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AGE, RACE, LIFE CONDITIONS, USE OF SOCIAL WELFARE SERVICES AND THE MORALE OF THE ELDERLY

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Although concerned professionals such as Kutner (1956), Cumming (1961), and Lawton (1972), have made strong beginnings in researching the psychological functioning of the elderly, only a few have explored the social and medical conditions of the aged, and especially their use of social welfare services, as these relate to a sense of well-being. Streib (1956) and Maddox (1968) were among the first to relate life-long patterning of social activity to later social activity and life satisfaction. Carp (1966), in a controlled study of housing, reported that housing did not affect the morale of low and middle income elderly. Lawton and Cohen (1974) looked at the reactions of an aged sample to new housing and found that there was only a modest effect on well-being. Adams (1971), in a literature review of correlates of life satisfaction among the elderly, highlighted the regularity with which health as a conditioning variable relates to overall leisure activities. Wolk and Telleen (1976) examined the social and psychological constraints of residence as these affect morale. Cutler (1976) reported that belonging to church-affiliated groups strengthened psychological well-being. Caslin and Calvert (1975) indicated that ethnicity (including race) has an important affect on use of services. Medley (1976) found that the degree of satisfaction with family was indicative of morale.

Nevertheless, there is a dearth of studies based upon face-to-face interview derived self-reports from the aged about the social-environmental conditions of their lives and particularly about their utilization of the social services as these relate to morale. The writers believe that such studies can assist helping professions in assessing present social resource use and may offer a sound base for planning social welfare service programs.

METHODOLOGY SETTING

This study was carried out in 1975 in a Florida urban community with a population of 103,000, comprised of 26,500 blacks and 76,500 whites. The data base was gathered as part of a descriptive assessment of the role that the Congregate Meals Program plays in the daily lives of its consumer-users within the community. As prescribed under the Older Americans Act, the program is available to all ambulatory elderly 60 years of age or older. Reflecting

traditional Southern attitudes and practices, its three neighborhood sites were racially segregated. All offered nutritious lunches on week days, as well as opportunities for socialization and access to various social services.

SAMPLE

A survey of the entire group of program users forms the data base for this study. Of the Congregate Meals Program's 128 participating elderly users, 55 were blacks and 73 were whites. Both groups were predominantly Protestant. Ages ranged from 60, the age of eligiblity for the Meals Program, to 92. The median age for blacks was 64 and for whites was 72. In terms of residency, the whites were mostly in-migrants; that is, 66% had lived in the community less than 20 years as compared with only 17% of the blacks. Indeed, for 34% of the blacks, but only 11% of the whites, the community was the place of birth.

Comparisons with U.S. Census data (1970) for the area indicated that the overall distribution by age and by sex of the entire group is representative of the aged in the community. In terms of racial composition, the black population is somewhat over-represented. Heuristic indicators of socioeconomic status such as eligibility for and/or use of public assistance programs like Medicaid and Food Stamps provide a basis for estimating general economic status. Again, the same census data grouped by age, race, occupation and utilization of income-related social services support a distinction using these indicators.

Since the elderly in the study voluntarily took part in the Congregate Meals Program they are not a random sample; hence, generalizations can be made safely only to similar populations. One further caveat concerning the sample is that race and general economic level are confounded in that the blacks tended to be poorer than the whites, as gauged by the heuristic indicators.

METHODOLOGY

The research study was strongly endorsed by the Congregate Meals Program administrator. Consequently the research team, while unaffiliated with the program, was given access to program participants and was able to offer them a careful explanation of the study. Social work students, both black and white, who were specially prepared to interview the elderly (i.e. to watch for fatigue and/or misperceptions due to hearing defects) administered the questionnaire at all of the program sites. Because of agency support and use of black and white student interviewers, it was possible to reach all program participants, even those with sight and literacy problems.

The 114-item questionnaire, which was administered by the interviewer, consisted of a mix of factually- and behaviorally-oriented questions that covered the areas of 1) type and condition of housing, 2) health status, both subjectively and as medically determined, 3) stamina, 4) sources of actual income and attitudes toward financial status, 5) social involvement, 6) utilization of the Congregate Meals Program, 7) knowledge about and utilization of a variety of social services, and 8) measure of well-being or morale. The morale measured consisted of 20 items and was based upon a modification of the work on Life Satisfaction by Neugarten, Havighurst, and Tobin (1961). In this study the operationalization of morale consisted of three components which

reflect present views and values: Zest, Self-Concept and Mood Tone. The reliability of this morale measure had been determined in an earlier unpublished study by Kosberg (1971). There is no particular reason for assuming this measure is racially biased. Each of the 20 questions appearing in the morale measure was rated on a two-step scale of agreement and disagreement. Each question had a "correct" response. Scores could range from a "low" to 0 to a "high" of 40. The summed "correct" replies were taken as the morale score for each individual.

