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The Well-Being of Urban Indian Elders in Rochester, New York

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Urbanization is a relatively recent (post–World War II) phenomenon for most Indian people, and it is only the current generation of elders who have chosen to remain in the city rather than return to their home communities on reservations.[1] Urban American Indian elders are a population whose well-being has not been fully examined. This study focuses on a small convenience sample of urban Indian elders in the Rochester, New York, area who are active in the local Native community. Initially, we observed that many of these elders enjoy a high degree of physical, mental, and emotional well-being, despite some chronic health conditions. We suggest that their strong extended family support network, involvement in the community, and a sense of cultural continuity contribute to a sense of overall well-being.

We have chosen to focus on wellness, looking at overall health, rather than simply at illness. *Health* in this sense refers to "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," as defined by the World Health Organization.[2] Weibel-Orlando used a similar approach to look at Indian elders in Los Angeles, as did Blandford and Chappell to study Native elders in Winnipeg.[3] Carstensen has urged researchers to focus on the strengths of elders, as well as the problems, noting that "we need to study not just the frail and sick senior citizens, but also people in the second half of life who are aging well, without an undue amount of illness and disability."[4] This model is increasingly used by the medical

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profession, including the World Health Organization, and is particularly important to a holistic Native view of health and well-being.

Compared to the general United States population, American Indians have poorer health and a lower life expectancy.[5] According to the National Indian Council on Aging, American Indians at age fifty-five experience the same functional limitations in their activities of daily living as do non-Indian people at age sixty-five.[6] Many tribes designate elders as those fifty-five and older; in 1981 the United States Congress amended the Older Americans Act to allow Indian tribes to define elderly for their specific communities.[7] For purposes of our study we defined elderly as those persons fifty-five years of age and above, although our sample did not finally include anyone younger than sixty-five.

Rochester is located in Monroe County, New York, which has an American Indian population of approximately 1,950 persons, according to the 2000 census. There is no defined Indian neighborhood; Native families are spread throughout Rochester proper and the surrounding suburbs.[8] Senecas and members of other Iroquois nations make up the majority of Rochester's Indian community, with fewer than fifty people from other tribes. The number of American Indian elders, defined here as persons over age fifty-five, was 259, or 13.2% of the total.[9]

A number of urban Indian organizations are active in the community, including educational and cultural programs, social and service clubs, and a sobriety group. The Native American Cultural Center (NACC) hosts several of the groups, as well as running education and employment training programs, a substance abuse prevention program, a disability assistance program, and social and cultural activities. The NACC is the largest of the urban Indian organizations in Rochester, with about two hundred paid members, although it serves many times that number of people with its varied programs over an eighteen-county area in western New York State.[10]

PREVIOUS STUDIES

Overall, elderly American Indians have not been adequately examined in terms of their health and well-being. Researchers have remarked on this lack of data and urged that more complete information be gathered.[11] There are few comparisons of urban and reservation elders and almost no longitudinal studies of any population of Indian elders. A series of studies undertaken in the 1990s of Great Lakes American Indian elders is now providing more long-term data, however, on both urban and reservation populations.[12]

Few published studies address the specific needs of Indian elders in urban areas, and these studies cover widely scattered populations (Los Angeles, Denver, Detroit, and other urban areas in Michigan). Kramer provides an overview of the demographics of this population and their under-utilization of Older American Act services.[13] Weibel-Orlando and Kramer and Barker look at the specific population of urban Indian elders in Los Angeles.[14] Elders with disabilities in Denver are the focus of a study by Marshall et al.[15] Chapleski et al. include urban residents in their samples of Great Lakes Indian elders, along with rural residents, both reservation and nonreservation.[16]

The single published source on Indian elders in western New York is a study by John of elders from the Allegany Reservation, part of the Seneca Nation of Indians. John's work indicates that health status has a strong effect on social integration of the elderly on this rural reservation. This specific study is important but does not address the urban Indian population of western New York. As John himself notes, "future research will need to systematically address the needs of American Indian elderly in reservation and urban populations."[17]

Weibel-Orlando reported on a study involving elders from three different ethnic groups, including her own research on American Indian elders who were living in or had lived in Los Angeles. Specifically, this project looked at the contribution of ethnicity to aging well and found that "factors that support and sustain good mental health and personal well-being in Indian old age include active involvement in Indian community life, enactment of community recognized and valued political and spiritual roles, regular interaction with family (particularly grandchildren) and coethnics, continued community contribution and service, personal acts of altruism, and community recognition of such good works."[18]

Blandford and Chappell also conducted a comparative study of different ethnic elders, in this case Natives and non-Natives in Winnipeg, Manitoba, Canada. Their research indicated that Native elders experienced lower levels of subjective well-being than non-Natives and attributed that to their poorer health and social circumstances rather than to their being Natives. Specifically, Blandford and Chappell point out the importance of social variables, including satisfaction with family relationships and number of persons seen for instrumental purposes, as correlates of well-being.[19] While our own study is significantly more limited in scope, our findings concerning the importance of family, community, and cultural involvement correlate with those of these two larger studies.

