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Elders and Elderlies: Well-Being in Indian Old Age

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INTRODUCTION

In contrast to the exhaustive ethnographic and ethnohistoric literature on American Indian life generally, there has been, until the last decade, limited ethnographic description of the quality of life and possible career paths available to Indians in old age. The dearth of research findings that describe what it means to be old in contemporary American Indian society is due, in part, to the relatively small size of this subsection of the ethnic group. In 1980, 1.5 million American Indians lived in the United States. Of this number only 116,606 were over 60 years of age.[1] This figure represents a considerably smaller proportion (7.6 percent) of the total American Indian population when compared to the 16 percent of the general population who are over 60 years of age for the nation as a whole.[2]

Those findings about American Indian old age which have been developed in the last decade can be broadly divided into six categories: demographic profiles, definitions of Indian old age, condemnation of the current deplorable state of the older Indian, needs assessments with their findings and recommendations, ethnographic descriptions of roles and functions of elders in nineteenth-century Indian societies, and ethnographic descriptions of positive and enhanced status and roles for contemporary Indian elders vis-a-vis their ethnic community.

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DEMOGRAPHICS OF AMERICAN INDIAN OLD AGE

Findings from census data analysis support the following assertions:

1. The number of elderly Indians is increasing.
   Improved health conditions on reservations and in urban centers have increased substantially the percentage of elderly Indians in the last three decades. In 1970, 63,823 Indians were at least 60 years of age.[3] In 1980, that figure had nearly doubled. Currently the growth in percentage of Indians of 60 years of age parallels the growth in percentage of elderly in the nation as a whole.[4]
2. Indian elderly tend to be rural.
   The majority of older Indians are located west of the Mississippi River on or near reservations.[5] Approximately one-third of American Indians leave reservation lands as young adults, but well over half of those who do so return and spend their old age on the reservation.[6] While Indians over the age of 60 represent 7 percent of the urban population, that same age cohort represents 8.7 percent of the rural population.[7] Out of every one hundred rural Indian adults, twenty-three are over 61 years of age.[8]
3. The number of elderly Indians living in urban areas is increasing.
   While American Indian elderly were predominantly rural (57 percent) in 1970, there were approximately equal numbers of older Indians in urban (57,854) and rural (58,752) areas in 1980. Based on a 20 percent sample of the 1970 census data on American Indians broken down by age and residence, 27,410 Indians over 60 years of age live in urban areas. In 1980, that figure had more than doubled.[9]
4. Indian elderly are familistic.
   Indian elderly on reservations are four times as likely, and those in urban areas are twice as likely, as their Anglo counterparts to live within extended families. Nine percent of the urban and 17 percent of the reservation Indian households are three to four generations deep.[10]
5. Indian elderly are poor.
   "Indian elderly compose the most deprived group of individuals in the United States. Existing on little or no income,

the aged Indian lives in a state of grinding poverty, the scope and impact of which is unknown to any other population group in the United States."[11] Poverty is particularly pronounced in rural areas.[12]

6. Indian elderly have unmet health needs.
   Older American Indians suffer disproportionately from certain diseases and health problems. Epidemiological data analysis underscores the inordinately high rates of adult-onset diabetes, hypertension, clinical obesity, and gastrointestinal problems among older American Indians.[13] These health problems are, in part, the functions of environmental conditions, among them poverty-associated lifestyles and diet.[14] Additionally, some research findings suggest a genetic predisposition for certain diseases in Indians.[15]

DEFINITIONS OF INDIAN OLD AGE

Comparability of findings and definition of terms are two major methodological issues which are yet to be resolved in attempts to analyze the limited findings currently available about American Indian old age. Just how old does an Indian have to be to be considered elderly in his or her community? Are there quantitative as well as qualitative measures by which one can assess the differences between elderliness and elderhood?

Chronological markers for the onset of Indian old age range widely. For example, in the Montana state plan for the elderly, authority was sought and granted under the Older Americans Act to consider American Indians "old" at age 45 in recognition of the social facts of these people's life conditions.[16] Federally funded nutrition programs for Indian senior citizens use 55 as the age at which Indians qualify for senior citizenship benefits. Studies have variously used 55, 60, 62, and 65 years of age as the onset of Indian old age.[17]

Hill argued that there is general confusion between life expectancy and age at death rates.[18] Measures of longevity are often misused by persons describing the differences between the health status of American Indians and those of other ethnic groups. In 1967, the expectation of life at birth for Indians was 60 years; the average age at death was 46 years. Life expectancy

of the general United States population at that time was 70 years, and the average age at death was 65. Careless comparison of the Indian average age at death with the life expectancy of the general population tends to exaggerate, unnecessarily, the gap between Indian life expectancy and that of the general population.[19] Even though general Indian mortality rates are improving, any definition of Indian old age must take into account that Indians, on the whole, still have significantly lower life expectancies than non-Indians.[20]

Consensus about when old age begins may be culture-specific. An exclusively chronological definition of old age ignores a complex system of social markers.[21] The title of this paper represents two such social markers. The terms *elders*[22] and *elderlies*[23] represent connotatively different but not necessarily discrete indigenous social categories. An Indian elder is not necessarily an elderly person. Rather, to be regarded as an elder implies recognition by the community of one's embodiment of certain exemplary and ethnically valued traits (e.g., sagacity, high moral standards, responsibleness). Elderhood is a status to which most Indians aspire, but not all achieve it. It represents a set of relationships between the elder and his or her constituency (e.g., stewardship, advisory and counseling duties on the part of the elder, and respect and compliance on the part of the constituents).

