



# Health and Health Care of American Indian Older Adults

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## 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.

World view, life experiences, and the cultural context in which today's American Indian elderly live are described as it relates to health care.

Information in the content section is based on evidence from research, and citations to the published studies are included.

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## MODULE CHARACTERISTICS



**Time to Complete:** 2 hrs, 0 mins



**Intended Audience:** Doctors, Nurses, Social Workers, Psychologists, Chaplains, Pharmacists, OT, PT, MT, MFT and all other clinicians caring for older adults.



**Peer-Reviewed:** Yes

*Note*

Data depicted in this module are relevant to the overall American Indian population but individual tribes may have higher or lower rates.

## LEARNING OBJECTIVES

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



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

## INTRODUCTION & OVERVIEW

### Demographic Characteristics of American Indians

#### Overview

The 2000 Census indicates that there are 4.1 million people who identify themselves as American Indian (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 respondents in Census counts since 1960 have dramatically increased. The 1990 Census, however, contained a severe undercount of American Indians estimated to be 4.6%, and 12.2% in tribal areas due to inadequate data collection methods. (Passel, 1996).

The number of older American Indians increased 69% between 1980 and 1990 and is projected to show an even more dramatic jump in the 2000 census. The nation's American Indian, Eskimo and Aleut population is projected to grow steadily to 2.4 million in 2000, 3.1 million in 2020, and 4.4 million in 2050. The proportion of the U.S. population that is American Indian, Eskimo or Aleut would rise to 1.1 percent in 2050.

#### Geography

Regionally speaking, nearly half of the projected increase in American Indians between 1995 and 2025 would be added in the West. The Census Bureau projects that in the Northeast, Midwest and West, this group will grow faster over this period than either Whites or African Americans. In the South, its population would increase faster than that of Whites. 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,

**(INTRODUCTION & OVERVIEW CONT'D)**

approximately 106 of which are still spoken. (See **Figures 1 & 2**). The diversity and heterogeneity of the American Indian community cannot be overstated.

### States with Largest Concentration of American Indian Older Adults

Preliminary data from Census 2000 including multiple racial identifications indicate that California now has the greatest number of American Indian elderly population, followed by Oklahoma, Arizona, Texas and New Mexico (Garretts, personal communication, 2001).

### Living Arrangements

Census 2000 identified 27% of American Indian women and 18% of American Indian men, age 60 and over, living alone. In 2000, about 34 percent of the American

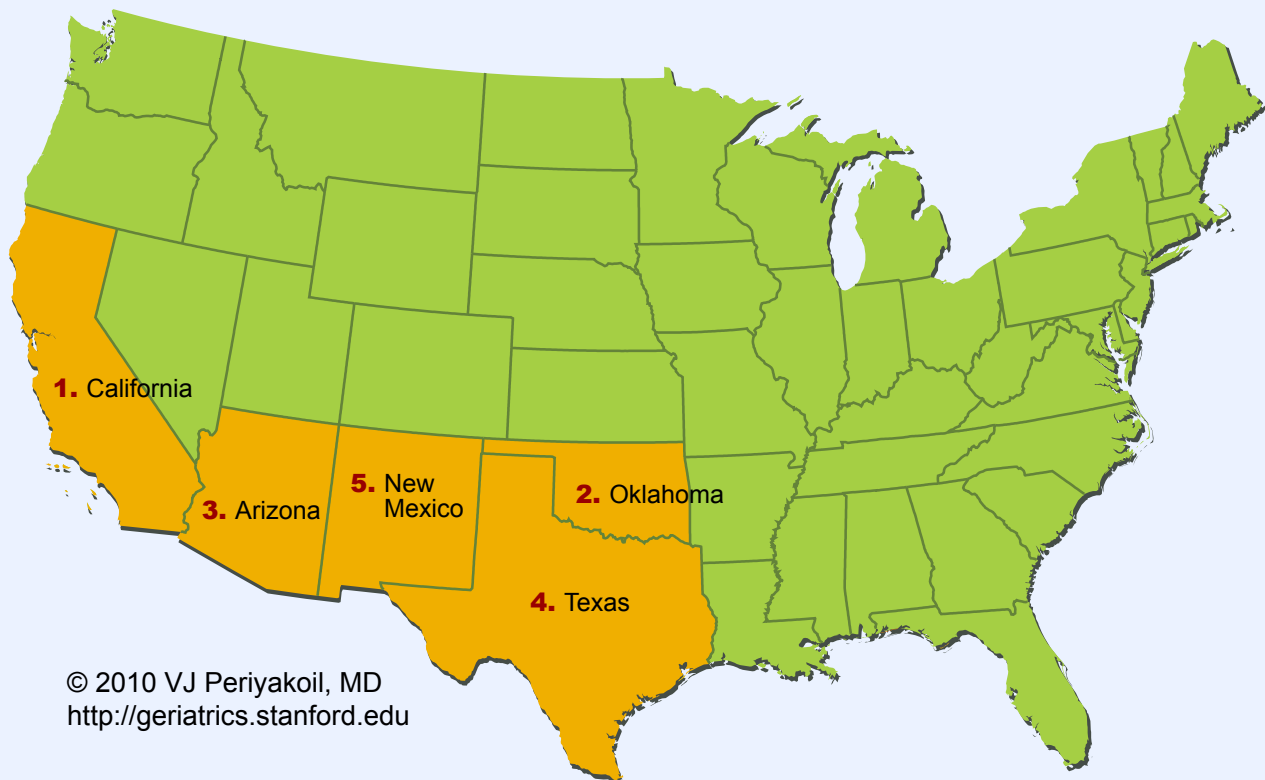
Indian population lived in American Indian areas. Two percent of the American Indian population lived in tribal areas, while 64 percent lived outside these tribal areas (See **Figure 3**).

There are now more people who identify themselves as American Indian in urban areas (62%) than on reservations and other rural areas, according to the 2000 Census. In this urban American Indian subculture many of today's older adults 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 in Lobo & Peters, 2000). (See **discussion of Pan-Indianism in Appendix A: Chronology of Selected Historical Events**) (*continued on page 9*)