DATA ANALYSIS

The data analysis sought out relationships between the dependent variable (morale) and the independent variables of age, race, and life conditions -- defined as housing, health, finances, patterns of social involvement, level of Congregate Meals Program participation, and utilization of various social welfare services. Measures of all variables were based upon self-reports. Spot checking of agency-kept records on such items as attendance and use of the social services supported the reliability of the responses.

On the housing variable, the reported availability of heat and air conditioning, toilet facilities, phones, and major kitchen appliances constituted a measure of basic amenities. The respondents' assessments of the state of repair and overall level of satisfaction with housing and with neighborhood were also measured. Health status was assessed by self-reports of any medically diagnosed ailment. Stamina or physical endurance was measured by the reported capability to walk and remain on one's feet to get around without the interference of fatigue or discomfort.

The variable of social involvement was defined as direct or indirect, a distinction suggested by Maddox (1963). In this study, direct involvement was a measure of frequency for: 1)in-person contacts with relatives and/or friends, and 2) non-Congregate Meals organizational/social group attendance. A high score on direct social involvement was a minimal weekly occurrence for a combination of 1 and 2. Indirect social involvement included the frequency of: 1) reading, 2) watching T.V., 3) listening to the radio, 4) working on a hobby alone, and 5) telephoning others. A high score for indirect involvement was a minimal daily frequency for any one of these activities.

An estimate of financial status included sources of income such as SSI, savings, financial aid from signficiant others, and utilization of public assistance programs including Food Stamps or Medicaid. A measure of financial concern was the respondents' subjective appraisal of ability to meet present and/or anticipated needs.

In the data analysis, the tests of statistical significance applied here are considered appropriate for the assumptions of purposive sampling, the scale level of the obtained data and the exploratory nature of the study.

FINDINGS

Age, Race and Morale

Morale measures could range from a low of 0 to a high of 40; the results indicate that the entire sample attained relatively high morale scores. The

range for the total sample of 128 was from 13 to 40, which was also the range for the white aged. For the black aged, the range was 20 to 39. The total group mean was 35.5; for the blacks, 34, and for the whites, 37. Variance for the entire sample was 8.74. However, for the whites it was 2.02 and for the blacks 15.5. Application of the median test corrected for continuity yielded a chi-square of 8.2 significant at the .02 level. Thus, the white elderly sample seemed to score consistently higher on the morale measures than did the aged black sample.

The age distribution of the sample along with its relationship to morale is of considerable interest. For the entire sample the age range was 60 to 92 with a median of 74. Among the white elderly the median age was 76 and for the blacks it was 71. This difference supports other findings of McNevin and Rosencrans (1967) of age disparity between white and black populations. As shown in Table 1, there are racial differences in age distribution and in the dispersion of morale scores. Whereas 44% of the white elderly had reached the

TABLE 1

AGE, RACE AND MORALE

Age	Blacks N = 55		Whites N = 73	
	Low	High	Low	High
Young Elderly (60-70)	18	10[a]	9	16[a]
Middle Elderly (71-76)	12	5	8	8
Old Elderly (77 and over)	7	3[b]	8	24[b]

[a]For the two-tailed test, $x^2 = 3.15$, df 1, $.05 > p > .05$
[b]For the two-tailed test, $x^2 = 4.90$, df 1, $.05 > p > .02$

age of 76 or beyond, only 18% of the blacks had done so. However, the relationship between age, race and morale is somewhat surprising. While the differences between high and low morale among the youngest group of aged (60-70) blacks and whites showed a trend toward significance ($x^2 = 3.5$, df = 1, $p = .10 > p > .05$, only the difference between the oldest group of aged blacks and whites (77 and older) reach statistical significance ($x^2 = 4.9$, df = 1, $.05 > p > .02$). Thus only blacks in their late seventies expressed lower morale than whites. Because of the small numbers in these age ranges, the results must be viewed cautiously. There are no adequate explanations as to why race does not bear a more consistent relationship with morale throughout the aging span. However, it is clear that in examining the relationship between race and morale, it is important to differentiate stages within the aging process.

