MALTREATMENT AND NEGLECT IN AMERICAN INDIAN COMMUNITIES

Suzanne Cross, PhD, MSW, ACSW

In the United States, most attention to elder abuse has been focused on the Caucasian population. Therefore, awareness of maltreatment and neglect of minorities, especially American Indians is limited (Brown, 1989; Carson, 1995). Data collected by the Administration on Aging, National Elder Abuse Incident Report estimated that “the national total of 449,924 elderly persons, aged 60 and over, experienced abuse and neglect in domestic settings” (September 1998, p.7). The report indicated that 0.4 percent (1,800) of reported and substantiated cases of the abused and neglected were American Indian and Alaskan Natives. This number may appear low in comparison with other populations but, for a population with the traditional and culturally grounded value of placing elders in high esteem, it is extremely disturbing.

Historically, in all tribal nations, community elders were held in high regard, viewed as oral historians, kinship keepers, leaders, counselors, mediators, and, often, spiritual healers. Their roles were an integral part of the sacred circle of life in their communities. Today, this cultural value is being sustained within the majority of tribal nations. Many families and communities, both on and off reservation land, continue to exemplify this cultural value by placing elders in high regard. Unfortunately, this is not the circumstance for all American Indian elders.

It has been shown that some elders are being maltreated and/or neglected both on and off of reservation land (Brown, 1989; Carson, 1995; Maxwell & Maxwell, 1992). The types of maltreatment and/or neglect (i.e. physical, psychological, and economic abuse, and lack of appropriate care), characteristics of abusers (i.e. personal problems, substance abuse, and familial relations), characteristics of the abused (i.e. female, physical and/or mental disabilities, frail, isolated), and the elders’ reaction to the maltreatment (i.e. protect abuser, feelings of shame, embarrassment) are similar to all other populations. While there are similarities, there are also differences social workers should consider when providing services to American Indian communities, since considerations given to historical events and existing cultural values can increase and enhance positive outcomes. Examples of these differences are presented, including the experiences of historical traumas, definition of the term “elder”, longevity and health issues, cultural values of sharing, and extended-family interdependence.

Historical Traumas and Current Social Issues

It is difficult to understand why maltreatment and neglect occur in a population with a traditional cultural value of respect for elders. However, historical events have contributed to some family and extended family members’ level of commitment to these values. The American Indian popula-
From the Chair

It has been a great ride! This summer I step down as Chair of the Section on Aging. I have enjoyed immensely the opportunity to serve the profession in this capacity. My work with NASW has opened doors and provided important opportunities for the Section, other members of the Steering Committee, and me to work with so many talented colleagues and organizations in social work, nursing, occupational therapy, psychology, and more. It has been very, very satisfying. It has also aroused in me a newfound allegiance to, and appreciation of, the critical work that NASW performs day in and day out for all of us.

Over the past couple of years the Section on Aging has grown significantly to over 2,000 members and now represents the second largest special interest section in NASW. We have published, on a continuous basis, what I think is a very strong national newsletter that has real value for practitioners, educators, and researchers alike. We have organized, sponsored, and participated in numerous workshops and seminars at national, regional, and state conference programs throughout the United States. We have taken the lead in reviewing and updating NASW’s long-term care standards of practice. We have partnered with other professional organizations in the offering of Web-based continuing education programs for social workers. We have published a resource guide for gerontological social workers and have taken the lead role in advocating for a new gerontological social work practice book series that I anticipate will soon be announced by NASW Press.

If I have learned anything during my tenure as Chair, it is that efforts to bring about significant advancement in the field of gerontological practice will fail miserably if we don’t commit ourselves to the imperative of collaboration. We must not go it alone. Resources are much too scarce. Sources of support, whether private foundations, federal agencies, or state and regional governments, want to see partnerships among individuals, organizations, and communities. We will accomplish so much more, and secure so much more in the way of funds required to mount creative-program initiatives, if we combine forces. That means nurses and social workers, academic and community groups, policy makers and clinicians, not-for-profit and corporate entities, social service and health care organizations need to be willing to sit at the same table to plan and implement sound policy and state-of-the-art programming. It means we need to appreciate the fact that combining diverse expertise, knowledge, and creativity will have synergistic effects in terms of what can be accomplished.

