Decision making and identifying services: Differences among elderly women

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DECISION MAKING AND IDENTIFYING SERVICES: DIFFERENCES AMONG ELDERLY WOMEN

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

Kris Kaufmann Johnson
Melissa Noelle Moelter

June 1999
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ABSTRACT

Past research has evaluated indicators of service use or decision-making styles and processes. This study combined these concepts to evaluate the relationship between decision-making styles and indicators of service use. A sample of 15 Caucasian, African American and Latino women over age 65 were given a vignette and asked to generate a range of solutions and services that would be appropriate for the given situation. Responses were then quantified and tested for significance against independent variables (primarily demographic) obtained through a brief questionnaire. Results may be used by service providers to improve service delivery.
**TABLE OF CONTENTS**

ABSTRACT ................................................................. iii

LIST OF TABLES ........................................................... v

PROBLEM STATEMENT/PROBLEM FOCUS ............................... 1

LITERATURE REVIEW .................................................... 6

RESEARCH DESIGN AND METHODS ................................... 21

RESULTS .................................................................. 26

DISCUSSION ................................................................. 33

APPENDIX A: Vignette .................................................... 36

APPENDIX B: Questionnaire ............................................. 37

APPENDIX C: Interview Guide .......................................... 39

APPENDIX D: Informed Consent ........................................ 41

APPENDIX E: Debriefing Statement ................................. 43

APPENDIX F: Assigned Responsibilities ............................ 44

REFERENCES .............................................................. 46
LIST OF TABLES

Table 1. Bivariate Correlations for Variables: Formal Solutions, Days with Others, Days with Spouse Solutions on the First Day, Education ..........................30

Table 2. Bivariate Correlations for Variables: Formal Solutions, Solutions on the Second Day, Number of Solutions, Years in Residence, and Solutions on the First Day ........................................31

Table 3. Independent T- tests for Variables: Solutions on Second Day, Seriousness Rating, and Ethnicity .................................32
PROBLEM STATEMENT/PROBLEM FOCUS

In 1965, the United States Congress passed the Older Americans Act (OAA) in response to the needs of the elderly (Baker and Pullet-Hahn, 1995). Since that time, the number and types of services to support the elderly have grown. Although these services exist, many elderly do not use them, prompting studies to assess this underutilization and the barriers to service use. These barriers may include lack of information or knowledge (McCaslin, 1981; Yeatts, Crow, and Folts, 1994), inability to admit need or accept help (Moen, 1978), costs of services (McCaslin, 1981; Yeatts et al., 1994), lack of transportation (McCaslin, 1981; Yeatts et al., 1994), and lack of trust in the system (Baker and Pallett-Hehn, 1995; Yeatts et al., 1994).

Studies have also identified the factors influencing the use of services to seniors. These factors include ethnicity (McCaslin, 1988; Mitchell and Krout, 1990; Nelson, 1993; Roy, Dietz, and John, 1996), socio-economic status (Spence and Atherton, 1991), existence of social supports (Choi, 1994; Richardson, 1992; Spence and Atherton, 1991), knowledge of existing services (Richardson, 1992), and one's definition of need (O'Conner, 1995).
Organizations and agencies catering to the elderly have used this wealth of research data in attempts to make their programs and services more responsive to elderly need. However, despite their efforts, services and programs still are underutilized. To further understand service utilization and to make the delivery system more effective, new and creative ways to study this problem are needed. McCaslin (1988) concluded that a need for new approaches to studying service use existed by analyzing four studies (Krout, 1983; McCaslin, 1982; Mindel and Wright, 1982; Starrett and Decker, 1986) which looked at the predictors of service use.

All four studies provided consistent results: Demographics variables and functional capacity variables are poor predictors of service use. On the other hand, knowledge of existing services and acceptance of these formal services as a source of help are better predictors of service use. Consistencies in the findings of these four studies suggest that research may need a new way of looking at service utilization among the elderly. "The inability of more rigorous methodologies to increase the explanatory power of these variables suggested that the limits of underlying conceptualization have been reached" (McCaslin, 1988, p. 598). McCaslin (1988) notes the need for new research methodologies is essential in order to
increase our understanding of the variables affecting service use among the elderly.

This study will examine service utilization by studying the decision making styles and processes used in identifying services. McCaslin (1981) stresses that a better understanding is needed of the decision making process that "brings an individual to request formal assistance in obtaining service and that can differentiate that person from the one who opts to seek information and/or solutions through other channels" (p. 190). Krout (1983) also notes that more research is needed on the decision process the elderly use when accessing services and on the individuals who influence those decisions. Knowledge about the decision process that precedes the use of services and the sources of influence on decision making can be used to identify ways to improve the current system of service delivery.

The issue of service utilization among the elderly is not new, and while much has been learned about various factors affecting service use, many aspects of differences in service use among the elderly are still unaccounted for. Even less is known about how mature adults go about making decisions to use or not use services, and the thought processes involved in reaching a decision.

Such knowledge can be used when addressing service
design and delivery. Information about the thought processes used by seniors when faced with a problem or crisis could be used to modify service delivery, making it more comprehensible or appealing to an older population. If more is understood about who seniors listen to (community representatives, service providers, family, friends, etc.), services could be more carefully designed to target those individuals and agencies most likely to influence seniors.