Though the specific ways in which economic conditions influence longevity are as yet unknown, it might be assumed that income influences life conditions

such as nutritional level, access to medical care, and housing, among others which, in turn, may play a role not only in survival but also in morale or sense of well-being (U.S. Senate, 1971, and Jackson, 1971). Nevertheless, in this study, general economic status (as measured heuristically by eligibility for or use of several sources of public aid) did not relate to morale. Certainly, economic status is not a panacea and more subtle factors affect morale. Perhaps factors not tested in this study (such as reference group perception) affect this finding.

Life Conditions

Life conditions as used in this study include 1) housing, 2) health status, 3) finances and 4) social involvement. A summary of the findings on this multifaceted dimension is shown in Table 2. Each dimension will be discussed as to its relationship to morale.

TABLE 2

LIFE CONDITIONS AND MORALE

Life Conditions	Morale Scores N = 128 Low	High	X^2	df	p
HOUSING					
Presence of Basic Amenities	58	62			ns
State of Repair	59	69			ns
Overall Satisfaction with Housing	54	71			ns
Neighborhood Attachment	29	74	14.8	3	.003
HEALTH STATUS					
Any Health Problem	59	63			ns
Visual Problem	81	38	16.31	3	.001
Hearing Problem	32	15	13.23	3	.005
Two or More Health Problems (in addition to sight and hearing)	38	16	15.9	3	.002
Lack of Stamina	28	13	14.02	3	.004
FINANCIAL CONDITION					
Worry over Future Medical Expenses	27	11	13.27	3	.005
Actual Financial Status	37	52			ns
SOCIAL INVOLVEMENT					
Direct Involvement					
Face-to-Face Visiting	19	23			ns
Organizational Attendance (Non-Congregate Meals)	37	42			ns
Indirect Involvement					
Communication Media	28	41			ns
Hobby	56	63			ns

1. Housing conditions. Housing for the white and black elderly in this study differ markedly and are a combined function of economic level and of segregation. Most of the whites lived in well-maintained air-conditioned apartment buildings near a small shopping area. In contrast, the blacks lived in enclaves of modest, individually-maintained homes equipped with kitchens, baths, stoves, and heat. They were generally without air-conditioning and had slightly fewer phones than the white sample.

While many blacks reported their homes in need of repair, they expressed overall satisfaction with their housing. Thus, housing conditions did not relate to morale in either group.

Housing existed within the broader social context of neighborhood. When asked to rate attachment to their neighborhood and its suitability for older people, both subgroups' responses related significantly to high morale scores ($x^2 = 14.8$, df = 3, $p > .003$). Those among the white sample who scored low on both neighborhood attachment and on the morale measure were a small group who had lived in the area four years or less. Thus, in terms of life adjustment or in opportunities to form attachments, they were newcomers. The relationship between neighborhood attachment, morale and housing is shown in Table 3. It

TABLE 3

RELATIONSHIP BETWEEN HOUSING AND MORALE
BY NEIGHBORHOOD ATTACHMENT

	LOW NEIGHBORHOOD ATTACHMENT		HIGH NEIGHBORHOOD ATTACHMENT	
	Unsatisfied With Housing	Satisfied With Housing	Unsatisfied With Housing	Satisfied With Housing
LOW MORALE	65%	29%	43%	24%
HIGH MORALE	35%	71%	57%	76%
	100%	100%	100%	100%
	N = 16	N = 21	N = 18	N = 73

is possible that some of the ambiguity found in the literature on relationships between housing conditions and morale of the elderly may be due to the suppressor effects of other variables such as safety, convenience, adequacy of city services, congeniality of the neighborhood, and - particularly - length of residence. Together such factors may comprise a perception of "neighborhood attachment." In retrospect it would have been desirable to have included each of these variables to find out how they relate to neighborhood attachment.

2. Health and Finances. A profile of the participants' physical status and health needs, reported both as perceived and as medically diagnosed, was determined. Sight problems, often associated with cataracts, were mentioned

as interfering with mobility and activity by over four-fifths of all aged in the study. For the entire sample, as well as for the racial subsamples, the relationships between low morale scores and the presence of visual problems was significant ($x^2 = 16.31$, df = 3, $p > .001$). Hearing difficulties were mentioned by one-third of the entire sample; equally divided between both racial groups. The presence of hearing problems was also found to relate significantly to low morale scores ($x^2 = 13.23$, df = 3, $p > .005$).

