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HEALTH AMONG NATIVE AMERICAN ELDERS

by

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DISSERTATION

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ABSTRACT

of

HEALTH AMONG NATIVE AMERICAN ELDERS

by

Diane C. Hatton

University of California, San Francisco, 1988

The purpose of this study was to explore the phenomenon of health among members of an aggregate of urbanized, Native American elders. Utilizing a grounded theory methodology, the investigation considered the phenomenological and social aspects of health in a multicultural context. Research among members of this population is important for several reasons including that these elders are from a cultural group different from that of the majority and also that they are particularly susceptible to a number of health problems. Often nursing textbooks portray Native Americans as a homogeneous group whose view of health is predominantly sacred and traditional. This representation does not reflect the enormous complexity of constructing health meanings and managing perceived health problems in an evolving multicultural context.

The majority of these elders were hardy individuals. They "pulled through" and survived the harsh circumstances in the past and managed chronic health problems as well as

persistent adversity in the present. They were "pragmatists" who tested and evaluated a variety of health care options in search of what "worked."

These individuals had multiple interactions with Western, non-Indian providers from whom they sought and obtained health care. The majority of these interactions took place within an opportunity structure which emerged as a consequence of the general condition of wardship. Generally, these older adults perceived the health care options connected to wardship as accessible.

Ethnicity did not emerge as a salient dimension linked to the health perceptions and health actions/interactions of these individuals. What did emerge as important was a social environment comprised of dimensions including wardship, opportunity structure, and past/present world. This discovery contradicts that body of nursing literature which represents Native Americans as a homogeneous ethnic group whose perspectives of health are most often blended with traditional beliefs and practices. The discoveries, instead, illuminated the saliency of additional environmental factors, including those which are historical, economical, political, and social, for the construction of health meanings and consequent health actions and interactions.

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CHAPTER ONE: INTRODUCTION

This study explores the phenomenon of health among members of an aggregate of urbanized, Native American elders. Using the field research method guided by grounded theory methodology (Glazer & Strauss, 1967; Schatzman & Strauss, 1973; Strauss, 1987), the investigation focuses upon the enormous complexity of the concept of health by considering its phenomenological aspects as well as its social context. A number of nursing textbooks tend to represent Native Americans as a homogeneous group who perceive their health from traditional, sacred perspectives only. This representation of Native Americans does not appreciate the diversity within this population, nor does it reflect the complexity of constructing health meanings and managing perceived health problems in a multicultural context. The latter concern is the focus of this study.

This introductory chapter includes three sections which consider: 1) the importance of research with Native American elders; 2) the concept of health and its relationship to nursing; and 3) the importance of exploring health from a phenomenological and social perspective. The chapter concludes with a brief overview of the chapters to follow in order to provide a succinct background for the remainder of the dissertation.

Importance of Research with Native American Elders

Many members of ethnic minorities in the United States are more vulnerable to health problems than are others in the general population (Institute of Medicine, 1981). The Native American is particularly susceptible to a variety of health problems including accidents, influenza, pneumonia, obesity, diabetes, hypertension, liver and kidney diseases, suicide, and homicide. Alcohol abuse has been implicated in a number of these problems (U. S. Congress, 1986).

For the Native American elder, this vulnerability is exacerbated not only by biological changes associated with the aging process, but also by what Block (1979) refers to as a lifetime of deprivation--deprivation associated with conditions such as substandard housing, limited education, inadequate income, malnutrition, a lack of urgently needed services, and a changing culture. In spite of this situation, scholars have conducted only a few studies of health among Native Americans elders, and, therefore, research which generates knowledge about health among members of this population are warranted.

An understanding of clients' health perceptions and health actions has consequences for the delivery of health care services. Well-intended programs often fail when health care providers view health differently from their clients (Steffin & Francis, 1978). These different views contribute to a situation in which the expectations of the

provider and the client are "mismatched" (Strauss, 1976). Research which yields an understanding of clients' health perceptions and health actions provides an important basis for nursing practice.

The Commission on Nursing Research of the American Nurses' Association (1980) has affirmed the significance of research with clients culturally different from the majority, and its directions for future work include research with Native Americans. More recently, the American Nurses' Association Cabinet on Nursing Research (1985) has reconsidered the importance of research with groups culturally different from the majority. This latter group has identified priorities for nursing research that will generate knowledge enabling nurses to:

> "promote health, well-being, and ability to care for oneself among all age, social, and cultural groups...(and) ensure that the care needs of particularly vulnerable groups, such as the elderly..., individuals from diverse cultures..., and the poor, are met in effective and acceptable ways."

In this statement, the American Nurses' Association acknowledges the importance of a broader understanding of health among groups such as Native American elders--a group culturally different from the majority and particularly susceptible to a variety of health problems.

In summary, research which explores health among Native American elders is important for several reasons. First, these older adults are particularly vulnerable to a number of health problems and have often experienced a lifetime of deprivation which exacerbates these situations. Second, understandings of client's health perceptions provide an important basis for nursing practice. Third, the American Nurses' Association Cabinet on Nursing Research has targeted such groups for research because of their cultural differences, age, and vulnerability. Finally, scholars have conducted only a few studies which deal with the health situation of these older adults and, therefore, studies such as this are warranted.

Nursing and the Concept of Health

Health has been identified as a major phenomenon of nursing's concern by a number of writers (Yura & Torres, 1975; Fawcett, 1978; Newman, 1983; Meleis, 1985). Although this phenomenon is a central focus for nursing, considerable variability prevails as to its interpretation. For this investigation, a preliminary understanding of this phenomenon assisted in the development of the lines of inquiry.

Margaret Newman (1979; 1986) argues that much of the health related literature contains the notion that health is a disease free state. Newman, in contrast, perceives disease as a manifestation of health and rejects this

other, polarized view. Her view dialectically fuses the opposites--disease and nondisease--to bring forth the concept of health.

Tripp-Reimer (1984) utilizes the work of Newman to conceptualize health. Tripp-Reimer also views health dialectically, but rather than fusing the opposites of disease and nondisease, this author fuses the continua of wellness-illness and disease-nondisease. The wellness-illness continuum represents the perspective of the client whereas the disease-nondisease continuum represents the perspective of the practitioner. For this study, the preliminary lines of inquiry encompassed these multiple aspects of health; thus, inquiry considered not only wellness, but illness, disease, and nondisease.

Health from a Phenomenological and Social Perspective

Symbolic interaction informed this investigation with regard to understanding health from a phenomenological and social perspective. According to Blumer (1969), three premises form the basis of symbolic interaction: first, "human beings act toward things on the basis of the meaning the things have for them"; second, "the meaning of such things is derived from, or arises out of, the social interaction one has with one's fellows"; three, "these meanings are handled in, or modified through, an interpretive process used by the person in dealing with the things he encounters" (p. 2). More succinctly, the

perspectives which a person brings to interpret a situation are social in origin and emanate from definitions of countless situations in which individuals find themselves (Schatzman & Strauss, 1973). Perceptions of health, too, are subject to interpretive processes which arise out of one's interactions in countless social situations.

Culture is a shared framework which supplies symbols, such as language and gestures, for individuals to use in the interpretation of situations and the construction of meanings for phenomena such as health. Since health meanings develop within these shared frameworks, they often have consistency within various groups, such as an ethnic group. Yet, change and transition pervade modern societies rendering these consistencies problematic. Streams of new situations arise and the images of old situations become unstable. Additionally, those symbols and tools, which were previously utilized to interpret the world, begin to vary and shift considerably (Blumer, 1969). For the individuals in this investigation, new situations and shifting interpretations have shattered the images of traditional approaches to health and furnished a matrix of commercial and medical images in their place.

In order to grasp these dynamic, complex understandings of health, this study utilizes the grounded theory methodology. This approach allows the investigator to explore the situational and structural contexts in which

these older, Native American adults construct meanings of health and manage their perceived health problems. It further provides a method by which the complexity of this phenomenon can be analyzed through the development of many concepts and their linkages (Strauss, 1987). In sum, the grounded theory method allows this investigation to consider the phenomenological and social aspects of health in a multicultural context.

Initially, the study proceeded along several lines of inquiry based upon the review of the literature, the investigator's experiential data, and leads emerging from the data analysis. These lines of inquiry follow:

How do the elders perceive their past and present health?

What self care practices do the elders use?

How do they manage illness?

What are their patterns of seeking health care?

What are their experiences with regard to those health problems that are discussed in the literature as significant for the Native American population?

How do the elders compare the present health of Native Americans with that of the past?

What constitutes their support system, and how do they perceive the effectiveness of this system when they become ill?

In the grounded theory tradition, data gathering and analysis proceed concomitantly in order to pinpoint saliencies before leaving the field. Theoretical sampling verifies discoveries and, eventually, a substantive theory evolves which provides an understanding of the phenomenon of concern. In this study the substantive theory provides an understanding of how these older adults construct meanings of their health and how they manage their perceived health problems.

Overview of Chapters to Follow

In the chapters that follow, the substantive theory emerging from this study unfolds. Chapter two presents a review of literature which includes a consideration of health from the perspective of the Native American as well as from the Western health care provider. Chapter three presents the methodology utilized in the study through a discussion of the sample, setting, data gathering, and data analysis. Chapter four presents the discoveries of this study of health among members of an aggregate of Native American elders, and chapter five considers implications for nursing research, education, and practice.

Summary

The purpose of this study is to explore the phenomenon of health among members of an aggregate of urbanized, Native American elders. Utilizing a grounded theory methodology, the investigation considers the

phenomenological and social aspects of health in a multicultural context. Research among members of this population is important for several reasons including that these elders are from a cultural group different from that of the majority and also that they are particularly susceptible to a number of health problems. Often nursing textbooks portray Native Americans as a homogeneous group who have a unitary view of health which is predominantly sacred and traditional. This representation does not reflect the enormous complexity of constructing health meanings and managing perceived health problems in an evolving multicultural context.

CHAPTER TWO: REVIEW OF LITERATURE

This chapter reviews literature from two general areas which have relevance for this investigation among members of an aggregate of urbanized Native American elders. First, it considers health from the perspective of Native Americans and, second, health from the perspective of the Western health care provider. The discussion focuses upon the cultural frameworks and, in particular, meanings of health constructed within those frameworks by Native Americans and Western health care providers. These frameworks have consequences for interaction in health care situations.

In considering health from the perspective of the Native American, the first section of the chapter explores the importance of culture and considers how the link between culture and health perceptions has been demonstrated in studies among groups of Native Americans. Findings indicate changing perceptions of native healing arts as well as immense diversity among members of this population which render a unitary understanding of health from the perspective of the Native American problematic.

With regard to health from the perspective of the Western health care provider, limited here to those practicing in the United States, several areas of literature are important. First is that literature dealing with the provider's cultural framework as well as understandings of health constructed within this framework. Second is that

literature dealing with the health status among Native Americans from the perspective of this framework. This section of the chapter also provides a description of the historical and contemporary contexts in which Western health care services have been provided to the Native American.

Health from the Perspective of Native Americans

Although the title of this section indicates that it considers health from the perspective of Native Americans, these understandings have been filtered through an interpretive process by various writers and researchers, and they represent a view that is presented by the literature. The literature focused upon here is primarily from nursing and medical anthropology.

Culture and Health

Utilizing a symbolic interactionist point of view, perceptions of health are subject to interpretive processes and arise out of one's interactions in countless social situations (Schatzman & Strauss, 1973). Moreover, culture is the framework which supplies symbols, including language, for individuals to use in the interpretation of situations and the construction of meanings for phenomena, including health. Since meanings develop within shared frameworks, they often have consistency within various groups (Blumer, 1969). From the symbolic interactionist perspective, health represents a phenomenon interpreted within the context of culture.

The literature addresses the relevance of culture for health perceptions. Harwood (1981), a medical anthropologist, notes that studies of individual ethnic groups have shown culturally distinctive ways to evaluate symptoms. In nursing, too, a number of writers argue that health must be considered within its cultural context--a context that may differ from than that of the provider (Leininger, 1978; Henderson & Primeaux, 1981; Brink, 1976; Steiger & Lipson, 1985; Spector, 1985). Others emphasize that when a provider omits considerations of cultural differences, individuals do not receive safe, effective care (Branch & Paxton, 1976; Fong, 1985). In sum, meanings of health emerge in the context of culture and hold implications for nursing practice.

Perceptions of Health among Native Americans

Studies of health as it is perceived among Native Americans are few, and much of the literature related to this topic confines itself to the largest tribal group in the United States--the Navajo. From the literature dealing with health perceptions among the Navajo emerges an understanding of health that is traditional and sacred in nature. Although not all tribal groups experience health under the same conditions as do the Navajo, findings made among members of the Navajo tribe have been generalized to others.

Discoveries from a classic study by Adair and Deuchle (1970) provide the basis for much of the literature regarding Native Americans which has followed. These authors report the close association between health beliefs and religious beliefs in the Navajo culture. From the traditional Navajo view, an infraction of the rules of human conduct causes disease. These authors argue that when a Navajo accepts a Western treatment for an ailment such action indicates that contacts with the non-Navajo world have modified the religious belief system of that individual. These contacts lead to acculturation and, from the perspective of symbolic interactionism, to the formation of a new framework for the construction of health beliefs.

Joe, Gallerito, and Pino (1976) also discuss the close association between religion and health found among the Navajo. These authors note that to members of this tribe a series of bad dreams may be as significant as a traumatic illness such as cancer and that the Navajo's holistic view of health has its basis in religious beliefs. As Davis (1980) notes, the idea of locating the cause of disease in physiological processes does not fit into the Navajo way of thinking.

Language plays a significant role in these interpretations of health. According to symbolic interactionism, language is a symbol utilized for the transmission of culture (Blumer, 1969); moreover, writers

have commented upon how language has consequences for the transmission of health ideas. For example, Wauneka (1976) describes her experiences teaching Navajos about tuberculosis utilizing the Navajo language which has no word for "germ." This missing term makes it difficult for learners to assign meaning to this disease; thus, language is important for perceptions of health.

Adair and Deuchle (1970), in their earlier work, also describe this situation. These authors note that the Navajo language does not have a word for "lungs," but only a general word for "chest." As in Wauneka's case, teaching about lung disease, especially tuberculosis, is problematic under these conditions.

From the perspective of symbolic interactionism, the reader will recall that individuals act toward objects based upon the meaning those objects have for them. As language provides the symbols which people use to interpret situations, it sets conditions for action (Blumer, 1969). When a language has no terms for a phenomenon, the meaning of that phenomenon and action with regard to that phenomenon become problematic. In sum, one's language has important consequences for health perceptions as well as health actions.

In a more recent work Sobralske (1985) also explores health among members of the Navajo tribe. Although today most Navajos use some form of modern health care, Sobralske

argues that their traditional belief system remains intact. The reader is led to understand that although the Navajo client utilizes Western health care, traditional approaches to health are commonplace.

Studies which focus upon health among other groups of Native Americans include one by Aamodt (1978). Aamodt's investigation explores the everyday notions of health among a group of Papago Indians. This researcher notes that the phenomenon of "controlling one's thoughts" is crucial for if they are not controlled, it is believed that sickness or death of oneself or one's relatives may result. Other beliefs this author reports as important for health include speaking the name of someone who died which is likely to invoke illness, misfortune, accident, or fire and utilizing foods and ceremonies in order to prevent illness and maintain health. The idea that health is associated with religious and supernatural factors emerge in these findings as in the previous works discussed with the Navajo.

Changing perceptions of traditional healing arts among Native Americans have been noted by Wilson (1983). Moreover, Wilson argues that a decline in the utilization of and a loss of respect for traditional healing beliefs and practices is not necessarily associated with an increased utilization of non-Indian health care.

The findings in a study by Bushnell (1981) offer evidence for Wilson's thesis. Bushnell reports a study with

a small sample of American Indian women living on the northwestern coast of the United States. The younger women in the sample hold, what Bushnell refers to as, "transcultural beliefs" rather than "traditional beliefs." Transcultural women in the study report that they wish special clinic time in order to receive information about pregnancy and childbirth, and they express a feeling of discomfort about being in the clinic with non-Indian women. Bushnell explains that in the traditional culture, the responsibility for passing on health beliefs and practices important for childbirth lies with the older female relatives. However, the younger women in this study do not have close ties to their extended families and do not make use of this traditional practice. This study illustrates the argument noted earlier by Wilson that a decline in the utilization of traditional approaches to health is not necessarily associated with a concomitant increase in the utilization of non-Indian health care.

In a study of urban Indians living in the San Francisco Bay area, Fuchs and Bashshur (1975) report that traditional Indian medicine is utilized by about 28 percent of the 277 families surveyed. This usage is highest among those Indians originally from the southwestern region of the United States. Usage of traditional Indian medicine in this study is also associated with several other factors including native language ability and preference for living

on the reservation. Those families using traditional Indian medicine in this investigation are reported to be using Western medicine as well.

From these works one is able to visualize the diversity, both intertribally and intratribally, that exists in the Native American population with regard to health. Swanton (1952) has identified more than 432 tribes in North America and estimates that at least 391 reside within the United States. Calculations are that members of these tribes still speak over 149 languages with additional dialects among them (Manson & Trimble, 1982; Wilson, 1983). Moreover, religion, folklore, and approaches to health often vary from tribe to tribe (Spector, 1979). Thus, intertribal and intratribal heterogeneity renders a unitary understanding of health among Native Americans problematic.

Ablon (1965) in a study of Native Americans who relocated to a metropolitan area also concludes that it is difficult to speak in generalities about Indians. This author notes that each family has differing cultural and educational situations which is rendered more complex by the nature and amount of experiences they have with whites. In addition to this discovery, Ablon explores the general problems of dependency and the paternalistic orientation of white officials dealing with Native Americans. She concludes that the situation of the urban Indian differs considerably from that of the Indian living on the

reservation. Her research illustrates how place of residency and interactions with non-Indians contribute to the heterogeneity found among Native Americans.

Ferguson (1968) also notes factors which he considers critical to any understanding of the Native American. These factors include facility with English and native languages, level of education, military service, and employment history. Thus, "Indianness" can not be viewed as a unitary phenomenon (Leland, 1975), and this situation holds some important implications for nursing education and practice.

Chrisman (1982) offers a caveat with regard to considering culture and nursing practice. He says that sociocultural knowledge can not be viewed as concrete units of information about specific groups (e.g. health beliefs and practices, food preferences, etc.). These "trait list" approaches promote stereotyping and reify esoteric cultural patterns as definitive aspects of a group's behavior. A culturally sensitive approach is necessary for all patients, argues Chrisman, not just those from specific cultural groups.

Fong (1985) also speaks to this issue. She acknowledges the importance of the client's cultural orientation; yet, she cautions against stereotyping individuals according to ethnic and cultural group characteristics. She notes that intracultural diversity is an essential consideration as not

all individuals possess the characteristics of the ethnic group with which they identify.

Nevertheless, in recent years a number of nursing textbooks have presented "trait lists" in their representations of health among members of various ethnic groups. Drawing from a chapter written by Primeaux and Henderson (1981), Logan and Dawkins (1986) list the "health beliefs and practices of Native American families." This trait list states that Native Americans view health and illness holistically, use medicine men and herbalists, and use treatments which combine "rational and religious practices" (p. 115). The presentation indicates, in small print at the bottom of the list, that the statements may not be applicable to all group members. Yet, such descriptions have little empirical basis and, as Chrisman and Fong argue, they promote stereotypical portraits of these individuals.

In their text, Murray and Zentner (1985) present what they define as "basic values of cultures with selected cultural examples" (p. 437). This trait list indicates that "Native American subcultures" have a "becoming-in-being orientation" which is defined as "the person is important for what he/she is, but must continue to develop" (p. 438). Further clarification of this idea is not given, and additional references recommended by these authors about Native Americans and their nursing needs are based primarily

on accounts dealing with one tribal group--the Navajo--and/or have little empirical basis.

Ebersole and Hess (1985) in a discussion of Native American older adults draw from the work of Spector (1979) and generalize that "health to the approximately 300 Native American tribes means living in harmony with nature and the ability to survive under exceedingly difficult circumstances. The earth and the self are tied; what affects one affects the other. The body is treated with respect and is viewed as having two parts, a positive and a negative energy. Every sickness or pain that occurs results from something that happened in the past or will in the future, representing a cause-and-effect relationship" (p. 719). The empirical basis for this generalization is unclear; moreover, it does not take into account the enormous diversity among the many tribes by its opening generalization.

In all, these examples demonstrate nursing textbook generalizations of Native Americans which ignore the variation within this population. These presentations often have a limited empirical basis and nursing authors draw conclusions based upon previous work often done with one only tribal group.

Summary of Health from the Perspective of Native Americans

Studies in nursing and medical anthropology have explored perceptions of health among aggregates of Native

Americans. Findings support the argument that among some members of this population a declining utilization of traditional approaches to health exists, and it is not always accompanied by a concomitant utilization of Western health care. Generalizations about this population are suspect in light of the intertribal and intratribal heterogeneity, and it is important to take into account that much of the literature which deals with this population is based upon work with one tribal group--the Navajo. This heterogeneity also holds implications for measurement of demographic characteristics and health status indicators to be considered in the next section of this chapter which reviews literature addressing health from the perspective of the Western health care provider.

Health from the Perspective of the Western Provider

This section of the chapter addresses the cultural framework of the Western health care provider and meanings assigned to health within this view. The discussion also includes, more specifically, meanings assigned to health by nursing which have evolved and shifted within the larger context of Western health care as practiced in the United States. Finally, the chapter explores health of the Native American from what may be considered the vantage point of a Western health care provider. The cultural frameworks of both the provider and the client and the meanings assigned

to health within these frameworks have important consequences for interaction in health care settings.

The Cultural Framework of the Provider

A number of writers analyze the framework brought to social situations by health care providers. Leininger (1978) discusses the culture of the nurse as it connects with the broader "American" culture and considers particular ideas from this culture as they relate to the delivery of nursing care. These ideas include "optimal health," "democracy," "individualism," "achieving and doing," "cleanliness," "time," and "technology and automation." Leininger argues that these components of the nurse's cultural background may differ from those of the client and that many nurses have limited knowledge and academic preparation to assist them with the identification of areas where their values contrast with that of the client.

Zola (1979) argues that study of the provider's culture is frequently neglected. Rather, he notes, the culture focused upon is that of the patient and "it is still the negative side--how the individual's culture gets in the way of his/her obeying or complying with the doctor's orders...In the sociomedical world, we too easily feel that someone else, the recipient of care, is the one with a culture, not the provider" (p. 75). Zola acknowledges that the origins of his ideas with regard to the culture of the

provider stem from the work done by Becker, Geer, Hughes, and Strauss (1961).

This latter work (Becker, et. al., 1961) presents an investigation of student culture in medical school. These researchers report that medical students develop a coherent way of thinking and acting. A culture evolves among the students which includes guidelines for organizing their activities in various situations. These authors argue that the medical culture serves the physician with a language and point of view toward things which is technical and impersonal; thus, these students come to see events, such as death, not so much as human tragedy but rather as problems in the use of medical responsibility.

This medical culture, argues Zola (1979), is itself part of a larger cultural system and "thereby embodies, albeit implicitly, unwittingly, and unconsciously, certain social values and political and economic beliefs" (p. 76). Zola considers the medical culture to be closely linked to the larger "American" culture as did Leininger in the previous discussion of the nurse's culture.

Allan and Hall (1988) address concerns which are relevant to this discussion of the provider's culture. In particular, they analyze biomedicine's basic definition of health which they view as too limited in scope to deal with contemporary health problems. They argue that medical science has not experienced a paradigmatic revolution since

the discovery and acceptance of the germ theory, and, as a consequence, this view of health blocks the vision of the person, health, and environment and prevents an understanding of health as a complex, multidimensional phenomenon rather than merely the absence of disease. Like Zola, Allan and Hall note that this approach to health is deeply entrenched with American values, and these authors consider economic factors related to this situation as well. Allan and Hall emphasize that nursing questions this understanding of health grounded in biomedicine, but the latter view is so entrenched that nursing and other disciplines struggle to develop an alternative paradigm which incorporates mind-body-society interactions.

Smith (1985) also analyzes ideas of health and approaches to health care delivery. This author states that a definition of health is the indispensable basis of any health care policy. Smith argues that the "narrowest view of health, the clinical model, is accepted as the directing idea of much contemporary medical practice" (p. 139). Considering the factors responsible for marked health improvements in modern times, Smith identifies conditions which must be addressed in order to provide a minimum standard of adequate health. These conditions include: nutrition, housing, economic circumstances, social circumstances, and psychological factors in individual and

family life. Smith concludes, however, that health policies often do not address these factors.

