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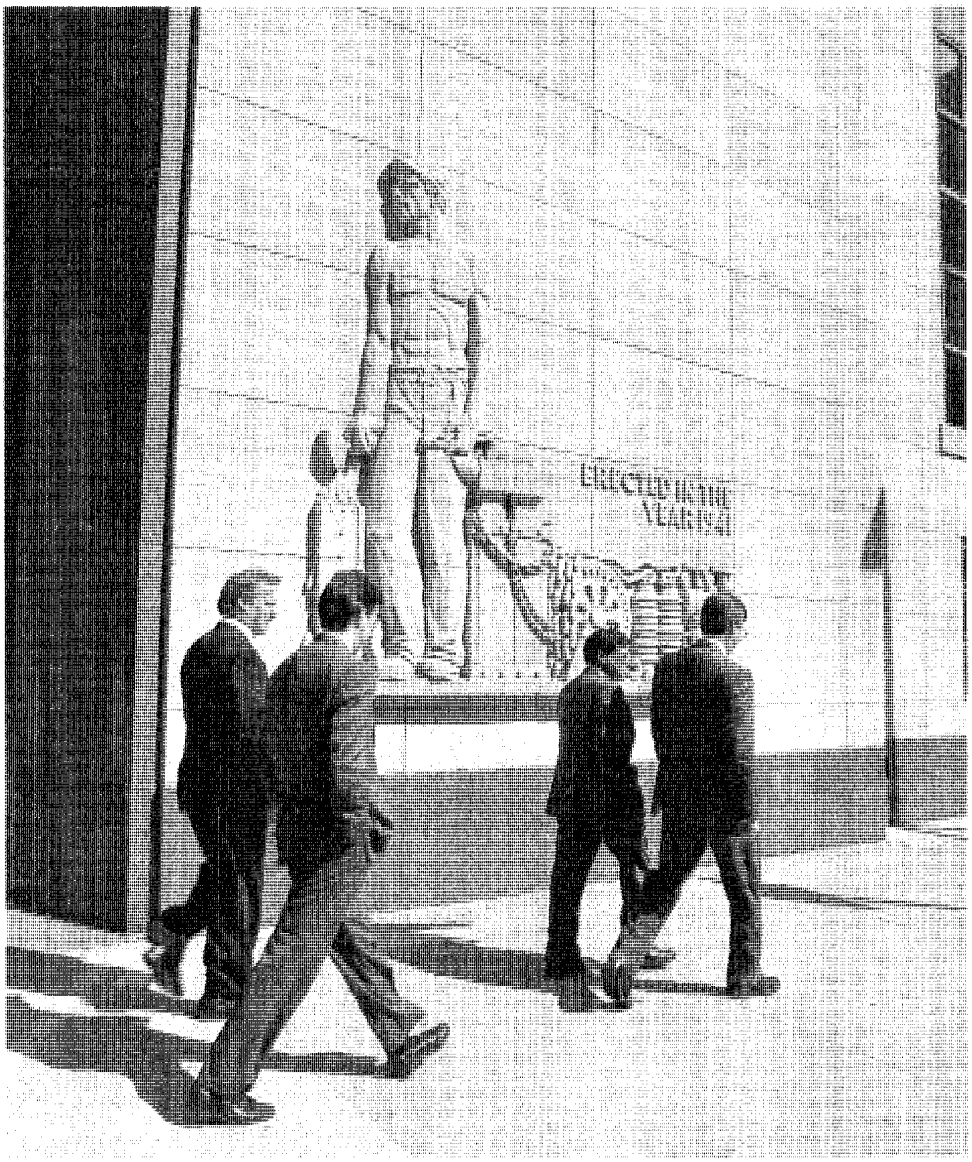
# Income and Poverty in Minnesota

*by William J. Craig and John Tichy*



This report is based on the 1990 Census. It looks at income and poverty across the state of Minnesota in 1990, as well as changes over the preceding decade. We find that Minnesota households are doing quite well, better than the national average and better than we were in 1980. But there are problem areas where we need to focus our concern. One major problem is that, while most households are better off, there has been a large growth in the number and proportion of very poor households. Another concern is that men and women are working harder than ever to gain this growth in income, and this is taxing families as well as those individuals. Three demographic groups are doing much worse than average: single-parent families, where there is only one worker; all minority groups, but especially Blacks and Indians; and young adults, trying to get started. Geographic areas of concern include outstate Minnesota and the inner cores of Minneapolis and St. Paul.

We think this is the most complete analysis yet undertaken of income and poverty in Minnesota. We have looked at all of the standard measures. And we explored many of the factors behind these findings and the implication of changes underway in our state. Behind much of the work was a

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desire to examine myths about income and poverty. For example, we explored the myth of the decline of the middle class. We hope our findings will provide the reader with a clearer sense of where real problems and opportunities exist. Our goal is more intelligent discussion of these topics among public officials, within the private sector, and in the population at large.

## Income

The state median household income in 1989 was $30,909, 17th highest in the country.* This means that half the households earned more than $30,909 and half earned less. Minnesota's median household income increased by 2 percent in real terms from 1979. The national median household income, however, grew by 5 percent in this same period so Minnesota fell three ranks, from 14th in 1979 to 17th in 1989. We did well, but became more "average" compared to the nation as a whole.

The aggregate income of all households in the state in 1989 was $62 billion, an increase of 21 percent over 1979 after accounting for inflation. About two-thirds of that increase was due to an increase in the number of households in the state and one-third due to increased household incomes.

There has been substantial debate over whether this country (and this state) is losing its middle class. Wages are declining, but median household income is going up. What's happening? Is it just a case of the rich getting richer and the poor getting poorer? Is the increasing median income masking redistribution that signals the decline of the middle class? Our analysis says "no," at least not yet.

The proportion of households in nearly every income class below $60,000 declined or remained constant between 1979 and 1989 (Figure 1). The portion of households in the highest class, on the other hand, increased sharply. This does not signify that the rich are getting richer. It means that lower income households are moving up the income ladder. It means that more households are better off. This pattern of improvement holds for Minnesota and for the United States. It holds whether measuring family income alone or all households. The only exception we could find was outstate Minnesota, a significant topic discussed later.

How can this be, when the feeling is so widespread that things got worse, not better for most Americans during the 1980s? A major reason is the increased participation of women in the labor force. Over the preceding two decades, the national proportion of women in the labor force has increased dramatically. Minnesota was in the vanguard of this trend: women's participation in the labor force grew from 43.5 percent in 1969 to 62.5 percent in 1989—a rate that was the highest in the country. Two-thirds of Minnesota families now have two or more wage earners and such families earn nearly half again as much as one-earner families.

There are other factors to explain this general improvement in household income. The large baby-boom generation is moving into its peak earning years as they become "forty somethings." The elderly, who comprise many of the single person households, had a 16 percent increase in median incomes, largely due to improved Social Security and their being the first beneficiaries of the vastly improved retirement programs that were developed after World War II. The young kept their household incomes relatively high by delaying family formation and by increased living with roommates. Other research has shown that men are working more hours in order to keep income levels up.

People are doing what they can to increase household incomes. Some of what they are doing, like the retirement programs benefiting the elderly, may continue to work in the long run. Other factors, like the baby boomers hitting their peak earning years, could last for another twenty years without intervention. But there is a real limit to the ability of men and women to work more. At some point in time this limit will combine with declining wages and the bubble will burst.

## Poverty

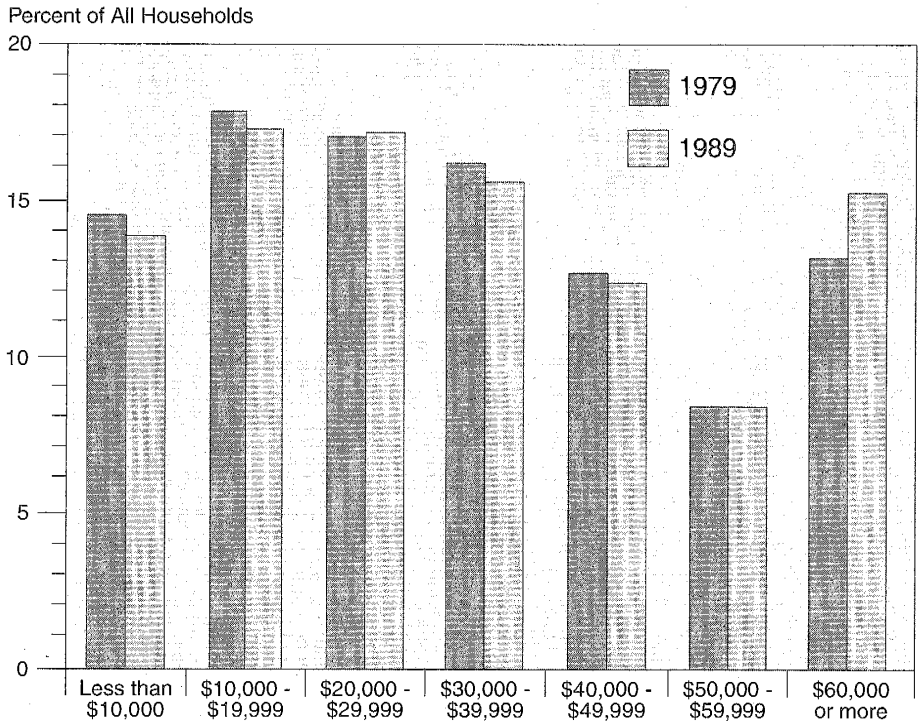
Poverty rates increased during the 1980s and here, too, Minnesota has slipped to become more like the national average. In 1989, the state poverty rate stood at 10.2 percent, up from 9.5 percent a decade earlier. During this period we slipped from having the sixth lowest poverty rate in the country to having the twelfth lowest rate. We still stood above the national average of 13.1 percent and ahead of any of our neighboring states.

All of the growth in poverty was among the poorest of the poor, those earning less than 75 percent of the poverty level. The proportion of people earning between 75 and 99 percent of the poverty level stayed constant over the decade. So while incomes are increasing, the poor are worse off. This is not good news.