There is no place for lone rangers in this scenario. It is all about playing well with others. From immediate first-hand experience at NASW, as well as my role in developing a new center on aging at
DE-INSTITUTIONALIZING AN INSTITUTIONAL SYSTEM

Christine Krugh, MSW, LICSW

The hospital emergency room waiting area was full to overflowing. A middle-aged nurse dressed in crisp blue scrubs entered the crowded room. “Bruce Krugh’s family?” She spoke it more as a statement than a question. I looked up and gave a slight nod of confirmation. My twelve-year-old son and I quickly stood and followed the gurney carrying my husband down the hall to the x-ray room. Before long, we found ourselves waiting again.

Outside the x-ray lab, in the colorless, vacant hallway, my son busied himself by trying to read the Braille etchings on several closed doors. I looked around me. Tile floors, dim lighting, walls void of pictures…this could have been any hallway, outside any x-ray lab, in any hospital across the country. Exactly what I had come to expect of a facility adept at providing emergency-medical treatment for a county with a population of more than 250,000 people. Still, for some reason, I felt something wasn’t right.

My feelings were more than just worry about my husband’s acute abdominal distress. “What was it?” I contemplated. When he lost interest in reading Braille, my son broke the silence. “Mom,” he said, “I just keep expecting a big greyhound to run out of one of those doors.” I smiled instantly. My son did not understand the depth of the statement he had made to, but he was right—what we had both come to know in another healthcare setting, a nursing home, was, not to be found here, and rightly so. But he was associating one with the other, no differently than we, as a society, have done for more than 50 years.

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I am a nursing home social worker. My son grew up visiting the medical environment in which I work. He no longer remembers the weekly visits he made as a newborn and toddler to a nursing home that looked and felt much like this hospital-emergency setting. He was much too young.

My son’s earliest memories of a nursing home are of a place full of life, with hundreds of green plants growing, fragrant seasonal flowers in bloom, and birds perched on top of cages. It was a place where the sounds of chirping birds fill the halls; where dogs and cats share the attentions of caring elders; where staff truly enjoy the work they do; where children play and visitors come in abundance. The nursing home my son knows is a place he looks forward to visiting; a place he loves to experience hour upon hour; and a place where he feels at home. The nursing home he knows has undergone a transformation over the past six years, into a new culture of caring.

I have worked in the sterile, institutional environment of “old culture” nursing homes for most of my 20 years of practice. I have felt the isolation that is so much a part of the job of a nursing home social worker. For many of the early years, I was one voice in a crowd of well-trained medical personnel, and discovered what it was like to be alone in feeling “something is not right, here”, that it was time for a change. I experienced heartfelt sorrow as I held elders in my arms, soothing their saddened souls—they feeling helpless as I about trying to fix a broken system of care. The hospital environment where my son and I waited, designed for efficient emergency treatment, reminded me of the nursing homes I once knew, nursing homes as institutional as the hospitals from which they were born.

I work in a different environment now. My nursing home is growing and changing by leaps and bounds. Not only my voice, but the voices of thousands of committed caregivers across the country are being heard. Many in the nursing home industry are beginning to recognize that we can wait no longer. Now is the time for a revolution. It is time for a movement beyond our dreams. It is time for a deep-culture change within the 17,000 nursing homes in our country.

For me, hope began when I was on the brink of leaving the career to which I had committed my
life, feeling helpless to repair a system with so many problems. On the eve of my exodus, I was introduced to an entirely new way to look at the old system. The underlying philosophy of this new model of care is based on the premise that the highly efficient medical environment we have created for our elders to “live in” does not promote well being, healing, or growth—elements essential to life.

