% provide financial help most of the time, and 10% always provide financial help.

5. Have you told your elderly family member that you would put them in a nursing home?

Israeli Caregivers - 40% reported that they never told their elderly family members that they would put them in a nursing home; 45% have told them once in a while, and 15% have told them some of the time.

California Caregivers- 80% of Arab-American caregivers reported that they have told their elderly family members at least once in a while, that they would put them in a nursing home; 20% have never told them that they would put them in a nursing home.

6. Do you feel comfortable having your elderly family member in your home?

Israeli Caregivers - 100% stated that they feel comfortable having their elderly family member in the home; 40% of which feel comfortable some of the time, 5% of which feel comfortable once in a while; 45% of which feel comfortable most of the time, and 10% of which always feel comfortable.

California Caregivers - 100% stated that they feel comfortable having their elderly family member in the home; 40% of which feel comfortable some of the time, and 60% of which feel comfortable most of the.

7. Have you been unable to fill a prescription for your elderly family member because of the high cost of medicine?

Israeli Caregivers - 75% of the time, prescriptions were not always filled, which consisted of 40% where not filled once in a while; 30% were not filled some of the time, and 5% were not filled most of the time.

California Caregivers - 40% of the time, prescriptions were never not filled; 60% of the time, prescriptions were not filled once in a while.

8. Have you ever thought about getting help from outside of the family, such as professional services, to help with the care you provide?

Israeli Caregivers - 20% reported that they never thought about getting help from outside of the family; 15% thought of getting help once in a while; 25% that of getting help some of the time; 10% thought of getting help most of the time, and 30% always thought of asking for help outside of the home.

California Caregivers - 20% reported that they never thought about getting help from outside of the family; 30%

thought of getting help once in a while; 40% thought of getting help some of the time, and 10% thought of getting help from out side of the family, most of the time.

9. Would you be willing to take your elderly family member to a place where he or she can socialize with people of their own age and culture?

Israeli Caregivers - 100% reported that they would take their elderly family member to a place where he or she could socialize with people of their own age and culture; 20% would take them once in a while; 50% would take them some of the time; 25% would take them most of the time, and 5% would always take them.

California Caregivers - 80% reported that they would take their elderly family member to a place where he or she could socialize with people of their own age and culture; of this 80%, 30% would be willing once in a while; 30% would be willing some of the time; 10% would be willing most of the time, and 10% would always be willing. In addition, the California caregivers stated that 20% of them would never be willing to take their elderly family member to a place where he or she could socialize with people of their own age and culture.

10. How often do you display physical affection to the elderly person in your care?

Israeli Caregivers - One person was not willing to respond to that question. However, 95% of the Arab-Israelis reported that they demonstrated physical affection; 25% reported that they demonstrate physical affection at least once in a while, 30% reported to do so some of the time; 25% reported that they display physical affection most of the time, and 5% stated that they always display physical affection.

California Caregivers - The Arab-American caregivers reported that they display affection according to the following: 10% always display physical affection; 60% do the same most of the time, and 20% display physical affection some of the time.

11. Have you ever applied for financial support or other services that are available to you and to your family?

Israeli Caregivers - Out of the 100% who reported that they have applied for financial support or other services, 15% stated that they would never apply; 50% stated that they gave applied once in a while; 25% reported that they have applied some of the time; 5% reported that they have applied most of the time, and 5% reported that they have always applied for financial support or other services that were available to them and to their families.

California Caregivers - The Arab-American caregivers stated that 40% of the time they have never applied for

financial support or other family services that are available to them and to their family; 40% have applied once in while, and 20% have applied some of the time. An analyses of the preceding questions posed to caregivers and carereceivers is as follows:

Chi Square Results and Analyses

Caregivers from both countries:

1. Has your elderly family member been unable to be seen by a dentist, doctor, optometrist or other health care provider due to the expenses related to health care?

With a Pearson Chi-Square value of 12.143[a], 2 degrees of freedom, and a p value of .002, we could conclude that there was a pattern that did not seem to occur on a random basis. Therefore, it is statistically significant. It would appear then, that a significantly higher number of Arab-Israelis receive no or less care than Arab-Americans. One may assume then, that this statistically significant number is to be expected due to the fact that the Arab-American elderly in California may have benefits such as Medi-Cal and/or Medicare, and that the Arab-Israelis do not have this type of health insurance or availability to health care.

2. Does the older member provide you with financial help in order to help pay for his/her care?

The value of the Pearson Chi-Square test was 17.932[a], 4 degrees of freedom, and a p value of .001. This is statistically significant and one may conclude, based on these results, that a significantly higher number of Arab-Israeli elderly family members pay for their care much less often then their counterparts in California. Again, this may be accounted for due to the fact that the United States has social security, which provides income to the elderly population. This is not the case for Arab-Israelis, which could make them even more dependent on their families for care.

Carereceivers from both countries:

1. Does someone stay with you all day and all night?

With a value of 20.663[a], 5 degrees of freedom, and a p value of .001 indicates that a much larger percentage of Arab-Israeli elderly family members have someone in the home twenty-four hours a day, seven days a week. The majority of Arab-Americans in California stated that 70% of the time, someone is not in the home with them. This may be an indicator of Arab-Israelis having someone at home who does not work outside of the home; or, if they have larger families than Arab-Americans, there is a greater likelihood of someone being home all the time.

