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AN EVALUATION OF ETHNIC DIFFERENCES IN RESPONSES
TO AN ADULT ABUSE RISK FACTOR QUESTIONNAIRE

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Janet Hawkins and Roxanne Young

June 1993

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Assigned Responsibilities

This was a group project and a team effort where authors collaborated throughout the project. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

Assigned Leader: Janet Hawkins

2. Data Entry and Analysis:

Assigned Leader: Roxanne Young

3. Writing Report and Presentation of Findings:

a. Introduction and Literature

Assigned Leader: Roxanne Young

b. Methods

Assigned Leader: Janet Hawkins

c. Results

Assigned Leader: Roxanne Young

d. Discussion

Assigned Leader: Janet Hawkins

ABSTRACT

This exploratory study evaluated whether clients of different cultures would respond dissimilarly to questions related to adult abuse. A non-random sample of clients from the In-Home Support Services of San Bernardino County (IHSS) program were surveyed to identify ethnic differences in responses to an adult abuse risk factor questionnaire. The IHSS program provides assistance to adults 18 and over who are unable to remain safely in their home without assistance. The responses obtained in our survey will be helpful to Adult Protective Service workers and others who provide services to this primarily elderly population.

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INTRODUCTION/LITERATURE REVIEW:

This study was conducted to determine whether elders from different ethnic groups respond differently to questions related to elder abuse. An exploratory study was done to determine whether ten risk elements, identified by previous researchers were effective in assessing elder abuse for both the minority and non-minority elderly. The researchers developed a series of questions relating to each element in order to determine whether the minority and non-minority elderly responded dissimilarly to each set of questions.

The ten most common risk factors identified by the previous researchers were determined based on an exploratory study done to assess which criteria and variables should be included in assessment of risk of abuse to elder adults. The researchers developed an instrument for the screeners who process adult protection referrals. The methods used by the previous researchers in identifying these ten risk factors were literature search, questionnaire, correspondence, and face-to-face interviews with Adult Protection workers and management in San Bernardino County. The following ten elements were identified as the most common risk factors based on their study: mental status, activities of daily living, living arrangements/support systems, housing/ environmental status, caregiver, access to community resources, health

status/physical impairments, psychiatric/ suicidal issues, money management and substance abuse. The questions were to relate to each risk element.

Problem Statement:

Do elders from different ethnic groups respond differently to questions related to adult abuse?

At the present time, there are no guidelines in either state or national legislation that takes into consideration the varying degree of client response by culture in the risk assessment tools used by Adult Protection agencies (Haviland, 1989). Although the research literature contains much information on elder abuse in this country, little has been published that specifically addresses cultural factors related to abuse. The social conditions, needs, and problems in a cross-cultural environment must also be taken into consideration. The literature reviewed here will focus on two such groups, the Hispanic and African-American elderly because they are the largest minority groups that we are likely to serve.

In order to understand these two groups, efforts must be made to appreciate cultural influence at two levels: the client's culturally defined behavior in specific environmental contexts (e.g., the family, the neighborhood); and, the client's culturally defined

behavior within the professional process (Olmstead, 1983, Newton & Archiniega, 1983).

For the minority elderly, social economic, and environmental factors render them particularly vulnerable to acute and prolonged psychological and emotional distress. The most common source of stress is decreased economic resources. Poverty rates among African-American elders are particularly disturbing. The higher incidence of poverty among elderly black individuals is a reflection of the disparity between the income of black and white adults. Although the percentages of impoverished elderly people generally has declined dramatically since 1959, the poverty rate in 1986 among elderly African-Americans was still 41 percent, compared with 17 percent for the elderly white American (Markides & Mindel, 1989). For the Hispanic elderly 3 out of 7 were poor or near poor in 1985 (Lacayo, 1987). In great part, these conditions also define one's life chances and adaptation to old age.

The family structure of both Hispanics and African-Americans is one in which the older members enjoy much respect and protection from the "outside" world (Markides, 1983 & Larson, Hepworth, 1982). Recent findings from the National Survey of Black Americans (NSBA) provide some insight into the formal support networks of elderly blacks. Taylor (1986) found that the elderly blacks reported significant levels of interaction with family

members, residential proximity to their immediate families, extensive familial affective bonds, and a high degree of satisfaction with family life. Household arrangements were flexible in that the subjects and members of the extended family moved freely into one another's homes according to need.

Studies of the mental health of Hispanics have found that they experience less impairment than Anglos, Jaco (1985), suggested that a plausible interpretation of his findings is the protective nature of the Hispanic kinship structure, which operates to shelter the individuals against stress and thus, reduce the rate at which psychoses appear in this group. Other studies conducted in the Southwest have shown that Hispanics underutilize mental health facilities. According to Gaitz and Scott (1985) such factors as cultural attitudes toward illness, roles in the family, and resistance to obtaining professional help in formal and impersonal Anglo institutions are contributing factors.

