ETHNOGERIATRIC CURRICULUM MODULE

Health and Health Care of
AMERICAN INDIAN AND
ALASKA NATIVE ELDERS

AUTHOR: Levanne R. Hendrix, MSN, RN, GNP, PhD
Affiliated Core Faculty, Stanford Geriatric Education Center.
Assistant Clinical Professor, Department of Physiological Nursing,
University of California, San Francisco

Table of Contents

Description ............................................................................................................. 2
Learning Objectives .............................................................................................. 2

Content

I. Introduction and Overview ............................................................................. 3
II. Patterns of Health Risk .................................................................................... 12
   Culturally Appropriate Geriatric Care
III. Fund of Knowledge ....................................................................................... 17
IV. Assessment ..................................................................................................... 23
V. Prevention and Treatment .............................................................................. 28
VI. Access and Utilization ................................................................................... 33

Instructional Strategies ....................................................................................... 35

Student Evaluation .............................................................................................. 36

References and Resources ................................................................................... 40

Appendix A: Chronology of Selected Historical Events ......................... 50
Appendix B: Dementia in an Oklahoma Choctaw Woman ...................... 59
HEALTH AND HEALTH CARE FOR AMERICAN INDIAN AND ALASKA NATIVE ELDERS

DESCRIPTION

This module is designed to provide information to increase the health care provider’s awareness of specific cultural, racial, ethnic, and tribal influences on health and health care of the older American Indian and Alaska Native. World view, life experiences, and the cultural context in which today’s American Indian elderly live is described as it relates to health care.

LEARNING OBJECTIVES

Upon completion of this module the learner will be able to:

1. Describe the unique relationship between the older American Indian/Alaska Native and the United States government.
2. Develop awareness of the importance of the historical context in the lives of today’s American Indians and Alaska Natives.
3. Identify the major sources of data for American Indian/Alaska Native epidemiology and issues with the data collection.
4. List the top five causes of death for American Indian/Alaska Natives, and how they might be affected by culturally appropriate prevention programs.
5. Recognize indicators of conflicting expectations and responses to conflicting values of the American Indian/Alaska Native and the Euro-American value based health care system.
6. Describe the use of an American Indian/Alaska Native cohort analysis to understand the historical life influences and experiences of an AI/AN patient.
7. Describe strategies for the development of culturally appropriate verbal and non-verbal communication skills with the older American Indian/Alaska Native and their families.
8. Discuss the importance of eliciting explanatory information regarding illness and wellness from the American Indian/Alaska Native elder and his family for collaborative treatment planning.

CONTENT

I. INTRODUCTION AND OVERVIEW

A. Demographic Characteristics of American Indians and Alaska Natives (AI/AN)

The 2000 Census indicates that there are 4.1 million people who identify themselves as AI/AN (either alone or in combination with other races) in the United States (U.S. Census Bureau, Census 2000.) This is more than twice the count in the 1990 census of 1.9 Million. (It should be noted,
however, that in 1990 individuals were asked to list only one racial identification.) Researchers believe that self-identification of race by American Indian (AI) respondents in Census counts since 1960 have dramatically increased, but that the 1990 Census contained a severe undercount of American Indians estimated to be 4.6%, and 12.2% in tribal areas (Harris, 1994; Passel, 1996). The number of older AIs increased 69% between 1980 and 1990 and is projected to show an even more dramatic jump in the 2000 census.

There are at least 558 different federally recognized tribes/nations and 126 tribes/nations applying for recognition. At the time of first contact with Europeans, the continental United States was fully occupied by Indian Nations, and some 300 Indian languages existed, approximately 106 of which are still spoken. (See Figures 1 and 2.) The diversity and heterogeneity of the American Indian community cannot be overstated.

About half of the Indian population 60 years and older lived in five states in 1990: Oklahoma (18%), California (13%), Arizona (9%), New Mexico (9%), and North Carolina (5%) (John, 1999). The other states with a large number of American Indian elderly are Alaska, New York, Texas, Washington, and Michigan (John, 1999; US Dept. of Commerce, 1999). Preliminary data from Census 2000 including multiple racial identification indicate that California now has the greatest number of Indian elderly population, followed by Oklahoma, Arizona, Texas and New Mexico (M. Garretts, personal communication, 2001). (See Figures 3, 4, 5, and 6.) 1990 census identified 27% of AI/AN women, and 18% of AI/AN men, age 60 and over, living alone.

There are now more people who identify themselves as Indian in urban areas (62%) than on reservations and other rural areas, according to the 1990 Census. In this urban Indian subculture many of today's elders have been part of the development of Pan-Indianism, where individuals from many different tribal backgrounds band together to preserve their cultural heritage and develop culturally relevant services, programs and activities (Straus & Valentino, 2000). (See discussion of Pan-Indianism in Appendix A: Chronology of Selected Historical Events.) These urban elders are more likely to live alone than their reservation counterparts but less likely to live in poverty. Many are not served by the Indian Health Service (IHS).
Figure 2
Present Indian Reservations
WHERE AMERICAN INDIANS and ALASKA NATIVES LIVE: 1990

- Reservations and Trust Lands: 22.3%
- Tribal Jurisdiction Statistical Areas: 10.2%
- Tribal Designated Statistical Areas: 2.7%
- Alaska Native Village Statistical Areas: 2.4%
- Remainder of the United States: 62.4%

**Figure 3**

TEN MOST POPULOUS AMERICAN INDIAN TRIBES, 1990

Figure 5

Source: U.S Bureau of the Census
Figure 6
AMERICAN INDIAN POPULATION, AGE AND SEX DISTRIBUTION
BY PLACE OF RESIDENCE, 1990

Urban

Rural

Source: U.S. Department of Commerce, 1992, Table 19 as included in NICOA, 1996
The 1990 Census indicated that: 84% of American Indian elders reported income of less than $20,000, the highest percentage of any ethnic group; 19% of American Indian elders receive Supplemental Security Income (SSI), proportionately higher than any other ethnic group; one in ten American Indian elders reports some mobility limitation but not self-care limitation; one in five American Indian elders lives in housing without a telephone; and one in every eight American Indian elders received less than a fifth grade education (National Indians Council on Aging, Inc. [NICOA], 1996).

B. Influence of Historical Experiences on Today’s Cohort of Indian Elders

The lives of today's Indian elders are likely to have been influenced by the history of oppression, repression, intergenerational anger, and intergenerational grief, experienced since North America was colonized by Europeans. The disenfranchisement, the tradition of extermination, the broken treaties, the forced marches of the 18th and 19th centuries were all part of the context of the world and family experiences in which many spent their childhood. In addition, there were specific events that made dramatic impacts on individual lives. One of the most powerful influences was that of the Indian boarding schools. (See descriptions of Boarding Schools and other events in Appendix A: Chronology of Selected Historical Events.)

C. Indian Self-Determination and Self-Governance

In the late 1970s and 1980s American Indian lawyers shifted their fight to the courtrooms, claiming treaty violations and the undervaluing of tribal lands. The Nixon administration pushed through the Indian Self-Determination and Education Act of 1975, and the next twenty years saw tribal development through many growing pains, but with the ultimate goal of self-sufficiency. This Act authorized Indian tribes/nations to administer their own programs, and the Indian Health Service to grant moneys for operation of health services. This Act is a major force for Indian decision making and self-governance today. (Some Indians, however, believed that "self-determination" was another disguise for "termination," in that the federal government was attempting to terminate its responsibility for providing health care and other services promised by treaty, legislation, and judicial review (Nabokov, 1991, p. 385)

D. Religion

The basic tenets of Christianity (love for God and fellow man, honor, generosity and sharing, compassion, forgiveness, and self-sacrifice for the good of the community) were already institutionalized in the belief systems of many indigenous cultures before the missionization of North America. Therefore it was not difficult for Indians to “convert” to Christianity under pressure from the ever-increasing numbers of White men, and a changing world (Treat, 1996). However, Christian beliefs were likely to be added to Indian beliefs, rather than replacing them. For example, the Lakota belief system (as recorded by the spiritual leader and warrior Black Elk) differs from Christianity in that belief is in a parallel spirit world rather than one above this world, and that any member of the Indian community may be given a vision by God to benefit the whole community living on this earth. Prior to European contact, the Lakota did not have a concept of sin, redemption, salvation, or eternal damnation, but many believed that spiritual guidance was sent in the form of visions to sustain the whole community (Rice, 1991).

Many boarding school graduates and their descendents are Christian, since the boarding schools were run predominantly by Christian missionaries. Missionaries from different Protestant and Catholic denominations divided up the reservation and tribal lands among themselves, so as not to "compete for converts". Therefore, the Christian denomination of the region may still be the religion of preference for Indian families, and denominational support is often solicited at the time of family crisis or serious illness (Hendrix, 1999). A survey conducted by the Indian community in 1992 in Santa Clara County, California, indicated that 35% of the 158 adult Indian respondents considered
themselves "Christian", 27% stated that they followed both traditional American Indian and Christian religion, and 16% stated that they followed only an Indian religion; 22% are unknown (Hendrix, 1999).

E. Spirituality and Healing

Spiritual belief is a pervasive aspect of Indian culture, although belief systems vary widely between tribes/nations and geographic areas. Most Indian traditions teach that the “interconnectedness” of all things leads to a relationship between man, Creator/God, fellow man, and nature. In many Indian traditions, healing, spiritual belief or power, and community were not separated, and often the entire community was involved in a healing ceremony and in maintaining the power of Indian “medicine.” (The term “medicine” is often used to denote actions, traditions, ceremony, remedies, or other forms of prayer or honoring the sacred. The concept of healing power that is maintained by the collective consciousness and belief of people of an Indian community is referred to here. [Mails, 1991] In some tribes/nations causes of illness were considered to be an "imbalance" between the spiritual, mental, physical, and social interactions of the individual and his family or clan (Bennahum, 1998).

Healing is considered sacred work and in many Indian traditions cannot be effective without considering the spiritual aspect of the individual. Many contemporary Indians use “white man's medicine” to treat "white man's diseases." For example, diabetes, cancer, and gallbladder disease, and use Indian medicine to treat Indian problems (pain, disturbed family relationships resulting in physical symptoms, or sicknesses of the spirit, which may include mental illness and alcoholism). (Alvord, 1997; Hendrix, 1999.) In addition, many Western pharmaceuticals were actually based on Indian herbal medicines (for example, aspirin is derived from willow bark).

F. Definition of Terms

1. American Indian. Many older American Indians prefer the term “Indian” to “Native American,” believing that anyone born in the United States is a “Native American,” and that the term “Indian” reflects the language used in treaties with the federal government. There is no one legal definition for the term “Indian.” Courts have used a two-part definition for being Indian, in the absence of definition by Congress: 1) that the person must have some identifiable Indian ancestry, and 2) that the Indian community must recognize this person as an Indian. At the tribal level, each tribe determines the criteria for enrollment, and there is considerable concern about the dilution of Indian blood through intermarriage. The issues of being Indian, at an individual level, center around the artificially imposed concept of "blood quantum" levels - i.e. how much ancestry is needed to enroll in a given tribe; 1/2, 1/4, and 1/8 "Indian Blood" are fairly standard measures, but it varies from tribe to tribe. The Cherokee Nation accepts anyone whose ancestor's name appears on any one of several rolls, including the Dawes Roll. The Dawes Roll is a list drawn up by the federal government during the Allotment Era, of Indians receiving a 160-acre "allotment" of land as their portion of the Indian Territory in Oklahoma. The U.S. Census category includes anyone who self-identifies as "Indian."

2. American Indian Elder. The term “elder” in the Indian community denotes a position of leadership, based on experience, spirituality, and community service, rather than on chronological age. There are elders in their 40s and 50s, and many Indian grandparents in their late 30s. Therefore, “elders” are distinguished from “old Indians”. In addition, Indian elders are considered those 55 years of age and older by most Indian Health Service agencies. However, many tribes consider 50 years of age and older, and Medicare and Social Security consider 65 years, to be the age of eligibility for benefits.

3. Indian Country. The term "Indian country" refers to all reservation lands (there are 278 federally recognized reservations), dependent Indian communities, and all-
Indian allotments within the borders of the United States. In a social context, due to the geographic dispersment of American Indians to urban centers, with maintenance of strong ties to ancestral tribes and lands, “Indian Country” is also considered “a state of mind.” As Indians were not confined to “reservations” before contact with Europeans, many Indian people consider the entire United States to be Indian country, and continue to hold sacred many sites that are not on reservations or on tribally held lands (for example, the Black Hills area of South Dakota).