San Bernardino County in southern California extends across a large and diverse area, encompassing urban, suburban, and rural communities. Many ethnicities are represented, including Caucasians and African Americans, as well as a significant Hispanic population for which little information is currently available.

This community and ethnic diversity within the County can be used to provide more generalizable data. Qualitative and quantitative research techniques will be used to provide both extensive and intensive information and understanding, despite a sample size smaller than typically used in survey research. By limiting the sample to women, more effort can be given to obtaining representative data from rural and urban residents of various ethnicities.
San Bernardino County has been selected by the state to develop a Long Term Care Integrated Pilot (LTCIP) project, which is expected to radically change service design and delivery to its residents. Because of the timeliness of this project (currently striving for the first stage of implementation in 2000), this research seeks to identify significant factors involved in how elderly women learn about, process, and make decisions about using services, with the hope that the LTCIP project can consider relevant results when designing new service delivery options.

Information obtained can be useful not only to San Bernardino County residents benefiting from the LTCIP project, but also any other areas or agencies that duplicate the Pilot program or seek to revise service delivery.

This research assesses: How do the decision-making styles and processes of elderly women affect their ability to identify services and generate solutions to problems?
LITERATURE REVIEW

Before considering how decisions are made, a better understanding of how families, social support, knowledge of resources and other factors affect service utilization by the elderly is required. This will allow for a better evaluation of the interaction between decision making and service use.

Social workers and other professionals have been studying service utilization for decades. A review of the literature frequently leads to the Behavioral Model, developed by Ronald M. Andersen (1968, cited in Andersen, 1995). Andersen (1995) 'revisited' this model recently and has periodically updated it over the years, but the basic concepts remain the same.

Andersen's model identifies 1) predisposing, 2) enabling, and 3) need factors as the primary determinants of service use. Predisposing factors include social structural variables, such as sex, marital status, race, family composition, and health beliefs (attitudes, values, and knowledge about health and health services). Enabling characteristics affect the ability to use a service, and include income, insurance coverage, travel, waiting time, and relationships with others that facilitate service use. The need factor considers the level of difficulty one is experiencing in areas such as health or ability to

Although the behavioral model was initially designed to study Health Services use, Andersen and his contemporaries have made efforts to apply the model to social service use as well. To help facilitate this, some researchers have grouped services based on how discretionary they are. Less discretionary characteristics include hospitalizations and in-home rehabilitation which are largely unavoidable and are generally referred or requested by a service provider. In contrast, more discretionary characteristics include home delivered meals and minor housekeeping. These services are generally based on the choice of the senior or caregiver, rather than a service provider or other professional (Kosloski & Montgomery, 1994; Mitchell & Krout, 1998; Wolinski et al., 1990, cited in Kosloski & Montgomery).

Despite the wide use of the behavioral model, its empirical utility in explaining or predicting service use by older adults has been limited, and the effects of its variables have been small (Kosloski & Montgomery, 1994). Mitchell and Krout (1998) found that the behavioral model is more appropriately applied in research on the use of discretionary services. They applied the model in their
study of non-institutionalized adults aged 60 to 104 (N=2,178) and found that age, race, and rural and small town residence appear to be significant predictors of the most discretionary services. Respondents who are older, African-American, rural, and small town residents are more likely to use these services than their counterparts. Mitchell & Krout (1998) found the behavioral model to be least effective in predicting the use of services classified as least discretionary. This is interesting to note, since the model was designed to measure health service use, including hospitalizations which are categorized as least discretionary. However, Kosloski and Montgomery (1994) found, in their study of 503 'caregiver dyads', that Andersen's original finding that predisposing factors were stronger predictors of nondiscretionary services was supported.

Another useful framework to be aware of is the "Functional Classification of Services for Older People" (Golant & McCaslin, 1979). While the authors themselves note potential problems with the classifications based on the qualitative judgment required to place given services in any group, the classifications still hold value when used to help evaluate and assess services for seniors.

When considering service use, gender and racial factors must be acknowledged. There are a largely
disproportionate number of elderly women compared to men, which is attributable to the greater life expectancy of women in this country. When both men and women are studied after age 65, samples usually contain 65 to 75% women. Yet, "despite recognition that old age is increasingly an experience of women, very little scholarly attention has been given to the status, characteristics, and problems of older women" (John et al., 1997, p.70). Gender differences are not generally noted unless gender is a specified characteristic of the research (as in Goldberg, Kantrow, Kremen, and Lauter, 1986; John et al., 1997; Kohen, 1983; Pellman, 1992). More often, gender comparisons and differences are neither sought nor acknowledged. More research is needed that seeks to explain differences in service use by gender. If thorough comparisons are not feasible, then studies focusing on needs and issues of elderly women are appropriate, given the feminization of old age.

More research is available on racial differences among the elderly. For instance, several studies have noted a significantly low rate of service use among African Americans, which is often correlated with very low income and limited health insurance (Mitchell et al., 1997; Nelson, 1993; Richardson, 1992; Spence & Atherton, 1991). A growing body of research pertains to Hispanic
populations (John et al., 1997; Nelson, 1993; Roy et al., 1996). John, Roy, and Dietz (1997) make a very good point when they caution against the tendency to assume that Mexican-American elders receive needed support from families. While their research indicated that only 19% of impaired Mexican-American female elders received no help, help from family members tended to limit rather than boost the use of formal services. There is a growing awareness that these family members cannot meet the needs of their elders, so Mexican-American elders will require additional aging services (Dietz, 1995, cited in John et al., 1997).