**Fig. 1**

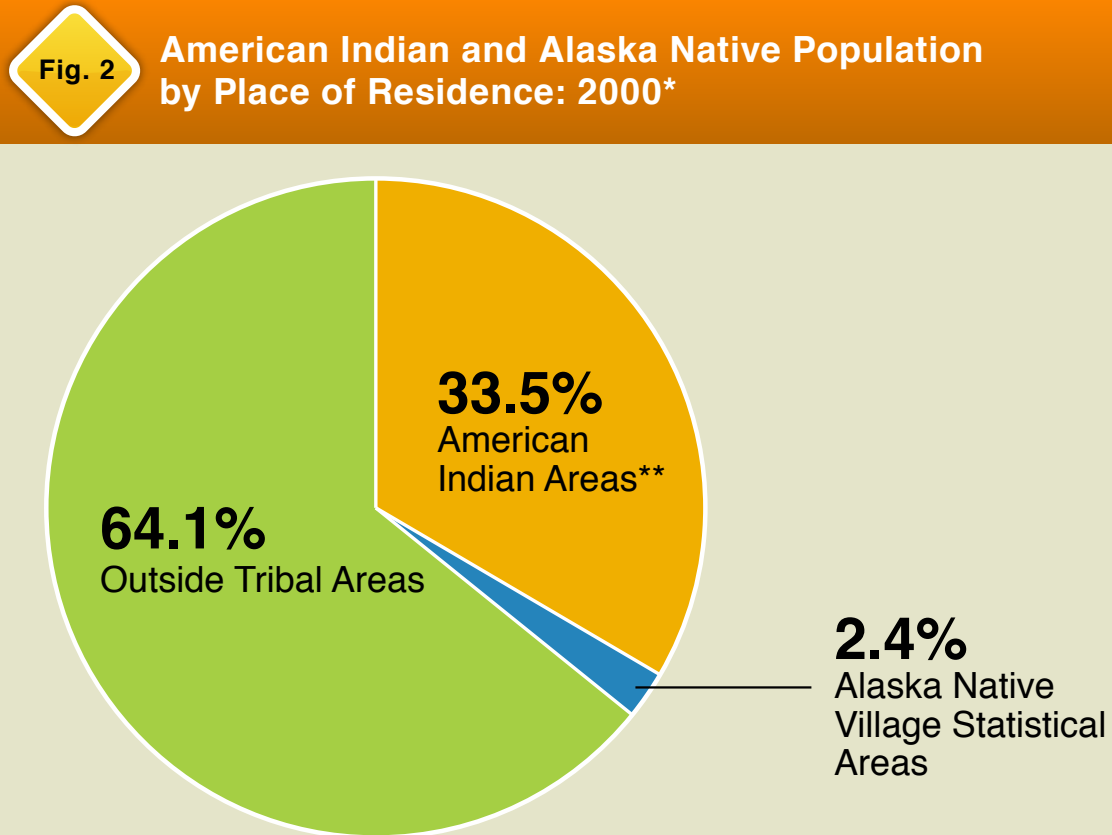
### States with Largest Concentration of American Indian Older Adults

Based on preliminary US Census 2000 Data (Garretts, Personal Communication, 2001)



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## (INTRODUCTION &amp; OVERVIEW CONT'D)



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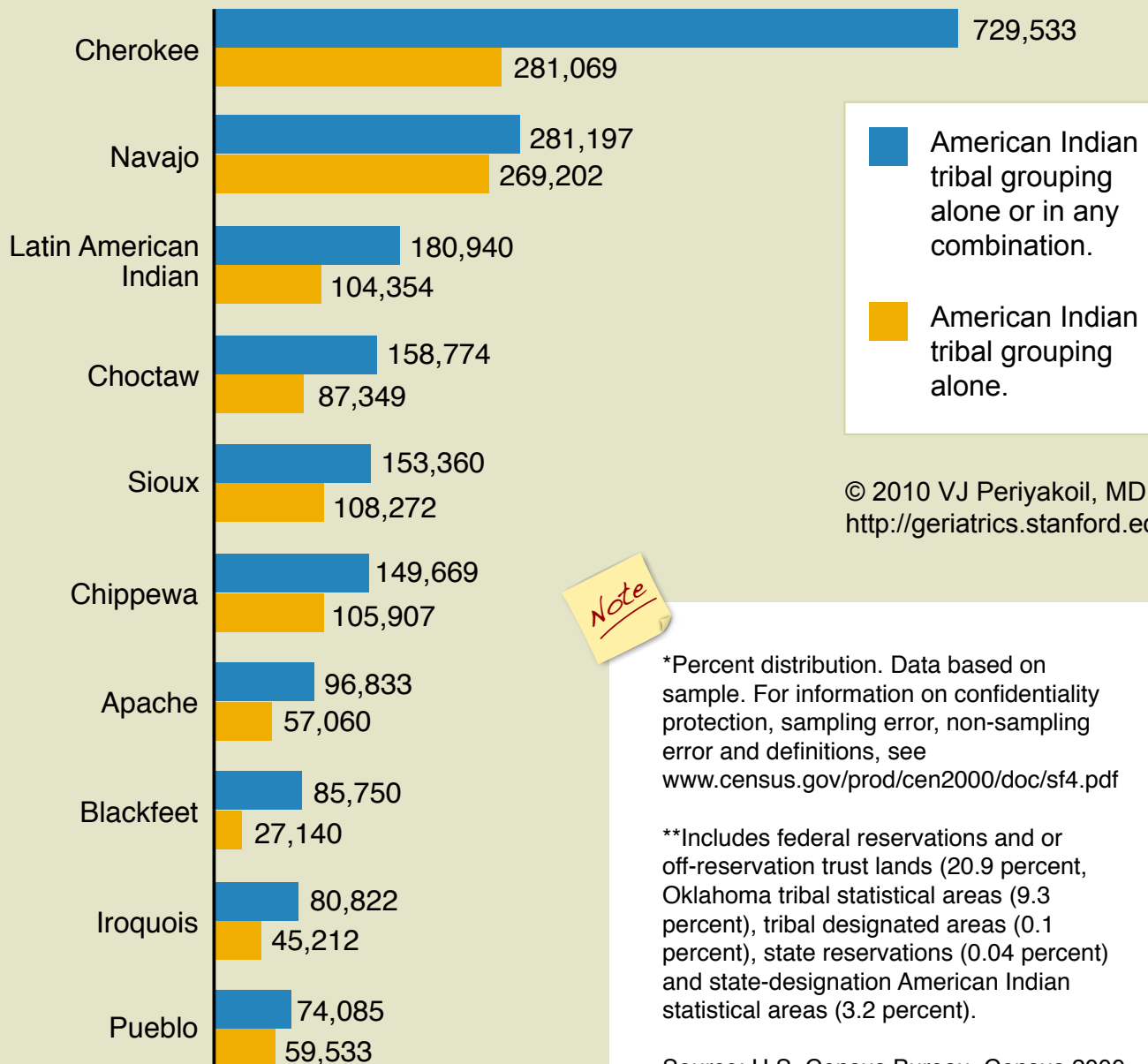
*Note*

\*Percent distribution. Data based on sample. For information on confidentiality protection, sampling error, non-sampling error and definitions, see [www.census.gov/prod/cen2000/doc/sf4.pdf](http://www.census.gov/prod/cen2000/doc/sf4.pdf)

\*\*Includes federal reservations and or off-reservation trust lands (20.9 percent, Oklahoma tribal statistical areas (9.3 percent), tribal designated areas (0.1 percent), state reservations (0.04 percent) and state-designation American Indian statistical areas (3.2 percent).