In a critique of health policy, McKinlay (1979) describes the interventions utilized by the providers of American health care as "downstream endeavors." By downstream endeavors he refers to superficial efforts which do not focus attention "upstream" where the problems originate. McKinlay describes an analogous situation in which a number of forces push people into a stream--upstream--and somewhere downstream a health care provider pulls them out. McKinlay sees the American system of health care blaming individuals because they are unable to swim rather than exploring how and why they are pushed into the stream in the first place.

To summarize, the Western health care provider brings to interactions in the health care arena a cultural framework which, in the United States, is often based upon a perception of health as the absence of disease. Interventions generally focus upon medical manifestations of disease processes rather than on the other sociocultural factors associated with these disease processes. Nursing struggles with the development of an alternative understanding of health which considers it a complex and multidimensional phenomenon encompassing factors that are not only biological but are also sociocultural. Yet, nurses

practice within a broader cultural context in which the former understanding of health prevails.

Indeed, this broader cultural context is the same context in which the Indian Health Service (IHS) provides the majority of health services to the Native American elder and "hospital-based and ambulatory medical services...are by far the most important components of the IHS services delivery" (U.S. Congress, 1986, p. 156). Further consideration of health from the perspective of nursing follows.

Health from the perspective of nursing

Nursing approaches the complexities of health from a number of vantage points. Writers outside of nursing, particularly in medical anthropology, have also contributed to nursing's understanding of this phenomenon as have the definitions of such groups as the World Health Organization. This section of the chapter considers the significance of health for nursing, definitions of health, and disease as a component of health.

Significance of health for nursing. During the last decade considerable discussion has ensued in the nursing literature with regard to the question: what is the perspective of nursing? Is nursing's perspective unique? What ought to be the focus of nursing inquiry? Donaldson and Crowley (1978) argue that by definition a discipline is not global; rather, a unique perspective--a distinct way of

viewing all phenomena--characterizes a discipline. According to these authors, nursing's perspective is the wholeness or health of humans who are in continuous interaction with their environment.

Similarly, Colaizzi (1975) argues that the proper object of nursing science is the human experience of health and illness. She states that this experience is uniquely human and that this human dimension is what confronts nursing with a concern different from that of technology. Although variation prevails with regard to approaches to the study of this phenomenon, nursing writers regard health and health problems as an appropriate focus for nursing inquiry (Greene, 1979; Heinrich & Bloch, 1980).

Health, which nursing has considered significant since the time of Florence Nightingale, has come to be formally identified as one of the major phenomena of nursing's concern. Yura & Torres (1975) reporting a study of the conceptual frameworks within baccalaureate nursing programs identify the units of interest to nursing as: man, society, nursing, and health. Building upon this work, Fawcett (1978) notes the phenomena of interest to nursing science as person, environment, nursing, and health. More recently, nursing writers note the increasing emphasis and the consensus about the importance of the concept of health (Newman, 1983; Meleis, 1985).

Definitions of health. Although consensus regarding the importance of health for nursing exists, much variability remains with regard to interpreting the meaning of this concept. The World Health Organization's (WHO) definition of health reflects a broad interpretation of this concept which states that health is:

> "a state of complete physical, mental, and social well being, and not merely the absence of disease or infirmity" (WHO, 1947, p. 1-2).

In an analysis of this latter definition, Pender (1987) notes that it considers the individual as a total person rather than a sum of parts, places health within the larger context of the environment, and equates health with productive and creative living. Pender argues, however, that although the definition addresses the complexity of health, it represents an ideal rather than an achievable goal.

In spite of this criticism, the WHO definition is valuable for it illuminates the complexity and multidimensionality of the concept. Although WHO's goal may or may not be achievable, an understanding of health necessitates an exploration of its complexity or it is rendered a superficial consideration.

This immense complexity emerges in a study reported by Smith (1981) which explores fundamental ideas of health by means of an extensive literature search. Smith groups her

findings into four health models: clinical, role-performance, adaptive, and eudaimonistic. A brief overview of each of these models follows.

The clinical model views health as the absence of disease. Smith argues that this model of health evolved in large part because of the mechanistic outlook which has dominated the development of the biomedical sciences. Just as man is generally viewed by physicians as a physico-chemical system, medical science considers disease a malfunction of this system. Another writer (Kelman, 1975) refers to this idea of health as "bio-chemo-surgical" and notes its conflict with more social, epidemiological, and environmental approaches to health. The differences between this model and other interpretations of health become more apparent in the descriptions below.

The work of Talcott Parsons (1979) provides the basis for Smith's second model--the role-performance model. According to Parsons, health may be defined as the "state of optimum capacity for the effective performance of valued tasks" (p. 123). Building on Parson's work, Smith notes that health as role-performance has a common sense notion derived from experience. Thus, when people have an incapacity or inability to perform their usual functions, they are generally led to the idea that something is wrong, i.e., they are sick.

Smith cautions that conceiving health as role-performance has limitations, for an individual may be physiologically ill even though able to fulfill his/her roles. Findings in a classic study by Koos (1954) demonstrate this latter phenomenon. In Koos' study, respondents report how they perform roles in spite of sickness. One respondent comments, "Most of us can't be sick--even when we need to be" (p. 30). Smith concludes that the role-performance model provides a minimal conception of health because it emphasizes an individual's performance of roles without considering the other complexities of this phenomenon.

The origins of the third model--the adaptive model--are in the writings of Dubos (1959). For Dubos, health has a broad meaning in that it refers not only to the individual but also to the interaction between that individual and his/her environment--an environment which is both social and physical. The predominant feature of this interaction is adaptation and failure in adaptation represents disease. Interventions to treat disease which have a basis in this model include not only the individual but also his/her physical and social environment.

The fourth, the eudaimonistic model, considers health as a state of general well being and self-realization. Although Smith traces this model's roots back to ancient Greek medicine and the moral philosophies of Plato and

Aristotle, she considers Maslow (1971) to be the most significant modern proponent of this conception of health. Here, Maslow's concept of self-actualization represents achievement of health. In contrast, a condition impeding or preventing self-actualization represents illness. Smith argues that this model portrays health holistically in contrast to the clinical which is reductionistic in its focus upon biological parts.

Disease as a component of health. Although three of the models which Smith identifies tend to reject the idea of health as the absence of disease, an underlying notion in all of them is the accomplishment of a disease-free state. Margaret Newman (1986) criticizes this emphasis and states that most writers dichotomize health and illness with a view of health as being desirable (positive) and illness as being undesirable (negative). Newman proposes another view in which disease fuses with its opposite, nondisease, and brings forth a new concept of health. Newman considers disease to be a manifestation of health and both disease and nondisease as expressions of the life process.

Tripp-Reimer (1984) utilizes the work of Newman and others to conceptualize health. Like Newman, Tripp-Reimer views health dialectically, but rather than fusing the opposites of disease and nondisease, this author fuses the continua of wellness-illness and disease-nondisease. She

develops this conceptualization from Newman's work as well as work in medical anthropology.

Frabega (1979), a medical anthropologist, refers to disease as the physical changes in the body elicited or measured using biomedical procedures. Illness, this writer argues, is what disease means to the lay subject. Kleinman (1980) refers to this dichotomy as a key axiom in medical anthropology. Disease represents the malfunctioning of biological and/or psychological processes while illness refers to the psychosocial experience and meaning of perceived disease. Tripp-Reimer's conceptualization of health takes these concepts (illness and disease), places them into respective continua (wellness-illness and disease-nondisease), and dialectically fuses them. The product is a concept of health which encompasses what some consider positive and/or negative aspects as well as the perspectives of the client and the provider.

Tripp-Reimer notes that these perspectives are emic (client) and etic (provider). The emic and etic perspectives come into conflict in circumstances such as those where clients perceive themselves as well and providers perceive the health of their clients to be within the realm of disease. These situations are similar to the mismatches (Strauss, 1976) noted in chapter one. Matching and mismatching of client and provider health perceptions is

particularly significant for nursing in cross-cultural contexts.

Summary. Consensus exists as to the importance of health for nursing but interpretations of this complex, multidimensional concept vary considerably. Generally, Laffrey (1986) notes a shift in the health paradigm from a pathogenic view which considers health as freedom from disease to one in which health is seen as a "fluid flexible process, a subjective phenomenon of each human being. Disease is not excluded in this view; rather it is part of the entire life process and may affect that process in various ways" (p. 97). A number of nursing authors approach health from this point of view as well.

Nursing struggles to redefine health within a larger context where this phenomenon is generally understood to mean the absence of disease (Allan & Hall, 1988). The discussion which follows considers health among Native Americans from this latter perspective. In addition to health indices, a number of demographic factors will be considered which, from a broader understanding of health, provide an important background for this phenomenon.

Native American Health from a Western Perspective

This section considers the following four areas: 1) methodological issues, 2) demographics of this population which bear upon an understanding of the phenomenon of health, 3) history of the relationship between the Native

American and the government of the United States as it bears upon health; and 4) measurement of health status among members of this population. Although health status indicators demonstrate dramatic improvement in a number of areas, severe health problems remain for many Native Americans. Moreover, social and cultural factors impinge upon the health status of these individuals in a manner more intense than that found in the general population.

Methodological issues

A number of methodological issues are significant for gathering data which is expected to reflect characteristics of minority groups. These issues pertain to the demographics discussed here as well as to the health status indicators which follow at the end of this chapter section. Although the 1980 Census of Population utilized improved techniques for counting people, the ancestry and racial characteristics of those counted is not always clear. In particular, the Bureau of the Census definition of race has been criticized for its lack of clarity (U.S. Congress, 1986). These problems of measurement do not apply solely to data gathering among Native Americans. Similar difficulties have been discussed in the literature with regard to data gathering among other ethnic minority groups.

Hayes-Bautista (1980) addresses this problem in a discussion of the label "Hispanic." This writer notes that the term "Hispanic" encompasses a wide variety of

individuals. For example, an individual descended from a family who immigrated from Spain hundreds of years ago has a different social situation than the individual who recently immigrated from Mexico. Hayes-Bautista cautions researchers to clarify the characteristics of their samples and to make generalizations judiciously. Similar problems emerge when discussing Native Americans considering the inter- and intratribal diversity previously described in this chapter.

These issues have relevance for health status indicators as well. For example, problems arise when researchers combine several non-White groups for consideration of their health status. Findings among Asian Americans, particularly Chinese and Japanese Americans, often indicate a health status which is more favorable than that of the general population. Combining Asians with other ethnic minorities, such as Blacks, Hispanics, and Native Americans, alters the health picture and obliterates important differences between these latter groups and the general population (Institute of Medicine, 1981).

Trevino (1982) raises yet another methodological issue regarding the health status of ethnic minorities. This author notes variance in the reporting of race and/or ethnic origin on death certificates. Often funeral directors complete death certificates, and Trevino speculates that directors base these recordings on observation rather than upon inquiry of family members. Speculation also exists

regarding the underreporting of Indian deaths in many states, particularly in California which is the state with the largest number of Indians (U.S. Congress, 1986).

Another area for concern is that of infant mortality. Powell-Griner and Streck (1982) question the accuracy of neonatal mortality for the Spanish-surnamed population. In addition to the inaccuracies in coding race, these authors argue that a substantial amount of underreporting of Spanish surnamed neonatal deaths exists. Fear of contact with authorities because of undocumented residency status contributes to this underreporting, but underreporting may also occur in other groups who are citizens. For example, does underreporting of neonatal deaths occur among Native Americans living on remote reservations? Shortcomings with regard to the problem of recording the race of newborns arise as a consequence of a practice whereby states do not record paternal race when a birth occurs out of wedlock. This practice leads to problems in measurement of births to non-Indian mothers in which the father of the infant is Indian (U.S. Congress, 1986). With this practice the size of a population can be underestimated.

Other circumstances which render the accuracy of measurement problematic include the problem of data gathering by members of the majority group with minority groups who may be suspicious of "outsiders" doing research. With this restriction as well as the others mentioned, some

conclude that data necessary to assess many racial/ethnic differences in health status simply do not exist (Institute of Medicine, 1981). In sum, measurement of demographics and health status among groups, particularly those from ethnic minorities in this country, presents a number of methodological concerns. Taking these issues into consideration, a discussion of demographics relevant to health among Native Americans follows.

Demographics bearing upon health

Estimates are that ten million Native Americans lived in North America at the time of its discovery by Europeans. After this contact, the population progressively declined due to a number of factors including disease, famine, warfare, and hardship. In 1890, the population reached a nadir of an estimated 274,000 (Sievers & Fisher, 1981). Gradually, the population grew to what the 1980 Census estimated to be 1.4 million Indians, Eskimos, and Aleuts (U.S. Congress, 1986).

A number of factors such as population size, economic resources, social situations, and the level of education of Native Americans are significant for this discussion of health. Yet, these data are limited. As Block (1979) notes, the literature on various ethnic minority groups has traditionally ignored the aged and, in particular, little information is available on Indian elderly. Block argues that this situation is due in part to the relatively small

numbers of Indians in comparison to that of the U.S. population as a whole; moreover, this small population has the smallest number of elderly of all the minority groups. As this author notes, such data are important for a number of reasons including that these elderly Indians have lived under adverse conditions including "substandard housing, limited education, inadequate income, poor health, malnutrition, a lack of urgently needed services, and the emotional problems inherent in a changing culture" (p.184).

This discussion presents a summary of demographic data dealing with Native American elders, elders from other minority groups, United States minority groups in general, and the United States population of all races. "American Indian" is used in this discussion rather than "Native American" and refers specifically to data gathered by the United States Bureau of the Census in which the question of race and ancestry includes the option for an answer of "Indian (Amer.)" (U.S. Congress, 1986). Occasionally, the discussion includes data which apply not only to these individuals who identify themselves as American Indians, but also to those who identify themselves as "Eskimo" and "Aleut." When data apply to these latter two groups they are so indicated. Much of the work here synthesizes data from the United States Bureau of the Census, the Indian Health Service, the National Indian Council on Aging, and several other sources. Generally, these data represent

Indians throughout the United States, both urban and reservation. When specific groups are considered (for example, those living on a specific reservation), they are so indicated. The discussion addresses those factors noted above as important for health: population size, economic resources, social situations, and levels of education.

In the 1980 census, the percentage of the White population 65 and older was 12.2; in contrast, for the American Indian, Eskimo, and Aleut population, 5.3% were 65 and older. Future projections indicate increases in the number of elderly from both minority and nonminority groups. For example, estimates are that the White elderly population will increase by 22.7% by the year 2000. Black aged will increase by 45.6% (Manuel & Reid, 1982).

Projections of the numbers of Indian elders in the future are complicated by federal and tribal definitions of who is "Indian" as determined by a number of factors including "blood quantum." Blood quantum is used to mean the percentage of "Indian blood" often required for membership in a tribe and/or other federal services. The multiple views regarding the utilization of this concept are beyond the scope of this discussion except to note the complexity of projecting the size of this population. One projection is that in the year 2000, 149,227 Indians will be older than 60 years which will represent 14% of the total American Indian population (U.S. Congress, 1986). In sum,

numbers of older adults who are both Indian and non-Indian are increasing.

Data analyses reflect that older adults from minority groups have limited economic resources. Utilizing the poverty index and United States Bureau of the Census data, Manuel & Reid (1982) conclude that not only are families from minority groups disproportionately represented below the poverty threshold, but among the elderly, the respective proportions are even higher. These authors estimate that in the early part of this decade, 13.2% of the White elderly were below the poverty threshold, whereas 35.5% of aged Blacks and 26.7% of aged Hispanics were below the poverty level. Markides and Mindel (1987) conclude that "minority aged have always had a much lower standard of living than White aged" (p. 57).

Income levels reported for American Indians also reflect this lower standard of living. For American Indian families, both urban and reservation, the median income in 1979 was $13,678. Indian families living on reservations had median incomes in 1979 of $9,924. For the United States families of all races, the corresponding figure was $19,917. Twenty-seven and five-tenths percent of American Indian families lived below the poverty level in 1979. This latter finding indicates that poverty occurs among American Indian families at more than twice the rate than it occurs for the general United States population (U.S. Congress, 1986).

Another economic indicator--unemployment--is of importance when considering economic resources. In the general population of all races the unemployment rate was estimated at 6.5 % in 1980. In contrast, during the same year, unemployment was reported to be 13% for American Indians and for those living on reservations, it averaged at 27.8%--more than four times higher than for the general population in the United States (U.S. Congress, 1986). Utilizing these indicators of income, poverty level, and unemployment, the economic disadvantage experienced by many Native Americans in the United States becomes apparent.

This economic disadvantage is associated with a number of factors. Markides and Mindel (1987) conclude that the high levels of poverty among ethnic minority groups are associated with low levels of education. Education, these authors note, is an important predictor of earning power which has severe consequences for old age. During 1980, in the general population, 16% of those 25 years and older completed 4 years of college while only 8% of American Indians had done so. Some argue that this figure represents a substantial improvement for American Indians based upon government and tribal scholarship and financial aid programs. However, budgets of many Indian scholarship programs have been reduced in recent years and are increasingly ridden with time restrictions; as a result, the Office of Technology Assessment argues that "serious

deficiencies in educational opportunities for Indians" prevail (U.S. Congress, 1986). These deficiencies have consequences for earning power as noted above.

Manuel and Reid (1982) argue that in addition to education, another factor impinging upon the incomes of these elders is their lifelong experiences with discrimination in employment opportunities. Income, education, and discrimination are complex factors linked with one another which are crucial to an understanding of economic resources among members of ethnic minorities in the United States. In addition to these factors, another consideration--head of household--has important consequences for economic resources.

Estimates for the general United States population indicate that 14% of all families are maintained by women. In contrast, women maintain 22.7% of American Indian families, and for American Indian families living on reservations, women maintain approximately 25.8% (U.S. Congress, 1986). This situation accelerates when one also considers age.

Manuel & Reid (1982), analyzing 1980 census data for age, sex, and ethnic composition of the elderly population, conclude that a distinct female advantage prevails among ethnic minority groups as it does in the general population. This advantage increases by age and clearly those in advanced old-age (85 years and over) are mostly female.

Based upon what they note above and also the data from the United States Congress, one can speculate that women outnumber men significantly among older Indians, and, indeed, a study by Dukepoo (1980) supports these findings. This factor, women as head of households, also places the American Indian and, particularly the elder, at an economic disadvantage as it leads to what some have noted occurs when women are the heads of households, i.e., the "feminization of poverty." In sum, American Indians, particularly older adults who are American Indians, are more likely to be economically disadvantaged than members of the general population.

Dukepoo (1980) reports an investigation of age, gender, income, employment, and education among Native American elders living in the San Diego area. Dukepoo's sample of 62 American Indians range in age from 54 to 92 years of age. Thirty-four reside on reservation land, and the remaining 28 live in urban areas. Females outnumber males in both settings. The researcher reports the mean income for sample Indians to be $4,428.00 with the urban Indians having overall levels of income higher than those living on reservations. Those employed are either domestic servants or blue collar workers with the total number of employed being 12% full time and 36% part time. Most derive income from Social Security or Supplemental Security Income (SSI). The educational achievement level is 7.7 years for the total

group. Most reservation respondents (41%) report attending Bureau of Indian Affairs boarding schools as children in contrast to 18% of the urban subjects. Dukepoo's findings support those reported by other researchers with regard to demographic data and elderly Native Americans.

In summary, this presentation of demographic data along with a consideration of methodological limitations provides a background for understanding the contemporary situation of the Native American. Economic, social, and educational indicators reflect the impoverished conditions in which many members of ethnic minority groups, including Native American elders, live. In light of the definitions of health previously discussed, these factors provide a critical background for understanding this phenomenon among members of an aggregate of urbanized Native American elders.

Federal/Indian relationship

In order to provide a background for the health status indicators which follow, a consideration of the relationship between the American Indian tribes and the federal government is important. As the sociological theorist Mannheim has suggested, ideas are related to the social and historical situation from which they emerge (Coser, 1977). Thus, the social and historical situation of the Indian, too, holds relevance for health ideas warranting the brief overview of this situation which follows.

The American Indian has a unique status with the federal government of the United States. This status is what Linton (1936) has termed an "ascribed status," i.e., a status based upon an inherited position in society. Race, according to Linton's view, is an example of an ascribed status. American Indians have an ascribed status by virtue of their "Indianness" which is sometimes interpreted by federal and tribal governments in terms of "blood quantum" or percentage of Indian blood as described earlier in this chapter.

This unique status has consequences not only for eligibility for health care services but also for other aspects of Indian life which bear upon health. The argument made by Deloria and Lytle (1984) in the following reflects these distinctive circumstances:

> "The fact that many Indian tribes continue to exist unassimilated is not due to the practice of traditional ceremonies as much as it testifies to the complex of legal and political ideas that have surrounded Indians for two centuries and made them understand the world in much different terms from any other group of American citizens" (p. 2).

This portion of the chapter explores legal and political structural conditions that have had consequences for health and the American Indian.

During the discovery of the New World, the papacy articulated the Doctrine of Discovery. This doctrine

proposed that when a Christian leader discovered a new land, he had recognized title to it, subject only to the willingness of the original inhabitants to sell their lands to the discoverer. Legal doctrines today that separate and distinguish American Indians from others trace their roots conceptually back to this Doctrine of Discovery (Deloria & Lytle, 1984).

As a consequence of the Doctrine of Discovery, settlers could not acquire land from Indians as individuals; rather, only the federal government could acquire Indian land. This system of land acquisition is a critical component of the relationship which has evolved between the Indian tribes and the United States, for the federal government perceives the Indian tribes as separate and legally different from others. Gradually, the federal government has assumed other activities, in addition to land acquisition, which reflect this philosophy (U.S. Congress, 1986).

In the 1830's, Supreme Court Chief Justice John Marshall described Indian tribes as "domestic dependent nations" and noted that the relationship between the United States and these tribes resembles one of a "ward to his guardian." The interpretation of this relationship involved the meshing of treaties, statutes, constitutional provisions, and international law and theory (U.S. Congress, 1986). Yet, it is unlikely that American Indians of that time perceived themselves as "subordinate" or "dependent"; rather, they

continued to consider themselves as sovereign over their lands (Churchill, 1988).

Since the United States Constitution gives Congress the exclusive power to regulate commerce with foreign nations and among the several states, this governmental body consequently derived much of the power to deal with the Indian tribes. Today, Congress determines tribal operating funds and other matters such as permission to exploit the natural resources (Deloria & Lytle, 1984). Moreover, Congress determines many other aspects of tribal life including the funding of health programs (Bee, 1982). An extensive study of the legislative acts important to the American Indian is beyond the scope of this chapter; however, two areas of interaction between the federal government and the American Indian which are particularly relevant for health will be considered: education and health care.

As a trustee, the federal government perceived a its role as one in which its task was to "assimilate" the American Indian. The Bureau of Indian Affairs (BIA) "actively suppressed traditional modes of tribal governance, Indian languages, and Indian religious and cultural practices" and assimilation was an "aggressive part of education and medical services" as well (U.S. Congress, 1986, p. 44). These two aspects of the federal/Indian relationship are particularly important for the older adults

participating in this study; therefore, an analysis of these two services follows.

Education. Indian education provided by the federal government reflected the cultural framework of the White majority and, as noted previously, education's stated purpose was to "assimilate" or "civilize" its students. As early as 1819, Indian education received support from a "civilization fund" established by Congress which provided a small annual sum for instruction. Later, in 1879, more extensive efforts in the area of Indian education brought about the first Indian boarding school--the Carlisle Indian School. After the establishment of the Carlisle Indian School, an expansion of off-reservation industrial boarding schools took place. By the turn of the century, twenty-five were open and operating (Szasz, 1977).

The BIA dealt stringently with those families who resisted sending their children to the BIA boarding schools. Szasz (1977) notes: "Incidents of enforced seizure of children to fill the quotas of off-reservation schools during this period have been reported too frequently to be considered mere exaggeration" (p. 11). This education system actively ignored customs and symbols of Indian life; for example, speaking native languages was prohibited (McBeth, 1983). Moreover, this educational experience ultimately forced the children to choose either the culture

of the White man or the culture of the Indian. Compromise was impossible (Szasz, 1977).