Elderlies, too, are not necessarily ancients. Rather, the label connotes stereotypically negative qualities abhorred in youth and adulthood but anticipated in old age (e.g., non-productivity, impairment, dependency, inactivity, neediness). Elderlies are thought of as needing looking after rather than as having some contribution to make to family and/or community. Providing for them becomes a "social problem" addressed through institutionalized responses.

CONDEMNATION OF THE CURRENT AND DEPLORABLE STATE OF OLDER INDIANS

Some contemporary writers view older American Indians as disenfranchised members of their communities.[24] Lack of social cohesion and well-being among contemporary Indian elderly, it is felt, results from younger Indians adopting the dominant soci-

ety's values and mores and, in the process, losing much of their own cultural ethos.[25] As a result, elders are no longer considered the most important members of their society. Loss of former political and spiritual leadership roles, combined with lack of interest on the part of the younger generation in the cultural lore that is the purview of the elderly, can constitute double jeopardy for the elderly, i.e., old and in minority status[26] or even triple jeopardy, i.e., old, in minority status, and poor.[27] Often neglected or, even worse, exploited and abused, many elderly Indians live out lonely lives of poverty, deprivation, and depression.[28]

NEEDS ASSESSMENTS, THEIR FINDINGS, AND RECOMMENDATIONS

Adequate housing, comprehensive and age-specific medical screening, illness prevention outreach, holistic health care, improved nutrition, reliable transportation, and in-house and, preferably, within-family care are most frequently cited as unmet needs of many older American Indians.[29] Documentation of the severity of living conditions among the Indian aged has prompted expenditures of substantial sums of federal funds for social services designed within a culture-sensitive operational framework.[30]

ETHNOGRAPHIC DESCRIPTIONS OF ROLES AND FUNCTIONS OF ELDERS IN NINETEENTH-CENTURY INDIAN SOCIETIES

The aging Indian as described in the then nascent and now classic turn-of-the-century American school of anthropological inquiry was not a tribal member grown old and tired, who had lessened personal capacity and social function. Rather, the older Indian became an elder: a person of substance and value, a person with inviolate dignity, a person held in great respect by his or her community members.[31] Councils of elders were the active centers of tribal decision-making. Elders held places of prominence in governmental and political affairs. It was through the elders that the culture of the people was transmitted across generations. In the absence of a written tradition, the entire history, language, arts, and value system of a people were passed on to younger gener-

ations by the elderly through their oral tradition.[32] Old age was not viewed as pathology. Rather, it was an ascribed as well as an achieved social status to which all tribal members aspired. One needed to have conducted his or her life in such a way that old age was achieved. Given long life, however, political, economic, and spiritual power were social coin which took on the quality of ascriptive rights accrued through having lived into old age.

Schweitzer cautions, however, that "although old-age status among Indian societies was marked by veneration, aged Indians at times became very vulnerable."[33] Among some nomadic societies, particularly the Eskimo, when old Indians became too enfeebled to do those family and community activities expected of them, and in times of extreme community crisis (famine, drought, epidemic), the elderly were at risk of abandonment or neglect.[34]

ETHNOGRAPHIC DESCRIPTIONS OF POSITIVE AND ENHANCED STATUSES AND ROLES FOR INDIAN ELDERS IN CONTEMPORARY INDIAN SOCIETY

In many Indian societies the elderly are still a needed and highly respected segment of the community.[35] Being old and American Indian can provide a synergistic power to the individual who controls valuable cultural resources, i.e., ritual knowledge and healing lore, property, ethnic paraphernalia, political power, and oral histories of both the family and the community.[36] Older Indians can and do make valuable contributions to community life. They are included in tribal councils. Many function as spiritual leaders of their communities.[37] Some participate in foster parent programs in both urban and reservation and/or rural areas.[38] Attainment of these and other culturally viable roles or old age careers contributes significantly to a sense of well-being among Indian elderly.[39]

RESEARCH DESIGN AND METHODS

In 1983, my colleagues, Barbara Myerhoff and Andrei Simic', and I began a three-year, cross-cultural study of ethnicity's contribution to successful aging.[40] We sought to discover those cultural

features, strategies, and social and psychological conditions that provide for well-being, that is, a sense of competence, autonomy, accomplishment and contentment in old age, in three ethnic-American communities.[41] An individual who expresses and embodies these traits is said to be aging successfully.

