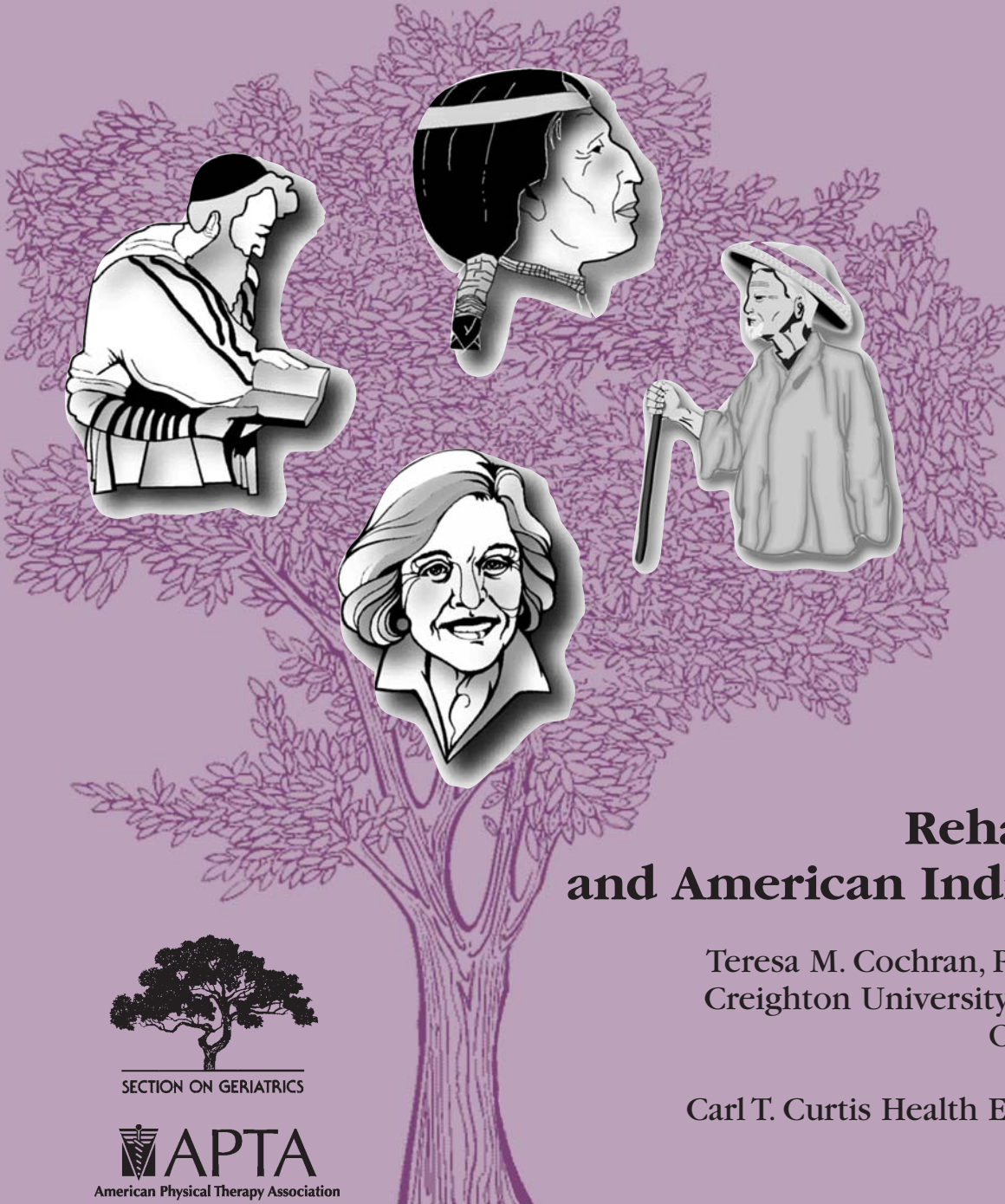


Cultural Diversity of Older Americans

An Independent Home Study Course for Individual Continuing Education

March–August 2003



Rehabilitation and American Indian Elders

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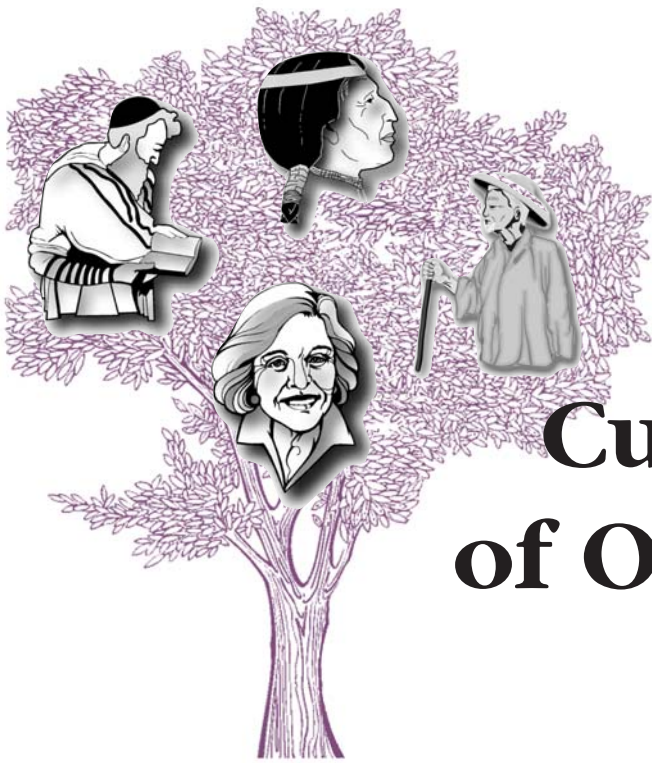


SECTION ON GERIATRICS



American Physical Therapy Association
The Science of Healing. The Art of Caring.

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Cultural Diversity of Older Americans

Editor's Note

May 2003

Dear Home Study Course Participant,

This course includes 2 monographs dealing with Native American cultures. While it is one of the smallest cultural groups in the United States, both monographs illustrate the diversity within this segment of the population and the vulnerability of its oldest members.

Dr Teresa Cochran, PT, DPT, GCS, MA begins by examining rehabilitation and American Indian elders. She believes that it is in the building of community that health care providers and American Indians can best work together to meet the unique health challenges of this vulnerable population. It is out of this belief that Dr Cochran works with the Omaha nation in Nebraska. In this monograph, Dr Cochran shares with us the health concerns of American Indians in general as well as core themes in this culture that may challenge competent cross-cultural practice. We hope that you find her in-depth examples a practical guide to incorporating successful strategies in your own clinical practice.

Mary Thompson

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Rehabilitation and American Indian Elders

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LEARNING OBJECTIVES

Upon completion of this monograph, the course participant will be able to:

1. Understand health disparity and rehabilitation needs of American Indian elders.
2. Identify cultural characteristics that may influence the clinical encounter.
3. Integrate cultural beliefs with clinical strategies to improve rehabilitation outcomes and patient well-being.

