To my Great Uncle
OTTO E. MOORE

Through the portions of his over 40 years in retirement that I have seen, I have come to appreciate the complexities of aging, its losses and its rewards. When I asked if he would like me to use his name, he replied, "All I can say is that, that name has been in use for over 86 years and is about used up. So please use it any way you want." I thus dedicate this book to Otto E. Moore with the hope that the readers will come to appreciate the resourcefulness, vitality, and humanity of older adults everywhere.

AGING IN CULTURE AND SOCIETY

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and Contributors

Comparative Viewpoints and Strategies

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12 Dependency and Reciprocity: Home Health Aid in an Elderly Population

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Independence–dependence is an evaluative duality prompting people to affirm the positive, independence. One of the most common laments of older adults, especially Americans, is, "I don't want to be a burden, I want to be independent..." Dependency is one of the most pervasive problems of aging. It is a problem for older adults themselves, and for their families, friends and even society. The roots of this problem are planted in an elementary quality of social life. All social relations are interdependent with the interlinkages mediated by giving and taking or by the norm of reciprocity. Giving and taking are more or less balanced by sanctions, such as being called a free loader, directed against those who take too much. Dependence, or the inability to reciprocate and hold up one's end of a social relationship is a very real problem for both takers and givers.

We have seen this issue among the Chinese, the Black Caribs, and elderly Corsicans in Paris. Cultures work out solutions to this problem. Karen Jonas and Edward Wellin investigate the informal mutual aid networks in the same public housing projects for the elderly in Milwaukee as Eunice Boyer reported on in the previous chapter. Again anthropologists have come up with another surprise for the critics of age concentrated residences. In the informal mutual aid networks, Jonas and Wellin find interdependency with well articulated norms of reciprocity. Although materially impoverished, residents who need and receive care from friends and neighbors, actively reciprocate. Reciprocation is not always even, help episode for help episode. Where help giving becomes one way, the receiver has a number of alternative ways in which to hold up his/her end of the relationship.

As with other cultural phenomena, there are patterns. Jonas and Wellin systematically document these patterns in the quantitative analysis of their survey data. By careful use of the qualita-

tive data obtained through months of observation, they are able to resolve the apparent inconsistencies and probe deeper. Sex differences and degrees of prior acquaintance and intimacy are important features in structuring mutual aid networks. Females, in giving aid are more likely to follow what the authors identify as the mother hen pattern characterized by intimacy and long term giving and taking of a diffuse nature (generalized reciprocity). Males practice the customer pattern where intimacy is less intense and reciprocation is immediate (balanced reciprocity). Where there is no prior acquaintance, help may be given, but if demands persist, the norms are violated in that someone is trying to get something for nothing (negative reciprocity).

So what? The import of these findings is that for some older adults, in a culture that emphasizes independence, the problem of dependency is to a large extent resolved. As Jonas and Wellin point out, everyone gains in this situation. Families gain in that their older members remain independent and the quality of their relationship improves. Public agencies (the state) gain since institutionalization is delayed or thwarted completely. The elderly also gain in that by actively exchanging, their self-esteem is reinforced. Thus, in an environment which is stereotyped as warehouses for old people, we find networks of interdependent people maintaining their independence.

"It's very important that I do not become a burden on somebody. That's the most important thing in my life today."

Clark, quoting a San Francisco elderly informant (1972:272)

Being dependent, or a "burden", on others violates one of the pervasive values in American society, that of independence. To be dependent on others for the means of survival, without appropriate reciprocation, has traditionally been regarded in our society as "a confession of one's own incompetence or inadequacy and justification for . . . degradation in the eyes of the community" (Cowgill 1972a:243).

The norm of reciprocity (essentially, "one should help those who have helped one") has been described as a universal, a principle that apparently occurs in the value systems and moral codes of all societies (Gouldner 1960:171). Forms of reciprocity, often studied under the rubric of exchange theory (Malinowski 1922; Mauss 1954; Blau 1964; Sahlins 1965; Homans 1974; Dowd 1975; Emerson 1976; Befu 1977) are seen as pervading the entire social fabric and serving as networks that hold society together (Belshaw 1965:7). For contemporary Americans, with their strong cultural emphasis on independence and general bias against dependency, numerous empirical studies provide evidence that the norm of reciprocy exerts powerful effects throughout the society in structuring social relationships (e.g., Blau 1964; Homans 1961, 1974; Stack 1974).

Clark (1972:263-274) analyzes types of dependency and notes that in American society norms of reciprocity are held in cultural abeyance in only two types. One is developmental or transitional dependency, involving predictable periods of relative helplessness for affected individuals, when they require one-way care and resources from others, e.g., early childhood, critical phases of the child-bearing cycle, and senescence. The other is crisis-related dependency, generally unpredictable in occurrence and timing, such as sudden illness or injury, bereavement, and divorce. Both types of dependency tend to be institutionalized as permitting or requiring varying periods and intensities of essentially one-way support from others. However, the dependency is acceptable only if it is limited in time; should it persist beyond some culturally arbitrated period, the individual becomes a burden—the recipient of nonreciprocal support.