Participant selection was purposive. Since it was our goal to explore the contributions of ethnic community membership to successful aging and to identify those attributes of human experience that mark or define successful aging, we sought out participants who were participating members of their ethnic community and who both self-identified and were labeled by members of their communities as successfully managing the exigencies of the aging process.

Measures of successful aging include the assessments of other coethnics, the participants' self-assessments, and the investigators' ranking of a participant as to relative level of successful aging vis-a-vis the other members of the participant sample.

After considering the epidemiological and cultural criteria by which Indian old age has been determined, we designated 50 years of age as the low-end cutoff point for our samples. A person did not have to be retired to be included in the study. There was no high-end age cutoff point. Critical to inclusion in the study were self-identification as an older member of the ethnic community, active membership in that community, and a high level of discernible ethnic traits and identification. People who were too frail to take part in community activities were excluded from the study.

Participants were located in several ways. Initially, I reviewed the names of over two hundred Los Angeles-based American Indians I had interviewed since 1973. Those people who would have been at least 50 years of age in 1983 were contacted and screened for inclusion in the study. From this participant pool, I located sixteen American Indians still living in Los Angeles who were included in the study. At that time I discovered that nearly 50 percent of the older Indians I knew were no longer in Los Angeles, but had "gone home."[42] That is, after spending most of their adult lives in urban centers, they had made the choice to live out the rest of their lives in or in the vicinity of the rural and reservation communities in which they had grown up.

As a result of these findings, I refined my research design to include older Indians who had returned to their rural homelands.

Through the informal networks of their families, friends, and voluntary associations in Los Angeles, I was able to locate twenty returned individuals. Their informal networks included four additional returned families. In all, twenty-four Indians who have "gone home" and sixteen Indians who were still living in Los Angeles during the study period are included in the participant sample.

Demographic and life history data were collected for all forty Indian participants. The life history interviews were designed to elicit information about the participants' connectedness to ethnic life and about those aspects of their lives to which they pointed with pride, which they found self-satisfying, and by which they measured their level of life satisfaction, contentment and well-being.

Both quantitative and qualitative analyses were used to analyze the interview responses. Content and cross-ethnic analyses of the life history narratives and observations provided seventeen conceptual categories or markers by which the participants defined their success in managing their lives in old age as well as the success of their ethnic and age cohorts.[43] These indigenous markers of successful aging include good health, social contacts, family contacts, ethnic skills, involvement in a national religion, charitable activities, personality structure, high level of activity, financial security, community roles, mobility/independence, community and peer recognition, ability to handle crisis, service to the community or others, success in the non-ethnic world, successful children, and use of services available to senior citizens. These concepts were used across the three ethnic groups, but in variable levels of saliency, to describe successful aging and well-being.

Each researcher then ranked his or her group of participants with respect to each participant's relative success in managing old age vis-a-vis the other sample members. We then determined the relative presence or absence of markers in the participants' profiles. Each participant was assigned a value (from 0 to 10) on each of the seventeen successful aging criteria (0=absence of the trait, 10=extremely important in determining the participant's successful aging).

The strength of each of the seventeen successful aging markers in influencing ranking order and in discriminating between the highest and the lowest ranked participants was determined. The

values assigned to individual participants on each successful aging marker and the successful aging rankings of the participants in the three ethnic samples were subjected to three parallel non-parametric analyses. These analyses included (1) Mann-Whitney U test for mean-rank differences between the top half of the respective sample and the bottom half in terms of overall successful aging ranks; (2) a second Mann-Whitney U test for mean-rank differences between the top one-third and the bottom one-third of each sample; and (3) Spearman's *rho* correlations to permit an assessment of the criteria's overall fit (i.e., high with high, middle with middle, and low with low ranks) with successful aging rankings. The first test addresses the degree to which the criteria usefully discriminate between the higher ranked half of the sample and the lower ranked half. The second test measures the criteria's usefulness in discriminating extremes (within the range of variability) of successful aging in each sample. Finally, *rho* correlations were determined to explore the relationships among the various criteria.[44]

Results of these three analytical procedures are summarized in Tables 2 and 3 in the findings section of this paper. Only U scores with a relatively high probability of chance occurrence ($p = < 0.20$) are presented. All *rho* correlations which would attain a significance of $p < 0.05$ where the sample size is forty or more are included in Table 2.

FINDINGS

Demographic Profile of the Sample

Of the forty Indians in this study, all have spent at least ten years of their adult lives either in urban-industrial complexes on the West Coast or in rural areas at least five hundred miles from their original homelands. Sixteen (40 percent of the sample) still live in Los Angeles. Twenty-four (60 percent of the sample) have "gone back home" (see Table 1).

Twelve (30 percent) of the participants are Sioux. Ten of the Sioux live on the Pine Ridge Reservation in South Dakota; the other two still reside in Los Angeles. Twenty-six participants (65 percent of the sample) originally resided in eastern Oklahoma before migrating to other regions of the country as young adults.