Source: U.S. Census Bureau, Census 2000 Summary File 4

(INTRODUCTION &amp; OVERVIEW CONT'D)

**Fig. 3****Ten Largest American Indian Tribal Groupings: 2000**

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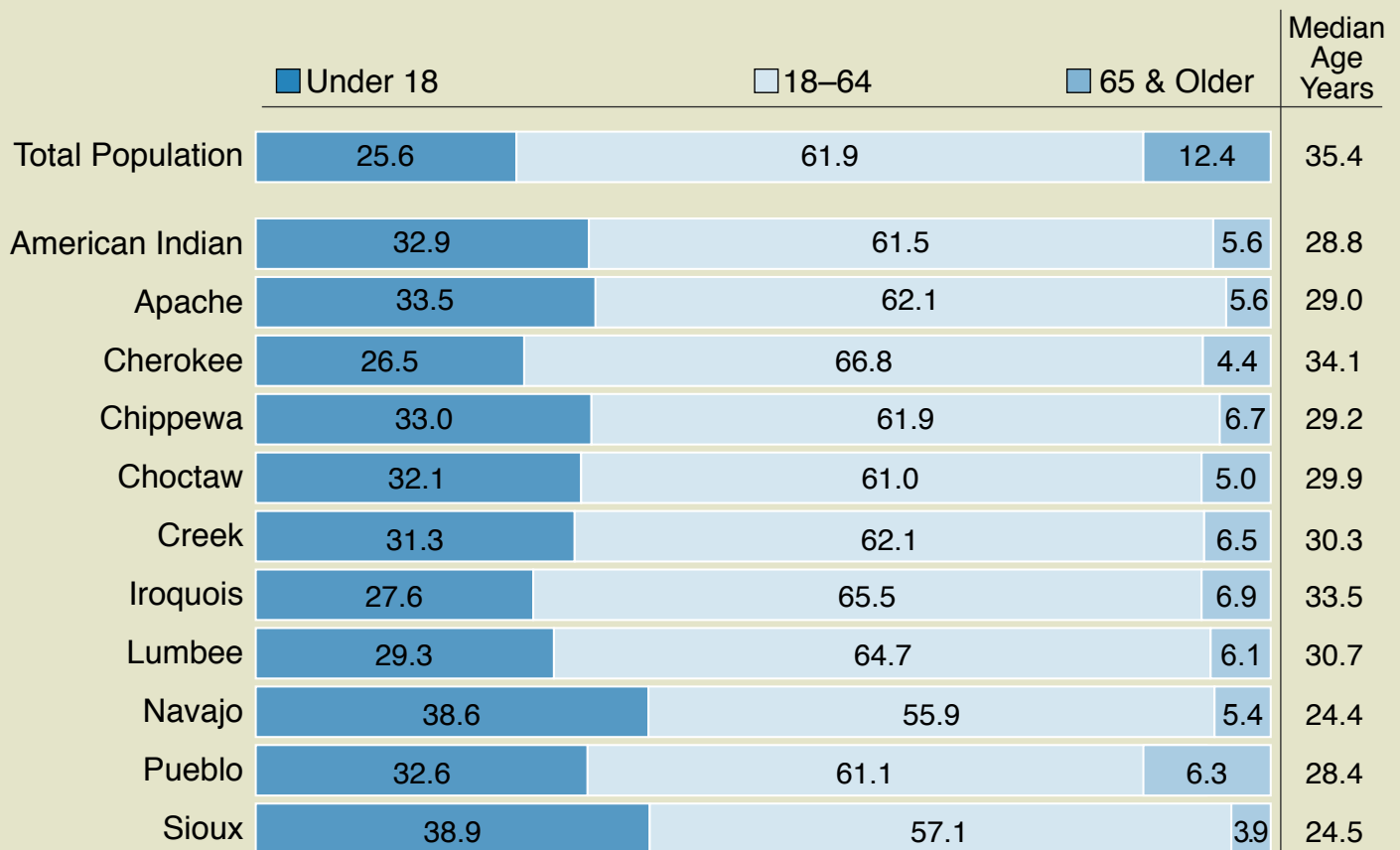
*Note*

\*Percent distribution. Data based on sample. For information on confidentiality protection, sampling error, non-sampling error and definitions, see [www.census.gov/prod/cen2000/doc/sf4.pdf](http://www.census.gov/prod/cen2000/doc/sf4.pdf)

\*\*Includes federal reservations and or off-reservation trust lands (20.9 percent, Oklahoma tribal statistical areas (9.3 percent), tribal designated areas (0.1 percent), state reservations (0.04 percent) and state-designation American Indian statistical areas (3.2 percent).

Source: U.S. Census Bureau, Census 2000 Summary File 4

(INTRODUCTION &amp; OVERVIEW CONT'D)

**Fig. 4****Selected Age Groups and Median Age: 2000**© 2010 VJ Periyakoil, MD <http://geriatrics.stanford.edu>*Note*

Percent distribution. Data based on sample.

For information on confidentiality protection, sampling error, non-sampling error and definitions, see [www.census.gov/prod/cen2000/doc/sf4.pdf](http://www.census.gov/prod/cen2000/doc/sf4.pdf)

Source: U.S. Census Bureau



**(INTRODUCTION & OVERVIEW CONT'D)**

*(continued from page 5)*

These urban older adults 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).

### **Influence of Historical Experiences on Today's Cohort of Indian Older Adults**

The lives of today's Indian older adults 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, all were part of the context of the world and family experiences in which many spent their childhoods. 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.**

### **Indian Self-Determination and Self-Governance**

In the late 1970's and 1980's, 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, pg. 385).

### **Religion**

The basic tenets of Christianity, existence of Creator, respect for 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 for 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

## (INTRODUCTION & OVERVIEW CONT'D)

traditional American Indian and Christian religion, and 16% stated that they followed only an Indian religion; 22% were unknown (Hendrix, 1999).

### 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).

### Definition of Terms

#### 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.”

#### 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” and the term “elderly” is used in many American Indian communities to denote those who are frail or not as healthy as others. 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

## (INTRODUCTION & OVERVIEW CONT'D)

and older, and Medicare and social security consider 65 years, to be the age of eligibility for benefits.

### 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 dispersal 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).

### 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)

### 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 experience is different from other ethnic minority groups in that:**

1. American Indian 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
3. Each older adult 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.

## PATTERNS OF HEALTH RISK

### Influences on Quality of the Data

#### Indian Health Service Data

The primary source for American Indian 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 American Indian who live off-reservation. (AoA, US DHHS, et al, 1996) Some American Indian older adults who live off-reservation are able to utilize IHS services, sometimes traveling long distances to do so.

#### Mortality: Misidentification and Misclassification.

Mortality for American Indian 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, pg 71).

#### Regional Variability

Prevalence rates vary widely, especially in IHS data, from service area to service area and by tribal affiliation. For example, in 1998, 49.5% of adult Pima Indians (Arizona) had diabetes mellitus, and the Oklahoma Cherokee had 20.2% (McCabe & Cuellar, 1994, pg. 21). Higher prevalence of hypertension (31%) was reported by urban American Indians in Los Angeles than a national sample of elderly American Indian (19%) (Kramer, 1991; Los Angeles Co. AAA, 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/>.