Some of this paradox can be explained by admitting that there have probably been downward shifts within the lowest income groups shown in Figure 1. Another explanation arises from the different ways the Census Bureau determines household income and individual poverty.

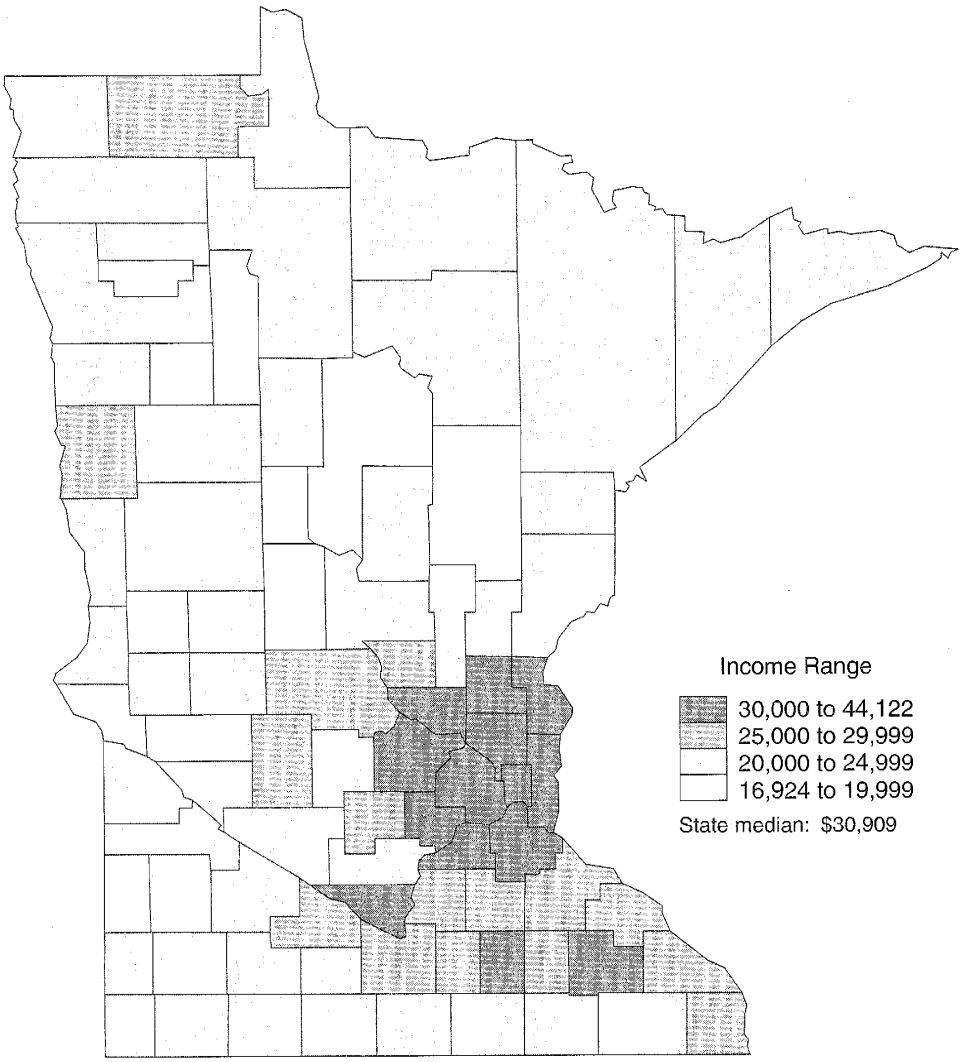
Household income is the sum of the incomes of all individuals in a home. The poverty level, however, is measured against *individual* income. If a single person earns $6,200 per year, that person is below the poverty level and stays there whether or not he or she takes on roommates. The household income goes up with additional workers, but that person's poverty status is unchanged. Interestingly, this approach is not used for families where everyone's poverty status is determined by the combined family income. If the single person got mar-

**Figure 1. Change in Distribution of Minnesota's Household Income**




* All numbers in this article are in 1989 dollars, i.e., earlier figures have been adjusted upward to account for inflation. Income is reported for 1989 (not 1990) because that was the last full year of income preceding the April 1, 1990 census. Household income is the total income of all people living in a household. For a family, this is the total cash income of every member of the family living at home—whether the income comes from work-related earnings, interest and dividends, Social Security, or some other source. Similarly, for a non-family household (this might be a single person living alone or a group of unrelated roommates) it is the sum of every person's income. Households may be families or non-families. About two-thirds of all households are families and about three-quarters of all non-family households contain only one person.

**Figure 2. Median Household Income, 1989**




ried to someone making the same income, their household income of $12,400 would put their family above the poverty level. Thus, the reduced formation of families during the 1980s explains part of the increase in the census-defined poverty rate.

Some people have argued that we are being overrun by poor people migrating to the state to benefit from our welfare programs, especially by people coming from industrial cities in the Midwest rust belt. We examined this theory by looking at the 1985 residence of poor people living in the central cities of Minneapolis and St. Paul in 1990.* We found that two-thirds of the poor had been residents of the Twin Cities five years earlier, while another 12 percent had migrated from the suburbs or other parts of Minnesota. In fact, only 6 percent came from the industrial midwest (Indiana, Illinois, Michigan, and Wisconsin). The median household income of these migrants was twice that of the resident poor. So we must reject the welfare magnet theory and admit that most of those migrants came looking for work and are doing better than average, even if they were still poor in 1989.

Poverty rates, like income levels, are age specific. The lowest rates of poverty are for those in the forty-five to fifty-four age group, which coincides with the peak earning years. Only 5.1 percent of these people are below the poverty level. Poverty levels for preschool children are nearly three times that high (14.8 percent). The rates generally drop from that point to the peak earning years, then rise to 17.2 percent for those age seventy-five and over. Rates for the early retirement years are relatively low (8.4 percent), well below those for any age of child. The sharply higher level for those over age seventy-five is due to the earlier death of the male spouse, resulting in decreased Social Security income for the widow; the leaner retirement programs of this age cohort; and the effect of living on a fixed income during a decade of high inflation.

The highest rate of poverty at 19.5 percent, nearly four times that of the lowest group, is for eighteen to twenty-four year-olds. This group includes those living in self-imposed poverty—being a student. But it also includes many young people starting out in life and not doing particularly well.

Poverty is also gender specific. Poverty rates are not much different in childhood. But in the working years, poverty rates are more than 2 percent higher for women. And this discrepancy increases in the retirement years. Then, female poverty rates are double those of men, because so many are becoming widows and losing income in the process.

### Statewide Differences

The Twin Cities are doing better than counties in outstate Minnesota on measures of both income and poverty (Table 1). The median household income in the Twin Cities is nearly half again as large as in outstate Minnesota. And the range is spreading as Twin Cities incomes rise while outstate incomes fall. Other studies have shown that the cost of living outstate is roughly equal to the cost in the Twin Cities, so this represents a real deficit in purchasing power. At the same time, not surprisingly, outstate poverty rates are considerably larger than those of the Twin Cities area. While outstate Minnesota has only 47 percent of the state's population, it contains 58 percent of those living below the poverty level.

The 1989 county-by-county income pattern shows that all of the Twin Cities' counties are in the highest income class (Figure 2). In fact, Washington County, on the Twin Cities eastern edge, has the highest median income in the state ($44,122), almost 50 percent higher than the figure for the state as a whole. The seven metropolitan counties are joined in this highest class by four adjacent counties (Wright, Sherburne, Isanti, and Chisago), and by Olmsted County (with the city of Rochester), Steele County (with Owatonna), and Nicollet County (next to Mankato).

Nearly all the counties in the next income class down are in the southeastern quad-

**Table 1. Income and Poverty in the Twin Cities Metropolitan Area and in Outstate Minnesota, 1989**

| | Twin Cities | Outstate |
|---|---|---|
| Median Household Income (MHI) | $36,785 | $25,248 |
| Change in MHI, 1979-1989 | 3.5% | -2.9% |
| Poverty rates | 8.2% | 12.5% |
| Change in poverty rates, 1979-1989 | +1.5 | +0.4 |

* Our thanks to Elvin Wyly, who actually prepared this analysis for us.

rant of the state, close to the state's population center and to national markets. The two exceptions are Clay County, on the western edge of the state, which is part of the Fargo-Moorhead metropolitan area, and Roseau County on the Canadian border. Roseau County contains several exceptional manufacturing companies, including Marvin Windows.

Our third category, though covering a range of only $5,000, contains nearly half of the counties in the state. And, at the lowest end of the spectrum, is a mix of counties having no urban center, a weak agricultural base, or containing Indian reservations. The lowest income is found in Mahnomen County, which is entirely within the White Earth Reservation. Here the median household income is only $16,924, just over half the median for the state and just over one-third of the income in Washington County.

Perhaps the really bad news is that income grew in most of the highest income areas during the decade and dropped in many of the low income counties. Median household income grew in Washington County and most of the metropolitan counties. The biggest percent increases were in the counties on the Canadian border which are sending workers to Marvin Windows and other successful manufacturing companies in the area. Lake of the Woods County's median income grew by 22 percent during the decade (to $24,383), the maximum increase statewide.