They include eleven Choctaws, three Chickasaws, eleven Creeks, and one Cherokee. Twelve of these people still live in Los Angeles. Fourteen of them have "gone back home." The two remaining urban-based participants include a Chippewa woman and a Piegan/Blackfoot man.

Twenty-seven participants (68 percent of the sample) are "full blooded" Indians. Four participants are at least three-quarters Indian, seven at least 50 percent Indian. Only two are one-quarter Indian, the minimum requirement for acceptance into this study sample.

The mean age of the sample is 65.7 years of age. The rural subsample tends to be older than the urban subsample. The urban sample clusters between the ages of 55 and 64 (between the onset of old age and preretirement). The rural sample clusters between 60 and 74 years of age. The urban sample and the women have the greatest ranges in age. One urban Choctaw woman was 53 when interviewed. A second Creek woman living in the Los Angeles suburb of Bell Gardens was 83 when she was contacted for the first time. They were both accepted into the study because of their elder statuses in an urban Indian Christian church subcommunity. The rural sample ranges from a 62-year-old Sioux woman member of the tribal council to a 78-year-old Chickasaw retired school teacher and church lay preacher.

Twenty-three (57.5 percent) of the participants are women, and seventeen (42.5 percent) are men. There tend to be more women than men in both the urban and rural groups. but more so in the urban (62.5 percent women) than in the rural one (54 percent women). This feature of the sample profile is consistent with the national Indian age-by-sex profile.[45] On an average, life expectancy for American Indians is still five years less than it is for non-Indians. American Indian men, however, can expect to live ten years less than their non-Indian counterparts.[46] Therefore, in a sample of aging Indians, one would reasonably expect to find fewer extremely old people and a higher proportion of women than would be found in a sample of aging members of the general population.

Markers of Well-Being in Old Age

For the American Indians in this study, ten of the seventeen markers of success in old age are significant at the probability

TABLE 1
Distribution of Sample by Age, Sex, and Location

	Urban (L.A. Area)		Homeland (SD & OK)		Total in Sample	
Sample Size	n=16	(40%)	n=24	(60%)	n=40	(100%)
Age	n	%	n	%	n	%
<55 Yrs	X	6.3		0.0	1	2.5
55-59 Yrs	XXXX	25.0	XXX	12.5	7	17.5
60-64 Yrs	XXXXXXX	43.6	XXXXXX	25.0	13	32.5
65-69 Yrs	XX	12.5	XXXXXX	25.0	8	20.0
70-74 Yrs	X	6.3	XXXXXX	25.0	7	17.5
75-79 Yrs		0.0	XX	8.5	2	5.0
>79 Yrs	X	6.3	X	4.0	2	5.0
Mean Age	63.75 Years		67.0 Years		65.7 Years	
Females	62.5%	n=10	n=13	54.0%	n=23	57.5%
Males	37.5%	n= 6	n=11	46.0%	n=17	42.5%

level of <0.05 on at least one of the three employed statistical tests (see Table 2). Eight of the markers are significant at the probability level of <0.01 on at least one test. Six markers of success in old age reach probability levels of <0.01 on all three tests of statistical significance.

Seven markers of success in old age do not discriminate in any of the three tests of significance between the older Indians ranked either high or low on successful aging. The categories include family contact, involvement in ethnic religion, mobility/independence, ability to handle crisis, success in the nonethnic world, having successful children, and use of available senior services.[47]

Family contact does not discriminate between the highly successful and less successful participants. This is a particularly unexpected finding, given the extensive literature about the primacy of the family structure in ordering American Indian life.[48] From

TABLE 2
Tests of the Discriminatory Powers of the Successful Aging Criteria

Criterion of Success	M-W-1	M-W-2	SPMAN	N
Health	U	U**	R**	40
Social Contact	U**	U**	R**	40
Family Contact				40
Ethnic Skills		U*	R*	40
Involvement in Ethnic Religion				37
Charitable Activities	U**	U**	R**	39
Personality Structure	U	U*	R**	40
High Level of Activity	U**	U**	R**	40
Financial Security			R*	40
Community Roles	U**	U**	R**	40
Mobility/Independence				40
Recognition by Community	U**	U**	R**	40
Ability to Handle Crisis				36
Service to Community/Others	U**	U**	R**	40
Success in Nonethnic World				40
Successful Children				39
Use of Available Senior Services				36
Age		U		28

M-W-1: U indicates top *half* of ranked cases differ at $p < .20$ from bottom half.
M-W-2: U indicates top *third* of ranked cases differ at $p < .20$ from bottom third.
**: Indicates significance $p < .01$
*: Indicates significance $p < .05$
Spearman: R indicates a ranked order correlation with total ranking on success of at least $r = 0.28$

observation, I suggest that close family ties are givens in American Indian life. The viability of the family as a social, emotional, and economic structure is not an extraordinary phenomenon. It is the cultural base all Indians share that needs neither explanation nor veneration.