INTRODUCTION

This monograph series focuses on the diversity of older Americans. Among the major ethnic and racial categories documented in Census 2000, American Indians and Alaska Natives made up only 0.9% of the total US population.¹ Almost 2 million people identify as American Indian, and this population tends to be concentrated in specific geographic areas (Table 1) rather than distributed throughout the nation.^{2,3} While comprising a relatively small group, the cultures, languages, and histories of the numerous American Indian tribes differ significantly from one another.⁴ Individuals also differ in terms of degree of acculturation and observation of traditional values and practices. For this monograph's purposes, the term *American Indian* is used instead of the term *Native American*, mainly because it is considered appropriate by the federal government⁵ and because the term *Native American* may include groups such as native Hawaiians, Samoans, and other Pacific Islanders.⁴ In reality, correct terminology is a personal choice that varies across tribes and among members within tribes.⁵ Although it has been this author's experience that most patients will select the term *Indian* instead of *Native American*, practitioners are best advised to ask for the patient's preference if in doubt.

Considering the wide variation within and among Indian tribes, this monograph will serve as an introduction to American Indian cultures and will include in-depth examples of rehabilitation considerations from the Omaha tribe. It is important to note that little specific information exists for elderly American Indians, and what is

Table 1. Geographic Distribution of American Indian/Alaska Native Population*

States with the highest number ²	California: 627,600 Oklahoma: 391,900
States with the highest percentage ²	Alaska: 19% Oklahoma: 11% New Mexico: 11% South Dakota: 9%
States with high density (>30%) counties ³	Alaska Montana Nebraska North Carolina North Dakota Oklahoma South Dakota Utah Wisconsin
Cities with the highest number ²	New York City: 87,200 Los Angeles: 53,100 Phoenix: 35,100
Cities with the highest percentage ²	Anchorage, Alaska: 10% Tulsa, Oklahoma: 8% Oklahoma City, Oklahoma: 6% Albuquerque, New Mexico: 5% Green Bay, Wisconsin: 4%
* Data extracted from Census 2000 ² and CensusScope. ³	

known is often reported in aggregate terms that combine all American Indian tribes and Native Alaskans. Despite these data limitations, it is clear that health disparities exist; American Indians have lower life expectancies, and the attributed health problems and causes of death differ from the problems associated with other races.

Health Disparity

Although the health status of American Indians has improved over the past 4 decades, mortality and morbidity rates differ markedly from the US population as a whole and from other subpopulations.^{6,7} Similar to other minority groups, the health status of American Indians continues to improve at rates lower than the aggregated United States population. The sources of these disparities are complex and rooted in both contemporary and historic inequities. Unlike other minority groups in the United States, the federal government is obligated through treaty and statute to provide health care to recognized American Indian tribes through the Indian Health Service (IHS).⁸ Dependence on federal rather than state government may contribute in part to diminished access to needed assistance and increase the risk of substandard housing, poverty, malnutrition, and poor health. In providing culturally competent rehabilitation for American Indian elders, it is first necessary to understand the distinct health needs of this vulnerable cohort.

Life Expectancy

Health disparities result in lower life expectancy among American Indians and an overall younger popula-

tion compared to all other US races. For example, American Indian elders (defined by the IHS as 55 years of age and older⁶) represent 11% of the total American Indian population, compared to elders comprising 21% of the population for all other United States races (ie, all races combined, with the exception of American Indians).¹ According to the IHS, from 1996 through 1998, the average life expectancy at birth for American Indian men was 67.4 years compared to 73.6 years for men of all other races. Average life expectancy for American Indian women was 74.2 years compared to 79.4 years for women of all other races.⁹ Collectively, the average life expectancy for American Indians is 70.6 years compared to the average life expectancy for all other races (after adjustment for race miscoding) of 76.5 years.⁹

Leading Causes of Death

In general, American Indians have a shorter life span than the remainder of the United States population,⁶ and the causes of death differ between the 2 groups. The 5 most common causes of death (listed in descending order) for American Indian elders and all other United States races for ages 55 to 64 years are presented in Table 2. Table 3 contains the leading causes of death for those 65 years and older.¹⁰ These tables show that chronic liver disease and cirrhosis, accidents, and diabetes mellitus are major health concerns for older American Indians. Knowledge of the prevalence of chronic disease and injury can help form policies and programs to improve the health of older American Indians.

Table 2. Leading Causes of Death in the United States for People Aged 55 to 64¹⁰

American Indian	All Other Races
1. Heart diseases	1. Cancer
2. Cancer	2. Heart diseases
3. Diabetes mellitus	3. Chronic obstructive pulmonary disease
4. Chronic liver disease and cirrhosis	4. Cerebrovascular disease
5. Accidents	5. Diabetes mellitus

Table 3. Leading Causes of Death in the United States for American Indian Elders Versus Elders of All Other Races (People Aged 65+)¹⁰

American Indian Elders	Elders of All Other Races
1. Heart diseases	1. Heart diseases
2. Cancer	2. Cancer
3. Cerebrovascular disease	3. Cerebrovascular disease
4. Diabetes mellitus	4. Chronic obstructive pulmonary disease
5. Pneumonia and influenza	5. Pneumonia and influenza

Substance Abuse and Alcoholism

Although the rate of drug abuse for Indian elders approximates the rate of abuse by the non-Indian cohort, alcohol abuse does occur with greater frequency.⁶ The death rate for Indian men ages 55 to 64 years associated with alcoholism is 5 times the rate for all other United States races of the same age category. In fact, this rate represents the highest age-specific alcohol death rate for any age group of Indian men.⁶ Although death rates associated with alcoholism in Indian women in this same age range is less than one-half the rate for the same age category of men, it remains over 9 times the highest rate documented for women of all other United States races.⁶ Alcohol abuse is a leading cause of health problems, including cirrhosis of the liver, accidents, and homicide.¹¹ Existing research has not yet conclusively identified reasons for the prevalence of alcohol abuse by American Indians. Genetic theories have been proposed (eg, inactivity of at least 1 ALDH2*2 allele resulting in a slowed oxidation of acetaldehyde in blood serum),^{12,13} but have not been supported unequivocally in research literature. It is likely that social and environmental constraints (eg, poverty, lower average educational levels, and financial stressors associated with large families) influence the high rate of alcoholism because of the diminished access to economic and social resources.¹⁴

Accidental and Nonaccidental Death

According to IHS statistics,⁶ American Indian elders are more likely to die from traumatic accidents and homicide than elders from all other races, with men at greater risk than women. In fact, the homicide rate for Indian men aged 75 to 84 years is nearly triple that of the same age cohort for all races.⁶ In contrast, both men and women American Indian elders are less likely than non-Indians to die from suicide.⁶

Motor vehicle accidents account for a major portion of accidental deaths and hospitalizations among American Indians and Alaska Natives compared to other ethnic groups.^{15,16} Researchers at the National Resource Center on Native American Aging at the University of North Dakota¹⁷ studied the state's ambulance-run data for 4 years (1995 through 1998) to examine factors that may contribute to motor vehicle accidents involving rural American Indians aged 55 and older. They found that older American Indians were 3 times more likely than whites to be transported in serious condition. Interestingly, alcohol was not a significant contributing factor among these older American Indians. Overall, just over 65% of older American Indians were not wearing seat belts, with those over 75 years more than twice as likely than their white counterparts to be unrestrained at the time of the accident.