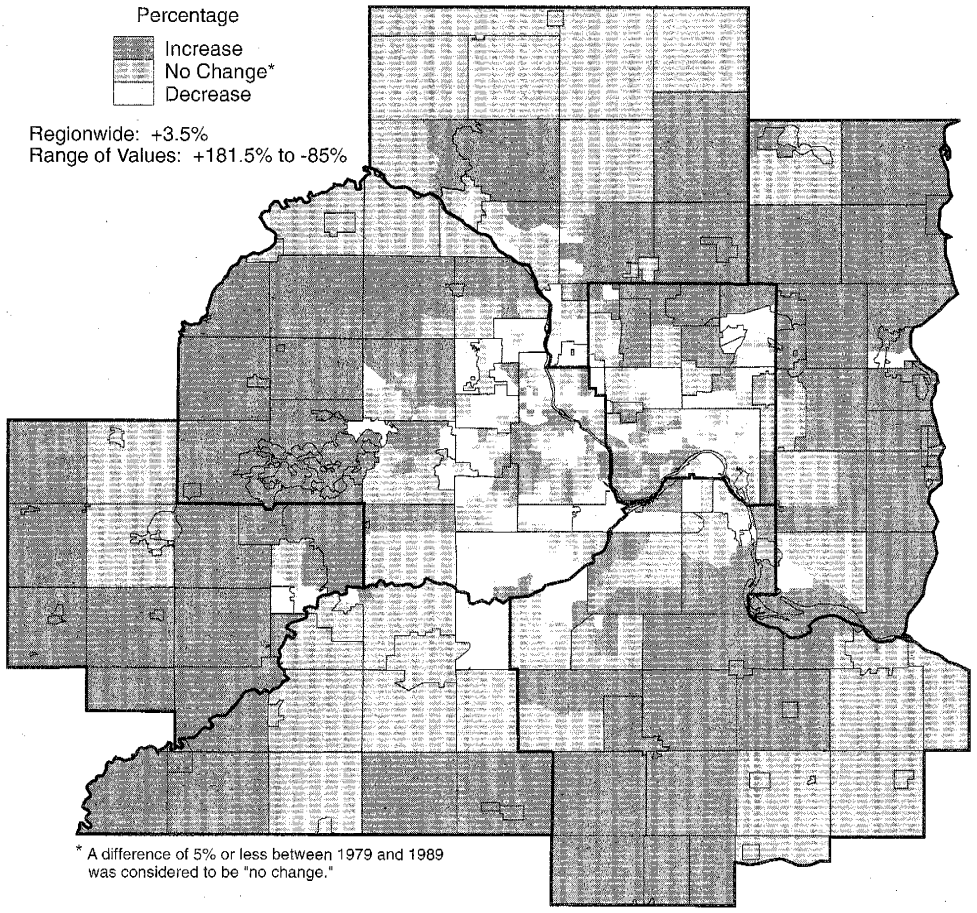
Income decreased in Mahnomen County and across all of the Arrowhead region, the northeastern quadrant of the state, where the economy is adjusting to changes in the taconite industry. Incomes also decreased in many agricultural counties, except those with very low incomes in 1979 where an increase during the 1980s still left them at quite low income levels.

Statewide poverty rates mirror this same pattern, with the lowest rates in the southeastern quadrant of the state and the highest rates in the counties containing Indian reservations. Twin Cities' poverty rates are lower than rates for outstate Minnesota at all levels, but they are increasing faster than rates in outstate Minnesota (Table 2). The single fastest growing segment of the state's poverty population was the very poor living in the Twin Cities. The number of very poor in the Twin Cities has grown by nearly 49,000 people in the last decade, an increase of almost 60 percent over the number of very poor ten years earlier.

### The Twin Cities Metropolitan Area

We offer no new insights on the distribution of income within the Twin Cities metropolitan area. The lowest income levels are found in the central cities of Minneapolis and St. Paul. The highest incomes are in the second and third tier suburbs—especially those to the east and west. In fact, one of the reasons that Washington County does so well on the statewide map is that it contains many high income areas and practically no low income areas.

**Figure 3. Change in Median Household Income in the Twin Cities Metropolitan Area, 1979-1989**




We studied the Twin Cities by looking at census tracts. These areas allow us to discriminate income and poverty below the city or even neighborhood level. There are 126 tracts in Minneapolis and 82 in St. Paul, for example. While the metropolitan area maps presented here use the tracts as the unit of analysis, we continue to show the more readily recognized municipal boundaries to assist in orienting the reader. The highest median household income was in the tract containing the affluent suburb of North Oaks. Its median of $113,354 was three times the metropolitan median. The lowest median household incomes were in the central cities. They were only $6,000 to $7,000, about one-sixth of the metropolitan median.

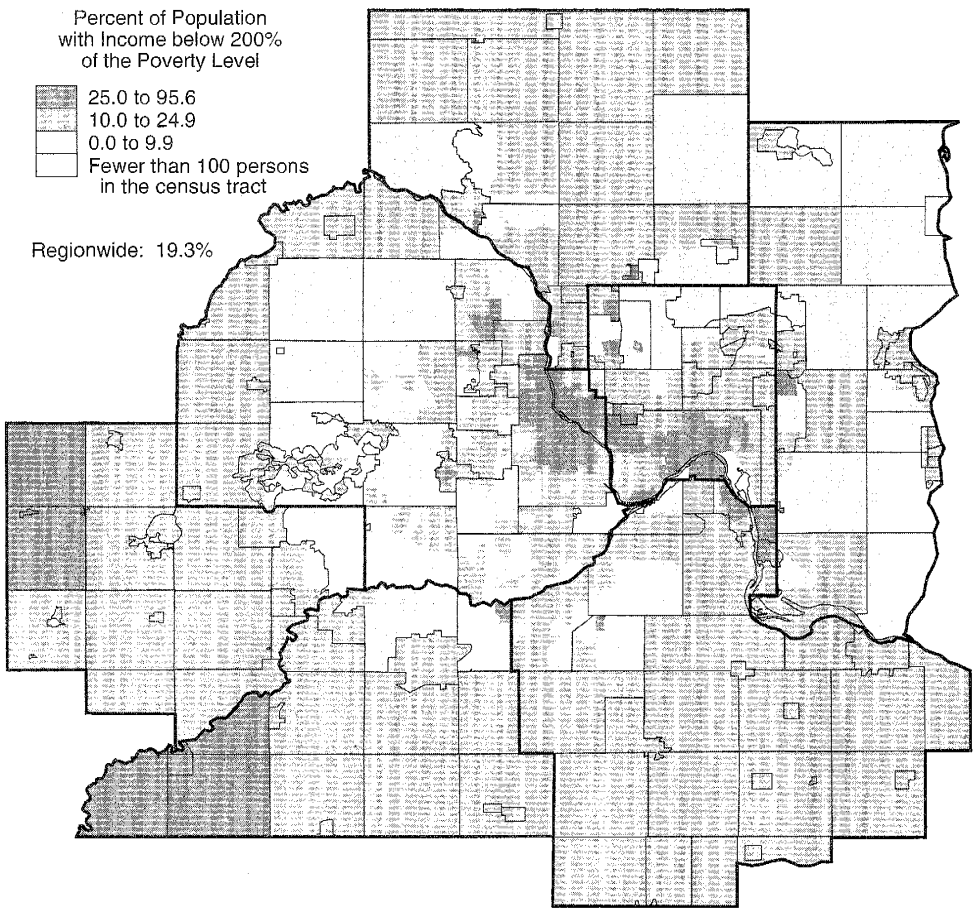
Tract level incomes increased during the 1980s in the second and third tier suburbs (Figure 3), but they increased in other areas as well. The distant townships on the edges of the metropolitan area have benefited from the arrival of exurban families. Most encouraging is the increase in many parts of the central cities. To be sure, some of these areas, like the lakes district of Minneapolis and Summit Avenue in St. Paul, were never in bad shape, but they have retained that strength and improved on it. More heartening is the improvement in some parts of the lower income areas of these central cities: in Minneapolis, in downtown and in scattered tracts north of downtown; and in St. Paul, in downtown, on West Seventh Street, and in the Midway area. Some of this improvement is on a very low base and the result is that they are still low income areas, but they are going in the right direction.

**Table 2. Percent of Persons at Various Levels of Poverty**

| | 1979 | 1989 | Change in Percent |
|---|---|---|---|
| Twin Cities Area | | | |
| very poor* | 4.2 | 5.9 | +1.7 |
| other poor | 2.5 | 2.3 | -0.1 |
| total poor | 6.7 | 8.2 | +1.5 |
| Outstate | | | |
| very poor* | 7.8 | 8.0 | +0.2 |
| other poor | 4.3 | 4.5 | +0.2 |
| total poor | 12.1 | 12.5 | +0.4 |
| Minnesota | | | |
| very poor* | 6.0 | 6.9 | +0.9 |
| other poor | 3.4 | 3.4 | 0.0 |
| total poor | 9.5 | 10.2 | +0.7 |

* Very poor are those with incomes below 75 percent of the poverty level.

**Figure 4. The Marginally Poor in the Twin Cities Metropolitan Area, 1989**




The worst off tracts in the core poverty areas saw the largest decreases in income. Some saw their median household income decrease by a third or more—on an already low base. The first ring suburbs also experienced a significant deterioration in income levels. Some of this deterioration is due to the aging of their populations, as they reduce incomes in their retirement years. For many of these areas, such as Edina and Bloomington, their incomes remain quite high. For other suburbs this decline is real and must be faced by city officials.

Few places are far from poverty in the metropolitan area. Every municipality in the seven-county area has some poor people. In fact we could find only one residential tract (out of nearly 600) that was without a single poor person. This tract is in Bloomington, overlooking the Minnesota River. Most of the Twin Cities' poor, however, are concentrated in the two central cities. The central cities have high rates of poverty and things are getting worse.

The growth of jobs in the last decade is, mostly, far removed from these areas. And it is these two factors—the location of poor people and the location of jobs—that are driving the discussion over affordable housing in the metropolitan area today. Sociologists argue that concentrated poverty isolates those living in it. Policy analysts point out that the geographic mismatch between job locations and residential locations of people who need jobs works to the disadvantage of both the employer and the potential employee. Both are arguing for more low income housing in the suburbs.

Figure 4 provides a spatial look at those near poverty. Here we raise the watermark and pay attention to the marginally poor, those whose incomes are up to double the poverty level, still only $25,000 for a family of four. Only the second and third ring suburbs appear to be relatively immune, having more than 90 percent of their people safely above the poverty line. By this measure, suburban well-being drops after passing the well-off areas, and falls at the fringes of the metropolitan area to match the higher poverty levels of outstate Minnesota. These are the same areas that are seeing rapid increases in income levels. The higher income levels of new exurban families mask the near-poverty of many rural residents, but this map brings our attention back to the fact of poverty on the edges of the metro area.