2. Does someone other than your primary caretaker provide care for you?

With a Pearson Chi-Square value of 7.371[a], 4 degrees of freedom, and a p value of .118. This is not statistically significant, but is worth mentioning. Again, this may be accounted for if Arab-Israelis have extended family living in the home who helps in providing care for the elder member.

3. Do you tell your family member that you feel well when you are feeling sick?

With a Pearson Chi-Square value of 7.445[a], 3 degrees of freedom, and a p value of .059, it may have some importance, and is worth mentioning. It appears that there may be some statistical significance with regard to how often elders tell the truth about their health status. Arab-Israeli elderly tell the truth 80% of the time, with 20% telling the truth once in a while, 50% telling the truth some of the time, and 10% telling the truth most of the time. In addition, 20% of the Arab-Israeli elderly never tell the truth about their health status. When compared with Arab-American elderly, 10% never tell the truth, 70% tell the truth once in a while, and 20% tell truth some of the time about their health. What could the reason be for Arab-Americans telling the truth less often about their health, than their counterparts in Israel?

Could it be that Arab-Americans are more aware of the institutionalization of the elderly? The availability of nursing and boarding homes is much higher in America than in Israel, and it is not necessarily considered a shameful act to place a parent in a nursing home in this country, especially if the parent is in need of that level of care.

4. Do you provide financial help to your family for the costs associated with your care?

The Pearson Chi-Square value was reported as 4.776[a], with 3 degrees of freedom and a p value of .189. This is not statistically significant, but when reviewing the break down of the data it showed the following: 25% of Arab-Israeli carereceivers never provide financial help; 50% provide financial help once in a while; 20% provide financial help some of the time, and 5% help most of the time. When compared with Arab-American carereceivers, it was reported that 10% never provide financial help; 30% provide help once in a while; 30% provide help some of the time, and 30% provide financial help most of the time. Thus, with 75% of the Arab-Israeli elders providing financial help once in a while or never, and 60% of the Arab-Americans provide financial help at least some to most of the time, it would appear that Arab-Israeli carereceivers help considerably less than the Arab-American carereceivers. Again, this may be a result of social

security benefits which are not available to Arab-Israelis. It also may be indicative of a lower socio-economic level for those elders who help less or not at all.

5. Have you not seen a doctor, dentist, optometrist or other health care provider because of the expense?

The Pearson Chi-Square value was 11.250[a], with 3 degrees of freedom, and a p value of .010. The Arab-Israeli carereceivers reported that a high number of them have not received health care, at least once in a while to most of the time, due to the expense. The breakdown is as follows: 5% of Arab-Israeli elders never have not had health care due to the expense; 50% have not received health care at least once in while; 40% have not received health care some of the time, and 5% have not received health care most of the time. In comparison with California, Arab-Americans there reported the following: 50% have never not had health care due to expense, and 50% have not had health care once in a while. Therefore, as reported, 95% of Arab-Israelis have not (at least once in a while) received health care due to the expense. On the other hand, as reported, only 50% of Arab-Americans have not (only once in a while) received health care. Again, this can be accounted for because of the insurance availability in the United States, as well as the availability of health care itself. This could be

statistically significant in spite of the .010 p value.

6. Do you feel welcome in your family's home?

With a Pearson Chi-Square of 8.775[a], 5 degrees of freedom, and a p value of .118, it does not show statistical significance. However, it is important to note that three Arab-Israelis and one Arab-American chose not to answer that particular question. The answers were reported as follows: Arab-Americans reported that 80% feel welcome at least some of the time, with a break down of: 40% feel welcome some of the time; 10% feel welcome most of the time, and 30% always feel welcome. With regard to the Arab-Israelis, the following was reported: 11% feel welcome once in a while; 47% feel welcome some of the time; 29% feel welcome most of the time, and 5% always feel welcome. With a discrepancy of this magnitude with regard to feeling welcome, one might conclude that Arab-Americans feel welcome more often than Arab-Israelis because it is not a part of the American culture to be responsible for the care of one's elders. When caring for an elder in Israel, the elder may see it as something their family has to do for fear of being shamed if they do not care of him or her. It is expected, in the Arab culture, that the elderly family members will be cared for by their children or other family members. An Arab-Israeli caretaker may seen by the elder as taking care of them because it is expected, not because it

is something that they really want to do. Therefore, it may be seen that if an Arab-American is caring for an elder, it is because they want to, thus making the carereceiver feel more welcome.

7. Do you have the opportunity to go places to see and enjoy the company of people your own age and from your own culture.

With a Pearson Chi-Square value of 7.786[a], 4 degrees of freedom, and a p value of .100, it would seem that it would be important to mention the following: 100% of the Arab-Israelis reported that they have the opportunity to go places to see and enjoy the company of people their own age and from their own culture, with a breakdown as follows: 15% have the opportunity once in a while; 50% have the opportunity some of the time, and 35% have the opportunity most of the time. In comparison with the Arab-Americans, 10% never have the opportunity; 40% have the opportunity once in a while; 20% have the opportunity some of the time; 20% have the opportunity most of the time, and 10% always have the opportunity. It appears then, that with 50% of Arab-Americans who do not have the opportunity to see and enjoy the company of people their own age and from their own culture at least once in a while, Arab-Americans are being deprived from socializing with their cohorts. Why this may be the case, what would be the reason for the lack

of socialization with their peer group remains to be examined. It may be a result of the fast paced environment in California, and the time constraints on caregivers, or there may be a lack of people who fit the description with whom carereceivers could associate. This would be a good area to look into further, for isolation of the elderly is a serious problem in this country.