When we turn to questions of dependence and reciprocity among the elderly in our society, we find, to be sure, that many older persons enjoy good health, perform their usual activities with little restriction, and make few if any dependency demands on others. At the same time, the incidence of chronic illness and of long-term limitations in activity and mobility increase sharply with advancing age (Commission on Chronic Illness 1957; U.S. National Center for Health Statistics 1974, 1977). While only 1 percent of the noninstitutionalized population age 18-44 suffer chronic incapacities severe enough to require dependency on others for assistance in mobility and personal care, this figure rises to 12 percent among persons age 65-74 and to 26 percent in the population age 75 and older; furthermore, the lower the levels of education and income, the higher the frequency of chronic incapacity (Nagi 1976). Thus, it is the older, poorer, and less-educated segments of our noninstitutionalized population—those with the fewest resources to reciprocate help from others– who present the highest rates of disability and, if they are to avoid institutionalization, the greatest needs for long-term dependency.

Every society develops some set of patterns for the care and support of the elderly and incapacitated. Between them, Simmons (1945) and Cowgill and Holmes (1972) provide the basis for broadly delineating the evolution of societal arrangements for such care and support. Simmons surveys the place of the aged only in so-called "primitive" societies, i.e., in societies which share at least three attributes—little or no techno-economic modernization, the pri-

macy of kinship in governing interpersonal relationships, and a low proportion of elderly in the population. Simmons finds that in such societies—irrespective of the form of the family, resources available to the elderly, or other cultural variations- aged men and women universally rely on younger kin for care and support (1945: 214).

Cowgill and Holmes also survey aging and its correlates cross-culturally but do so in a range of societies at different levels of modernization. They find that with advancing modernization—and with the interrelated factors of the reduced importance of kinship and increased proportion of elderly in the population—primary responsibility for the care and support required by elderly persons tends to shift from the family to the state. Although adult children in modern societies do retain some obligations for looking after aged parents, Cowgill and Holmes note that these obligations are often unclear and not wholly binding (1972b:307, 318-319).

In most societies, including our own, it can be argued that both the giver of support and the dependent can usually accommodate to dependency if at least one, or, preferably, two or more, of the following conditions are met: if (1) the dependency is of limited duration or intensity, (2) the dependent individual has something of value to exchange for help received, and (3) the participants share especially intimate socioemotional bonds, as among certain close kin.[2]

The object of the present inquiry is to examine patterns of dependence and reciprocity among an aggregate of elderly persons in a milieu in which, frequently, *none* of the foregoing conditions appear to be met. That is, we deal with a situation in which incapacitated individuals often require long-term support, possess few resources and apparently have little of value with which to reciprocate, and, for the most part, lack long-standing relationships or kinship ties with other elderly in the same setting. The opportunity to learn about various dimensions of the latter type of dependency situation was provided by a study of residents of public housing for the elderly in Milwaukee, Wisconsin. Among other things, the study investigated who provided and who received the care that sick or incapacitated persons received at home.

METHODS

The present research is part of a larger study of the general life situations and health needs of residents in 6 of the 13 public housing projects for the elderly in Milwaukee (Wellin, et al 1974). Two

data-gathering approaches were used. One, the ethnographic, begun in late 1972 and still ongoing, involved informal and repeated interviews with a limited number of informants, occasional attendance at resident gatherings and activities, and observation in a range of situations. The second, or survey-research type, was based on standardized interviews and was carried out during spring 1973. The latter phase produced interviews with 414 respondents, constituting a carefully randomized sample of 37 percent of the residents of the six projects. Material in this paper draws on both sources of data.

THE HOUSING PROJECTS AND CHARACTERISTICS OF THEIR RESIDENTS

This study is limited to one of the niches occupied by the aged in contemporary American society- that of public housing for the elderly. Among the characteristics distinguishing that niche, three are especially prominent. For one, its primary support is *governmental*, through a combination of federal, state, and local arrangements. Secondly, the population consists of *dense and exclusive* concentrations of older persons. Thirdly, not all elderly but only those who meet stated criteria of *poverty* are eligible for residence.

Somewhat over 2,500 persons reside in Milwaukee's 13 public housing projects for the elderly. Dispersed throughout the central city, the buildings range in height from 8 to 24 stories and in capacity from 100 to over 250 apartments. Most apartments consist of living room, dining alcove, bedroom, kitchen and bathroom; some units, available only to married couples, have a second bedroom. Criteria for admission are based essentially on age and income. One must be poor and at least 62 years of age, although the minimum age is waived under certain conditions. While no specific requirements are laid down as to health status or functional mobility, those admitted must be able to function more or less independently.

One finds negative and stereotyped attitudes among many people in the community that elderly housing projects constitute "storage bins" for poor aged folk. Some residents say they shared these feelings when first admitted. Nonetheless, overwhelmingly, residents are pleased with the projects and their apartments, although somewhat less so with some of the neighborhoods in which projects are located. In fact, current occupancy rates approach 100 percent, and there are long waiting lists of applicants.