Use of senior services facilities is nondiscriminatory. This may be due to the general lack of old age services specifically for Indians in both the rural and urban areas. The cultural barriers to access to non-Indian social services by Indians of any age are well

documented.[49] Finally, older Indians, like many non-Indian elderly, view having to ask for assistance as demeaning and proof of their inability to care for themselves or to contribute to their communities. Unless free hot meals are couched in the most social of contexts, accepting them underscores the elderlies' dependence on others for survival, a public display of neediness to be avoided at all costs.

I suggest that, if the rubric *interdependence* rather than the term *mobility and independence* had been used, the category would have correlated highly with successful old age. Indians place high value on the emotional, economic, and political roles of the extended and, in many cases, corporate family. Although the notion of independence in old age may be a viable concept in the dominant society, interconnectedness across generations and levels of kinship and social ties remains a valued trait of American Indian life into old age. The conceptual differences underscore the issues and difficulties inherent in comparative cross-cultural studies. Certain concepts viable in one society may have no semantic weight in another.

The ability to handle crisis, I suggest, is another given of American Indian life. Life below the national poverty level means a continuous cycle of economic, medical, and personal crises. Coping with crisis may simply be a way of life and not something by which acuity in old age is particularly measured.

The inability of the other four markers to discriminate between high and low ranking participants on successful aging is less easily explained by referencing either the life history narratives or the ethnographic observations. These markers of successful aging may simply be more relevant to the other two ethnic groups in the original study and not culturally relevant to the American Indian experience in old age.

Age of the participants only weakly discriminates between the upper and lower thirds of the ranked sample. In this case, advanced age is associated with high rank. Given the national Indian life expectancy profile vis-a-vis that of the general population, long life is an unexpected gift, an indication of personal strengths and resources still to be tapped.

Financial security discriminates significantly in only one test. The general lack of economic well-being among Indians, and especially in old age, is probably the reason for the lack of discriminatory power. For the few people who had been able to put

funds aside for retirement and had worked long enough to insure a substantial monthly social security payment, financial security was a marker of their successful old age. The majority of the older Indians in this study, however, even with their combined pensions, general assistance, and social security incomes, barely "get by."

Ethnic skills discriminates at the $p = < 0.05$ level on two of the three tests. Although skill at beading, hide work, quill work, ceremonial dancing, etc. are noteworthy skills per se, they do not seem to be weighted as heavily as the employment of these skills for the good of the community. A skillful potter, rug weaver or moose hair embroiderer is admired for his or her artistry. However, if that craftsperson regularly puts an art piece up for raffle to raise money for the tribe's annual powwow fund, that generosity and service to the community elevates the craftsperson's community prestige in geometrical proportions.

Personality structure discriminates between successful and unsuccessful aging Indians in all three tests and in one test at the $p = < 0.01$ level of statistical significance. Personality structure is an amorphous category that includes such descriptors as "a good sense of humor," "a survivor," "a real strong person," "a sunny disposition" and "a will of iron." The rubric subsumes several personality and behavioral traits that suggest a positiveness, continued energy, engagement in, and enjoyment or acceptance of life's offerings. Essentially, the constellation of personality traits used to define and describe people who have successfully dealt with the aging process are markers of good mental health. Those people who exemplify this condition are the antithesis of the stereotypically depressed tenants of the back wards of senior citizens' domiciliaries. Rather, successful aging means coming to terms with the aging process with wit, enthusiasm, and an energy for life's work that remain untouched by the limitations of an aging corpus.

Good health significantly discriminates in all three tests of the successful aging rankings and at the $p = < 0.01$ level of probability in two. Though the Indian Health Service has made major strides since the 1950s to improve the general health of its constituents, much work still remains to be done. Those Indians who participated in this study were born before the massive health interventions of the 1950s were initiated. Theirs is a legacy of preventable childhood diseases and, in some cases, malnutrition and self-

abuse that leave many aging Indians with life-threatening, life-shortening, and life-limiting infirmities.

Reservation Indian Health Service (IHS) facilities are still difficult to access, understaffed, underbudgeted, and overbooked. Most urban centers are not serviced by the IHS. Therefore, among American Indians, good health in old age is not thought to be a given. Rather, it is a blessing. Long life is an indication that a person may have been protected by powerful guardian spirits that kept him or her from harm's way when less well-endowed and protected age peers succumbed to diabetes, hypertension, alcoholism, or depression.

Six markers discriminate between participants ranked high and low on successful aging at the $p = < 0.01$ level of significance. These markers include social contacts, charitable activities, high level of activity, community roles, recognition by the community, and service to community members or others.

Social contact—that is, the individual's regular and face-to-face encounters with a wide-ranging network of kin, friends and other coethnics—is a phenomenon which the participants acknowledge as a particularly positive and valued aspect of Indian community life. To be cut off, marginal, or without social exchange is thought to be a particularly unhappy state of affairs, especially in old age.