4. **Euro-Americans.** Refers to colonizing groups of non-Indians or non-Natives, who arrived from overcrowded European countries and created the myth of “discovery” to justify the claiming of Indian land (Calloway, 1999, pp. 67-98).

5. **Tribal Sovereignty and the Unique Relationship to the Federal Government.** In general, states have no legal jurisdiction in Indian country, and therefore tribal and federal law govern in both criminal and civil cases. Divorce, inheritance, taxation, and contract disputes often get mired in this complicated legal system. The American Indian (AI) experience is different from other ethnic minority groups in that 1) AI nations were colonized by Europeans and did not immigrate from other places within the last 700 years, 2) health care, education, and social programs were bought and paid for with ceded land by treaty, and 3) each elder is defined by the experience of the tribe (or tribes) to which he belongs (whether officially enrolled or not) and that tribe’s relationship with the federal government. The term **tribal sovereignty** refers to this unique relationship by which Indian tribes/nations maintain the right (by treaty) to negotiate directly with the federal government as independent nations.
II. PATTERNS OF HEALTH RISK

A. Influences on Quality of the Data

1. Indian Health Service data. The primary source for AI/AN health data is the Indian Health Service. This information is collected only from eligible (tribally enrolled, living on-or-near reservation of federally recognized tribes) members, who actually utilize IHS services. Therefore, IHS data may reflect “availability of services” rather than incidence and prevalence of illness, and may not include most of the 62% of AI/AN who live off-reservation (Administration on Aging, US DHHS, et al., 1996). Some AI/AN elders who live off-reservation are able to utilize IHS services, sometimes traveling long distances to do so.

2. Mortality: Misidentification and Misclassification. Mortality for AI/AN may be underestimated by 10% due to errors of misidentification of the race of the decedent, and/or misclassification in the cause of death (John, 1999, p. 71).

3. Regional Variability. Prevalence rates vary widely, especially in IHS data, from service area to service area, and by tribal affiliation. For example in 1988, 49.5% of adult Pima Indians (Arizona, had diabetes mellitus, and the Oklahoma Cherokee had 20.2% (McCabe & Cuellar, 1994, p. 21). Higher prevalence of hypertension (31%) was reported by urban American Indians in Los Angeles, compared to national sample of elderly AI/AN (19%) (Kramer, 1991; Los Angeles County Area Agency on Aging, 1989). Regional Trends in Indian Health is published on a periodic basis by the Indian Health Service and is available at: http://www.ihs.gov/NonMedicalPrograms/IHS_Stats/index.asp.

B. Mortality

There appears to be a “mortality cross-over” by age 85, according to IHS data. AI/AN have a higher mortality than whites up to age 75, from 75 to 84 the rates are much the same, and after age 85 AI/AN have lower age specific mortality rates than Whites (John, 1999).

American Indian elders have lower rates of death than whites for the top four leading causes of death (heart diseases, malignant neoplasms, cerebrovascular diseases, and chronic obstructive lung disease), but higher death rates for all other causes of death (John, 1999, p.73) (See Table 1). These causes of death have implications for the health care providers and educators, as most are preventable to some degree and could be addressed by culturally congruent intervention programs.

Excess deaths are reported among older American Indians for tuberculosis, diabetes, pneumonia, and cirrhosis (John, 1997; McCabe & Cuellar, 1994). Refer to Table 2-1, Module 2, pg. 16, in the Core Curriculum in Ethnogeriatrics (2nd ed.) (Yeo [Ed.], 2000) for comparison of AI/AN mortality with other races.
Table 1

<table>
<thead>
<tr>
<th>Cause</th>
<th>Rate per 100,000</th>
<th>Proportional Mortality</th>
<th>Total # of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diseases of the Heart</td>
<td>1,327.3</td>
<td>1,538.5</td>
<td>31.1%</td>
</tr>
<tr>
<td>2. Malignant Neoplasms</td>
<td>824.1</td>
<td>931.0</td>
<td>19.3%</td>
</tr>
<tr>
<td>3. Cerebrovascular Diseases</td>
<td>294.4</td>
<td>325.2</td>
<td>6.9%</td>
</tr>
<tr>
<td>4. Diabetes Mellitus</td>
<td>272.9</td>
<td>312.3</td>
<td>6.4%</td>
</tr>
<tr>
<td>5. Pneumonia and Influenza</td>
<td>248.7</td>
<td>264.8</td>
<td>5.8%</td>
</tr>
<tr>
<td>6. Chronic Obstructive Pulmonary Disease</td>
<td>184.8</td>
<td>203.1</td>
<td>4.3%</td>
</tr>
<tr>
<td>7. Accidental Injuries</td>
<td>133.3</td>
<td>141.4</td>
<td>3.1%</td>
</tr>
<tr>
<td>8. Nephritis, Nephrotic Syndrome, and Nephrosis</td>
<td>92.2</td>
<td>100.7</td>
<td>2.2%</td>
</tr>
<tr>
<td>9. Chronic Liver Disease and Cirrhosis</td>
<td>68.9</td>
<td>74.7</td>
<td>1.6%</td>
</tr>
<tr>
<td>10. Septicemia</td>
<td>54.6</td>
<td>58.2</td>
<td>1.3%</td>
</tr>
<tr>
<td>11. All other Causes</td>
<td></td>
<td></td>
<td>18.0%</td>
</tr>
</tbody>
</table>

C. Morbidity and Functional Status

American Indian males over 65 reported higher proportions of diabetes (1.5 times), gallbladder disease (1.4 times), and rheumatism (1.3 times) than older men in the general population. American Indian women over 65 had 2.4 times the rate of diabetes as older women in the general population. In comparison with all Americans, American Indians had a lower prevalence of cancer, but higher prevalence of diabetes and gallbladder disease, as reported in the SAIAN (Survey of American Indians and Alaska Natives) conducted in 1987 of Indians eligible for IHS benefits (Johnson & Taylor, 1991).

Health related mobility and self-care limitations are more common among female than male AI elders, and more prevalent in AI elders than white age-mates. In 1985, 59% of American Indians over age 65 reported one or more activity limitations, the highest of any ethnic population (McCabe & Cuellar, 1994). Increases in longevity in AI/AN are often accompanied by disabilities resulting in inability to perform activities of daily living (ADLs) such as bathing, toileting, eating, and walking, and instrumental ADLs (IADLs) such as using the telephone, managing money, shopping, cooking, and making health care appointments (See Figure 7).

D. Mental Health

1. Depression. Prevalence and manifestations vary depending on background difference and areas of residence (Manson, Shore, & Bloom, 1985). There is concern about the validity of using western measures of depression with American Indian populations due to vast differences in cultural beliefs about mental illness, cultural labeling of different emotions, variability of manifestations of depression (rarely DSM IV criteria), and conceptual language differences (Manson et al.). The Indian Depression Schedule (IDS) was developed by Manson and colleagues, which includes consideration of local cultural context (Baron, Manson, Ackerson, & Brenneman, 1990). Chapleski (1997) used the Center for Epidemiological Studies Depression Scale (CES-D) in a study of 309 Great Lakes American Indian elderly from urban, rural, and reservation settings, with good internal consistency of the tool (Curyto et al., 1997). This study also corroborated earlier findings of an association between stressful life events, depressive symptoms and decline in functional health status.

2. Alcohol Abuse - In a large national study (the Behavioral Risk Factor Surveillance System), 3,940 AI/AN adults were surveyed in 36 states concerning drinking patterns. Respondents were compared by age and sex to non-Hispanic white respondents. Contrary to stereotypes, AI/AN men reported lower levels of chronic drinking than non-Hispanic white men at older ages. AI/AN reported less current drinking but about the same amount of binge drinking as non-Hispanic whites by age and sex, with all groups of women reporting low levels of chronic drinking (Denny & Taylor, 2001).
Figure 7

AMERICAN INDIAN ELDERS 65 AND OVER WITH A MOBILITY OR SELF-CARE LIMITATION BY AGE AND SEX, 1990

Source: U.S. Department of Commerce, 1993: Table 40, as included in NICOA, 1996
3. **Suicide.** Older AI/AN have much lower suicide rates compared to older whites of the same age and sex; AI/AN suicide rates are the highest between the ages of 15 and 24 years (John, 1999). Rates also vary by tribe and over time. Research in New Mexico showed age-adjusted rates (1980-87) for Apache at 48.8 per 100,000, Pueblo at 32.0 per 100,000, and Navajo at 18.2 per 100,000. Suicide rates also cycled differently over time, with peaks every 5 to 6 years among Apache, and every 7 to 8 years among Pueblo (Van Winkle, 2000, p.132).

4. **Dementia.** Although little is known about the prevalence of dementia in the AI/AN community, Alzheimer’s Disease is thought to be relatively rare. It has been hypothesized that as the Indian population ages relative to the white population, vascular type dementias may be more common than other types of dementia due to the high prevalence of diabetes (Henderson, 2001), but as yet we do not have any prevalence data on the various causes of dementia in the AI/AN population.

5. **Elder Abuse.** American Indian cultural standards are different from the non-Indian community. Most cases of elder abuse reported in Indian country are for neglect, although financial abuse is probably more widespread, but clouded by the cultural norm of sharing one’s material possessions, food and housing with other family members. Many AI elderly live in tribally subsidized housing and receive SSI income, which may be the only source of income for a family. Elder Abuse Codes must be adopted by the Tribal Council on each reservation, and the process has met with considerable resistance in some areas due to denial of the problem, and the fact that “reporting” may have grave political consequences for family standing in the community. In addition, some AI/AN may not be aware that their behavior is considered abuse. (For example, improperly medicating or withholding medication, or not providing proper nutrition.) Research in Indian Country has shown that 1) the abuse is probably financial or neglect; 2) the abuser is probably a family member; 3) the victim is usually female, frail, and disabled, and 4) the victim may not recognize the situation as abuse (Clouse, La Counte, Eagle Shield, & Barber, 1998).
III. Culturally Appropriate Geriatric Care: Fund of Knowledge

A. Cohort Analysis for AI/AN Elders

A cohort analysis is an examination of historical events that may have impacted the lives of age mates of a particular group of people, in this case an ethnic group. The racial/ethnic/cultural history is reflected in the values, health beliefs, illness behaviors, self-image, degree of trust, and expectations toward health care providers. Cohort analyses list significant events that may have been experienced by the persons of interest during the specific developmental age periods of childhood, adolescence, young adulthood, middle age, and older ages. Not only does this model provide a framework for history taking in the clinical setting, but also provides clues to intergenerational differences and perceptions, and clues to mental health issues. The following should be considered in using a cohort study as a starting point for gathering information:

1) Effect of age of elder at the time of event
2) Not all AI/AN elders are impacted by all events
3) Relevance of social histories in provision of clinical care.

HAND OUT: Table 2:
“COHORT EXPERIENCES - AMERICAN INDIAN ELDERS”

CASES FOR DISCUSSION:

Mr. C. is a 66 year old Oklahoma Indian who was orphaned at a young age and was raised in Indian boarding schools. His young adulthood was spent “riding the rails” and “hard drinking.” He was married twice and has no children. He has been a sober and productive member of a large urban Indian community for the last 20 years, and he presents with chronic uncontrolled diabetes.

Mrs. D. was born and raised on a large Southwestern reservation in New Mexico. Her mother was Indian and her father was white. Her husband moved the family to an urban area during the 1940s, and he served three years in the military during W.W.II. Mrs. D. is now 76 years old, and spends time with each of her five children, two of whom live on the “home” reservation, and three live in different urban areas. Although Mrs. D. is an enrolled member of her tribe, she becomes ineligible for medical services if she is off-reservation for more than 180 days. Mrs. D. has arthritis, hypertension, and coronary artery disease. She has recently had a stroke, and now has a right-sided hemiparesis.