The median age of residents is 75 years, but the range of ages spans 35 years, or more than a full generation. The youngest resi-

dents are not yet 60, the oldest over 90. Women and widows predominate; 83 percent of residents are women, and of these two-thirds are widows. Most residents have had eight or fewer years of schooling; only a handful report education or training beyond high school. Although all residents meet poverty criteria, some are virtually destitute, while others appear to have reasonably adequate material resources. There is a large minority of black residents and, among whites, representation from many ethnic backgrounds. Length of residence in the projects varies from under one year to over eight years; the majority have been residents for about three to four years. Although nearly all residents had been able to function with minimal or no impediment when first admitted, about one-third (139 out of 414) had some degree of significant physical incapacity at the time of the interview, including 15 percent (61) who were severely hampered in physical function.

HELP AND CARE AT HOME

As part of the standardized interview, residents were asked whether, because of illness or indisposition, they had been helped or given care at home during the two weeks preceding the interview. If help had been received, residents were queried further as to who had helped, how often, and of what the help had consisted. In addition, respondents were asked whether they had given help to others during the same period; if they had done so, details were elicited as to whom they had helped, how frequently, and in what way(s).

Types of help received from all sources by ill or impaired elderly fall into four categories. In descending order of frequency, they are: *domestic chores*—preparing food for the ill person, cleaning or "neatening up" the latter's apartment (44 percent); *socioemotional support*- visits to talk with, read to, "cheer up," or "check up on" the incapacitated resident (24 percent); *personal care*- bedside nursing, administering medication, assisting with exercises, and the like (20 percent); *errands*—mainly to market or pharmacy (12 percent).

Sources of help, shown in Tables 12.1A and 12.1B, include two broad categories—*personal* networks of the ill person and *impersonal* (community agency and professional) sources. Personal network sources include neighbors/friends, and relatives, the latter comprising younger kin (mainly children and grandchildren) as well as same-generation kin (siblings); another personal-network source, only for residents married and living with spouse, is the

wife or husband. Community and professional sources are primarily nurses and homemakers as well as, on occasion, social service workers and physicians.

TABLE 12.1. Sources and Frequency of home help over Two-Week Period as Reported by Recipients (A) and Givers (B) of Help

A. Help RECEIVED from:	No. of Respondents Who Received Help from Each Source		Total Number of Help-episodes Received	
Personal-network Sources		48		262
Neighbors/friends	16		85	
Spouse	9		98	
Siblings	8		44	
Offspring & other younger kin	15		35	
Community Agency/Professional Services		19		60
Nurse	5		32	
Homemaker	9		23	
Social service worker	3		3	
Physician	2		2	
Source not ascertained	2	2	4	4
Totals	69*		326	

B. Help GIVEN to:	No. of respondents Who Gave Help to Each Recipient		Total Number of Help-episodes Given	
Recipient Within Housing Project		58		390
Neighbors/friends	44		254	
Spouse	14		136	
Recipient Elsewhere in Community		16		91
Siblings	7		48	
Offspring & other younger kin	5		35	
Friends	4		8	
Recipient not ascertained	2	2	3	3
Totals	76**		484	

*The 69 reported sources were named by 50 respondents.

**The 76 recipients were named by 64 respondents.

Note that Table 12.1A deals with the home help that both originates within and comes from outside the projects, as reported by *recipients* of help, while Table 12.1B shows the help that circulates within the projects as well as some aid that flows outward, as reported by *givers* of help, both over a two-week period. Table 12.1A reveals that personal-network sources are not only cited more often than agency or professional sources but provide over four times as many helping-episodes. Among relatives, younger kin are named more frequently than same-generation kin, i.e., siblings, but the latter provide help on more occasions. For married residents living with spouses, the latter is the primary and an extremely frequent source of aid.

Table 12.1B indicates that while most residents who help incapacitated others do so within the confines of the housing projects, nearly one-fifth of all helping episodes (91 of 484) are directed toward persons who live elsewhere in the community—siblings, offspring and their families, and friends.

The remainder of this chapter focuses on the most frequent and important type of aid revealed by our research– that which circulates among and between elderly residents of public housing. Only limited data are presented on assistance from agency and professional sources and from (and to) relatives and friends elsewhere in the community.

Comparison of Tables 12.1A and 12.1B reveals certain discrepancies. The major one is that neighbors/friends report *giving* help to neighbors/friends three times more frequently than the latter report *receiving* it from the former (254 episodes as against 85). A parallel but less marked discrepancy occurs among spouses—somewhat more help-episodes are reported to be given than received (136 as against 98). Close scrutiny of the data, plus follow-up interviews, reconcile the differentials. Among neighbors/friends, the discrepancy turns on differing definitions by givers and receivers of certain kinds of "help". Essentially, the chief area of disagreement is that of socioemotional support. It appears that a resident paying a call on an ill neighbor to cheer up, check up on, or simply "visit with" the latter often regards the visit as "helping" the neighbor. It is equally evident that the person visited is likely to define such visits as "normal" neighborly friendliness, not the rendering of sickroom assistance. Among spouses, the discrepancy revolves around differing role expectations as between wives and husbands. Wives tend to "minimize" reports of help-episodes given to and received from husbands; in general, wives seem to view much of the help they provide to be part of the expected wifely role and that received from her spouse to be part of ordinary husbandly aid.