### Mortality

There appears to be a “mortality crossover” by age 85, according to IHS data. American Indian older adults have a higher mortality than Whites up to age 75, from

#### TABLES & CHARTS

For a comparison of American Indian mortality with other races, refer to

**Table 2-2 in the Patterns of Health Risk Module, Culture Med Ethnogeriatric Overview Curriculum:**

[http://geriatrics.stanford.edu/culturemed/overview/health\\_risk\\_patterns/mortality.html](http://geriatrics.stanford.edu/culturemed/overview/health_risk_patterns/mortality.html)

For leading causes of death for American Indian Older Adults, **see Table 1 online:**

[http://geriatrics.stanford.edu/ethnomed/american\\_indian/health\\_risk\\_patterns/mortality/death\\_causes.html](http://geriatrics.stanford.edu/ethnomed/american_indian/health_risk_patterns/mortality/death_causes.html)



75 to 84 the rates are much the same, and after age 85 American Indians have lower age specific mortality rates than Whites (John, 1999).

American Indian older adults 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). These causes of death have implications for 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).

## (PATTERNS OF HEALTH RISK CONT'D)

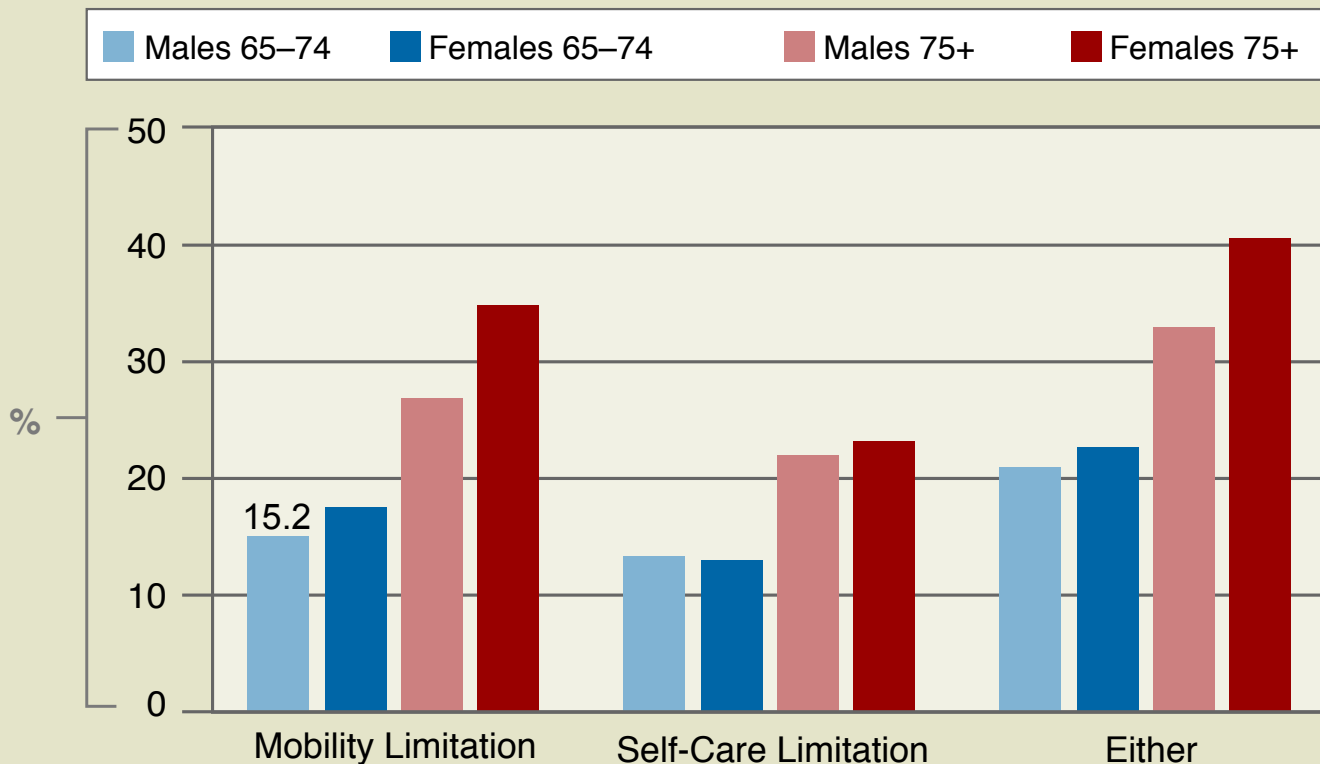
**Morbidity and Functional Status**

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 rates 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 American Indian older adults, and more prevalent in American Indian older adults 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 American Indians are often accompanied by disabilities resulting in inability to perform activities of daily living (ADL's) such as bathing, toileting, eating, and walking, and instrumental ADL's (IADL's) such as using the telephone, managing money, shopping, cooking, and making health care appointments. (See Figure 6).