Charitable activity, or the sharing of resources with friends, kin and community members (generosity), is ingrained in youth and underscored by ritual as a fundamental and pan-Indian value. Through altruistic acts, the aging person constructs a reality in which he or she still provides services to others, and these generous acts are both expected and valued by the recipient community. Through altruistic behavior, the community elder staves off the terrible knowledge that he or she is no longer of use, is discardable and noncontributing, and, worst of all, is only dependent upon others.

High level of activity means that the individual's interests and community contribution are not limited to isolated and infrequent social acts, but that the individual is involved on a regular basis in a number of contributory and satisfying activities. Perhaps it is a function of the scarcity of older individuals capable of accepting and fulfilling these role obligations that venerated elderly Indians tend to fill multiple roles in their communities and, therefore, enjoy a highly active social and ceremonial life.

Indian communities provide a wealth of roles and tasks which

motivated older Indians can and are expected to carry out and for which the elderly Indians are much venerated. Head dancers at powwows, song and prayer leaders at sundances, medicine men and women, tribal council members, family heads, and caretaking grandparents are among the much venerated roles older Indians still carry out within home and community contexts.

Recognition of one's special talents or contributions to the community validates one's sense of worth and contribution to Indian community life. This is accomplished through public honoring rituals, bestowing of titles or awards, media dissemination of information about the person's contribution or the seeking out of the older community member by others for the purpose of enlisting his or her assistance, skills or products. Through public displays of veneration, the older Indian is raised to the much valued social status of community elder.

Service to the community is defined as an individual act or a series of acts that improve the quality of community life as a whole. The service can be as modest as the dependability of an older woman who can always be counted on to bake her specialty for the yearly calendar of communal potluck meals. Or it can be as noteworthy and dramatic as going to Washington, D.C. in full ceremonial regalia to speak on behalf of the reservation before a Senate subcommittee on water or mineral rights. Importantly, the older Indian who provides services for the community creates and sustains a system of generalized reciprocity, a network of economic exchanges and social credit that can be referenced, accessed and cashed in when needed at some future point. Further, providing services to the community means that the aging individual is not yet in social debt, but is in control of valued cultural resources, negotiable social coin.[50]

As a second level of analysis, we tested the intercorrelation of the seventeen categories. Table 3 indicates that the criteria—social contact, charitable activity, high level of activity, community roles, recognition for community roles, and service to the community—are interrelated and may be, in fact, facets of a larger and subsuming dimension of successful aging.

We have labeled this dimension "engagement with ethnic life." In all three circumstances the successful older Indian is involved in activities that identify him or her as still a contributor to community life. This concept does not oppose the disengagement model as developed some years ago by Cummings and

TABLE 3
Intercorrelations of Successful Aging Criteria

Successful Aging Criteria	HEALTH	SOCIAL CONTACT	FAMILY CONTACT	ETHNIC SKILLS	ETHNIC RELIGION	CHARITABLE ACTIVITY	PERSONALITY STRUCTURE	HIGH LEVEL OF ACTIVITY	FINANCIAL SECURITY	COMMUNITY ROLES	MOBILITY/ INDEPENDENT	COMMUNITY RECOGNITION	CRISIS SKILLS	SERVICE TO COMMUNITY	SUCCESS IN NONETHNIC	SUCCESSFUL CHILDREN	USE SENIOR SERVICES
Health	XX	+					+	+		+	+	+		+			
Social Contact		XX		+		+	+	+		+	+	+	+	+			
Family Contact			XX								+						
Ethnic Skills				XX	+										(−)		(−)
Involvement in Ethnic Religion					XX	+											
Charitable Activities						XX		+		+		+		+			
Personality Structure							XX				+		+	+			
High Level of Activity								XX		+	+	+		+			
Financial Security									XX					+			
Community Roles										XX		+		+			
Mobility/Independence											XX		+	+			
Recognition by Community												XX		+			
Ability to Handle Crisis													XX				
Service to Community/Others														XX			
Success in Nonethnic World															XX	+	
Successful Children																XX	+
Use of Available Senior Services																	XX

Letter symbol indicates rank-order correlation of 0.28 or greater in respective sample.
+ = Positive Correlation; (−) = Inverse Correlation.

Henry and Havighurst, Neugarten, and Tobin.[51] Nor is it analogous to the activity model as proposed by Lemon, Bengston, and Petersen.[52] Rather, it connotes an active, purposive seeking out and use of mechanisms by which individuals maintain social integration and a sense of continuing cultural awareness, competence and personal viability in their communities of choice. The notion of not only being engaged with life and personally active, but making a positive, recognized contribution to community life and the welfare of others seems the qualitative power of this constellation of successful aging markers.

Importantly, all six of these successful aging markers are highly positively correlated with health (see Table 3). At this point in the analytical process, it cannot be determined if good health allows the individual to continue to take active and contributory roles in Indian community life, or if that commitment to engagement in the productive life of the community fosters continued good health. The interconnectedness of these two markers of successful aging, however, is clearly illustrated.