McBeth (1983) in an investigation of ethnic identity and the boarding school experience of a group of Oklahoma Indians notes that although tribal languages, lands, and Indian cultural distinctions disappeared as a result of the boarding school experience, a new ethnicity has emerged which links the individuals who shared this boarding school experience. In spite of pressures for change, a distinctive cultural framework persists among the Indians in her study. This researcher draws an important conclusion from her findings in the following:

> "The American Indians are not a vanishing people and a native way of life perseveres, which, while not completely traditional, adheres to Indian values as defined by the group...this survival is a profound statement of the power, persistence, and pervasive nature of the tribal groups, their sense of ethnic identity, and the symbols (traditional and emergent) which support this identity" (p. 3).

In spite of vigorous attempts to assimilate the American Indian through educational experiences, McBeth argues that an identity persists among members of her sample. Moreover, McBeth proposes that both "traditional and emergent symbols" support this identity. Consequences of boarding school experiences for the respondents in this study will be

considered in chapter four, particularly as they relate to health.

Health care services. The first Indian hospital was built in connection with the Carlisle Indian Boarding School in Pennsylvania in 1879. After this precedent, health services for the American Indian gradually evolved and, in 1921, Congress passed the Snyder Act which authorized the Secretary of the Interior to provide financial assistance for relief of "distress and conservation" of the Indian's health. The Bureau of Indian Affairs (BIA) within the Department of the Interior supervised the administration of these services (Americans for Indian Opportunity, 1981).

In spite of the Snyder Act's legal mandate, many Indians had only limited access to health services. For instance, in 1939, the BIA's health division employed only 110 public health nurses--a number inadequate to meet the needs of a diverse, widely scattered population often living on remote reservation areas. Discussion ensued at this time about the transfer of the health program to the Public Health Service, but this transfer did not occur until much later in 1954 (Bullough & Bullough, 1982).

In 1954, responsibility for health care services shifted from the BIA to what was then the Department of Health, Education, and Welfare under the jurisdiction of the Surgeon General of the United States (Bullough & Bullough, 1982). Today, the Indian Health Service is located within the

Health Resources and Services Administration (HRSA) which is one of five administrative branches of the Public Health Service in the Department of Health and Human Services (U.S. Congress, 1986).

In 1976, Congress passed Public Law 94-437, the Indian Health Care Improvement Act and reaffirmed the commitment to provide health services to the American Indian. The intent of this law was to assist the American Indian to achieve a health status equal to that of the general population of the United States (U.S. Department of Health, Education, and Welfare, 1979). Today, the Indian Health Service (IHS) interpretes its mission upon this act. The IHS defines its responsibilities in the following:

> "to include a comprehensive range of inpatient and ambulatory medical services, dental care, mental health and alcoholism services, preventive health (immunizations and environmental services such as sanitation and water safety), health education, and Indian health manpower development programs" (U.S. Congress, 1986, p. 155).

As noted above "hospital-based and ambulatory medical services...are by far the most important components of the IHS services delivery" (U.S. Congress, 1986, p. 156). The interpretation of these responsibilities reflects the culture of Western health care as practiced in the United States and has important consequences for Indian health.

The programs described above generally deliver health care services to American Indians living on reservations while only limited programs are available for those living in urban areas. "Direct care" provided by the IHS includes those services delivered by federal staff in IHS-owned and operated facilities or in IHS-owned tribally operated facilities. "Contract care" supplements direct care and generally refers to the purchase of specialized medical services from non-IHS providers for eligible Indians. Determining eligibility for both direct care and contract care is a complex process, but usually eligibility for contract care has more restrictions. The urban Indian is the one most frequently denied contract care, and, in some cases, direct care as well; yet, it is reported that 960,000 eligible Indians utilized the services provided by the IHS, in 1985 (U.S. Congress, 1986).

Since the transfer of administrative responsibilities of the health services from the BIA to the IHS in 1954, health status indicators for the American Indian have improved substantially. Statistical data indicate a decrease in the incidence of communicable disease including rates of tuberculosis, influenza, pneumonia, and gastroenteritis which have declined dramatically. Data on utilization of health care services reflect increases (U.S. Department of Health, Education, and Welfare, 1979). However, as the pandemics of infection have begun to subside, health status

indicators representing other chronic health problems continue to rise. A discussion of the health status indicators which illustrate this trend follows.

Health status indicators

The health status indicators presented here reflect a phenomenon which is occurring not only among American Indians but among the general United States population as well: an "epidemiological transition" (Omran, 1971). This epidemiological transition consists of three stages: first, the age of pestilence and famine; second, the age of receding pandemics; and third, the age of degenerative and man-made diseases. This third stage is the period in which the general population of the United States finds itself. In the more developed countries of the world, a transition is evolving whereby degenerative and man-made diseases displace the pandemics of infection as the primary causes of mortality and morbidity. Omran argues that these changing patterns of health and disease are associated with a number of factors in the environment including factors which are both economic and social. (Omran's argument will require some modification in light of the emerging epidemic of Acquired Immune Difficiency Syndrome; yet, the degenerative and man-made disease will remain a major problem facing health care providers.)

In 1982, Assistant Secretary for Health, Edward Brandt, Jr., in a discussion of shifting causes of death and

disability, notes that chronic illness and trauma, rather than infectious diseases, account for most of the 10 leading causes of death in the United States (U.S. Department of Health and Human Services, 1982). Although the general population in the United States suffers from these health problems, several non-White groups reportedly suffer from these afflictions at an increased rate. With regard to this phenomenon, one group of authors raises the question of whether or not the mass diseases of minorities are not the mass diseases the broader society enlarged and intensified (Cooper, Steinhauer, Miller, David, & Schatzkin, 1981). The remainder of this chapter considers these health status indicators for the American Indian with this epidemiological transition as the background.

When the incidence of acute, communicable disease declines and chronic and man-made diseases predominate, the ordinarily utilized indices of health become less accurate reflections of health status. Mortality rates, in particular, become much less precise because of their insensitivity to changes in other aspects of health. As chronic illness and man-made disease become more prevalent, death rates stabilize. Yet, chronic illness often increases an individual's disability and need for health care which indices of mortality, as well as morbidity, do not take into account (Sullivan, 1974).

Morbidity and mortality indices measure clinical signs and symptoms of disease; thus, they are based upon a clinical model which, as previously noted, offers a limited interpretation of health. If one understands health to include a sense of well being as well as the absence of disease, the incidence or prevalence of this sense is not reflected by indicators which emphasize signs and symptoms of disease. Utilizing available data, one approach for dealing with this limitation is to consider health status indicators together as a profile representative of health problems. A discussion of several such indicators follows (U.S. Department of Health and Human Services, 1985).

One of the most important indicators of the health status of the American Indian is that members of this population do not live as long as others in the general population. In 1981, 37% of Indian deaths were among Indians who were younger than age 45. In the general United States population, deaths occurring in this age group were at only 12% (U.S. Congress, 1986). Accidents are related to this situation. For the general population of the United States, accidents place fourth as a cause of death. When considering all IHS service areas, accidents rank as the second cause of death for American Indians, and in seven IHS areas accidents rank first. (These data also illustrate the variability in the various IHS service areas with regard to health problems.) In all, the death rate from accidents

among American Indians is 3.4 times that of the general population in the United States (U.S. Congress, 1986).

Indian mortality rates due to cardiovascular disease and to cancer are lower than those for the United States general population of all races. Nevertheless, diseases of the heart and malignant neoplasms do affect American Indian populations and some service areas have a particularly high incidence of various cancers and heart disease (U.S. Congress, 1986). This phenomenon has led some in the past to claim that Native Americans appear to be protected from the leading causes of death in the general population. However, Markides (1983) notes that this "protection" can be explained instead by very high mortality rates from accidents and other causes of death involving violence. In sum, the interpretation of these indices of mortality, particularly with regard to cardiovascular disease and cancer, requires a consideration of the indices together as a profile, as recommended earlier by Sullivan (1974).

Several other health status indicators among the Native American population are important for this discussion. Particularly, the diabetes death rate deserves mention as it is 2.8 times that for the general population of the United States. In one IHS area (Aberdeen), it was 5.2 times higher. Moreover, kidney failure, as a sequela of diabetes, continues to rise and deaths in the IHS population due to renal failure are 2.8 times higher than for the general

population of the United States. Moreover, this category of kidney problems has shown an apparent 50% increase from a data collection period in 1972-1974 to the most recent from 1980-82 (U.S. Congress, 1986).

The pneumonia mortality rate continues to be higher than the rates for the general population, especially for those who are very young and those between 25 and 55. Homicide and suicide, the 11th and 10th causes of death for the United States general population respectively, rank 8th and 9th among American Indians. Suicide tends to afflict younger Indians rather than the old.

Infant mortality is only 1.1 times the rate found in the general United States population. However, examining these infant deaths more closely reveals that most occur during the first year of life rather than the immediate period following delivery. Death rates among Indian infants in the period from 1 month until 12 months of age surpassed the United States general population rate in all of the IHS areas except for one.

Finally, no IHS area had a death rate from liver disease lower than that of the rate for the general population. The overall rate of deaths from liver disease is 4.2 times the United States all races rate and, in one IHS area, it is reportedly 10 times higher. Alcohol abuse has been implicated as the causative factor in the interpretation of these data reflecting liver disease and is considered to be

related to other health problems in this population as well (U.S. Congress, 1986).

This collection of health status indices reflect severe health problems which persist among members of the American Indian population in spite of a concomitant decline in the incidence of communicable disease. Much of the above data is from reservation areas. Those residing in urban areas, albeit comprising nearly 54% of the total Indian population, are underrepresented in the health data presented here. IHS collects little information from urban programs (U.S. Congress, 1986), and those Indians who do not utilize IHS services, many of whom are urban, are also not included in these measurements.

Summary

This section of the chapter addresses health of the American Indian from a Western health care perspective. The increased availability of Western health care for many American Indians has been associated with a declining incidence of acute, infectious disease. Nevertheless, as in the general population, chronic and man-made diseases continue to rise, and, for the American Indian, these diseases strike with an intensity more severe than observed in the general population. Approaches to these chronic health problems from the perspective of the "pathogenic paradigm" have limitations, for these problems "arise out of the social fabric of the community...[and] although

manifesting themselves medically or having medical consequences, [they] have their origins in the basic structure of human interaction" (Department of Health, Education, and Welfare, 1979). Policies dealing with these health problems require a focus which addresses not only clinical manifestations of disease but also their associated environmental factors.

Chapter Summary

This chapter considers health from the perspective of the Native American and from the perspective of the Western health care provider practicing in the United States. A cultural framework and the meanings assigned to health within that framework have consequences for interaction in health care settings. Investigations of Native American perceptions of health are few and much of the literature in this area reflects work done with one tribal group--the Navajo. Only a few investigators report research done with other tribal groups and, in particular, with urban Indians. The literature has informed this investigation as to the understanding of health from the perspective of the Western health care provider and, in particular, the policy of the Indian Health Service. The purpose of this investigation, therefore, is to offer an understanding of health from the perspective of the Native American elder, particularly members of an aggregate of urbanized, older adults.

CHAPTER THREE: METHODOLOGY

This chapter presents the methodology of this study through a discussion of the sample, the setting, and the data collection and analysis. Utilizing the field method, the investigator observed and interviewed respondents in natural situations (Schatzman & Strauss, 1973). Data gathering and analysis proceeded concomitantly using the constant comparative method of grounded theory (Glaser & Strauss, 1967; Glaser, 1978; Strauss, 1987) and dimensional analysis (Bowers, 1984; Olshansky, 1985; Schatzman, forthcoming). These data gathering techniques and analytical operations allowed the context in which these Native American elders construct meanings of health and manage perceived health problems to emerge. Ultimately, an understanding of health perceptions and health actions/interactions among the members of this aggregate evolved which is "grounded" in the data.

Sample

Three considerations support the focus upon the older members of this aggregate. First, by virtue of age and life experiences, the elders of a group are most likely to be familiar with traditional approaches to health; this group of individuals are, generally, the repositories of a peoples' accumulated lore and legend (Clark & Anderson, 1967). Second, as addressed in the previous chapters, elderly members of minority groups are particularly

vulnerable to health problems. Third, these individuals represent an aggregate with whom little research has been done. Elders of an aggregate of Native Americans, therefore, became the focus of this study as it is important to understand how these older adults characterize the nature of their health and how they manage their perceived health problems.

The sample was one of convenience. Health care providers from tribal clinics introduced the majority of the respondents to this investigator. A snowball sampling approach, by which respondents suggested friends and relatives who might be interested in participating in the study, provided others. Finally, this investigator knew several of the respondents from her practice as a community health nurse working with this population.

These elders who ranged in age from 52 to 80+ all spoke English. The majority were women, and all resided in their homes. The majority of the respondents had married and were either widowed or divorced; several subjects had never married, but these individuals were exceptions. The majority lived with their extended families although a few lived alone.

This sample represented a stable aggregate, for most had lived in their current communities several decades or more. With only four exceptions, the respondents were from one of three tribes: Washoe, Paiute, or Shoeshone. Each tribe was

represented by approximately one third of the sample. Those individuals from tribes not native to the state often experienced consequences with regard to health care eligibility; these elders were usually able to receive outpatient care at tribal clinics, but they were frequently not eligible for inpatient care.

The sample also consisted of two groups based not on tribal affiliation but upon method of data gathering. In the first group nineteen individuals participated in a semi-structured interview with this investigator which was audiotaped and transcribed verbatim. With members of the second group the investigator had less structured conversations of varying length bearing upon the research question. These conversations took place during the participant observation done by this investigator at senior lunches, outings, and home visits with community health nurses and nursing students. Approximately twenty subjects comprised this second group. Several of the elders fell into both groups because of the nature of these data gathering processes. Data gathering will again be described later in this chapter.

None of the older adults in this study were severely ill. None were institutionalized or had health problems with sequelae such as aphasia and/or fatigue which would hinder their ability to participate in the study. Each was alert and ambulatory and, in all, they represented a sample

relatively free from disease except for chronic health problems which they managed.

In summary, the sample was one of convenience comprised of English speaking older adults who were predominantly women. The majority of the respondents were from one of three tribal groups. These individuals were, generally, free from severe health problems. None were institutionalized and most lived with their extended families. A consideration of the setting where these older adults lived follows.

Setting

Respondents in this study resided in one of four urban sites: two "Indian colonies" and two urban communities adjacent to these colonies. The colonies and adjacent communities lie within 30 miles of each other in a western state. A more detailed description of history, government, employment, housing, transportation, and health care as they relate to these sites follows beginning with the colonies and concluding with the adjacent urban areas. Tribal publications as well as conversations with respondents in this study were the sources of the data which follow.

The colonies

Throughout their history up until the early 1900's, bands of Indians migrated throughout this western state temporarily settling at various locations in order to fish, hunt, and gather food. Members of the band played their

parts in essential activities, and life revolved around the nature of the land and the season of the year.

By the twentieth century the lands became increasingly crowded with non-Indians who continually forced the tribes to pack up their families and belongings and move to vacant spots. The non-Indians often referred to the Indians as "homeless" not understanding their communal concept of land use and ownership which sharply contrasted with that of the European tradition. Finally, near a number of urban centers, the federal government purchased tracts of land for these "homeless" Indians. These tracts of land, or "colonies", provided native people with permanent homesites in what had become a non-Indian world.

Colonies are similar to reservations but several features distinguish them from each other. First, colonies are near or within towns and cities; in contrast, reservations are often located in rural areas. Second, one is more likely to discover a variety of tribal groups on a colony than on a reservation. Finally, third, colonies are usually smaller and contain homesites, only. Reservations, on the other hand, have farming and grazing land, as well as homesites (Leland, 1976).

The two colonies in this study are referred to here as Colony A and Colony B. Colony A consists of 28.83 acres, and an urban center in which the population exceeds 200,000 surrounds its 623 residents. Colony A's borders include an

interstate freeway, paved and lighted city streets, and numerous commercial establishments including auto body shops, restaurants, and assorted convenience stores. Only two miles from this Indian land is an international airport. The 28.83 acres which at the turn of the century was remote from the non-Indian community has become geographically amalgamated into a sprawling urban center in which it is not unusual for warehouses to be more than 30 acres in size--a size greater than the colony itself.

Colony B and its adjacent urban non-Indian community are thirty miles south of Colony A. Colony B's 160 acres make it geographically larger than Colony A, but Colony B's population is only 184. The non-Indian community which is near Colony B has a population of only 37,000 with an additional 35,000 persons residing on the surrounding county land. Colony B is less densely populated than Colony A and the surrounding urban community is considerably smaller. Nevertheless, similarities exist between the two sites; for example, this second colony has homesites only with no space for farming or grazing which is the case on Colony A.

For their first two decades of existence, the federal government largely ignored the colonies. Then, in 1934, the United States Congress passed the Indian Reorganization Act which established a structure for future tribal affairs and dealings with the federal government. This legislation also influenced the processes by which members of the colonies

govern themselves. Presently, as a consequence of the Reorganization Act, members of the colonies elect governing bodies called tribal councils which are responsible for a number of important decisions including those which are related to the delivery of health care.

Colony residents elect the tribal council at designated intervals, and one of these council members is the tribal chairman. Occasionally, a member of the colony will contest a neighbor's right to vote in an election. The right to vote is based upon how long one has resided on the colony as well as one's tribal affiliation. Such challenges are significant as the voting population is small, and every vote is considered crucial in an election.

The council meets on a regular basis, and it is not unusual for members of the colony to attend when they have interest in the issues being discussed. On Colony A, the topics often include health related matters and, in particular, the functioning of the community's clinic as well as the performance of the health services staff. Occasionally, the council and others in attendance discuss specific health problems of colony residents publicly. Since the community is small and close knit, these discussions take place in a context in which almost everyone present at the meeting is familiar with the individual involved. Not only are health care and politics

intimately linked in this community, but privacy and politics are connected as well.

Business and employment opportunities have evolved out of the unique relationship the colonies have with the United States government. For example, colonies typically operate "smoke shops" which sell cigarettes at reduced prices since they are not subject to state and federal taxes. These businesses are on Indian owned land, and they provide some jobs for residents and revenue for the tribes. Besides the smoke shops, local residents work in tribal administration, recreation, and, important for this study, health services. Indians have "preference" for employment in all of these positions.

In addition to employment opportunities on the colonies, some residents seek wage work in the surrounding urban area as well. Yet, the unemployment rate at Colony A has been estimated by some at 28%--a condition related to members of extended families living together and supporting each other financially. This situation also contributes to adult children, and their children, living with elderly parents. Although this figure is high, it is in sharp contrast to colonies in the more rural areas of the state where rates climb to 60% and, on a northern reservation in the state, a tribal publication estimates unemployment at a rate of 53%. Living in or near an urban area does have the advantage of increased employment opportunities, and, as

might be expected, a number of the respondents in this study indicated they originally migrated to the area years ago to "find work."

As noted above, extended family members often reside in the homes of elders including adult children, grandchildren, and others. In comparison with other non-Indian, middle class dwellings in the same community, homes are often crowded with limited space for family members. Colony A is particularly densely populated with no room for housing expansion. Younger members of the community who move to the surrounding non-Indian community find the situation economically difficult as the cost of living continues to rise. Also, many young persons express a wish to live on the colony with friends and relatives as families tend to retain close ties. Recently, Congress awarded the members of Colony A funds for the purchase of new lands to relieve crowded conditions and to provide space for those eligible Indians now living in the surrounding non-Indian land. The new lands--consisting of over 1,000 acres--have been purchased in an area which, like the colony many years ago, lies on the outer boundaries of the urban center.

Housing on the colonies varies from trailers and older dwellings to units built with the assistance of the HUD (Housing and Urban Development) program in the late 1960's and early 1970's. Residences vary as to their level of sophistication from homes with modern kitchen appliances to

those in which the elder still cooks on a wood stove. Nearly all have radios and televisions, and watching afternoon soap operas is a common pastime. One elder in the study apologetically ended an interview with this investigator for her "program" or soap opera was beginning, and she did not want to "miss it." Although living conditions vary somewhat, the majority of elders in this study live with technology and pastimes found in other urban American homes.

A city bus line passes directly by Colony A, and residents use the line for transportation, but during the winter this source of transportation is difficult for the elders to manage. Individuals living on Colony B do not have access to a municipal transportation system. In both sites elders frequently rely on their children and friends for transportation, and health services staff provide some transportation to needed health care providers and agencies. Although some provision for transportation to health care services exists on each colony, for certain elders it is more problematic than for others depending upon sources of social support.

Congress funds the Indian Health Service, and the local tribal groups administer these monies to provide local health care services. Tribal leaders and clinic administrators anxiously await yearly congressional decisions which affect clinics budgets as well as those

related to other services. The clinic located in the center of Colony A provides health care to colony members as well as to eligible Indians residing in the surrounding urban area. Staff members include a nurse practitioner, a physician, a licensed practical nurse, a pharmacist, a nutritionist, a social worker, and various ancillary staff. Of this staff, the licensed practical nurse and ancillary staff (receptionists and file clerks) are Indian. The clinic includes laboratory facilities with the capacity for doing basic blood and urine studies while another facility in the non-Indian community performs more complex laboratory procedures on a contract basis.

Members of Colony B must drive thirty to forty-five minutes to a tribally run clinic which offers services much like those offered in the clinic on Colony A. This second facility serves several colonies, rather than only one, and the members of these colonies represent, generally, the same tribal group. Respondents in this study did not report transportation to this second clinic as a problem. Usually, residents of Colony B provide their own transportation or utilize the transportation provided by Indian Health Service staff.

Should a member of either colony need hospitalization, "contract care" with local hospitals is available to Indians native to the state. There is also an Indian Health Service hospital approximately 100 miles away. However, use of

this latter facility is becoming less and less common, and, as of this writing, it has closed. Some respondents in the study indicated that they believed the hospital will never reopen.

In addition to the ambulatory care provided by the clinics, community health nurses provide services to both colony and urban Indians. Although the elders' health care needs comprise a considerable portion of the community health nurses' workloads, other clients and responsibilities place constraints upon the time available for elders.

A lunch program operates for seniors on Colony A, and this program has gained increasing momentum with attendance averaging ten to fifteen members daily. Other senior outings which are coordinated by the community health nurse include fishing trips and trips to senior programs on other reservations. A number of the elders in this study reported that they were unable to participate in these senior activities because of their commitments to their families--usually child care responsibilities. This finding is similar to what has been reported by other researchers, such as Holmes (1983). For the urban Indians, transportation was frequently cited as condition that prohibited attendance at senior lunches.

In summary, the colonies are Indian lands adjacent to urban centers; residents utilize the land for housing as not enough space exists for grazing and farming. Colonies are

governed by tribal councils which make important decisions which include those related to the delivery of health care services. Density on the colonies varies as do housing situations and the availability of transportation, but, in general, similarities exist. For example, the majority of respondents on both colonies have technology found in other urban American homes, such as television. One of the colonies in this study has a clinic located at its center while residents of the second colony must drive thirty minutes to a tribally administered clinic.

The adjacent urban settings

Approximately half of the respondents in this study resided in the urban settings adjacent to the Indian colonies. Colony members refer to these Indians as "urban Indians" although the colony Indians reside in an urbanized area as well. Urban Indians live in a variety of residential settings including subsidized senior housing facilities, trailers, houses (owned and rented), and apartments. In contrast to the colony Indians who are clustered together, urban Indians are dispersed or scattered throughout the urban area living in predominately non-Indian neighborhoods. This group presents as much variability with regard to their living conditions as one might discover in the general population. Some of the urban Indians live with extended families in which elders often have responsibilities for grandchildren. Others live

alone. Urbans also have technology found in other urban American homes, and they frequently watch television soap operas as an afternoon pastime. In general, the homes and lives of the urban Indians are not remarkably different from those of the colony Indians.

Accessibility to health care is more problematic for the urban Indian than for the colony Indian, especially those of Colony A. If the Colony A elder is unable to walk to the nearby clinic for health services, usually this individual has family or other colony residents available for transportation. In contrast, urban elders living in the community adjacent to Colony A indicated that it is sometimes difficult to obtain transportation services to the clinic as well as to senior lunches and other functions. Urban Indians are eligible for services provided by the tribally administered clinics. However, some are not members of tribes native to the state. Consequently, these individuals are not eligible for contract care which, as previously noted, is that care provided through agreements with other, non-IHS providers in the community; this latter care includes hospitalization.