Family involvement and other social supports frequently appear in the literature on service use for seniors. McCaslin (1988), in a review of four studies, found contact with family or friends to be a predictor of service use in three of the four studies. McCaslin (1988) found church involvement to be significant in Hispanic populations, and Nelson (1993) found church involvement to significantly influence health service use among several races (although the influence differed among races and genders). Krout (1984), in his study of 250 residents aged 60 and over, found that contact with children is positively associated with awareness of services available, and negatively related to service use. This, Krout speculates, suggests that seniors with an informal
network of support may be less dependent on formal services.

Many seniors rely on informal and formal networks of assistance in their daily lives. Some will seek out advice from these networks when making decisions or even let people within the networks make decisions for them. However, an elder's caregiving network is not always the same as his decision making network (Smerglia, Deimling and Barresi, 1988; Townsend and Poulshock, 1986). Consequently, attention must be given to these decision making networks. Krout (1983) points out that "most research on decision making and service use has focused entirely on 'the' decision without any interest placed on the influence of significant others" (p.162). Several studies have looked at the role significant others play in decision making (Godwin and Scanzoni, 1989; Jecker, 1990; Padula, 1996; Pratt, Jones-Aust and Pennington, 1993; Pratt, Jones, Shin, and Walker, 1989; Prohaska and Glasser, 1996; Smerglia, Deimling, and Barresi, 1988; Townsend and Poulshock, 1986;). In order to understand the role social support plays when a senior makes a decision or solves a problem, a better understanding of decision making is needed.

Several models of the decision making processes and styles were identified in available literature. Maloney
(1996) identified a pattern of decision making consisting of several steps, beginning with a decision that a certain service or product is needed and wanted, and followed by identification of available options for obtaining that service or product.

In looking at the options, people will seek out advice from several different areas. Information will be obtained from formal channels, i.e., professionals, media, and advertisements. Information will also be obtained from informal channels, i.e., family, friends, and one's own personal experience. This information will provide the person with potential options for obtaining the product or service. Hence, the pros and cons of each of those potential options are weighed. Once this is done, a service or product is chosen from all the potential options.

Wheeler and Janis (1980) and Janis and Mann (1977) describe a similar process of decision making, with stages moving from appraisal of the challenge through making and adhering to a decision.

Although these are typical decision making models, Janis and Mann (1977) stress that such stages are only fully developed when the decision maker adheres to a vigilant pattern of decision making. The people using this pattern of decision making take the time and effort
to search for solutions to problems. Four other patterns of decision making exist which do not adhere to a process of decision making. These patterns are unconflicted adherence, unconflicted change, defensive avoidance, and hypervigilance.

Individuals adhering to an unconflicted adherence pattern do not engage in the decision making process because the current risk is not serious enough to warrant change. Unconflicted change is a pattern of decision making which identifies the problem as serious, but changes are made without looking at all the potential options and without much thought. The defensive avoidance pattern is used by people who want to avoid thinking about the problem. They realize a problem exists and there is a serious risk if no change is made; however, they try to avoid the available information about the problem and rationalize against the evidence showing a problem. People utilizing this pattern avoid the problem, rationalizing to themselves that no better solution exists. They may even let others make decisions for them. The hypervigilance pattern of decision making is used by those who feel they do not have enough time to search for alternatives. Decisions are made quickly and are often simple minded. Often these people will go along with what others are doing. It is important to note that these decision making
patterns vary depending on the type of problem, personality characteristics and the individual's past experiences.

Maloney (1995) also notes that when the elderly make decisions on long term care options, they often do not follow specific models of decision making. Using in-depth interviews with 63 elderly individuals and 56 of their relatives to study the decision making process, Maloney (1995) discovered four distinct decision making styles rather than variations on the decision making model. These four styles are classified as "Scramblers" - people who are forced to make changes due to an immediate crisis, "Reluctant Consenters" - people who are pushed to make a change by others who notice a problem, "Wake-up call" decision makers - people who make changes due to a near crisis, and "Advance Planners" - people who plan out a course of action before a crisis occurs. Only a fourth of the respondents were "Advance Planners"; the rest waited for a crisis or near-crisis before making a change.

Perlman (1975 cited in McCaslin, 1981) also identified different types of decision makers: "problem solvers" and "resource seekers" versus "buffeted clients". The "problem solvers" and "resource seekers" can define the problem, decide what they want to do, and seek information in order to solve their problem on their own.
The "buffeted client" identifies that he/she is having some difficulty but does not know how to solve the problem or even how to describe that problem.

Since these different types of decision makers exist, the particular patterns used by the elderly individual must be identified and utilized to modify the service delivery system to best meet the needs of the elderly. For example, elderly clients who use vigilant decision making patterns, or who are "Advanced Planners" or "problem solvers"/"resource seekers" may be able to access needed service through information and referral services provided by community-based organizations (McCaslin, 1981).