Furthermore, the informal support provided by kin and para-kin may influence participation by the elderly in the formal support systems provided by local and formal agencies. Given the disadvantaged socioeconomic status of many elderly blacks, the informal support network helps them to maintain a viable and independent existence. Kinship groups for all elderly people are typically viewed

as the most appropriate source of support, followed by other sources of formal support (friends, neighbors, and church members), and lastly, by formal organizations (Taylor and Chatters, 1985.)

According to a study done by Shanas, older Anglos are more likely to report positive evaluations of their health than are other Hispanics. Osborn (1976), contributes this factor to lower socioeconomic status of the Hispanic elderly. In addition to evaluating their health as poorer, Hispanics are more likely to be worried about their health. In a study of elderly blacks, they were less likely to report chronic health problems as inhibiting their functioning, but health issues were of major concern to them. For the elderly black as well as the Hispanic elderly, health is tied closely to the social and economic aspects of their lives (Carlton-LaNey, 1991). If persons with little or no education experience anxiety about their health, then part of the differences between ethnic groups in worry about their health may be explained by educational differences.

Religion and the church have an extensive influence in the lives of the African-American and Hispanic elderly. Recent work documents that church members are an important source of support to the elderly in general and to elderly blacks in particular. Religion has historically sustained African-American elderly through the hardships of slavery,

prejudice, and racism (Bochner, 1987). Likewise, Hispanic- American elderly lives have historically been deeply rooted in religious values. Hispanic American elders have a sense of morality and religious practice that stems from the church and their culture. According to a study conducted by Markides (1983), Hispanics report greater church attendance, high self-reported religiosity, and a higher practice of private prayer than the Anglo elderly.

Surveys of disabled and ill community-based elderly persons indicate that spouses, relatives, and friends are the primary care providers. Wives more often than husbands provided care to disabled spouses due to the fact that women outlive men by seven years. With increasing age of the elder, the adult children replace the spouse in providing increased amounts of help to the parents (Hamilton, 1984). Analysis of the size and composition of the informal helper networks of elderly blacks indicated that daughters were selected most frequently to help out in times of sickness or disability followed by sons, spouses or partners, sisters, brothers, friends, and neighbors (Taylor and Chatters, 1985).

Elderly blacks claim that the most impact of some physical health problems has meant that many of them have had to give up their social and community functions. Their complaints of vision impairments and "nerves" have

caused most of them to stop driving (Carlton-LaNey, 1991). The fact that they no longer drive, combined with the lack of public transportation in some instances, has meant that they must depend on others to transport them. Because they are dependent, most travel only when necessary. In one study, elderly blacks reported that with limited outside contact and the loss of personal mobility, they are more dependent on their families and others for social stimulation (Carlton-LaNey, 1991).

Based on the above cultural factors, the minority elderly may be assessed at a higher level of risk of abuse than the Anglo elderly. In the social sciences, researchers have relied on the validity and reliability of instruments that have been standardized on white, non-minority, middle class samples that fail to consider the unique cultural characteristics and attitudes of ethnic populations. Therefore, a question may be valid for white, non-minority, middle class respondents, but, will be invalid for the minority client because its validity is group specific. Thus, cultural differences and the possibility of a false assessment demand professional cultural sensitivity and awareness.

Problem Focus:

Only recently has attention been focused on abuse of the elderly as a major national concern. In a 1981

report, the U.S. House of Representatives Select Committee on Aging called elder abuse "alien to the American ideal." The report further stated, "The abuse of our elderly at the hands of their children/caretaker until recent times has remained a shameful and hidden problem" (Elderly Health-Council on Scientific Affairs, 1990).

For the same reason, elder abuse is far less likely to be reported than child abuse. While one out of three child abuse cases is reported, only one out of six adult abuse cases come to the attention of the authorities (Halamandaris, 1984). In addition to feeling ashamed, the elderly do not report abuse because they do not wish to bring trouble to their children/caretaker. In other cases, they are afraid of the reprisals if they complain, they do not have the physical ability, or sometimes they have been literally held prisoner and are unable to register a complaint even if they wanted to do so.

An ever-increasing life expectancy has resulted in many people living to an age in which they become more dependent on their families to meet their needs. In 1982, one of every nine persons was over the age of 65, and it is estimated by the year 2000, two of six persons will be 65 years of age or older (Neugarten, 1982). According to the United States Census Bureau (cited by Neugarten), by the year 2000, there will be at least 3.7 million persons over the age of 85. The stressful factors created by this

dependency may place the elder in danger of being abused by family members, friends, and service providers.