1. How could you use the cohort analysis in these two cases?
2. What events may have influenced Mr. C.? How might they affect his health care?
3. What events may influence Mrs. D.’s perception of health care? Her 50 year old children? Her 30 year old grandchildren?
4. What impact might Mrs. D.’s migration between her children’s homes have on her ability to access health care?
Table 2
COHORT EXPERIENCES: AMERICAN INDIAN ELDER

<table>
<thead>
<tr>
<th><strong>1900-1920</strong></th>
<th><strong>1920-1940</strong></th>
<th><strong>1940-1960</strong></th>
<th><strong>1960-1980</strong></th>
<th><strong>1980-Present</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reservations</td>
<td>Citizenship</td>
<td>World War II Service</td>
<td>Vietnam War</td>
<td>Education of Professionals</td>
</tr>
<tr>
<td>&quot;Vanishing American&quot;</td>
<td>Adoption of Indian Children by Whites</td>
<td>Relocation by BIA to Urban Areas</td>
<td>Indian Activism</td>
<td></td>
</tr>
<tr>
<td>Forced Boarding Schools</td>
<td>Loss of Land by Allotment System</td>
<td>Termination of 100 Tribes</td>
<td>Youths Return to Traditional Practices</td>
<td>Self-Determination of Tribes</td>
</tr>
<tr>
<td>Traditional Culture &quot;Bad&quot; Law Banned Spiritual Practices</td>
<td>Forced Assimilation</td>
<td>Forced Assimilation</td>
<td>Urbanization for Education &amp; Jobs</td>
<td>Urban Pan-Indianism</td>
</tr>
<tr>
<td></td>
<td>Boarding Schools</td>
<td></td>
<td></td>
<td>Reservation Gaming</td>
</tr>
</tbody>
</table>

**CURRENT AGE COHORTS**

<table>
<thead>
<tr>
<th>85</th>
<th>75-85</th>
<th>65-75</th>
<th>55-65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; Adolescents</td>
<td>Young Adults &amp; Middle Maged</td>
<td>Middle Aged &amp; Young Old</td>
<td>Young Old &amp; Old</td>
</tr>
<tr>
<td>Adolescents and Young Adults</td>
<td>Young Adults &amp; Middle Maged</td>
<td>Middle Aged &amp; Young Old</td>
<td>Young Old &amp; Old</td>
</tr>
<tr>
<td>Children &amp; Adolescents</td>
<td>Adolescents and Young Adults</td>
<td>Young Adults &amp; Middle Maged</td>
<td>Middle Aged &amp; Young Old</td>
</tr>
<tr>
<td>Children &amp; Adolescents</td>
<td>Children &amp; Adolescents</td>
<td>Adolescents &amp; Young Adults</td>
<td>Young Adults and Middle Maged</td>
</tr>
</tbody>
</table>

**AGE AT HISTORICAL EXPERIENCE**

Source: Hendrix, L. in Yeo et al. (Eds.) 1998
B. Chronology of Selected Historical Events and Impact on AI/AN Elders

It has been said that one cannot understand the American Indian without developing an appreciation of the unique relationship between the Indian and the federal government. Historical events, such as attendance in Indian boarding schools experienced by a high percentage of the current cohort of older American Indians, play a very important role in their daily lives. As a colonized people, these events have become a way of defining who one is in place and time, as well as those who went before. Intergenerational grief and anger may be based on these events, as well as intergenerational acceptance and survival. The health care practitioner working with elderly AI/AN should have this information, but also not assume cultural knowledge or practice by the older AI/AN.

HAND OUT: Appendix A
“AMERICAN INDIAN/ALASKA NATIVE CHRONOLOGY OF SELECTED HISTORICAL EVENTS”

LEARNING ACTIVITY:

Pick one of the historical events listed in the handout and research at: NATIVE HEALTH RESEARCH DATABASE, web site: http://hsc.unm.edu/nhrd/ The University of New Mexico Health Sciences Center Library, or NATIVE HEALTH HISTORY DATABASE, website: http://hsc.unm.edu/nhhdl/. Findings can be shared and discussed.

C. Indicators of Conflicting Expectations

Cultural values affect behavior, attitudes, and beliefs about health care and treatment, as well as expectations of health care providers. Cultural bias colors the way that individuals perceive the world around themselves and their response to situations and persons. Gaining an understanding of some potential areas of conflict in value systems will enhance the ability of the professional health care provider to collaborate successfully with AI/AN elders in planning and implementing health care in a culturally congruent and respectful manner.

Examples in the following handout are presented as a starting point for educational purposes and require direct follow-up with each individual patient for clarification and modification.

HAND OUT: Table 3. EXAMPLES OF CULTURAL VALUES WHICH MAY LEAD TO MISUNDERSTANDING AND MISINTERPRETATION OF BEHAVIOR
Table 3
EXAMPLES OF CULTURAL VALUES WHICH MAY LEAD TO MISUNDERSTANDING AND MISINTERPRETATION OF BEHAVIOR
Prepared by: Levanne R. Hendrix, MSN,RN, GNP, Ph.D.

NOTE: While many AI/AN elders were taught these values, not all AI/AN exhibit these values, depending upon Tribal/Nation variation, individual experience, level of acculturation, and the particular situation. The following are intended as examples of some of the more commonly held values in a Pan-Indian culture compared to those of many health care providers trained in the Euro-American value system.

<table>
<thead>
<tr>
<th>AMERICAN INDIAN</th>
<th>EURO-AMERICAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cooperation</td>
<td>1. Competition</td>
</tr>
<tr>
<td>2. Group Harmony</td>
<td>2. Individual Achievement</td>
</tr>
<tr>
<td>Physical modesty Not putting one’s self forward Non-attention seeking behavior (except in Sports)</td>
<td></td>
</tr>
<tr>
<td>4. Non-Interference</td>
<td>4. Advice giving, directiveness “Counseling” and “Educating”</td>
</tr>
<tr>
<td>5. Silence is valued Ability to listen and wait</td>
<td>5. Points made by aggressive verbal behavior, expression of opinion</td>
</tr>
<tr>
<td>6. Emotional Control Contemplation Non-demonstration of anger or other strong emotion</td>
<td>6. Action over inaction Direct confrontation Direct expression of anger</td>
</tr>
<tr>
<td>7. Patience Group decision by discussion and consensus</td>
<td>7. Rapid responses Decision making Problem solving</td>
</tr>
<tr>
<td>8. Generosity and Sharing Material possessions given away Respect earned by giving rather than saving Upward mobility within non-Indian society not sought</td>
<td>8. Individual Ownership Amassed material property Upward social mobility</td>
</tr>
<tr>
<td>9. Indifference toward future planning Saving for one’s own benefit not accepted Planning for future generations lost with the land The future, if there is one, “will take care of itself” Time orientation to the “present”</td>
<td>9. Saving for the future (Insurance, retirement, savings account)</td>
</tr>
<tr>
<td>10. “Work” done only as needed to feed the family Historically dangerous, risking injury or death</td>
<td>10. “Puritan Work Ethic” Work for work’s sake Rigid schedule</td>
</tr>
<tr>
<td>11. Indian Time Non-linear, relative to the activity at hand, flexible</td>
<td>11. Eurocentric obsession with time, “time is money”</td>
</tr>
<tr>
<td>12. Orientation to the Present</td>
<td>Delayed gratification for a future date</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>“Being” rather than “Becoming”</td>
<td></td>
</tr>
<tr>
<td>Living each day as it comes</td>
<td></td>
</tr>
<tr>
<td>Spirituality and joy are found in the present</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. Relationship with Nature</th>
<th>Ownership of land</th>
</tr>
</thead>
<tbody>
<tr>
<td>“We belong to the land, the land does not belong to us”</td>
<td>Science over Nature</td>
</tr>
<tr>
<td>“Love the Creator, love the creation”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14. Spirituality and Religion</th>
<th>For Christian Belief System:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-evangelical</td>
<td>Evangelical</td>
</tr>
<tr>
<td>Land-based</td>
<td>Activity based, portable</td>
</tr>
<tr>
<td>Pluralist, inclusive</td>
<td>Restrictive creeds, hierarchical</td>
</tr>
<tr>
<td>Integration with all daily activities</td>
<td>Worship at specific times</td>
</tr>
<tr>
<td>Each person responsible for own path</td>
<td>Salvation and/or 2nd coming</td>
</tr>
<tr>
<td>No original sin/damnation</td>
<td>of a Savior</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15. Extended Family Orientation</th>
<th>Nuclear Family Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aunts and uncles considered as mothers and fathers</td>
<td>Natural parents are only valid responsible parties</td>
</tr>
<tr>
<td>Grandparents traditionally parented</td>
<td>Measure of successful rearing is for children to “leave home”</td>
</tr>
<tr>
<td>Family members often “kept” by other relatives with no disruption of a family unit</td>
<td></td>
</tr>
<tr>
<td>Multi-generational and multi-geographical “homes” with family members</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16. Cultural Pluralism</th>
<th>Eurocentrism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jobs and educational system require some accommodation to Euro-American ways</td>
<td>“Dominant society”</td>
</tr>
<tr>
<td>Retention of Indian identity and cultural heritage</td>
<td>Defines a successful Indian as one who has adopted materialism, social and economic mobility, and Euro-American values to “get ahead”</td>
</tr>
<tr>
<td>Resistance to “assimilation”</td>
<td></td>
</tr>
</tbody>
</table>

LEARNING ACTIVITIES:

1. Discuss how the concept of “time” is different, and how that might affect a treatment regimen for diabetes.

2. Read “The Soul of an Indian” by Ohiyesa (aka Dr. Charles Alexander Eastman [1911]). (Available in most bookstores: Kent Nerburn [Ed.]. [1993], *The Soul of an Indian--and other writings from Ohiyesa*. Novato, CA: New World Library. Dr. Eastman (Santee Sioux) was educated at Dartmouth College, and Boston University as a physician, around 1900. He was widely acclaimed as an “Indian success” story. His childhood was spent in Canada as a traditional Native American, taught the ways of the forest and his people, when his band of Sioux fled to avoid internment and starvation after the Sioux uprising of 1862. Dr. Eastman spent many years in the Indian Health Service as a physician at the Pine Ridge reservation, and tended the survivors of the Wounded Knee Massacre (1890). He was an activist, organizer and leader. He seeks in this writing to explain the nature of Indian religious and spiritual belief and the tenets of Christianity -- how the two can be combined (pluralism), and how this may be a foundation for common ground between the Indian and non-Indian.

   a) Discuss how Indian spiritual values and Christian religious values might be in conflict; and how they might be complementary?

   b) Using the Historical Chronology of Significant Events in Appendix A, discuss what was happening during Dr. Eastman’s (1858-1939) childhood, middle-age, and older age, and how these events may have colored his world view.
IV. Culturally Appropriate Geriatric Care: Assessment
(For complete list of cultural issues in geriatric assessment domains, (see Module 4, p. 34-49 in Core Curriculum in Ethnogeriatrics [Yeo, Ed., 2000])

A. Appropriate Ways to Show Respect and Establish Rapport
Listening is valued over talking by most older AI; calmness and humility are valued over speed and self-assertion or directiveness. Avoiding the “invisible elder” syndrome, and asking for the elder’s help in understanding the current situation and in planning the components of further care are important aspects of showing respect for the elder’s experience.

B. Culturally Appropriate Verbal and Non-verbal Communication
Questions should be adapted to age and acculturation level. It is important for the health care provider to slow down when communicating with an Indian elder, especially during initial encounters, and when explanations of treatments/medications/health care decisions are being given. Questions should be carefully framed to convey the message of caring, and not indicate idle curiosity about the culture or cultural practices.

1. Conversational pace. American Indian languages have some of the longest pause times, compared to other languages, and especially English. Elders frequently complain that English speakers “talk too fast.” Silence is valued, and long periods of silence between speakers is common. Interruption of the person who is speaking is considered extremely rude, especially if that person is an elder.

2. Non verbal communication
   a) Physical distance: several feet is usual comfort zone.
   b) Eye Contact: not direct or only briefly direct, gaze may be directed over the shoulder
   c) Emotional expressiveness: may be controlled, except for humor
   d) Body movements: minimal
   e) Touch: not usually acceptable except a handshake.

C. Language Assessment.

Although many AI elders speak English, some are monolingual. Literacy level should be assessed, especially if written forms or educational materials are used. To evaluate type of interpreters, see “Benefits and Limitations of Interpreters”, by J. Enslein, (1999) in Yeo (Ed.) (2000), Core Curriculum in Ethnogeriatrics (Module 4, p p. 36-37). Adult same gender interpreter is preferred. “Probability” statements do not translate grammatically in some Indian languages, and may be misinterpreted as fact. Negative information may be culturally inappropriate, as “thought and word” may give reality to negative conditions, in some Indian traditions. Indirect discussion (e.g., someone other than patient in similar situation) is preferred to direct questioning. Older AI often need time to translate concepts into Indian language or thought, and then back to English/western thought to answer. Language Line Services may not be proficient in American Indian languages, of which some 150 are still spoken.
Table 4
EXAMPLES OF CULTURALLY MEDIATED COMMUNICATION PATTERNS AFFECTING HEALTH CARE ASSESSMENT  
Prepared by: Levanne R. Hendrix, MSN, RN, GNP, PhD

Note: Not all AI/AN elders will use these patterns, and not all AI/AN will use them all the time, depending on the situation. Euro-American patterns tend to be institutionalized within the health care system culture.