Husbands, on the other hand, are likely to "maximize" reports of assistance, especially that given the wife when the aid requires the husband to assume duties ordinarily performed by his spouse.

Measures of Estimated Annual Frequency of Help. To expedite analysis in all the following tables, two measures of estimated annual frequency of help are used. Each measure– one of help *received*, as reported by recipients of help, the other of help *given*, as reported by help-givers—is based on the frequency of assistance episodes during the two weeks preceding the interview. Each reported frequency is extrapolated to a yearly basis by multiplying by 26 (26 x 2 = 52 weeks) but is otherwise unweighted.

The assumption underlying the extrapolation is that the home-help experience of the sample for a two-week period is a rough but reasonable approximation of 1/26 of such events for the preceding year for the population from which the sample is drawn. The specific two-week period fell within the span from late April to about mid-May, a period of fairly mild temperatures without weather extremes in Milwaukee. Although the assumption is not error-proof, we believe that the procedure provides a workable estimate of a year's patterns of home help for the population under study. In any event, inasmuch as the extrapolation factor is a constant 26, the procedure does not impair or bias the comparisons of the various subgroups.

Receivers of Home Help. It is important to note that, except between spouses, little direct exchange of help-for-help occurs; rarely does the principles operate of "you help me when I'm unable to help myself, and in return I'll do the same for you". For the most part, those residents who receive help and those who give it tend to be different individuals; it is unusual for the same person to be both receiver and giver of help. We next look at each aggregate separately—first the receivers and then the givers—analyzing each according to sex and age, marital status, and health status.

Examination and comparison of Table 12.2A and 12.2B show striking differences by sex but only inconsistent differences by age. Thus women report receiving assistance far more frequently than do men and receive it from every personal-network source as well as from community agencies. Men, on the other hand, receive little help from any source. Excluding help from one's spouse,[3] the mean for women is to receive help an estimated 15 times per year, for men only once.

Turning to age, we had expected advancing age to be associated with higher frequencies of home help. However, this is clearly

TABLE 12.2 Sources and Estimated Annual Frequencies of Help Received at Home for Females (A) and Males (B) by Age of Recipient

A. Help RECEIVED from:	Age of FEMALE Recipients: Under 65 (28)	65-69 (55)	70-74 (87)	75-79 (95)	80 and older (64)	Mean, all Females (329*)
Neighbors/friends	14	11	2	7	2	6
Siblings	14	0	3	4	1	3
Offspring	5	1	4	1	4	2
Community agencies	4	1	6	5	3	4
Total	37	13	15	17	10	15

*Fifteen females, age not ascertained, removed from table.

B. Help RECEIVED from:	Age of MALE Recipients: Under 65 (9)	65-69 (9)	70-74 (15)	75-79 (19)	80 and older (14)	Mean, all Males (66*)
Neighbors/friends	0	0	0	1	0	‡
Siblings	0	0	0	0	1	‡
Offspring	0	0	0	1	2	‡
Community agencies	0	0	0	0	0	0
Total	0	0	0	2	3	1

*Four males, age not ascertained, removed from table.

‡Frequency less than once per year.

not the case with women, and is only mildly so with men. Among women, the relationship between age and help-episodes is almost inverse—the youngest age-group receives help most frequently, the oldest least frequently, and the intervening age-groups are intermediate in frequency, varying inconsistently around the mean. Among men, the association between advancing age and frequency of help is fairly weak, in that the rare help-episodes are reported only by the oldest age-categories.

We have not dealt above with help between spouses, reserving it for our examination of the effects of marital status in Table 12.3A and 12.3B. Four marital statuses are represented in our population—currently married (and living with spouse), widowed, separated/divorced, and never married—with widowed females so predominating that one might aptly describe each housing project as essentially a "community of widows." Every other marital status is a relatively small segment, with the never-married among both sexes the smallest.

TABLE 12.3. Sources and Estimated Annual Frequencies of Help Received at Home for Females(A) and Males(B) by Marital Status of Recipient

A. Help RECEIVED from:	Marital Status of FEMALE Recipients: Married (35)	Widowed (228)	Separated/ Divorced (48)	Never Married (27)	Mean, all Females (338*)
Neighbors/friends	8	5	10	14	6
Siblings	21	1	0	2	3
Offspring	1	3	4	0	2
Community agencies	3	3	11	1	4
Spouse	32	—	—	—	—
Total	65	12	25	17	15*

*Six females, marital status not ascertained, removed from table.

B. Help RECEIVED from:	Marital Status of MALE Recipients: Married (29)	Widowed (19)	Separated/ Divorced (13)	Never Married (8)	Mean, all Males (69†)
Neighbors/friends	0	1	0	0	‡
Siblings	0	0	0	0	0
Offspring	0	1	0	0	‡
Community agencies	0	0	0	0	0
Spouse	52	—	—	—	—
Total	52	2	0	0	1§

†One male, marital status not ascertained, removed from table.

‡"Total help received" excludes help from a spouse.

§Frequency is less than once per year.