### Variations by Household Type

Single-parent and non-family households fare much worse than other types of households. Single-parent families make up only 8 percent of the state's households, but three times that percentage of the state's households living below the poverty level. Non-family households comprise one-third of the state's households, but over half of its poor households. The poverty rates for these households are 35.9 percent and 17.8 percent respectively. Compare those rates to 4.0 percent for married-couple families. Of course one of the big differences is that married-couple families can provide two workers.

This bad news about income disparity is made worse by the fact that single-parent families and non-family households are the fastest growing household types in Minnesota. Married-couple families grew more slowly in the Twin Cities, and actually declined in real numbers in outstate Minnesota.

Regardless of the type of households, poverty rates are much higher in outstate Minnesota than in the Twin Cities area (Table 3). This has disastrous impacts for children. In both the Twin Cities and outstate, children in single-parent families have a disproportionate chance of being poor. In the Twin Cites, practically the only way for a child to be poor is to live with one parent—70 percent of poor children live in such families.

In outstate Minnesota, child poverty is more evenly distributed. Nearly half (46 percent) of children living with one parent are poor. Married-couple poverty rates are a relatively modest 5.8 percent, but the proportion of two-parent households is so much higher outstate that the children in poor two-parent families comprise 46 percent of all the poor children outstate.

**Table 3. Poverty Rates for Different Household Types, 1989**

| | Twin Cities | Outstate |
|---|---|---|
| Married-couple family | 2.1% | 5.8% |
| Single-parent family | 32.8 | 40.4 |
| Other family | 4.1 | 6.3 |
| Non-family household | 12.1 | 25.2 |

### Differences Among the Races

The gap in income and poverty among the races is a cause for much anxiety and tension. The 1990 Census showed that the differences among races remain profound. Whites earn far more than any other group and have a much lower rate of poverty. We documented these differences and explored some of their causes.

We restrict our discussion about the differences to the Twin Cities area, since that is where most of the minority populations live. The seven-county metropolitan area contains 97 percent of the state's Black population, 53 percent of the Indians, 89

percent of the Asians, and 77 percent of the Hispanics.*

Income levels for all minority groups are much lower than for Whites (Table 4). For Blacks and Indians, the median household incomes are half of what they are for Whites. Hispanics and Asians do much better, but still are a quarter to a third less than Whites. We want to point out that these well-known discrepancies should give no support to the idea that all minorities are poor. Indeed, even among the poorest groups, 40 percent have middle class incomes or better ($25,000 or more a year). In fact, nearly one in every eight Black and Indian households has an income of over $50,000 annually. There are, however, a large portion of all minority populations below the poverty level. While White poverty rates are under 6 percent, minority rates are three to seven times higher.

Are things getting better or worse for minorities? This is a tough question to answer. The 1980 Census reported *family* income by race and ethnicity while the 1990 Census reported *household* income, so we cannot make a direct comparison. But we can study how each group did compared to Whites on these measures. The median family income for Blacks in 1980 was only 48 percent of what it was for Whites, while Blacks' 1990 median household income was 51 percent of Whites. Using the same approach, we found that Indians improved from 43 percent to 49 percent, Hispanics improved from 73 percent to 77 percent, and Asians fell from 70 percent to 62 percent.

Poverty measures can be compared directly across census years and by these measures every minority group lost ground, while Whites stayed constant. Perhaps these different pictures, gains in income but losses in poverty, reflect the same paradoxes found when we compared income and poverty for the whole population. Perhaps they reflect a schism in each of the minority populations, a growing spread between those who are doing well and those who are mired in poverty.

Why is there such a large discrepancy between White and non-White incomes? One factor may be that non-Whites are much younger than Whites and therefore have not reached their earning potential. Indeed, the median age of the White population is 32 years compared to only 22 years for the non-White population. Some argue that as minority populations age and incomes rise, their overall income will catch up with White incomes.

**Table 4. Income and Poverty Levels for the Twin Cities Area's Racial and Ethnic Groups, 1989**

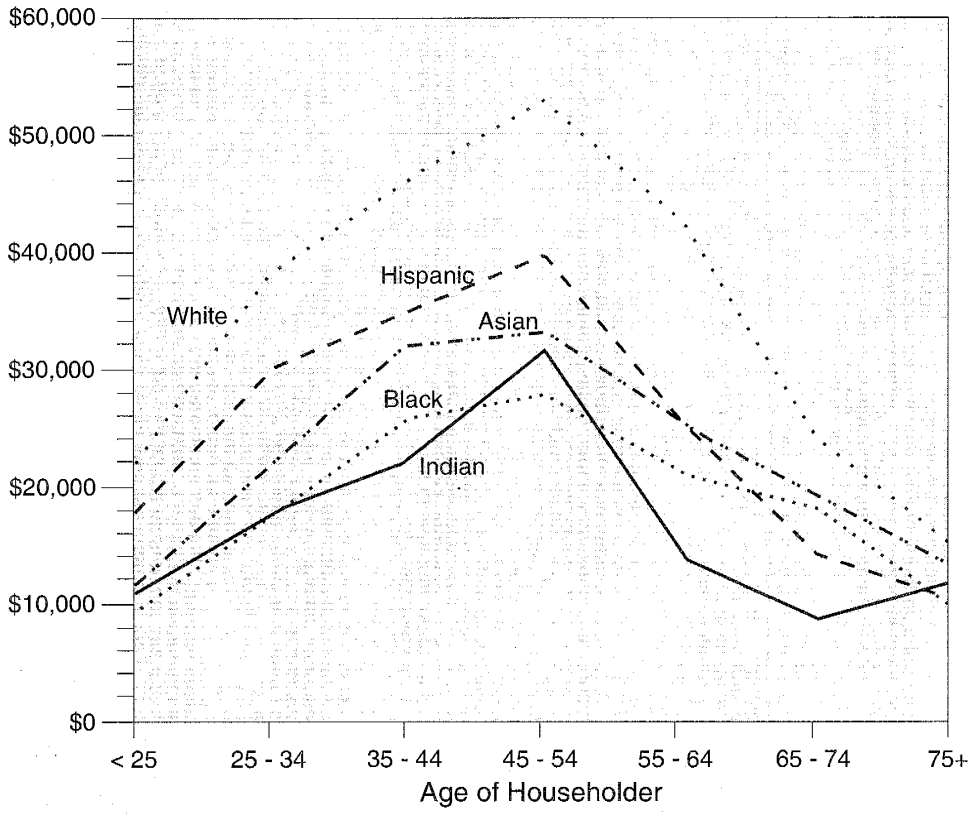
| | Median Household Income | Percent of Households with Incomes $25,000 or More | Poverty Rate |
|---|---|---|---|
| White | $38,000 | 70.3 | 5.8% |
| Black | 19,300 | 39.7 | 37.1 |
| Indian | 18,700 | 39.5 | 40.6 |
| Asian | 23,700 | 47.8 | 32.3 |
| TOTAL | 36,800 | 68.5 | 8.2 |
| Hispanic | 29,500 | 56.5 | 19.4 |

We addressed this hypothesis by looking at age-specific income (Figure 5). Incomes rise for all races and for Hispanics with increasing age, to a peak in the 45-54 age group. But at no age do minorities' incomes approach those of Whites, except for those age 75 or more. In fact, even in their peak years no minority group's median income surpasses the income level of any White age cohort except for White fledglings (still in college or just starting to work) and White retirees. The relative youth of the minority population may account for some of the difference in income, but the issue is deeper than this.

Another explanation for the relatively poor economic position of minorities is the disproportionate number of single-parent households. We have already shown that single-parent families are among the poorest of all households. For Black and Indian households, where single-parent families comprise about a third of all households, this could be a large part of the problem (Table 5). This is definitely not the answer for Asians, where the great majority of households are married couples, but where many are new migrants who have neither the skills nor the language to get good jobs. We performed a hypothetical analysis to see what the poverty of minority families would be if they had the same household composition mix as Whites. The analysis reduced Black, Indian, and Hispanic poverty rates for families by a substantial amount, but they remained two-and-a-half to four times as high as for White families. So household composition is only a partial answer as well.

Low minority incomes, then, can be partially explained by age difference and partially by household composition, but there are many other factors which we did not attempt to analyze. These include low graduation rates; many children, who strain household budgets; high unemployment rates; geographic isolation, which makes it difficult to get to jobs; the psychological frame that develops from living in multi-

**Figure 5. Median Household Income in the Twin Cities Metropolitan Area by Race/Ethnicity and Age of Householder, 1989**




* The census identifies race and ethnicity separately. One census question asked people to identify their racial background. The choices were White, Black, Indian, Asian, and *other*, but not Hispanic. A separate question on ethnicity asked people whether they had Hispanic ethnicity. Hispanics can be of any race (Tony Oliva, the Minnesota Twins Hall of Famer, is a Black Hispanic), but most choose White. So in the tables and figure that follow, the reader needs to remember that Hispanic rates present a different cut at the population and therefore we present them following the number for the total population. When we use the term *non-White* we mean all races except *White*. We use the term minority to refer to the non-White racial groups including Hispanics. We have used shorthand terms, like *Black*, to refer to each of the minority groups both because these terms most closely match the terms used in the census itself and because shorter phrases lend themselves better to presentation in tables and graphs.

**Table 5. Poverty Among Single-Parent Families of Different Races and Ethnicity, Twin Cities Area, 1989**

| | Single Parent as a Percent of all Families | Single Parent Poverty Rate |
|---|---|---|
| White | 6.1 | 24.6% |
| Black | 29.6 | 63.4 |
| Indian | 33.8 | 64.0 |
| Asian | 10.0 | 59.9 |
| TOTAL | 7.2 | 32.8 |
| Hispanic | 15.8 | 46.6 |

generational and concentrated poverty; and last, but not least, the debilitating effects of persistent racism.