However, elderly people who are "buffetted clients", "reluctant consenters", "wake-up call" decision makers or "scramblers" or engage in unconflicted adherence, unconflicted change, defense avoidance or hypervigilant patterns of decision making will require more sophisticated methods to help them access services. For example, in the case of "reluctant consenters" or people who engage in defense avoidance, information on services may need to be provided to family or health care professionals who are in a position to push the client to seek assistance. "Scramblers" and decision makers who have a decision making pattern dominated by hypervigilance
may benefit from emergency response service teams that can respond to an immediate crisis.

Once decision making patterns have been identified, one also needs to look at people who influence the actual outcome of the decision. Jecker (1990) and Pratt et al. (1989 and 1993) looked at the role adult children of the elderly play in making decisions. Jecker (1990) notes that in relation to the health care system, children of elderly clients often help their parents navigate the system.

Utilizing the same non-probability sample of 64 single mothers and 64 daughter respondents, Pratt et al. (1989 and 1993) studied strategies used by daughters to influence decisions, and studied how influential and involved daughters are when helping mothers make decisions. In terms of influence strategies, daughters and mothers used more positive strategies like giving partners things to read that are relevant to the decision and asking the partner what they think about the decision. Daughters and mothers sometimes even engaged in option seeking strategies, i.e., getting information from professionals and agencies (Pratt et al., 1993). Furthermore, even though the mothers in the sample were highly involved in making decision, their daughters were highly influential in the decision making process. This
was true especially if the mother was more dependent on her daughter for personal care. Townsend and Poulshock (1986) also found that the family is influential in the decision making network of the elderly. In the case of single elders, the adult children had the most influence over their parents' decisions (Townsend and Poulshock, 1986).

Marital status also seems to have an important impact on the elders' decision networks (Padula, 1996; Pratt et al., 1989; Prohaska and Glasser, 1996; Smerglia, 1988). For example, Padula (1996) found, from data collected from a qualitative sample of 59 elderly couples, that the majority of the couples relied on each other in making health decisions more than anyone else and often would make these decisions jointly. Prohaska and Glasser (1996) found similar findings from a sample of 136 elderly patients visiting outpatient health clinics. Of this sample, the majority identified their spouse as the person they talk to about medical care decisions.

Using a purposive sample of 101 impaired, white elderly, (i.e., elderly needing help with personal care or instrumental activities of daily living, but not seriously mentally or cognitively impaired) and their adult children and spouses, Townsend and Poulshock (1986) found that the decision making networks of widows and married women
varied. Married elders were as likely to name their spouse as the primary decision maker as they were to name themselves. Smerglia et al. (1988) also found that black, married elderly claimed that their spouses ranged from the most important decision makers to a very important decision maker. On the other hand, Townsend and Poulshock (1986) found that widowed elderly identified their children as the ones who have the most influence over their decisions. Furthermore, for both married and widowed elderly, the decision making networks consisted primarily of the immediate family. However, small numbers of children of elderly widows named professionals and paid sources as occasional members of the decision making network. Ethnicity also plays a role in decision making networks. Smerglia et al. (1988) studied a purposive sample of 193 white family caregivers and 51 black family caregivers. From this study, the data showed that twice as many white respondents as black respondents mentioned the elderly individual as the key decision maker. For black respondents, adult children were more likely to be named the central decision maker than anyone else. Furthermore, the black elder was typically excluded from having the final say about decisions. The adult children or the spouse took on this role. In contrast, the white elder was named the central decision maker. Moreover,
both black and white elderly rarely identified extended kin, friends, and neighbors as participants in decision making. Both racial groups also rarely noted professionals or formal decision makers as part of their decision making network.

The above-mentioned studies on decision making networks utilized purposive or non-probability samples (Padula, 1996; Pratt et al., 1989; Pratt et al., 1993; Prohaska and Glasser, 1996; Smerglia et al., 1988; Townsend and Poulshock, 1986) which may limit the results' generalizability. Despite this problem, these studies provide insight into the importance of significant others in elderly decision making networks. If individuals can be identified who help the elderly make decisions, then those individuals can be targeted as important people to include in the service delivery system. If the elder's spouse or child is influencing decisions regarding the use of services, service planners and providers must utilize these individuals as a means to develop a more effective service delivery system. Information about senior services must be supplied to these influential family members. Furthermore, if tactics used to influence elders' decisions can be identified, this information can be used to modify the service delivery system. For example, if a large majority of daughters influence their
parents' decisions to seek a service by obtaining information from doctors, then these doctors should be supplied with vast amounts of information on services for the elderly.

A final consideration when studying the decision making process of the elderly and those that influence decisions is the issue being decided. Depending on the problem or issue, a family member can exert more influence on the decision (Godwin and Scanzoni, 1989; Pratt et al., 1989). As Godwin and Scanzoni (1989) point out, "the processes and outcomes of joint decision making will be related to the salience or importance of each of the issues..." (p. 293). For example, if the decision has to do with something the elder's spouse or daughter feels is important, that spouse or daughter may exert more power over the decision. If the issues people view as most important are identified, service planners and providers can provide these influential family members with a wealth of information on these issues.

While the literature is rich with information on service utilization, social supports, and decision making processes, a review of the literature yielded no studies which linked these issues together to consider the process by which the elderly decide to use a service or not use a service. The decision making process, along with who
influences decisions, the type of decision making style people employ, and how those influences and styles affect one's knowledge of services, are areas needing study.