Table 12.3A shows the sources and estimated annual frequencies of home help received by females, according to the recipient's marital status; Table 12.3B presents corresponding data for males. Looking first at females, it is seen that *married women* are the most frequent recipients of help. Although they report help from every source, the assistance is rendered most often by the husband. The second most important source of help, an unexpectedly frequent one, is own-generation relatives, i.e., siblings, with relatively

little help reported from offspring, i.e., adult children. *Separated/divorced women* also report fairly frequent help received, but the pattern is different: they rely mainly on community agencies (nurses and homemakers) and almost as much on neighbors, supplemented by occasional help from offspring. For *never-married women*, neighbors are the single most important source of help. Finally, among the most numerous group, *widows*, help is reported from every source at relatively modest frequencies, more often from neighbors than from any others.

As to marital-status categories among men, *married males* report help received from only one source—their wives—from whom they receive assistance at a high rate. *Widowed men* report occasional help from siblings, neighbors, and offspring. However, men who are *separated/divorced* and *never-married* report no help received from any source whatever. It should be noted that whereas women in each marital status report assistance from community agencies, no men report help from this source.

How do patterns of home help vary according to the health of the receiver? Our measure of health is based on resondents' self-reports to the question: "Would you say your health in general is... excellent? Good? Fair? Or poor?" Our expectation, hardly a startling one, is that receivers of help are likely to be residents in poorer, i.e., in poor or fair, health. As Table 12.4 shows, this expectation is strongly borne out. That is, residents in "poor"health receive help more frequently, and from each source, than do residents in all other self-assessed health levels combined. In fact, except for infrequent assistance to persons in "good" health, *all* help flows *only* to those in "poor" and "fair" health.

TABLE 12.4. Sources and Estimated Annual Frequencies of Help Received at Home by Self-Assessed Health of Recipient

	Recipient's Self-assessed Health				
Help RECEIVED from:	Poor (94)	Fair (143)	Good (124)	Excellent (50)	Mean, Total (411*)
Neighbors/friends	10	7	3	0	5
Siblings	6	4	0	0	3
Offspring	5	1	2	0	2
Community agencies	12	2	0	0	3
Total	33	14	5	0	13

*Three cases, not ascertained as to self-assessed health status, removed from table.

To summarize findings to this point concerning the receivers of home help, recipients are more likely to be women than men and to be in poorer rather than better health. Women tend to receive assistance from all sources, from persons in their personal networks as well as from community agencies; the only men who receive significant amounts of home help are those who are married and living with spouse, and their wives are their only source of aid. Advancing age is not associated with the receipt of help among women and only mildly so with men.

Residents Who Give Help. Turning to the *givers* of help among residents of public housing for the elderly, Table 12.5A (women) and 12.5B (men) deal with estimated annual frequencies of help provided others, according to the age-bracket of the giver; help between spouses is excluded. Table 12.5A shows that just as women report receiving help from all sources, they also report *giving* aid to all categories of recipients—to neighbors and friends as well as to siblings and offspring. Their most frequent recipients are neigh-

TABLE 12.5. Estimated Annual Frequencies of Help Given to Others by Females(A) and Males(B) by Age of Giver

A.

	Age of FEMALE Givers					
Help GIVEN to:	Under 65 (28)	65-69 (55)	70-74 (87)	75-79 (95)	80 and older (64)	Mean, all Females (329*)
Neighbors/friends	3	31	15	16	6	15
Siblings	13	1	5	4	0	4
Offspring	0	3	3	1	6	3
Total	16	35	23	21	12	22

*Fifteen females, age not ascertained, removed from table.

B.

	Age of MALE Givers					
Help GIVEN to:	Under 65 (9)	65-69 (9)	70-74 (15)	75-79 (19)	80 and older (14)	Mean, all Males (66†)
Neighbors/friends	35	6	64	22	0	27
Siblings	0	0	0	0	0	0
Offspring	0	0	0	0	0	0
Total	35	6	64	22	0	27

†Four males, age not ascertained, removed from table.

bors and friends within the housing project; they provide help but much less frequently outside the project—to siblings, children and grandchildren.

Comparison of the tables shows that patterns of giving help differ sharply by sex. Men give help only to neighbors/friends but do so even more frequently than do women. As regards age, among women, if we exclude those under 65, the rate of helping others declines with advancing age; among men, however, there is no consistent association with age.

Data on the marital status of help-givers are presented separately by sex in Table 12.6. Among women, married females provide frequent assistance to their spouses and infrequent help to offspring, but almost none to neighbors. At the other extreme, never-married women give help fairly frequently but do so *only* to neighbors. The separated/divorced are also fairly frequent providers of assistance, but divide their helping efforts about evenly between neighbors within the project and relatives elsewhere in the community. The majority group, widows, help neighbors fairly often and assist siblings and offspring also, but less frequently.

TABLE 12.6. Estimated Annual Frequencies of Help Given to Others by Females (A) and Males (B) by Marital Status of Giver

A.