Lau and Kosberg, (1983) estimated that elder abuse occurs in approximately 10% of Americans who are over the age of 65 and more often among those living with a family member. In fact, abuse of the elderly by their loved ones and caretakers exists with a frequency and rate only slightly less than child abuse. According to Pedrick-Cornell and Gelles, (1981) cases of elder abuse range from 50,000 to 2.5 million a year. About 45 may be victims of moderate to severe abuse.

Professionals involved in care of the elderly are unable to agree upon one universal definition of elder abuse. Most, however, agree upon the following criteria such as non-accidental, causing harm, an act or omission, against an elderly person, involving two or more persons. Beating, roughing up, pushing, shoving, neglect, misuse of medication, inadequate diet, and homicide are all considered forms of physical abuse. Verbal and psychological abuse include actions as infantilization, derogation, threats of institutionalization, and threats of abandonment. Stolen or misused funds and property as well as appropriation of social security checks by the caregivers for use other than for care of that elderly person are all considered forms of financial abuse (Hamilton, 1989).

Variations in the definition of elder abuse present difficulties in comparing findings on the nature and causes of the problem. Elder abuse can be manifested in a variety of ways. A number of preliminary hypotheses have been proposed as possible risk factors that make some elderly persons likely to experience some form of elder abuse.

1. Dependency. As dependency on others to provide services increases, vulnerability to abuse and neglect is enhanced.

2. Lack of close family ties. A dependent elderly parent can precipitate stress if the love and friendship necessary to counteract the additional responsibilities placed on adult children are lacking.

3. Family violence. For some families, violence may be viewed as a normal reaction to stress; for others, caretakers may resort to violent behavior when faced with the elderly person's insatiable demands.

4. Lack of financial resources. When pressures mount on financial resources, the elderly parent may be viewed as an economic burden, resulting in increased incidence and prevalence of elder abuse.

5. Psychopathology of the abuser. Flawed psychological development of the caretaker, beset with problems of his or her own, may result in acts of abuse.

6. Lack of community support. Lack of facilities and resources in the community to provide additional care for the elderly may contribute to the frustration in the caretaker and may enhance the potential for elder abuse.

7. Institutional factors. Factors such as low pay, poor working conditions, and long hours may contribute to pessimistic attitudes of caretakers, resulting in neglect of the elderly (Elderly Health-council on Scientific Affairs, 1990).

While researchers continue to investigate the causes and dynamics of elder abuse, others are addressing their attention to preventive methods. Many states have enacted mandatory reporting of elder abuse as a means of combating the problem (Salend, 1984). The problem is that no uniform policy exists between offices and counties which creates a gap between policy and practice, confusing workers, and increasing the probability that decision making criteria will vary among workers and offices.

Research on Hispanic and African-American populations has been criticized because researchers have failed to include and be sensitive to cultural issues in their research design -- an omission that has been attributed to unconscious cultural biases. For example, until the 1960s, the "melting pot" dominated the social sciences. It held that racial and ethnic groups lose their socio-cultural identity. Thus, the normative American way of

life represented the major comparative focus of social science research, serving as the standard against which racial and ethnic groups were studied (Becerra & Zambrana, 1985).

One controversy in minority research is the issue of who is best qualified to do the research. There are three most commonly held points of view on this question:

(1) all research on minorities should be conducted by a minority (2) all research on minorities should be conducted by a non-minority, and (3) minority research should be conducted by whomever is best able to carry it out (Weiss, 1987).

Clearly, the major advantage of having a minority member conducting their own research is that they will be sensitive to and understand the cultural norms and language. They would have a perspective that has been gained primarily from life experience and, thus, have first hand knowledge of the people they are studying. Such sensitivity and understanding can provide insight into the conceptualization of research questions and objectives and the analysis and interpretation of the data.

Those in favor of having research on minorities conducted by non-minorities argue that objectivity can best be maintained by those who are well versed in other cultures. Furthermore, non-minorities who are trained in

research skills and have experience in carrying out large scale research efforts are more numerous.

The problem with the third argument -- that research should be conducted by whoever is best able to do so -- is that no criteria can be set as to who is best able. The determination of such ability involves subjective judgement, based on the particular research to be pursued, the needs of the project, the skills of the participants and any other criteria deemed necessary to fulfill the research goal (Weiss, 1987).

There are no absolute standards for constructing a questionnaire. However, it is essential that the researchers know the population they are surveying. Decisions about wording, the use of closed-ended questions, branching, and the need for mutually exclusion categories are major determinants of reliable data (Hayes-Bautista, 1980). Response categories should always be mutually exclusive. When close-ended questions are posed, respondents should choose a designated answer or write in their response. All questionnaires need to be pretested. For the Hispanic elderly especially, by conducting a pre-test, problems can be discovered in wording, ambiguity, the flow of the questions and responses from English to Spanish to English (Hayes-Bautista, 1980).