Dr. Bill Thomas and his wife Judy Meyers Thomas were my inspiration. Dr. Thomas first became medical director of a nursing home in upstate New York in the early 1990s. He recognized problems immediately, and asked himself, “What needs to be done differently here?” He did not stop with just the question, but set out to find the answer. Dr. Thomas obtained a grant from the state of New York, to create a better way of life for elders living in nursing homes. After five years of research and practical application, he and his wife created a process of culture change in which a nursing home can transform itself from an institutional to a social model of care. Bill refers to the process as “The Eden Alternative,” and to the newly-created environment as a “human habitat.”

The Eden Alternative is based on the simple concept that loneliness, helplessness, and boredom are diseases of the spirit. These emotions are abundant in our nursing homes and can result in elders’ death. To combat loneliness, our elders need endless opportunities for companionship including that of caregivers, families, children, and animals. In an Eden environment, friendships are nurtured between elders, caregivers, and families. Children enjoy the loving atmosphere and want to come to the nursing home to visit. An Eden environment has birds, cats, dogs, and other pets—not just one dog or cat, but multiple animals of many shapes and sizes. Because they live in the home, pets can be available 24 hours a day to give and receive love from the elders.

When an elder has nothing purposeful to do, helplessness takes over. Nursing homes breed helplessness by their nature. Elders come to receive care, which they are given over and over, day in and day out. Seldom are they allowed to give care in return, and when they do, those helping them are instructed to refuse. This imbalance results in hopelessness and depression in the elders served by nursing homes. In an Eden environment, the daily activities of elders revolve around maintaining the habitat and helping it grow. In this way, they are involved in meaningful activities that improve the lives of others. Elders work at tending houseplants and gardens, caring for pets, and giving back to their caregivers. With this comes a renewed sense of usefulness and purpose.

Nursing homes are filled with scheduled activities. There might be Bingo on Monday, beauty shop on Tuesday, and music group on Wednesday. The activities are provided for elders to attend and enjoy, but often they do not participate, or they leave the activity, burdened with a heavy blanket of boredom, until the next scheduled activity occurs. Boredom can become overwhelming to those whose lives lack variety and spontaneity.

By filling a nursing home with families, children, and pets, spontaneous events begin to happen every single day. In between breakfast and Bingo, the dogs nap in the hallway, the bird whistles at a visitor walking by, and the cat chases a catnip mouse on a string tied to the handle of a wheelchair. The antics of the animals and children add life to the environment that once was very predictable. Time in the nursing home, once spent by elders waiting patiently for death, evolves into “a life worth living” for those who reside there.

The Eden Alternative is still in its infancy, but amazing things have already started to occur. Eden homes have had positive results from their efforts toward culture change. Elders’ need for antidepressants and other medications has decreased. Their function and independence has been maintained for longer periods, and many live longer in Eden homes because their life begins to have purpose. In Eden homes, infection rates go down as those who reside there begin to have a better sense of well-being. Additionally, pets have been found to lower blood pressure, aid relaxation, promote health, and prolong life.
Elders take ownership for their home and become involved in life around them, and hospital stays are shorter because they want to return to the “nursing home”, the place they truly consider their own.

The Eden Alternative not only improves elders’ lives, but has a positive effect on caregivers’ lives, as well. As a natural part of the process, the loneliness, helplessness, and boredom so frequently felt by nursing home staff decreases. By enabling caregivers to make decisions about the daily running of a nursing home—decisions traditionally left up to management—Eden homes increase their control over the day to day events around them, while decreasing their feelings of helplessness. Caregivers and everyone else who comes in contact with the home also enjoy the variety and spontaneity. Eden homes result in a decrease in job burnout, improvement of caregiver performance, and an increase in retention of employees.

Social Workers play a paramount role in making a cultural transition to a social model of care, which, in this environment, means “helping people grow”. The strengths perspective social workers easily follow is taught to all disciplines within an Eden home, as they draw on their education and experience to train staff members to think about old systems in new ways. We teach caregivers and families to look at the whole person when working through anxiety, anger, and depression. To diminish the plagues of loneliness, helplessness, and boredom, we educate caregivers on the causes of the problems and the antidotes.