Help GIVEN to:	Marital Status of FEMALE Givers				
	Married (35)	Widowed (228)	Separated/ Divorced (48)	Never Married (27)	Mean, all Females (338*)
Neighbors/friends	1	16	12	31	15
Siblings	0	5	1	0	4
Offspring	5	2	8	0	3
Spouse	43	—	—	—	—
Total help GIVEN	49	23	21	31	22‡

*Six females, marital status not ascertained, removed from table.

B.

Help GIVEN to:	Marital Status of MALE Givers				
	Married (29)	Widowed (19)	Separated/ Divorced (13)	Never Married (8)	Mean, all Males (69†)
Neighbors/friends	0	13	54	101	26
Siblings	0	0	0	0	0
Offspring	0	0	0	0	0
Spouse	61	—	—	—	—
Total help GIVEN	61	13	54	101	26‡

†One male, marital status not ascertained, removed from table.

‡"Total help given" excludes help given to spouse.

Patterns of giving help among men of different marital statuses can be described quite simply. Married males provide help *only* to their wives and do so at a high rate. Males in all other marital statuses, especially the never-married and divorced/separated, provide help *only* to neighbors/friends and do so also at a relatively high rate.

As indicated in Table 12.7, the primary donors of help, especially to neighbors, are residents in "good" and "excellent" health. However, to an extent, residents in "poor" and "fair" health also give some help to neighbors as well as to siblings and offspring.

TABLE 12.7. Estimated Annual Frequencies of Help Given to Others by Self-Assessed Health of Giver

Help GIVEN to:	Giver's Self-assessed Health				
	Poor (94)	Fair (143)	Good (124)	Excellent (50)	Mean, Total (411*)
Neighbors/friends	10	5	24	42	16
Siblings	4	6	0	0	3
Offspring	2	1	4	2	2
Total	16	12	28	44	21

*Three cases, not ascertained as to self-assessed health, removed from table.

Some kinds of help to others—running outside errands or providing assistance that involves physical exertion or stamina—require reasonably good health and functional mobility. Such aid is usually provided by the ill resident's relatives or by neighbors in good health. However, many small chores and forms of socioemotional support can be and are rendered an ill or incapacitated resident by a neighbor whose health is only somewhat less impaired. In short, one can help another person without leaving the premises, braving inclement weather, climbing stairs (projects have elevators) or, as noted, being in robust health. Thus, one woman with a heart ailment seldom leaves the building but collects mail and performs other services for several neighbors who are confined to their apartments. Another woman who walks with a cane rides the elevator regularly with a man more disabled than she (he requires two

steel crutches) to make sure that he gets from and back to his apartment safely.

To summarize our findings concerning the givers of help, men exceed women in the number of help-episodes reported. However, married men help only their wives, and men living alone assist only other residents. Women help less often but distribute their help more broadly. While married women direct most of their assistance to their husbands, widows and the separated/divorced assist younger and own-generation relatives as well as neighbors. While residents in better health provide help to others much more frequently than do those in poorer health, the latter are also occasional sources of assistance to neighbors and relatives.

RECEIVING AND GIVING HELP: CONTEXTS AND RELATIONSHIPS OF HELPING PATTERNS

Having examined certain characteristics of receivers and givers of home-help during illness, let us turn to the contexts and relationships of helping patterns. The foregoing data, drawn largely from standardized interviews, show substantial differences betwen the sexes in the frequency, sources, and recipients of help. Data based on observation and other ethnographic procedures suggest that the quality and contexts of helping relationships also differ for men and women. Let us begin with women.

As noted by Anderson (1976), public housing projects for the elderly are essentially a female world, both numerically and in terms of their dominant social character. For any given resident, the probabilities are that five of every six neighbors are women. Furthermore, when groups of residents are observed chatting in the lobby, using laundry facilities, participating in the weekly card parties and bingo games, or interacting in many other situations, they are almost always or largely groups of *women*. Moreover, most of the women come from blue-collar backgrounds, in which their customary patterns of interaction were with other women.

Although there are several types of helping relationships among women, they have in common some degree of particularistic and diffuse interpersonal and emotional involvement. One pattern involves fairly active and healthy women shouldering responsibility to help one or more ill or incapacitated residents on a fairly regular basis. The specific help provided varies with given needs and circumstances but may include shopping or other errands, brief "check-up" calls, extended visits, or companionship. These

are similar to relationships described by Johnson (1971) and Hochschild (1973) in other settings with dense concentrations of the elderly.

Characteristically, relationships to aid others are chosen and initiated by the helping individual and are usually with those residents with whom the helping person already has or subsequently develops some degree of emotional attachment. The helping person is often quite motherly and protective toward those she helps; one woman calls them, some of whom are older than herself, her "chicks". Because of the impaired health or mobility of those who receive help, the relationship is virtually never a directly reciprocal, or help-for-help, exchange. Nor is it solely a one-way relationship; in exchange for assistance, the helped person returns gratitude, positive affect, or such items as homemade baked goods or small gifts.