<table>
<thead>
<tr>
<th>AMERICAN INDIAN</th>
<th>EURO-AMERICAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance of direct eye contact as a sign of respect</td>
<td>Direct eye contact considered sign of honesty and sincerity</td>
</tr>
<tr>
<td>Handshake lightly; some women touch only the finger tips</td>
<td>Firm handshake denotes power</td>
</tr>
<tr>
<td>Information passed by “word of mouth” rather than media, some Internet used</td>
<td>Lectures, Newspapers, TV, Radio, and Internet utilized</td>
</tr>
<tr>
<td>Personal information not forthcoming</td>
<td>Self-disclosure valued, “open and honest” communication style</td>
</tr>
<tr>
<td>Ideas and feelings conveyed through behavior rather than speech</td>
<td>Verbal expression of ideas and feelings</td>
</tr>
<tr>
<td>Words are chosen carefully and deliberately, as the power of words is understood</td>
<td>Verbosity and small talk is appropriate social behavior</td>
</tr>
<tr>
<td>Listening is valued over talking</td>
<td>Schools teach speaking over listening, importance of expressing one’s opinion</td>
</tr>
<tr>
<td>Use of observational skills and non-verbal communication</td>
<td>Verbal and written communication valued</td>
</tr>
<tr>
<td>Criticism communicated indirectly through another family member, direct criticism considered disrespectful and rude</td>
<td>Direct criticism used to alter behavior</td>
</tr>
<tr>
<td>Withdrawal used as a form of disapproval (“voting with your feet”)</td>
<td>Direct expression of disapproval</td>
</tr>
<tr>
<td>Request given through indirect suggestion</td>
<td>Directiveness of requests</td>
</tr>
</tbody>
</table>

D. Domains of ethnogeriatric assessment

1. Client background (See “Cohort Analysis” in previous section).

World view, life experience, current status are affected by: geographic location of birth (on-reservation, off-reservation, urban), childhood experience, boarding school experience, tribal affiliation, exposure to traditional Indian beliefs and practices, level of acculturation, inter-tribal marriages, military service, specific land issues of Tribe/Nation with US Government, treaty issues, status of health care benefits (IHS, Tribal contract/compact, Medicare, Medicaid, HMO).

2. Clinical Domains

   a) Health History. Information and self-disclosure may be guarded. An aggressive or dismissive approach to the AI elderly may irreparably damage the health care relationship. Reference to “a problem” that needs fixing by a health care provider, should be avoided (e.g., statements such as, “What is your problem?”), although many documentation systems are still “problem” oriented.

   b) Physical Examination. Modesty and privacy are valued, requests should be accompanied by explanation in a quiet, calm, pleasant manner. Loudness and brusque manner are associated with aggression. Touching of the body (by a stranger or family member) in some Indian cultures is inappropriate. Therefore, permission should be obtained before examination of each area, and care taken to keep the body covered. In some reservations clothes are removed only if absolutely necessary.

   c) Cognitive and Affective Status. AI elderly rarely present for treatment of “depression”, although symptoms may be present. The symptoms are more likely to be expressed as a cultural metaphor (e.g., “heavy heart,” “an esteem problem,” “lack of balance or harmony”), various physical complaints or normalized as “part of life.” Memory loss and dementia are often minimized by family and community, and may not present for treatment unless physical function is impaired. The Mini-Mental Status Exam (MMSE) (modified for cultural relevancy and language consistency), the Indian Depression Schedule (IDS), and the Center for Epidemiological Studies Depression Scale (CES-D) have been used with internal consistency for this population. DSM IV Diagnostic Criteria for mental disorders may not be applicable as there are vast differences in cultural (tribal) beliefs about mental illness, cultural labeling of different emotions, and conceptual language differences (Manson et al., 1985).

   d) Functional Status. Appropriateness of commonly used ADL and IADL scales should be assessed. For example, what kind of activities is the elder used to doing? Did they ever use a telephone or balance a checkbook? Or, did they chop wood and carry water, or engage in activities such as leatherwork, beading, or weaving?

   e) Home and Family Assessment. In addition to home safety, issues to consider include family care patterns, gender taboos, feelings about outsider assistance in the home (e.g., home health aides, Public Health Nurses, Community Health Representatives). Gender roles differ widely between Tribes/Nations. Family willingness and knowledge base to care for a dependent elder could be assessed with questions such as “How should family members treat one who has this condition?” In many tribes, clan relationships may also be important as possible participants in health care decision making situations.

   f) Advance Directives and End-of-Life preferences. Assessment when appropriate, and not usually until a relationship has been developed with some degree of trust.

3. Problem/Condition Specific Information. A “problem” oriented format may be offensive and patronizing to many older American Indians as it implies a power differential between
the health care “provider” (usually a member of the dominant society) and the “person with the problem”.

a) **Explanatory Models of Illness.** The importance of exploring beliefs concerning the causes and treatment of illness with the individual elder cannot be overstated. (See Module 4, *Core Curriculum in Ethnogeriatrics*, p. 42 [Yeo, Ed., 2000]) Examples of AI/AN Explanatory Models for Dementia demonstrates the diversity of culturally mediated belief systems for only one chronic health problem. With information about the patient’s explanatory model, providers can plan culturally acceptable intervention and treatment strategies in a collaborative relationship with AI elders and their families. Examples of questions that can be used to elicit the patients’ perspectives include: What do you think caused your problem? Why do you think it started when it did? What do you call it? What do you think your sickness does to your body? How does it work?

---

HANDOUT: Table 5. EXAMPLES OF AMERICAN INDIAN/ALASKA NATIVE EXPLANATORY MODELS FOR DEMENTIA

4. **Intervention specific data** (Tripp-Reimer, Brink, & Saunders, 1984).
   a) Adaptation of questions to age and cultural competence, e.g., How are you and your family treating this condition? What kinds of medicines, healings, have you tried? Have they helped? How has this condition been treated in the past?
   b) What type of treatment do you think you should receive from me?
   c) Culturally specific content for specific interventions (e.g., dietary/nutritional/food preferences, cultural basis for chronic pain management)
   d) Does anyone else need to be consulted?
   e) Is there any other information that might help us design a treatment plan?

5. **Outcome Criteria.** Negotiating outcome criteria with older adults/family members. Western biomedical linear model may be in conflict with circular model, more common in most Indian cosmology.

---

Learning Activity: Read the Case in Appendix B: “Dementia in an Oklahoma Choctaw Woman” and Answer the Questions that Follow

---

26
Table 5

EXAMPLES OF AMERICAN INDIAN/ALASKA NATIVE EXPLANATORY MODELS FOR DEMENTIA

Levanne R. Hendrix, MSN, GNP, PhD

Although dementia is relatively rare in American Indian elderly, it is anticipated that as Indians’ life expectancy increases, so will the incidence of dementia. Explanatory models vary from tribe to tribe, and individual to individual. These are only several reported examples:

1. Each person is put on the earth for a short time for a purpose. When that purpose is accomplished the person is ready to leave this world. Death and illness are not caused by others, and prolonged grieving prevents the spirit from crossing over to the next world where there is no pain, but peacefulness. Appropriate medical treatment and death are discussed openly (Isleta Pueblo, New Mexico). Dementia is a part of the Creator’s plan for that person’s ultimate learning and may not require intervention or help-seeking (“naturalization” of cognitive impairment and dementing behavior, with greater “tolerance” for a wide range of behavior than white communities) (Cherokee).

2. Dementia and illness are caused by an imbalance in the patient’s spiritual, emotional, and social environment. Speaking of negative consequences (prognosis) to an illness can bring those events to pass as thought and language have power to shape reality (Bennahum, 1998). Dementia may be caused by breaking a cultural taboo (e.g., a male speaking directly to his mother-in-law, touching a dead person) by the person with dementia or a family member. Treatment may require the services of traditional Indian medicine and not necessarily Western medicine (Navajo).

3. Dementia is a condition in which the person’s spirit has already crossed over into the next world, but the body remains behind as it prepares to leave. The caregiver’s job is to take care of the body until it is ready to leave, and this is sacred work. The person is communicating in the spirit world, which is why language and behavior appear to us as if overhearing one side of a telephone conversation. In some Indian communities this is a mark of elevated spiritual status for the family (Oklahoma Choctaw).

4. Dementia is caused by the stress on Indians of trying to live in two worlds at one time. Especially, the stress of a rigid Christian belief system of traditionally reservation-raised elderly, and the stress, over time, of urban Indian living and family life. The lack of a collective consciousness in Indian spiritual belief dilutes the power of the Indian spiritual community and allows stress to develop illness, of which dementia is one form. Evidence is cited that dementia has been very rare in elderly Indians in the past (Urban Lakota Sioux).

References: Correa, 1998; Henderson, 1998; Hendrix, 2001a

V. Culturally Appropriate Geriatric Care: Prevention and Treatment

Culturally appropriate interventions depend upon the elder’s individual tribal affiliation, level of traditional beliefs, and acculturation to Western biomedical health care system. Most American Indians have had some exposure to allopathic medicine through Indian Health Service units, or care in urban clinics or military settings. Many older AI/AN exhibit a basic distrust of the Western health care system based on historical abuses and belief that this system is based on “greed” rather than care for the individual (Hendrix, 1999). It is important to again emphasize the importance of obtaining a detailed history in a respectful manner in order to understand as much of the tribal and
cohort influence on the individual elder as possible, given the heterogeneity of responses among AI elders.

A. Health Promotion Strategies. These should be based on areas of increased risk for AI/AN, as well as risk for all elders (See Module 5, Core Curriculum in Ethnogeriatrics (2nd Ed.) [Yeo, Ed., 2000])

1. Health screenings and Immunizations. AI elderly are at increased risk for heart disease, hypertension, diabetes, vision problems due to retinopathy, functional decline due to arthritis, osteoporosis, and diabetic peripheral neuropathy.

2. Health Education. Most frequent causes of death for AI/AN elders are at least partially preventable and could be addressed by development of culturally congruent education programs. Recent educational projects in Indian Country have indicated that it is necessary to use an intercultural collaboration model in both planning and implementation of patient education with the specific A/I community to be served. In addition, elders have asked for one-on-one education with a trained provider, rather than written printed materials, or educational lectures. Pictures, videos, and demonstrations rather than explanations have also been requested. “Doing” rather than “Talking” has been a traditional way of teaching for many Indians (IHS Research Conference, 2001, Albuquerque, NM. See Hendrix, 2001).

3. Nutrition. Many older AI participate in Title VI food programs under the Older Americans Act. For many, it is the only meal they may have in a day. Commodities programs have provided such foods as cheese, peanut butter, lard, sugar, condensed milk, and white flour to contribute to an unbalanced diet. Many Indian communities are looking to re-create the more healthy diet of their ancestors, with squashes, melons, corn, beans, fruits, other vegetables, and some meat. Lamb, venison, and buffalo are used when available. Soups and stews are traditional dishes that may be nutritious and culturally appropriate. Nutrition guidance is helpful for special diets, especially for diabetes and gallbladder disease, but care must be taken to use culturally acceptable foods, portions, and timing of meals, as well as food preferences and foods used in ritual and ceremony. Also, oral health and dentition is a major factor in nutrition and general health of the older AI.

In hospital settings the AI/AN may wish to share hospital food with family and friends, and to eat food brought in by visitors. One recommendation is to accommodate these wishes whenever possible, as hospitality and generous sharing is a deeply held tradition. There is a saying in Indian Country that “you can’t refuse” food offered, and that “food is always offered”- as an expression of “taking care of our people.”

4. Exercise. Several programs have been implemented in Indian Country and in urban centers with varying results. Although “exercise” has always been a part of Indian life, in terms of daily activities and walking, exercise levels in today’s more sedentary life style seem to be dependent on individual motivation. However, in most cases, a relatively high level of activity is maintained despite poor health or functional impairment. The people of Zuni pueblo in New Mexico have developed an innovative approach to Alcohol and Substance Abuse treatment in combining tribally ordered driver’s license suspension, counseling, community service, and a 30, 60, or 90 day mandatory physical work-out at the Zuni Wellness Program’s gym, for DWI arrest. Zuni also has extensive physical fitness programming for older AI.