The California Welfare Directors Association (CWDA) feels the time has come for a curriculum and instrument

for Adult Protective Services to assist in working with a difficult population in these times of fiscal constraints (CWDA Proposal, 1991). Thus, one way to improve services in the area of APS was through the design of an instrument to assess the risk factors to those elderly at highest risk. Most of the instruments currently in use were developed based on field experiences of the respective agencies rather than theoretical or empirical research findings. The tool in question was developed after a very extensive exploratory study. One of the weaknesses cited by the developers of this tool was that it had not been tested for cultural sensitivity. In order to address the possibility of cultural bias in determining risk factors, a comparison of each was made, taking into consideration cultural factors.

In conclusion, research is not an isolated phenomenon. Rather, it reflects and is molded by the larger societal context. A distinct advantage of considering cultural factors when assessing for elderly abuse is that the findings will be reliable and valid and, perhaps, better aid in the development of services that better fit the minority reality.

RESEARCH DESIGN AND METHODS:

Purpose of the Study:

The purpose of this study was to determine whether clients of different cultures would respond dissimilarly to questions related to adult abuse. The study conducted was exploratory. The intent was to determine whether ten risk elements, identified by previous researchers, were effective in assessing elder abuse for both the minority and non-minority elderly.

Research Question:

This was an exploratory study to determine whether clients of different cultures respond dissimilarly to questions related to adult abuse. The data that were collected were expected to provide evidence either to confirm or refute the idea that there is a difference in the way these ethnic groups would respond. The research question was, therefore, do clients of different cultures respond dissimilarly to questions related to adult abuse.

Sample:

A random sample of clients from the In-Home Support Services of San Bernardino county (IHSS) were surveyed to identify ethnic differences in response to an adult abuse risk factor questionnaire. A systematic sample, with a random start was then selected from the entire list of

clients. However, a non-random sample was eventually selected to complete the study. To have proceeded with a random sample would have meant that the minority elderly would have been underrepresented in our study.

The list of IHSS clients was separated into categories based on ethnicity. Two populations of minority elders were selected for this project. In order to provide for a match between the ethnicity of the researchers and the study population, the Hispanic and African-American populations were selected.

A total of 60 clients were initially proposed for this study, but this number was eventually reduced. The actual sample contained 40 individuals, age 65 or over, who had been assessed for IHSS services. Out of the 40, eleven were from the African-American population, 14 from the Hispanic population and 15 from the Caucasian population. These numbers were determined based on the study population selected in a telephone survey. The total number of IHSS clients were 911, out of that total, 134 were Hispanic and only 43 were African-American. These numbers limited our sampling size.

The IHSS list was selected because of eligibility requirements. This program provides services to individuals 65 and over who are unable to remain safely in their home without assistance. Eligibility for the program is based on an income of \$700 or less a month.

Each client is assessed by a social worker to determine level of functioning in a variety of areas such as cognitive and physical. The clients, once assessed, are generally cared for by a relative. All these factors, according to the ten risk factors identified, place the IHSS client at high risk of being abused by their family member.

Data Collection and Instruments:

The IHSS sample of clients was surveyed by phone. Each client was asked a set of questions as they related to the ten risk factors identified by previous researchers. The length of time required to obtain consent and conduct each interview averaged approximately 20-25 minutes. Each element was tabulated based on the ethnicity of the client.

The biggest weakness of this study was the method selected for obtaining data. By only selecting one method, the telephone, we created a problem in obtaining the sample size we originally desired, especially among the minority populations.

In addition, by selecting the telephone, a majority of the IHSS clients were inaccessible because of wrong numbers or disconnected phones. One option would have been an alternative means of collecting data such as the mail. We had no back-up plan for just such a situation.

Furthermore, when the questions were developed, no consideration was given to cultural differences. Several of the interviews with the Hispanic population were conducted in Spanish. This proved to be very difficult due to the wording of the questions.

A strength of our study was that the telephone survey allowed us greater control over data collection. The client was in a position to receive answers to any questions that may have come up when answering the questionnaire. In addition, the client was able to provide us with immediate responses and was more likely to complete the questionnaire. This was also cost efficient in that no postal costs were incurred in order to collect the data.

Procedure:

The information was gathered over a period of three months, beginning in January of 1993 and ending March, 1993. Verbal consent was given by each client prior to the interview. Once consent was given, each question was addressed in a systematic manner.

One of the questions on the mental status exam was eventually eliminated due to difficulties. The question asked the client to subtract 3 from 20 and to keep subtracting from each new number all the way down. We attributed this problem more to the wording of the question

than to the mental status of the client. This task proved to be difficult, not only for the clients, but for the developers of the questionnaire.