Although some women accept payment for services to an ill neighbor, this is not the norm and occurs only when there are extenuating circumstances, such as when it is known that the helper needs the additional pin money and the helped person can afford it. The norm, however, is to provide help without the expectation of monetary recompense. One 80-year-old widow makes it her business to pick up medicine or other items for several neighbors when she goes shopping. The day before her shopping trip, she visits them to find out what they might need. On one occasion, she made such a visit to a disabled neighbor who was being interviewed by the senior author. She stayed to chat and gossip for an hour; as she left, her neighbor somewhat surreptitiously pushed a list and a dollar bill into her hand. This incident serves to highlight the normative expectation in helping patterns among women. That is, emphasis is placed on the socioemotional transaction; even should payment occur, the monetary aspect is somehow made secondary.

Some women who regularly visit and help less healthy neighbors view these activities as a kind of "calling" or avocation, as their way of fulfilling a need to perform useful and needed services. One woman said that she helped others "because you never know when you might be in the same position". Another woman said that following her husband's death several years ago, she resolved to busy herself in regularly visiting and helping two or three ill residents.

As noted above, housing projects for the elderly are largely a female world; for most women residents, the project and their own apartments are, in Goffman's terms (1959) "center stage," to which important aspects of their lives are oriented, and where they conduct their significant "performances." By contrast, for many

men, the project and apartment are "backstage," places mainly for storing one's props and for repairing to between performances. Thus, in general, the "neighboring" types of transactions that exist in the housing projects—visiting back and forth, exchanging goods or services, engaging in gossip, developing cohesive social networks—occur largely among women; men tend on the whole to be excluded, or exclude themselves, from them. To be sure, there are some men who are deeply involved in the interpersonal world of the housing project, and some women who participate minimally in it, but these tend to be exceptions.

While helping patterns among women depend on and reinforce personal and socioemotional relationships, corresponding patterns among men tend, by contrast, to emphasize impersonal and businesslike, including monetary, aspects. As noted in Tables 12.5B and 12.6B, men who live alone, especially the divorced/separated and never-married, are important sources of help to ill residents. For many of these men, helping activities tend to be assimilated to a "handy-man" role, in which more or less specific assistance is rendered to persons, largely women, who either temporarily or permanently cannot perform the tasks themselves. While such aid is often provided without payment being offered or expected, the help is given at least as often in the context of a relatively impersonal or "businesslike" transaction, in which a nominal fee is expected, offered, and accepted.

Among the men who own cars, there are several who have a more or less regular clientele, mainly women, for whom they provide a range of services, many of which require a need for transportation—driving residents to doctors' offices, on shopping trips, to church, and the like. A few men have fairly large numbers of clients or, as some men call them, "customers." The customers must arrange for the transportation in advance to ensure that the driver will be available. If the customer is physically impaired, the driver is expected to help her out of the building and into the car, deliver her to her destination, provide additional assistance if needed, wait until her business is finished, and then transport her home. Fees vary but usually range between 50 cents and a dollar.

The essential contrast between men and women helpers is perhaps best illuminated by the differing connotations of "chicks" and "customers." Each, of course, implies a kind of contract. The woman who tends her chicks is a "mother hen" who shares a socioemotional bond with them, provides a set of competencies and care to individuals who are vulnerable and need care, and receives evidences of socioemotional feedback in return for her help. On the other hand, the man who serves customers provides some

range of services to persons who request them, usually on a relatively impersonal basis, in return for compensation which may range from a simple "thank you" to nominal payment.

Between spouses, the frequency of help is extremely high. Although there are married pairs among whom both partners are active and healthy, the fact that an ill or incapacitated resident lives with a spouse frequently permits the former to avoid or defer institutionalization well beyond the point that would be possible were he or she living alone. One typical case is that of a man whose wife is severely crippled with arthritis and who has taken over the entire domestic management of the household in addition to providing personal care for his wife. Another involves a woman whose husband is bedridden with cancer; without her care, according to neighbors, he would have been hospitalized long ago.

FRIENDS, NEIGHBORS, AND CORESIDENTS

Most residents recognize three categories of persons among other residents—friends, neighbors, and co-residents. The terms for the first two categories are often those employed by residents; for the third, there appears to be no agreed-on term. "Friends" are persons, usually few in number and of one's own sex, with whom one enjoys relatively high degrees of social reciprocity, interpersonal intimacy, and diffuse personal involvement. "Neighbors" refers to a larger number of persons, usually of both sexes, with whom various reciprocities occur in relationships marked by variable but limited reciprocity, intimacy and personal involvement.[4] "Coresidents," essentially all other residents of the project, are persons with whom there are degrees of social distance rather than intimacy, a general lack of personal involvement, and with whom reciprocity may involve little more than "passing the time of day." With respect to specific ego-alter relationships, the lines between friend and neighbor, and between neighbor and coresident, are often blurred and in states of flux. They are also occasionally subject to discrepant perceptions—as when A sees B as a neighbor, but B views A as a friend; or when C casts D as a coresident, but D perceives C in a neighbor role.

The foregoing categorizations have significant implications for helping patterns. Relations between friends sometimes involve frequent, regular, and indispensable assistance. In one case of close friends, for example, a woman with severe arthritis is helped into and out of bed twice daily, every day, by a woman who has been doing this for several years. Another case involves an 80-year-old

woman who for about two years has been preparing dinner for and eating with a much younger woman who suffered a stroke; the younger friend reciprocates in several ways, including paying a greater share of the grocery bill.