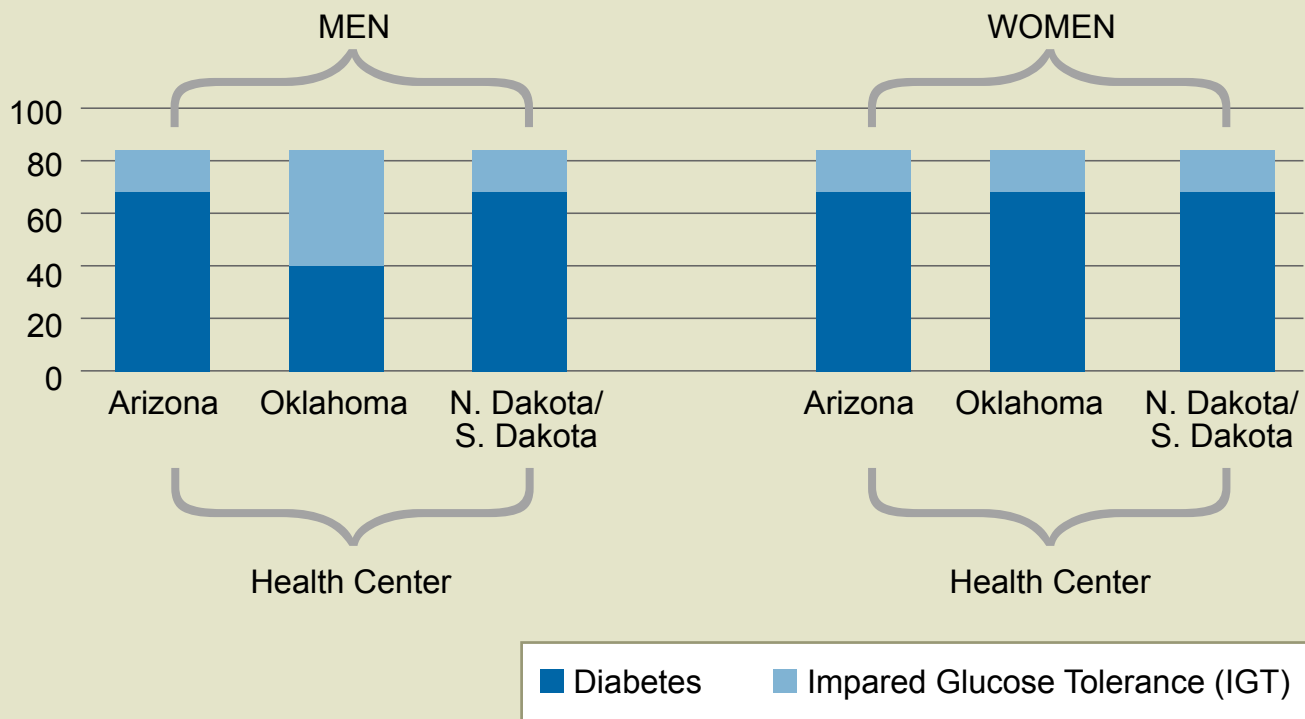
**Fig. 5**

### American Indian Older Adults Age 65 and Over with a Mobility or Self-Care Limitation, By Age and Sex: 1990



© 2010 VJ Periyakoil, MD <http://geriatrics.stanford.edu> Source: 2000 U.S Bureau of the Census

## (PATTERNS OF HEALTH RISK CONT'D)

**Fig. 6****The Strong Heart Study: Diabetes in American Indians by Gender and Health Center (in percentages)**© 2010 VJ Periyakoil, MD <http://geriatrics.stanford.edu>**Heart Disease and Diabetes**

Heart disease is the leading cause of death among American Indians. The Strong Heart Study reports 2,467 deaths from heart disease last year. Among American Indian women age 18 and older, 61.4 percent have one or more cardiovascular disease risk factors - hypertension, current cigarette smoking, high blood cholesterol, obesity or diabetes. American Indian women have the highest prevalence of cigarette smoking (40.8%) compared to any other ethnic group. According to CDC, 36.5% of men 18 years and over currently smoke (2002-2004).

Type 2 diabetes is a serious chronic health problem facing American Indians. Approximately one third of

**FOR MORE INFORMATION ON  
THE STRONG HEART STUDY, SEE—**  
<http://strongheart.ouhsc.edu/>



American Indians age 45 or older have diabetes (CDC, 2005). Native American women suffer from the second highest rate of being overweight, which places them at a higher risk for diabetes. Native American women have the highest age-adjusted death rates for diabetes, one that is 3.5 times greater than the overall population (see figure 6). 65% of American Indians receiving care from Indian Health Services have diabetes.



**(PATTERNS OF HEALTH RISK CONT'D)**

American Indian's are almost 3 times as likely to have diabetes as non-Hispanic whites. Rates of end-stage-renal-disease, a complication of diabetes, are increasing at a rate of 10% per year for American Indians compared to 6% per year for whites.

**Mental Health****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, 1985).

The Indian Depression Schedule (IDS) was developed by Manson and colleagues, which includes consideration of local cultural context (Baron, Manson, Ackerson, & Brennenman, 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, Chapleski, Lichtenberg, Hodges, Kaczynski, & Sobeck, 1997).

This study also corroborated earlier findings of an association between stressful life events, depressive symptoms and decline in functional health status.

**Alcohol Abuse**

In a large national study (the Behavioral Risk Factor Surveillance System), 3,940 American Indian adults were surveyed in 36 states concerning drinking patterns. Respondents were compared by age and sex to non-Hispanic White respondents.

Contrary to stereotypes, American Indian men reported lower levels of chronic drinking than non-Hispanic white men at older ages. American Indian reported less

“ 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, 1985). ”

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.)

**Suicide**

Older American Indians have much lower suicide rates compared to older Whites of the same age and sex; American Indian 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)

**Dementia**

Little is known about the prevalence of dementia in the American Indian community. It has been hypothesized that as the Indian population ages relative to the White population, that 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 American Indian population.

**(PATTERNS OF HEALTH RISK CONT'D)****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 American Indian elderly live in tribally subsidized housing and receive SSI income, which may be the only source of income for a family.

Elder Abuse Codes have been adopted by some tribes, but 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 American Indians may not be aware that their behavior is considered abuse. (For example, improperly medicating or withholding medication, or not providing proper nutrition.)

**“ Elder Abuse Codes have been adopted by some tribes, but 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. ”**

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
4. The victim may not recognize the situation as abuse. (Clouse, et al, 1998)



# CULTURALLY APPROPRIATE GERIATRIC CARE: FUND OF KNOWLEDGE

## Cohort Analysis for American Indian Older Adults

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 older adult at the time of event
2. Not all American Indian older adults are impacted by all events
3. Relevance of social histories in provision of clinical care

## Impact of Historical Events on American Indian Older Adults

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.


### MORE ONLINE

#### Table 4: Cohort Experiences:

 [http://geriatrics.stanford.edu/ethnomed/american-indian/fund/cohort\\_analysis/cohort\\_experiences.html](http://geriatrics.stanford.edu/ethnomed/american-indian/fund/cohort_analysis/cohort_experiences.html)

#### Learning Activity:

##### Chronology of Selected Historical Events

 [http://geriatrics.stanford.edu/ethnomed/american-indian/learning\\_activities/learning\\_1/index.html](http://geriatrics.stanford.edu/ethnomed/american-indian/learning_activities/learning_1/index.html)

Intergenerational grief and anger may be based on these events, as well as intergenerational acceptance and survival. The health care practitioner working with elderly American Indians should have this information, but also not assume cultural knowledge or practice by the older American Indian.

## 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 American Indian older adults in planning and implementing health care in a culturally congruent and respectful manner.

## (FUND OF KNOWLEDGE CONT'D)

**Case Studies 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 1940's, and he served 3 years in the military during World War 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.

**Questions for Discussion**

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?

# CULTURALLY APPROPRIATE GERIATRIC CARE: ASSESSMENT

## Appropriate Ways to Show Respect and Establish Rapport

Listening is valued over talking by most older American Indians; calmness and humility are valued over speed and self-assertion or directiveness. Avoiding the “invisible elder” syndrome and asking for the older adult’s help in understanding the current situation and in planning the components of further care are important aspects of showing respect for the older adult’s experience.

## 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 older adult, especially during initial encounters and when explanations of treatments/medications/health care decisions are being given. Questions should be carefully framed to convey a message of caring, and not indicate idle curiosity about the culture or cultural practices.

### Conversational Pace

American Indian languages have some of the longest pause times, compared to other languages, and especially English. Older adults 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.

“Questions should be carefully framed to convey a message of caring, and not indicate idle curiosity about the culture or cultural practices.”