DISCUSSION AND CONCLUSIONS

Ethnically inflected community statuses and roles in old age contribute positively to social and psychological well-being. Factors that support and sustain good mental health and personal well-being in Indian old age include active involvement in Indian community life, enactment of community recognized and valued political and spiritual roles, regular interaction with family (particularly grandchildren) and coethnics, continued community contribution and service, personal acts of altruism, and community recognition of such good works.

Some older Indians, however, are not incorporated or are not able to access the resources of their ethnic communities. This is particularly true among, although not exclusive to, the geographically dispersed and growing numbers of urban Indian elderly. Their sociocultural marginality contrasts starkly with their age mates who continue to be involved in ethnic community life. Lack of community role contributes to the older Indian's sense of loss, isolation, and lack of well-being. Not recognized by a referent group as elders, isolated older Indians are at risk of thinking of themselves as elderlies.

The opportunities for engagement with ethnic community life which Indian communities, both rural and urban, provide for older Indians are not finite. As the urban and rural Indian populations age, both their members and the social service delivery systems which provide for their well-being will have to address, support, and expand the sociocultural mechanisms which provide for the integration of individuals into meaningful community service. Maintenance of positive and contributory community careers and continued social viability act as antidotes to social isolation, loss of purpose, and depression in old age. Existing social and service delivery structures which support such community integration of the elderly need support and enhancement, and development where they are not now in place. These findings underscore the viability of ethnic community membership as a positive resource for and contributor to well-being in Indian old age.

NOTES

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2. U.S. Department of Commerce, Bureau of the Census, *1980 Census of Population, Vol. 1, Chapter B General Population Characteristics, Part 1 United States Summary PC80-1-81* (Washington, D.C.: U.S. Government Printing Office, 1983).

3. U.S. Department of Commerce, Bureau of the Census, *1970 Census of Population, Subject Report: American Indians PC9(2)-1F* (Washington, D.C.: U.S. Government Printing Office, 1973), 2.

4. M. R. Block, "Exiled Americans: The Plight of Indian Aged in the United States," in *Ethnicity and Aging: Theory, Research and Policy*, ed. D. E. Gelfand and A. J. Kutzik (New York: Springer Publishers, 1979), 184-92.

5. U.S. Department of Commerce, *1980 Census of Population*, 1-20.

6. R. P. Doherty, "Growing Old in Indian Country," in *Employment Prospects of Aged Blacks, Chicanos, and Indians* (Washington, D.C.: National Council on Aging, 1971); J. C. Weibel-Orlando, "Indians, Ethnicity as a Resource and Aging: You Can Go Home Again," *Journal of Cross-Cultural Gerontology* 3(1988): 323-48.

7. U.S. Department of Commerce, *1980 Census of Population*, 1-20.

8. National Indian Council on Aging, *The Continuum of Life: Health Concerns of the Indian Elderly* (Final report on the Second National Indian Conference on Aging, Billings, MT, 1978), 130.

9. U.S. Department of Commerce, *1970 Census of Population*, 2; U.S. Department of Commerce *1980 Census of Population*, 1-20.

10. National Indian Council on Aging, *The Continuum of Life*, 130.

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16. National Indian Council on Aging, *The Continuum of Life*, 69.

17. *Ibid.*, 90.

18. C. A. Hill, "Measures of Longevity of American Indians," *Public Health Reports* 85:3 (1970): 205.

19. *Ibid.*, 203.

20. National Indian Council on Aging, *American Indian Elderly: A National Profile* (Albuquerque: Cordova Printing, 1981).

21. National Indian Council on Aging, *The Continuum of Life*, 69, 123.

22. William Powers (in discussion, 1985) states that the contemporary Native American usage and intent of the terms *elder* and *elderlies* are fairly recent neologisms. Powers maintains that the term *elder* was introduced in the late 1960s by Indian activists and restorationists. Its current usage reflects the nostalgic assumption that Indians, generally, revered and honored their oldest tribal members.

The term *elderlies*, Powers asserts, reflects the labeling effect of sweeping government welfare assistance programs introduced in the mid-1970s. Those older people who became dependent on government subsidies as opposed to more traditional forms of social assistance earned this essentially negatively loaded label.

23. The term *elderlies* is a misapplication of the English language general rule for pluralization. Many American Indians hypercorrect by agglutinating an *s* to collective nouns (e.g., *furnitures, jewelries, sheeps*) to indicate multiple units of a given item.

24. Benedict, "A Profile," *Occasional Papers in Gerontology*, 51; Block, "Exiled Americans," *Ethnicity and Aging*, 184; F. Dukepoo, *The Elder American Indian* (San Diego, CA: Campanile Press, 1980).

25. J. Levy, "The Older American Indian," in *Older Rural Americans*, ed. E. G. Youmana (Lexington, KY: University of Kentucky Press, 1967), 221-38; S. K. Tefft, "Intergenerational Value Differentials and Family Structure among the Wind River Shoshone," *American Anthropologist* 70(1968): 330-33.

