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

<table>
<thead>
<tr>
<th>Race</th>
<th>Single Parent as a Percent of all Families</th>
<th>Single Parent Poverty Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>6.1</td>
<td>24.6%</td>
</tr>
<tr>
<td>Black</td>
<td>29.6</td>
<td>63.4</td>
</tr>
<tr>
<td>Indian</td>
<td>33.8</td>
<td>64.0</td>
</tr>
<tr>
<td>Asian</td>
<td>10.0</td>
<td>59.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7.2</td>
<td>32.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>15.8</td>
<td>46.6</td>
</tr>
</tbody>
</table>

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 Anishinaabe colleague and seven Anishinaabe 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 Anishinaabe 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 themes were then reviewed by the Anishinaabe 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 Anishinaabe 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 status 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 change 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 outside 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 Anishinaabe 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 every time 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 Anishinaabe 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. Every-time 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 Anishinaabe 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 caregiving 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 really 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.
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 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 Alzheimer's 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 Populat 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 Ogemauy, is an enrolled member of the Bad River tribe of Anishinabe in Odanah, Wisconsin.