B. Issues in Treatment and Response to Treatment

1. Informed Consent. Whether or not interpreters are needed, literacy level should be assessed, as well as English language skills. Many Indian languages do not have equivalent words or concepts for many English words, especially medical language. The cultural nuance of language (e.g., voice inflection and accent) can influence the meaning of words and phrases.
Some Indian cultures do not speak of death, dying, or of negative outcomes to medical procedures, as “thought” and “speech” can cause the negative outcome to occur (e.g., Navajo). Speaking the name of a deceased person may hold that person’s spirit in limbo, and delay their journey to the next world.

Ample time should be given for consideration of information given, and consultation with other persons in the AI community. Consultation may be sought from Clan leaders, matriarchs, patriarchs, religious leaders, and/or medicine persons. Also, translation of written material and medical jargon may be sought from other sources. Medical procedures may be appropriate only on certain dates for an individual in consultation with traditional Indian healers.

After slow and deliberate consideration of treatment options, an elder may choose not to accept the procedure or treatment, or in some Indian traditions, an elder may choose not to allow treatment for a member of his/her family (Alvord, 1999). Use of a cultural guide, or spiritual leader, may be helpful if not already engaged, but ethical and confidentiality issues are at stake. Ultimately, empowerment lies with the patient.

2. Surgery. It is not unusual for AI patients to request any removed body tissues be returned to them after surgery. This includes hair, nail clippings, tonsils, organs surgically removed (appendix, gallbladder, etc.), and often, amputated limbs or digits (Alvord, 1999). Some AI communities believe that the body must be whole in order to “cross over” into the next world, and some believe that body products could be used to cause the individual or his family harm if they are used in casting spells (e.g., Navajo) (Levy, Neutra, & Parker, 1987).

3. Advance Directives. Although Older American Indians may be less likely to have written Advance Directives, due to historical misuse of signed documents, distrust of the dominant system, and belief that families will take care of decision making, many Indians know what their preferences are. A survey of 50 AI over the age of 55 years in a community clinic in a large urban area of California revealed that only one respondent had written Advance Directives, “because he wanted to make sure a certain member of his family had no say” (Hendrix, 2000).

The heterogeneity of Indian tribal beliefs affects the provider’s ability to speak directly about negative outcomes in some situations (especially Navajo) as mentioned above. One way to work within this framework is to discuss with the family or spokesperson situations requiring decisions that have happened to others, come to an understanding with the treatment team regarding the patient’s wishes, and document the results of these discussions in the patient record.

Other AI tribal communities have no difficulty speaking directly about death or dying situations, and wish to have all the information available (e.g., some Pueblo, Lakota, Northern Plains, Midwestern, and Northeastern Tribes). These tribes tend to look at death as a natural part of the circle of life, not to be feared, as it may include a reunion with the ancestors who went before.

4. Medications. Sharing of medicines (Indian and biomedical) is common within clan groups and extended families. Pharmaceuticals may be stopped by the AI when s/he feels better, and “saved” to self-medicate if the problem recurs. There is also some anecdotal indication that benzodiazepines and anti-depressants (SSRIs) may have a stronger effect at lower doses in the AI/AN population in general. Many AI will take Indian “medicine” concurrently with Western pharmaceutical medicines, as Western health care tends to focus on body parts and disease systems rather than on the person in need of healing. Indian medicine considers the individual’s spiritual, emotional, mental, physical, and relationship state, and may consist of ritual, ceremony, special songs, fasting, sweating, herbal and/or animal medicines, avoidance or inclusion of specific foods, natural elements, or situations, usually prescribed by a medicine person, spiritual advisor, or
diagnostician, depending on Tribal tradition and availability. Cost of medications can be a major factor in utilization by AI/AN elderly, especially in urban or rural areas where Indian Health Service benefits are not available.

5. **Chronic Pain Management.** Many traditional AI/AN were taught to withstand pain as a skill for survival. Overt expression of pain (verbal or non-verbal) is unacceptable in many AI cultures today. Older AI/AN may be less likely to ask for pain medication and more likely to use internal resources to manage pain (Hendrix, 2001b). AI/AN are also generally undertreated for chronic and acute pain. A request for assistance may not be repeated, or may be told to a family member who will relay the request (Kramer, 1996).

6. **Dementia and Caregiving.** American Indians appear to have a lower frequency of dementia than other populations and are less likely to be institutionalized than older Whites or Blacks despite higher rates of chronic illness (Chapleski, Lichtenberg, Dwyer, Youngblade, & Tsai, 1997). Orientation to the present time, taking life as it comes, and a general acceptance of physical and cognitive decline as a part of aging are believed to be contributing factors in caring for a cognitively impaired elder in the community (Ogrocki, Welsh-Bohmer, & Allen, 1997). It has been suggested that AI caregivers differ from White caregivers in the use of “passive forbearance” as a coping strategy, which was not found with White caregivers. Also, AI caregivers did not expect to control or to be able to gain control of the situation of caregiving for a cognitively impaired elder, whereas the White caregiver did expect control, leading to anger and frustration (Strong, 1984).

It is unlikely that “memory loss” would be the presenting complaint of a cognitively impaired AI/AN elder. The most common problems in one study were understanding instructions and recognizing people they know. Approximately 1/3 exhibited restless and agitated behavior all the time, and the two least common demented behaviors were wandering/getting lost or exhibiting dangerous behaviors to self or others (John, Henessey, Roy, & Salvini, 1996).

The concept of caregiver “burden” is unacceptable in many AI cultures, and behavior by a person with dementia that may be considered inappropriate in Euro-American culture, is accepted in the AI elder’s community without social stigma (Henessey & John, 1996b). AI caregivers from the southwestern Pueblos reported that they “often felt inadequate dealing with behavioral difficulties” such as stubbornness, resistance to caregiving regimens and repetitive requests. However, cultural respect for elders with or without dementia does not allow for the direct expression of anger toward the elder or for infantilization witnessed in Anglo settings (John et al., 1996). The cultural incongruence of caring for an elder with cognitive impairment and the cultural values of non-interference, individual freedom, non-directive communication and respect for elders may increase stress felt by the caregiver significantly. Culturally appropriate support systems would be important resources for providers to offer as resources to AI caregivers.

7. **End-of-Life Care.** Varies from tribe to tribe with cultural tradition and individual acculturation. There is a general preference for naturalness, and home care is preferred unless there is a cultural taboo regarding death (Navajo). Many AI tribes/nations have specific rituals and ceremony concerning care of the body after death in order that the spirit crosses over safely to the other side, and is not held here by inappropriate behavior or thoughts by the deceased person’s family. Most AI traditions teach that there will be a joining with the ancestors and those that have gone before, and that death is a natural part of the life cycle.

8. **Organ Donation / Autopsy.** Generally, AI do not desire organ donation or autopsy (Kramer, 1996). However, some changes in this area are occurring due to the large numbers of AI/AN on renal dialysis due to end stage renal disease (ESRD) from diabetes.

9. **Coordinating Biomedical and Traditional Therapies.** Marbella, Diehr, G. Ignace, & G. Ignace (1998) surveyed 150 patients at an urban Indian Health Service clinic in Milwaukee,
Wisconsin, on concurrent use of Native American healers and physicians. Authors reported that 38% were utilizing the services of a healer, and that 86% of those not seeing a healer would consider seeing one in the future. In this study, greater than 1/3 of the patients received differing advice from the healer and the physician, and they were more inclined to follow the advice of the healer. Only 14.8% of this population shared this information of concurrent treatment with their physician. Respondents indicated thirty tribal affiliations, the largest numbers being Oneida, Chippewa/Ojibway, and Menominee. This study underscores the need for culturally sensitive dialog with patients about concurrent treatment and collaborative relationships with American Indian healers.

In many urban areas there are no Native American healers, and medicine persons travel long distances when called to these areas. Often, patients must travel “home” to find medicine/spiritual healers of the same cultural heritage and tradition. Whenever possible, co-therapy with traditional healers and medicine persons or diagnosticians should be encouraged. In some situations it is possible to have the traditional healer participate as a member of the interdisciplinary team. If an AI elder is hospitalized and requests it, arrangements may be made for ritual or ceremony at the bedside, which may include smudging with sage or sweet grass smoke. Other arrangements could be for Indian medicine pouches, bundles, or other specific items of sacredness and healing, that should not be disturbed or touched by health care personnel or hospital staff.
V. Access and Utilization

A. Need vs. Utilization.
Existing research indicates high levels of need for health care services for AI/AN elderly, and relatively low levels of service utilization for those services which may be available (John, 1999). Some of the barriers that reduce utilization include those listed below

1. Availability
Transportation, meals programs, Public Health Nurses, and Community Health Representatives (health paraprofessionals) are the most consistently used services. Some AI elders use non-IHS services such as the VA or private health care provider (Medicare HMOs), and thus would not show in utilization data. To help serve the urban Indian population there are a small number of urban Indian health programs which comprise only 1.2% of the IHS annual budget.

a) Long-Term Care
The Indian Health Service does not have a program for the provision of long-term care (LTC) services for the growing numbers of elders. A large focus group of American Indian Elders (IHS Annual Research Conference, Albuquerque, NM, 2001), indicated that elders considered Long-Term Care and Diabetes their #1 and #2 priorities. Most long-term care services are given by extended family, clan, and fictive kin. There are very few LTC resources in Indian Country, and no Adult Day Health or respite services, although some tribes have established social models of Adult Day Care. Since IHS does not include LTC services, tribes are responsible for providing any LTC that exists. There are only 12 tribally run Nursing Homes, and elderly AI have to be placed sometimes several hundred miles away from family, ancestral lands, and other Indians. Isolation and functional decline have been shown to result from this kind of placement. (Hennessey & John, 1996a) Lack of LTC services is of major concern to elders in Indian Country, and to their caregivers. Caregiver studies indicate that LTC services would be utilized if available (John et al., 1996).

Although most care is still given by extended family members, lack of development on Indian lands has led to permanent migration of young and middle-aged AI to urban areas, thereby reducing the availability of caregivers in rural and reservation areas. It has been suggested that poverty is a major determinant of extended family households due to cultural norms and the sharing and reciprocity of scarce resources (Manson & Callaway, 1990b). However, today’s Indian families are subject to the same stresses for economic survival as other ethnic groups. Despite a high need for social support, AI elders consistently underutilize services which may be available (John, 1999).

2. Accessibility.
A major barrier to service provision for many elders living on or near reservations is the long distance to clinics and hospitals, many times coupled with lack of transportation. Lack of ability to communicate in English with providers and staff of health care agencies who speak only English also reduce the accessibility. Bruce Finke, MD, (IHS Elder Care Initiative, personal communication) points out that IHS data indicate increased use of services as a percentage of population, but decreased hospital use when compared to all races (based on discharge days), and increased length-of-stay. This is believed to reflect scarcity of subacute care services and resources in the IHS service areas.

3. Acceptability. Potential barriers in acceptability of services include culturally incongruent treatment regimens; cultural differences in concepts of modesty and propriety; lack of respect; long clinic waits; and, staff turnover. Many AI/AN elders will not apply for Medicaid benefits for which they are eligible as a matter of pride because it is perceived as a hand-out from the government, or because it is believed that medical care was assured by treaty, or because the system is too complicated. A “fatalistic attitude” toward health also sometimes makes care seem less acceptable.
B. Managed Care. There is considerable concern in the Indian community that the health care system, built over the last 20 years to address the needs of American Indians in a culturally competent delivery system, will disappear with the advent of managed care contracting for Medicare and Medicaid funding. It is estimated that 30% of all Indians are utilizing Medicare or Medicaid coverage, but that less than 0.5% of any state Medicaid funding is spent on services to Indians. The concern is that with the “invisibility” of the urban Indian population, managed care by assignment to non-culturally sensitive providers will further reduce utilization, especially by elders who would not seek needed services, rather than be treated "rudely" by staff. Increased health care cost occurs when older AIs do not seek treatment until they are in severe distress.
INSTRUCTIONAL STRATEGIES

In addition to lecture and discussion, the following teaching/learning activities are suggested:

1. Use Learning Activities inserted throughout the module.

2. Assign students to read and prepare for discussion one or more of the cases included in the module and Appendix B.

3. Ask students to research the availability of outpatient care, hospital care, long-term care and senior centers for Indian elders in their area.

4. Ask one or more elders from American Indian or Alaska Native backgrounds for permission to have students visit and interview them or to come to class and talk about their experiences, especially in relation to issues such as Boarding Schools. (See Appendix C in Core Curriculum in Ethnogeriatrics (2nd Ed.), “Instructional Strategies for Interviewing Elders from Diverse Ethnic Backgrounds” [Yeo, Ed. 2000]).