As part of the process, social workers teach other caregivers to view the world through the eyes of elders, to look at the whole person, not just his or her medical needs. We remind others that a pill is not always the answer to loneliness, helplessness, and boredom, but that the whole environment in which the elder lives can make the difference. Through the leadership social workers provide, caregivers learn the concepts that will guide their future decision-making. Most of all, social workers’ role is to be persistent with the process and to keep it moving in a positive direction. We are the voice of a population that is growing faster than any other in the nation: our population of elders.

To change a nursing home’s culture is not easy. Many compare the attempts at change to “two steps forward and one step back.” It is a process with some established guidelines and tremendous freedom for creativity. In implementing the Eden Alternative, nursing homes discover that they are in new territory, pioneers on a new frontier.

Whether a nursing home chooses to follow the Eden Alternative or to adopt another model of culture change, change must happen. We have come to a point in history in which our next generation of elders will not be as accepting as those in the past have been. We are being called to change our nursing homes to something better, into the nursing homes we, ourselves, will someday call home.

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Resources

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SPIRITUALITY AND THE FRAIL ELDERLY

Anna Kirshblum MSW, LSW

The frail elderly must contend with a daunting list of losses that can be overwhelming to both the individual and the clinician. This list includes the loss of physical abilities, status, individuality, independence, and, of course, the loss of life. It is difficult to view life as a gift if one’s very existence is fraught with pain.

As clinicians working with the aging population, we are familiar with the need to approach clients from a multidisciplinary standpoint that includes medical, psychological, financial, and social perspectives. We are also aware that sometimes, no matter what method we use, nothing seems to help, and the client’s mood continues to deteriorate. There is an often-overlooked approach however: Spirituality. Spirituality is often thought of as a clinically insignificant topic, a private matter, or one with which clinicians are uncomfortable. We will see, though, that addressing spiritual issues is both beneficial and relevant.

Definition of Spirituality

Spirituality is the desire to feel connected with others and the need to find meaning in life. It is the recognition that the essence of human beings is not defined by their physical shell, but by their inner beings or spirits. A spirituality perspective helps us avoid labeling people by their afflictions, and forces us to look beyond the surface to see the core of a human being. It is a key component of palliative care.

Symptoms of a Spiritual Problem

Most people are unaware that they are experiencing a spiritual crisis. The following list of symptoms can help diagnose a spiritual problem:

• Guilt: I am being punished for things I did in the past.

• Isolation: Nobody cares. I am so lonely. I feel abandoned.

• Anger: Why me? I’ve led a good life and always done the right thing. It’s not fair.

• Fear: How will I cope with what is happening to me?

• Hopelessness: It is no use. Life has no meaning. I want to die (Abramowitz, 2001).

Spirituality addresses issues concerning regrets in life, perceived inequity of life, and questions about the afterlife. Untreated spirituality problems can result in depression, anger, agitation, and isolation. Physical symptoms include eating and sleep disorders, as well as pain.

Spiritual Paths

There are many paths to achieving spirituality in one’s life. Religion is a particular faith-based approach that usually involves a specific belief structure such as Judaism, Catholicism, or Islam. Often religion provides us with a well-defined community, which helps us feel less isolated. Clients struggling with illness and end-of-life issues often find solace in the traditions and culture of religion. Familiar rituals bring comfort and a sense of connectedness with the past. The transmission of cherished beliefs can help individuals transcend their current situation by giving meaning to their lives.

Many of us are aware of individuals who are spiritual, but not necessarily religious. Other spiritual paths include the following:

• Nature: Feeling connected with the beauty and wonder of the world.

• The Arts: Feeling connected to humanity through music, dance and works of art.

• Family: Feeling a part of eternity through the generations.

The overall key is the feeling of being linked to others by universal thoughts and feelings: One is not alone and, despite one’s current situation, there is still beauty and value in life.
Regulations
Spirituality is not only a therapeutic approach but also a requirement of accrediting organizations and the federal government. According to standards put forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), spiritual services are to be “provided to residents, consistent with their personal preferences.” In addition to religious services, art and music therapy are also considered “means of spiritual expression” (JCAHO, 2000-2001).