### Conclusion

We had hoped to test some myths in this paper and we think our investigation proved a few of them wrong. We looked at the "disappearing" middle class and found it alive and well. If anything, the middle class is better off than it was in 1980. Low income households are moving up the income ladder, too. Some would argue that this improvement in income has come at a high price, with women and men spending more and more time in the workplace, and less with their families. We respond that people have looked at their options and have chosen work and higher incomes. No one is forcing them to work.

Many people think Minnesota is well above national norms for income and poverty. This is true, but becoming less so. In 1990, Minnesota ranked 17th best among the states in median household income and 12th lowest in terms of poverty. Both ranks had dropped significantly during the 1980s: three slots for income and six slots for poverty. We are being pulled back toward the national average.

Being a single parent is often seen as the sure path to poverty, but in fact, two-thirds of these families live above the poverty level. In outstate Minnesota, where income levels are lower and poverty rates higher, nearly half the poor children live in two-parent families. So there are multiple paths to poverty and being a single parent is no guarantee of poverty.

And then there are myths about minority income and poverty. To be sure income is lower and poverty rates are higher for these populations, but in every minority group at least 40 percent of the population is middle class or higher. And most groups seem to be catching up with White income levels, though slowly. Arguments that disproportionately youthful populations and higher percentages of single-parent families work against minority income levels are true, but fall far short of explaining all the disparity in income levels.

In most of this article we have ignored the policy implications of our findings. The increases in the number of very poor people, both in the Twin Cities and outstate, is the most disturbing finding of our study and the one that calls loudest for policy intervention. The rift between the haves and the have-nots appears to be widening and this can lead to an explosive situation. It is beyond the scope of this article to suggest answers, but if something is not done, the good life we are working so hard to attain will be threatened by social violence.

**Will Craig is CURA's assistant director. He has a Ph.D. in geography and a deep interest in the use of data for better policy making. John Tichy is a doctoral student in geography at the University of Minnesota. This article presents a sampling from their full report, *Income and Poverty*, the first in a series of reports on *What the 1990 Census Says About Minnesota* that is being published by CURA this year. Readers interested in more detail can order a copy of the full report free-of-charge by phoning 612/625-1551.**

# Accepting the Circle of Life:

## Lessons from the Anishinabe about Caring for Elders

*by Pauline Boss, Lori Kaplan, and Michele Gordon*

Families have different belief systems and when one of their elders becomes seriously ill their beliefs play a large part in determining how they view the situation of caregiving for that elder. Some families, high on mastery and self-determination, will see the disease as failure and a catastrophe; others will see an elder returning to childhood in old age as part of the natural course of life. How the situation is viewed, research has shown, has a substantial impact on how well the caregivers do and subsequently how well the elder does. If caregivers don't take care of themselves, there will be two patients instead of one.

In our Euro-American culture in the United States a high value is placed on individuality and independence, on being in charge of one's own destiny. We tend to designate one person in the family as caregiver, placing an enormous burden on that caregiver. When an elder is stricken with a dementia of the alzheimer's type, the elder will be seen as psychologically absent though physically present. This often creates feelings of helplessness and depression in the caregiver, who has been left virtually alone with the situation. Caregiver depression, research has shown, depends on the meaning attributed to the uncertainty surrounding the illness rather than on the degree of burden or the seriousness of the illness itself.

While these links have been found in studies of white, middle class families, another research question remains: Will caregivers who value harmony with nature more than independence and mastery of nature, be as highly stressed when caring for a family member with dementia? To explore this question, we conducted a preliminary study with Native American family caregivers in northern Minnesota. The Anishinabe (Ojibwe) are a people that explicitly value harmony with nature.

### The Research Design

Through Native American contacts at the University of Minnesota-Duluth, we were put in touch with a trained social worker and family therapist who is also a member of the Anishinabe tribe. The third author joined our project as a collaborator, interviewer, and coauthor. At our first meeting she brought a gift of tobacco which was later scattered around the trunk of a giant oak tree on the University campus. At first, it was as if we women were in separate worlds and shy about crossing over. For those of us in the Euro-American culture there was much to be learned.

Interviews were a collaborative project between our Anishinabe colleague and seven Anishinabe women in the Duluth area who were caring for a family member with dementia. During the interviews, the interviewer took the role of learner. While a set of semi-structured questions were used as probes, each woman who was interviewed took the role of storyteller, telling us how she constructed meaning from her experiences of caregiving.

The questions asked covered various aspects of the caregiving experience. There were questions about how each woman saw her job of caregiving, about who helped her in her role as caregiver, and about changes in her life as a consequence of taking on the caregiving responsibilities. Each woman was asked if she felt as though she was in charge of how her life was going. How did she see the illness in the elder she was caring for? When was the turning point when she realized that things would never be the same again between the elder and herself? What had helped her most to manage her situation and what had been least helpful? And how did she make sense out of her situation?

Though these questions were available as a framework for what we hoped to learn from the interviews, we found that the Anishinabe women did not respond well to the questions. When we asked them simply to tell us their story we got a much fuller response. They were used to telling stories.

The interviews were audiotaped, with permission, and transcribed verbatim after they were completed. Each interview lasted between one and two hours. The qualitative analysis of the interviews was performed in two stages. First, the Euro-American researchers independently analyzed the transcribed interviews for common themes. The lists of themes were then reviewed by the Anishinabe interviewer and five of the caretakers in a celebratory meal in Duluth. Additions, clarifications, and corrections were made at this time. This mode of collaborative analysis was necessary and useful because we were working with a culture unfamiliar to the principal investigators. The women we interviewed literally became our teachers. And from this process, we found that four themes emerged.

### Stories of Acceptance

The strongest and most common theme expressed by these Anishinabe women was one of spiritual acceptance. This seems consistent with other research which has described fatalism and resignation as common responses to the onset of chronic illness among groups of minority elderly. In the Euro-American culture, this would be interpreted dualistically as showing an orientation of low mastery. Mastery means being in charge of your own destiny.

However, the women we interviewed here specifically mentioned their uneasiness in expressing their beliefs about acceptance. They said that their acceptance of "the way things are," rather than seeking to master things, to "fix" them or "make them better," had previously been misunderstood and viewed negatively within the Euro-American and academic cultures.

These women described their belief system as a helpful way to deal with the present. They found themselves, generally, less focused on the future and more accepting of the present situation, whatever it may be. Their stories about caregiving are filled with expressions of acceptance, but, surprisingly, not to the exclusion of knowing the value of taking charge, as much as possible, and mastering the situation.

Stories about acceptance were so frequent that we separated them into three different categories. First were general statements about acceptance. Second, specific feelings about spirituality as they related to caregiving. And finally, a focus on the "circle of life" that begins to close naturally when a person gets old and frail.

Interestingly, most of the women used the word "acceptance" when describing their experiences of caring for an elder with dementia. This theme was most striking to all of us because of its high frequency in the narratives:

*I just believe things happen the way they happen because that's the way they're meant to be. And that's what's happening now. Mother's meant to be the way she is and everything that happens bad, I don't care what it is, there's always good comes out of it if you look far enough.*

*I wouldn't really say more fatalistic, but more accepting of the idea that we can't control everything in our lives. But there's things beyond our control and we just have to deal with them the best we can.... You have to say goodbye before the body leaves. But you deal with it as it happens. You just accept it and continue to do the best you can.*

*...a real good value (I was taught) was to help us find acceptance and that we're never given more than we can handle.... I've always been able to look on it like that.*

*I think it was probably meant to be. You know, I think it all seemed to fall in place. It was almost like, this is the next step; this is the next road. And this is what's going to happen.*

These women expressed accepting attitudes about life events in general and caregiving in particular. While chronic illness of a loved family member is not desirable, these caregivers spoke of other, more tragic events that they had endured in their lifetimes. Euro-Americans, being more mastery-oriented, tend to get stuck by trying to fix an incurable illness such as alzheimer's, or they become immobilized because they define the situation as horrible.

The Anishinabe women's spiritual beliefs formed a second category in the statements about acceptance:

*I was always taught that things happen for reasons, and my Aunt being sick, there was a reason that God had her be sick. And that's the only way I can justify it.*

*What I think is that God does not give you more than you can deal with, is what I think, to be honest. And I think that everything that is happening is sort of happening in a way that everytime I do something, it leads me to something else.*

*(Caregiving) is a test of endurance, strength, and how (one is) leading one's life; (caregiving) is NOT a test of skills.*

*There's a reason (caregiving) is given to you.*

In elaborating on the last question, about spirituality, the interviewer asked one of the Anishinabe women, "Can you teach me a little bit about whether or not your spirituality is helpful for you and how you use it?" She answered:

*Well, I was baptized as a Catholic. I guess I just have some real problems with that mortal sin, unforgiving God, and all of this, and I guess I just go along. Everyday I am either asking for help or guidance or whatever from my spirit guides, my guardian, the higher powers, whatever they may be. Everytime I can think about it, I give thanks, because whatever little part went wrong that day...you can always find something that went right that day.*

The words of these women indicate that acceptance comes, in part, by having faith in their spiritual beliefs. A strength of these Anishinabe caregivers seems to be that they are being guided through a natural rather than a catastrophic process. The final set of expressions which indicate their acceptance more than their sense of mastery, focus on the "circle of life" that naturally begins to close with elders who are demented:

*I look at Mom almost the same darn way as I do my children and grandchildren. It's like the old story they tell—you crawl into this world and then back out.*

*She came in as a small child. It was like this whole circle and she's winding down and just going back into. That's why it was so pleasant. Her death was pleasant.*

*...part of her life was just part of the circle of life; she became a little child again.*

*I think this might sound cruel, but I believe what goes around comes around, and how we live our life, you know, will eventually come back to us.... I felt like I had a child.... I actually felt like I was a parent once again.*

*A chance to grow—you may not think it all the time while caregiving, but in hindsight, it is a chance to come full circle with a parent. I fed him (her father) like he did to me.*

**Responsibility for Taking Care of Family**

A second theme in the interviews with these Anishinabe women was their sense of responsibility for taking care of the elders. We were told that in the Indian culture, it is not just a woman's experience to agonize with decisions about frail elders. Instead, the eldest child—whether daughter or son—is raised to know that their responsibility is being in charge of taking care of their elders, when the time comes. The oldest child then plays a significant role in an Anishinabe family, so much so, that often he or she is given a special name. With that specialness, comes a responsibility toward their elders.