8. When you feel stress, can you talk about it with your family?

With a Pearson Chi-Square value of 7.191[a], 4 degrees of freedom, and a p value of .126, there is little likelihood of statistical significance. However, it may be important to note that 90% of Arab-Americans can talk with their families about stress some of the time and 10% can talk about stress with their families most of the time. In comparison, however, Arab-Israelis reported the following: 5% never talk with their families about stress; 25% talk once in a while; 40% talk some of the time; 25% talk most of the time, and 5% are always able to talk with their families about stress. Thus, 30% of the Arab-Israeli elders cannot talk with their families about stress at least once in a while, and 100% of Arab-Americans can talk with their families about stress at least some of the time. Why this is so is another area that would be beneficial to explore further. Possibly because Arab-Americans feel more

welcome in their caregivers' homes more often than Arab-Israelis feel welcome, they may also feel more comfortable to speak out about issues that would not normally be discussed in the Arab-Israeli home where care is provided to an elder family member.

Limitations

The limitations of this study should be acknowledged for we were faced with certain limitations. The first limitation we found was that there is a lack of social service agencies that specifically deal with issues of care and living arrangements for elder Arabs in southern California, as well as the non-existence of services in the West Bank of Israel (where this study was conducted). As a result, this limited the ability of the student researchers to include a section in this study on how professionals view the need for services for the aging Arab population. We also found that the small sample size of the number of participants in both countries, may have prevented us from obtaining clear, definitive, accurate data that could be used to give policy makers an idea of the severity of the problem. Having a larger sample may have generated more credible data. Some of the participants elected not to answer a few of the questions on the questionnaire. A large number of participants in a future study may lead to an increased awareness and a better understanding of the

needs regarding this population. With data from a larger group of caregivers and carereceivers, we may have been able to make some generalizations, however cautiously.

Further limitations occurred by not being able to find an adequate number of professionals who would talk about the impact of growing old as a member of the Arab population, both in the United States and in Israel. In addition, by not being able to track the psychological impact, (if any), of the participants, we are not aware of specific support that they may have needed and not received. Of course there were time constraints and limited resources which influenced the researchers' decision as to how to conduct the study, which research design to use, how many questions to ask, etc. The student researchers believe that the study could be improved by including a higher number of participants in both countries. In addition, more information could be gathered by including a follow-up interview with the participants, and to increase the number and type of questions asked of both caregivers and carereceivers.

APPENDIX A: Questionnaire for Caregivers

Questions Regarding the Caregiving of Arab-American and Arab-Israeli Elderly

Since you are now caring for an elderly family member, please answer the following questions to the best of your ability and as accurately as possible. The student researchers will help with clarification of the questions, if necessary, during the interview.

DIRECTIONS

Circling #1 means:	Never
Circling #2 means:	Once in a while
Circling #3 means:	Some of the time
Circling #4 means:	Most of the time
Circling #5 means:	Always

1. Do you think that you should get paid by your elderly relatives for your caretaking services?

1 2 3 4 5

2. Have you told your elderly family member that you would put them in a nursing home?

1 2 3 4 5

3. Have you withheld information that would be important for your relative to know?

1 2 3 4 5

4. Have you been unable to fill a prescription for your elderly family member because of the high cost of medicine?

1 2 3 4 5

5. Has your elderly family member been unable to be seen by a dentist, doctor, optometrist or other health care provider due to the expense related to health care?

1 2 3 4 5

6. Would you be willing to take your elderly family member to a place where he or she can socialize with people of their own age and culture?

1 2 3 4 5

7. Do you feel comfortable having your elderly family member in your home?

1 2 3 4 5

8. How often do you display physical affection to the elderly person in your care?

1 2 3 4 5

9. Does your elderly family member eat with the rest of the family when they eat?

1 2 3 4 5

10. Does he or she eat the same types of food as the rest of the family?

1 2 3 4 5

11. Do you have to administer any medication to your elderly family member?

1 2 3 4 5

12. Does the elder member provide you with financial help in order to help pay for their care?

1 2 3 4 5

13. Do you miss work in order to provide care as needed?

1 2 3 4 5

14. Do you haves someone to provide care for the elderly family member when you need time off?

1 2 3 4 5

15. Do you think that you could use extra help in caring for your elderly family member?

1 2 3 4 5

16. Have you ever thought about getting help from outside of the family such as professional services to help with the care you provide?

1 2 3 4 5

17. Have you ever applied for financial support or other services that are available to you and to your family?

1 2 3 4 5

18. Do you experience stress that is related to the care of your elderly family member?

1 2 3 4 5

19. Do you partake in any activity that helps you to relieve the stress in your life?

1 2 3 4 5

APPENDIX B: Questionnaire for Carereceivers

Questions Regarding the Caregiving of Arab-American and Arab-Israeli Elderly Family Members

Since you are now receiving care from a family member, please answer the following questions to the best of your ability and as accurately as possible. The student researchers will help with clarification of the questions, if necessary, during the interview.