Diabetes Mellitus

Type 2 diabetes mellitus is reaching epidemic proportions in the American Indian population. Compared to other populations, a higher prevalence,^{15,18,19} increased

morbidity,^{18,20-22} and increased mortality^{7,18} associated with diabetes is documented for American Indians. In some communities, particularly in the Southwest, 40% to 50% of American Indian adults have diabetes.^{23,24} Overall almost 21% of American Indians ages 65 and older have diabetes.²⁵ Consequences of this high rate of diabetes are serious and include retinopathy (72.8% of 515 Oklahoma Indians with diabetes),²⁶ renal disease (almost 3 times the rate of Whites),²⁷ and lower-extremity amputation.²⁶ According to the IHS, American Indian elders experience increased complication rates because of diabetes.²⁵

INDIAN HEALTH RESOURCES

Some may credit the health challenges faced by American Indians to poor care and long waits associated with the IHS.¹⁹ Others note that the IHS was originally designed as a hospital-based acute care system, and it is poorly equipped to deal with the predominantly chronic problems of today. Most agree that the IHS is severely underfunded. To understand the American Indian elder's attitude toward Western medicine, it is important to understand the context of the elder's experiences with the IHS, its structure and services, resource limitations, and the role of rehabilitation.

Structure and Services

Since 1955, the IHS has coordinated provisions of federally mandated health-related services for American Indians and Alaska Natives.¹⁸ The IHS, an entity under the United States Department of Health and Human Services, currently serves 1.5 million members of over 500 federally recognized tribes of American Indians and Alaska Natives across 35 states.⁹

Administration of IHS activities is monitored through 12 regional offices: Aberdeen, Alaska, Albuquerque, Bemidji, Billings, California, Nashville, Navajo, Oklahoma, Phoenix, Portland, and Tucson.¹⁸ The 12 regions are further divided into service areas comprised of counties on and near federal Indian reservations.^{15,18} Approximately 60% of all American Indians reside in the service areas.⁶ Depending on size and proximity to other service areas, available health resources may include: IHS hospitals, health centers, school health centers, or health stations. Health centers and health stations are both free-standing clinics, but health centers offer a full range of outpatient services including laboratory, pharmacy, and radiology, whereas health stations provide scheduled physician availability less than 40 hours per week).¹⁵ As of 1997, all IHS hospitals had received accreditation by the Joint Commission on Accreditation of Healthcare Organizations.¹⁵

Because the IHS strives to provide "preventive, curative, rehabilitative and environmental services,"^{18(p1)} such services may be directly administered through IHS departments or may be provided through tribal programs or through contracts with private entities.^{15,18} Additionally, the 1975 Indian Self-Determination Act (PL 93-638) allows tribes to independently manage health services, allowing for flexibility in addressing specific

community needs via networks with other government agencies or nonfederal partners (eg, private foundations or academic medical centers).^{15,18}

Resource Limitations

Although the IHS strives to improve Indian health status, significant deficits in financial resources, available health care facilities, and qualified personnel contribute to the inaccessibility to health services for many American Indians.¹⁹ According to IHS statistics, the 2002 fiscal budget allocated for Indian health care is \$2.8 billion, yet tribal leaders project that realistic health care needs are near \$18 billion.¹⁹ In 2001, American Indians received only one third of the health care expenditure per capita compared with individuals in the United States general population.¹⁹

In addition to profound financial constraints, many reservations are located in rural regions that are geographically isolated from adequate clinical facilities, telephone and transportation access, and insufficient infrastructure mechanisms to officially enroll persons eligible for state or federal resources, all of which are concerns consistent with care provision in many rural settings, independent of cross-cultural factors impacting care. In addition, the inadequate number of health care practitioners to meet the needs of the 1.46 million eligible patients¹⁵ prevents patients from receiving adequate care. In 1995, there were 6.5 million ambulatory care visits to IHS tribal and contract facilities, representing an increase of over 1300% since fiscal year 1955.²⁸

American Indians living in urban areas also face resource limitations. Over 50% of the American Indian population resides away from recognized reservations.⁴ Those living in urban areas are not eligible for the health care provided by the IHS on reservations. Funding for IHS urban clinics began in 1976, which improved access to care, and urban American Indians may also receive care through non-Indian sources.⁴

Role of Rehabilitation

The increased prevalence of chronic disease and the associated burden of care among American Indians are profoundly challenging to IHS resources.^{19,29} The IHS health care delivery system was created using an acute care paradigm, but shifting demographics of chronic disease¹⁹ and functional limitations with elders increase the need for rehabilitation professionals. In addition, the highest rate of disability for any ethnic group in the United States is claimed by American Indians.²⁹ The IHS health priorities have historically provided for maintenance of life and limb, so emergent cases obviously demanded priority for scarce financial resources. The role of rehabilitation in restoring functional mobility and independence and the underdeveloped role of prevention are gaining acceptance as benefits of regular exercise are realized by American Indian patients and health care practitioners. The profound resource limitations, health disparities, increasing prevalence of chronic diseases, and an aging population create a significant need for health

practitioners to provide culturally competent rehabilitation care for American Indian elders.

INFLUENCE OF CULTURE

In addition to the physical and economic constraints consistent with clinical practice in many underserved rural sites, the superimposition of cross-cultural interactions may create a confusing environment for the non-Indian physical therapist and may require significant awareness, understanding, and modification of the therapist's role in providing patient care.^{30,31}

Although the definition of *culture* has assumed hundreds of forms, culture may be considered the "dynamic perceptual lens" used to interpret and provide meaning for behaviors and surroundings.³² Culture influences relationships, distribution and access of resources, personal decisions, and universal life events.^{32,33} The importance of accurate culture-specific assessment as being fundamental to effective health care provision has been well documented.^{30,32,34-36}

Diversity Within and Among Tribes

It is essential to remember that, as a group, American Indians are extremely diverse and wide cultural variation exists across tribes.^{4,33,34} The federal government recognizes over 500 distinct tribes,⁴ which means there is variability in language, customs, and health beliefs and behaviors. Intratribal variation among members is common as well. Much variation depends on the degree of acculturation to dominant American society.^{35,37} Depending on age and economic resources, older American Indians may have been reared on rural or urban reservation settings, may have been forced into educational training in nonreservation boarding schools, or may choose to live with adult children no longer living on reservation lands. According to Yeo, "Even when providers of geriatric services are very motivated to become culturally competent, it would be almost impossible to become familiar with the whole range of clinically relevant cultural differences they are likely to encounter."^{34(p72)}

CORE CULTURAL THEMES

Despite the tremendous variation in beliefs and behavior patterns, and the impropriety of generalization across cultural characteristics of American Indians, literature supports several core themes central to many American Indian groups, which are especially apparent with individuals who have been less influenced by acculturation into dominant society.³⁸ Cultural themes related to time, communication strategies, autonomy, and spirituality have been well established in research literature.^{38,39} Understanding cultural characteristics that conflict with Western beliefs is essential for effective cross-cultural health care.