In summary, urban Indians reside in a variety of settings from subsidized senior housing to privately owned homes and trailers. Some of the elders live with extended families and others live alone. Generally, homes have technology found in other urban American dwellings, and

urban elders, like their colony counterparts, often enjoy soap operas as an afternoon pastime. A rather complex system of eligibility determines what health services the urban Indian may receive, and these are sometimes less than that of the colony Indians. Transportation to these health care services is sometimes more problematic for the urban Indians than the colony Indians. With this setting and the sample as background, a consideration of the data gathering and analysis follows.

Data Gathering and Analysis

As previously indicated, data were gathered and analyzed in this study by means of field research guided by grounded theory and dimensional analysis. This method avoids "a priori" variables, definitions, and propositions and allows salient dimensions to emerge from the data. For instance, rather than making prior judgments about what aspects of health are salient for members of this aggregate of urbanized, Native American elders, the investigation explored the respondents' own perceptions of their health and its management. A core of salient dimensions ultimately emerged from the data which further guided the study. Eventually, a constellation of saliencies and relevancies formed which represent the health situation of these interviewees (Schatzman, forthcoming). A more detailed discussion of this process follows.

Data gathering

The processes of data gathering and data analysis proceeded concomitantly in order that salient dimensions could be pinpointed and pursued before leaving the field. The two are separated here for purposes of discussion only. This section on data gathering considers entre, interviews, and other sources of data.

Entre. This investigator had practiced as a community health nurse with this aggregate in the past. Through this experience the investigator gained familiarity with tribal leaders, clinic administrators, health care providers, and others, including older adults, in the community. The researcher discussed the study with these individuals and informed them of its purpose to explore health among members of an aggregate of Native American elders. A commitment was made to make available to these individuals a summary of the discoveries which emerged from this investigation. In all, these past interactions with the community seemed to facilitate entre.

Because of her identity as a clinician, situations arose during data gathering when the elders in the study perceived the investigator as a "nurse" rather than a "researcher." In the course of conversation, health problems were, occasionally, uncovered which warranted nursing intervention. With the respondent's permission, the researcher made referrals to appropriate community health

nurses. Thus, an attempt was made to separate the roles of clinician and researcher in the investigation to the extent that this was feasible.

Interviews. Nineteen respondents participated in semi-structured interviews. A number of preliminary questions derived from the review of literature and what this investigator understood to be true from experiential data provided a basis for these interviews. Also, the investigator consulted with others who had worked with this population including Rund (1978) as well as an informant from the aggregate of Native American elders utilized in this study. The preliminary questions focused upon Tripp-Reimer's emic component of health: wellness-illness. (The reader will recall the discussion of Tripp-Reimer's work in chapter one and chapter two.) These preliminary questions were as follows:

What are the understandings of health for these individuals?

Under what conditions are these understandings constructed?

How does one become ill?

What modes of treatment are used for illness?

Who are the medical decision makers, i.e., those who determine assistance is needed for an illness?

What experiences have these individuals had regarding their own health?

What experiences have these individuals had regarding the health of others, e.g. family, friends, and other members of the community?

What is the understanding of chronic and "man-made" diseases, in particular, accidents, diabetes mellitus, hypertension, and alcoholism?

How have these "man-made" and chronic diseases touched these individuals and those close to them?

How is the presence or lack of health services related to their experiences and/or understandings of health?

The preliminary questions guided initial interviews which were flexible in order to explore facets of each interviewee's concerns. The investigator pursued topics that arose in conversation which appeared relevant (Becker & Geer, 1969). After the initial interviews, the investigator added and deleted questions depending upon emerging patterns in the data.

Data gathering and analysis proceeded concomitantly during this interview process. A dialogue transpired in which new knowledge discovered in the interviews was checked with prior knowledge. Ultimately, a semi-structured interview guide evolved which was, itself, "grounded" in the data (L. Schatzman, personal communication, 1984). Appendix A contains the final version of this guide.

The interviews, themselves, varied in length considerably. Some were brief lasting only forty-five

minutes. Others lasted for two hours. The investigator conducted the interviews in the homes of the elders and other accessible locations which allowed for privacy. All were tape recorded and then transcribed verbatim.

Other sources of data. In addition to the interviews, participant observation in excess of 60 hours at senior citizen lunches, senior trips to outlying reservations, and home visits with community health nurses and nursing students provided data for analysis. The investigator gathered this data through conversations of varying length bearing upon the research question. Observational notes of these discussions and activities as well as methodological and theoretical notes provided "packages" of data for consequent analysis (Schatzman & Strauss, 1973).

Informal conversations with providers including nurses, other health services staff, and tribal administrators also produced data for analysis. Notes, as described above, organized these "packages" of data as well. Finally, other "diverse materials" including tribal publications and articles in the local newspapers provided additional, indispensable sources of data for this research (Strauss, 1987).

Summary of data gathering. Data for this study of health among members of an aggregate of urbanized, Native American elders were gathered from a number of sources. These sources included semi-structured interviews, less

structured conversations bearing upon the research question, participant observation, and other diverse materials, including tribal publications. Packages of data in the form of methodological and theoretical notes facilitated the data analysis to be described below.

Data analysis

As indicated previously, data gathering and data analysis proceeded concomitantly in order that salient dimensions could be pinpointed and pursued before leaving the field. Grounded theory and dimensional analysis informed this analytic process from which emerged an integrated, substantive theory of how these individuals assign meaning to the phenomenon of health and how they manage their perceived health problems. This section of the chapter considers grounded theory and dimensional analysis and how they informed the analytic process of this investigation.

Grounded theory. Grounded theory is a style of doing qualitative analysis that includes theoretical sampling, constant comparisons, and the use of a coding paradigm. From this approach emerges a substantive theory which is conceptually dense enough to be able to grasp actors' viewpoints for understanding interaction, process, and social change (Strauss, 1987). Several specific illustrations of how this style of qualitative analysis applies to this investigation follow.

As the data were gathered, the investigator began to read the transcribed interviews, field notes, and other materials line by line in order to discover and name categories. Initially, this process consisted of "open coding" whereby unrestricted considerations of the data "opened up" the inquiry. Theoretical memos were written with regard to these codes which were both "in vivo" and "sociologically constructed." Comparative cases were constantly utilized in order to refine these categories (Strauss, 1987).

Open coding revealed several "in vivo" codes which are codes taken directly from the language of the actors in the field. The respondents used one of these codes, "hard lives/hard times," in their descriptions of their past lives. Another "in vivo" code, "pulling through," is a process by which these respondents said they were able to make it past the hard times. Other codes were sociologically constructed by this investigator such as "wardship" and "health perceptions."

After this initial coding phase, the analysis proceeded by means of a selective coding procedure. This procedure was more systematic as the investigator identified a number of "core" categories and analyzed the data in relation to these core codes. In this stage of the analysis, the core categories guided the theoretical sampling and data gathering as well. Theoretical sampling means that the

"analyst decides on analytic grounds what data to collect next and where to find them" (Strauss, 1987). An illustration of theoretical sampling follows.

It had become apparent after a number of interviews that for many of these individuals the images of traditional approaches to health were "fragmented recollections" of the past. Repeatedly, respondents were unable to recall aspects of various Indian treatments that their families used for their past health problems. The investigator came to wonder about the conditions associated with this loss and added such a question to the interview. This question was: "A number of people have told me about old ways of treating sickness, and often they have forgotten much about them. How do you think these have been lost?"

This theoretical sampling led to the discovery of important characteristics of the "opportunity structure," a core category which in this analysis represents perceived health options. Through the process of theoretical sampling the subdimensions of the opportunity structure began to emerge. In response to the above question, the elders frequently talked about how accessible Western, non-Indian health care had become and how the accessibility of traditional Indian health care had declined. This accessibility included aspects which were designated as geographic(al), economic(al), and information(al). This dimension, opportunity structure, and its subdimension,

accessibility, became part of the conditions which had consequences for health perceptions and health actions/interactions.

In summary, utilizing the grounded theory method the investigator coded incoming data and, then, the emergent categories guided the research that followed. Data grouped into these categories were further analyzed by means of dimensional analysis. Dimensional analysis is defined here as a method of analysis which renders theoretical and informs the operations of grounded theory methodology (Olshansky, 1985; Schatzman, forthcoming).

Dimensional analysis. Dimensional analysis guides the investigator's attention to dimensions or concepts uncovered by the data gathering process. A dimension is an aspect of an object being observed or of an idea. Through dimensional analysis that aspect is considered in the foreground while the other aspects are held constant in the background. While in the foreground a dimension may be subdimensionalized to illuminate variation (Schatzman, 1983). An illustration of this process as it relates to the discoveries in this study follows.

As indicated above, the core dimension of "opportunity structure," representing perceived health care options, emerged from the data. Holding this dimension in the foreground, its subdimension, "accessibility," could be further subdimensionalized into "geographic(al)

accessibility," "information(al) accessibility," and "economic(al) accessibility." Eventually, properties, more concrete features, arose from these subdimensions; for instance, properties of "geographical accessibility" were "proximate" and "remote." Thus, dimensional analysis allowed the complexity of this category to evolve.

As the analytic process continued, five dimensions emerged as "core dimensions" since they were considered the most salient. These core concepts were so designated because most of the other dimensions were related to them, and they became the means to integrate the other saliencies and relevancies which had emerged from the data analysis. An integrative diagram was developed to graphically represent this constellation of saliencies and relevancies; a multiplicity of representations were tried until one was found that allowed for "theoretical completeness" as well as parsimony (Strauss, 1987; Schatzman, forthcoming). Chapter four presents this integrative diagram which includes the core dimensions of this study: past/present world, wardship, opportunity structure, health perceptions, and health actions/interactions.

In the next chapter the core dimensions, their subdimensions, and properties unfold. Processes which link them together unfold as well. Through grounded theory and dimensional analysis, the respondents' view of the phenomenon of health becomes apparent. The analysis grasps

the enormous complexity of this phenomenon by considering its social context as well as its phenomenological aspects.

Summary

The sample in this study consisted of members of an aggregate of Native American elders who resided in urban settings. These elders lived in several different sites, but they shared similar living situations which included technology, such as television, available to other urban Americans. Generally, these elders utilized health care services provided by tribal clinics. They often lived with extended families in which they had responsibilities for the care of grandchildren.

Data were gathered from a variety of sources. Utilizing the grounded theory method and dimensional analysis, data analysis proceeded concomitantly with data gathering in order to pinpoint salient dimensions before leaving the field. Theoretical sampling was used to verify emerging dimensions and hypotheses and eventually a constellation of saliencies and relevancies emerged which represented the complexity of the health situation of the elders in this study. This constellation is graphically displayed in the integrative diagram which is contained in the next chapter; the core dimensions which emerged in this study unfold there and become components of a substantive theory which provides an understanding of how these individuals construct

meanings of health and how they manage their perceived health problems.

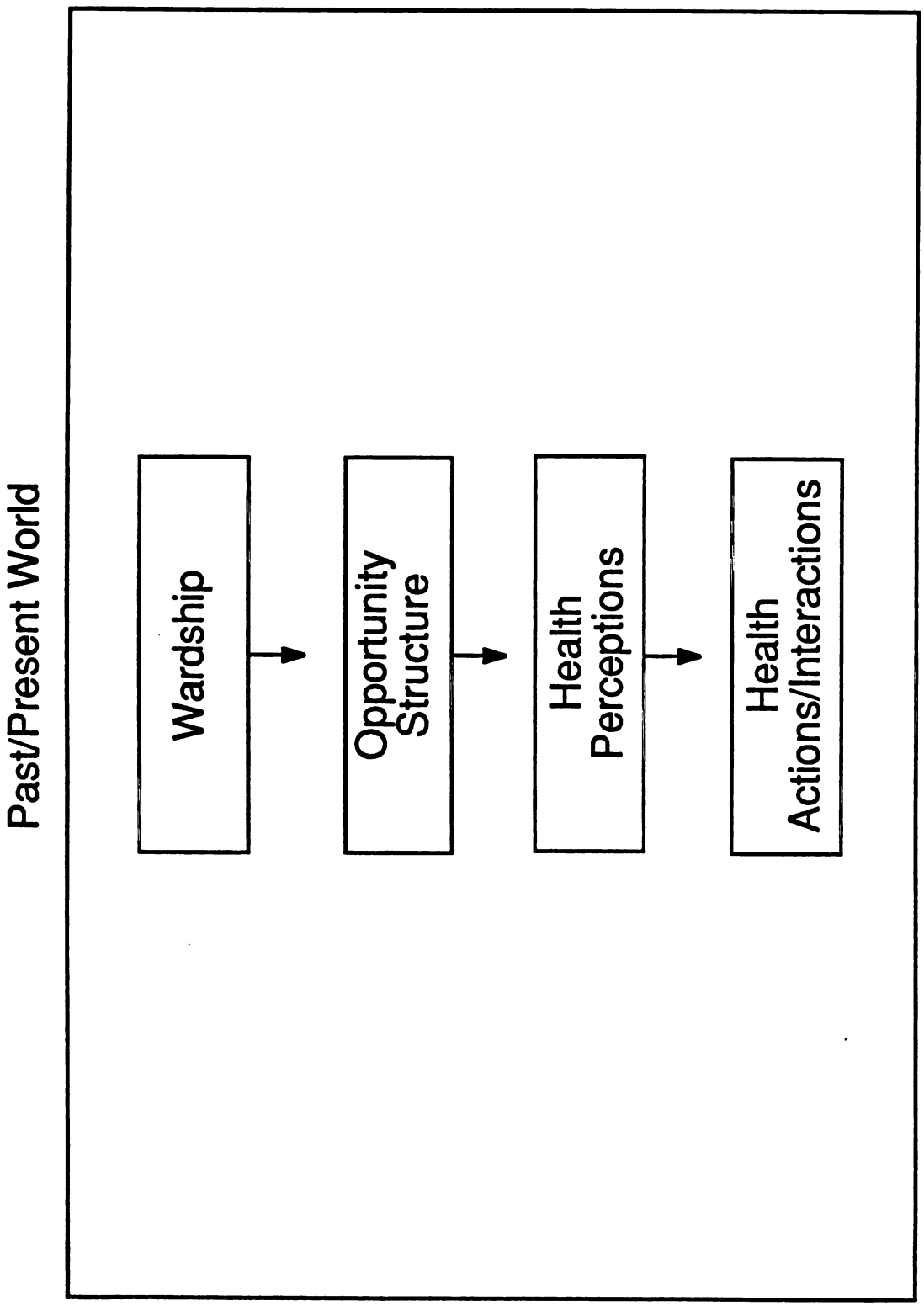

Figure 1. Integrative Diagram

CHAPTER FOUR: DISCOVERIES

This chapter presents the discoveries made in this study of health among members of an aggregate of urbanized, Native American elders. The chapter consists of two major sections. The first considers an overview of the core dimensions which emerged in this study and utilizes an integrative diagram to provide a skeleton upon which the second section builds. The second section contains greater elaboration of each category in order to sufficiently define each and all. This latter section illustrates how the discoveries are grounded in the data through specific examples from interviews and participant observation. What ultimately emerges is an understanding of how respondents in this study construct meanings for their own health and how they manage their perceived health problems.

The Integrative Diagram

The integrative diagram in Figure 1 summarizes the salient dimensions which emerged in this study of health among members of an aggregate of urbanized Native American elders. The core dimensions include: <u>past/present world</u>, <u>wardship</u>, <u>opportunity structure</u>, <u>health perceptions</u>, and <u>health actions/interactions</u>. This first section of this chapter presents an overview of these core dimensions utilizing the integrative diagram while the second section follows with a more detailed analysis of each as well as a consideration of linkages between them. Each of these

dimensions has a cluster of subdimensions and properties which the second section considers in greater depth as well. In sum, this overview briefly outlines each of the core dimensions and its cluster of related subdimensions, properties, and processes.

Past/Present World

The dotted line surrounding the core dimensions represents still another core dimension, the past/present world. At a macro level, the past/present world encompasses the larger social structure of the United States. It is from this larger structure that the condition of wardship emerges since wardship evolved as a consequence of the interaction between the Native American and the government of the United States.

At a more micro level, the past/present world encompasses a number of conditions in the social environment including adversity. Adversity is characteristic of both the past and present worlds. Respondents often referred to this condition in the past world as hard times which were linked to living conditions, the boarding school experience, untimely deaths of parents, and bouts with devastating disease. In the present world, the majority of these elders continued to manage persistent adversity as well as the sequelae of chronic health problems. Generally, these images of the past and the present conditions have

consequences for health perceptions and actions which the second section of this chapter considers in greater depth.

The dimensions, subdimensions, and processes which emerged in this study have temporal characteristics which the past/present world reflects. Symbolic interaction informs this analysis with regard to the complexity of time, i.e., there is no "real" past, but rather the past consists of images which are themselves present (Mead, 1932; 1964). Although the discussion analyzes the past world separately from the present world, respondents in this study have interpreted past conditions and health related events from images that are indeed present. Thus, this separation provides an organizing scheme for the presentation of the discoveries in a chronological fashion rather than definitively categorizing dimensions as either "past" or "present."

Wardship

Wardship refers to the general condition by which the American Indian had and has a unique ascribed status vis-a-vis the government of the United States. As a consequence of this unique status, the Indian has had special experiences in a number of areas including education, land ownership, housing, local governance, and, particularly relevant for this study, health care. Wardship has consequences for the other core dimensions of opportunity

structure, health perceptions, and health actions/interactions.

An example of one of these consequences is the educational experience of the majority of the respondents in this study. These respondents, and many other American Indians who are now older adults, attended Bureau of Indian Affairs boarding schools. It was in this context that respondents experienced childhood diseases, received non-Indian treatments, and participated in the delivery of non-Indian health care to their cohorts. The health care options in the boarding school generally ignored the more traditional, Indian health beliefs and practices.

From a contemporary perspective, wardship serves as a general condition under which respondents continue to seek and obtain health care. All of the respondents in this study were eligible to receive at least some of the care provided by the Indian Health Service. In this context, older adults in this study not only received care and but also incorporated the ideas of providers into their own perceptions of health. Wardship serves as a general condition having consequences for the opportunity structure as well as for health perceptions and actions/interactions.

Wardship is difficult to differentiate from the other analytic categories. Discussing wardship is comparable to discussing oxygen--it is everywhere, taken for granted, and invisible. Wardship emerged from the data as a general

condition and is so pervasive as a social environment that it gives salience to the categories of opportunity structure, health perceptions, and health actions/interactions. Since wardship is so closely linked to the other dimensions, it is not fully considered in isolation. Rather, it is appreciably integrated with discussions of the other dimensions. The next core dimension to be considered, the opportunity structure, exemplifies this pervasiveness to some degree as well.

Opportunity Structure

The opportunity structure represents the health care options perceived as available by the older adults in this study. These options included those of the past world and the present world as well as those which were more characteristically Indian and those which were non-Indian. In the present world, this structure, which itself is a consequence of the general condition of wardship, has limited semblance of the traditional structure which was blended with traditional health beliefs and practices and Indian identity. Instead, contemporary options, which are mostly medical and commercial, dominate the structure.

A subdimension of the opportunity structure having relevance for this analysis is accessibility. Accessibility, itself, has several additional subdimensions important for the consideration of the opportunity structure: informational, geographical, and economical. For

example, in the past, Indian Health Service facilities were located in remote areas of the state. In the present setting, respondents comment upon the proximity of health facilities. Geographical accessibility as perceived by respondents in this study has changed appreciably over the years; moreover, all three of these subdimensions have important consequences for health perceptions and health actions/interactions.

Health perceptions

Health perceptions refer to the vocabulary and meanings of health, more particularly wellness and illness. These phenomenological components of the analysis represent both specific and general understandings and provide the conceptual structure and basis for health actions. For these older adults, health perceptions emerged from the process of defining health and its subprocesses: evaluating signs of sickness, incorporating the perceptions of others, finding cause, and evaluating doing, working, and getting around. Utilizing these processes, respondents characterized their health into one of three ideal types: sound, frail, or qualified. Each of these types has distinguishing properties which will be expanded later in the second section of this chapter.

As noted in chapter two, a view persists in the nursing literature which depicts the health perceptions and actions/interactions of Native Americans as homogeneous and as

characterized by religious or sacred beliefs. However, for the respondents in this study, the health perceptions which had evolved over the years often tended to be secular in nature. Generally, respondents incorporated ideas from providers, usually physicians, and from commercial presentations in the media into their understandings of health. Consequently, the contemporary health actions and interactions linked to these understandings were also secular and predominantly non-Indian.

Health Actions/interactions

Health actions discovered in this study included the processes of practicing self care and seeking care from providers. Self-care involved utilizing both Indian and non-Indian lay treatments administered by the respondents themselves or by family members for health related problems. Seeking care from providers encompassed not only seeking care, itself, but obtaining care as well. This latter care from providers also included that which was both Indian and non-Indian.

Accessibility, noted above as a subdimension of the opportunity structure, was critical to health actions. Respondents considered the geographical, economical, and informational accessibility of their health care options prior to action taking. In all, health actions emerged as complex activities with oneself and/or a variety of others and these activities have links to the other core dimensions

of the study. Two other processes critical to health actions were evaluating efficacy and synthesizing old and new. Utilizing these processes, respondents evaluated their actions and the care obtained and, at times, amalgamated traditional Indian practices with those which were new. As a consequence of these processes, respondents in this study emerged as "pragmatists," i.e. fairly sophisticated consumers of health care who were generally willing to test out a variety of solutions to their health problems in search of what "worked."

Summary

The integrative diagram is a representation of the core dimensions of this study: past/present world, wardship, opportunity structure, health perceptions, and health actions/interactions. The second section of this chapter elaborates on each of these dimensions in greater depth and considers the cluster of subdimensions, properties, and processes linked to each. By expanding the dimensions of the integrative diagram, the next section explores how these urbanized, Native American elders interpret the phenomenon of health as well as how they take action with regard to their own health based upon these interpretations.

Expanding the Dimensions of the Integrative Diagram

The remainder of this chapter expands the core dimensions identified in the preceding overview--wardship, opportunity structure, health perceptions, health

actions/interactions, and the past/present world. Two major sections comprise this analysis: first, the past world and, second, the present world. These two time periods provide an organizing scheme for the discussion of the core dimensions and the clusters of subdimensions and properties which emerged as salient in this study of health among members of an aggregate of Native American elders.

Past World

The analysis of the past world focuses upon conditions and health perceptions and actions/interactions. The conditions considered in this discussion are those which emerged in this investigation as relevant for health. These conditions provide a background for the analysis which follows regarding health perceptions and health actions/interactions among members of this aggregate of urbanized, elderly Native Americans. What emerges here is a portrait of how these individuals were able to "pull through" and survive the harsh circumstances of the past and how interaction in these past social situations have had consequences for the meanings assigned to health and consequent health actions/interactions.

Conditions of the Past World

Conditions addressed here relate to both the childhood and young adulthood of these respondents and include: 1) adversity, a subdimension of the past world which impinged upon the lives of these individuals, 2) wardship,

particularly as reflected in the boarding school experience, 3) the opportunity structure which emerged, in part, as a consequence of wardship, 4) occupation, 5) activity, and 6) community. The conceptual boundaries of these conditions and their properties frequently intersect and overlap; thus, they not always distinguishable and are, at times, integrated in the discussion.

Adversity. As noted above, adversity is a subdimension of the past (and later the present) world. Adversity emerged from the data in the accounts that respondents gave of their past lives where, as children, the majority resided on reservations and colonies located in remote rural areas of the western state where this study was conducted. (Some of the respondents spent a large portion of their childhood years in boarding school which will be presented shortly.) Generally, the respondents described their lives in the past world as "hard"--not only during their childhood years, but also during young adulthood and when they became parents. "Hard times/hard lives" is an in vivo code which emerged as the respondents reflected upon the conditions of the past world, particularly living situations. Hard times/hard lives in this analysis is a property of the subdimension of adversity. A consideration of these hard times/hard lives as well as two other properties of adversity--bouts with disease and the deaths of parents--follows. The quote below vividly portrays living conditions which characterize

the hard times and lives of these individuals in the past. In this account, the respondent describes her life on a rural reservation and the situation faced by her family following her mother's untimely death. She said:

> "Yeah, my mother died when I was small. My sister and my little brother, we were all small when my mother died. One little cabin we lived in--with a dirt floor. It was a hard life. Somedays it was really hard living, but, you know, the Indians really make it through--pull through."