DIRECTIONS

Circling #1 means:	Never
Circling #2 means:	Once in a while
Circling #3 means:	Some of the time
Circling #4 means:	Most of the time
Circling #5 means:	Always

1. Do you think that you should pay for the care that you receive from your family?

1 2 3 4 5

2. Has your family told you that you will be sent to a nursing home?

1 2 3 4 5

3. Do you tell your family that you feel well when you are feeling sick?

1 2 3 4 5

4. Have you told your family not to fill your prescription because you felt it was too expensive?

1 2 3 4 5

5. Have you not seen a doctor, dentist, optometrist or other health care provider because of the expense?

1 2 3 4 5

6. Do you have the opportunity to go places to see and enjoy the company of other people your own age and from your own culture?

1 2 3 4 5

7. Do you feel welcome in your family's home?

1 2 3 4 5

8. How often do you get to eat with the rest of the family?

1 2 3 4 5

9. Do you eat the same foods as the other family members eat?

1 2 3 4 5

10. Do you take your medications on a regular basis?

1 2 3 4 5

11. Do you provide financial help to your family for the costs associated with your care?

1 2 3 4 5

12. Does a family member stay home from work to care for you?

1 2 3 4 5

13. Does anyone other than your primary caretaker provide care for you?

1 2 3 4 5

14. Do you think your caretaker needs help to provide you with the care you want?

1 2 3 4 5

15. Have you ever asked for help from outside of your family?

1 2 3 4 5

16. Have you ever applied for financial support or other services that are available to you?

1 2 3 4 5

17. Do you feel a lot of stress in your life?

1 2 3 4 5

18. When you feel stress, can you talk about it with your family?

1 2 3 4 5

19. Are you able to perform any household chores or duties?

1 2 3 4 5

20. Does your family need to help you with your activities of daily living, such as bathing, dressing, and eating?

1 2 3 4 5

21. Do you have activities that keep you busy during the day?

1 2 3 4 5

22. Does someone stay home with you all day and all night?

1 2 3 4 5

APPENDIX C: INFORMED CONSENT

The study in which you are being asked to participate is designed to study caregiving patterns of the elderly and the needs of elderly Arab-Israelis and Arab-Americans who receive care as well as their respective family members who provide such care. Pauline Calderone and Jawad Hajawad, second year graduate social work student at California State University, San Bernardino, are conducting this study. It will be conducted under the supervision of Professor Morley D. Glicken, Ph.D. at California State University, San Bernardino. This study has been approved by the Institutional Review Board, California State University, San Bernardino.

In this study, you will be asked to participate in an interview that will last no longer than 20 minutes. During the interview, you will be asked questions about your experiences in receiving care as an elderly family member, and/or your experiences in providing such care. No names will be kept in any part of the record which is compiled during the data collection process. All data will be reported in group form only. Your participation in this project is totally voluntary, and you may decide to withdraw from the study at any time, or refuse to respond to a specific question or questions.

If you believe that you are being abused or neglected and you wish to discuss this with one of the researchers, please be aware that the researchers are obligated to report what you have told them to the proper authorities. It is your right to refuse to take part in the study.

If you have any questions or concerns about the study, the student researchers and Dr. Glicken can be contacted by calling the following numbers: Dr. Glicken, (909) 880-5557; Pauline Calderone, (909) 880-7574, and Jawad Hajawad, (909) 593-2192, who may also be called collect. Mr. Hajawad does speak Arabic fluently.

It is our hope that by conducting this study, we will have a better understanding of the needs of Arab-Israeli and Arab-American caregivers and the recipients of that care.

By placing a mark in the space provided below, I acknowledge that I have been informed of and understand the nature and purpose of this study, and I freely consent to participate.

Give your consent to participate by making an 'X' mark here _____. Today's date is: _____.

APPENDIX D: DEBRIEFING STATEMENT

Thank you for participating in the study entitled

"Caregiving Patterns Among Arab-Americans Living in California and Arabs Living in Israel". The research was conducted by Pauline Calderone and Jawad Hajawad, second year graduate students at California State University, San Bernardino. The study was approved by the Institutional Review Board at the University, and the research advisor was Dr. Morley D. Glicken.

If this study has caused you any emotional stress or concerns, a list of professional counselors, local social service agencies, and a community health agency in your area, has been attached for your use and convenience. The student researchers as well as Dr. Morley Glicken, Professor at California State University, San Bernardino, will also be available to answer your question or to help in any way they can. They can be reached by calling them at the following numbers: Dr. Glicken, (909) 880-5557; Pauline Calderone, (909) 880-7574, and Jawad Hajawad, (909) 593-2192, who may also be called collect.

A brief summary of the research will be available after June 1, 1999, and can be obtained by contacting either one of the research students or Dr. Morley Glicken.