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27. W. R. Jeffries, "Our Aged Indians," in *Triple Jeopardy . . . Myth or Reality?* (Washington, D.C.: National Council on Aging, 1972).

28. National Indian Council on Aging, *The Continuum of Life*, 69.

29. *Ibid.*, 126-27; Benedict, "A Profile," 53; B. S. Williams, "Older American Indians," *Facts and Figures*, No. 9 (Washington, D.C.: Administration on Aging, 1977).

30. National Indian Council on Aging, *The Continuum of Life*, 53-55; Williams, "Older American Indians."

31. There are any number of classic ethnographies that could be cited here. One of the earliest and most comprehensive attempts to systematically organize information on roles for aged members of tribal societies across cultures is L. W. Simmons, *The Role of the Aged in Primitive Society* (New Haven, CT: Yale University Press, 1945).

32. National Indian Council on Aging, *The Continuum of Life*, 69.

33. M. M. Schweitzer, "The Elders: Cultural Dimensions of Aging in Two American Indian Communities," in *Growing Old in Different Societies*, ed. J. Sokolovsky (Belmont, CA: Wadsworth Publishing Co., 1978), 169.

34. L. Guemple, "Human Resource Management: The Dilemma of the Aging Eskimo," *Sociological Symposium* 2(1969): 59-74.

35. P. T. Amoss, "Cultural Centrality and Prestige for the Elderly: The Coast Salish Case," in *Dimensions: Aging, Culture, and Health*, ed. C. Fry (Brooklyn, NY: J. R. Bergin, 1981), 47-63; P. T. Amoss and S. Harrell, eds., *Other Ways of Growing Old* (Stanford, CA: Stanford University Press, 1983); Schweitzer, "The Elders."

36. B. Myerhoff, A. Simic', and J. Weibel-Orlando, *Ethnicity, Continuity and Successful Aging* (Unpublished grant proposal submitted to the National Council on Aging, Washington, D.C., 1982).

37. M. R. Munsell, "Functions of the Aged among Salt River Pima," in *Aging and Modernization*, ed. D. O. Cowgill and L. D. Holmes (New York: Appleton-Century Crofts, Education Division, Meredith Corporation, 1972), 127-32; Amoss, "Cultural Centrality"; Schweitzer, "The Elders."

38. J. C. Weibel-Orlando, "Grandparenting Styles: American Indian Perspectives," in *Old Age in Culture's Context: World-wide Perspectives*, ed. J. Sokolovsky (Westport, CT: Greenwood Press, in press).

39. For an in-depth discussion of the life's career concept, see B. Myerhoff and A. Simic', eds., *Life's Career—Aging: Cultural Variations on Growing Old* (Beverly Hills: Sage Publications, Inc., 1978).

40. The research project entitled "Ethnicity, Continuity and Successful Aging" was funded by Grant 1 RO1 AGO 3794-1-3 from the National Institute on Aging.

41. Myerhoff worked with elderly Jewish Americans in the Fairfax area of Los Angeles. Simic' worked with Serbian-Americans in the San Francisco Bay

area, and Weibel-Orlando worked with American Indians in Los Angeles, South Dakota and Oklahoma.

42. Terms regularly used by the American Indians with whom I worked are set off by quotation marks. While the majority of the people who had returned to their childhood homelands in old age had lived most of their adult lives in urban centers, the cities had never been "home" to them. In previous interviews, when asked what place they called home, only rarely did individuals not say, "where I grew up" or "back on the reservation."

43. An early impression that the age of the participant would have a significant effect on sense of successful aging was not borne out by the statistical analysis. I have included age in Table 2, because, although not a statistically significant finding, it was more strongly associated with successful aging among the Indians than among the other two ethnic groups.

44. I gratefully acknowledge the analytical insight and advice which John Long, research associate of the Ethnicity, Continuity and Successful Aging Study, provided throughout the data analysis process.

45. U.S. Department of Commerce, *1980 Census of Population*, 1-92.

46. National Indian Council on Aging, *American Indian Elderly: A National Profile*, 23.

47. In preliminary analyses, location (rural versus urban), sex of the participant, and tribal affiliation were found to be not significantly correlated statistically with success and well-being in old age. These variables were not addressed in the ranking exercise.

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49. Murdock and Schwartz, "Family Structure," 117-130.

50. Mutran and Reitzes, "Intergenerational Support," 117-130; A. Simic', "Winners and Losers: Aging Yugoslavs in a Changing World," in *Life's-Career Aging Cultural Variations on Growing Old*, ed. B. Myerhoff and A. Simic' (Beverly Hills: Sage Publications, 1978), 77-105; A. Simic', "Ethnicity as a Resource for the Aged: An Anthropological Perspective," *Journal of Applied Gerontology* 4:1 (1985): 65-71.

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