RESEARCH DESIGN AND METHODS

This study identified and described decision making styles and processes of elderly women and attempted to explain how they affect their ability to identify resources. This study also explored differences among Caucasian and minority (Latino and African American) women. The sample of 15 women over 65 years of age was obtained by contacting churches throughout San Bernardino County. Clergy were requested to ask church members to volunteer themselves or identify others outside the church who met the criteria for the study. Encouraging involvement of people not directly affiliated with the church helped reduce the potential bias of having only active church members in the sample (however, most participants were church members, with varying levels of church involvement).

An attempt was made to obtain equal numbers of Latino, Caucasian, and African American respondents, as these ethnicities are most prevalent in this county. Limiting the sample to women allowed for greater generalizability among different ethnicities within a
community because a majority of the elderly are women. Also, women are often 'gatekeepers' to services; they are most likely to be the primary person to seek services for themselves and their male partners.

Interviews were conducted on two consecutive days to capture responses that seniors might think of after the researchers left, and to allow them to spontaneously talk with family or friends concerning the questions asked on the first day. Both open and closed questions were utilized. Responses to a vignette (see Appendix A) were used to allow for breadth of information and allow respondents to freely create possible solutions. This open-ended approach was chosen to elicit more varied responses than would a solely forced response questionnaire. An analysis of problem solving responses to a given scenario allowed for comparisons among respondents.

The vignette utilized in this study described a situation in which an elderly woman had broken her hip, and was about to be discharged from the hospital. Respondents were asked to rate how serious the problem was (on an ordinal scale of one to ten). In addition, participants were asked an open ended question regarding what this woman should do. Responses to this question were quantified by identifying a) how many solutions were
given, b) how many formal services were considered, and c) how many informal services or alternatives were considered as possible resources (all measured at a ratio level). If the respondent did not volunteer the information, a question was asked regarding whether she knew anyone who had been in a similar situation.

A questionnaire was used to record several independent variables: marital status, ethnicity, living arrangement, religious affiliation, prior service use, current service use, and social supports, all measured at a nominal level. Income level and perceived socio-economic status were measured at the ordinal level. Age, education, length of residence in the community, extent of religious involvement, and frequency of social contacts were measured at a ratio level.

The questionnaire was left with each participant and later retrieved in a sealed envelope during a follow-up visit the next day. Using a sealed envelope allowed for a sense of anonymity to ensure honest and reliable responses to some of the more sensitive questions.

During the follow-up visit, information was gathered to further assess the respondent's decision-making processes and styles which were ultimately used as intervening variables. Allowing extra time for the elderly participant to process the information and
consider different resources was thought to reflect more realistically the processes used in actual decision-making situations. Questions asked included the following: Have you thought of any other possible solutions to the problems in the vignette? How did you arrive at these solutions? Did you talk to anyone else when considering this? Who? What other resources do you think might be available? Do you generally make decisions on your own, or with the help of others? What type of decision maker are you? Considering all the possible solutions, what do you think is the best thing for the woman in this situation to do? (See attached interview guide, Appendix C.) A content analysis was subsequently used to evaluate these open ended questions.

The vignette, questionnaire and follow-up questions were pretested with women over age 65 prior to obtaining data from respondents. Minor procedural modifications were made following the pretest.

A written copy of the vignette was brought to the interview, and respondents were invited to read along as the vignette was read to them. This accommodated visual learners and the hearing impaired and did not exclude participants who may have been illiterate or visually impaired. Similarly, instruction was given regarding the questionnaire, encouraging respondents to have a friend or
neighbor help complete it if necessary. The researchers also provided assistance in writing down responses when asked. Bilingual interpreters and Spanish versions of the vignette and questionnaire were available, but not needed.

Obtaining information through the use of a vignette has some potential validity and reliability problems. Because of unwillingness or inability, there is a potential for respondents to have difficulty imagining themselves in a particular situation (Moen, 1978), or they may be reluctant to imagine themselves or significant others in a potentially unfavorable situation (Janis and Mann, 1977). In this study, the vignette used described a fairly common situation (hip fracture), and it identified a neutral third party as the individual in the given situation to help avoid leaving the participant feeling threatened or emotionally involved. Slight variations in the vignette were made so the living situation more closely matched that of the respondent (i.e. the woman in the vignette was described as living alone, with a spouse, or with family).

Sample size was limited due to time and resource constraints. Also, there was a potential for researcher bias when quantifying vignette responses to measure aspects of the decision making process. However, the
benefits of the breadth of information obtained outweighed the limits and risks.

RESULTS

This study yielded results from a sample of fifteen women, age 65 or older, with an average age of 73. The ethnic distribution of the sample consisted of 53% (N=8) Caucasians, 13% (N=2) African Americans, and 33% (N=5) Latinos; 47% (N=7) were married, 40% (N=6) widowed, 7% (N=1) divorced, and 7% (N=1) never married. Of these women, 47% (N=7) were living alone, 40% (N=6) living with a spouse and 13% (N=2) living with a daughter. The income levels of the respondents were almost equally distributed, with 27% (N=4) reporting $700 to $1,199 monthly, 20% (N=3) $1,200 to $1,599 monthly, 20% (N=3) $1,600 to $1,999 monthly, and 20% (N=3) reporting monthly income at $2,000 or more. The majority (68%, N=10) identified themselves as middle class.