Project Advisor:

_____

Professor Morley D. Glicken, Ph.D.
Department of Social Work
California State University, San Bernardino
5500 University Parkway
San Bernardino, CA 92407 (909) 880-5557

_____

Pauline M. Calderone, M.S.W. Student

_____

Jawad Hajawad, M.S.W. Student

APPENDIX E: Demographic Data

Demographic data of Israeli Carereceivers

1. Age: 59 Gender: Female
2. Age: 59 Gender: Male
3. Age: 73 Gender: Male
4. Age: 71 Gender: Male
5. Age: 68 Gender: Male
6. Age: 53 Gender: Female
7. Age: 57 Gender: Female
8. Age: 63 Gender: Male
9. Age: 59 Gender: Male
10. Age: 74 Gender: Female
11. Age: 73 Gender: Male
12. Age: 55 Gender: Female
13. Age: 53 Gender: Female
14. Age: 57 Gender: Female
15. Age: 61 Gender: Female
16. Age: 49 Gender: Female
17. Age: 49 Gender: Female
18. Age: 53 Gender: Female
19. Age: 55 Gender: Female
20. Age: 56 Gender: Female

Demographic data of Israeli Caregivers

1. Age: 33 Gender: Female
2. Age: 19 Gender: Female
3. Age: 21 Gender: Female
4. Age: 29 Gender: Female
5. Age: 36 Gender: Female
6. Age: 22 Gender: Male
7. Age: 19 Gender: Male
8. Age: 23 Gender: Male
9. Age: 22 Gender: Female
10. Age: 35 Gender: Female
11. Age: 20 Gender: Male
12. Age: 29 Gender: Male
13. Age: 33 Gender: Male
14. Age: 45 Gender: Male
15. Age: 18 Gender: Male
16. Age: 22 Gender: Female
17. Age: 26 Gender: Male
18. Age: 31 Gender: Male
19. Age: 22 Gender: Female
20. Age: 27 Gender: Male

Demographics of U.S. Carereceivers

1. Age: 57 Gender: Female
2. Age: 55 Gender: Female
3. Age: 60 Gender: Female
4. Age: 81 Gender: Female
5. Age: 61 Gender: Female
6. Age: 57 Gender: Female
7. Age: 71 Gender: Female
8. Age: 73 Gender: Female
9. Age: 59 Gender: Female
10. Age: 63 Gender: Female

Demographics of U.S. Caregivers

1. Age: 44 Gender: Female
2. Age: 39 Gender: Female
3. Age: 22 Gender: Male
4. Age: 33 Gender: Female
5. Age: 22 Gender: Male
6. Age: 31 Gender: Male
7. Age: 29 Gender: Male
8. Age: 25 Gender: Female
9. Age: 37 Gender: Female
10. Age: 23 Gender: Female

APPENDIX F: Statistical Tables

Frequencies of Arab-American Caregivers

Table 1.

	N		Mean	Median	Mode
	Valid	Missing			
keep busy daily w/activities	10	0	2.7000	2.0000	2.00
Caretaker need help with your care?	10	0	3.1000	3.0000	2.00
truthful w/family re/wellness	10	0	2.1000	2.0000	2.00
Not received health care due to cost?	10	0	1.5000	1.5000	1.00[a]
told you will go to a nursing home?	10	0	1.8000	2.0000	2.00
Helping family with cost of care?	10	0	2.8000	3.0000	2.00[a]
Feeling "welcome" in family's home?	10	0	3.2000	3.0000	3.00
Unfilled RX's due to cost?	10	0	2.0000	2.0000	2.00
associate w/people of own age & culture	10	0	2.8000	2.5000	2.00
Asked for help outside of family	10	0	2.4000	2.5000	3.00

a. Multiple modes exist. The smallest value is shown

keep busy daily w/activities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Once in a while	6	60.0	60.0	60.0
	Some of the time	2	20.0	20.0	80.0
	Most of the time	1	10.0	10.0	90.0
	Always	1	10.0	10.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

Caretaker need help with your care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	10.0	10.0	10.0
	Once in a while	3	30.0	30.0	40.0
	Some of the time	2	20.0	20.0	60.0
	Most of the time	2	20.0	20.0	80.0
	Always	2	20.0	20.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

truthful w/family re/wellness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	10.0	10.0	10.0
	Once in a while	7	70.0	70.0	80.0
	Some of the time	2	20.0	20.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

Not received health care due to cost?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	5	50.0	50.0	50.0
	Once in a while	5	50.0	50.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

told you will go to a nursing home?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	3	30.0	30.0	30.0
	Once in a while	6	60.0	60.0	90.0
	Some of the time	1	10.0	10.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

Helping family with cost of care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	10.0	10.0	10.0
	Once in a while	3	30.0	30.0	40.0
	Some of the time	3	30.0	30.0	70.0
	Most of the time	3	30.0	30.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

Feeling "welcome" in family's home?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	1	10.0	10.0	10.0
	never	1	10.0	10.0	20.0
	Some of the time	4	40.0	40.0	60.0
	Most of the time	1	10.0	10.0	70.0
	Always	3	30.0	30.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

Unfilled RX's due to cost?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	3	30.0	30.0	30.0
	Once in a while	4	40.0	40.0	70.0
	Some of the time	3	30.0	30.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

associate w/people of own age & culture

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	10.0	10.0	10.0
	Once in a while	4	40.0	40.0	50.0
	Some of the time	2	20.0	20.0	70.0
	Most of the time	2	20.0	20.0	90.0
	Always	1	10.0	10.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

Asked for help outside of family

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	10.0	10.0	10.0
	Once in a while	4	40.0	40.0	50.0
	Some of the time	5	50.0	50.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

Frequencies of Arab-Israeli Caregivers

Table 2.