Evidence of trouble surfaced in four areas during the course of the study. First, a few clients were apprehensive about participating in the study and asked that we call back at a later time or date. Secondly, the amount of distrust encountered by the minority population. These clients were very guarded and gaining their trust was found to be a challenge. One method in which rapport was established, for the Hispanic population, was through the use of language. Several Hispanic clients in the study required that the survey be conducted in Spanish. The third area of difficulty was that clients were made inaccessible because of disconnected telephone numbers or inaccurate information on the list provided by IHSS. Lastly, a few of the clients were deceased. This problem was unavoidable due to the age of the population under study.

A letter of approval was obtained in June 1992 from the San Bernardino County Department of Public Social Services to conduct the telephone survey with IHSS clients. The IHSS clients were provided with code numbers, no names were used. Upon completion of the questionnaire with each client, the telephone number of the Supervisor over this project as well as the number to

Adult Protective Services was provided. The list of names and telephone numbers provided by the IHSS program was discarded once this research project was completed.

RESULTS:

The sample population consisted of 15 Caucasians, 15 Hispanics and 11 African-Americans who were taken from a list of In-Home Supportive Services (IHSS) clients who lived in the High Desert region of San Bernardino County. They ranged in age from 56 to 88, with a mean age of 64. They each required some assistance from a caretaker/family member ranging from at least minimal help around the house or running errands to assistance needed with grooming, bathing, or feeding. Eighty percent of the respondents were female (n=33); 33% of the respondents were Spanish speaking only (n=5).

Responses to questions addressing each risk element were tabulated and compared for responses of each ethnicity. Chi squared was used to determine whether there were any significant differences among the ethnic groups in their responses to each item.

The following were found to be significant. Sixty-four percent (64%) of the Hispanic respondents stated they did not handle their own finances as compared to the African-American clients and the Caucasian clients (see

Table 1). Caucasians were more likely to handle their own finances (80%) than African-Americans and Hispanics.

Only 13% of the Caucasian respondents stated they were not able to bathe and/or groom themselves safely without help from another person as compared to the Hispanic clients and the African-American clients (see Table 2). African-Americans were most likely to require assistance with bathing and/or grooming themselves (64%).

Caucasian respondents (87%), were most likely to state that they were not members of a local church. African-Americans were most likely to be a member of a local church (64%). (see Table 3.)

None of the Caucasian clients reported they were not able to dress themselves. Fifty-three percent (53%) of the Hispanic respondents and 18% of the African-American clients stated they were not able to dress themselves. Caucasians were more likely to dress themselves with no assistance than African-American and Hispanics (see Table 4).

Other cross tabulations could not be tested for statistical significance due to small expected cell sizes, but showed interesting trends. No respondents from either the African-American or Caucasian groups reported they had any difficulty with feeding themselves. Thirty-three percent (33%) of the Hispanics stated they did not have control over their bowels and/or bladder. On the other

hand, only one person admitted they did not have control of their bowels and/or bladder among the African-Americans and all of the Caucasians reported they did have control over their bowels/ bladder.

Another analysis showed that as many as 27% of African-American clients do the housework and laundry for themselves as compared to none of the Hispanic clients and 0.06% of the Caucasian clients. Hispanics were most likely to receive help with errands (100%), primarily from family members. Forty-six (46%) of Caucasian respondents and 32% of African-Americans received help with errands from their caretaker. Caucasians (53%) tended to report that their transportation was primarily provided by non-family members, mainly their caretaker. Hispanic clients (80%) stated their transportation was primarily provided by family members. African-American clients (55%) were found to be more likely to drive than were Hispanics and Caucasians.

Caucasian clients (20%), responded that they had been involved with a mental health agency in some capacity. All of the Caucasian clients were able to pass the mental status exam compared to only 82% of the African-American clients and 73% of the Hispanic clients.

When the respondents were asked whether they lived alone, Caucasians were more likely to live alone (40%) than were African-Americans and Hispanics. African-

Americans and Hispanics were more likely to live with a family member, usually the daughter.

African-Americans were more likely to have contact in person with their family members than were Hispanics and Caucasians and the Hispanics were most likely to have contact by phone with their family members. Only one person (Caucasian) admitted they had problems that had come up since having their family/caretaker help out. Forty-seven percent (47%) of the Caucasian clients had caretakers who did not volunteer to help. Only 18% of the caretakers for African-American clients and 21% of Hispanic client's caregivers had not volunteered. African-Americans were more likely to have a caretaker who had volunteered than were Caucasians and Hispanics.

None of the Hispanic clients reported attending any senior citizen functions. One of the Caucasian clients admitted to being under the care of the doctor for four different medical needs and Caucasians tended to report having or had at least two to three major illnesses. Hispanics were more likely to be under the care of the doctor for zero to one different medical needs. The African-American, clients on the other hand, reported only one major illness (100%).