Analysis of the distribution and central tendency of key variables revealed the following. For decision making alone or with help, 53% (N=8) of respondents indicated they generally make decisions on their own. Only 27% (N=4) noted they regularly make decisions with the help of others, and 20% (N=3) make decisions on their own and with help. Regarding decision making style, the majority of
respondents (67%, N=10) viewed themselves as Advanced Planners; 7% (N=1) identified as Scramblers, 13% (N=2) as Reluctant Consenters, and 13% (N=2) as Wake-Up Callers. (S

When respondents rated the seriousness of the problem presented in the vignette on a ten-point scale, two (13%) rated it a ten (most serious), five (33%) rated it a nine, and one each rated it eight, seven, or six (7%). However, four (27%) of the respondents rated the problem in the middle range, giving it a five. Only one respondent (7%) gave a low rating of three.

The mean for the total number of solutions generated was five. The distribution of responses ranged from three to eight as follows: 20% (N=3) generated three solutions, 7% (N=1) generated four, 40% (N=6) generated five, 20% (N=3) generated six, 7% (N=1) generated seven, and 7% (N=1) generated eight solutions.

The mean number of informal solutions generated was two, and the mean of formal solutions was three. Of the informal solutions, 47% (N=7) generated one, 27% (N=4) generated two, 13% (N=2) generated three, and 13% (N=2) generated four. Of the formal solutions, one each (7%) generated zero, one, five, and six. Three each (20%) generated two and three, and five (33%) generated four formal solutions. There were a total of 55 solutions (72%)
generated on the first day and 21 solutions (28%) generated on the second day.

Many of the bivariate relationships between the variables proved not to be statistically significant. Using chi squares, significant relationships were not found between decision making style and ethnicity, living situation, marital status, or ability to make decisions alone or with help. Furthermore, t-tests comparing Advanced Planners with other decision making styles revealed no statistically significant relationships by age, education, seriousness rating, number of past services used, number of years in residence, number of informal and formal solutions, total number of solutions, and number of solutions made on both the first and second day. T-tests also identified no statistically significant differences between Caucasians and minority respondents in the mean number of total solutions generated, informal solutions generated, and number of solutions offered on the first and second day. Last, there were no statistically significant differences between those who rated the problem as serious or not and number of past and present services used.

Pearson correlations did show a statistically significant relationship between number of formal solutions generated and number of days one visits or talks
to people other than a spouse, child, friend or neighbor (r = -.523). Another statistically significant relationship (r = -.620) existed between number of formal solutions and number of days one visits or talks to a spouse. (See Table 1)

Statistically significant relationships were also found between education and number of formal solutions generated (r = .527), number of solutions generated on the first day and number of total solutions generated (r = .648), number of solutions generated on the first day and number of formal solutions generated (r = .574), number of total solutions and number of formal solutions (r = .732), number of years in residence and number of formal solutions (r = -.564), and number of total solutions and number of solutions generated on the second day (r = .603). (See Tables 1 & 2)

T-tests identified significant differences between Caucasians and minority respondents in the mean number of solutions generated on both the first and second day, as well as number of solutions generated on the second day and the seriousness rating of the problem. (See Table 3)
Table 1

Bivariate Correlations for Variables: Formal Solutions, Days with Others, Days with Spouse Solutions on the First Day, Education

<table>
<thead>
<tr>
<th></th>
<th>Formal solutions</th>
<th>Days with others</th>
<th>Days with spouse</th>
<th>Solutions first day</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal solutions</td>
<td>1.000</td>
<td>-0.523*</td>
<td>-0.620*</td>
<td>0.574*</td>
<td>0.527*</td>
</tr>
<tr>
<td>(P=0.046)</td>
<td>(P=0.014)</td>
<td>(P=0.025)</td>
<td>(P=0.043)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days with others</td>
<td>-0.523*</td>
<td>1.000</td>
<td>0.570*</td>
<td>-0.246</td>
<td>0.158</td>
</tr>
<tr>
<td>(P=0.046)</td>
<td></td>
<td>(P=0.026)</td>
<td>(P=0.378)</td>
<td>(P=0.573)</td>
<td></td>
</tr>
<tr>
<td>Days with spouse</td>
<td>-0.620*</td>
<td>0.570</td>
<td>1.000</td>
<td>-0.343</td>
<td>-0.132</td>
</tr>
<tr>
<td>(P=0.014)</td>
<td>(P=0.026)</td>
<td></td>
<td>(P=0.211)</td>
<td>(P=0.638)</td>
<td></td>
</tr>
<tr>
<td>Solutions first day</td>
<td>0.574*</td>
<td>-0.246</td>
<td>-0.343</td>
<td>1.000</td>
<td>0.228</td>
</tr>
<tr>
<td>(P=0.025)</td>
<td>(P=0.378)</td>
<td>(P=0.211)</td>
<td></td>
<td>(P=0.414)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>0.527*</td>
<td>0.158</td>
<td>-0.132</td>
<td>0.228</td>
<td>1.000</td>
</tr>
<tr>
<td>(P=0.043)</td>
<td>(P=0.573)</td>
<td>(P=0.638)</td>
<td></td>
<td>(P=0.414)</td>
<td></td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed).
Table 2