These data illustrate several facets typical of respondents' reports of the past world. First, the elder describes a harsh living situation. Second, this elder experienced a formidable adversity--the death of a parent when she was a small child. Third, in this quotation the process of "pulling through" emerges. This respondent's life career exemplifies this pulling through process, for, not only did she experience a hard life characterized by impoverished living conditions and multiple adversities, but also she has managed a health problem which severely limits her mobility. She has, as she states above, "really made it through--pulled through."

A number of other respondents reported that one or more of their parents died when they were children. For example, one woman noted that after her father had been sent to a penitentiary, her mother began drinking heavily and

eventually died. It then became necessary for her to assume major household responsibilities including the care of her siblings. Thus, this case again illustrates the hard lives and times which characterized the adversity of the past.

Another example is a situation in which the respondent discussed how her mother was a victim of homicide. The following quotation illustrates this respondent's experience:

> "My sister and I were over at our aunt's house, and we heard a shot. We ran home, and--my mother--she was on the floor. That was terrible; so, we had to go and get our aunt. We never talked about it anymore, and then, my sister, she tried to kill herself. She tried to drown herself after that, 'cause she felt for her. We both did. She taught us things that comes in handy nowadays; you wouldn't ordinarily think so. Things that she told me--I listened, and I went by. I got along pretty good."

This account relates, again, adversity which in this case is characterized by the untimely death of a parent as well as the attempted suicide of a sibling. Moreover, this vignette provides further evidence of the process of pulling through, for the respondent heeded the mother's advice with regard to "things that come in handy nowadays" and, as a consequence, "got along pretty good."

Some who lost their parents at an early age were sent to the Bureau of Indian Affairs boarding school located in the state. For example, one respondent reported that her father had been killed in an accident and, as a consequence, her mother decided she was unable to raise her alone and placed her in the boarding school when she was an infant. She noted:

> "I guess as a baby my mother put me in the boarding school. Yeah, I lived there for all those years, but I went home in the summer time, you know, when school was out. I went to (a small rural community in the state), because I have an aunt over there."

It was not uncommon for children to be sent to boarding school at this time. The majority of the other respondents in this study also attended the boarding school, although the circumstances of this particular case differ from most in that her mother placed her in the school when she was an infant. The boarding school will be considered in greater depth later in this chapter.

In sum, hard times/hard lives and the impoverished living situations characterized the adversity of the past world. Individual exceptions to these circumstances emerged from the data, but adversity often arose as an important subdimension of the past world. In addition to hard times/hard lives, other relevant characteristics of adversity included the untimely deaths of parents and bouts

with disease. The preceding quotations allude to these latter two characteristics but they require further analysis here. Loss of parental figures and bouts with disease contributed not only to the hard times/hard lives of the past, but also had consequences for the exposure these individuals had to those who could pass to them Indian traditions. These circumstances were particularly relevant for developing health perceptions and consequent health actions/interactions.

As noted above, bouts with disease emerged as a property of adversity in this analysis. For example, tuberculosis was a health problem which many of these elders experienced personally or which their family members and friends experienced. Several noted that, as children, they were confined--often for years--in tuberculosis sanatoria. The state in which this study was conducted had a sanatorium, and one of the respondents moved to the state during her childhood because she had been sent to this sanatorium. She said:

> "When they found out I had tuberculosis, they had to send me to a drier climate. Yeah, when I came here, it was like being in the Gobi Desert. So, when I was a small child, from 4 through 9, I was in a tuberculosis sanatorium...I lost one brother with tuberculosis,too."

Another victim of tuberculosis in the past noted:

"When I was a child, I was sick a lot. Yeah, I had TB when I was about 7, I guess. They sent me to a sanatorium, so I was there for about a year, I guess. You know, just off and on, I was sick. I didn't know I had it until I got sick one day. I was coughing an awful lot, you know, and that's when they found out I had it. So, I missed about a year of school. Yeah, I couldn't get rid of the cough".

The untimely deaths of parents was occasionally related to bouts with disease, including tuberculosis. The following are representative of these cases:

"My mother died from tuberculosis. She died when my brother was one, and I was 10 weeks old. My older brother was four. So, my dad was mother and father to us."

"I was about six years old when my mother died from tuberculosis."

These accounts demonstrate how tuberculosis was a formidable adversary for these individuals, how its treatment often resulted in isolation of individuals from family and friends, and how it accounted for deaths among parental figures. Additional data and analysis of this health problem will be presented later during the discussion of health perceptions and actions. The disease has relevance for the present discussion in that it represents

the adversity experienced by these respondents during the past world.

In sum, adversity emerged as a subdimension of the broader core dimension, past world. The majority of the respondents in this study reported experiencing hard lives/hard times--a property of adversity--during their childhood. These times were characterized by impoverished living conditions, the untimely deaths of parents, and bouts with disease, particularly tuberculosis. In addition to these conditions, the majority of elders in this study attended Bureau of Indian Affairs boarding schools. This experience was particularly relevant for the consequent development of health perceptions. A consideration of the boarding school experience and the opportunity structure follows.

Wardship and the opportunity structure. As a consequence of the American Indian's unique status with the United States government--a general condition referred to in the overview as "wardship"--the majority of the respondents in this study attended Bureau of Indian Affairs boarding schools. The literature review considers the development of this educational structure from a historical perspective. As noted there, in 1819, Indian education received support from a "civilization fund" established by Congress. Later, in 1879, the first boarding school was founded and, by the end of the nineteenth century, 25 off reservation boarding

schools were operating in other areas of the country including the state where this study was conducted.

Approximately two-thirds of the subjects in this study reported attending off reservation, Bureau of Indian Affairs boarding schools. Those respondents who did not attend the boarding schools usually resided in small rural communities where they had access to non-Indian schools. For this analysis, the relevant properties of this boarding school experience include: its mission, length of stays, and health experiences. The latter concern, health experiences, also overlaps with the core dimension, opportunity structure.

As noted in the literature review, proponents of the boarding school stated explicitly that its mission was "assimilation" of Indian children into the dominant culture. Separating the children from their parents also separated them from Indian ways of life; moreover, boarding school regulations--such as prohibiting the children to speak their native language--facilitated this aim. Suppression of the native language has important consequences for this study of health.

As noted earlier, language is a symbolic vehicle for the transmission of culture (Blumer, 1969). Without the native language, many of the words which reflected traditional interpretations of health and approaches to health care were

lost. One respondent, when asked about traditional Indian health practices, replied:

> "Oh, I don't know anything about those. When I was a baby, my mother gave me over to the Indian School. I don't even speak my language and, you know, I am embarrassed about that."

The above respondent's lack of fluency in her native language and limited information regarding traditional health practices was, at least in part, a consequence of her boarding school experience and infrequent contact with other tribal family and friends. She had only limited exposure to traditional interpretations of health related phenomena. Later in this chapter, analysis of the respondents' "fragmented recollections" in the present further illustrates this situation. The intention of the boarding school experience--assimilation--had consequences for the conditions which evolved within that educational structure and, eventually, consequences for the loss of traditional symbols which provided a shared framework for the interpretation of health related phenomena.

Respondents in this study had stays at the boarding school which varied from only one or two years to over twelve years. Six to ten years was common. A number of factors are associated with this range in stays. Some of the respondents noted they had left the school after attending for several years. Others, as noted earlier, had

lost parents and spent their early preschool years at the school; depending upon the length of stay, the experience tended to isolate these individuals from close family and friends who could pass on Indian ideas, and language. The following account illustrates this situation:

> "I was about five years old when my mother passed away. She died from tuberculosis. There was no orphan's home in them days, so they put me in what they call, the tuberculosis sanatorium. That's where I went. That's where they put me 'til I was ready to go to school. Then, they sent me out to the boarding school, and I stayed there for 13 years."

This account resembles that of the previous respondent, for both spent considerable time during childhood in the boarding school.

Stays in the boarding school are important for this study because, as a consequence, many of the respondents were in this setting when they experienced childhood illnesses. During these illnesses the children had limited contact with an opportunity structure which provided traditional Indian options for health care; instead they utilized options provided in the boarding school which had their bases in Western approaches to health. These health related experiences in the boarding school had important consequences for developing Western health perceptions and actions/interactions.

The school in the state was situated at some distance from the reservations where families of the children resided. These distances varied from thirty miles to over three hundred miles. The school had a small infirmary and, when the children became ill, they received care in the infirmary instead of going home. As one respondent noted:

> "I don't think I was ever really sick until I went to boarding school, and then I must have had the chickenpox. I remember it was the end of school, and I couldn't come home. I always remember that. I don't know why. They made me stay in bed. It was just like a regular little hospital."

Another respondent also reported being in this infirmary in the following account:

> "I think out at the boarding school, I was in the hospital once with double pneumonia. That was the only time, I think, and I was at the school for ten years."

Although experiences in the infirmary varied from individual to individual, they demonstrate that as the children became ill at school, rather than at home, they had limited contact with those who could provide traditional Indian health care. Moreover, the health care they did receive was from Western providers. Many reported experiencing common childhood diseases in a place which was perceived as a "little hospital" rather than in their homes

with care provided in a traditional manner by family members.

In addition to their personal experiences with illness, respondents had other interactions with Western health care providers in this setting. In the following account, an elder reflected upon such interactions:

> "I was there (the boarding school) for a long time because I stayed there and took up a trade. I got to know them, and finally, they hired me to work in the hospital there. I was around those patients, and that's where I learned to take pulses and read blood pressure. So, I told my son, `You know, you can't fool me. I can feel pulses and all that, and I know how to bandage any cuts.' And, you know, one time when the doctor was there--like I said, in those days we didn't have much--we didn't have a nurse. So about that time, a boy broke his wrist, and the doctor said, `I'll have to put him to sleep.' So, he tried to give the anesthetic himself, and the boy was coming around. So he said to me, `I want you to give this boy ether, just a little drop at a time.' So I did. I put him to sleep! I told my son about that, and he couldn't get over it."

This anecdote depicts the interaction between this respondent and a Western health care provider. It demonstrates how Western health practices became common place in the lives of these individuals and how, as

illustrated by this case, some even actively participated in the provision of Western health care to others.

Summary. The boarding school experience occurred as a consequence of the American Indian's unique status as a ward of the United States government--wardship. As a consequence of wardship, options for health care--the opportunity structure--included the option of Western health care provided in the boarding school. In contrast, because these individuals were at considerable distance from families and friends, the opportunity structure which included traditional Indian approaches to health became inaccessible. Accessibility is an important subdimension of the opportunity structure in the past and the present as well. A more in depth consideration of the opportunity structure and accessibility follows later in this chapter.

Thus far the discussion has dealt primarily with conditions as they occurred during the childhood of these subjects. Yet, these conditions often persisted into young adulthood. Subdimensions of the past world which emerged as relevant for health during young adulthood included: 1) occupation, 2) activity, 3) adversity, and 4) community.

Occupation. The majority of the elders in this study migrated during their young adult years to the urban centers where this study was conducted. In general, they migrated in search of wage work, for unemployment was, and still is, higher on rural reservations and colonies than in the urban

centers. Typically, women sought work as domestics in private homes and in hotels and motels while men often worked on ranches and for the railroad. A few of the elders worked in health care settings as auxiliary health personnel, and one operated a small business. A few worked in teaching settings. In all, occupations varied and often involved interaction with non-Indians.

Activity. As young adults, nearly all married and had children. Generally, their lives had been rich with activity which often took place outdoors. Several--women and men--talked about their past lives in which they were quite physically active as hunters, horseback riders, and ranch workers. One respondent commented upon her process of aging and her sense of remorse over the lack of activity in her present life. She said:

> "The more active you've been, the more it bothers you when you get old and stiff. I see those mountains, and I can't believe I've been up there deer hunting and, gee, it does bother you. I don't know. If you've been a home body, when you get older there's no difference in your way of life. Whereas if you've been out--and you know we used to go hunting every fall and go out in those mountains--you can't believe that you can't do it."

Another respondent who also had spent much of the adult

years being quite active and working with horses made the following remark to this investigator:

> "I've worked outdoors practically all my life, with horses. We went all over that back country. You know, I don't think you've had as much adventure as I have!"

These respondents perceived these years of activity as an important component of their young adult lives. Often when respondents had been quite physically active in the past, they would consider this activity to be the basis of their present health status which, in these cases, was usually perceived as "good."

Adversity during young adulthood. For a number of the respondents, the times during the adult years contained adversities as had childhood. There were those who survived not only their spouses and siblings but their children as well. For example, one elder reported how three family members--including a spouse and an adult child--had died within weeks of each other, and the deaths were all alcohol related. In the following, this same respondent commented upon how difficult these times had been, and how she now enjoyed her life's activities:

> "I'm doing all right. I do things, you know. I like the things I'm doing now, 'cause I've worked hard all my life-- hard work, very hard. I raised my six children, and I'm raising my three grandchildren. Yeah, their mother died."

This account is another example of a respondent pulling through hard times and surviving. Often, as a consequence of such conditions, elders become responsible for the care of grandchildren and other family members.

Other examples of the adversity experienced during the young adult years include the following incident in which a child of one of the respondents was shot to death in the yard of a heavy equipment company:

> "Yeah, she got shot in the back. They said it was an accident. Yeah, there was a bunch of kids, and they were around the machines and the watchman came, and I guess they all ran. But he shot her."

This example represents the adversity experienced by these individuals as well as their interactions with the surrounding non-Indian community. The elder reported that the other children involved in this incident were fearful of testifying and that the watchman, who allegedly shot the child, was never prosecuted.

In sum, although the respondents led varied lives throughout their adult years, a number of subdimensions of the past world characterized these times including occupation, activity, and adversities. Additional discoveries pertinent to the adult years, particularly with regard to wardship and the opportunity structure, emerge later in the discussion of health perceptions and

actions/interactions. A consideration of one final subdimension of the past world, community, follows.

Community. Community emerged as a subdimension of the past/present worlds and has important consequences to be discussed later in this analysis with regard to "privacy." The term "community" is not limited to groups who live within specific geographical boundaries. As used here, this term indicates an aggregate of people with a common identity or perspective; they share symbolic boundaries (Bellak, 1964). This idea of community, as Bellak notes, has historical overtones. Indeed, in this study, the idea of community emerges with the recollections of past encounters with other Indians throughout the state and accounts of shared experiences. The principal property of this community is intersecting life careers.

Intersecting life careers emerged repeatedly in the data as it became apparent that the lives of the majority of this aggregate intersected in a number of ways including: 1) family and tribal relationships, 2) shared boarding school experiences, and 3) shared health care experiences. As noted in the discussion of the sample, the majority of these individuals were from tribes native to the state and represented a relatively stable aggregate with regard to residency. They had lived in the state for their entire lives and had lived in their current setting for several decades or more. Many of the elders' life careers

intersected through shared relatives and friends and through tribal relationships. Elders often had family and relatives in the rural areas they had left decades ago. Moreover, through the years a web of relationships and ties evolved between and among families that encompassed not only the two urban settings where this study took place, but the entire state as well.

In addition to familial ties, a number of the elders knew each other in the boarding school. Several of the elders had even met their future spouses in boarding school and, consequently, married. Lifelong ties evolved out of this shared school experience, and boarding school situations have been noted in the review of literature as promoting cohesion and a shared ethnic identity (McBeth, 1983).

The opportunity structure, in this case as represented by those health care options available as a result of wardship, was another means by which these individuals lives intersected. One respondent noted an example of a shared health care experience which demonstrates how the opportunity structure was a vehicle for intersecting life careers in the following:

> "I was in the hospital in (another state) and X was there. Do you know her? She was there getting her teeth pulled. So, they knew we were both from the same tribe, you know, and the nurse had went and got X and

> brought her over to the ward where I was at, and we'd visit, you know. So one day the nurse came in and said `X is going home today'; and I said, `I wish I was going.' So, I was out of that bed and girls was helping me get ready to go, and so we went on the bus. Boy, if that wasn't a trip!"

As a consequence of receiving health care through the status of wardship, these two individuals encountered each other in a health care facility in another state. Their lives had intersected in this setting.

Intersecting life careers and the consequent web of ties and relationships has persevered into the present world. This community emerged out of interactions in the past world not only with family and friends, but also as a consequence of wardship--in boarding school and in health related events. These intersecting life careers have consequences in the present world for the symbolic sense community which evolved out of years of multiple interactions remains.

Summary of past world conditions. A number of conditions in the past world have relevance for health among members of this aggregate of Native American elders. These conditions include adversity, wardship, opportunity structure, occupation, activity, and community and are associated with childhood as well as young adulthood. These conditions provide an important background for the analysis

of health perceptions and health actions/interactions to follow in the next section of this chapter.

Generally, respondents in this study viewed the past world as characterized by adversity. Data from a recently published tribal monograph lends additional support to the portrait of hardships recollected by these respondents. This document contains a photograph taken during the 1920's in which an Indian couple--man and woman--are bending from the weight of railroad ties strapped to their backs. The caption under the photograph states: "Nationally, the Indian population had declined to its lowest point; traditional tribal institutions were dismantled, and the future looked very bleak." This description is similar to those provided by respondents in this study. Yet, these elders commented upon, and are examples of, the strength to "pull through" these difficult times.

Health Perceptions and Actions/Interactions in the Past

The intent here is to explore and analyze health for members of this aggregate of urbanized, elderly Indians from a social and phenomenological perspective while taking into account the conditions of the past world previously analyzed. In this section of the chapter, therefore, the conditions of the past world become the background, and the discussion draws health perceptions and health actions/interactions into the foreground. Consequences of the past conditions emerge in this analysis as salient for

the health perceptions and health actions/interactions among these older adults.

As in the previous analysis of the past conditions, respondents' health perceptions and actions include those of childhood and those of young adulthood. The perceptions of the young adulthood, however, are not remarkably different from each other and provide minimal data for comparative analysis. Generally, respondents indicated that their health during this young adulthood was "pretty good," "fine," or they had "never been sick," etc. Although the discussion presents this data from young adulthood when appropriate, the data surrounding childhood health dominates this analysis as it provides richer details for the comparative analysis of health perceptions and actions/interactions.

Defining health. Perceptions of health evolved from a process called here: "defining health." Defining health represents a process by which the respondents characterize the nature of their health and set forth a meaning of this phenomenon for themselves. Subprocesses of defining health include: 1) evaluating signs of sickness, 2) incorporating the health perceptions of others into one's own, and 3) finding cause(s). As a consequence of these processes, health perceptions emerged which can be distinguished by the following three properties: "sound," "frail," or

"qualified." An analysis of these processes, dimensions, and properties follows.

Evaluating signs of sickness emerged from those responses whereby the respondents characterized the nature of their health during childhood. The majority of the respondents considered their childhood health as sound. These "sound" individuals assessed signs of sickness as having been minimal during their childhood years, and what sickness they experienced was not perceived as serious. For example, these respondents generally referred to common childhood diseases such as measles and chicken pox as "usual" and did not attach a property of seriousness to them. Responses below reflect this evaluative process as well as sound perceptions of childhood health:

> "I can't think of being sick except, of course, I had measles and chicken pox and the usual things. But as far as being sick, I can't recall being sick really."
>
> "I had pretty good health. Only thing I had was tonsils. I've still got 'em, but it infected my ear one time, and it broke, you know. There was no doctors where I was living, but I got over that."
>
> "I just had colds and the usual, you know. Nothing serious."
>
> "Shucks, I was never sick a day in my life until this (present illness) hit. 'Course, I had my appendix out. I had all the child sicknesses--mumps, measles, and all

that. I had all that. Outside of that, I was never sick a day in my life until this."

These remarks demonstrate how these respondents assigned the property of "soundness" to their understanding of their childhood health by means of evaluating signs of sickness. Health is sound as long as one is not sick or the sickness one experiences is assigned the characteristic of being "usual" or "ordinary" and does not warrant the characteristic of "serious." These respondents were fairly precise and explicit in the identification of signs of sickness.

Occasionally, signs of sickness were difficult to evaluate and the respondents perceptions of health reflected a property of frailness. In these cases, respondents were equivocal when evaluating their past health and, in contrast to the sound evaluations, the nature of past health related events was unclear. In the descriptions of childhood health problems these individuals had difficulty "finding cause," i.e., identifying those factors which they considered to be the etiology of their past health problem. Generally, as was the case of those who perceived their health as sound, a sickness was the focus for the process of defining health. The following remarks illustrate evaluations which reflect more frail characterizations of health:

"My health wasn't very good (as a child). I had something wrong with me where my bones are crooked now.

I must have been lacking in a vitamin or something. My mother said I couldn't walk no more. I don't know what cured me; being out in the sun, I suppose. Finally, I was old enough to go with her and work. This lady--she used to raise all kinds of vegetables. Everything she had, I ate. So maybe for that reason, I got over it."

"I don't know how my health was. I guess I used to have fainting spells. That's all I remember. My mother told me not to play too hard because I would have one of those fainting spells again. If I did faint, I don't remember it."

"Well, I was sick a lot. Yeah, when I was a little girl. I don't know what I had, but I used to get so sick."

The above hunches made about cause range from "lacking in a vitamin or something" to "playing too hard." The former can be considered for this analysis as an "environmental factor"; the vitamin she needed was perceived as lacking, and she saw her improvement as related to "being out in the sun" and/or eating vegetables. The other etiology represents a "bodily factor." In this latter case the respondent interpreted her mother's perception of the problem to be that she would faint when she played too hard. The first two above comments illustrate a second subprocess of defining health: the process of incorporating the perceptions of others into the respondent's own health

perception. In these cases, as children, perceptions which were incorporated were those of maternal figures. This process of incorporating the perceptions of others into the respondent's perception emerges again later in the context of older adulthood when respondents incorporate providers' perceptions into their own.

Some elders evaluated their past health as qualified, i.e., the perception of their health had specific, identifiable restrictions assigned to it. Those who presented an understanding of past health which was fairly sound but, at the same time, reported physical disabilities which had compromised mobility throughout their lifetimes best illustrate this group. The following two remarks demonstrate these evaluations:

> "My health was all right. It was just that I was born crippled. Born crippled--outside of it, my health was good. Never had any kind of sickness, only colds or a touch of pneumonia or something like that".
>
> "I guess my health was all right, but you know I got my hip out of joint since I was little. I got hurt. It wasn't hard to get around when I was young, but now it's hard."

In these cases, physical restrictions compromised a perception of health which the respondent otherwise considered sound. These definitions differ from the previous frail understandings in that factors relevant to

health are not obscure, rather they are clearly identifiable. These definitions differ from those which are more sound in that they have qualifiers attached to them.

Summary of past health perceptions. Utilizing the processes of evaluating signs of sickness, incorporating the health perceptions of others into one's own, and finding cause(s) these respondents characterized the nature of their past health as either sound, frail, or qualified. Noteworthy is the discovery that these respondents constructed their past perceptions of their health around signs of sickness which reflected Western disease categories. A comparison of these past perceptions with those of the present follows later in the analysis.

This portion of the analysis explores two health actions/interactions: practicing self care and seeking care from health care providers. Self care practices here refer to those actions and interactions which are not directed by health providers but are undertaken by the respondents in this study, or their family members in their behalf, in order to manage their health and its related problems. Self care includes both Indian and non-Indian approaches to health.

Seeking care from providers includes those who were both Indian and non-Indian; the former represents Indian healers and the latter includes "country" and/or "public doctors" and Indian Health Service providers. Seeking care includes

not only the process of "seeking," itself, but also "obtaining" care as well. This section analyzes these two processes and explores how they relate to the other dimensions of the study. Two additional processes also considered below which are closely linked to actions/interactions include synthesizing old and new and evaluating efficacy.

Practicing self care. As noted above, self care treatments included both Indian and non-Indian, and the respondents generally reported using the treatments for health problems such as "pneumonia," "ear aches," and "whooping cough." The following account illustrates practicing traditional Indian self care and, in this case, the respondent's grandmother administered the treatment:

> "I remember when we were real small, small kids. I was staying with my grandmother and we got that cough--whooping cough. I would get to coughing, coughing so hard, and Mom took us to doctors and everything. Well my grandmother said, `Heck with these doctors! I'll doctor them myself.' She went up in the hills, and I don't know what kind of brushes she got. She washed them a little bit and then boiled them in a pot. I don't know how much water she'd put in but she boiled 'em up, and then she strained it after she watched the color of the water. Those old people knew just when to take it out and everything and how long it

should sit and what time they should do all of that. You know, we never coughed after that. I slept so good, and that was it. I never asked her what it was, and she is gone today. It worked and we were up in two or three days. No coughing and we went back to school. The teacher asked what happened to us 'cause we all came back to school. `We're not coughing. Is there a law that says we can't come to school?' (Respondent laughed.) She asked how we got better and we said, 'Grandma's medicine'."