It should be pointed out that not every woman interviewed was an eldest daughter. Nevertheless, each identified themselves as the primary caregiver to an elder with dementia. Despite the importance of birth order in the Anishinabe culture, it does appear that there is more to becoming a caregiver. For example, some caregivers in this study were middle children in their families. When asked about this, one woman responded, "Something tells you inside that caregiver is your designated role. This makes it more difficult to give up." So while it is said that the oldest child (son or daughter) is supposed to serve as the caregiver for elders, this was not always the case in this study.

All the women in this study struggled with how to fulfill their responsibilities for their elders. One woman, who lived in New Mexico, returned to Minnesota when her parents became old and frail. The move required her to find a new job and change her children's schools, but she did this because of her feeling of obligation as a first-born child.

Other women talked about the agonizing they had gone through before making their decision to take on the caretaking role. One had asked, "Do I change my whole life to go and take care, especially if it's my responsibility as an Indian woman?" Another spoke of it "lingering in my head that I know I must." And a third kept coming back to the idea that she would "probably feel really guilty for not going (home to the reservation to take care of the family) once my parents pass away."

**Realizing and Grieving the Loss**

A third theme to come out of the interviews was the importance of realizing that a loss had occurred and of grieving that loss. Often there had been a turning point when they realized that things would never be the same again with the elder for whom they were caring. These women spoke of two kinds of grief. First, they and their family were grieving the loss of the elder they once knew. And second, the elder was grieving his or her own losses. There was no denial that the elder had changed:

*We lost the mother that we once knew, but we also look at it that she was the child and I was the mother now.*

*I had a funeral for my Ma because the woman that I knew was just not there.*

Grieving was therefore a clear part of these women's experience. There was no ambiguity about what was being lost; there was no denial. They were good at grieving, as it turned out, for a very good reason. The women themselves say it best:

*As Indians, we've grieved so much. We have so many grieving skills, survival skills. Every piece of our lives has been grieving. So we accept this (alzheimer's disease). I accept death. I believe in going to another place after death.*

*It (dementia of the alzheimer's type) isn't the worst thing that has ever happened in the family.*

*I accept death. ...Death, to me is a natural thing, so if one thing doesn't get you, something will sooner or later.*

In contrast, the Euro-American culture has a different orientation to death and dying. It is a culture which is death-denying. Such cultural differences in beliefs and values make significant differences in how stressed or depressed caregivers become as they care for those with incurable illnesses.

### The Role of Siblings

Finally, a fourth theme to emerge from the interviews was the valuable assistance that siblings provided to caregivers among the Anishinabe. The positive influence of siblings was felt in a number of ways. First, siblings often commiserated together about the impaired elder. Being able to confide one's frustrations and fears was comforting to the caregivers we interviewed. Second, help was offered, ranging from financial assistance to housecleaning and other household chores. Finally, one woman talked about the importance of her family's meetings.

In addition to these positive influences, sometimes there were conflicts with siblings. A common example was siblings denying that anything was wrong with the elder, especially when they lived out of town and didn't see the elder very often:

*I know my sister was into denial at first. When my mother first asked me to start doing her income tax, and I wrote my sister—she was in England at the time—and said `Look, I'm wanting power of attorney so I can take care of the money.' And my sister was just adamant that I was sort of making this up and that it wasn't as bad as I was saying it was, and so on and so forth. But my sister had some catching up to do.*

There were also conflicts with siblings who did not want to become involved. Some women said that their siblings simply stayed away. And there were conflicts about how to care for an elder. One woman described how her siblings were used to being more playful and less serious with their mother, "but someone had to be firm and make decisions, set limits." Another told about a disagreement about where their mother should receive care:

*(My mother) did go into a nursing home. The older ones just made that arrangement.... My younger brothers and sisters were really upset.... And anyway, we decided—we were so upset and everything—that I went right to the nursing home and packed her up and took her out of there, and I took her home with me.... I was going to keep her there with me until... because they were just the young against the old.... And I was real happy I had the opportunity to be with her through her last...*

### Lessons from the Anishinabe

Our purpose in talking with these Anishinabe women was not to pinpoint tribally specific or racially defined information. Rather we were looking for a coarse screen by which we could compare patterns of caregiving coming from different belief systems and different world views. It is our belief that world views are learned, taught by the society in which one lives. If learned, they can be unlearned and thereby changed when the situation calls for new patterns of behavior.

What surprised us was that in the Anishinabe culture—a culture where harmony with nature is valued more than mastery over nature—we found caretakers who were not only accepting of the incurable illness of their elders, but also able to take charge of what they could master. It was not a matter of either/or, it was a matter of both/and.

One of the Anishinabe women, for example, was a nurse. She told of how she had pushed the doctor to get the right medication for her mother and then pushed her mother to comply in taking the medication. This was clearly what we would call a mastery orientation. Yet a few minutes later in the interview, she said, "I just believe things happen the way they are because that's the way they're meant to be. And that's what's happening now." This showed, at the same time, her acceptance orientation. She was both in charge and accepting of the natural rhythms of life. This parallel orientation was reflected in all of the Anishinabe women that we interviewed.

The caretakers that we interviewed appeared to be balancing "taking charge" and "letting go." They sought harmony in many ways. They sought harmony with the illness of their elder. In fact, some denied that it was an illness at all, preferring to see it only as a natural course of events. They sought harmony with other family members. And they sought harmony with the elder, in spite of the dementia. Harmony seemed paramount even though mastery skills were constantly used by these Anishinabe caregivers to cope with their heavy responsibilities. As a result, these women appeared to be less stressed by their situation than most Euro-American caregivers whom we have studied in earlier research. Further research is needed to test this idea.

Our Euro-American culture is increasingly depending on families to care for chronically ill family members. As the baby-boomer generation ages we can expect that the incidence of dementia of the alzheimer's type will increase. It may be that the creative combination of mastery along with a spiritual acceptance of the situation that we found among these Anishinabe caretakers is just the combination that can be most helpful to caregivers of all cultures and ethnicities. It is fitting to close with a quote from the Anishinabe heritage:

> *In the evening of life, the aged give way to decrepitude and must accept the loss of strength, the lessening of endurance, and the wane of agility as part of life's destiny and the consequence of continuing to live. A former way of life must be forsaken; a new mode of living accepted. ...Perhaps it is the knowledge that what was can never be again—can never be restored except in fresh modes—that renders old age most difficult. Men and women are destined for it from birth. The end must be accepted as part of life.**

**Pauline Boss is a professor of family social science at the University of Minnesota. Her research interest in alzheimer's disease began in 1980. She has been the principal investigator for a National Institute on Aging grant on caregivers for alzheimers patients, which used a Euro-American sample. The Duluth study reported here was conducted with an exploratory "seed grant" from the All-University Council on Aging to help bring a new population into her research. She will be a visiting professor at Harvard for the 1995-96 school year and will also continue the work begun in Duluth with a Native Indian population near Montreal where she will collaborate with a cultural psychologist. Boss is a licensed marriage and family therapist and a supervisor of marriage and family therapists.**

**Lori Kaplan was a doctoral candidate in family social science at the time this study was conducted. She is now a postdoctoral fellow in the Population Research Center of NORC and the University of Chicago. Her research focuses on later life caregiving and nursing home placement of a spouse with alzheimer's disease. She has published and presented her work at international, national and regional conferences.**

**Michele Gordon is a licensed independent clinical social worker and a licensed marriage and family therapist. She works at Miller-Dwan Counseling Resources in Duluth. Her work is primarily with the Native American population. Michele, whose Indian name is Ogemaquay, is an enrolled member of the Bad River tribe of Anishinabe in Odanah, Wisconsin.**

* From *Ojibway Heritage*, Basil Johnston (Lincoln, Neb.: University of Nebraska Press, 1976), pp. 117-118.

# All-University Council on Aging Moves On

The study reported here was carried out with the support of an AUCA seed grant. These grants have been awarded by the All-University Council on Aging to University of Minnesota faculty members for a number of years. They provide seed funding for faculty research projects related to aging.

The All-University Council on Aging was created in 1975 by faculty from across the University interested in teaching and research on the problems and issues of aging. In 1977 CURA became its administrative home and sponsor. Over the years the program has grown, promoting the study of aging and serving as a community resource about aging.

AUCA has created a solid interdisciplinary education program in aging at the University of Minnesota. In 1987 it established the Graduate Minor Program in Gerontology for masters and doctoral students. The program now involves sixty-four faculty members. AUCA sponsors two courses: Multidisciplinary Perspectives of Aging and The Biology of Aging. Visiting scholars are brought to the University on a regular basis to strengthen interdisciplinary studies in aging. Their public lectures are open to community professionals as well.

AUCA publishes *Aging: News* two or three times a year to keep both University and community professionals and scholars up-to-date on research, seminars, classes, and programs on aging at the University and to publicize local and national meetings and research opportunities. AUCA also publishes an annual directory listing up-to-date information on the sixty and more courses on aging that are taught at the University of Minnesota.

In keeping with CURA's tradition of spinning off successful programs, AUCA became independent of CURA in July of 1994. It has merged with the Minnesota Area Geriatric Education Center to form the Center on Aging. In July of 1995 the new Center on Aging moved its offices into the School of Public Health. The director for the center is Robert Kane, a professor in the Institute for Health Services Research. The Center on Aging will promote applied research on aging, expand the University graduate education programs in aging, and facilitate the creation of a network of regional gerontology centers that will link academic, community, and provider organizations.