Although help circulates within the projects between persons who relate to each other not as friends but as neighbors or even coresidents, such aid is governed by norms whose existence and strength become apparent when the norms are violated. Residents physically able to do so expect and are expected to help indisposed or incapacitated neighbors or coresidents on occasion, i.e., in a one-time crisis or on an irregular or infrequent basis. However, complaints are heard about neighbors or coresidents (i.e., persons with whom there is no prior intimacy or personal involvement) demanding too much help, or expecting it too frequently, or wanting one to provide what was initially a one-shot or infrequent service on a continuing basis.

To some extent, helping patterns within the projects can be sorted out in terms of Sahlins' distinctions between generalized, balanced, and negative reciprocities (1965:147-149):

> It is notable of the main run of generalized reciprocities that the material flow is sustained by prevailing social relations; whereas for the main run of balanced exchange, social relations hinge on the material flow... "Negative reciprocity" is the attempt to get something for nothing...[and]...is the most impersonal sort of exchange.

Thus generalized reciprocity often marks helping patterns involving two women who relate as friends, in which the help transactions are embedded in and serve as extensions of emotionally-toned interpersonal relationships. Balanced reciprocity frequently describes situations in which men are helpers—relatively impersonal and businesslike transactions in which some definite recompense is expected, offered, and accepted. Negative reciprocity, or something like it, seems to prevail in situations in which coresidents expect more than potential givers are prepared to offer.

Although this paper focuses on informal patterns and networks of aid among elderly residents of public housing, it should be noted that organized and institutionalized health and social services also occur. Services are provided by the Visiting Nurse Association, several schools of nursing, the health department, Project Involve (a local agency that serves the elderly), various social service agencies, and others. The Housing Authority staff also promotes various procedures for monitoring the health and safety of residents.

Friends outside the housing projects are occasionally helped by project residents. In addition, as we have noted, relatives living elsewhere in the community—both younger and same-generation kin—provide help to residents and, on occasion, are helped by them. Although many residents have adult children in the Milwaukee area and usually engage in many exchanges with them, most residents prefer to accept help from children only if the help can be rendered in the older person's apartment. One resident expressed the prevailing sentiment: "My children would do anything for me if I asked them, but I wouldn't want to live with any of them. If they had to take care of me, I would hate it as much as they would. It wouldn't work."

DISCUSSION AND IMPLICATIONS

In a setting sometimes stereotyped by outsiders as a dumping ground for poor elderly, we have found a viable community of peers involved in active exchanges between the relatively healthy and the ill. In this niche of public housing, problems of long-term dependency due to chronic incapacity are at least partially resolved by several kinds of reciprocities—*generalized* among women, often *balanced* when the helpers are men. In terms of cost-benefit considerations, we apparently have a situation in which for everyone concerned benefits appear to outweigh costs. Everyone seems to gain—relatives of elderly residents, agencies and programs supported by public funds, and the residents themselves.

The fact that peers assume some, often considerable, responsibility for the long-term support of disabled friends means that pressures on relatives are somewhat relieved, and the quality of the relationships between incapacitated parents and children and younger relatives may thereby be improved. Also, care by peers reduces, or at least defers, needs for institutionalization, which lightens otherwise costly demands on public funds. By no means least important, the givers/receivers of help are also the gainers. The givers have opportunities to play useful and needed roles, in return for rewards ranging from socioemotional gratification and heightened self-esteem to material compensation. At the same time, the receivers of aid are able to avoid or defer institutionalization (or living with relatives), retain a degree of independence by continuing to live in their own apartments, and maintain self-esteem by participating in varied reciprocities instead of being objects of one-way dependence.

As noted, this research has focused on but one of the niches in our society occupied by the elderly. There are other niches, each

marked by somewhat different physical and social features, with populations of varying characteristics. There is a need to study and compare patterns of handling disability and dependence in the various niches. Rosow (1967) has made a beginning along these lines, studying apartment buildings with various concentrations of older people. Also, there are inner-city slum hotels and rooming houses, with a predominance of elderly single males (Stephens 1976), middle-class retirement communities peopled largely by retired married pairs (Jacobs 1974), working-class retirement communities (Hochschild 1973; Ross 1977), and others, including those niches in which the majority of elderly are found—individuals or pairs of spouses living in rented or owned quarters throughout the community as well as the numerous elderly, also dispersed, who live with younger relatives.

NOTES

1. The overall study from which present data are drawn was conducted pursuant to a contract between the U. S. Department of Housing and Urban Development and the National League of Cities, with the cooperation of the Milwaukee Urban Observatory. The authors are solely responsible for the accuracy of statements or interpretations in this paper.

2. However, as Clark points out, close kinship is not always or necessarily sufficient to legitimize an individual's "right" that his or her dependency claims be honored indefinitely (1972:270).

3. One source of help available only to currently married persons—the spouse—is not included in Tables 12.2A and 12.2B, but is presented in Tables 12.3A and 12.3B.

4. The present distinction between friend and neighbor is similar to that made by Keller (1968:25).