To evaluate type of interpreters, see “Benefits and Limitations of Interpreters”, by J. Enslein in *Culture Med Ethnogeriatrics Overview, Assessment*:

<http://geriatrics.stanford.edu/culturemed/overview/assessment/>



## Non-Verbal Communication

**Physical Distance:** Several feet is usual comfort zone.

**Eye Contact:** Not direct or only briefly direct, gaze may be directed over the shoulder, and sustained gaze as this may reflect aggressiveness.

**Emotional Expressiveness:** May be controlled, except for humor

**Body Movements:** Minimal

**Touch:** Not usually acceptable except a handshake

## Language Assessment

Although many American Indian older adults speak English, some are monolingual. Literacy level should be assessed, especially if written forms or educational materials are used. 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 American Indians 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.

**(ASSESSMENT CONT'D)****Domains of Ethnogeriatric Assessment****Client Background**

See “Cohort Analysis” in previous section

World view, life experience, and 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).

**Clinical Domains****Health History**

Information and self-disclosure may be guarded. An aggressive or dismissive approach to the American Indian 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. A better approach is to ask about family members and their well-being, followed by a query such as, “why did you come to see me today?”, and work backwards from there to illicit a health history.

**Physical Examination**

Modesty and privacy are valued. Requests of the older adult during examination 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.

**Cognitive and Affective Status**

American Indian elderly rarely present for treatment of “depression” (as the word is not commonly known or used), 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 American Indian older adults 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

**(ASSESSMENT CONT'D)**

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).

**Functional Status**

Appropriateness of commonly used ADL and IADL scales should be assessed. For example, what kind of activities is the older adult 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?

**Home and Family Assessment**

In addition to home safety, issues to consider include family care patterns, gender taboos, and 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 older adult 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.

**Advance Directives and End-of-Life Preferences**

Assessment when appropriate, and not usually until a relationship has been developed with some degree of trust. General information may be given as a story about another person in a similar situation, and what he or she did as a method of assessment of acceptability of the topic.

**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”.

**MORE ONLINE****Examples of American Indian Explanatory Models for Dementia:**

[http://geriatrics.stanford.edu/ethnomed/american\\_indian/downloads/american\\_indians\\_dementia.pdf](http://geriatrics.stanford.edu/ethnomed/american_indian/downloads/american_indians_dementia.pdf)

**Learning Activity: Dementia in an Oklahoma Choctaw Woman**

[http://geriatrics.stanford.edu/ethnomed/american\\_indian/learning\\_activities/learning\\_3/index.html](http://geriatrics.stanford.edu/ethnomed/american_indian/learning_activities/learning_3/index.html)

**Assessment, Culture Med Ethnogeriatrics**

**Overview:** <http://geriatrics.stanford.edu/culturemed/overview/assessment/>

**Explanatory Models of Illness**

The importance of exploring beliefs concerning the causes and treatment of illness with the individual older adult cannot be overstated.

**Examples of American Indian Explanatory Models for Dementia** demonstrate 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 interventions and treatment strategies in a collaborative relationship with American Indian older adults and their families. Examples of questions that can be used to elicit the patient’s 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?

## (ASSESSMENT CONT'D)

**Intervention-Specific Data (Tripp-Reimer, Brink, and Saunders, 1984)**

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

**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. For example, Mr. B. was always known in the Indian community as an older adult who “talked and talked”. Mr. B. was admitted to a nursing home, after having had a serious stroke , with a tracheotomy tube.

The first month he pulled out his tracheotomy tube several times, much to the alarm of the staff, and was labeled as “non-compliant”. The second month after closure of the tracheotomy, his friends asked why he had pulled out his breathing tube. He told them that he needed to be able to talk to the spirits that were visiting him after he had a healing ceremony performed in his room. The health care staff expected Mr. B. to understand that the breathing tube was necessary for his survival. For Mr. B. it was more important for him to be able to talk to the spirit world to aid in his healing.



## CULTURALLY APPROPRIATE GERIATRIC CARE: DELIVERY OF CARE

Culturally appropriate interventions depend upon the older adult'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 American Indians 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 older adult as possible, given the heterogeneity of responses among American Indian older adults.

### Health Promotion Strategies

Should be based on areas of increased risk for American Indians, as well as risk for all older adults. **See Delivery of Care, Culture Med Ethnogeriatrics Overview:** [http://geriatrics.stanford.edu/culturemed/overview/delivery\\_of\\_care/](http://geriatrics.stanford.edu/culturemed/overview/delivery_of_care/)

### Health Screenings and Immunizations

American Indian 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.

### Health Education

Most frequent causes of death for American Indian older adults 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 American Indian community to be served. In addition, older adults 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 (Indian Health Service Research Conference, 2001).

### Nutrition

Many older American Indians 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 American Indian.

In hospital settings the American Indian 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".

**(DELIVERY OF CARE CONT'D)****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 seems 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 driving while intoxicated arrest. Zuni also has extensive physical fitness programming for older American Indians.

**Issues in Treatment and Response to Treatment****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 American Indian 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 older adult may choose not to accept the procedure or treatment, or in some Indian traditions, an older adult 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.

**Surgery**

It is not unusual for American Indian 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 American Indian 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).

**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 American Indians over the age of 55 years in a community clinic in a large urban area of California revealed that only one respondent had a 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



**(DELIVERY OF CARE CONT'D)**

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 American Indian 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.

**Medications**

Sharing of medicines (Indian and biomedical) is common within clan groups and extended families. Pharmaceuticals may be stopped by the American Indian when s/he feels better, and "saved" to self-medicate if the problem recurs. There is also some anecdotal indication that benzodiazepines and antidepressants (SSRI's) may have a stronger effect at lower doses in the American Indian population in general.

Many American Indians 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 American Indian elderly, especially in urban or rural areas where Indian Health Service benefits are not available.

**Chronic Pain Management**

Many traditional American Indians were taught to withstand pain as a skill for survival. Overt expression of pain (verbal or non-verbal) is unacceptable in many American Indian cultures today. Older American Indians may be less likely to ask for pain medication and more likely to use internal resources to manage pain (Hendrix, 2001). American Indians 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)

**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, et al, 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 older adult in the community (Ogrocki, et al, 1997).

It has been suggested that American Indian caregivers differ from White caregivers in the use of "passive forbearance" as a coping strategy, which was not found with White caregivers. Also, American Indian caregivers did not expect to control or to be able to gain control of the situation of caregiving for a cognitively impaired older adult, 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 American Indian older adult. 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, Hennessey, Roy, & Salvini, 1996).

**(DELIVERY OF CARE CONT'D)**

The concept of caregiver burden is unacceptable in many American Indian cultures, and behavior by a person with dementia that may be considered inappropriate in Euro-American culture is accepted in the American Indian older adult's community without social stigma (Henessey & John, 1996). American Indian 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 older adults with or without dementia does not allow for the direct expression of anger toward the older adult or for infantilization witnessed in Anglo settings (John, et al., 1996). The cultural incongruence of caring for an older adult with cognitive impairment and the cultural values of non-interference, individual freedom, non-directive communication and respect for older adults may increase stress felt by the caregiver significantly. Culturally appropriate support systems would be important resources for providers to offer as resources to American Indian caregivers.