	N		Mean	Median	Mode
	Valid	Missing			
keep busy daily w/activities	20	0	3.3500	3.0000	2.00
Caretaker need help with your care?	20	0	3.3500	4.0000	4.00
truthful w/family re/wellness	20	0	2.5000	3.0000	3.00
Not received health care due to cost?	20	0	2.4500	2.0000	2.00
told you will go to a nursing home?	20	0	1.6000	1.0000	1.00
Helping family with cost of care?	20	0	2.0500	2.0000	2.00
Feeling "welcome" in family's home?	17	3	3.2353	3.0000	3.00
Unfilled RX's due to cost?	20	0	2.6500	3.0000	3.00
associate w/people of own age & culture	20	0	3.2000	3.0000	3.00
Asked for help outside of family	20	0	2.3000	2.0000	2.00

keep busy daily w/activities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Once in a while	6	30.0	30.0	30.0
	Some of the time	5	25.0	25.0	55.0
	Most of the time	5	25.0	25.0	80.0
	Always	4	20.0	20.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

Caretaker need help with your care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	2	10.0	10.0	10.0
	Once in a while	4	20.0	20.0	30.0
	Some of the time	3	15.0	15.0	45.0
	Most of the time	7	35.0	35.0	80.0
	Always	4	20.0	20.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

truthful w/family re/wellness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	4	20.0	20.0	20.0
	Once in a while	4	20.0	20.0	40.0
	Some of the time	10	50.0	50.0	90.0
	Most of the time	2	10.0	10.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

Not received health care due to cost?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	5.0	5.0	5.0
	Once in a while	10	50.0	50.0	55.0
	Some of the time	8	40.0	40.0	95.0
	Most of the time	1	5.0	5.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

told you will go to a nursing home?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	11	55.0	55.0	55.0
	Once in a while	6	30.0	30.0	85.0
	Some of the time	3	15.0	15.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

Helping family with cost of care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	5	25.0	25.0	25.0
	Once in a while	10	50.0	50.0	75.0
	Some of the time	4	20.0	20.0	95.0
	Most of the time	1	5.0	5.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

Feeling "welcome" in family's home?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Once in a while	3	15.0	17.6	17.6
	Some of the time	8	40.0	47.1	64.7
	Most of the time	5	25.0	29.4	94.1
	Always	1	5.0	5.9	100.0
	Total	17	85.0	100.0	
Missing	System Missing	3	15.0		
	Total	3	15.0		
Total		20	100.0		

Unfilled RX's due to cost?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	5.0	5.0	5.0
	Once in a while	8	40.0	40.0	45.0
	Some of the time	9	45.0	45.0	90.0
	Most of the time	1	5.0	5.0	95.0
	Always	1	5.0	5.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

associate w/people of own age & culture

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Once in a while	3	15.0	15.0	15.0
	Some of the time	10	50.0	50.0	65.0
	Most of the time	7	35.0	35.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

Asked for help outside of family

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	4	20.0	20.0	20.0
	Once in a while	9	45.0	45.0	65.0
	Some of the time	4	20.0	20.0	85.0
	Most of the time	3	15.0	15.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

Frequencies of Arab-American Carereceivers

Table 3.

	N		Mean	Median	Mode
	Valid	Missing			
no or less care by doctors due to cost	10	0	1.6000	1.5000	1.00
assistance with care provision	10	0	3.6000	3.5000	3.00
contribute to cost of care?	10	0	2.0000	2.0000	1.00
financial help by recipient of care?	10	0	3.3000	3.0000	3.00
alternative care/nursing home	10	0	2.1000	2.0000	2.00
feeling welcome in family's home	10	0	3.6000	4.0000	4.00
rx not filled due to cost	10	0	1.6000	2.0000	2.00
help from outside professionals	10	0	2.4000	2.5000	3.00
socialization time w/others of own age & culture	10	0	2.6000	2.5000	2.00[a]
apply for $ and other support services?	10	0	1.8000	2.0000	1.00[a]
frequency of physical affection	10	0	3.5000	4.0000	4.00

a. Multiple modes exist. The smallest value is shown

no or less care by doctors due to cost

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	5	50.0	50.0	50.0
	once in a while	4	40.0	40.0	90.0
	some of the time	1	10.0	10.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

assistance with care provision

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	10.0	10.0	10.0
	some of the time	4	40.0	40.0	50.0
	most of the time	2	20.0	20.0	70.0
	always	3	30.0	30.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

contribute to cost of care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	4	40.0	40.0	40.0
	once in a while	3	30.0	30.0	70.0
	some of the time	2	20.0	20.0	90.0
	most of the time	1	10.0	10.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

financial help by recipient of care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	some of the time	8	80.0	80.0	80.0
	most of the time	1	10.0	10.0	90.0
	always	1	10.0	10.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