5. Assign students to read the book by Lori A. Alvord & Elizabeth Van Pelt (1999). The Scapel and the Silver Bear: The First Navajo Woman Surgeon Combines Western Medicine and Traditional Healing. Or one of the other books or articles on the Suggested Reading list, and write a critique or present it in class.

6. If there is an Indian or Alaska Native community available, ask the students to use the cohort analysis model as a basis to develop one that is specific to the historical experiences of the elders in that community.

7. Ask students to identify the tribal affiliation(s) of older patients that health care providers are most likely to see in your area and research the explanatory models of dementia (or another illness), preferences for end-of-life care, and healing ceremonies traditionally found in those communities.

8. If native healers/medicine people are available, ask them to speak to the class.
ESSAY QUESTION
Mrs. J. is 60 years old, an enrolled member of a large tribe in the Great Lakes region. As a child attending public school in the area in which she lived, she was beaten and severely punished (as were her older brothers and sisters) for speaking her Indian language. As a result, she did not participate in class, and developed an intense distrust of White people. Mrs.J. did not speak her language while raising her two children so as to spare them similar abuse and discrimination. One of her two children was later able to develop an understanding of the language and culture during the “culture-seeking” of the 1970s and 1980s, but the other child did not.

1. How might this experience have affected Mrs. J.’s communication patterns? How might her motivation to pass along knowledge of Indian ways to her children have been affected?
2. What would you anticipate that Mrs. J.’s attitude and demeanor might be like during an initial interview?
3. What approaches might be appropriate and culturally sensitive?
(Refer to Table 4: Examples of Culturally Mediated Communication Patterns Affecting Health Assessment.)

POSTTEST
1) The unique relationship of AI/AN elders to the federal government includes:
   A. AI/AN lands were colonized by Europeans
   B. AI/AN did not immigrate from other countries
   C. AI/AN have given up 500 million acres of land
   D. Health care, education, and social programs were paid for with ceded land, by some 800 treaties with the US Government.
      a) A and B only                  c) B and C only
      b) A and C only                  d) All of the above
   (Answer: d)

2) There are 558 federally recognized tribes, each with their own traditions, history, and perceptions of the sacred. Therefore, the AI/AN population is extremely heterogeneous, which may affect health care utilization and acceptability.
   a) True                   b) False
   (Answer: True)

3) Tribal sovereignty, independent nation status, and tribal self-determination continue to be a major priority of AI/AN tribes/nations in the 21st century.
   a) True                   b) False
   (Answer: True)

4) Tribal affiliation and ethnocentrism is a strong force in AI/AN communities.
   a) True                   b) False
   (Answer: True)

5) “Pan-Indianism” refers to inter-tribal gatherings and community activities designed to preserve Indian culture in mostly urban areas.
   a) True                   b) False
   (Answer: True)

6) Appreciation of the historical context of the AI/AN is important because:
   A. Myth of “discovery” is often taught in educational institutions
   B. Indians throughout the 20th century were told that their culture, religion, and way of
life was without value.

C. Entire AI/AN families, villages, tribes and cultures were wiped out by measles, smallpox, influenza, and tuberculosis during the late 1800s and first half of the 1900s.

D. The illegal taking of land, rights, and religion has produced intergenerational anger and grief.

a) A and B only  c) A, B and C only
b) B and C only  d) All of the above

(Answer: d)

7) Which of the following are NOT significant AI/AN cohort life influences?

A. Intergenerational grief  E. Indian self-determination
B. Boarding schools  F. Spirituality and religion
C. Military service  G. Discrimination and racial oppression
D. Federal relocation programs  H. Acceptance and survival

a) E and F  c) H only
b) F and G  d) None of the above

(Answer: d)

8) Health care is guaranteed for all AI/AN by treaty rights, no matter where they live.

a) True  b) False

(Answer: b, refer to “Introduction and Overview”)

9) Which of the following are major sources of data collection for AI/AN epidemiology?

A. Indian Health Service  D. Researchers
B. US Census Bureau  E. Private Hospitals
C. Mortality data and death certificates

a) A, B and C  c) C,D and E
b) B,C and D  d) A,B,C and D only

(Answer: d)

10) Issues with AI/AN data collection include: Census undercount, utilization-based data by the Indian Health Service, errors of racial misidentification of decedents, and large regional variation in prevalence rates.

a) True  b) False

(Answer: a)

11) The top 5 causes of death of older AI/AN (in order) are:

a) Diabetes, Cancer, Heart Disease, Kidney Disease, and Liver Disease.
b) Heart Disease, Cancer, Cerebrovascular Disease, Diabetes, and Pneumonia/Influenza.

(Answer: b)

12) Indicators of potential conflicting values may include the following: time orientation, conversational pace, emotional expression, expression of physical pain/discomfort, group decision-making, avoidance of direct confrontation.

a) True  b) False

(Answer: a)

13) Cohort analysis is an examination of historical events that may have impacted the lives of age mates of a particular group of people. A cohort analysis may be useful in which of the following ways?

A. Provides a framework for history taking in the clinical setting.
B. Provides clues to intergenerational differences and perceptions.
C. Lists significant events that may have been experienced during specific developmental stages.
D. Should be used only as a starting point for the gathering of information concerning a particular individual.

(a) A and B only
(b) A, B and C only
(b) B and C only
(c) A, B, C and D

(Answer: c)

14) Mrs. Begay (not her real name) has come to a clinic for evaluation of a large mass in her right breast. She is 60 years old, and monolingual in her Navajo Indian language. The health care provider notices that she has worn her traditional velvet dress and beautiful turquoise jewelry, and has brought her adult daughter to translate. This is the health care provider’s initial interview with Mrs. Begay. What are some strategies for appropriate communication that the health care provider may want to consider in the interview session?

ANSWERS SHOULD INCLUDE, BUT NOT BE LIMITED TO:

a) Communication of respect for the elder
b) Eye contact levels of comfort
c) Use of “indirect” questions, rather than “direct” - may use the example of a third party under similar circumstances
d) Conversational pace and space for silence
e) Appropriateness of the family member as translator
f) Avoidance of the “invisible elder” method of interview (directing questions only to the translator)
g) Avoidance of listing of negative outcomes
h) Translatability of medical terms, probability statements, and concepts
I) Modesty and touching during physical examination
j) Literacy level and individual learning style for printed or educational materials

15) ESSAY QUESTION:
Discuss why it is important to illicit information concerning beliefs about the causes and treatment of illness (explanatory models) from AI/AN elders in the health care setting.

ANSWERS SHOULD INCLUDE THE FOLLOWING:

a) Health and illness beliefs are culturally mediated
b) Health and illness beliefs are extremely diverse among AI/AN groups and tribes
c) Appropriate questioning about causes and treatments of illness can convey respect for the elder and his/her world view
d) Understanding and acceptance of AI/AN elder’s health beliefs is required in order to plan culturally congruent intervention and treatment strategies
e) Acculturation influences should be assessed along with cultural influences
f) Spiritual and religious beliefs are often not separated from healing practices, and healing is considered sacred work
g) Combinations of biomedical and traditional Indian therapies may be used concurrently by the older A/I.
REFERENCES


**SUGGESTED READINGS**


**RESOURCES and INTERNET WEB SITES**
Indian Health Service, Eldercare Initiative  
Zuni PHS Hospital, P.O. Box 467, Zuni, NM 87327  
Phone: (505) 782-7357  FAX: (505) 782-7405  
e-mail: bfinke@albmail.albuquerque.ihs.gov  
www.ihs.gov/MedicalPrograms/elderCare/index.asp  

Indian Health Service Program Statistics Team  
http://www.ihs.gov/NonMedicalPrograms/IHS_Stats/index.asp  

**Comprehensive Geriatric Assessment In Indian Country**--Co-Produced by the New Mexico Geriatric Education Center and the Indian Health Service Elder Care Initiative. Contact either organization to obtain a copy.  

**Native American Elders Health Care Series: Balance: A Native American Perspective, Past, Present, and Future**--Module One addresses culturally congruent nursing care based on Lakota Sioux traditions for the Aberdeen Indian Health Service unit providers. South Dakota State University, College of Nursing--a SHARE Award Project (2000). Available on video for $25.00 including written materials, tests, and evaluation forms. CEs available. Also available via Internet. http://learn.sdstate.edu/Share  

**Native Elder Research Center**, University of Colorado Health Science Center, Resource Center for Minority Aging Research  
http://www.uchsc.edu/sm/nerc  

**Awakening the Spirit: Pathways to Diabetes Prevention & Control**--American Diabetes Association. 1-800-DIABETES (342-2383). e-mail: awakening@diabetes.org  
http://www.diabetes.org  


**Native Health Research Database**--AI/AN, provides bibliographic information and abstracts of health-related articles and resource documents by IHS, tribal, urban, and clinicians on-reservation and Alaska Native villages, 1966 to present. A partnership between University of New Mexico Health Sciences Center Library and the Indian Health Service.  
http://hsc.unm.edu/nhrd/  

**Native Health History Database** - University of New Mexico Health Sciences Center Library. Archival database of health related articles and documents (approx. 3300 entries) dating from 1672 to 1966.  
http://hsc.unm.edu/nhhd/  

**National Resource Center on Native American Aging & University of North Dakota Center for Rural Health** - P O Box 9037, Grand Forks, ND, 58202-9037.  
Phone: (701) 777-3720/1-800-896-7628  
http://www.und.edu/dept/nrcnaa  

**American Indian/Alaskan Native Caregivers: Taking Care of Each Other in Native Communities Focusing on Elders**, AARP Family Caregiver Series. A training manual for American Indian caregiver groups, including lecture format with overheads, role playing cards,
sensory impairment game cards, and case studies for discussion. Could be used in formal or informal setting for caregiver training. American Association of Retired Persons. Washington, DC.

**National Congress of American Indians**  
(202) 466-7767 (Washington, DC)  
[http://www.ncai.org](http://www.ncai.org)

**National Native American AIDS Prevention Center**  
(510) 444-2051 (Oakland, CA); e-mail: information@nnaapc.org  
[http://www.nnaapc.org](http://www.nnaapc.org)

**Native Web**  
[http://www.nativeweb.org](http://www.nativeweb.org)

**Stanford Geriatric Education Center**--Ethnogeriatric education, professional training, publications, seminars, Urban American Indian collaboration.  
Physical Location: c/o VA Palo Alto Health Care System, Building 4, 3801 Miranda Avenue, Room A-236 (GRECC/SGEC), Palo Alto, CA 94304  
(650) 494-3986, FAX: (650) 494-3617  
Mailing Address: 703 Welch Road, Suite G-1, Palo Alto, CA 94304  

See also the following resource available on the SGEC website:  
Yeo, G. (Ed.). (2000, October). *Core curriculum in ethnogeriatrics* (2nd ed.). Stanford, CA: Stanford Geriatric Education Center [Developed by the members of the Collaborative on Ethnogeriatric Education; supported by Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services.]

**New Mexico Geriatric Education Center**--Continuing Education presentations, seminars, publications (*Comprehensive Geriatric Assessment In Indian Country*). Southwest American Indian collaboration.  
University of New Mexico Health Sciences Center  
1836 Lomas Blvd., NE, 2nd Floor, Albuquerque, NM, 87131  
(505) 277-0911, FAX (505) 277-9897; e-mail: dfrankin@salud.unm.edu  
[http://hsc.unm.edu/gec](http://hsc.unm.edu/gec)

**The Consortium of New York Geriatric Education Centers** - Collaboration with Tribal and Urban Indian organizations.  
246 Greene Street, 5th Floor  
New York, NY 1003-6677  
Phone: (212) 998-9016  FAX: (212) 995-4561

**Lii Biyiin--(Horse Song)** a video by Norman Patrick Brown about the life of Jack White, a traditional Navajo man who is diagnosed with diabetes and his difficult journey back to health. It is a film about diabetes prevention for Native Americans. The film premiered at Sundance Film Festival, and was funded by the Indian Health Service. The 60 minute video is available at Four Directions Health Communications, Northern Navajo Medical Center, Shiprock, New Mexico, (505) 368-6499.

**The IHS Primary Care Provider**--A monthly journal for health professionals working with American Indians and Alaska Natives. Published by the Indian Health Service Clinical Support Center (CSC), subscriptions are free of charge. Phone: (602) 364-7777; FAX: (602) 364-7788; e-mail: the.provider@phx.ihs.gov
Previous issues beginning with Feb., 1994 can be found at the CSC home page: http://www.csc.ihs.gov.