**End-of-Life Care**

Varies from tribe to tribe with cultural tradition and individual acculturation. General preference for naturalness and home care is preferred unless there is a cultural taboo regarding death (Navajo). Many American Indian tribes/nations have specific rituals and ceremonies 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 American Indian 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.

**Organ Donation / Autopsy**

Generally, American Indians do not desire organ donation or autopsy (Kramer, 1996). However, some changes in this area are occurring due to the large numbers of American Indians on renal dialysis due to end stage renal disease (ESRD) from diabetes

**Coordinating Biomedical and Traditional Therapies**

Marbella, et al. (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 American Indian older adult 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.

## ACCESS AND UTILIZATION

### Need vs. Utilization

Existing research indicates high levels of need for health care services for American Indian 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.

### Availability

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

### 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 older adults. A large focus group of American Indian Elders (IHS Annual Research Conference, Albuquerque, NM, 2001) indicated that older adults 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 few LTC resources in Indian Country, 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 American Indians 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, 1996) Lack of LTC services is of major concern to older adults in Indian Country and to their caregivers.

Caregiver studies indicate that LTC services would be utilized if available (John, Hennessey, Roy, & Salvini, 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 American Indians 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.

### Accessibility

A major barrier to service provision for many older adults 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) 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.

**(ACCESS AND UTILIZATION CONT'D)****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 American Indian older adults 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” (whatever comes, the people will survive) toward health also sometimes makes care seem less acceptable.

**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 older adults who would not seek needed services, rather than be treated “rudely” by staff. Increased health care cost occurs when older American Indians do not seek treatment until they are in severe distress.

## LEARNING ACTIVITIES

The activities below can be used to enhance students' understanding of the material discussed throughout this module. They can also serve as an instructional strategy for teachers concentrating on health and health care issues of American Indian older adults.

### Activity 1: Chronology of Historical Events

#### Instructions

1. Browse through **Appendix A: Chronology of Historical Events**.
2. Choose ONE of the events and research it in the **Native Health Research Database**, University of New Mexico, Health Sciences Center Library <https://hscssl.unm.edu/nhd/>
3. Findings can be shared and discussed.

### Activity 2: Cultural Values

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 (Dr. Charles Alexander Eastman), 1911. (Available in most book stores: Kent Nerburn, ed. Navato, CA: New World Library, 1993). 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, 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.

### Activity 3: Case Study, Dementia in an Oklahoma Choctaw Woman

*BY PERMISSION: Dr. J. Neil Henderson Department of Community and Family Health, College of Public Health, University of South Florida*

**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 1800's when the Choctaws were forced from Mississippi to Indian Territory. The more acculturated Choctaws settled along river basins and farmed while



**(LEARNING ACTIVITIES CONT'D)**

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 store's 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.

**Questions for Discussion**

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

## INSTRUCTIONAL STRATEGIES

### Teaching & Learning Activities

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

1. Use the Learning Activities on pages 29–30.
2. Assign students to read and prepare for discussion one or more of the case studies under Learning Activities and on page 18
3. Ask students to research the availability of outpatient care, hospital care, long term care and senior centers for Indian older adults in their area.
4. Ask one or more older adults of American Indian background 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.
5. Assign students to read the book by Lori A. Alvord & Elizabeth Van Pelt, *The Scalpel 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 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 older adults 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.



#### INTERVIEW GUIDE

For a guide on how to conduct interviews with ethnic American older adults, see “Instructional Strategies for Interviewing Elders from Diverse Ethnic Backgrounds” in **Culture Med**

[http://geriatrics.stanford.edu/culturemed/interview\\_strategies.html](http://geriatrics.stanford.edu/culturemed/interview_strategies.html)

## STUDENT EVALUATION

### 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 1970’s and 1980’s, 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?

### Post-Test

*see page 35 for answer key*

### Multiple Choice

1. **The unique relationship of American Indian older adults to the federal government includes:**

- A. American Indian lands were colonized by Europeans
- B. American Indians did not immigrate from other countries
- C. American Indians 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.

**Choose one:**

- ☐ A and B only
- ☐ B and C only
- ☐ A and C only
- ☐ All of the above

2. **There are 558 federally recognized tribes, each with their own traditions, history, and perceptions of the sacred. Therefore, the American Indian population is extremely heterogeneous, and which may affect health care utilization and acceptability.**

- ☐ True
- ☐ False

3. **Tribal sovereignty, independent nation status, and tribal self-determination continue to be a major priority of American Indian tribes/nations in the 21st century.**

- ☐ True
- ☐ False



## (STUDENT EVALUATION CONT'D)

**4. Tribal affiliation and ethnocentrism is a strong force in American Indian communities.**

- ☐ True  
☐ False

**5. “Pan-Indianism” refers to inter-tribal gatherings and community activities designed to preserve Indian culture in mostly urban areas.**

- ☐ True  
☐ False

**6. Appreciation of the historical context of the American Indian 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 American Indian families, villages, tribes and cultures were wiped out by measles, smallpox, influenza, and tuberculosis during the late 1800’s and first half of the 1900’s
- D. The illegal taking of land, rights, and religion has produced intergenerational anger and grief.
- ☐ A and B only  
☐ A, B and C only  
☐ B and C only  
☐ All of the above

**7. Which of the following are NOT significant American Indian cohort life influences?**

- A. Intergenerational grief  
B. Boarding schools  
C. Military service  
D. Federal relocation programs  
E. Indian self-determination  
F. Spirituality and religion  
G. Discrimination and racial Oppression  
H. Acceptance and survival
- ☐ E and F only  
☐ H only  
☐ F and G only  
☐ None of the above

**8. Health care is guaranteed for all American Indians by treaty rights, no matter where they live.**

- ☐ True  
☐ False

**9. Which of the following are major sources of data collection for American Indian epidemiology?**

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

## (STUDENT EVALUATION CONT'D)

10. Issues with American Indian 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.
- ☐ True
- ☐ False
11. The top 5 causes of death of older American Indians (in order) are:
- ☐ Diabetes, Cancer, Heart Disease, Kidney Disease, and Liver Disease.
- ☐ Heart Disease, Cancer, Cerebrovascular Disease, Diabetes, and Pneumonia/Influenza.
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.
- ☐ True
- ☐ False
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 and B only
- ☐ A, B and C only
- ☐ B and C only
- ☐ A, B, C and D

**Short Answer and Essay**

1. 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?
2. Essay Question. Discuss why it is important to illicit information concerning beliefs about the causes and treatment of illness (explanatory models) from American Indian older adults in the health care setting.