alternative care/nursing home

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	2	20.0	20.0	20.0
	once in a while	5	50.0	50.0	70.0
	some of the time	3	30.0	30.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

feeling welcome in family's home

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	some of the time	4	40.0	40.0	40.0
	most of the time	6	60.0	60.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

rx not filled due to cost

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	4	40.0	40.0	40.0
	once in a while	6	60.0	60.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

help from outside professionals

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	2	20.0	20.0	20.0
	once in a while	3	30.0	30.0	50.0
	some of the time	4	40.0	40.0	90.0
	most of the time	1	10.0	10.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

socialization time w/others of own age & culture

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	2	20.0	20.0	20.0
	once in a while	3	30.0	30.0	50.0
	some of the time	3	30.0	30.0	80.0
	most of the time	1	10.0	10.0	90.0
	always	1	10.0	10.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

apply for $ and other support services?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	4	40.0	40.0	40.0
	once in a while	4	40.0	40.0	80.0
	some of the time	2	20.0	20.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

frequency of physical affection

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	1	10.0	10.0	10.0
	some of the time	2	20.0	20.0	30.0
	most of the time	6	60.0	60.0	90.0
	always	1	10.0	10.0	100.0
	Total	10	100.0	100.0	
Total		10	100.0		

Frequencies of Arab-Israeli Carereceivers

Table 4.

	N		Mean	Median	Mode
	Valid	Missing			
no or less care by doctors due to cost	20	0	2.3000	2.0000	2.00
assistance with care provision	20	0	3.6500	4.0000	3.00[a]
contribute to cost of care?	20	0	2.9500	3.0000	3.00
financial help by recipient of care?	20	0	2.1000	2.0000	2.00
alternative care/nursing home	20	0	1.7500	2.0000	2.00
feeling welcome in family's home	20	0	3.6000	4.0000	4.00
rx not filled due to cost	20	0	2.1500	2.0000	2.00
help from outside professionals	20	0	3.1500	3.0000	5.00
socialization time w/others of own age & culture	20	0	3.1500	3.0000	3.00
apply for $ and other support services?	20	0	2.3500	2.0000	2.00
frequency of physical affection	19	1	3.3158	3.0000	3.00

a. Multiple modes exist. The smallest value is shown

no or less care by doctors due to cost

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	once in a while	14	70.0	70.0	70.0
	some of the time	6	30.0	30.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

assistance with care provision

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	once in a while	1	5.0	5.0	5.0
	some of the time	8	40.0	40.0	45.0
	most of the time	8	40.0	40.0	85.0
	always	3	15.0	15.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

contribute to cost of care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	3	15.0	15.0	15.0
	once in a while	2	10.0	10.0	25.0
	some of the time	9	45.0	45.0	70.0
	most of the time	5	25.0	25.0	95.0
	always	1	5.0	5.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

financial help by recipient of care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	3	15.0	15.0	15.0
	once in a while	13	65.0	65.0	80.0
	some of the time	3	15.0	15.0	95.0
	most of the time	1	5.0	5.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

alternative care/nursing home

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	8	40.0	40.0	40.0
	once in a while	9	45.0	45.0	85.0
	some of the time	3	15.0	15.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

feeling welcome in family's home

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	once in a while	1	5.0	5.0	5.0
	some of the time	8	40.0	40.0	45.0
	most of the time	9	45.0	45.0	90.0
	always	2	10.0	10.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

rx not filled due to cost

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	5	25.0	25.0	25.0
	once in a while	8	40.0	40.0	65.0
	some of the time	6	30.0	30.0	95.0
	most of the time	1	5.0	5.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

help from outside professionals

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	4	20.0	20.0	20.0
	once in a while	3	15.0	15.0	35.0
	some of the time	5	25.0	25.0	60.0
	most of the time	2	10.0	10.0	70.0
	always	6	30.0	30.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

socialization time w/others of own age & culture

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	once in a while	4	20.0	20.0	20.0
	some of the time	10	50.0	50.0	70.0
	most of the time	5	25.0	25.0	95.0
	always	1	5.0	5.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

apply for $ and other support services?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	3	15.0	15.0	15.0
	once in a while	10	50.0	50.0	65.0
	some of the time	5	25.0	25.0	90.0
	most of the time	1	5.0	5.0	95.0
	always	1	5.0	5.0	100.0
	Total	20	100.0	100.0	
Total		20	100.0		

frequency of physical affection

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	once in a while	5	25.0	26.3	26.3
	some of the time	6	30.0	31.6	57.9
	most of the time	5	25.0	26.3	84.2
	always	3	15.0	15.8	100.0
	Total	19	95.0	100.0	
Missing	System Missing	1	5.0		
	Total	1	5.0		
Total		20	100.0		

Crosstabulations and Chi-Square Tests for Caregivers and Carereceivers from Both Israel and the U.S.

Table 5.

Crosstabs

someone in the home w/you 24-7? *COUNTRY

Crosstab

Count

		COUNTRY		
		U.S.	Israel	Total
someone in the home w/you 24-7?	.00	1		1
	never	7	1	8
	once in a while	2	3	5
	some of the time		4	4
	most of the time		4	4
	always		8	8
Total		10	20	30

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	20.663[a]	5	.001
Likelihood Ratio	25.432	5	.000
Linear-by-Linear Association	16.666	1	.000
N of Valid Cases	30		

a. 10 cells (83.3%) have expected count less than 5. The minimum expected count is .33.