Having a single diagnosed health problem in addition to sight or hearing deficiencies did not relate to morale, since nearly everyone in the sample had at least one health problem. While many reported such physical ailments as high blood pressure or heart problems, those with low morale scores in both racial groups also mentioned a number of additional disorders such as arthritis, asthma, bronchitis, neuritis, or prostate cancer. However, the diagnosis of two or more health problems beyond sight and hearing was strongly related to low morale ($x^2 = 15.9$, df = 3, $p > .002$). A strong correlation ($r = .84$) was found between the variable of multiple health problems and lack of stamina. In turn, lack of stamina significantly related to low morale scores ($x^2 = 14.02$, df = 3, $p > .004$).

For the elderly in poor health, the problem of paying for medical care loomed large. Medicaid, which is tied to low income eligiblity criteria, was received by one-tenth of the whites and by over two-thirds of the blacks. Similarly, three quarters of the black aged as compared to fewer than one-tenth of the whites used the income supplement of Food Stamps. These disparities reflect the economic differences within the sample. However, for both samples, concern and worry about financing possible future medical expenses, rather than actual amount of income, was linked significantly to low morale scores ($x^2 = 13.27$, df = 3, $p > .005$).

3. Social Involvement. It is reasonable to expect that health conditions affect the level of social involvement. Social involvement can be measured by the type of activity and frequency of activity (with frequency providing an estimate of the intensity of involvement). It was assumed that direct social contacts, defined as face-to-face visiting and/or organizational attendance, would decrease with lack of stamina. Similarly, it was assumed that indirect social involvement, measured through utilization of the communication media (in keeping up with daily local and world events) and through individual work on hobbies, would not relate to lack of stamina. In fact, these assumptions were supported. A strong correlation ($r = .82$) was found between lack of stamina and indirect social involvement and between satisfactory stamina and direct social involvement ($r = .87$).

It was found that 68% of the entire sample, about equally distributed between the two racial groups, maintained a high level of interest in daily events even when stamina interfered with personal visiting. Most who had phones used them daily. Among those for whom stamina was not a problem, nearly three-fourths of both groups saw friends and relatives at least weekly. And despite social class differences thought to relate to organizational affiliation and involvement, findings support those of Clemente's (1975) that the black elderly belonged to and attended community centers, social clubs and churches more often than white elderly. The entire sample maintained a high level of social involvement. In sum, there was no racial differential

in social involvement nor did social involvement relate significantly to morale, inasmuch as the type of social involvement rather than intensity of involvement is affected by stamina, which in turn is a function of overall health status.

Use of Social Welfare Services

The utilization of social welfare services, as defined here, includes Congregate Meals Program participation, as well as use of the Program's auxiliary services such as the Information/Referral, Shopping Help, and Transportation and Escort. A summary of these findings is presented in Table 4.

TABLE 4

UTILIZATION OF SOCIAL WELFARE SERVICES AND MORALE

Social Welfare Programs	Morale Scores N = 128 Low	High	X^2	df	P
CONGREGATE MEALS PROGRAMS					
Overall Attendance	35	42			ns
Attitude Toward Program, Positive	57	71			ns
CONGREGATE MEALS SPONSORED SOCIAL SERVICES:					
Counseling	9	10			ns
Information/Referral	5	17	8.7	3	< .05
Shopping Help	18	48	8.2	3	< .05
Transportation/Escort	32	96	12.1	3	< .01

Congregate Meals Program Participation

Nutritional habits varied in the total sample of aged. The blacks more often than the whites reported that they did not eat breakfast. A greater proportion of the blacks attended the meals program on a daily basis and depended on it for their main meal (76% for blacks and 51% for whites). Additional research is needed to determine whether this difference is due to economic disparities between the groups or to differences in life-styles. Congregate Meals Program attendance did not relate to morale. However, since the primary reasons for taking part in the program (as expressed by over 80% of the users) were to receive prepared meals and to socialize with others, it is fairly clear that regular attendance of this meals program was addressing the nutritional and social needs of its participants. This finding is similar to findings by Holmes (1972) in his study of nutrition programs.