## (STUDENT EVALUATION CONT'D)

**Post-Test Answer Key****Multiple Choice**

1. All of the Above
2. True
3. True
4. True
5. True
6. All of the above
7. None of the above
8. False
9. A, B, C and D only
10. True
11. B
12. True
13. A, B, C and D

**Short Answer and Essay**

1. 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.
2. Answers should include the following:
  - a. Health and illness beliefs are culturally mediated.
  - b. Health and illness beliefs are extremely diverse among American Indian 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 American Indian 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 American Indian.
  - i. Modesty and touching during physical examination
  - j. Literacy level and individual learning style for printed or educational materials.

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## MULTIMEDIA AND COMMUNITY RESOURCES

### Web

#### **Awakening the Spirit: Pathways to Diabetes Prevention & Control—**

##### **American Diabetes Association**

1-800-DIABETES (342-2383).

<http://www.diabetes.org>

#### **The Consortium of New York Geriatric Education Centers**

Collaboration with Tribal and Urban Indian organizations.

246 Greene Street, 5th Floor

New York, New York 1003-6677

Phone: (212) 998-9016 FAX: (212) 995-4561

<http://www.nygec.org/>

#### **National Indian Council on Aging, Inc.**

10501 Montgomery Blvd., Suite 210, Albuquerque, New Mexico 87111

Phone: (505)292-2001; FAX (505) 292-1922

[www.nicoa.org](http://www.nicoa.org)

#### **Native Health Research Database**

Provides bibliographic information and abstracts of health related articles and resource documents by IHS, Tribal, urban, and clinicians on-reservation and villages, 1966 to present. A partnership between University of New Mexico Health Sciences Center Library and the Indian Health Service.

<https://hscssl.unm.edu/nhd/>

#### **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>

#### **National Congress of American Indians**

(202)466-7767 (Washington, DC)

[www.ncai.org](http://www.ncai.org)

#### **National Native American American Indian DS Prevention Center**

(510) 444-2051 (Oakland, CA); e-mail: [information@nnaapc.org](mailto:information@nnaapc.org)

[www.nnaapc.org](http://www.nnaapc.org)

#### **Native Web**

[www.nativeweb.org](http://www.nativeweb.org)

#### **Stanford Geriatric Education Center—Ethnogeriatric education, professional training, publications, seminars. Urban American Indian collaboration.**

703 Welch Road, H-1

Stanford, CA 94304-1708

(650) 723-7063; FAX (650) 723-9692

<http://www.stanford.edu/dept/medfm/gec/page1.html>

### Video

#### **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. CE's available. Also available via Internet.

<http://learn.sdstate.edu/Share>

#### **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.

**(MULTIMEDIA AND COMMUNITY RESOURCES CONTINUED)****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 49783 ; Phone: (906) 635-7001.

**Publications and Journals****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.

**American Indian 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.

**The IHS Primary Care Provider**

A monthly journal for health professionals working with American Indians. 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](mailto:the.provider@phx.ihs.gov)

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## APPENDIX A: CHRONOLOGY OF 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 and Whipple, 1971).

### 1778 First US and Indian Treaty

Treaty between the Delaware Indians and the United States.

### 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 Georgia Compact

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

### 1824 Creation of Office of Indian Affairs

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

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

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 describes this inclusion in the treaty as “the first clear-cut case of fraudulent dealings on the part of Congress.” (Deloria, 1988), as this language allowed for the unreimbursed removal of copper and other minerals.

### 1827 Cherokee Nation Declaration of Independence

Cherokee Nation of Georgia declares itself “independent” and adopted 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 Presidency

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

**(CHRONOLOGY CONT'D)**

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 NIOA 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. and Baldrige, D., The NIOA Report, 1996, p.12 .)

**1838 Trail of Tears**

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-Mexico War**

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 and Whipple, 1971) and is remembered by local descendants as one of the Indian Holocausts.

**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 Forced Migration**

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

**1865–1875 Reservation Period****1868 Sioux Treaty**

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

**1876 Little Big Horn**

Custer defeated at the Battle of the Little Big Horn.

**1878 Establishment of Boarding Schools**

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

**(CHRONOLOGY CONT'D)**

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, pg 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 (Nabokov, 1991; Hendrix, 1999).

Despite the harsh realities of life in the Boarding schools, many Indian older adults 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, pg 363-4; Hendrix, 1998; Lomawaima, 1994.). Many of today's older adults went through a Boarding school experience.

**1883 Native American Religions Made Illegal**

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 (Pever, 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.)

**1900's Dwindling Population**

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”.



**(CHRONOLOGY CONT'D)****1880's to 1934 Suppression and Repression of American Indian Culture**

- Boarding Schools – (See 1878)
- American Indian children were removed from impoverished Indian families during the 1920's until the 1970's (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 in Jaimes, 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**

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. 242-3.)

**1928 The Miriam Report ("The Problem of Indian Administration, The Institute of Government Research, Washington, D.C.")**

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 and Lytle, 1983, pp. 12-13).

**1934 Indian Reorganization Act (RA) (Wheeler-Howard Act)**

- John Collier (Commissioner of the BIA) reversed laws banning ceremonies and spiritual practices by American Indians living on reservations.
- Ended the federal government's policy of "allotment".
- Established a credit fund for tribal economic development.
- Promised expanded social programs and federal funding for projects.

Tribes were authorized to form "constitutional governments" which could employ legal counsel, 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.

**1934 Johnson O'Malley Act**

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).



## (CHRONOLOGY CONT'D)

**1941 to 1946 World War 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, pg 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****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”.

- 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).
- California rancherias were phased out. These tracts of land were established during the

Depression as reserved land for homeless Indians (Deloria and Lytle, 1983, p18).

- 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).

- Preserved hunting and fishing rights to tribal and federal protections.
- 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 and Lytle, 1983, p19).)*

**RELOCATION**

**1954 Transfer Act of August 5** 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 & Baldrige, 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** 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

**(CHRONOLOGY CONT'D)**

training centers. Thousands of Indians were moved off reservations to the cities in an effort to force assimilation. Many of today's older adults 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.

**1968 Menominee Tribe v. United States**

Supreme Court ruled that the Minominee 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 (Pevor, 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.

**1970's Activism**

The American Indian Movement 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, 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 1970's.

**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 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.

**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 traditionalist's 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). (Nabokov, 1991, pp.361-2)

**(CHRONOLOGY CONT'D)****1972 Land Return**

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

**1974 Eagle Bay Occupation**

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

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

- Authorized Indian tribes to assume responsibility for direct operation and administration of programs administered by federal agencies, including the Indian Health Service.
- Authorized the Indian Health Service to make grants to tribes for planning, development, and/or operation of health programs. (John & Baldrige, 1996.)
- Many Indians believed that “self-determination” is another disguise for “termination” in that the federal government is 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 (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.

(Pevar, 1992, John, et al, 1996.)

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

**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 1920’s to 1978) (Jaimes, 1992, p.326).

**1980’s Economic Survival and Self-Sufficiency**

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, pg.489-90.), and elders were called upon to put perspective on the situation.

**(CHRONOLOGY CONT'D)****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).

**1990's 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.