This account illustrates several important points with regard to the process of practicing self care. This case involved Indian treatments which a family member, in this case a grandmother, administers. The respondent recollects the details of the treatment as fragments: she was unable to recall the name of the brush as well as the details involved in its preparation. The account reflects the synthesizing of old and new for the grandmother administered a traditional Indian self care treatment for a health problem categorized into a Western disease. Finally, the traditional treatment's ability to relieve the signs and symptoms of the sickness attested to its utility and illustrates the process of evaluating efficacy. In this case, the treatments from Western "doctors" were not judged efficacious. On occasion, individuals reported borrowing self care treatments from non-Indians. Generally,

respondents who utilized non-Indian self care lived in close proximity to non-Indians. The following illustrates these circumstances and the borrowed practice:

> "Well, one time my ear was infected, and it broke. The people that lived near us were white people, and my grandfather worked for them. So, that's why we were living there. This girl who lived there had this tobacco juice and oil, and she gave it to my great aunt. Yeah, it took away the pain, and I got over that. That was all I had all them years. I worked like a dog, too. You know, being poor."

This case represents practicing non-Indian self care which the respondent evaluated as efficacious, i.e. it took away the pain and she recovered. The case also illustrates the geographical accessibility of non-Indian options for self care: her great aunt obtained the treatment from a non-Indian family who lived nearby. Finally, this account again demonstrates the adversity of childhood and the process of pulling through.

Occasionally, the health actions/interactions reflect an amalgamation both self care and care from providers. One respondent described such a situation in a recollection of a bout she had with pneumonia during late adolescence. This account includes the self care treatment administered by her grandmother and the care sought and obtained from non-Indian

providers in Indian Health Service facility located in the state.

> "I had pneumonia when I was about 18 years old. I had it really bad, I guess, because I saw people that weren't there. At that time my son got scared and went to my grandmother. She prayed over me and took some roots--they boil it and then give you the juice. It's really bitter! It's terrible, but it did the job because that evening I got better. But they sent me to the (Indian Health Service) hospital anyway--just to watch."

In addition to combining self care and care from providers, this situation also demonstrates the process of "synthesizing old and new." What could be done for the pneumonia with traditional Indian ways was done; yet, just in case further untoward events might arise, the family sought care from non-Indian providers--"just to watch." The family integrated the two approaches to health care in order to reap the benefits of both. The account also reflects the process of evaluating efficacy for the respondent noted the self care practice "did the job."

In summary, practicing self care in the past world involved utilizing Indian and non-Indian treatments usually administered by older family members to these respondents during their childhood years. The accounts reflect the process of synthesizing old and new, and in spite of

fragmented recollections, respondents often evaluated Indian self care treatments as efficacious. The opportunity structure, particularly with regard to its accessibility, emerged as an important condition for the practice of self care. The opportunity structure was also an important condition for the second health action/interaction: seeking care from health care providers.

Seeking care from health care providers. As in the case of practicing self care, seeking care from health care providers includes both those who were Indian and non-Indian. Indian providers in this discussion represented Indian healers or "shaman" which is what they were called by several of these respondents. The non-Indian others included "country" and/or "public" doctors and Indian Health Service professionals. Like the practice of self care, seeking care from others involved evaluating efficacy and, as illustrated in the previous account of the respondent who had pneumonia, synthesizing old and new. Perceived geographical accessibility with its properties of proximity and remoteness was relevant for the utilization of these providers. The following discussion expands upon these processes and dimensions beginning with Indian providers followed by non-Indian providers.

Several of the respondents related accounts of seeking health care from Indian healers in the past. In some instances, the Indian healer resided nearby and this

proximity facilitated access to his care. Respondents varied in their evaluations of Indian healers' treatments; some viewed them as having been efficacious and others did not. In the following account, the respondent evaluated the services of the Indian healer as efficacious and noted the proximity of these health care options:

> "There used to be an Indian doctor who lived right next door. Yeah, and my dog bit me when he got hit. He got hit, and I didn't know that, and he came in the yard here, and I guess he got underneath the house, and I said, `What's that bumping around under there? It sounds like my dog. Let's get under there.' So, I went outside to look and called her, and I didn't see her. I guess she come from behind me. When I had my hand down she come up to me, and she grabbed my hand like that, and she bit into it--cut it open. When I get cut I usually get infection in it quick. So, I thought, `I'm not going to have that kind of infection set in.' So I ran over to the Indian doctor's and asked for help. He prayed for me and rubbed my arm for me. I thought it was going to throb all night. Didn't even bother--like that dog didn't even touch me! Things like that, you know. We were lucky then to have him. We miss him."

This account illustrates how the respondent evaluated the efficacy of the treatment administered by the Indian healer. The wound did not throb as anticipated, and she

felt fortunate that the healer was nearby and his care was perceived as accessible. There is also sense of sadness that he is no longer there. This respondent noted that she did, from time to time, use the services of an Indian provider in the present which will be considered later in that portion of the analysis.

Other recollections of seeking care from Indian healers included evaluations of outcomes which were not efficacious. The following response illustrates such circumstances and the process of evaluating efficacy:

> "In them days they had a lot of tuberculosis--wiped out whole bands of Indians, at that time. I seen that. And I seen that flu, when there used to be little bands of Indians. See my uncle was a shaman, and they'd call him to go and try to help people. He'd have to go. He never refused anybody, and he saw people in these little bands. He'd have to take me along because I didn't have any parents. My mother and dad died from tuberculosis. Gee, that's too bad see whole families just perish. Oh, there used to be lots of Indians, and it just wiped 'em out. That flu in 1918. I wasn't born then, but he used to tell me about it. There was nothing he could do about it."

In contrast to the previous situation in which the respondent noted the efficacy of the Indian healer's treatment, this case presented circumstances for which for

which this care was not effective. This latter respondent's evaluation reflects a sense of overwhelming circumstances perceived as beyond the control of the healer: "There was nothing he could do about it." Consequently, many Indians were "wiped out."

Another respondent reported an instance in which the Indian healer's care was judged ineffective and non-Indian options--particularly Western medical care--were considered inaccessible. This situation illustrates that neither form of health care was perceived as able to manage the health problem: the first because of efficacy and the second because of inaccessibility. As a consequence, the respondent notes that a child died.

> "Most of the time when the Indians got sick, they stayed home and died home, you know. No nurses. No hospital like we do have now...The old timers they have this Indian doctor. They try that but sometimes they can't help them. I remember my brother had a little baby and he was real sick and some older people--they had an Indian doctor one night-- and my brother took this little baby over there to have the Indian doctor doctor him, you know. He went over there and toward morning the baby died over there. So he never helped them."

This account references both the traditional and Western approaches to health care but they are not synthesized as they have been in other recollections. Rather, the

individual perceived both as ineffectual in dealing with the sickness of this infant and other health problems: the traditional approaches because of efficacy and the Western because of inaccessibility. As in the previous case, a sense of overwhelming health events which were beyond the control of the Indian doctor emerges in this account.

In sum, respondents evaluated health care from Indian healers in the past as both efficacious and non-efficacious, based upon their perceptions of circumstances and outcomes. The opportunity structure, particularly as characterized by its perceived accessibility, emerged as a condition relevant to seeking health care from providers. The analysis now focuses in more depth upon seeking care from non-Indian providers.

In the past these respondents occasionally sought health care from non-Indian providers including "public" and/or "country doctors" and health providers at the Indian Health Service facility. Once again, the opportunity structure and its accessibility arose as a condition relevant for seeking care from these health care providers. Perceived inaccessibility changed options for seeking care and when families failed to get care from one provider, they consequently explored alternatives. Accessibility in these situations was both geographic and economic. The literature review described the intricacies of the structures through which federally funded health services

were administered for the American Indian in the past; several details of these bureaucratic structures require clarification here. The federal government provided some limited health services to Indian populations in the early 1900's which was generally disease specific. In 1924, a health division was created within the Bureau of Indian Affairs, and in 1955, this health service transferred to the United States Public Health Service, and it is known today as the "Indian Health Service." Although respondents generally referred to all past services as "Indian Health Services," they were administered by different federal agencies and reflected different philosophies.

The concern of the present discussion is to illuminate the interactions these individuals had with federally supported providers as a consequence of the dimension of wardship and not to explore the intricacies of the bureaucratic structures behind the scenes. Thus, the discussion here refers to these federally supported health services as did the respondents in this investigation, i.e., collectively as "Indian Health Services," without regard to the nature of their administrators.

In this study respondents reported seeking care from providers in Indian Health Service facilities located throughout the state. Often individuals would have to travel great distances in order to reach these services, for the state is vast, and Indians resided in numerous,

scattered, often rural locations. It was not unusual for families to travel 100 miles in order to reach one of these facilities, and there were cases where the individual's residence was 300 miles from the hospital. Thus, remoteness was a property of this past opportunity structure and is closely linked to accessibility. The following account illustrates how limited access to health care exacerbated the adversities experienced by this aggregate:

> "I don't recall we had any Indian Health service as a child. I would have died if I needed it. We did have X (Indian Health Service hospital). I remember a girl who had an older sister dying of tuberculosis. I guess they stayed up with her sister all night because she wasn't feeling too well--she was on the verge of death. This little girl, she kept laying on her mother, and she would never complain. I guess she just couldn't hardly go toward morning, and only then she complained that she was having pains in her tummy. So, they rushed her up to the hospital about 90 miles away and just as they got there, this little girl passed away and died. 90 miles with all that jarring and everything, and they have a hospital there in X (town), too. Had I been younger, and needed any kind of hospitalization, I'm sure that I'd have never got it. Then, in later years, they started to have field nurses, and they took patients 90 miles away to the hospital. Well, then, they took care

> of emergencies in X (town), too. It had to be an emergency before they did. But if you needed hospitalization of any kind, well, it just was not available. Of course, if you had the means and the money, it was--which today is the same thing."

This account reflects several facets of seeking health care from Indian Health Service providers in the past world. As a child, this woman perceived Indian Health Services as a "non-option" because of perceived geographic inaccessibility as characterized by remoteness. She speculated about her own demise had she needed health services and reflected upon the death of a childhood acquaintance. She noted improvements in the services, i.e., the advent of the public health nurse and the limited provision of emergency care in the local community. Finally, another subdimension of accessibility which had the potential to increase options for the seekers of care emerged--the "means and the money." The respondent perceived this subdimension, called here "economic accessibility," as unchanged in the present world.

As noted above, often considerable distance separated the rural Indian reservations and the health care facilities. These distances ranged from 30 miles to over 300 miles; moreover, the means utilized for transportation intensified these distances. One elder reminded this investigator:

"Them days there was horse and wagon. How would you get around? Yeah, we used to have horse and wagons them days. Doesn't seem like it, but I seen that. I lived through it, anyway. Yeah, if there were an emergency, you would just lie there and suffer."

In the past world, these individuals lived among circumstances common to other rural people in the state at that time: great distances confounded by limited transportation which rendered health care options geographically inaccessible.

In later years, particularly during young adulthood, the Indian Health Service facility became more accessible and respondents reported traveling there for the delivery of their babies as well as to have surgery. Generally, respondents evaluated the services received at the facility effectively as indicated in the following account by a respondent who had surgery thirty years ago:

"I had a gallbladder operation. I had that in X (the state's Indian Health Service hospital). I forgot about that. It was a long time ago. 30 some years ago. Those days that doctor was really good. Well, I had pain and used to heave and then I went to the doctor, and they told me I'd have to stay there because of what I had. I told him I had a couple of kids at home and he said you be back here on the 4th of July, and I told him I would but I never went back 'till I go so sick that I

> couldn't even walk. My back was hurtin' so bad. I didn't care if I went back or not. So, they took me back and they operated on me right away as soon as I got there. They sent me on the ambulance. I got better. The doctors up here all those years later would always look at my scar and they would say `That was a really good job.'"

This account indicates that as the years passed and transportation became more readily available accessibility to this Western health care facility increased. In this particular situation, the respondent considered this health care option as efficacious and incorporated a later "efficacious evaluation" by a physician into her own.

In a previous quotation, the respondent mentioned the field nurse who represents another example of a non-Indian, federally funded provider. These public health nurses provided transportation to health care facilities and delivered other services, such as the administration of immunizations, directly to Indian communities. Several of the respondents commented upon the work of the field nurse as illustrated in the following:

> "The nurse, Miss X, she used to travel from reservation to reservation. She was a great friend of the Indians, and they'd do anything for her up there. If they knew she's coming in, they all baked cakes or something so she could have something when she comes. Well, she used

to always detour to my mother's because she used to like tortillas. I'd say to mom, `How come you're making extra tortillas? How come?' She'd say, `Miss X is coming in to see you kids. So you kids come home from school in a hurry today so she can examine your health.' Yeah, from home to home, sometimes if people were pretty sick for one reason or another she used to send them to the Indian Hospital. She was very nice, very wise."

This respondent's account demonstrates how the public health nurse bridged the geographical accessibility by assessing health needs directly in the community and providing transportation to Indian Health Service facilities. This respondent evaluated the public health nurse's care as effective, and she considered the nurse to be a "great friend of the Indians" as well.

In addition to those non-Indian providers supported by federal funds, there were those supported by local or county funds and those in private practice who respondents in this study utilized. One respondent who lived in a rural community in the state at some distance from the federal facilities discussed seeking care from these providers in the following:

"I never took advantage of it (Indian Health Services) when I was a kid. There was none around X (town). The county doctor took care of all of us. It was mostly the county doctors that took care of everybody. We had the

county hospital there in X. Those Indians from Y and Z (nearby valleys), if they got real ill or was injured in someway, then they'd bring them in there to the county hospital. So it was more the county paying for things like that."

This situation illustrates how when federally funded providers were inaccessible, some opted for county care. In this instance the county provider was more geographically accessible and, as the respondent noted, the service was economically accessible as well for the "county paid."

In addition to services funded federally or by the county, private providers represented another option for some of the respondents in the past. A number of the respondents reported getting health care from such providers whose reputation spread by word of mouth through the Indian community. The following account illustrates the use of a private provider from whom this individual received care in the past. This particular person had private insurance which facilitated the perceived economic accessibility to such a provider.

"Well, I had my children and then they discovered I was diabetic. I remember it was in '58. I lost a real lot of weight. I got really thin, and then I start itching and then they turned into welts. I made an appointment with Dr. X. I don't know if you remember him; he died a couple of years ago. He discovered, well, he tested

my urine right away, and that's how he discovered it. I used to take insulin shots for a couple of years, and then they talked me into taking pills. So, I took Orinase for I don't know how many years. He was just a doctor in town, but it seemed like a lot of the Indians used to go to him. He was, you know, well known."

This narrative demonstrates that, for some, the private provider of Western health care represented an option in the opportunity structure. Noteworthy is that the respondent perceived this provider as "well known." When asked how she had come to know him, she said that her Indian friends had told her about him. This elder regarded the physician's treatment as efficacious. Because of insurance, this provider was economically accessible and, consequently, she did not seek care for this health problem at the Indian Health Service facility located, at that time, some 100 miles away from where she lived.

In sum, these respondents sought and received care in the past from a number of non-Indian providers including federally funded providers who were available as a consequence of the general condition of wardship. Also, the opportunity structure included other options such as locally funded providers and private providers. The accessibility of the options had consequences for this health action/interactions and, generally, respondents sought care from those who were perceived to be economically and

geographically accessible. When many of these respondents were children, limited transportation intensified the great distances between the Indians seeking care and non-Indian providers. In later years as transportation improved, accessibility to these services, and options, increased.

Summary of Past World

This section of the analysis explored the past world focusing upon conditions and their consequences for health perceptions and actions/interactions. Conditions relevant to health among this aggregate included the past world and its subdimension of adversity, as well as the core dimensions of wardship, and opportunity structure. Health perceptions emerged as a consequence of the process of defining health and its subprocesses of evaluating signs of sickness, incorporating the perceptions of others, and finding cause. Health actions/interactions of the past world included practicing self care and seeking care from health care providers. Self care and care from providers included both Indian and non-Indian approaches to health. The opportunity structure's perceived accessibility--both geographical and economical--emerged as an important condition for the process of seeking care from providers. Finally, these individuals engaged in two other processes important for seeking health care: evaluating efficacy and synthesizing old and new. These considerations of the past

world hold relevance for the analysis of the present world which follows.

Present World

This analysis of the present world focuses upon contemporary conditions and health perceptions and actions/interactions. This section of the chapter reconsiders dimensions previously discussed by comparing their present characteristics with those of the past. Also, this section explores subdimensions and properties which are specific to the present world. The majority of the respondents in this study survived the harsh conditions of the past and emerged as "pragmatists," i.e. sophisticated consumers of health care who were generally willing to test out a variety of solutions for their health problems in search of what "worked."

Conditions of the Present World

In the previous discussion of the setting in the chapter on methodology a number of factors emerged which are relevant to this consideration of present conditions. These factors include aspects of history, government, employment, housing, transportation, as well as health care options in the communities where this study's respondents resided. The present discussion analyzes the factors identified in the setting in greater depth and within the context of the core dimensions: past/present world, wardship, opportunity

structure, health perceptions and health actions/interactions.

Subdimensions of the present world, adversity, activity, and community provide the organizing scheme for this section of the chapter dealing with conditions. Wardship and opportunity structure, the two core dimensions which emerged as conditions for the present world as they did for the past, are not considered in isolation; rather, they are appreciably integrated into the discussion along with adversity, activity, and community.

Persistent adversity. Respondents described past times as "hard" and related accounts of harsh living situations, untimely deaths of parents, and bouts with disease. Generally, contemporary living situations are less harsh than those of the past. The description of the setting in the chapter on methodology describes aspects of contemporary living situations for the older adults in this study. Briefly, these elders live in a variety of dwellings from modern homes built with federal subsidies to older homes, trailers, and apartments in need of repair and having limited amenities. With only a few exceptions, the elders in this study have in their homes certain of the technology--such as radios and televisions--as do many other Americans. Migration to urban areas in search of wage work had been common during young adulthood and, during childhood, the majority of respondents left their families

and lived in boarding school. .This past pattern of migration contrasts with the present pattern in which a sense of permanence characterizes these older adults "settled" living situations. Most of the elders in this study have lived in the present area for decades ranging from two to more than five. Most retain ties with and occasionally visit family and friends in other parts of the state, and some even own land on distant reservations of the state. These individuals are not sojourners. They have established roots in the contemporary community.

Improved living conditions and, more specifically, the availability of housing, facilitates the permanence of living situations. Tribal leaders, particularly on Colony A, consider housing a priority and with the assistance of federal subsidies, substantial building has taken place. For those on the colonies, options available as a consequence of the general condition of wardship have been utilized to ameliorate the harsh living situations characteristic of the "hard times" in the past.

Those living on non-Indian land in the adjacent urban areas must seek housing options other than that available as a consequence of wardship. Housing utilized by urban Indians in this study varied considerably. One respondent who lived in the adjacent urban area discussed her concerns with regard to land ownership in the following:

"I never wanted to live on a reservation because it will never be ours. I used to tell people on our colony to buy a home and get a title to the land. Then you can build your home on it so you can say, 'It's mine.' What if the government comes and says, 'The lease is up. You have to move your home.' Where are you going to move it to? My mother, that's what she was fighting for many years. She used to tell the reservation people to fight for the land and the title for it. Then, we can build our homes on it. It's ours. This other way the government can just tell us to go. You lose everything. You've got no money to move the homes, and all the work you put into it. That's why, I'm buying this place. I never want a home until I buy it. I remember my mother and dad living up there (on a rural colony). They could never say, 'It's ours,' because the land wasn't ours. I don't want nothing like that for myself. I want a home and the land."

For this elder, ownership of land in the adjacent urban area symbolized a sense of permanence that she did not perceive as possible on a reservation or colony. She expressed a distrust of the federal government with regard to land ownership and consequently rejected some of her wardship options. Although housing and land ownership were aspects of wardship which this respondent rejected, she utilized other aspects such as the health services available

at clinic situated on the Indian colony. This case illustrates the elder's evaluation and selective utilization of wardship options.

Another elder expressed feelings about the lack of housing on the rural colony where she lived as a child. The following account reflects these concerns and illustrates using wardship options to promote change on this rural Indian land:

> "There's been a lot of changes there (the colony located in the rural area) since I left. There's new homes and it's such an improvement. You should have seen where we lived. I have an interesting experience. Years ago before they had these homes, they were talking about houses at that time. I was all for it. You know we didn't have the means to have a house. If you had the means, of course, that would be the first thing you would want. So, I kind of spoke up and wanted these homes for the people up there. So bright and early, after my children's dad went to work, oh, between 5:30 and 6:00 he went, this little old lady came down and she wasn't one bit friendly about me wanting these houses. She wanted to know why anybody would want anything like that. She said 'You people aren't going to take care of it anyway.' I said, 'If you don't bring the children up in this kind of an environment, they're not going to know anything else.' That was my argument."

This account reflects not only the seeking of wardship options in order to ameliorate adversity as characterized by living situations, but also the importance this elder placed upon housing for residents, particularly the children, of this rural colony. She describes the reaction of a non-Indian woman to the planned housing project as well as her own philosophy about how the housing was an important factor in the environment for the community's children.

Both these accounts illustrate difficult interactions these individuals have had with the non-Indian world, and they provide further evidence of this aggregate's ability to pull through and survive adversity which in this situation meant interacting with a non-Indian world to change harsh living conditions.

In sum, a variety of living situations characterized the present world and, generally, the adversity reflected by past living situations has improved considerably. A number of the respondents utilized their wardship options to ameliorate housing needs while others rejected these options and obtained housing through other means. In all, present living situations were in sharp contrast to recollections of those in the past. One of the respondents noted, "It's such an improvement."

It is notable that there are other older Indian adults with whom this investigator is familiar because of her clinical practice who live in situations considerably

harsher than those described above. These other individuals include those with severe health problems, severely limited economic resources, and/or minimal support from family and friends. A caveat with regard to the living conditions presented in this discussion is, therefore, in order: not all older Indian adults live in the housing situations described above. Generally, these older adults, those described in this analysis and the others who are known to this investigator from past clinical experience, would present to a community health nurse as a typical caseload of clients who have much variability with regard to where and how they live. However, the majority represent families having limited economic resources and struggling with problems which in this analysis cluster under the subdimension of adversity.

Even those in this sample who have access to modern technology, transportation, and health care, still confront adversity. Adversity emerged in the present world most frequently as the untimely death or other demise of adult children which consequently placed complex family responsibilities upon these older adults. Many of these respondents have raised, or were in the process of raising, grandchildren. One respondent described her experiences with adversity and the consequent responsibilities in the following:

"We raised them (three grandchildren). They were abandoned, those kids. We raised them from babies. High chairs to young men, now. They're good kids. They don't drink or, you know, use anything either."

Another elder whose daughter had died recently at age 36 noted:

"Two years ago I lost my daughter. She had a heart attack. She left two children--teenagers--and there was nobody to take them, so I had to take them. She was buying a home up here that was a HUD home and had been paying on it for ten years. Well, after she passed away the kids didn't have enough of (X) tribe in them; so, they were told that they couldn't keep the house. The boy was not quite 17 and the girl was 14."

These accounts reflect the responsibility for child care which evolved as a consequence of a contingency: the death or inability of adult children to parent their children. In addition to these cases, some of the adult children of these elders maintained major parental responsibilities but the grandchildren required care while their parents worked. The elders often assumed the responsibility for this care. Frequently, the only respite from these daily tasks occurred when children attended public schools or, for those children aged three to five, "Headstart" programs. Respondents perceived child care duties as both a pleasant task and as a burden. One elder discussed the restraints as well as the

joys of these tasks which she took upon herself after her daughter's death:

> "I think they (grandchildren) keep you active. If it wasn't for them you'd be sitting on your 'you-know-what' and then pretty soon you wouldn't want to get out, but now you have to go and see where they're at and what they're doing and that's exercise for me. But I don't want to take care of any more kids! I don't want to (laughs). I think, I want more freedom. You know, I want to go when I want to. I don't want to say, well, I can't go because I have to watch (grandchild). When my friends go, I want to go."

For this elder her enjoyment and the stimulation of caring for her grandchild contrasted with her perception of the concomitant limited opportunity to participate in other activities. These perceptions are not unlike those of others, regardless of ethnicity, who are responsible for the care of children.