The Minimum Data Set (MDS) is used in determining Medicare and Medicaid payments to nursing homes. The MDS manual refers to past spiritual observances in section, AC: u and current spiritual needs in section N4. Facilities can receive deficiencies if the spiritual needs of their residents are not properly met. (MDS manual, 1999).

Practical Suggestions
It is important that clinicians become familiar with assessing spiritual needs. In fact, an essential part of being a professional is knowledge of spiritual needs. A spiritual assessment performed at intake, consisting of more than a cursory view of religious affiliation, is a necessary first step.

Familiarity with symptoms and expressions of spiritual problems is also important. It is not necessary to have the answer to your client’s questions or soul searching. Your presence, concern, quiet empathy, and touch are often all that is needed (Abramowitz, 2001). The problems do not necessarily disappear but they become easier to bear.

Make appropriate referrals to clergy, music, and art therapists, develop connections in the community with local houses of worship, and encourage intergenerational activities. It is also important to adapt religious programming to fit the needs of your particular population. Small-group programming that is short in duration, focused on sensory stimulation, and that emphasizes song is better suited for individuals who are cognitively impaired. Spiritual legacies (life reviews), in the form of ethical wills are also helpful in allowing elderly individuals to communicate values with special meaning to them.

Spiritual Healing
When people experience spiritual healing, they do not necessarily experience physical healing. In all likelihood, our elderly clients will continue to physically decline and all, eventually, will die. If, despite their physical or mental limitations, they continue to feel loved and connected, then their lives have meaning. “A whole heart is one that can still love, despite pain … a healed heart is one which has glimpsed its own loss and can still be filled with meaning” (Hirsch, 2001). Spiritual illumination is a precious gift. As clinicians dedicated to helping individuals, we must use every tool at our disposal to enable others to reach their maximum potential.

Anna Kirshblum, MSW, LSW is the Spirituality Programs Coordinator at Daughters of Israel in West Orange, New Jersey. Ms. Kirshblum received her BA from State University of New York (SUNY) Albany and her MSW from Columbia University, and has extensive experience in the continuum of geriatric social work practice. She welcomes any comments and can be reached at akirshblum@comcast.net

References


VISION LOSS IS NOT A NORMAL PART OF AGING

Cynthia Stuen, DSW

Gerontological social workers need to know the difference between normal vision changes as people age and changes due to age-related eye disease. Most normal age-related vision changes are not severe and can be accommodated. By distinguishing between normal and abnormal age-related vision changes—and by seeking vision rehabilitation for older adults who experience abnormal changes—social workers can have a tremendous impact on the safety, well-being, independence and autonomy of the population we serve.

Normal vision changes as we age include:

• Presbyopia: Between the ages of 40 to 50, most people begin to experience presbyopia. The lens of the eye begins to lose elasticity, making it harder to focus up close, especially for reading. Presbyopia can easily be corrected with reading glasses, bifocal, trifocal, or graduated lenses.

• Declining Sensitivity: The lens of the eye becomes denser and more yellow with age. These changes may affect color perception and contrast sensitivity, making tasks like distinguishing colors and seeing the edge of steps or curbs more difficult. Building color contrast into the environment can be very helpful.

• Need More Light: As we age, our pupil gets smaller so we require more light to see well. We also need more time for our eyes to adjust to changing light levels. Utilizing task lighting indoors and allowing more time for visual accommodation can be effective.

It’s also important to recognize warning signs for age-related eye disorders—the most common being macular degeneration, diabetic retinopathy, glaucoma, and cataract. Encourage your clients to have an annual eye exam to ensure early recognition of age-related eye disorders. Once it is determined that eyeglasses, contact lenses, medication, or surgery cannot correct vision to the normal range, an older person should be referred for vision rehabilitation.

Lighthouse research has shown that a majority of Americans believe—mistakenly—that older adults become visually impaired as part of the normal aging process. As a result, they may not seek help. In fact, 94 percent of middle-aged and older adults who reported vision problems did not take advantage of any type of vision rehabilitation services.