Time

Time and time consciousness may vary tremendously by culture. Western culture emphasizes linearity of time

flow from past to future.³⁸ Consciousness of time is even somewhat obsessively defined by specific measures of minutes, seconds, and fractions thereof. The American Indian concept of time has been described as intuitive, personal, and flexible.³⁸ Historically, many American Indians referenced time relative to natural phenomena such as morning, night, moons (rather than months), and seasons (rather than years).⁴⁰ Cultural norms for arrival to an event, appropriate length of time to wait, and duration of pre-event socialization all vary depending on cultural norms.³⁸

Time challenges

Western clinical practice promotes strict scheduling of patient appointments and vigilant punctuality relative to maintaining appointments. Clinical practitioners caring for American Indian patients may find themselves in direct conflict when attempting to establish patient care schedules and return visits. Frustrations may be compounded if health care services are limited in availability and patient need is high, thus requiring strict schedules to ensure access to care for the majority. Once trust is established, it is not uncommon for American Indian elders to arrive early for physical therapy visits, not expecting to be seen until later, but arriving for socialization with other patients or health care personnel. Understanding this is very helpful to the non-Indian physical therapist and may serve as a reinforcing or motivating aspect of care for patients.

Communication Characteristics

Eye contact

The study of kinesics indicates that patterns of eye contact and duration of gaze are generally determined in childhood and persist throughout life.⁴¹ Many cultural groups, including European Americans, engage in direct gaze of the eyes and face during verbal communication. Conversely, American Indians may exhibit peripheral gaze or engage in eye contact for very brief time periods during conversation.⁴¹ To many American Indians, especially elders, maintenance of direct eye contact may be perceived as impolite or even threatening,^{4,39} but level of acculturation contributes to tremendous variability for this characteristic.

Noninterference

In American Indian culture, the principle of noninterference is considered a behavioral norm facilitating uncoerced interpersonal interaction and preventing an individual from establishing dominance in a relationship.^{38,42} The non-Indian health practitioner who is unaware of noninterference may find some interactions quite confusing. Western medicine encourages frank, direct questioning of patients, yet American Indians, especially elders, may perceive such discourse as aggressive, authoritative, and in violation of patient dignity.³⁹ Use of silence by American Indian patients, answering only with information sufficient to address specific questions, is often perceived as respectful. Communication is often

filled with thoughtful silences and interruption by the health care practitioner should be avoided. Conversation, even during physical therapy subjective or objective examinations, often proceeds at its own pace, and a therapist's attempts to persuade or advise may be undesirable until a sufficient level of trust has been established.^{30,39} American Indian culture is characterized as *high context* as compared to the *low context* of Western-influenced communication.⁴³ Low context implies that the dialogue is straightforward and meaning is conveyed through word choice. High-context communication may be implicit and indirect, and meaning from the unspoken message may not become clear until later clinical encounters or through consultation with American Indian health care practitioners.

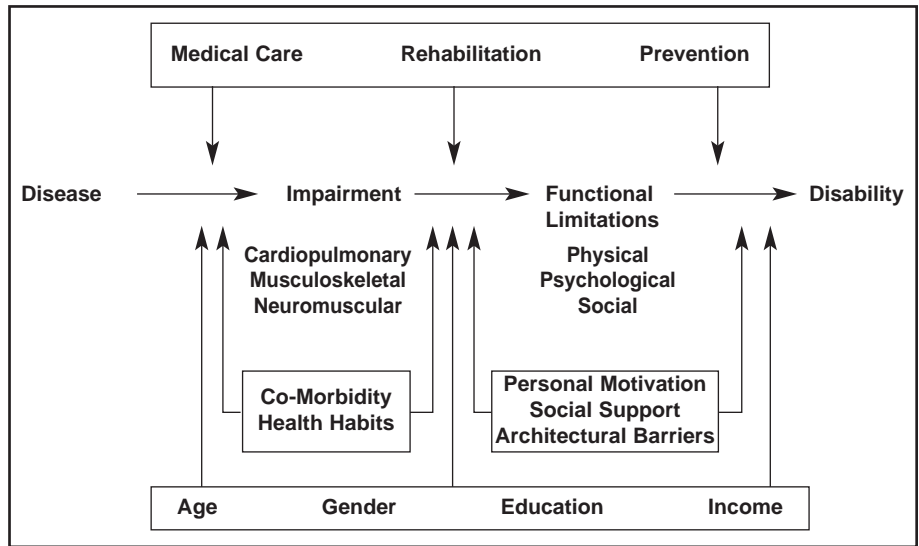


Figure. Working expansion of the Nagi model to account for factors that affect the process of disablement. Reprinted from Guccione AA. Arthritis and the process of disablement. *Phys Ther.* 1994;74:408–414, with permission of the American Physical Therapy Association.

Communication challenges

If the physical therapist is unfamiliar with customary patterns of eye contact and the ethic of noninterference, the patient may be incorrectly and unfairly labeled as apathetic or nonadherent.³¹ Unfortunately, the time needed to build trust, especially when faced with profound time constraints and patient need, may initially seem overwhelming to the non-Indian physical therapist; however, perseverance, active listening skills, and patience will greatly facilitate the therapeutic process.³¹

Autonomy

American Indian beliefs about autonomy may differ from values promoted by Western medicine.^{44,45} Understanding potential conflict will impact patient-care decisions, especially concerning older patients. Western biomedicine and bioethics fiercely promote the rights of patient autonomy and self-determination, thus protecting patient goals relative to medical and rehabilitation interventions and end of life issues.^{39,44} Western-trained practitioners sometimes inappropriately equate autonomy with independence,³¹ which can lead to conflict in a physical therapy goal setting. The meaning of the American Indian caregiver role may be very different from that associated with Western culture. American Indian groups have traditionally revered the wisdom associated with elders and age,³⁹ and the importance of the extended family structure is emphasized in American Indian culture.^{30,39} It is often considered an honor to care for an aging elder, and is sometimes perceived as an opportunity for adult children to reciprocate for their own care earlier in life.³¹