The Sault Ste. Marie Tribe of Chippewa Indians--"Preserving Our Past." Video series (5 tapes) of the history and culture of the tribe as told by the Elders. (Awarded a silver medal at the 41st Annual International Film Festival and a 1998 Communicator Award.) Check or money order to: Sault Tribe Video Production, for $49.95. Mail to: "Preserving Our Past Video Series," Two Ice Circle Drive-Chi Mukwa, Sault Ste. Marie, MI 49783; Phone: (906) 635-7001.
Appendix A

AMERICAN INDIAN/ALASKA NATIVE CHRONOLOGY OF SELECTED HISTORICAL EVENTS
Prepared by Levanne R. Hendrix, MSN, GNP, PhD

50,000 - 5,000 B.C. - Lithic or paleo-Indian period - Migratory big game hunting and chipped stone artifacts - Indians already dispersed throughout the Americas (Waldman, 1985).

Before 1492 - Precontact Period - Before the arrival of Christopher Columbus, estimates of between 5 and 10 million population in North America.

1769 - 1834 Missionary Period in California - Indians were forced into slave labor at Spanish Missions. The California Indian population declined by 72% (Heizer & Whipple, 1971).

1778 - Treaty between the Delaware Indians and the United States. First United States and Indian treaty.

1787 - The Northwest Ordinance, ratified by Congress in 1789, declared: “The utmost good faith shall always be observed towards the Indians; their land and property shall never be taken from them without their consent; and in their property rights, and liberty, they never shall be invaded or disturbed, unless in just and lawful wars authorized by Congress; but laws founded in justice and humanity shall from time to time be made for preventing wrongs being done to them, and for preserving peace and friendship with them.” (Acknowledged the sovereign integrity of Indian tribes.)

1802 - Thomas Jefferson signs the Georgia Compact, which includes support of Indian removal.

1824 - Office of Indian Affairs is created by the Secretary of War, in the U.S. War Department. Army posts are used to supply annuities provided by treaty, and to provide services to Indians in the area.

1825 - Treaty of 1825 at Prairie du Chien, Wisconsin. Sioux, Sac and Fox, Menominee, Ottawa, Chippewa, Pottawatomie, Iowa, and Winnebago were prohibited from waging war against one another, and that the United States was the final arbiter of disputes.

1826 - Treaty of August 5, 1826, with the Chippewa. Article III stated: “The Chippewa tribe grant to the government of the United States the right to search for, and carry away, any metals or minerals from any part of their country. But this grant is not to affect the title of the land, nor the existing jurisdiction over it. Deloria (1988) describes this inclusion in the treaty as “the first clear-cut case of fraudulent dealings on the part of Congress,” as this language allowed for the unreimbursed removal of copper and other minerals.

1827 - Cherokee Nation of Georgia declares itself “independent” and adopts a written constitution. Sequoyah invented an alphabet for the Cherokee language, and almost the whole tribe could read and write their language.

1828 - Andrew Jackson elected President of the United States. Executor of the federal Indian policy of removal of all Eastern Indians to west of the Mississippi. President Jackson was well known for his military campaigns against the Indians.

1830 - Indian Removal Act passed by Congress to “remove” all Indians to west of the Mississippi River and authorized the President to negotiate with Eastern tribes for their relocation.
One month later Governor Gilmer of Georgia announced that gold had been found on Cherokee lands and that the gold belonged to the state of Georgia (Deloria & Lytle, 1983).

1831 - Cherokee Nation v. Georgia - US Supreme Court holds that Indian tribes are not foreign nations but “domestic dependent nations.” “As early as 1831, the Supreme Court characterized Indians as dependent on the United States for protection. Congress has implemented its responsibilities through treaties and statutes that have established a comprehensive program of special services to tribes and individuals (Cohen, 1982, in The NICOA Report, 1996, p. 12).

1836 - Treaty with the Ottawas and Chippewas. One of several treaties specifying medical care as partial compensation for Indian land and other resources ceded by treaty. Other treaties promised the “support of poor infirm persons”, or the “support and comfort of aged and infirm Indians.” (John, R. & Baldrige, D., The NICOA Report, 1996, p.12).

1838 - The Cherokee Trail of Tears begins. Four thousand Cherokee lost their lives in the forced migration from the Southeastern states to land in Oklahoma and Kansas.

1848 - US defeated Mexico; California became part of the United States.

1849 Gold Rush - Mass genocide of Indians by miners and soldiers in California. The California Indian population declined by 82% (Heizer & Whipple, 1971) and is remembered by local descendants as one of the Indian Holocaus.

1861-1865 - Civil War - As punishment for supporting the Confederacy, the Five Civilized Tribes (Cherokee, Choctaw, Chickasaw, Creek, and Seminole) were forced to give up the western half of the Indian Territory.

1864 - Navajo (Dine’) “Long Walk” to Bosque Redondo, thousands died on the forced migration.

1865 - 1875 - Reservation Period

1868 - Sioux Treaty of 1868 - included permit for non-reservation Sioux to claim land the government had taken for forts and other uses and later abandoned. It is the basis for the first Occupation of Alcatraz, March 8, 1964, by a small group of Sioux.

1876 - Custer defeated at the Battle of the Little Big Horn.

1878 - Boarding Schools are established. The purpose was to “civilize” Indian youth and resulted in de-culturation. The federal government had educational responsibility by treaty for many Indian tribes, and requested that Church societies run the schools. Most of the Indian students were shipped to schools that were purposely geographically distant from tribal lands in order to inhibit communication with family and to discourage running away. Attendance was mandatory, with children frequently being rounded up from their homes by Bureau of Indian Affairs (BIA) personnel and literally dumped on trains. (One particularly disturbing example occurred in 1887 when African American troops were sent to round up Hopi children and forcibly take them to the boarding school at Keams Canyon, Arizona [Calloway, 1999, pg. 361]. Several Hopi men were imprisoned in the dungeons of Alcatraz for refusing to send their children to boarding schools, as a lesson to other Indian parents (Fortunate Eagle, 1992).

When children arrived, some as young as two years, their Indian clothes were burned and their traditionally long hair was cut, which was very traumatic. Children were severely punished physically and mentally for speaking an Indian language, or participating in Indian culture. There were no family members or visits, sometimes for years. The absence of nurturing and warm human
contact was replaced with the necessity of attending church on a regular basis, converting to Christianity, and the task of learning to read and write English and do arithmetic. Many Indian cultures did not sanction physical punishment of children. As a learned behavior in American schools, many Indians brought this form of punishment into their homes. Missionaries in the early period of the schools expected rapid conversion to Christianity and "civilization" by their Indian charges, meaning farm work and domestic service.

Not until 1934 and the passing of the Indian Reorganization Act by Congress were Indians given the right to determine where their children attended school, and emphasis was placed on reservation day schools (Hendrix, 1998, pp. 12-13).

Upon returning to the reservation, many Indians were distressed to find that they no longer felt they belonged to the community they left. The young adult was uncomfortable in the once familiar surroundings, and the Indian community was suspicious and distrusting of the indoctrinated youngster dressed in western clothes. Many Indians left the reservations for extended periods of time, or made lives elsewhere as a result (Hendrix, 1999; Nabokov, 1991).

Despite the harsh realities of life in the Boarding schools, many Indian elders feel that it was a necessary experience to gain an education, and an understanding of the dominant society. These contemporary elderly Indians survived, took a positive mental attitude, and made meaningful and productive lives for themselves and their families (Calloway, 1999, pp. 363-364; Hendrix, 1998; Lomawaima, 1994.). Many of today’s elders went through a Boarding school experience.

1883 - The practice of Native American religions became a federal offense.

1887 - General Allotment Act (Dawes Act) - The allotment system forced individual ownership of land by Indians (by “allotments of 160 acres”), and destroyed the Tribal function. White farmers were allowed to purchase “surplus” pieces of the land. The purpose of the Dawes Act was to 1) break up tribal governments; 2) abolish Indian reservations; and, 3) force Indians to assimilate into a dominant society. The Dawes Act prepared Native Americans for eventual termination of tribally held lands. Thousands of Indians lost land due to poverty, foreclosure, or sale to other farmers. Of the 140 million acres of land collectively owned by the tribes in 1887, only 50 million were left in 1934 when the allotment system was abolished (Pevar, 1992).

1890 - Wounded Knee Massacre - 350 Sioux men, women, and children of Big Foot’s band of Miniconjou Sioux were killed at Wounded Knee, South Dakota, it is said on their way to a Ghost dance, by the Seventh US Cavalry (defeated fourteen years earlier at Little Big Horn), in subzero weather of winter. Dr. Charles Eastman (Santee Sioux) treated the wounded and mutilated, and searched the field for survivors (Calloway, 1999).

1900s - The Lowest point for American Indian populations. The first count was done by the Federal Government, and the number was estimated at only 237,000 Indians in the United States. It has been estimated that there were 5-10 million indigenous people on the continent of North America at the time of first European contact. Millions of Indians died due to disease, starvation, and deprivation. The era of the “Vanishing American.”

1880s to 1934 - Suppression and Repression of American Indian culture.
1) Boarding Schools – (See Above)

2) American Indian children were removed from impoverished Indian families during the 1920s until the 1970s (Indian Child Welfare Act, 1978) by “social workers,” and given to White families to raise. Many Indian children experienced social and cultural deprivation as a result (Jaimes & Halsey, 1992, p. 326).
1914 - 1918 World War I - American Indians fought and died in WWI defending from invasion by outside forces what was considered “Indian Land” -- the United States.

1921 - The Snyder Act - provided first moneys permanently appropriated for Indian health. Authorized the BIA to expend moneys that Congress might appropriate for the benefit, care, and assistance of Indians throughout the U.S. (John & Baldridge, 1996).

1924 - Citizenship Act of 1924. Indians were given full US citizenship.

1924 - Piper v. Big Pine School District, California - This case is viewed as the legal authority for a state assumption of responsibility for public education of Indians when states accepted federal funds and lands for Indian education (Deloria & Lytle, 1983, pp. 242-243).

1928 - The Miriam Report (“The Problem of Indian Administration, The Institute of Government Research, Washington, DC.”) Lewis Miriam and associates were authorized to conduct a survey of the social and economic status of Indians. The report covered health, education, general economic conditions, family and community life, migration of Indians, legal concerns, and missionary activities. The report bluntly described the federal Indian policy as ineffective and underfunded, and conditions as deplorable. The Miriam Report also included specific recommendations and procedures for improvement. The Senate Indian Committee decided to conduct its own study, which took another eight years, and reached basically the same conclusions (Deloria & Lytle, 1983, pp. 12-13).

1934 - Indian Reorganization Act (RA) (Wheeler - Howard Act) -
1) John Collier (Commissioner of the BIA) reversed laws banning ceremonies and spiritual practices by American Indians living on reservations.
2) Ended the federal government’s policy of “allotment”.
3) Established a credit fund for tribal economic development.
4) Promised expanded social programs and federal funding for projects.

Tribes were authorized to form “constitutional governments” which could employ legal council, and negotiate with federal, state, and local governments. 181 Tribes voted to accept RA provisions, and 77 tribes voted to reject the act (including the large Navajo tribe and the Indians of Oklahoma). Deloria and Lytle (1983) explain that while the new forms of Tribal Councils were akin to some tribal traditions, they were completely foreign to others, and that almost all of the traditional Indians opposed RA as another means of imposing “white institutions” on tribes.

Johnson O’Malley Act of 1934 - provides for the Secretary of the Interior to enter into contracts with state and local governments to provide for education, medical care, and social services for Indians displaced off reservations due to “allotment.” (John & Baldridge, 1996).

1941 to 1946 - WW II - During World War II (WWII) American Indian men were recruited to serve in the communication units, since they could send messages in Indian languages between American troops without enemy forces being able to break their code (e.g., the Navajo “Code-Talkers”). More than 25,000 American Indians served in WWII, many with distinction. Indian women were also involved in the war effort, and many left the reservations for the first time in their lives. After the war, Indians who had been treated with dignity and respect while serving in the armed services, came home to discrimination, racism, unemployment, and deplorable conditions on the reservations (Calloway, 1999, p. 421; Nabokov, 1991).

1948 - Hoover Commission - Recommended that responsibility for Indians be transferred to the states as soon as possible (Deloria & Lytle, 1983).

1953 to 1968 - Policy of Termination and Relocation
A. Termination:

1953 - House Concurrent Resolution 108 - States that, “at the earliest possible time, all of the Indian tribes and the individual members thereof located within the States of California, Florida, New York and Texas, should be freed from Federal supervision and control and all disabilities and limitations specifically applicable to Indians.”