Lighthouse International is spearheading a national public-awareness campaign, “Vision Loss is Not a Normal Part of Aging—Open Your Eyes to the Facts!” to promote awareness of the normal changes we can expect as we age; common eye disorders that can permanently impair sight; and the benefits of vision rehabilitation for people with vision loss and those close to them.

Educational booklets in English and Spanish, promotional posters, bookmarks, radio public service announcements, news releases, and Web letters are being used to reach older adults and organizations that serve them—with a targeted effort on public libraries. To date, more than 850 organizations and over 1000 individuals have requested materials. An evaluation of the effectiveness of various dissemination strategies is underway to determine the best ways to reach older adults.

The booklets and other awareness materials are made possible by a grant from the AARP Andrus Foundation with supplemental funds from the National Eye Institute. To view the materials online, go to http://www.lighthouse.org/vision_loss/ To order a sample packet or free supply of materials (in English and Spanish) to share with older adults, call 800-829-0500 or send an e-mail to info@lighthouse.org. Lighthouse International also has two other practical publications that social workers creating print materials for older adults should consider. These two booklets—“Making
Chair, from Page 2

University of Maine, School of Social Work, I now know that progress in improving quality of life for older adults is directly tied to the ability to create genuine and enduring ties with other groups and organizations with complementary missions and goals. Surely you will agree that a chorus of voices advocating for policy change, service expansion, or an innovative new initiative will more likely be heard than the chant of one.

Does coalition building take time, effort, and patience? Yes! Is it, at times, frustrating, exasperating, and burdensome? Of course! Is it worth it in the longer term? Absolutely!

I step down as Chair with one remaining request: that each of you makes it your business to recruit one new member to the Section on Aging from the ranks of NASW. Doubling our membership from more than 2,000 to more than 4,000 would send a message loudly and clearly to the world that we are in this together—wholly committed to expanding gerontological practice and cognizant of the overriding importance of approaching the challenges of an aging community as a united force.

I’m done talking. Go pick up the phone and recruit a colleague. I’ve already made my call. Take care.

Lenard W. Kaye, D.S.W.

JOIN NOW!

✓ Yes! I am an NASW member and I want to join the Section on Aging for only $35 per year.

Name: ______________________________ Member ID #: _____________________

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Payment Information:

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❑ Please charge my:
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tion has experienced numerous traumas throughout history, including “removal of Indian people from their ancestral lands, prohibition against religious and spiritual practices, forced removal of Indian children into foster homes and boarding schools at the rate of 5-20 times the national average... (and) drastically undermined traditional life ways.” (Quinn & Tomita, 1997, p.38) All of these historical events have had a negative effect on this population’s cultural values, causing a rupture or “fracture” (Carson, 1995) in the transmission and practice of American Indian cultural values. Additionally, there is an overlay of current issues, including health problems, substance abuse, unemployment, isolation, mental health problems, discrimination, lack of formal education, and a lack of training to assist in elder care (Brown, 1989; Maxwell & Maxwell, 1992). These historical events, together with current issues, have had a significant impact on many American Indians’ quality of life, including elders. Thus, some members of the population do not adhere to the cultural value of placing elders in high regard, resulting in maltreatment and/or neglect.

Concept of Elderhood
Each tribal nation defines the term “elder” within its individual set of criteria. Elderhood is not based solely on an individual's chronological age, but is defined, in part, by life experiences, service to the community, grandparenthood, and the need for services. For example, in response to shortened life span and health issues, enrolled members of the Saginaw Chippewa Indian Tribe are considered elders at 40 years of age. At that time, they become eligible for services and benefits provided for the tribal nation's elders.