Visualizing the impact of culture on disability

The Guccione^{46,47} expansion of the Nagi disablement model (Figure) provides a framework for recognizing events associated with disease process and identifies an individual's resultant functional status (functional limita-

tion) within the social environment (disability). Without consideration and understanding of the patient's cultural context, the extent of dysfunction at each level in the framework becomes inaccurate and meaningless.³¹ Terms like functional limitation, disability, independence, and autonomy should be followed with the question: From whose perspective?³¹

For example, an American Indian elder might be capable of achieving functional independence and independent living status, but her adult child wants to care for her and minimizes rehabilitation goals or gains. The physical therapist interpreting the situation from her own cultural perspective may misinterpret a patient's dependence as weakness, laziness, or nonadherence.³¹ However, if the patient and family behaviors are interpreted in the cultural context of valuing strong extended family relationships,³⁰ then dependence on family is viewed as an honorable modification of the caregiver's status. Because the disablement model is predicated on role definition for meaning, it becomes clear that one must carefully view the disablement model from patient *and* therapist perspective in order to avoid conflict, role bias, and inaccuracy of judgment.³¹

Challenges in the area of autonomy

If the non-Indian physical therapist fails to understand the important fundamental meaning of the caregiving role, the therapist's goal of patient independence may be in direct opposition to patient and family goals, especially when social honor redefines the concepts of independence and autonomy learned in dominant culture.³¹ It is critical for the physical therapist to gain an understanding of a patient's level of acculturation, depth of traditional belief, and level of family support prior to intervention,^{30,35,39} because skillful care planning with American Indians extends far beyond the safety and function issues typically addressed by physical therapists.³¹

Spirituality

The role of spirituality in the healing process may be very important in American Indian culture,⁴⁸ and again is dependent on level of acculturation to Western practices. Tremendous variation may be found across the multitude of American Indian tribes. Spirituality and wellness are often intertwined, and life events such as illness and death may be viewed as steps in a natural, inevitable progression along the life cycle.^{39,48} In some cases, this natural progression should not be avoided or modified, especially by intrusive, non-Indian health practitioners who are demanding otherwise.³¹

The influence of spirituality on healing practices may take many forms and emphasize balance of the physical, mental, and spiritual aspects of life.⁴⁸ In order to achieve balance, traditional healing practices may include interventions such as chants, rituals (eg, sweats or smokes), body adornments, sand paintings, and herbal medicines,⁴⁸ to name just a few. Reliance on traditional healers may be influenced by cost, travel requirements, and the physical or spiritual problem requiring intervention.⁴⁹ The decision to use a traditional healer or “Indian doctor”^{4(p283)} depends on personal preference, and healers may be accessed in conjunction with or independent of Western health professionals.⁴⁸

Challenges in the area of spirituality

Because many traditional healing practices complement the Western health approach, rehabilitation professionals are often in a comfortable position to acknowledge and support the integration of both perspectives. Physical therapists typically are adept at creatively identifying and modifying patient strategies to achieve patient-centered and family-centered goals. This core ability offers a natural partnership with American Indian spirituality, traditional healing practices, and meaningful goals, but only if the non-Indian physical therapist is first aware of potential culture-based conflict.

CHALLENGES OF CROSS-CULTURAL PRACTICE

For each of the general cultural characteristics previously described, clinically related challenges have been presented. When attempting to engage in effective cross-cultural practice, it is first essential for a health care practitioner to be aware that the potential for conflict exists between one’s own beliefs and the patient’s beliefs. This recognition may serve as the foundation for integration of Western and traditional perspectives.

A second caveat when working with American Indians is to respect the historical context of Indian life in the United States, which literally exists as culture within culture. Federally recognized American Indian tribes may operate under complete or limited sovereignty from the US federal government, claiming specific territorial regions, governmental structures, and protection of religious practices (in reality, Supreme Court decisions have reversed rulings that originally were consistent with the American Indian Religious Freedom Act of 1978).⁵⁰ The history of oppression of American Indians by the US

government should be understood and not underestimated by non-Indians working or conducting research in Indian country.^{19,34,38} Even today, much of the federal allotment of financial resources is distributed to non-Indian agencies and academic centers to be used for the benefit of tribes.

Many American Indians have grown accustomed to the presence of non-Indian persons on the reservations for periods of time, until the research is complete or until the funding is interrupted, which is when the non-Indian practitioners and researchers disappear.³¹ Researchers should remember that the research is not being *done on* American Indians, rather it is being *done with* cooperation of the tribe to better understand phenomena that will improve quality of life and care. Practitioners should remember that one is not present to fix the problems on the reservation (especially perceived problems), but rather to offer resources and solutions should patients and the larger community identify such goals as a priority. No matter the reason for non-Indian presence on Indian reservations, one must respect such issues to create a therapeutic rather than an exploitive presence and gain the trust of the Indian community.

IN-DEPTH EXAMPLE OF HEALTH BELIEFS: THE OMAHA TRIBE

The Omaha Nation claims reservation land on the bluffs overlooking the Missouri River in northeast Nebraska, approximately 80 miles north of the city of Omaha in the Aberdeen IHS region. The tribe migrated from the Ohio River Valley and is comprised of the Sky People and Earth People clans. Health care services are provided at a health education center facility, with an IHS hospital approximately 10 miles north on the Winnebago (Ho-Chunk) Indian reservation.

Understanding Elder Health Beliefs

Since 1994, a federally subsidized academic-community partnership between an academic health center and the tribe has formed, resulting in consistent clinical and community physical and occupational therapy, and disease prevention and wellness programs for mother and child, mental health, pediatric, and geriatric patients. In developing culturally appropriate health programs, qualitative research methods were first employed to gather insight into health beliefs and behaviors of tribal elders (HRSA grant 1D36AH10082-01 and the National Institute of General Medical Sciences/Indian Health Service). Results from the research findings greatly enhanced the physical therapists’ understanding of the Omaha tribe’s health beliefs and attitudes toward exercise. The themes⁵¹ are:

- Health and wellness are important and are equated with the ability to be active, participate, and fulfill a social role, or do your job. Conversely, illness represents the inability to participate in activities.
- Illness usually results from 2 main causes: a failure to care for oneself or a fatalistic view of the inevitability of disease.

- Healing involves regular exercise, good eating habits, rest, and positive thoughts.
- Exercise is understood as essential, but is performed through daily activities.
- A strong component of healing involves spirituality and is carried out through prayer and traditional healing methods (eg, herbs, teas, sweats, peyote, and the symbolism of water).
- Health care practices were generally learned from mothers and aunts or boarding school faculty, whereas traditional practices (eg, sweats or use of peyote) were learned from fathers or influential men. Storytelling was a common format for information exchange.