Bivariate Correlations for Variables: Formal Solutions, Solutions on the Second Day, Number of Solutions, Years in Residence, and Solutions on the First Day

<table>
<thead>
<tr>
<th></th>
<th>Formal solutions</th>
<th>Solutions second day</th>
<th>Number of solutions</th>
<th>Years at residence</th>
<th>Solutions first day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal solutions</td>
<td>1.000</td>
<td>0.337 (P=0.220)</td>
<td>0.732** (P=0.002)</td>
<td>-0.564* (P=0.029)</td>
<td>0.574* (P=0.025)</td>
</tr>
<tr>
<td>Solutions second day</td>
<td>0.337 (P=0.220)</td>
<td>1.000</td>
<td>0.603* (P=0.017)</td>
<td>-0.286 (P=0.302)</td>
<td>-0.217 (P=0.438)</td>
</tr>
<tr>
<td>Number of solutions</td>
<td>0.732** (P=0.002)</td>
<td>0.603* (P=0.017)</td>
<td>1.000</td>
<td>-0.448 (P=0.094)</td>
<td>0.648** (P=0.009)</td>
</tr>
<tr>
<td>Years at residence</td>
<td>-0.564* (P=0.029)</td>
<td>-0.286 (P=0.302)</td>
<td>-0.448 (P=0.094)</td>
<td>1.000</td>
<td>-0.275 (P=0.321)</td>
</tr>
<tr>
<td>Solutions first day</td>
<td>0.574* (P=0.025)</td>
<td>-0.217 (P=0.438)</td>
<td>0.648** (P=0.009)</td>
<td>-0.275 (P=0.321)</td>
<td>1.000</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed).

**Correlation is significant at the 0.01 level (2-tailed).
Table 3

Independent T-tests for Variables: Solutions on Second Day, Seriousness Rating, and Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second day/ Seriousness in two categories</td>
<td>-2.208</td>
<td>13</td>
<td>0.046</td>
</tr>
<tr>
<td>First day/ Ethnicity</td>
<td>2.370</td>
<td>13</td>
<td>0.034</td>
</tr>
<tr>
<td>Second day/ Ethnicity</td>
<td>-2.184</td>
<td>13</td>
<td>0.048</td>
</tr>
</tbody>
</table>
DISCUSSION

Although an analysis of decision-making styles compared with service use yielded no significant findings with this research design, useful information was obtained. Much of the significant data concerned the respondents' generation of formal solutions to the presenting problem.

For instance, as respondents talked and visited more with others, or had frequent contact with a spouse, they identified fewer formal services. This information is valuable to service providers, as it supports the need to target information about resources not only to seniors but to friends and family as well.

While a higher education correlated with a higher generation of formal solutions, an unanticipated finding is that the longer a respondent lived in an area, the fewer formal services she identified. The expectation was that people who lived in an area for a long time would be more familiar with local resources. Perhaps when a person lives in an area for a long time, she comes to rely more on neighbors and friends, and has less need to seek out formal services. These results suggest a need for outreach to established communities, as well as to the less educated.
As expected, the total number of solutions generated correlated well with the number of solutions generated on the first and second day of interviews. It is unclear, however, why Caucasian women generated more solutions on the first day, while minorities generated more on the second day. Also of note, those who rated the problem as most serious generated more solutions on the second day. Perhaps these women, being more concerned, spent more time worrying and considering options after the vignette was initially presented.

It is likely that decision making styles were not clearly identified within the context of this study for two reasons. The depth of data gathered resulted in a small sample size, and self-reporting by respondents may have biased the results. Respondents may have decided that the "Advanced Planner" style of decision making sounded most desirable, even though it was not a true representation of their style. It is believed that further research on decision making styles and service use is needed to better explore the relationship.

This research also suggests that there is value in seeking feedback from seniors during a second visit; had there not been a follow-up interview, 28% of the total solutions generated would have been missed. Seniors need more time to process information, and to assume a full
understanding of what an older person knows based on one interaction may be quite inaccurate. Further research in this area would likely be relevant to many fields of practice.
APPENDIX A

Vignette

Mrs. Smith recently broke her hip. She has had surgery and is now ready for discharge from the hospital. Before she broke her hip, she was living alone/ with her husband/ with her daughter. She can walk with a walker. She needs help with bathing and can't stand for long periods of time. She sometimes needs help getting up and down. What should Mrs. Smith do?
APPENDIX B

Questionnaire

Please complete this questionnaire so that it can be picked up tomorrow. Do not put your name on this. To ensure confidentiality, only your case number will be used to identify your responses. Most of the following questions may be answered by simply circling the appropriate response; other questions ask for written-in answers. However, you may write in additional comments whenever you wish to do so.

Please CIRCLE only one response unless otherwise noted.

1. What is your marital status?
   Married   Widowed   Divorced   Separated   Never married

2. Do you currently live:
   Alone   With spouse   Other

   How long have you lived in this community? Years___ Months

3. Please circle the ethnicity you most closely identify with:
   Anglo   African American   Latino   Other

4. What is your approximate monthly income?
   
a. Less than $699
   b. $700 - $1,199
   c. $1,200 - $1,599
   d. $1,600 - $1,999
   e. $2,000 or more

5. Do you consider yourself to be:
   
a. Upper class
   b. Upper middle class
   c. Middle class
   d. Lower Middle class
   e. Lower class

6. What is your religious affiliation?

   How often do you attend religious services?