Health Issues
Social workers need to be knowledgeable about this population's overall health status. In fact, over 70 percent of those over 60 years of age suffer from limitations in their ability to take care of their own activities of daily living (Brown, 1989). Older American Indians tend to report having multiple diseases like hypertension, cataracts, arthritis, pneumonia, obesity, diabetes, dental problems, depression, substance abuse disorders, and physical disabilities that limit functions like sight, mobility, and physical agility (Meketon, 1983; Novak, 1997; Stuart & Rathbone-McCuan, 1988). This information will be beneficial for social workers conducting assessments and developing treatment plans for maltreated and/or neglected elders. In addition to health issues, social workers should also be aware of the various resources and services available that can enable them to provide care and support for maltreated and/or neglected elders. These sources may include tribal nations’ health, mental health, social and legal services, Indian Health Services, in addition to state and local services. It is important for social workers to ascertain whether a tribal nation is able to offer services and, if so, to determine the eligibility requirements (i.e. age, tribal membership, and whether the client resides on or off reservation land). Indian Health Services, a federal government program, also provides services to members of federally-recognized tribal nations. These services are offered on and off reservation land, separately or in conjunction with the federally-recognized tribal nations’ service-delivery system.

Cultural Differences of Sharing and Extended-Family Interdependence
While each tribal nation has its own cultural values, there are some common values, like sharing and extended-family interdependence. Historically, these were two of the many ways tribal nations were able to survive. Today, these values continue to be adhered to in varying degrees.

Sharing with others in the family and extended family is viewed as a cultural privilege and a duty (Brown, 1995). When an elder person freely and openly shares his or her income and personal property, it may be more difficult for social workers to assess exploitation as a case of abuse. This is not to deny the fact that exploitation occurs, or to imply that it is a cultural value, but rather to emphasize the challenge faced by social workers who must determine when a cultural norm has been adhered to or when exploitation has taken place. Secondly, the extended family is viewed as a source of strength, encouragement,
and support (Quinn & Tomita, 1997). Tribal nations represent “communities of relatedness” characterized by relationships that have endured from one generation to the next for centuries (Hand, 1996). Elders are taken advantage of when this relatedness is misconstrued and the cultural values are exploited, suffering the consequences of following their long-standing traditions.

**Conclusion**

Maltreatment and neglect occur both on and off reservation land. There are several issues social workers should be aware of and take into consideration when addressing the maltreatment and/or neglect of American Indian elders. It is important to be knowledgeable about cultural strengths, values’ differences, and the importance of strong family ties and cultural identity (Stanford & Du Bois, 1992; Stuart & Rathbone-McCuan, 1988). Social workers will be more effective if they are also knowledgeable about this population’s different health issues and services necessary to meet elders’ needs. An awareness of the various agencies that provide health and social services on and off reservation land is also critical. When addressing the legal aspects of maltreatment and abuse, social workers need to be aware of existing tribal-justice systems, adult codes or ordinances enacted by tribal nations to protect elders on reservation land, and the processes required to facilitate clients accessing these systems. Social workers can provide additional assistance by developing and implementing training sessions for elders and elder care providers about the dangers of maltreatment and neglect.

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THE TRIALS AND TRIBULATIONS OF WORKING WITH FAMILY CAREGIVERS OF THE ELDERLY

The NASW Aging Section Committee invites you to participate in an online discussion in June on The Trials and Tribulations of Working with Family Caregivers of the Elderly.

This discussion will explore the special challenges faced by social workers who work with sons, daughters, husbands, wives, and others who care for older relatives in need of their assistance. Interventive strategies, community resources, and special issues that most frequently need to be addressed will be considered. We will also discuss policy and program gaps in meeting family caregivers’ needs, regional variations in the experience of working with caregivers, and differences in issues arising in rural versus urban communities. Please join us on the Aging Section Web site’s online forum discussion by posting your ideas, experience, and questions. Dr. Len Kaye, Chair of the NASW Section on Aging, will take the lead in encouraging discussion and information sharing. To access the online forum, please go to www.socialworkers.org/sections and click on aging.

THANK YOU

The NASW Aging Specialty Practice Section committee and staff would like to thank you for your continued support of the program. Our goal is to provide you with key information, resources and the expertise you need to stay at the forefront of your practice area on an on-going basis. It is our pleasure to serve you.

OLDER AMERICAN MONTH

The NASW Specialty Practice Section on Aging acknowledges the month of May as Older American Month. This year’s theme is “What We Do Makes A Difference.” Please check the Aging Section Web site at www.socialworkers.org/sections for the information and advocacy alert that will be posted in May to coincide with Older American Month.