Delineation of the themes provides an example of elder beliefs toward health and also provides a framework from which to discuss examples of how specific health beliefs may be incorporated into physical therapy practice. In caring for Omaha elders, the themes impact physical therapy examination and intervention in a variety of ways.

First, during subjective examination, the physical therapist should now know to include queries about the patient's thoughts about exercise, healing, and spirituality. Good clinical examination may be facilitated using explanatory models described by Kleinman.⁵² Explanatory models pose a series of questions to the patient that are related to the patient's perception or interpretation of the problem; that information guides subsequent intervention, thus allowing for patient choice.^{52,53} Open-ended questions are used to gather information relative to the cause or etiology of the problem, the expected course of illness, the effect on the patient's life, and the form of intervention that may help alleviate the problem.^{52,53} Unfortunately, health care practitioners caring for older patients seldom receive formalized training in use of explanatory models to understand the patient's meaning of illness.⁵⁴ Asking the patient to reflect on the cause of the illness and its life impact will offer a great amount of information relative to successful intervention—in any culture.

The second major theme of the Omaha tribe's health beliefs impacts prevention and wellness programs. It is important to understand the extent to which a patient perceives an internal locus of control and self-efficacy with regard to illness prevention. For some patients, diabetes mellitus appears inevitable, and no amount of healthy behaviors or lifestyle changes will likely prevent the onset of disease. For such patients, exercise and healthy activities will need to be developed very specifically, perhaps day to day rather than monthly, so patients may receive reinforcement for components of larger short-term and long-term goals, eventually improving patient control over health behaviors.

It is clear from the health beliefs of some Omaha tribe elders that exercise is perceived as important. Health practitioners need not spend time trying to convince patients of the benefits of exercise; rather, physical therapists need to use problem-solving techniques to find alter-

nate strategies for patients to continue daily activity routines that contain dose-dependent exercise prescriptions. American Indian elders commonly describe reasons, such as balance disturbances and arthritic joints, that prevent continuation of walking programs and dancing at powwows and other traditional community events.

Finally, the themes discussed in the Omaha tribe study reveal the importance of traditional healing practices and spirituality. Questions in the explanatory model ask patients to comment on potential successful treatment interventions. This line of questioning allows flexibility for pursuit of alternative healers and integration of Western medicine with traditional practices. Truly successful practitioners caring for American Indian patients will support patients in accessing a shaman, Indian doctor, or faith healer, and thus integrate rehabilitation goals and interventions with traditional practices. Of course, as previously mentioned, belief in the effectiveness of traditional healing practices varies widely by members within and across tribes. Just as it would be inappropriate to overlook potential use of traditional practices, it would be inappropriate to assume that all American Indians wish to access traditional methods of care.

SUCCESSFUL STRATEGIES IN CLINICAL PRACTICE

With the identification of potential cultural conflicts challenging effective patient care, how can the non-Indian physical therapist be successful in caring for American Indian elders? Many successful strategies are fairly straightforward.³¹ Obviously, this monograph is not designed to give specific cultural information about specific American Indian tribes. Rather, it is designed as a guide outlining the key skills practitioners must possess to serve many different American Indian cultures, skills that are necessary for effective cross-cultural practice. Seven key skills and strategies are as follows.

1. It is critical to realize that the non-Indian physical therapist is a guest in the American Indian community. Humility, respect, and genuine interest in people, tradition, and culture are essential to establishment of trust in American Indian communities.
2. For those practicing within American Indian communities, it is essential to maintain a visible, consistent presence. Consistent with human nature, trust develops over time. American Indians have grown accustomed to non-Indian imposition on their land, in their schools, in religious practices, and in health care delivery. It is critical to earn the community's trust and to remain present, consistent, and accountable. To accomplish this, the physical therapist must be patient and cooperative, and learn to accept and expect uncertainty.
3. In communication with American Indian elders, it is helpful to follow the lead. Because wide variation exists in communication style both within and across tribes, it is desirable to reciprocate eye contact, non-verbal cues, and physical contact consistent with patient modeling.³¹ As in any health care setting, patients should always be asked for permission to be

touched or for removal of clothing. The therapist should *never* underestimate the importance of gaining permission during cross-cultural interactions. Communication with other health care practitioners and administrators is best handled in a face-to-face manner. The use of memos, telephones, or electronic mail rarely seems to expedite communication, especially for non-Indians working in an American Indian community. It appears that the personal aspect of face-to-face communication may enhance the formation of trust that is so critical to successful interaction.³¹

4. It will be very beneficial for the physical therapist to build a strong network of resources with medical, social work, and community health resources (including public health nurses and transportation personnel); senior center and pharmacy staff; contract health officers; and members of all other disciplines or resources involved in the care of American Indian patients within the reservation community. Because reservations are often rural and underserved, the role of the physical therapist may shift somewhat from direct clinical provider to educator and patient advocate. Ethical dilemmas, as well as social and distributive justice decisions, become an aspect of daily practice and require the physical therapist to possess an understanding of ethical analysis and the tenacity and communication skills to advocate for patient rights and services. In addition, creativity, flexibility, and program development skills are essential to practice in American Indian communities. Consistent with successful practice in other underserved communities, health care disciplines band together to extend scarce resources. It is important for the non-Indian practitioner to understand that as she enters the community network, the true extent of the community's interconnectedness emerges. Intensely strong social relationships bind community members and quickly inform its members of transgressions committed by careless non-Indian practitioners lacking cultural sensitivity. Just as quickly, community members will inform others of non-Indian practitioners who make errors but at least desire to practice in a culturally sensitive manner.³¹
5. Successful practitioners recognize the role of elders as the vulnerable link to community acceptance. Elder designation is conferred out of respect, not necessarily chronological age. Elders are the living historians guarding and teaching traditional language and beliefs. Successful physical therapy management of a community elder may build trust and strengthen the therapist's position in the community network.³¹ Unfortunately, elders comprise a potentially vulnerable cohort in any culture due to complicated health needs, mobility issues, and lack of advocates. Superimposing cross-cultural care in a setting with scarce resources magnifies the vulnerability. Rehabilitation options may be particularly inaccessible to American Indian elders if the non-Indian phys-

ical therapist does not make a concerted effort to understand the cultural background of the patient.³¹

6. As discussed earlier, the use of explanatory models in patient assessment may be very beneficial in allowing the patient an opportunity to articulate his own thoughts about cause, impact, and alleviation of disease or dysfunction.
7. Perhaps most importantly, development of culturally competent care requires the therapist to engage in cultural self-assessment. Critical and honest self-appraisal may begin with questions such as those offered by Padilla and Brown³²: "What values do I hold that are consistent with dominant culture? Have I examined the values embedded in my discipline that may confuse and disturb my patients? Are the examples I use to illustrate key points meaningful and sensitive to my patients? Do I have creative and effective ways to learn more about my patients' lives and interests?"^(p27-28) While the development of cultural sensitivity is a life-long process of growth, the preceding framework allows one to create an awareness of potential areas of conflicting values and beliefs impacting interaction with others. Leavitt⁵⁵ aptly reminds us: "It is not merely the 'other' who has a unique culture, but each one of us."^(p3)