1) The Klamath of Oregon and the Menominee of Wisconsin were terminated, as well as many smaller tribes from West Coast reservations (Deloria & Lytle, 1983). These tribes were ordered to distribute their land and properties to their members and dissolve their governments, and federal benefits and services were terminated (Pevar, 1992).

2) California rancherias were phased out. These tracts of land were established during the Depression as reserved land for homeless Indians (Deloria & Lytle, 1983, p. 18).

3) Over one hundred tribes were terminated from federal assistance.

1953 - Public Law 280 - Allowed state governments to assume criminal and civil jurisdiction over Indian reservations in California, Minnesota, Nebraska, Oregon, Wisconsin, and the territory of Alaska, but states were not given rights to tax Indian lands (Deloria & Lytle, 1983).

1) Preserved hunting and fishing rights to tribal and federal protections.

2) It was not until 1970 that the policy of “termination” was officially ended by President Richard Nixon, although most federal termination activities had ceased by 1958.

(Note: At the same time the federal government was terminating its responsibilities to tribes, Congress included Indian reservations in federal education programs created by Congress (1950), in the school construction programs (PL 815) and impact aid programs (PL 874), resulting in increased federal involvement in Indian education by 1958 (Deloria & Lytle, 1983, p. 19).

B. Relocation:

1954 - Transfer Act of August 5, 1954 - The Transfer Act transferred all functions and duties of the Department of the Interior concerned with the maintenance and operation of hospital and health facilities for Indians to the Department of Health, Education and Welfare (now the Department of Health and Human Services) (John & Baldridge, 1996). Hospital, health facilities, property, personnel, and budget funds of the Indian Health Service were transferred to the US Public Health Service.

1955 - Bureau of Indian Affairs (BIA) Relocation Office is established in San Jose, CA. There were four relocation sites in California: Los Angeles, San Francisco, San Jose, and Oakland, as well as the cities of Chicago, Detroit, Cleveland, Dallas, and Denver. Los Angeles and the San Francisco Bay Area were designated as vocational training centers. Thousands of Indians were moved off reservations to the cities in an effort to force assimilation. Many of today’s elders in urban areas were relocated during this period. BIA relocation programs looked at least hopeful to Indians for a better future, and most intended to eventually return to the reservations. Adjustment to urban dominant society living was very difficult for most Indians, and many returned to the reservations without completing the relocation program. Urban Indians suffered the same racial discrimination and inner city dysfunctions as other minorities. Some of those who stayed, established Indian cultural communities within the urban environment, and helped create the urban Pan-Indian movement of today.
1959 - **Alaska** becomes a state.

1966 - **Alaska Federation of Natives** is founded, representing Eskimos, Aleuts, and Indians.

1968 - **Menominee Tribe v. United States.** Supreme Court ruled that the Menominee retained its fishing and hunting rights even though Congress had “terminated” its reservation. Affirmed the principle that every tribe retains its hunting and fishing rights unless specifically extinguished by Congress (Pevar, 1992, p. 191).

1959 to 1975 - **Vietnam War** 42,500 American Indians served in Southeast Asia. Veterans are especially honored and carry the colors at the invocation of most Pow Wows today.

**1970s Activism** -
The American Indian Movement (AIM) was the most militant of the Indian protest groups, and started in Minnesota during the Vietnam Era to protest police discrimination in Minneapolis. The group had a following mainly in Montana, North and South Dakota, and Idaho (Nabokov, 1991, pp. 373-380). Depending upon the tribe of origin and geographical experience with reservation living and culture, the older American Indian will have very different perspectives on the activism of the 1970s.

1) **Occupation of Alcatraz - November 27, 1969** - Although this occupation was conceived and supported by the inter-tribal group at the San Francisco Indian Center for “Indians Of All Tribes,” shortly after the occupation by mostly activist Indian students from the Bay Area, some of the more militant American Indian Movement (AIM) members joined the group which resulted in serious internal conflicts, and many of the local Indians withdrew support. The Ohlone did not participate as they said the island is cursed.

The intention of the invasion was to demand attention to the health, educational, employment, and cultural needs of Indians, and especially the lack of social services available for off-reservation Indians. Of major import were religious freedom (guaranteed all citizens under the Constitution), the return of ancestral artifacts, and the continued desecration of Indian burial sites.

2) **Occupation of Wounded Knee** - February 27,1973 began the 71 day occupation of Wounded Knee on the Pine Ridge reservation, site of the 1890 Sioux Indian massacre by US soldiers. The dispute started with the Oglala Sioux traditionalists’ claim that they were being denied participation in tribal decisions by the authoritarian regime of Pine Ridge Reservation chairman Richard Wilson. Armed AIM members joined the conflict, and two AIM members were killed in the crossfire. Many Indians, including Vine Deloria Jr., felt that an opportunity was missed to educate the public to the problems of Indians on and off reservations, but many felt that it was a return to warrior tradition after decades of oppression and signaled an era of “Red Power” (Dennis Banks, AIM leader, see Nabokov, 1991, pp. 361-362).

1972 - **Yakima Tribe** is returned 21,000 acres in the state of Washington.

1974 - **Mohawks** occupy Eagle Bay at Moss Lake in the Adirondack Mountains, claiming original title to it.

1975 - **Indian Self-Determination and Education Assistance Act of 1975** -

1) Authorized Indian tribes to assume responsibility for direct operation and administration of programs administered by federal agencies, including the Indian Health Service.
2) Authorized the Indian Health Service to make grants to tribes for planning, development, and/or operation of health programs (John & Baldridge, 1996).

3) Many Indians believed that “self-determination” was another disguise for “termination,” in that the federal government was attempting to “terminate” its responsibility for providing health care and other services promised by treaty, legislation, and judicial review (Nabakov, 1991).

1976 - **Indian Health Care Improvement Act of 1976** - (PL 94-437) Affirmed the federal government’s “trust responsibility” to provide for the welfare of Indians including legal rights of Indians to certain health services. Provides ability for IHS to “contract” with local providers and agencies for services, and to provide services for both reservation and urban Indians (John et al., 1996; Pevar, 1992).

1) Indians are eligible for Medicare, Medicaid, and Veterans Administration benefits on the same basis as other citizens, regardless of eligibility with IHS.

2) Some “contracting” local health facilities provide health services to eligible Indians by contract with IHS. When an Indian is eligible for both federal care under IHS, and for state assistance (Medicaid), Medicare, or private insurance, federal assistance is considered the secondary source (Pevar, 1992).

1978 - **Indian Child Welfare Act** - Designed to stop removal of Indian children from reservations by state welfare agencies and state courts. It has been estimated that 30% of Indian children were placed with non-Indian families from the 1920s to 1978 (Jaimes, 1992, p. 326).

1980’s - Attention focused on **economic survival** of tribes/nations and self-sufficiency through gaming, tourism, and management of natural resources. Individual focus on preservation of traditional values, and activism turns toward litigation and education of more Indian professionals. The number of urban dwelling surpasses rural and reservation dwelling. A turbulent time for many tribes defending hunting and fishing rights (for example, Great Lakes tribes, Northwest coast tribes). Intense racial issues over treaty rights often resulted in violent confrontation with local non-Indians (Calloway, 1999, pp. 489-490), and elders were called upon to put perspective on the situation.

1989 Urban American Indian Elders Outreach Project - A cooperative needs assessment research, outreach and referral effort by the Los Angeles County Area Agency on Aging in cooperation with the Los Angeles Indian Council on Aging, Inc., University of Southern California, Dept. of Anthropology, and The Andrus Center on Gerontology. A demonstration project utilizing peer American Indian coordinators who identified local elders, administered an extensive needs assessment questionnaire, and helped elders access support services. Results demonstrated the systematic under-utilization of support services funded by the Older Americans Act (Kramer et al., 1990).

1990s - **Tribal Self-Determination and Self-Governance** - Self-sufficiency, and economic growth continue in tribal and reservation communities. The right of tribes to determine how they will utilize their own resources and develop tribal services continues in the 1990s. Tribal rights and sovereignty continue to be litigated in the courts. Over half of the Indian Health Service budget goes directly to tribes to fund health service programs.

**Urban Era of Pan-Indianism** - Inter-tribal marriages, urban relocation, and focus on acculturation without assimilation. Traditional values and culture are sustained through community gatherings, Churches, and Inter-tribal Pow Wows in rural and urban areas. Being "Indian first and tribal second" is being promoted within the larger context of multi-racial and ethnically diverse
urban populations in order to define identity. Tribal identity and affiliation is frequently maintained and expressed in the form of **tribal ethnocentricity**.
Appendix B

DEMENTIA IN AN OKLAHOMA CHOCTAW WOMAN

You have been called to make a home visit. In so doing, you find the situation described below:

Mrs. Mary Maytubbee (pseudonym) is extremely angry and yelling at her husband to stop having sex with that African-American woman right in the living room in front of everyone. Her granddaughter assures her grandfather by saying, “That’s not her,” meaning that normally his wife would not talk to him like that. Another granddaughter will not visit the house again because the grandmother had noticed her entry to the room and then loudly asked, “Who’s that Jersey cow over there?”

**Background:**
Mrs. Maytubbee lives in a remote part of Oklahoma where the greatest density of monolingual Choctaw speakers reside. This community is a holdover from the early 1800s when the Choctaws were forced from Mississippi to Indian Territory. The more acculturated Choctaws settled along river basins and farmed while those with less integration with whites went to the remote mountains of eastern Oklahoma.

As you drove through the community, you see that it is marked by two wood-framed stores with a gas pump in front of one. The pavement from the main road stopped a mile back, leaving the front of the stores opening onto dirt streets. On your last visit to “town” there were three horses being ridden and two cars (one was yours). Yet, for all its pristine isolation, there are satellite TVs and VCRs everywhere. The Choctaw Nation’s only hospital is one hour and fifteen minutes from her house.

Mrs. Maytubbee lives with her husband in a two-bedroom house. The husband is generally well with a good functional status. He does not work any longer. However, he does not respond well to his wife’s condition. He says that any time he tries to help her, she screams at him and is always upset with him. Her social network consists of mainly her husband and her granddaughter who is an IHS community health worker (CHR) for that area. Another granddaughter is estranged from her. Both granddaughters live on adjacent parcels of the family’s allotment lands. There are great grandchildren, but they are very young.

**Medical History**
Mrs. Maytubbee’s medical history includes a diagnosis of diabetes over 20 years ago at the Choctaw Nation Hospital. She was obese at that time and has since lost weight from 180 to 130 pounds. Also, she is slightly hypertensive and takes a diuretic. She is reported to have urinary incontinence. There have been no other significant medical illnesses, surgeries, or injuries.

Over the last year, Mrs. Maytubbee, who is 84 years old, has been getting worse cognitively. Her current status is a score of 12 on the Folstein Mini Mental State Exam. Five years ago she had a severe CVA with right side hemiplegia. Two months ago she had her right leg amputated above the knee. Her vision is extremely poor. Diabetes is the culprit in her visual loss and leg amputation. Diabetes is rampant among the adult Choctaws of Oklahoma. Her diet is only fair relative to her diabetes. Mrs. Maytubbee’s CHR granddaughter makes some effort to monitor her diet.

Mrs. Maytubbee “sees things that aren’t there,” according to her CHR granddaughter. She also constantly wants to go home because she thinks she’s in the hospital, possibly due to the bed with side rails in which she lives. She also cries a lot. She frequently reports seeing her dead parents riding by on their horses and doing various gardening chores. The patient’s daughter who lives...
about twenty miles away considers her mother’s hallucinations to be evidence of her preparing to
go to the “other side.” She speaks somewhat reverently about this. The daughter seldom visits or
provides support in any way.

DISCUSSION QUESTIONS:

• What are the main issues in this case?
• Why do you think you have selected the issues you selected, and considered others less
important?
• How do you evaluate physical and cognitive function and dysfunction in the elderly, with an
emphasis on Indian populations?
• How are you going to involve patient, family, and community in care of this patient?
• How do you determine caretaker stress?
• What resources are available to provide long term care for Indian elders?
• What cultural and health belief practices are most important in your consideration of this case?
• What additional information, studies, or investigations would you want to get or do?
• How would you involve Mrs. Maytubbee in decision-making?
• How do you assess the daughter’s behavior?

By Permission: Dr. J. Neil Henderson
Department of Community and Family Health, College of Public Health,
University of South Florida
13201 Bruce B. Downs Blvd.,
Tampa, FL  33612-3805