The child care responsibilities described above had consequences for health actions/interactions. With regard to what can be considered here as mental health, several respondents noted they were unable to attend senior lunches because of child care responsibilities. The child care responsibilities sometimes socially isolated these elders and limited their participation in tribal functions. Another elder informed this investigator that she did not

seek health care at the nearby clinic for a physical ailment because of her responsibilities for her grandchildren. Thus, these responsibilities for the care of grandchildren have consequences for health actions and interactions.

In all, adversity emerged as a subdimension of the present world manifesting itself most frequently by the untimely death or other difficulties associated with adult children and the consequent responsibilities for the care of grandchildren. Although these adverse events presented as contingencies impinging upon the lives of these older adults, these individuals seemed to have more control over events in the present world than in the past and were able, perhaps by virtue of maturity, to manage responsibilities and pull through. As noted previously in the past world, one elder said:

> "I'm doing all right. I do things, you know, especially doing things that I'm doing now. `Cause I've worked hard all my life, hard work, very hard, and I raised my six children and now my three grandchildren. Yeah, their mother died. So even then, I don't feel so bad."

Activity. Activity, which emerged as a subdimension of the past world, was more variable in the present world. For some, activity remained a major facet of daily life and certainly the respondent above who describes her responsibilities for the care of her grandchild exemplifies this group's "vivaciousness." For another elder living in

the adjacent urban area who did not have the responsibilities of child care, activity still was an important factor in her daily life as indicated in the following:

> "I go outside and work in my garden every day. I have beefsteak tomatoes out there and some tomatoes that are acid free. They have no acid whatever in them, and I have those growing out there. Oh, I've got flowers, too. I water my plants all the time. And I walk! I walk!"

Gardening and exercise were two of the activities reported by this respondent who appeared younger than her stated age of 75. Although this individual had several chronic health problems, none constrained her activity, and she continued to lead a vivacious life.

In contrast, for other respondents activity was not characteristically vivacious; this group reflected, instead, a sense of "weariness." One of the elders in this latter group had limited mobility which constrained much of her activity. The following reflects her consequent weariness:

> "I'm just tired out. Every day is the same. I'm getting old and that's all. Just old. Yeah. I can't do much work. Nothing no more like I used to, you know. I can't get around without my cane now. I used to, but now I can't."

This client's perceptions of her activity and health will be explored again in greater depth later in the chapter. For purposes of this discussion, they represent how chronic health problems render activity problematic for some of these older adults. This client also noted that she was unable to walk to the community's clinic any longer and that she had to rely on others for transportation. The activity which was so characteristic of her past has been tempered in the present by chronic health problems--problems which afflict other older adults, regardless of their ethnicity.

The analysis considers activity and chronic health problems again in the discussion of health perceptions and actions. These factors have relevance for this discussion in that they represent a component of the conditions related to health which these older adults face. Chronic health problems managed by these elders and reported to this investigator included (utilizing their terminology): ulcers, weight problems, arthritis, diabetes, deaf(ness), eye problems, and high blood pressure. In the past, these respondents confronted devastating communicable disease; in the present, chronic health problems have replaced communicable disease a formidable adversary.

Community. Community which emerged as a subdimension of the past world has relevance for the present world as well. The historical community evolved as respondents had

intersecting life careers in a number of arenas which included not only "usual" interactions with family and friends, but also interactions in the boarding school and in health care settings. (The latter two social situations emerged as consequences of wardship and the opportunity structure.) Repeated interactions produced a web of friendships, family relationships, and ties between and among kith and kin which encompassed not only the settings involved in this investigation, but the entire state as well.

It is not uncommon for a community health nurse practicing in the state to encounter an individual in her service area who is staying with family and/or friends because they need care for a health related problem. Although the individuals in this study represent a relatively stable aggregate with regard to living in one setting, this does not preclude periodic trips to visit others in the state and to rely on them when in need of assistance for health related problems. The reader will recall that the use of the term community here is not limited to an area with geographic boundaries, but rather it means one which operates at a symbolic level--upon the ties individuals have with one another and the shared understanding of symbolic boundaries as noted in the past world.

The community in this investigation has the property of "gemeinschaft," a concept developed in 1887 by Ferdinand Tonnies along with the concept, "gezellschaft." According to Tonnies, as interpreted by Martindale (1981), the characteristics of gemeinschaft include fellowship, kinship, neighborliness, family law, extended kin groups, land, family life, and concord. Gesellschaft, in contrast, includes exchange of money contracts, city life, legislation, and rational life. In the community described in this investigation, generally, there is much intermarriage, extended families often live together, and much interaction takes place. The community, the boundaries of which are shared symbolically by the majority of the respondents in this study, represents Tonnies' "gemeinschaft."

These polarities, gemeinschaft/gezellschaft, are Weberian "pure types." The concepts provide a guide for the clustering of the discoveries of this study, and cases arise which are exceptions to the types. Variation with regard to the concepts depends particularly upon sites where the respondents resided. For example, colonies illustrate more closely the characteristics of gemeinschaft. (The reader will recall the discussion of Colony A and Colony B in chapter three.) This phenomenon is particularly present on Colony A where intermarriage between families is common and familiarity between families and evidence of

neighborliness exist. For example, on Colony A a community center is frequently utilized for gatherings. Many of the colony's residents attend dinners prepared for holidays such as Mother's Day, Thanksgiving, birthdays of colony residents, and other miscellaneous occasions. These events illustrate the sharing of food and comradeship characteristic of gemeinschaft.

As for the elders residing in the adjacent urban areas, they often know and share family ties with those on the colonies and with others in the urban area, itself. Familiarity exists although it is without the same intensity as on the colonies. For the several elders in this study who were native to another state and lived in the adjacent urban area, these ties were less apparent. For such elders, the concept of gezellschaft would more aptly apply.

The familiarity characteristic of the majority of this sample had consequences for health actions/interactions. As noted in the description of the setting, the governing body of the tribal groups administers funds awarded by the federal government for health care services. Particularly on Colony A, this situation rendered privacy problematic. The reader will recall that on Colony A, a centrally located clinic provided health care services to colony Indians as well as to those living in the adjacent urban area. The tribal council in this community frequently discussed health problems of various members of the community in order to

provide evidence for or against the performance of the health services staff. It was not uncommon for the specific details of an elder's health related problem to arise in public meetings of this body. In this community, characterized by gemeinschaft, health became a collective matter and was frequently politicized with considerations for privacy disregarded.

In addition to this public disclosure of health related problems, there were other instances of privacy being problematic with regard to the delivery of health care services. Many of those involved in the delivery of health care services include residents of the colony itself and Indians who reside in the surrounding urban area. There is much familiarity between staff and patients based upon ties with family and friends. As a consequence patients often have little anonymity on clinic visits as they are generally known by the staff as well as those who are seated in the waiting room. Moreover, findings of a clinic visit may be discussed outside the boundaries of the professional clinic situation. Some of the respondents in this study identified this familiarity and its consequent lack of privacy as a problem for the community. One respondent expressed this concern in the following:

> "You know what's the biggest problem over there? Confidentiality. People who work in there, if they just keep their mouths shut, the people outside wouldn't

> hear. If you tell the doctor or somebody that something is wrong with you, then you don't want anybody to know that you got some kind of a disease, cancer. You don't want nobody to know about it. It's between you and the doctor and that one person puts it on your record. But at the colony they've got the wrong person to write up some of them things. Yack, yack, yack all the time."

Interestingly, this respondent expressed the thought that "uptown," in non-Indian health care settings, confidentiality would not be as much of a problem as it was for those residing on the colony.

Several of the urban Indians also noted privacy was a problem. For example, one of the urban Indians told this investigator that a member of the clinic staff was a close relative and that she was uncomfortable with this individual's knowing about her health problems so that the problem was not confined solely to the colony residents but affected urban Indians as well.

While some expressed concern regarding this issue of privacy, for others familiarity was reassuring and was perceived positively. For both groups of respondents, the familiarity, characteristic of gemeinschaft, held consequences but perceptions of this situation varied as to whether or not this was favorable or unfavorable. In general, the situation illustrates how the lack of privacy

characteristic of gemeinschaft became an integral component of the opportunity structure as supported by the general condition of wardship.

Conditions as reflected by other data sources. In addition to the data gathered specifically with this aggregate, this investigation has also considered data from articles in local newspapers which reflect conditions in the present world among this aggregate of Native Americans. A consideration of two of these news articles follows.

In the first instance, a group of men had drowned while fishing at a lake situated on an Indian reservation thirty miles from Colony A and its adjacent urban area. Frequently, when a drowning occurs, speculations emerge in the media as to the supernatural causes of the tragic events, and these speculations were the focus of the news article considered here. After a review of these possible supernatural causes for the accident as well as the causes for the bodies not resurfacing or being found on the shores of the lake, the tribal leader of the reservation was quoted as saying:

> "A lot of legend is associated with the lake, but I don't think there is some mysterious reason (for the bodies not being found). I don't give much credence to anything other than a scientific reason for them (the bodies) not resurfacing."

In another recent event, a local art gallery held an exhibit of an Indian photographer native to the state. A flyer which described this self-taught photographer contained the following remark:

> "I want to show non-Indian people that we wear Nikes and designer jeans, eat at McDonald's, watch Monday Night Football, and some of us even watch the stock market."

These remarks reflect the integration of non-Indian perceptions and interactions into the social situations of this aggregate of Native Americans. Certainly, variability exists with regard to these portrayals of contemporary life among this aggregate, the elders and their families. Yet, what continues to emerge in this investigation is that conditions of the present world among these respondents have as much variability as one might find in a typical community health nurse's caseload and that many of these conditions are in contrast with the images portrayed by nursing textbooks as presented in the review of literature.

Summary of the present conditions. In this study of an aggregate of urbanized, Native American elders, this investigator discovered present conditions which, generally, represent an improvement over those in the past. Adversity persists in the lives of a substantial portion of these individuals, and some had lost adult children and bore the consequent responsibility for the rearing of grandchildren. Activity, which had been a predominant factor in the lives

of these individuals in the past, had much variability; some of the elders continued to have lives characterized by vivaciousness while others reported a sense of weariness. Finally, the symbolic community which emerged in the past world and included those characteristics as described by the theorist Tonnies as gemeinschaft, had consequences for privacy and had become intricately weaved into the opportunity structure and the health care options provided by the community clinic. This situation also connects with the general condition of wardship.

From the perspective of a community health nurse, these individuals represent a typical caseload of older adults who have some of the conveniences and amenities of contemporary American life as well as some access to health care. Yet, at the same time, these individuals continue to struggle with persistent adversity, particularly with members of their own families, and manage chronic health problems. The next section of the present world, health perceptions and actions/interactions, considers these health problems in greater depth.

Health Perceptions and Actions/Interactions in the Present

This section of the chapter focuses upon present health perceptions and actions/interactions among members of this aggregate of urbanized, elderly Native Americans. The discoveries previously considered, including the past and present conditions and the past health perceptions and

actions/interactions, provide the background for this discussion. This discussion draws the present health perceptions and actions/interactions into the foreground by analyzing the characteristics of these core dimensions, considering their linkages to the study's other core dimensions, and comparing them with those of the past.

Defining health. Perceptions of health in the present emerge, as did those in the past, from the process of defining health. These elders characterized the nature of their health utilizing the subprocesses of defining health noted as important in the past world: 1) evaluating signs of sickness, 2) incorporating the health perceptions of others, and 3) finding cause. On occasion, elders utilized a fourth subprocess to define their present health, "evaluating doing, working, and getting around." From these subprocesses emerged definitions of health which, as was the case in the past world, were distinguished by the properties: sound, frail, or qualified. These perceptions provide the conceptual structure for the actions/interactions to follow later in the discussion.

In contrast to past perceptions of health, whereby the majority of recollections characterized health as having been "sound," present health perceptions separate fairly evenly with regard to their being sound, frail, or qualified. Although those who consider their health as sound usually reported some form of chronic health problem,

it did not emerge as serious enough to warrant an understanding of health that is less than sound. In response to the question, "How is your health?", this group of elders replied:

> "It's really pretty good. I was in a car accident a year and a half ago, and I was really disabled for awhile. I still have some problems, but I'm able to get around and do things, take care of myself mainly. I couldn't do anything, let alone cook. Everybody had to do for themself."
>
> "Well, it's fine. I mean, I found out in June I was a borderline diabetic, and so I started on a diet. I lost a lot of weight, and I feel good."
>
> "Pretty good. Well, my sugar runs pretty good."
>
> "Well, I don't have to go to the doctor very often; only once every three months. I think I'm pretty healthy."
>
> "Fine, I'm not having problems like I did before, and I go to the clinic at least once a week."
>
> "Well, I went for my regular check up and that doctor said I was doing pretty good."

These remarks illustrate how these respondents characterized their health as sound, for they describe it as "fine," "pretty good," and make statements such as, "I feel good," and "I'm pretty healthy." Moreover, the responses reflect the subprocess of evaluating signs of sickness in their considerations of blood sugar levels, weight loss, and

the absence of sickness, itself. Additionally, in the first response the elder not only evaluates the signs of sickness, but also "doing" and "getting around."

Also, the above responses demonstrate how some of these elders incorporate health perceptions of others into their own. For example, one respondent sees her health as "good" because her blood sugar is perceived as "good"; another respondent considers her health as good because, as she indicates, the doctor said she was "doing pretty good." In sum, these respondents define their health as sound, and their perceptions reflect the subprocesses of evaluating signs of sickness and incorporating the health perceptions of others.

As one might expect in a group of older adults, considerably more respondents characterized their present health as frail in contrast to that of the past. These perceptions differ from the past in which those who perceived their health to be frail were often equivocal and obscure with regard to their health definitions; in the present, these definitions more precisely reflect the processes of finding cause and evaluating signs of sickness. The following examples, in which the respondent replied to the question, "How is your health?", illustrate these frail interpretations:

> "Not too good. This stomach, it is giving me a lot of trouble. Of course, I've had it for years, off and on."

"Oh, I get headaches. A friend of mine told me that maybe my blood pressure is high".

"My health is kind of sketchy. They recently found in an x-ray that I got an opening in my heart somewhere."

"I want to be able to get around. I've fallen eight times with my walker."

These respondents defined their health by evaluating signs of sickness including headaches, stomach "trouble," and an x-rayed heart defect. In addition, the last respondent defined her health by evaluating her ability for "getting around." In two of the above responses, the older adults found the cause for their perceived health problems; in one case, the respondent perceives high blood pressure as the potential etiology of her headaches and, in another, the respondent attributes her "sketchy" health to an "opening in her heart."

A third group of respondents perceived their health as qualified. Qualified health was fairly sound, but respondents assigned specific restrictions to it. Examples of responses which illustrate health as qualified follow:

"Well, I went for my regular check up--monthly--and the doctor said I was doing pretty good. But the only trouble is that I still have these headaches. Everyday, everyday. Like right now I'm having it. It's just like a burning feeling all the time."

A respondent who expressed concerns about recurring cancer characterized her health in the following:

"It could be worse."

Another respondent who expressed concern with regard to her weight stated:

"I'm not really healthy, but I'm not sick either. I should walk more."

As with the qualified perceptions of the past, the respondents assigned restrictions to these otherwise fairly sound definitions of their health, thus, characterizing the nature of their health as "qualified."

In addition, these responses illustrate the process of incorporating the perceptions of others. In the first case, the elder noted that the persistent headaches which she experienced rendered the validity of the provider's impression questionable for her. In contrast, both of the other respondents incorporated the perceptions of others; in one case, the elder perceived her cancer as arrested since her physician told her he could find no further signs of this sickness; in the other case, the respondent's provider had counseled her about her weight as a health problem and had told her to "walk more" in order to remedy this problem.

The subprocesses. Generally, most respondents, whether they characterize their health as sound, frail, or qualified, evaluated signs of sickness when defining their own health. The majority reported having one or more

chronic health problems including diabetes, hypertension, heart disease, and arthritis and often utilized sophisticated medical terminology such as "pancreas," "insulin shock," and "palpitations" in the descriptions of these ailments. Instances arose in which the respondent's reported health problem sent this investigator to the medical dictionary.

Additionally, respondents reported having common, mundane ailments including diarrhea, headaches, colds, and flu which also become focal points for the construction of health definitions. When concerned about signs of sickness, the respondents tended to perceive their health situations as negative whereas when signs were not perceived as a concern, the elders viewed health positively. In all, evaluating signs of sickness was critical for defining their own health. One respondent stated simply:

"I guess I'm all right. I don't feel sick."

Finding cause was another important subprocess encompassed by the process of defining health. This subprocess has particular relevance for this study since a body of literature exists in nursing textbooks which portrays a unitary view of Native Americans in which illness is perceived as having supernatural etiologies. In contrast, the respondents in this study generally reported the etiologies of their sicknesses in terms of medical science. One respondent who was a diabetic said she had the

disease because her "pancreas was dead"--a medical, pathophysiological interpretation. Another respondent who had recently experienced an episode of severe diarrhea said he thought the symptoms had been caused by "spoiled milk"--milk he reportedly left out of the refrigerator during the night and then used on his cereal. This "spoiled milk" interpretation again has a basis in medical science, i.e., the germ theory. Others articulated the relationship between weight gain and high blood pressure, stress and ulcers, and insulin shock and an excess of insulin in the bloodstream.

In sum, rather than finding causes for their sicknesses which were supernatural in nature, these elders generally based their interpretations on medical science. The following quotation from a 65 year old woman demonstrates such an interpretation:

> "Well, I was bothered with a weight problem, and I don't know what year this was, but I weighed 215 pounds and had high blood pressure besides. So the doctors put me on a salt free diet. I was on a salt free diet for over a year before I came down to 195, and I was just absolutely thrilled to be down to 195 lbs. My last weight now was 165 and I've been without my blood pressure medicine."

This woman associated her hypertension with her weight and

diet. Again, this response illustrates how the perceived cause was found within the realm of medical science.

Summary of health perceptions in the present. The respondents in this study characterized their health as sound, frail, or qualified as a consequence of the process of defining health. Defining health has a number of subprocesses including evaluating signs of sickness, incorporating the health perceptions of others, finding cause, and evaluating doing, working, and getting around. Generally, respondents utilized sophisticated medical terminology to describe their health perceptions and evaluate signs of sickness and were familiar with categories of disease based upon medical science. These specific and general understandings of health provide the conceptual structure for the health actions/interactions which follow below.

This next portion of the chapter explores present health actions/interactions and, more specifically, the processes of practicing self care and seeking care from providers. As in the past world, self care refers here to those actions and interactions which are not directed by health care providers but are undertaken by the respondents in this study or by their family members in their behalf. The purpose of such actions is to manage health and its perceived problems. Self care, here, includes both Indian and non-Indian approaches to health.

Seeking care from providers in the present includes providers primarily from the Indian Health Service and those providers in the health care arena who are commonly available to other Americans living in urban areas. More discussion on who these latter providers are follows later in this section of the chapter. Seeking care encompasses not only the process of "seeking," itself, but also "obtaining" care. This section considers these two processes and explores how they link to the other core dimensions in the study as well as how they compare with the health actions/interactions of the past. Evaluating efficacy is also important in the present world and will be appreciably integrated into this discussion as are the core dimensions of opportunity structure and wardship.

Practicing self care. The respondents in this study reported a number of practices which, for purposes of this study, represent practicing self care. Elders generally reported practicing self care for mundane ailments such as colds, diarrhea, and minor arthritis. Frequently, the elders reported shopping at local drug stores and purchasing over the counter medications for the treatment of their health related problems. For example, when asked what she did for a cold, one elder replied:

"I take Alka Seltzer. I don't take aspirin."

Another respondent discussed practicing self care for her

shoulder which she had injured in an automobile accident and said:

> "I had arthritis after my car accident. I had it in my arm and my shoulder here. Kind of sore and stiff in the joint. So, I used to rub that with Ben-Gay."

Others reported using a variety of over the counter remedies including Alka Seltzer, aspirin, Ben-Gay, Pepto-Bismal, and Nuprin for their various ailments. These reports support the idea that for the care of common, mundane ailments, these elders frequently utilize typical, "American," over the counter remedies. The opportunity structure, and, particularly, its subdimension of accessibility, are closely linked to these self care practices; a consideration of this link follows.

The opportunity structure represents perceived health care options, both traditional Indian and non-Indian, available to these elders. Just as individuals construct interpretations with regard to their health, they also make interpretations of the opportunity structure. Although the existence of an option may be perceived, it still may be interpreted as inadequate, too costly, too far away, etc. In particular, respondents interpret the opportunity structure with regard to its informational, geographical, and economical accessibility. These subdimensions of accessibility are important for practicing self care in the present.

Informational accessibility in this discussion represents the accessibility to knowledge regarding health care options, both Indian and non-Indian. A number of the respondents reported only fragmented recollections of traditional Indian practices for the treatment of sickness. Often individuals perceived traditional treatments as efficacious and indicated they would continue to use these treatments if they had knowledge of the treatment's details. Knowledge regarding a self care practice, its informational accessibility, provides an essential conceptual structure for consequent health actions/interactions.

Limited informational accessibility emerged as a consequence of limited exposure, or, again, access, to those who were the repositories of knowledge in the past. As noted in the past world, a substantial portion of these respondents reported that one or both of their parents had died when they were children before they had the opportunity to learn and practice traditional Indian approaches to health care. Older Indians, who were parents and grandparents, were repositories of knowledge for the traditional practices. One respondent noted this lack of knowledge in a discussion of her own experiences during childbirth:

> "If I could find a way that someone could help me, I'd have had them (her babies) at home, but, uh, like if I had a mother that would help me. I lost my mother when

> I was 17 and I would rather had it that way but you needed somebody that was close and could take care of you. I never had any at home, but I just would assume it would be better because they had ways that I don't know about. Usually after my children were born, I always had chills so bad. The Indians kept them (new mothers) warm, and they let them sleep on the ground where they heated rocks."

In sum, this woman perceived a void in her knowledge about traditional practices of childbirth. She had lost her mother, a repository of this knowledge, before she was able to obtain from her an understanding of these traditional practices. The elder perceived this information as inaccessible. Other instances of not having access to repositories of knowledge occurred in the past world when the respondents were separated from their families and sent to the Bureau of Indian Affairs boarding schools. These instances, too, have consequences for present health perceptions and actions/interactions.

Whereas the accessibility to the knowledge of traditional practices has declined, information, which is predominantly commercial and medical, has increased concomitantly. As noted earlier, the majority of these respondents own televisions and watching soap operas is commonplace. Characters in these television dramas experience sicknesses reflecting medical understandings of

health; moreover, advertisements for commercial, over the counter treatments bombard these individuals via television. One respondent hurriedly ended an interview with this investigator because a soap opera which she watched faithfully each day was beginning. Television is a vehicle for the transmission of ideas, including health perceptions, and contributes to the informational accessibility of commercial and medical perceptions of health among members of this aggregate.

In addition to television as a source of information about commercial and medical ideas of health, respondents in this study had a number of other sources of information for self care. Friends and family members would often recommend over the counter remedies, such as Pepto-Bismal and Alka-Seltzer. In sum, a number of sources facilitated the informational accessibility of commercial and medical ideas of health utilized in practicing of self care.

In addition to informational accessibility, geographical accessibility to over the counter remedies also emerged as having consequences for practicing non-Indian self care. The following quote illustrates this geographical accessibility in a response to the question of why the traditional Indian treatments had been lost over the years:

> "You can go to the drugstore and get headache medicine from there or the grocery store. They've got all the stuff that you want."

For this elder the medications she might "want" for self care were geographically accessible at the drugstore and the grocery store. Moreover, she informed this investigator that she perceived that this accessibility contributed to the declining use of traditional Indian treatments.

In contrast, indications are that geographical accessibility to traditional Indian self care treatments is declining. For example, one respondent was experiencing a cold when this investigator interviewed her. When asked why she was using Alka Seltzer instead of a traditional Indian treatment for this health problem, she answered that there was a brush that she had used for colds when she was younger, but it grew in the desert near her hometown some eighty miles from where she now resided. Since her family was currently without an automobile, travel to this remote desert area was not feasible. For this elder this Indian self care treatment was perceived as geographically inaccessible.

In sum, perceived accessibility, both informational and geographical, has important consequences for practicing self care among these elders. Decreased informational and geographical accessibility have had consequences for the use of traditional Indian self care practices. As informational and geographical accessibility to commercial and medical approaches to self care has concomitantly increased, so have the health actions and interactions which have their basis

in these health perceptions. The discussion which follows considers seeking care from providers and accessibility is linked to this process as well.