While the ability to access and understand culturally relevant information is essential for competent and effective health care delivery, it is just as important for health care practitioners to not overemphasize the differences. As Padilla and Brown³² assert: "When we transform our patients into 'cultural beings' rather than human beings, we run the risk of 'exoticizing' or making them other than ourselves."^(p27)

Perhaps the most important advice for physical therapists working with American Indians is to recognize that many values and beliefs transcend culture and represent shared values of humanity: compassion, protection of valued resources, and respect. The foundation of successful cross-cultural work involves conveying respect on the most human of levels; the question then becomes: How does one show respect within this culture? This monograph offers strategies to begin the process of identifying general and specific cultural information related to display of respect. In caring for American Indian elders, one will unknowingly make mistakes, but humility and respect will often allow forgiveness, insight, and development of new strategies and skills during cross-cultural interactions. It has been this author's consistent experience that the majority of American Indian elders are wise and fair.

CASE STUDIES

Case Study 1

History

Mrs Horselooking is a 57-year-old member of the Lakota tribe. She was admitted to the IHS hospital last evening for symptoms consistent with Bell palsy (paralysis of cranial nerve VII), with onset 2 weeks ago. After the physician ruled out other medical conditions (eg, cere-

brovascular accident), a physical therapy referral was written. A chart review revealed that her medical history is positive for diabetes mellitus and osteoarthritis in both knees. A corticosteroid prescription was begun this morning.

Entering Mrs Horselooking's room, the physical therapist found the patient sitting on the edge of her hospital bed, clad in a gown. Mrs Horselooking was pleasant, but she spent much of the interview looking at the floor or looking out the window past the therapist.

The therapist learned that the patient's symptoms began insidiously, and nothing seemed to improve her ability to control the right corner of her mouth. In addition, the patient was having difficulty closing her right eye, was experiencing dryness of the eye, and also complained that sounds in her right ear were louder than sounds in her left ear.

Following some brief discourse about local events, the patient's family, and her past medical and rehabilitation experiences, the physical therapist assessed the patient's understanding of her medical condition by using questions from the Kleinman explanatory model. When asked, "What do you think caused your facial muscles to weaken?" the patient was silent for almost 1 minute. After the silence, Mrs Horselooking stated, "A ghost has attached itself to my soul." The physical therapist further queried as to how this happened, and Mrs Horselooking was not sure of the exact mechanism, what she might have done to encourage this attachment, or how long such symptoms would last. The physical therapist asked, "How do we get the ghost to detach itself?" Again after prolonged silence, Mrs Horselooking stated that she would need to see the Indian doctor who would extricate the ghost by use of traditional prayer, chanting, and burning grasses. The physical therapist asked the patient her goals and found the patient assumed that normal function of her facial muscles would return and the dryness in her eye and hyperacusis would likely diminish following intervention.

Understanding the patient's perspective allowed the physical therapist to integrate Western and traditional healing approaches. The physical therapist proceeded to explain to the patient the probable cause of the paralysis by saying: "Something has likely caused some swelling or inflammation around the nerve that controls the muscles in your face and ear." Because in Western medicine the exact cause of Bell palsy is unclear, the physical therapist saw no reason to argue over the exact cause of the inflammation. Rather, the physical therapist explained the reaction Mrs Horselooking's body was having to the *presence* of inflammation (regardless of cause) and explained why her eye and ear were also affected.

The physical therapist instructed the patient to visit the Indian doctor as soon as she is able, but in the interim, there were some interventions that might help moisten the eye and prevent the facial muscles from weakening further. Mrs Horselooking was very interested in learning, so the physical therapist used a mirror to instruct the patient in passive and active exercises for the facial mus-

culature and advised the patient to use eye drops and wear an eye patch. There was no electrical stimulation unit available, and even if there were, it would not have been appropriate to use it because of the invasive nature of the electrical current. If available, its purpose would have to be clearly explained, demonstrated on another part of the patient's body (eg, arm), and permission for use obtained. Although the preceding steps are often completed in most practice settings, they would be especially important when working with American Indian elders who would likely view the modality as invasive.

In this case, the patient was discharged with the physical therapy home program later that day. She would not be returning regularly for physical therapy services because she lived 70 miles from the IHS hospital and could not afford to travel that distance. Mrs Horselooking did visit the Indian doctor and stopped into the hospital clinic 3 weeks later (after her physician follow-up appointment). She indicated that she no longer needed the eye patch because she could close her right eye, and she also stated that she had been performing her exercises as instructed. The therapist did not hear from Mrs Horselooking again, but ran into Mrs Horselooking's daughter at a pow-wow 6 months later and learned that the patient had fully recovered.

Discussion

This case study illustrates the importance of understanding when a patient's beliefs are culturally appropriate rather than the basis for psychiatric evaluation. The case demonstrates how use of an explanatory model during patient assessment revealed the patient's beliefs about the cause of her symptoms that could have potentially conflicted with Western-based physical therapy intervention. By learning the patient's perception of the cause of paralysis, the patient's ideas for intervention, and the patient's goals, the therapist was able to explain the probable cause of the illness without violating the patient's explanation, thus maintaining the patient's trust. The physical therapist was also able to integrate Western and traditional healing practices for successful patient management.

The physical therapist allowed Mrs Horselooking plenty of time to respond to questions, realizing that using silence was important when interacting with American Indian elders. In addition, the physical therapist understood that the patient's limited eye contact was not a sign of disinterest or a lack of respect, rather it was a culture-bound pattern of interaction often exhibited among American Indians. The physical therapist was able to follow the patient's lead by matching a similar amount of eye contact and diverting her own gaze when appropriate during the examination and intervention.

Case Study 2

History

Mr Snake is a 77-year-old member of the Winnebago nation. He was seen 9 days after a right cerebrovascular accident and requires maximum assistance for all trans-

fers and mobility skills. His current medical conditions included diabetes mellitus, hypertension, chronic obstructive pulmonary disease, and use of a Foley catheter. The patient chart indicated he had undergone right rotator cuff repair 9 years ago and experienced a myocardial infarction status 3 years ago.

Until the recent cerebrovascular accident, Mr Snake had been living at home with his 75-year-old wife (of the Santee tribe). He had functioned independently except for use of a straight cane for balance.

Mr Snake had just been transferred to the 22-bed IHS hospital from a nonreservation regional trauma center 30 miles away. While at the larger hospital, Mr Snake had received physical and occupational therapy services that had emphasized rolling, bed mobility, and sitting tolerance. Physical therapy evaluation was ordered for today.