Crosstabs

Do you have more than one caretaker? * COUNTRY

Crosstab

Count

		COUNTRY		
		U.S.	Israel	Total
do you have more than one caretaker?	never		2	2
	once in a while		3	3
	some of the time	2	6	8
	most of the time	3	7	10
	always	5	2	7
Total		10	20	30

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.371[a]	4	.118
Likelihood Ratio	8.600	4	.072
Linear-by-Linear Association	5.942	1	.015
N of Valid Cases	30		

a. a. 8 cells (80.0%) have expected count less than 5. The minimum expected count is 67.

Crosstabs

truthful w/family re/wellness * COUNTRY

Crosstab

Count

		COUNTRY		
		U.S.	Israel	Total
truthful w/family re/wellness	never	1	4	5
	once in a while	7	4	11
	some of the time	2	10	12
	most of the time		2	2
Total		10	20	30

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.445[a]	3	.059
Likelihood Ratio	7.953	3	.047
Linear-by-Linear Association	1.475	1	.225
N of Valid Cases	30		

a. a. 6 cells (75.0%) have expected count less than 5. The minimum expected count is .67.

Crosstabs

Not received health care due to cost? * COUNTRY

Crosstab

Count

		COUNTRY		Total
		U.S.	Israel	
Not received health care due to cost?	never	5	1	6
	once in a while	5	10	15
	some of the time		8	8
	most of the time		1	1
Total		10	20	30

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.250[a]	3	.010
Likelihood Ratio	13.689	3	.003
Linear-by-Linear Association	9.990	1	.002
N of Valid Cases	30		

a. a. 5 cells (62.5%) have expected count less than 5. The minimum expected count is 33.

Crosstabs

Feeling "welcome" in family's home? * COUNTRY

Crosstab

Count

		COUNTRY		Total
		U.S.	Israel	
Feeling "welcome" in family's home?	never	1		1
	Once in a while	1	3	1
	Some of the time	4	8	3
	Most of the time	1	5	12
	Always	3	1	6
Total		10	17	4 27

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.775[a]	5	.118
Likelihood Ratio	10.412	5	.064
Linear-by-Linear Association	.006	1	.941
N of Valid Cases	27		

a. a. 11 cells (91.7%) have expected count less than 5. The minimum expected count is .37.

Crosstabs

associate w/people of own age & culture * COUNTRY

Crosstab

Count

		COUNTRY		Total
		U.S.	Israel	
associate w/people of own age & culture	never	1		1
	once in a while	4	3	7
	some of the time	2	10	12
	most of the time	2	7	9
	always	1		1
Total		10	20	30

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.786[a]	4	.100
Likelihood Ratio	8.282	4	.082
Linear-by-Linear Association	1.296	1	.255
N of Valid Cases	30		

a. a. 8 cells (80.0%) have expected count less than 5. The minimum expected count is 33.

Crosstabs

Talk w/family re stress? *COUNTRY

Crosstab

Count

		COUNTRY		Total
		U.S.	Israel	
Talk w/family re stress?	never		1	1
	once in a while		5	5
	some of the time	9	8	17
	most of the time	1	5	6
	always		1	1
Total		10	20	30

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.191[a]	4	.126
Likelihood Ratio	9.276	4	.055
Linear-by-Linear Association	.102	1	.750
N of Valid Cases	30		

a. 10 cells (83.3%) have expected count less than 5. The minimum expected count is .33.

care provider's absence from work * COUNTRY

Crosstab

Count

		COUNTRY		Total
		U.S.	Israel	
care provider's absence from work	.00	1		1
	never		1	1
	once in a while	2	7	9
	some of the time	3	9	12
	most of the time	2	2	4
	always	2	1	3
Total		10	20	30

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.375[a]	5	.372
Likelihood Ratio	5.796	5	.327
Linear-by-Linear Association	.632	1	.427
N of Valid Cases	30		

a. 10 cells (83.3%) have expected count less than 5. The minimum expected count is .33.

no or less care by doctors due to cost * COUNTRY

Crosstab

Count

		COUNTRY		
		U.S.	Israel	Total
no or less care by doctors due to cost	never	5		5
	once in a while	4	14	18
	some of the time	1	6	7
Total		10	20	30

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.143[a]	2	.002
Likelihood Ratio	13.380	2	.001
Linear-by-Linear Association	7.983	1	.005
N of Valid Cases	30		

a. 4 cells (66.7%) have expected count less than 5. The minimum expected count is 1.67.

financial help by recipient of care? * COUNTRY

Crosstab

Count

		COUNTRY		
		U.S.	Israel	Total
financial help by recipient of care?	never		3	3
	once in a while		13	13
	some of the time	8	3	11
	most of the time	1	1	2
	always	1		1
Total		10	20	30

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.932[a]	4	.001
Likelihood Ratio	22.527	4	.000
Linear-by-Linear Association	11.847	1	.001
N of Valid Cases	30		

a. 8 cells (80.0%) have expected count less than 5. The minimum expected count is .33.

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