Seeking care from providers. The providers in the present world are primarily those employed by the Indian Health Service and those other health care providers commonly available to urbanized Americans. Elders in this study usually sought and obtained care from the providers at the tribal clinics supported by Indian Health Service (IHS) funds. Other providers included private physicians, chiropractors, and pharmacists. A discussion of the interactions with these non-Indian providers follows as well as a consideration of seeking health care from Indian providers in the present.

A health clinic is centrally located in Colony A and the tribal clinic which serves Colony B is a forty-five minute drive away. For elders living on Colony B, transportation is provided by tribal staff and staff from urban programs also provided transportation to clinics for those living in the urban areas adjacent to both colonies. At times problems arise with regard to this transportation service, but, generally, elders utilize it effectively in order to keep appointments with providers in the tribal clinics and with other providers in the adjacent urban areas.

Those living on Colony A perceived the clinic as geographically accessible. Those without mobility problems were easily able to walk to this clinic which was only a few blocks for most. Transportation was provided for the others. The following account, in which the respondent commented upon her perception of how the health of Indians had generally improved over the years, illustrates this geographic accessibility:

> "Oh, God, there's a lot of improvement. I think. You know, it is real easy. You can just walk over there (to the clinic); unless you are really sick, and then you could just call them. I've never done that, but I'm sure they would call the ambulance or something."

Many of the elders discussed the remoteness of health care in the past when the Indian Health Service hospital was located some one hundred miles away from the site where the above elder lives, and one had to cross the state's desert in order to gain access to this facility. In contrast, this comment reflects the proximity of Western health care, particularly outpatient care, to these elders in the present.

In addition to the outpatient care obtained at the clinic, a number of these respondents obtained health care which required inpatient stays during their adulthood. Often, these stays followed surgery which for these respondents included: a hysterectomy, herniorrhaphy, dental

extractions, cataract extractions, a gastrectomy, a coronary artery bypass, and a cholecystectomy. The surgeries took place at both the Indian Health Service facility located some one hundred miles away and at local hospitals under what was described in the literature review as "contract care."

In sum, the respondents have had multiple interactions with Western, non-Indian health care providers in both inpatient and outpatient settings throughout their adulthood and into the present. In many instances, these interactions were a consequence of the general condition of wardship, for these respondents were eligible to obtain these services as a consequence of their wardship status. As a consequence of general condition of wardship and its emergent opportunity structure, these elders sought and obtained care from Western, non-Indian, health care providers in order to manage their health and its perceived problems.

In addition to the options which evolved as a consequence of the general condition of wardship, options commonly available to other urbanized Americans are, on occasion, perceived as accessible and sought by members of this aggregate. These other options include providers such as pharmacists, chiropractors, and private physicians. A discussion of these options and interactions with providers follows.

In one case, an elder reported she had sought care at the tribal clinic for her arm which had been "itching," and she obtained a medication which she did not evaluate as efficacious. She continued to perceive the situation as a health problem and consequently sought care from a pharmacist at a nearby drug store. The following account describes her interaction:

> "I was worrying about my itching arm, and I went to that doctor down there at the clinic, and he didn't help me much at all. I had to go to the drug store and show them my arm. He (the pharmacist) said, 'You've got allergies.' So, he gave me some pills and some other lotion to put on and that worked."

In this case the Western health care at the drugstore was not only geographically accessible but perceived as more effective than the care obtained at the tribal clinic. This respondent appraised the efficacy of two sources of Western health care, and she based her health interaction upon her evaluations. Her identity as a "pragmatist" emerges from the above description for she sought and finally found a treatment that "worked."

In addition to this case in which the respondent sought care from a pharmacist, respondents also reported seeking care from private physicians in the community. This practice was most common when the elder had private insurance which only several had. Also, elders would

occasionally seek care from private physicians when they were eligible for state medicaid which covered such services. Generally, elders used options when they perceived them as economically accessible.

The discussion of the past world considered other instances of elders using private physicians; generally, this practice seems to have been more common in the past world than in the present. In the past world, the options linked to the general condition of wardship were sometimes perceived as geographically inaccessible; while in the present, wardship options are usually perceived as geographically accessible. Thus, in some instances, the perceived accessibility of wardship options has consequences for seeking health care from other providers.

In addition to private physicians, one respondent had sought care from a chiropractor for neck pain which she perceived as severe. In a discussion of this pain she said:

> "Maybe I should go to the chiropractor sooner, but he told me to come on the ninth. 'Cause he's been working on my neck. There for awhile he worked on me every other day, and it seemed to get better. He worked on my hip, too."

This respondent considered the chiropractor a viable option for health care. The economic accessibility of this provider was facilitated by insurance held by this elder.

She concomitantly sought health care from the tribal clinic, and thus, interacted with a number of non-Indian providers .

In summary, these elders sought and obtained health care from a variety of health care providers in the present including private physicians, pharmacists, and, even, a chiropractor. Accessibility to these providers was facilitated in many cases by the general condition of wardship. Other options were accessible depending upon the individual respondent's circumstances such as private insurance coverage or eligibility for the state medicaid program. Respondents in this study often focused upon non-Indian providers when discussing seeking health care in the present. A consideration of seeking care from Indian providers follows.

Seeking health care from Indian providers most commonly emerged from the data related to the past world. When describing perceived health problems, elders in this study generally focused upon, as noted previously, signs of sickness as categorized by medical science. The process of theoretical sampling, discussed in the chapter on methodology, yielded the discoveries regarding seeking health care from Indian providers. A consideration of these discoveries follows.

One respondent, when asked about current use of Indian treatments denied that she used any herself but added:

"Well, there's some people that use it. Yeah, there's some people that still use it. I think it helps them. It's just that they believe in it."

This woman, who, incidentally, had open heart surgery prior to talking with this investigator, did not seek health care from Indian providers, herself, but judged this option as efficacious for others who chose to use it.

Another respondent noted that she had frequently sought health care from an Indian provider in the past who was a close relative. She evaluated this care as efficacious and noted that in the present she would, on occasion, use an Indian healer primarily for injuries to herself or her grandchildren. She said:

"They're (Indian healers) still around. Yeah, yeah, instead of running to a doctor and a big doctor bill. We just go here, and they take the pain away."

This woman concomitantly obtained care from the Indian Health Service provider for her diabetes which she managed with her diet and oral medications.

Others noted that at times they had sought care from Indian providers, but, generally, non-Indian options for health care dominated these elders' perceived opportunity structures. One elder summed it up in the following:

"They don't have Indian medicine the way the old people did."

In sum, as in the past, the health actions/interactions in the present cluster around two processes: practicing self care and seeking care from providers. Self care treatments tended to be commercial and medical and closely linked to informational and geographical accessibility. Respondents frequently obtained care from non-Indian providers employed in tribal clinics and, occasionally, from private providers in the adjacent urban area. Respondents considered geographical and economical accessibility of these health care options, and they continually evaluated their efficacy. These elders emerged as "pragmatists" who were generally willing to seek out a variety of options for their health problems in search of what "worked."

Summary of the Past and Present Worlds

Five core dimensions emerged from this study of health among an aggregate of urbanized, Native American elders: wardship, opportunity structure, health perceptions, health actions/interactions, and the past/present worlds. These dimensions represent the conditions in which the respondents of this study lived and consequences of these conditions for the meanings constructed around health and the management of perceived health problems. These elders emerged as a hearty aggregate of older adults who have "pulled through" and survived adverse circumstances. They have become "pragmatists" who are generally sophisticated consumers of health care and who search for what "works."

Elders in this study constructed meanings of health primarily by evaluating signs of sickness as categorized by medical science. Respondents utilized a sophisticated vocabulary which incorporated the ideas of their Western health care providers, and they found cause for their sicknesses which reflected medical science as well. These general and specific understandings of health, the health perceptions, provided a conceptual structure for consequent health actions and interactions.

Health actions and interactions discovered in this study included the processes of practicing self care and seeking care from providers. Informational and geographical accessibility of commercial approaches to self care have had consequences for self care actions and interactions among these individuals. Moreover, as a consequence of the general condition of wardship and its emergent opportunity structure, these elders have had multiple interactions with Western, non-Indian health care providers in which they sought and obtained care in order to manage their health and its perceived problems.

In all, the health actions and interactions discovered in this study do not reflect so much the ethnicity of the members of this aggregate, but rather the interpretations they have come to give health as a consequence of years of interactions in countless health situations with Western,

non-Indian providers. The implications of these discoveries for nursing practice, research, and education follow in chapter five.

CHAPTER FIVE: IMPLICATIONS

This chapter explores implications of the discoveries which emerged in this study of health among members of an aggregate of urbanized, Native American elders. The discussion begins with a summary of the core dimensions, subdimensions, and properties found salient in this investigation. The chapter then proceeds with a consideration of these discoveries with regard to their: 1) limitations, 2) relationship to the literature, and 3) specific implications for nursing research, education, and practice. Much of this discussion arises out of the contradiction between these discoveries and the images presented in the nursing literature with regard to health among Native Americans.

Summary of the Discoveries

Five core dimensions emerged from this study including wardship, opportunity structure, health perceptions, health actions/interactions, and past/present world. These dimensions have clusters of subdimensions, properties, and processes which link together and become the components of an emerging substantive theory. This theory provides an understanding of how members of this aggregate construct meanings for their own health, in particular wellness and illness, and how they manage their perceived health problems.

Respondents in this study constructed meanings of health as a consequence of a several interrelated processes including evaluating signs of sickness, incorporating the perceptions of others, finding cause(s), and evaluating doing, working, and getting around. The general and specific understandings of health discovered in this study reflect shattered images of traditional approaches to health care and an emerging matrix of images which are predominantly medical and commercial.

Two processes represent the health actions and interactions discovered in this study: practicing self care and seeking care from providers. Consequences for practicing self care arose from the health perceptions as well as informational and geographical accessibility to commercial, over-the-counter medications. In general, respondents in this study practiced self care with commercial remedies commonly available to other urbanized Americans.

These individuals had multiple interactions with Western, non-Indian health care providers in which they sought and obtained care for their perceived health problems. The majority of these interactions took place within the opportunity structure which had emerged as a consequence of the general condition of wardship. Generally, these older adults perceived the health care options connected to wardship as accessible.

The majority of these elders were hardy individuals. They "pulled through" and survived the harsh circumstances of the past and managed chronic health problems as well as persistent adversity in the present. They had become "pragmatists" who tested and evaluated a variety of options in search of what "worked" for the management their perceived health problems.

Ethnicity did not emerge as a salient dimension linked to the health perceptions and health actions/interactions of these individuals. What did emerge as important was a social environment comprised of dimensions including wardship, the opportunity structure, and the past/present world. This discovery contradicts that body of nursing literature which represents Native Americans as a homogeneous ethnic group whose perspectives of health are most often blended with traditional beliefs and practices. This literature tends to ignore other factors in the environment which emerged in this study as relevant for health perceptions and actions/interactions.

The environment or context (Kim, 1983) which emerged in this study held important consequences for the manner by which elders interpreted their own health, more specifically wellness and illness, and managed their perceived health problems. These discoveries demonstrate the immense complexity of the interaction between and among the nursing concepts of person, health, and environment. Moreover, the

discoveries illuminated the saliency of a number of environmental factors including those which are historical, economical, political, and social for the construction of health meanings and consequent health actions and interactions.

Limitations

Generalizability. Diversity within and among the many American Indian tribes makes a general understanding of most any phenomenon, including health, among members of this population unfeasible. Intertribal diversity is reflected by the multitude of tribal groups residing within the United States whose health beliefs and practices vary from tribe to tribe (Spector, 1979). In addition, other considerations such as educational background, military experience, and employment history contribute to intratribal diversity (Ferguson, 1968). The substantive discoveries in this investigation are, therefore, limited to the members of this aggregate and cannot be applied to members of other Native American tribal groups.

Another limitation stems from the study's sample of convenience. Difficulty negotiating entre with Native American communities for the purpose of doing research has been noted in the literature (Brink, 1969; Bushnell, 1981) and those who are most comfortable speaking with a researcher may present interpretations of health which differ from those who are not. Scotch and Scotch (1963)

comment upon this problematic situation in their study of hypertension with an aggregate of Native Americans. They argue that those interviewed could have been biased in some manner and different from non-contacts; therefore, Scotch and Scotch interpret findings from their investigation cautiously. In light of these concerns, the discoveries which emerged from this study, also, need cautious interpretation. There is the possibility that non-contacts in this aggregate interpret and manage health differently from the contacts.

This consideration of diversity and the application of the substantive discoveries to other tribal groups is both a limitation and, at the same time, a strength of this research. The practice of generalizing from one aggregate to another with regard to health among Native Americans is commonplace in the nursing literature, but the substantive discoveries which emerged from this study render such these representations problematic. Therefore, the discoveries which emerged in this study, through their own limitations, bring into the foreground the same limitations in the "received" or accepted view of Native Americans in the nursing literature.

Relationship between the Discoveries and the Literature

Discoveries from this study are relevant to several areas of the literature as reviewed in chapter two. First is the relationship between the discoveries and the trend in

nursing textbooks which the above limitations considered to some degree. Briefly, the trend consists of presenting in nursing textbooks lists of traits which portray understandings of health among members of various ethnic groups. With regard to Native Americans, these lists generally represent members of this population as having a homogenous, sacred view of health which relies upon traditional Indian approaches for the management of health problems and rarely utilizes approaches based upon medical science. Discoveries which emerged in this study indicate that a unitary perspective based upon traditional images of health has been shattered among members of this aggregate of urbanized, Native American elders. Moreover, an emergent matrix of images which are predominantly medical and commercial provide a conceptual structure for health actions and interactions. Thus, this study's discoveries contradict the nursing textbook portraits of the Native American.

The discoveries in this study have relevance for a second area of the literature with regard to the definitions or ideas of health. These elders most frequently perceived their own health by focusing upon the signs of sickness--sickness which the respondents generally viewed through the categories of medical science. With regard to Smith's (1981) four models of health, these health perceptions reflect what this author would consider within the realm of the "clinical model." Several of the respondents, through

the process of evaluating doing, working, and getting around, perceived their health as "role performance," and, perhaps, the process of "pulling through" reflects aspects of the adaptation model of health.

With regard to the work done by Tripp-Reimer (1984), these elders' understandings of health locate on the wellness-illness continuum and have boundaries which intersect with the providers' perspectives on the disease-non-disease continuum. The views do not contradict each other, which is often the concern raised in discussions of cross cultural interactions; rather, their ideas of health "match" (Strauss, 1976). If, indeed, their ideas of health match, then the question arises with regard to what other factors are important for these interactions between clients and providers? This question has relevance for future research.

Implications for Nursing

The discoveries which emerged in this study of an aggregate of urbanized, Native American elders have implications for nursing research, education, and practice. These considerations are, at times, overlapping and, thus, the discussion integrates them appropriately. The implications stem from the discoveries' contradiction and agreement with the nursing literature as well as the substantive theory evolving from this research.

Nursing research. In the tradition of the constant comparative method, this study's discoveries generate a number of implications for future research. The present analysis would be enriched by further studies of the same substantive areas as well as widely differing ones. This comparative process extends the similarities and differences brought into the analysis making it more dense and, eventually, it becomes possible to formulate a formal theory (Strauss, 1987). According to Strauss, a substantive theory is one which deals with a particular topical area whereas a formal theory is one developed for a conceptual area of inquiry, such as stigma, formal organization, or socialization. A formal theory is on a higher level of generality. This discussion focuses upon what substantive cases could provide data to enrich the discoveries made here and broaden the scope of the substantive theory developing from this investigation.

Studies of other Native American aggregates would provide comparative data with regard to conditions as well as health perceptions and actions/interactions. Investigations with elders living on rural reservations as well as those residing in more metropolitan centers are warranted. Such studies might consider: What characterizes the conditions experienced by these other Native Americans? How have they "pulled through" and survived life's

circumstances? How do they construct meanings of health, and how do they manage their perceived health problems?

Studies of aggregates from other ethnic groups who are also portrayed in the nursing literature as having unitary views of health would yield comparative data. Investigations among Latino, Black, and Asian elders would yield important data for comparative analyses. Since the general condition of wardship does not apply to the social situations of these individuals, it would be important to explore other conditions which have consequences for their health perceptions and actions/interactions.

Indigenous populations, not just those living within the boundaries of the United States, represent other examples of aggregates with whom similar research would provide fruitful data. One such population could be Australian Aborigines. Theoretical sampling with regard to the conditions which bear upon health would provide rich comparative data for the conditions of wardship, opportunity structure, and the past and present worlds which emerged in this study. Also, data with regard to the construction of health meanings and management of perceived health problems in relation to the health perceptions of their providers would also yield important data for comparison.

Besides focusing upon the client, research directed toward the study of health care providers is also of importance. Areas for research include exploring providers'

understandings of clients from ethnic minority groups. Do providers' views reflect the images of the Native American as portrayed in the nursing literature? If so, do these images have consequences for health interactions? Study of the perceptions held by nursing educators and nursing students with regard to members of ethnic minority groups is equally important.

Each of the above illustrates how investigations, which are both similar to and different from the present study, could provide data for comparative analysis. Through this process of analysis, health perceptions and health actions/interactions, which emerged as core categories in this research, could be raised to a higher level of generality, and the scope of the emergent substantive theory would be broadened potentially becoming a formal theory.

Nursing education. The emergent substantive theory holds implications for nursing education with regard to two areas: 1) the utilization of extant cross cultural nursing knowledge in teaching situations, and 2) the goals of cross cultural nursing education. Utilization of cross cultural knowledge, itself, requires critical evaluation, for that which is commonplace in undergraduate nursing textbooks presents homogeneous portraits of ethnic minority groups which often has little empirical basis. An account by one member of an ethnic group does not necessarily represent the perceptions of other members of that group; such accounts

are valuable, but their value lies in their representation of a reality as constructed by a single "informant." These accounts require judicious interpretation by nursing educators for they are commonplace in nursing textbooks which present cross cultural knowledge.

As for the goals of cross cultural nursing education, the discoveries in this study suggest that variability in health perceptions and health actions/interactions exists among Native Americans in the United States. Teaching cross cultural nursing by utilizing lists of traits that create images of ethnic minorities as homogeneous discounts the heterogeneity among these groups.

Nursing educators, particularly undergraduate nursing educators, frequently discuss the importance of teaching students not about the operations of specific technological procedures and equipment, but rather about critical thinking, problem solving, and applying the nursing process. Teaching nursing students about cross cultural nursing is analogous to this situation for the trait list approach is comparable to the mechanistic approach of teaching specific technological procedures. Implied here is a teaching approach which increases the student's ability to assess and become sensitive to the client's health perceptions and actions/interactions which may differ from the student's own. Also implied here is the importance of teaching students about those conditions which have consequences for

health perceptions and health actions/interactions; these conditions include ethnicity as well as other factors in the client's social environment.

In summary, the substantive theory which emerged from this investigation of health among members of an aggregate of Native American elders has implications for teaching strategies in the area of cross cultural nursing. The empirical basis of cross cultural nursing knowledge requires scrutiny. Accounts which represent the view of one member of an ethnic minority group do not necessarily correspond with the views of other members of that group. Trait list approaches to the presentation of cross cultural nursing knowledge promote images of ethnic minorities as homogenous groups; alternative strategies include an emphasis upon assessment and sensitization to clients whose health perceptions, health actions/interactions, as well as living conditions, differ from the student's own.

Nursing practice. The discoveries which emerged in this study have implications for nursing practice which are twofold. The first implication is the more obvious. The discoveries reflect the importance of adequately assessing the client's health perceptions and health actions/interactions and basing nursing care upon individual assessments rather than upon the "received" view of an ethnic group as represented in the literature.

The second implication for nursing practice is more subtle and requires a brief consideration of relevant literature. Holleran (1988) argues that a "greater awareness of others' cultural and ethical values and an acceptance of their way of life is essential if one expects to work beyond one's own boundaries" (p. 74). In addition to addressing the processes which the nurse experiences in working with clients of other cultures, Holleran notes that American nursing has been considered imperialistic by some in the past. This situation occurs when nursing attempts to move too fast and spread its ideas to others without "getting" as well as "giving." Holleran alludes to the importance of cultural heterogeneity which others also regard as having great value (Stauffer, 1979).

Stauffer argues that cultural heterogeneity is not only of great value, but he considers that the destruction of indigenous cultures and the neglect of cultural pluralism have consequences for human survival. "Homogenization reduces options, closes out alternative futures, increases rigidity, lessens adaptability (Stauffer, 1979, p. 271). Thus, beyond specific cross cultural interactions, loom larger concerns regarding the consequences of interactions between groups who have divergent cultural frameworks.

In this study, discoveries suggest that the health perceptions of these individuals match those of their Western health care providers. A number of factors are

related to the emergent commercial and medical images of health found among these individuals, and the process of incorporating the provider's perceptions into one's own was among these. Blumer (1969) states that according to symbolic interactionism, parties to interaction take each other's roles, i.e., mutual role taking. Given this premise, a conceptualization emerges in which these individuals interacted with Western, non-Indian providers in countless situations over a lifetime taking on the role of the other. The process of "incorporating the provider's perceptions into their own," discovered in this study, reflects this process of role taking.

This conceptualization leads to the following: these elders have interacted with Western health care providers who have been, as Holleran notes, culturally imperialistic, i.e., they have "given" with out "getting." Such situations have consequences for the maintenance of the indigenous culture. If one assumes that cultural pluralism is to be valued, then an ethical dilemma arises as to how nurses, as well as other health care providers, can interact in settings with clients from cultures different from their own and give Western health care while not contributing to the concomitant destruction of the client's traditional framework. This question has implications for the delivery of Western health care to other indigenous groups.

Chapter Summary

The substantive theory derived from this investigation of health among an aggregate of urbanized, Native American elders provides an understanding of how these individuals construct meanings for the phenomenon of health and how they manage their perceived health problems. These findings contradict the "received" or accepted view of Native Americans presented in a number of nursing textbooks by suggesting that there are members of this population who perceive their health as having medical and commercial characteristics. The discoveries further suggest that concepts such as "Native American views of health" can become "traps"--traps which restrict the variability among members of this population to emerge. Implications for nursing research, education, and practice arise from these considerations.

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APPENDIX A

Interview Guide

1. How is your health?

   Probes for specifics based upon response, e.g. What makes you think you are healthy/unhealthy?

2. What do you do to stay healthy?

   Probes for specifics, e.g. What do you do to keep yourself from getting sick?

3. Tell me about your health as a child.

   Probe for childhood illnesses, e.g. earaches and/or running ears, pneumonia, etc.

   Were you ever in a hospital? If yes, what for?

   Probe for caregiver during childhood illnesses.

   Probe for treatments of illnesses.

4. Tell me about your health as a young adult.

   Probe with women about childbearing and neonatal mortality.

5. Tell me about your health during the last ten years.

6. Many people your age describe problems like the ones on this list (show check list). I'd like you to take a look at it and tell me what problems you might have had:

   Check List:

   High blood pressure
   Heart attacks
   Diabetes or high blood sugar
   Arthritis
   Tuberculosis
   Cancer
   Liver problems
   Weight problems
   Car accidents
   Gun accidents
   Childhood accidents
   Falls
   Strokes
   Other problems, such as loneliness and other mental health concerns as appropriate

7. How do you think the health of Indian people today differs from when you were a child? What about the health services?

8. A number of people have told me about old ways of treating sickness and often they have forgotten much about them. How do you think these have been lost?

9. If you were going to make a change in the health services for Indian people, what would you do?

10. What if you became ill and needed someone to help you care for yourself? What would you do?

11. In other studies, people have said that they are concerned that when they go to get health care it isn't confidential. Do you think this is a problem?

12. Review face data as necessary:

    Age
    Marital status
    Birthplace
    When came to this area
    Places lived
    Tribal ancestry
    Tribal affiliation
    Education
        Boarding school
        History of illness in boarding school
    Family constellation
    Household composition at present
    Work history

13. Do you know of anyone else who would be interested in talking with me?

When interviewee discusses illness:

    What was done for it?

        What did you do for it yourself?

        What did a family caregiver do for it?

    Who decided you needed to go for care?

    Where did you go for care?

How far was it?

How long did you have to wait?

What was it like for you there?

Do you think they understood your problem?

How could it have been different?

If answered with a physician, etc.. may need to probe for an Indian healer, if appropriate.