Entering Mr Snake's room, the physical therapist found the patient in bed, his wife seated in a chair next to the bed and 2 adult women in the room (1 seated in a chair at the foot of the bed and 1 leaning against the wall). There was also an adult man leaning against the heating register. The physical therapist (who still had 2 evaluations to complete before lunch time) moved and spoke rather quickly. The physical therapist smiled at everyone on entering the room and said, "Good morning" directly to the patient. The patient said, "Hello." The physical therapist proceeded with his examination, standing over the patient's bed and asking questions about Mr Snake's prior functional status. Attempting to begin the physical examination, Mr Snake stated, "Not right now," and the patient's wife explained that he was tired from the transfer trip this morning. The physical therapist stated that he was very busy and would not be able to return until the next day. When passing by Mr Snake's room later in the day, the physical therapist noticed the same visitors were still present.

The next day, the physical therapist completed the evaluation and discussed plans with Mrs Snake, with the patient, and the same visitors present as the day before. The physical therapist discussed his goals and his plan to improve Mr Snake's functional and mobility skills, suggesting that with rehabilitation, the patient should be able to return home with some modifications. The patient's wife stated that Mr Snake would not be returning home, rather he would be living in their daughter's home (also on the reservation). The daughter corroborated this plan. As the discussion progressed, the physical therapist became frustrated, continuing to explain the functional deficits and how he planned to improve them and return Mr Snake home. The physical therapist even explained what would happen if the patient did not participate in the rehabilitation process. The daughter explained that her husband and adult son would be home to help transfer her father from bed to wheelchair should he need it. The physical therapist was able to perform a few rolling exercises with the patient, but left the encounter rather

frustrated. Later that afternoon, the social worker (also American Indian) visited the physical therapist to help him understand the situation.

Discussion

This study case illustrates the importance of family interaction and long-term care planning with American Indian elders. The physical therapist was destined to be challenged from the beginning. In Western culture, it is fairly typical to address the patient, but in most American Indian cultures, it is better to enter a room with multiple family members by introducing oneself and extending a general greeting (eg, "Good morning, I'm Bob, the physical therapist."). By so doing, the physical therapist learns who is the family's communication contact—at times it will not be the patient. The patient's right to choose care alternatives is commonly protected, and once the decision is known, the family group will be "unmovingly supportive"^{39(p101)} in protecting the patient's choice. In Mr Snake's case, the patient had chosen to live with his eldest daughter's family, but the physical therapist wasn't aware of this and the principle of non-interference meant that the information was not offered without direct questioning.

Secondly, the physical therapist's focus on independence was somewhat at odds with American Indian culture. In this case, the daughter wanted to care for her father—a role of honor in her culture. The physical therapist felt he could significantly improve the patient's functional status and return him home. In this case, the culturally competent skill would have involved accepting that the patient would return to his daughter's, not his, home, and understanding that the patient could become more functional and live with his daughter. There is no problem in improving Mr Snake's functional level, and that is where the physical therapist's goals should have centered. The question of autonomy and focus on independence were not as important as the daughter's caregiving role. Again, all of this depends on level of acculturation into Western culture and will vary with family dynamics, whether elders have children, whether elders or children were educated in forced boarding schools, and whether the parent or children resided off the reservation for an extended period of time.

Finally, the only way for the physical therapist to gain the patient's and family's trust is to spend time in conversation. This might mean pulling up a chair and visiting, understanding that the principle of noninterference might require use of open-ended queries to decrease the opportunity for single-word responses to specific questions. Although the need to spend time with patients is important across most cultures, it is essential when working with American Indians. The physical therapist needed to realize that Western demands of time, expectation of frank communication, and patient autonomy might all be in conflict with American Indian patterns of communication and importance in care planning with elders.

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NOTES

Cultural Diversity of Older Americans

MONOGRAPH EVALUATION FORM

“Rehabilitation and American Indian Elders”

by Teresa M. Cochran, PT, DPT, GCS, MA

Directions: Please rate this monograph on the categories of “Organization, Clarity, and Presentation,” “Relevance of Material,” and “Fulfillment of Needs” by circling the number that best describes your opinion. Record your thoughts as you complete the monograph and while they are fresh. At the end of the series, you will receive a course evaluation form; you will have the option of transferring information from the monograph evaluation form to that form or returning the individual forms you completed for each of the 6 monographs.

Organization, Clarity, and Presentation

5	4	3	2	1
Material well organized; clearly written, interesting		Satisfactory organization and presentation		Poorly organized, hard to follow, confusing

Relevance of Material

5	4	3	2	1
Meaningful, accurate, comprehensible, contemporary		Satisfactory, but limited at times		Deficient, inaccurate, dated material

Fulfillment of Needs

5	4	3	2	1
Needs fulfilled, goals achieved, stimulated by content		Satisfied with content		Needs unfulfilled, goals not met

Author Rating _____ (Scale of 1 to 5, with 5 being the highest rating)

Please Comment: _____

Thank You!

Cultural Diversity of Older Americans

Rehabilitation and American Indian Elders

REVIEW QUESTIONS

1. Which of the following statements is true regarding American Indians?
 - a. in 2001, dollars spent for American Indian health care exceeded the amount spent for health care on non-Indians.
 - b. limited transportation and telephone access challenge delivery of health care services for American Indian elders.
 - c. the average life span for American Indians is essentially the same as the average life span for non-Indians in the United States.
 - d. there are fewer than 300 federally recognized tribes in the United States.
2. According to the Centers for Disease Control and Prevention, the leading causes of death for American Indians aged 55 and older that *are not* leading causes of death for all other races in the United States are:
 - a. accidents and chronic liver disease and cirrhosis.
 - b. cerebrovascular disease.
 - c. chronic obstructive pulmonary disease.
 - d. heart disease and cancer.
3. The Indian Health Service:
 - a. has coordinated health-related services since 1985.
 - b. is an agency in the United States Department of Interior.
 - c. is comprised of 4 regional offices.
 - d. serves approximately 1.5 million members of federally recognized tribes.
4. Which of the following is an accurate statement concerning American Indian culture?
 - a. intracultural differences among tribes are minimal, so cultural self-assessment will not likely benefit the health practitioner who has already worked with American Indian patients.
 - b. many American Indians may exhibit limited eye contact in conversation as a sign of respect.
 - c. most American Indian elders are acculturated into Western culture and do not recognize traditional Indian healing practices.
 - d. the culture is such that the use of explanatory models to gain insight is *not* helpful in plan-of-care development and patient management.
5. American Indian elders:
 - a. age 75 to 84 who are men have a homicide rate nearly triple the rate of non-Indians of the same age.
 - b. average life expectancy at birth is approximately the same as the life expectancy for all other United States races.
 - c. have the lowest rate of disability for any ethnic group in the United States.
 - d. represent 20% of the American Indian population.

ANSWERS

1. b
2. a
3. d
4. b
5. a