Congregate Meals Program - Related Social Services

The Congregate Meals Program includes an Information/Referral and a Liaison/Linkage Component with a variety of social services in the community, and has its own Transportation/Escort Service for assisting its client-users to keep medical appointments or to visit friends. Shopping Help is also offered which includes advice on buying as well as escort and transportation. The Information Service informs participants about SSI benefits, Food Stamps, and Medicaid and Medicare. A short-term counseling service for personal or practical concerns is also offered.

It was found that the utilization of these four services was evenly distributed within the total sample. Though only 17% of the total sample were aware of having received Information/Referral Serfice, this service is significantly related to high morale ($x^2 = 8.7$, df = 3, $p < .05$).

Counseling services were used by 15% of the total sample and were not related to morale. Slightly more than half of the entire sample used Shopping Help, a service also significantly related to high morale ($x^2 = 8.2$, df = 3, $p < .05$). Finally, Transportation/Escort Service was relied upon by four-fifths of the total sample and was significantly related to high morale ($x^2 = 12.1$, df = 3, $p < .01$).

Since stamina, which was found to relate to severity of health problems, was an important correlate of morale (and might logically affect going shopping, keeping appointments and visiting), a test of its association with the use of Shopping Help and of Transportation/Escort Services was applied. No relationship was found. In explaining this it might be speculated that the escort person - the personal company of a congenial companion/assistant - is a strong ingredient in an elderly persons' mobility and that this variable overcomes concerns about physical condition and endurance. In retrospect, it would have been advantageous to have sought separate measures of the escort person factor.

DISCUSSION

This descriptive-exploratory study of factors associated with morale among the elderly was undertaken on a purposive sample of black and white participants of a community-wide Congregate Meals Program for the aged within a traditional southern city of about 103,000.

The level of morale scores for the entire sample was found to be high. Racial differences in morale were conditional in that only the oldest black group - those 77 and over - obtained significantly lower scores than their white counterparts. This suggests that the work in differentiating phases within the developmental process of aging should be continued, refined, and applied to various ethnic groups. Not unexpectedly, and as reported by German (1975), several health-related factors bore a strong relationship to morale, though under conditional circumstances. Sight problems and hearing problems were associated with low morale levels. When these were compounded by as many as two other major health problems, respondents, regardless of race, reported a lack of stamina that intervened to contribute to significantly

low morale. And within the context of feared rather than actual medical care costs, worry about finances rather than actual income was a source of low morale. That a majority of the elderly fear that they will have insufficient income is hardly a new finding. Universal health care for aging citizens is long overdue.

Quality of housing was found not to be related to morale because neighborhood attachment suppressed its association. Future research could aid in understanding the complexities of neighborhood attachment and the contributions made to it by length of residency, convenience to shopping and medical services, safety, congeniality of neighbors, and quality of municipal services. All these factors may play a role in the perception of housing and are also indicators of a social support network.

Despite the fact that the elderly used the Congregate Meals Program for nourishment and for social needs, its use was not associated with morale. Social involvement, a complex variable defined here both by type and frequency of activity, was not associated with morale. It is possible that, as Keith (1975) has suggested, the emphasis placed by professionals on maintaining high levels of face-to-face social involvement reflects their own work-leisure orientation rather than the wishes of the elderly. If so, then social programs might be less concerned with offering social stimulation, per se, and more concerned with reinforcing coping behaviors that will enable the elderly to carry out basic functions.

A major concomitant of high morale for all elderly studied was the utilization of a particular array of social sources. The use of Information, Referral Service, Transportation/Escort assistance in visiting or in obtaining other services, and Shopping Help all had a significant positive association with high morale. However, in assessing the influence of Transportation/Escort Service, future research might explore the characteristics of escort persons, since it may be that such individuals enable the elderly (with multiple health problems and low stamina) to overcome their concerns and to desire getting out and around. Another individually-offered service, counseling for personal or monetary concerns, did not relate to morale. Thus, the social services associated with high morale are mainly the support services that tangibly assist the elderly in maintaining their physical and social mobility.

Evidence from other studies, such as by Keith (1975), suggest that other personal care services such as telephone reassurance, home repair and home health care are desired by the aged. As helping professions continue to move to develop services, participation of the aged in decision-making regarding services and programs offered should be given priority. This not only is consistent with effective planning principles, but in keeping with consumer input and participatory considerations.

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