7. What is your age?

   37
8. How many years of education have you completed?

9. Which of the following services have you personally used in the past? (Circle ALL that apply)
   - Home health care
   - Transportation services
   - Senior center
   - Friendly Visitor/Companion
   - In-Home Supportive Services (IHSS)
   - Homemaker services
   - Home delivered meals
   - Case work/Social work
   - Information and Referral
   - Exercise program
   - Adult Education

   Other:

10. Which services do you currently use?
   - Home health care
   - Transportation services
   - Senior center
   - Friendly Visitor/Companion
   - In-Home Supportive Services (IHSS)
   - Homemaker services
   - Home delivered meals
   - Case work/Social work
   - Information and Referral
   - Exercise program
   - Adult Education

   Other:

11. In the past month, please indicate how many days you have seen or talked to each of the following people:
   - Adult child: _____ days
   - Neighbors: _____ days
   - Spouse: _____ days
   - Friends: _____ days
   - Other (Relationship: __________________________) # _____ days

   Is this past month's amount of social contact typical for you?
   - Yes
   - No (Why not? _________________________________)

   If this past month is not typical, please describe what is typical contact for you:
APPENDIX C
Interview Guide

First Day:
1. On a scale from one to ten, ten being extremely serious, how would you rate the seriousness of the problem presented in the vignette?
2. What do you think this woman should do in this situation?
3. (If needed) Have you known anyone in a similar situation?

Second Day:
1. Have you thought of any new solutions to the original problem? If so, what are those new solutions?
2. How did you arrive at these new solutions?
3. Did you talk to anyone? If so, who?
4. Did you seek advice from any other resource to come up with new solutions?
5. What other resources do you think are available for this problem?
6. Considering all the possible solutions, what do you think is the best thing for the woman in this situation to do, and why?

Assess decision making style:
1. In general, do you make decisions on your own or with the help of others? Who's help do you seek?
2. Listen to the following descriptions and state which one most accurately reflects how you make decisions:
   a. [Scramblers] I generally wait to make a change until it is absolutely necessary.
b. [Reluctant Consenters] I generally make a change when someone else has a concern about me and encourages me to make that change. Sometimes these suggestions are hard for me to accept.

c. [Wake-Up Call Decisionmakers] I will generally make a change when I realize a situation is getting worse and may become a crisis.

d. [Advance Planners] I will generally make a change or look for possible solutions when I anticipate future problems, before those problems occur.
APPENDIX D

Informed Consent

The study in which you are about to participate is designed to investigate how decision making processes and styles affect ability to identify services and generate solutions to problems. This study is conducted by Kris Johnson and Melissa Moelter under the supervision of Dr. Rosemary McCaslin, Professor of Social Work at (909) 880-5507. This study has been approved by the Institutional Review Board of California State University San Bernardino.

In this study you will be interviewed on two consecutive days for approximately 1 hour each day. You will also be asked to complete a brief questionnaire which will be given to you on the first day of interviewing and returned the following day. The questionnaire requires approximately 10 minutes of your time.

Please be assured that any information you provide will be held in strict confidence by the researchers. At no time will your name be reported along with your responses. All data will be reported in group form only. At the conclusion of this study, you may receive a report of the results.

Please understand that your participation in this research is totally voluntary and you are free to withdraw at any time during this study without penalty, and to remove any data at any time during this study.

_______ I acknowledge that I have been informed of, and understand, the nature and purpose of this study, and freely consent
to participate.

I consent to have this interview recorded on audio tape.
APPENDIX E

Debriefing Statement

This study is being conducted to look at how seniors make decisions that may affect their use of community services and resources. The ultimate goal is to make this information available to agencies and individuals who provide services to seniors so they might better meet the needs of seniors accessing services. The results of this study will be available at the California State University San Bernardino library when it is complete. We have provided a copy of the local Resource Guide to services in San Bernardino County in case you have any questions about available resources as a result of your participation in this study. If you have questions about your participation in this research study, you may contact Dr. Rosemary McCaslin at (909) 880-5507.
APPENDIX F

ASSIGNED RESPONSIBILITIES

This was a two-person project where authors collaborated throughout. 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: Melissa Moelter
   Assisted by: Kris Johnson

2. Data Entry:
   Assigned leader: Melissa Moelter
   Assisted by: Kris Johnson

3. Data Analysis:
   Assigned leader: Kris Johnson
   Assisted by: Melissa Moelter

4. Coding Qualitative Data:
   Assigned leader: Melissa Moelter
   Assisted by: Kris Johnson
5. Writing Report and Presentation of Findings:

a. Abstract
   Assigned leader          Kris Johnson
   Assisted by              Melissa Moelter

b. Problem Statement/Problem Focus
   Assigned leader          Kris Johnson
   Assisted by              Melissa Moelter

c. Literature Review
   Decision making          Melissa Moelter
   Service use              Kris Johnson

d. Research Design and Methods
   Assigned leader          Melissa Moelter
   Assisted by              Kris Johnson

e. Results
   Assigned leader          Melissa Moelter
   Assisted by              Kris Johnson

f. Discussion
   Assigned leader          Kris Johnson
   Assisted by              Melissa Moelter
REFERENCES