*Aging: News* is merging with *Long-Term News*. Current subscribers will receive a copy of the new publication this fall. *Courses on Aging 1995-96* is available now. Call the Center on Aging's new offices (612/624-3904) if you would like a copy. Their new address is:

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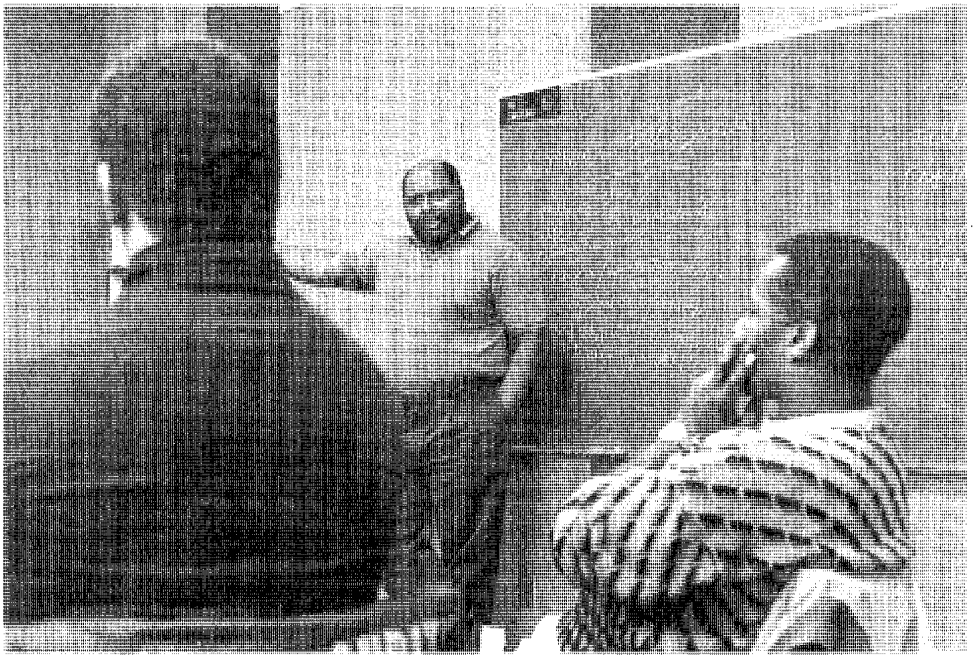
# Treatment for African American Men Who Batter

*by Oliver J. Williams*

The problem of partner abuse is experienced by all cultures. White men and African American men beat up women for the same reasons. Their acts are criminal acts and they are also acts of illness. Interventions, through partner abuse treatment programs, can sometimes transform the lives of these men. Though there is a group of men who can't be helped, many can be transformed, learning new ways of relating to other people and to their community.

Traditional programs for partner abuse, however, have had limited success with minorities. The men who complete such programs tend to be white, middle class, and educated. Because of this, some have questioned the usefulness of these programs for minorities. Many partner abuse treatment programs limit attention to and services for minority clients because the conventional wisdom is that minorities gain little from treatment. While it is true that African American men are very resistant to treatment, it may also be true that they are no more resistant than their white counterparts. That African Americans do less well in treatment begs the question that most needs to be asked. Why is it that they don't do as well as whites?

The qualitative study reported here was designed to answer this question. African American men who had completed partner abuse treatment programs were questioned about their experiences. Some had been treated in traditional groups, where minorities and whites were treated in the same group. Others had been treated in homogeneous groups, where only African Americans participated. This type of treatment group is relatively unusual, offered in fewer than a dozen cities across the country. The opportunity to compare the responses of men who had gone through these two types of treatment seemed particularly promising. The hope was that these men might be able to provide some insight into how the treatment environment influences participation. The limits of the study were in the selection biases of the sample, but since no other exploration seems to have been conducted into why whites do better than African Americans in partner abuse treatment programs, this study provides at least a beginning in the search for explanations.



**Confrontation is an essential element of partner abuse programs. This study suggests that the level of confrontation may be greater and more therapeutic in same-race groups.**

### Selecting the Sample

During the summer and fall of 1990, three Twin Cities domestic violence programs took part in this study: the Domestic Abuse Project, Wilder Community Assistance Project, and Phyllis Wheatley Community Centers' Education for Cooperative Living. Each program had a long history of reducing violence among men who batter. Further, each program had made a commitment to include men of all races in their programs. These programs contacted former clients by mail with a description of the study and asked if they were willing to be a part of the study. Other participants were members of treatment groups which were nearing the end of the treatment cycle.

Originally, there were sixty African American men who indicated their interest in taking part in the study. However, eleven could not be located and eight changed their minds. Forty-one were interviewed for the study. Twenty-four had gone through treatment in a racially-mixed group, while seventeen had been in a group of African Americans only. About half were interviewed by phone and the other half at the agency which sponsored their treatment. The interviews were conducted by two graduate students. One was African American and the other Caucasian.

The men who were interviewed spanned a wide range of ages, though the average age was thirty-three (Table 1). All except six had at least one child. Most had not gone beyond high school with their education. A thirty-seven item semi-structured questionnaire was used for the interviews. Data analysis employed a constant comparison method. In order to understand the responses it is useful to know something about the methods used in partner abuse treatment programs.

### How Treatment Programs Work

Typically, cognitive behavioral treatment methods are used in confronting men who batter. In fact, they have been proven effective. Treatment programs use group therapy sessions. The focus is on the behavior of the men and techniques to change their behavior. First, they must gain an awareness of what they are doing. These men are predisposed to violence and socialized to behave this way. They will, for example, use language to put women down and not be aware of how hurtful their language is.

Men who are violent are caught up in control issues, in trying to control the woman. The issues of power in relationships are central—emotional power, physical power,

and financial power. When men "get that feeling" they hit the woman. The feeling may be jealousy or insecurity or something else, but the men are making the woman responsible for "that feeling." They must learn that it is not the women who are responsible. They are responsible, and they are 100 percent responsible for the violence.

Men who are violent have difficulty telling you what they feel. They have to learn to separate thinking from feeling. And they must learn that violence is a choice. They believe that it is inevitable. When they get angry it doesn't help to tell them they must learn to control their anger. Anger, in fact, is a good thing. It tells us where we are. It is learning to control their behavior, not their anger, which is essential.

Treatment groups for men who batter must create an atmosphere inducive to change. This means creating a place of trust where each man can speak his own reality and is expected to speak it. It means a place where people understand each others' realities and help each other to figure out what is dysfunctional about their realities. It means confronting men when they need to be confronted. It means showing men new ways, different ways of responding to their situation, because the second essential part of the treatment, after becoming aware of what they are doing, is learning ways to intervene with themselves when they are in conflict situations.

The group sessions often discuss problems at work. Men may feel that they are working in a hostile atmosphere. One man told of being put down all the time. One day his car keys were stolen, his car was moved—parked behind a truck. The truck backed up into the car and smashed it. He felt helpless. Where could he turn? The man was African American and his boss was white. His boss was a good friend of the man who had stolen his keys. He went home and beat up his wife. This is called "displacement," the anger at his work situation was displaced onto his partner. It is a common practice among violent men.

Learning to recognize the chain of events that leads one to violence is important. Learning to recognize one's feelings before one explodes is important. Learning how to react differently is important. Calling a friend and talking it through with the friend can help. Walking out of the room when one gets "that feeling" can help. The group sessions often use role playing to show appropriate ways of dealing with anger and conflict.

Treatment programs tend to use a generic approach in dealing with men who batter. The assumption is that one size fits all, one program will work for everyone. This is the traditional approach, but is a generic treatment really best? This study looked at the experiences of African Americans who had completed partner abuse treatment programs. Out of the forty-one men interviewed, thirty-five had been referred for treatment from the court system. The remaining six were referred by ex-partners (two), by counselors (two), by friends (one), or by themselves (one). After reviewing the responses of these men to each of the questions, a number of themes began to emerge.

**Table 1. African Americans in the Study Sample**

| | |
|---|---|
| Age | 20-50 years |
| Marital Status | |
| single | 14 |
| separated | 13 |
| married | 13 |
| divorced | 1 |
| Number of Children | |
| none | 6 |
| one | 10 |
| two | 10 |
| three | 2 |
| four | 6 |
| five | 3 |
| six | 2 |
| seven | 2 |
| Education Completed | |
| < high school | 7 |
| G.E.D. | 4 |
| high school | 24 |
| college | 4 |
| > college | 1 |
| Average Income | $26,000 |

### Reactions to the Treatment Program

The men were asked what they found most beneficial about their counseling group. Those who had been in racially-mixed groups (the traditional groups) said that learning about control was most helpful. They learned about how they were controlling their partner's behavior and how to stop doing that. They also learned about self control. The men noted the importance of personal responsibility—that the perpetrator is responsible for the abuse and that men who batter must have a self-control plan.

The men who had been in all African American groups (the homogeneous groups) also said that learning about their control issues was very beneficial. In addition, however, they talked about learning that they were not unique, isolated, or alone with this problem. Other African Americans had the same behavior problems. Further, they noted that they had learned how to feel comfortable talking to other men in the group about their problem. They learned that they did not always have to talk, that they could listen.

What did you like the most about being in the mens' counseling group? was another question. Men from both the homogeneous and traditional groups noted that they learned from other group members and from the counselor. They also liked talking about their feelings.

What did you dislike most? was a question that brought a variety of responses. Men in racially-mixed groups said that there was a need to be more sensitive to men from different cultures. In one group, a minority man left because a counselor was culturally insensitive. They also noted that they "wished there was more time to learn about behaviors." "There was a lack of anonymity." And "there was slow progress before the group members started being truthful." Some men felt that there were no problems.

In the homogeneous groups, the men said that they "did not like to be confronted." "Sometimes the confrontations in the group were very painful." And that they "did not like coming to the group at first but began to like it and look forward to it."