Only one person in the survey was willing to admit they had ever tried to commit suicide. Only one person was willing to admit they had a problem with drugs/

alcohol. The respondent each time was Caucasian. Hispanics were more likely to admit they felt someone in their family had problems with mental health than were African-Americans and Caucasians. African-Americans were more likely to feel no one in their family had problems with drugs/alcohol than were Caucasians and Hispanics. Hispanics, on the other hand, felt they did have family members who had a problem with drugs/alcohol (21%).

DISCUSSION:

The discussion of findings section encompasses a further presentation of the data and is summarized in Figure 1. There will be a more detailed interpretation of the findings with emphasis placed on the patterns in the risk factors as they relate to elder abuse.

Money Management: Most of the minority respondents in this study did not handle their own finances. Based on the literature review, this finding could be contributed to the disadvantage of socioeconomic status of many elderly minorities. One can suggest, that for many minority clients, the financial support provided by kin and para-kin is essential in helping them to maintain a viable and independent existence.

Activities of Daily Living: Information from the literature suggests that Caucasians are more likely to report positive evaluations of their health than are minorities. This factor can be accounted for by

socioeconomic differences. Our finding that Caucasians reported needing less support and assistance dressing themselves than did the minority respondent are consistent with this conclusion. In addition, the minority client required more assistance bathing and/or grooming than the Caucasian respondents. Our findings revealed few marked differences between Caucasians and minorities in the area of feeding themselves. However, wide differences were revealed in the area of bowel control: only one person in the African-American group admitted they did not have control of their bowels and none in the Caucasian group would admit to bowel problems.

Religion: The findings show that a vast majority of the minorities were members of a church and attend church more regularly than Caucasians. They were more likely than Anglos to view themselves as religious. The African-American respondents were more likely than even the Hispanic respondents to be a member of the church. According to the literature reviewed earlier, this can be attributed to the fact that religion has historically sustained African-Americans through the hardships of slavery, prejudice, and racism (Bochner, 1987).

Living Arrangements/Support Systems: A greater amount of residential proximity and more multigenerational living arrangements were found among the minority responses. One possible explanation to this fact is the

inability of many minorities to maintain independent living arrangements because of limited financial resources, not necessarily because of a cultural imperative.

When the minority and non-minority groups were compared on frequency of social interaction with relatives outside of the household, the African-American reported significantly higher levels of interaction. This could be attributed to the high value the minority client places on the family. They are more firmly rooted in the family and strongly subscribe to the familial values of the family over the individual. At the same time, the minority client reported less interaction with friends and neighbors than the Caucasian client.

Psychiatric/Suicidal Issues: Only one person in this study admitted trying to commit suicide. This was one of the Caucasian clients. The Hispanic clients were more willing to admit to mental health issues for a family member. Overall, the minority client found our question on suicide to be offensive; because of their religiosity, they would never consider such an alternative. Many responded by saying their faith in God gives them strength and encouragement to deal with day-to-day life stressors.

Drugs/Alcohol: Again, only one Caucasian admitted to having a problem with drugs or alcohol. The African-Americans made no such reports and the Hispanics would only admit to a family member having the problem.

There are several conclusions that can be drawn from the results of the survey that have implications when assessing for risk of the minority elderly. The data identify significant differences involving four risk factors. These four were money management, bathing/grooming, religion, and dress. The issue of concern is whether the differences observed in these four areas can be attributed to cultural factors or the client's actual environmental context.

For example, the minority groups were more willing to discuss mental health issues than personal care needs. This could be attributed to the value system of the minority client, speaking about personal issues may be in conflict with what is defined as proper by their particular ethnic group.

On the other hand, the difference may be attributed to environmental factors. For the minority client, high value was placed on family members as the primary source of support. The Hispanic clients identified a family member as their primary care provider. As a result, support with personal needs are provided by a family member. On the other hand, for the Caucasian client, there is no system to maintain them at home. Disclosure of such personal information may place them at risk of placement in a facility.

Due to the small sample size, we were able to test for significant differences in only four of the risk areas. We can only speculate at this point that had our sample size been larger, it would have yielded a greater number of significant differences in the responses of the two ethnic groups. However, our data was successful in identifying patterns in the risk factors as they relate to elder abuse. A comparison will be made of the three groups under study.

Neglect: According to studies summarized by Wolf and Pillemer, (1989), four times as many active neglect cases and two times as many passive neglect cases were identified among victims who had poor health and were more dependent on their caretaker. Eight activities were significant predictors of neglect in these studies: personal care, mobility, meal preparation, security of property, financial management, general shopping, transportation, and household management. In our study, seven of these activities were identified as being common among minority clients. On that basis, it would appear that the minority client would more likely be neglected than would the Caucasian client.