### Reactions to Others in the Program

The men were questioned in more detail about others participating in the program and particularly about other minority participants. Were there people from your race/ethnic group in the counseling group? How did you feel about that? Their responses varied. Those who had participated in the racially-mixed groups said that there were few men from the same culture in their group. Some said that there was no one else from their cultural group in the treatment group. Attitudes were split as to how comfortable they felt with the situation in their group. Most men noted that they did not like the absence of minority men but they learned to deal with it. They did not always feel comfortable talking because "I was the only one." Some said they "did not mind as long as it did not get racial." Others mentioned a mild level of discomfort. Finally, some felt that it was not an issue because there were several minorities from other cultures in their group.

In the all African American groups men said it was very important to have men from the same culture in the group. They felt more free to express their point of view. They were interested in hearing people talk about problems they could relate to. They felt it important to share ideas and experiences with men from their own cultural group. They said they were confronted on many issues but the others understood what they were talking about. They did not have to justify their answers. They felt as though they could trust the feedback more.

Did the men in these groups develop friendships with others in the group? Members of racially-mixed groups made friends with other African Americans if there were others in the group. They would contact them outside the group about homework or call them when they were in a conflict at home. Some said they made friends with other African Americans early on and then made friends with white men towards the end of the group. Others, who had no other minorities in their group, said they related to whites when they were inside the group but never contacted them outside the group.

The men in the African American groups said they developed friendships within the group and contacted these friends outside the group. Some emphasized the importance of contacting them when they were in crisis. Others noted that they interacted with group members socially. Two men said they thought the guys in the group were great and they felt comfortable with them, but they would only see these men within the group.

### Reactions to the Counselors

Finally, the men were asked how they felt about the counselor in their treatment group and why. In the racially-mixed group responses varied. Some found the counselor considerate and compassionate: "Nice person to be in charge." "Liked him a lot." "He knew the program and showed us how to use it." "This counselor let you voice your views." "I developed enough trust with him that I could talk to him on a one-on-one basis." "There was a man and a women counselor. I liked their strictness and adherence to the rules." Others voiced a different kind of response: "He was frank, abrasive, but up-front." "The counselor maintained a real distance." "I did not like the counselor because he seemed too aggressive and had no sense of humor."

In the African American groups, most of the men seemed to feel comfortable with their counselor. Many thought that he was great. A sampling of responses gives the spread of opinion. "He could help you spot your problem, then helped me get the help I needed." "Although he was nice, he could be very confronting." "The counselor came down on me to make me reveal myself." "When the counselor confronted me it was hard, but good for me because I learned more about myself."

### Discussion of the Survey

All the men in the sample viewed learning about their control problem and how to manage it as beneficial. Men in the African American groups, however, learned to break the isolation they felt and to identify the problem of abuse as a problem of many African American men. This was critical since minorities will often distance themselves from the issues of partner abuse because they see the problem as a problem of the white community and therefore not their own. Increased ownership of the problem occurs when minority men understand that the problem is as common among minorities as it is among whites.

Regardless of the type of treatment group, the men learned to discuss their feelings and to value the information they received from others in the group. In the racially-mixed groups, some of the African Americans disliked the lack of cultural sensitivity, particularly by counselors. In some groups this caused drop-outs and in general it reduced trust. In the all African American groups the most difficult thing for the men was being confronted. Yet, many men felt that they learned more about themselves as a result. It may be that the level of confrontation is greater in same race groups and that the confrontation comes out of given cultural understandings. Certainly, cultural issues are more likely to be raised and addressed in these groups. In racially-mixed groups it is easier to marginalized those themes that are important to minorities.

Most African Americans in racially-mixed groups were uncomfortable if there were no other minorities in the group. They felt uncomfortable speaking or they felt somewhat isolated at the beginning of the group. In the African American groups, the presence of other African Americans encouraged the men to trust, talk, and listen. They did not have to keep checking the level of safety in the group, checking to see if they were included, and if they were expected to be a member of the group.

Although some African American men in mixed groups developed friendships with whites and other minority men in the group, most did not. In the same-race groups, friendships were much more likely to develop. Developing connections among group members can be an important element in treatment. In these groups men are given an opportunity to relearn their patterns of relating to others. When the treatment works, they learn how to be concerned about other people and how to be aware of themselves. The group gives them an opportunity to practice these new skills. Developing close relationships in the group supports the teaching that is going on in the group. Outside of the group, members may call on each other for support during a crisis, in the same way that members of Alcoholics Anonymous and other twelve-step groups use fellow members for support when they are tempted to revert to old and maladaptive behaviors.

Most of the men in both types of treatment groups felt positive about their counselors. Yet, some African Americans in the traditional, mixed groups found they could not develop rapport with their counselors. The client-helper relationship is critical in treatment, particularly with men who have been referred through the court system. Although confrontation is an essential element, so is trust. If clients don't trust the person doing the confrontation or don't believe that he has their interests at heart, the treatment is very unlikely to touch them in a way that will bring positive changes.

### The Value of Same-Race Treatment Groups

It is clear that the all African American groups provide inherent benefits for African American men who batter. In these groups the men have a greater opportunity to be engaged, develop supportive relationships, and develop trust in the treatment environment. It is important to note that for some African Americans there is a very limited trust of formal treatment programs and even of any white institution. The experience of these men has been such that they do not believe that whites will either hear them or believe them. They are not willing to feel vulnerable. Yet it is their vulnerability that needs to be encouraged if the treatment is to work. Same-race treatment groups are an acknowledgement of this fact.

All African American groups have the added advantage that they allow the participants to discuss their experiences of racism. These experiences, in fact, can often be used to help the batterer get in touch with the kind of oppression that he is causing for his partner. If he can understand the oppression he has experienced, he can also understand the oppression he is creating.

In African American groups the issue of what the battering is doing to the African American community itself can also be explored. The responsibility that a man has to his partner, his children, and his community can be addressed. The connections that are built in same-race treatment groups foster a new sense of community. These very isolated men are in reality men who want to be part of something. When they start to connect with one another, they are beginning to have their needs met, they are beginning to be able to talk. It is this connection that tends to bring about changed behavior. Living with racism is an isolating experience. The treatment groups offer men who don't know how to live their lives and don't know how to deal with conflict a whole new way of approaching life, one that depends on connections with other people.

### Reframing Racially-Mixed Groups

It is clear that African American men can complete traditional (racially mixed) partner abuse programs and retain useful information which will reduce their violent behavior. It is also clear that minority men who batter complete these programs at lower rates than do white men. One possible cause is the environment in which the treatment takes place. However, many partner abuse programs around the country may find it impractical to develop same-race treatment groups because the number of African American clients is too small. For some programs this may be a recruitment problem, but for others it may simply be their location and the size of the African American population. In this instance, it is important for treatment programs to examine how they conduct their racially-mixed groups. How can they take the elements that make same-race treatment work and incorporate them into their traditional programs?

One of the key elements is developing an atmosphere of trust within the group. When there are minority men included this will mean going to extra lengths to let them know that they are included and are as accepted as any other group member. The counselor must be able to hear the voice of the African American man when he is speak-

ing. Often there is a tendency for minorities to be treated as scapegoats. This must be avoided. It is important not to marginalize the reality of African Americans, but rather to engage them.

The counselor must be a model. He must be sensitive and aware, able to both engage and confront the batterer, even when the batterer is African American. If the batterer is distanced the potential for change is lost. In the hands of a credible counselor, one with authenticity and knowledge of other cultures, even issues of racism can be addressed in the group.

How can counselors gain the cultural knowledge necessary to deal with African Americans effectively? There are a number of ways. Having friends who are African American can help enormously. Friends can be called on for advice and for explanations when difficult or puzzling situations come up in a treatment group. Co-facilitating with an African American is another option. This can also be a way of building bridges between cultures. Pairing an expert on African Americans with an expert on domestic violence can create a powerful therapy team.

**Partner abuse treatment helps men get in touch with their responsibilities both to their community and to the health and well-being of their families. They learn to look beyond themselves for help with their problems.**

### Organizational Factors

The survey described here led to a national survey of partner abuse programs which was designed to learn more about how much effort is actually being made to understand and accommodate the needs of minority populations. One hundred and forty-two partner abuse programs were included in the national study.* When these programs were asked about what types of clients they were prepared to serve, 96 percent (n=136) said they were prepared to work with any batterer regardless of race. Yet, only 17 percent (n=24) had a specific part of their program that was designed to encourage participation by minority clients. And over half of the programs (51 percent) made no special effort to understand or accommodate the needs of minority populations.

It seems clear in light of this study that minorities—and in particular African Americans, which was the group focused on in the Twin Cities survey—are underserved when it comes to treatment for partner abuse. There is much that organizations across the country and here in the Twin Cities could do to make their programs more effective for minority clients.

### The Treatment of Minorities in Perspective

Though programs for men who batter began as a form of treatment that men generally attended voluntarily, the recent trend is to fill them with men referred by the courts. Among those mandated by the court to attend, minorities are, for whatever reason, disproportionately represented. This means that partner abuse treatment programs will increasingly be facing the issue of how they treat minorities.

In other social service areas it has been found that cultural sensitivity and the counseling environment are important ingredients of positive treatment outcome. The interviews with African American men who completed partner abuse programs in this study indicate that here too cultural sensitivity and the counseling environment make a distinct difference. Minorities have special service delivery needs.

The results of the comparative analysis in this study provide strong evidence that there are differences in how minority men who batter view treatment groups. Few programs are minority focused or include recognition of diversity in their treatment services. Although some programs do a fine job, the majority serve all populations in the same way, with a traditional, generic

* Oliver J. Williams and R. Lance Becker, "Domestic Partner Abuse Treatment Programs and Cultural Competence: The Results of a National Survey," in *Violence and Victims*, Vol. 9, No. 3, 1994, 287-296.

approach. Programs that counsel men who batter must become more culturally aware and sensitive if minority men who batter are to be truly served. To become culturally competent, partner abuse programs must examine their approach. They must prepare themselves to respond to cultural differences in meaningful ways.

Agency and practitioner changes do not mean that perpetrators will be let off the hook. Rather, they allow the removal of barriers to service delivery. In this way counselors will be able to engage and confront minority men who batter, helping them to change their lives toward more healthy patterns, both for themselves and their communities.

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CURA reporter

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