Physical: Generally, Pillemer and Wolf (1989) identified elders who had a higher degree of functioning as likely to be victims of physical abuse. The significant predictors for such abuse were companionship and

daily needs, with more physical abuse cases associated with victims who were independent. In addition, physical abuse is closely linked to the mental health of the perpetrator and to a lesser degree, to that of the victim (Wolf and Pillemer, 1989). In our study, a significantly higher proportion of Caucasian clients reported the ability to perform instrumental activities of daily living without assistance. Based on that factor, they are more likely to be victims of physical abuse. In the area of mental health, the Caucasian clients report more involvement than the minority client. However, The Hispanic clients were more likely to admit they felt someone in their family had problems with mental health, placing both groups at risk of being physically abuse.

The psychologically abused elders in Pillemer's and Wolf's (1989) analysis were the least likely to be disabled, dependent or socially isolated. The significant predictors of dependency were: financial, management, companionship, transportation, daily needs, and property maintenance (Wolf and Pillemer, 1989). According to these factors, both the minority and Caucasian client are at risk of being psychologically abused. In our study, the Caucasian client reported less dependency but more social isolation than the minority client. However, in the area of dependency, the minority client rated higher in the five areas identified by Wolf and Pillemer, (1989).

Financial Exploitation: Factors related to the physical and mental state of the victim were reported by Wolf and Pillemer, (1989), as unimportant in financial exploitation. It was found that this type of abuse involved distant relatives or parties who were unrelated by birth or marriage, and who did not live together. Based on these facts, the Caucasian client is at a higher risk of being exploited than the minority client. The lack of family support places them at a higher risk of being exploited by their unrelated caretaker.

Implications for Research and Practice:

These findings suggest that there are distinct differences when assessing for risk of abuse for both the minority and non-minority client. The data provides further evidence of the importance of considering cultural factors as well as the environmental context when assessing for risk of abuse. The possibility of a false assessment demands of us that consideration be given to all possible alternatives when assessing for risk of abuse.

This survey was limited to clients that already been assessed for In-Home Support Services. A more extensive study needs to be done including other elderly. In addition, instead of utilizing only self-reports of respondents, efforts need to be made to go make home

visits and to assess first hand the respondent's actual situation and what they are capable of doing.

An implication for social workers working with the elderly is to remember to take into consideration cultural factors when assessing for risk. The risk assessment tool is only a screening guide. Before social workers attempt to use this device to identify problems and assess needs, they must educate themselves about the minority populations they are serving.

The social worker often encounters minority clients who present varying degrees of minority-group identification ranging from traditional-ethnic to Americanized. Therefore, it is the worker's responsibility with the minority client to determine the level of representation as a member of a particular group. An awareness of the range of minority differences is the first step in the right direction. Educating one's self on cultural diversity is meaningless unless the information is translated into change of services and attitude.

TABLE 1

Do you handle your own finances?

	<u>BLACK</u>	<u>HISPANICS</u>	<u>WHITE</u>	<u>TOTAL</u>
YES	7	5	12	24
NO	4	9	3	15
TOTAL	11	14	15	40

 $\chi^2 = 6.31$

2df

 $P < 0.05$

TABLE 2

Are you able to bathe and groom yourself safely without help from another person?

	<u>BLACK</u>	<u>HISPANIC</u>	<u>WHITE</u>	<u>TOTAL</u>
YES	4	8	13	25
NO	7	7	2	16
TOTAL	11	15	15	41

$\chi^2 = 5.64$

2df

$P < 0.05$

TABLE 3

Are you a member of a local church?

	<u>BLACK</u>	<u>HISPANIC</u>	<u>WHITE</u>	<u>TOTAL</u>
YES	7	8	2	17
NO	4	6	13	23
TOTAL	11	14	15	40

$\chi^2=8.46$

2df

$P<0.05$

TABLE 4

Are you able to dress yourself?

	<u>BLACK</u>	<u>HISPANIC</u>	<u>WHITE</u>	<u>TOTAL</u>
YES	9	7	15	31
NO	2	8	0	16
TOTAL	11	15	15	41

$\chi^2=10.76$

2df

$P<0.05$

FIGURE 1 -- SUMMARY TABLE

MONEY MANAGEMENT:

BLACKS: Do not handle own finances
HISPANICS: Do not handle own finances
CAUCASIANS: Handles own finances

ACTIVITIES OF DAILY LIVING:

BLACKS: Need assistance: Bathing and/or grooming
Getting dressed
HISPANICS: Need assistance: Bathing and/or grooming
Getting dressed
Laundry/housework
Driving
CAUCASIANS: Need no assistance or very little

RELIGION:

BLACKS: Attend church regularly
HISPANICS: Attend church regularly
CAUCASIANS: Does not attend church regularly

LIVING ARRANGEMENTS/SUPPORT SYSTEMS:

BLACKS: Tend to live with family
HISPANICS: Tend to live with family
CAUCASIANS: Tend to live alone

PSYCHIATRIC/SUICIDAL ISSUES:

BLACKS: Deny any suicide attempts
Deny use of mental health services
HISPANIC: Deny any suicide attempts
Admitted family member use of mental health services
CAUCASIANS: Admitted to suicide attempt
Admitted being involved with mental health agency in some capacity

DRUGS/ALCOHOL:

BLACKS: Made no report of using either drugs or alcohol
HISPANICS: Admitted to family member having problems with drugs
CAUCASIANS: Admitted to having problems with alcohol

APPENDIX A
QUESTIONNAIRE

1. Mental Status Testing: Orientation, Memory, Concentration
 - a. What is the date today? month/day/year
 - b. What day of the week is it?
 - c. What time of day is it?
 - d. What is your telephone number or street address?
 - e. How old are you?
 - f. When were you born? month/day/year
 - g. Who is the current president of the United States?
 - h. Who was president just before him?
 - i. What was your mother's maiden name?
2. ADL's/personal care:
 - a. Are you able to feed yourself? If not, what type of assistance do you get?
 - b. Do you use a respirator or any other oxygen equipment?
 - c. Do you have control of your bowels and bladder?
 - d. Are you able to get out of bed or sit up on your own?
 - e. Can you bathe and groom yourself safely without help from another person?

- f. Are you able to dress yourself?
 - g. Can you walk around inside the house with no problems?
 - h. Do you prepare your own meals?
 - i. Do you do the housework and laundry for yourself?
3. Living Arrangements/Support Systems:
- a. Do you live alone? If not, with who?
 - b. Do you have any family in the local area?
 - c. Do you have a close relationship with your family?
 - d. How often do you have contact with your family?
 - e. Is this contact by phone or in person?
 - f. Do you have a friend or neighbor that you associate with on a regular basis?
4. Housing/environmental:
- a. Do you need any repairs done?
 - b. Are there other elderly people in your neighborhood?
5. Caregiver: Name/relationship/attitude/ability to provide care:
- a. Have there been any problems that has come up since having your son/daughter/other help you?
 - b. Are you happy with services by your caretaker?
 - c. Did your caretaker volunteer to care for you?

- d. Are you happy with services by your caretaker?
- e. Did your caretaker volunteer to care for you?
- 6. Access to community resources/transport?
 - a. Are you able to drive. If not, how do you get around?
 - b. Are you a member of a local church?
 - c. Do you attend any senior citizens functions?
- 7. Health status/physical impairments:
 - a. Are you currently under the care of a doctor? If so, for what?
 - b. Are you taking any medications.
 - c. Any major illnesses you can recall that exist either presently or in the past?
 - d. Are you able to walk without assistance? If not, do you use a cane, walker, or wheelchair?
- 8. Suicidal/psychiatric history:
 - a. Have you ever tried to commit suicide?
 - b. Have you ever been involved with a mental health agency in any capacity?
 - c. Do you feel you or anyone in your family has problems related to mental health?
- 9. Money management/fiduciary:
 - a. Do you handle your own finances? If not, who does?
- 10. Alcohol/substance abuse:
 - a. Do you have a problem with alcohol or drugs?

b. Do you feel you or anyone in your family has a problem with alcohol or drugs?

APPENDIX B
CONSENT FORM

Hello, I'm _____, a student in the Masters in Social Work Program at California State University, San Bernardino. It would be very helpful if you would be willing to participate in a voluntary survey. The survey is being conducted to collect responses from different types of elderly people in order to determine whether their responses would be the same or different. The questions include some of the problems older people sometimes have with their families. All the information you will be giving will be kept in the utmost confidentiality, no names will be used, only numbers. If we feel your family could benefit from services, the local Adult Protection Services Agency will be contacted on your behalf. If you would like to receive more information you may contact my faculty supervisor, Rosemary McCaslin at (714) 880-5501.

Thank you for agreeing to participate. I would like to ask you a few questions, if that's all right with you. It shouldn't take much time. I will ask you some questions that may sound silly but they help us know if someone needs help. If you feel uncomfortable answering any of the questions, please feel free to stop or tell me so.

APPENDIX C

DEBRIEFING STATEMENT

Adult Protective Services Agency does provide services for the kinds of problems we've been discussing. If you feel you would like to contact this agency yourself, the number is (619) 243-2280, and you may ask for Jim Maher.

Your assistance is greatly appreciated. If you have any further questions, please feel free to contact me at (619) 243-2280. A copy of the survey can be provided to you upon request.

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