METHODS

The researchers involved in this study included an anthropologist and a nurse. The anthropologist, herself an Indian involved in the Rochester Native American community, made initial contacts with twenty elders, all of whom were known to her; hence, this is a convenience sample.[20] Contacts included telephone calls and conversations at community events, which helped to determine the elders' willingness to participate. Scheduling conflicts prevented several individuals from participating; eight individuals ultimately were able to meet with us. Parameters for inclusion in the study included meeting our definition of elder (over age fifty-five), being willing and able to be interviewed (not affected by senility), having lived and worked in Rochester for a majority of one's life (as opposed to living on a reservation or in another urban community), and specifically participating in the activities of the Rochester Indian community.

Although eight elders is a limited number, it does constitute a significant portion of our defined study population. Taking the total population of

American Indian elders in Monroe County (259), our group of eight is about a three percent sample. However, the relevant population included those elders who were able to be interviewed, had lived in Rochester most of their lives, and were active in the local Native community. The Native American Cultural Center is the primary sponsor or cosponsor for many of the events in the Rochester Indian community; hence participation in those activities was one of the ways we used to identity active urban Indian elders. All of the twenty elders contacted initially were members of the NACC, representing about 10 percent of that urban Indian organization's total membership of about two hundred.

We chose to use open-ended interviewing as the means by which we gathered data on urban Indian elders. With the help of a graduate research assistant, we developed an interview schedule to guide us, with a series of questions including basic demographic data, residential history, educational history, occupational history, family history, and community activities. We chose a narrative format to elicit information, such as "Tell us about the jobs you had." This approach provided a chance for the elders to elaborate and was less invasive than asking about specifics such as finances. The final section of the interview schedule was a basic health history, including a checklist of activities of daily living and the specific question, "Do you think you're healthy?" The presence of a nurse as part of the interview team prompted several of the elders to discuss not just their health conditions but also possible treatments.

The interview schedule served our purposes well, helping us to stay focused and to cover the questions we wanted to investigate. Nonetheless, interviews ranged widely over topics as diverse as child rearing and contemporary politics. The interview schedule assisted us in bringing the conversation back to specific topics. Because we were dealing with an elderly population, we tried to limit interviews to one hour to avoid tiring the elders. However, our visits often ran for twice that length. Interviews, with one exception, were conducted in the elders' homes, often with other family members present and contributing. One interview was completed by telephone, speaking with the elder from her home. All the interviews were tape-recorded and transcribed by the interviewers.

Responses were analyzed according to our primary categories of interest, looking at health and health practices, family, community, and culture. Transcriptions of the interviews were marked for specific responses to these areas, and then all responses were consolidated and compared.

ELDERS

Our sample of eight urban Indian elders in the Rochester, New York, area, ranged in age from sixty-five to eighty-four at the time of the interviews, with a mean of 72.5 years. Five were female, three male. Half of the group was still married, three were widowed, and one was divorced. The mean educational level was 12.25 years, with a range of ten to sixteen years of formal education. We did not gather specific information on income, but, as retired persons, these elders have limited incomes, although none are destitute.

Six elders reported that they were not born on a reservation, whereas two were reservation born. These two individuals still identified as urban Indians because they lived off the reservation for the majority of their lives. All were from Iroquois nations, five were Mohawk, with Senecas making up the remainder of the group. Tribal affiliations have not been identified for specific individuals in order to preserve their privacy.

Seven of these elders reported that they were in good health, whereas only one individual reported being in poor health. This individual was the oldest in our sample and had the most health problems. The elders had an average of 5.25 chronic diseases, with the most common conditions being hypertension (afflicting seven), vision problems (six), dental disease (four), diabetes mellitus (four), and osteoarthritis (four). Reported health-promotion activities included exercise (practiced by five), diet (four), diet supplements such as vitamins (four), and regular physical checkups (three). Only one reported using traditional medicine on a regular basis to promote health and prevent disease.

One-half of our sample reported independence with activities of daily living such as bathing, dressing, toileting, transferring, eating, and mobility, as well as with the instrumental activities of daily living such as managing finances, telephone, shopping, transportation, cooking, and housework. None of the elders required total assistance with all activities, but mobility and transportation (including shopping) were problematic for half, including one elder who has an above-knee amputation. Only one elder reported taking public transportation; however, the urban setting in Rochester, New York, has limited bus service and is not noted for being user-friendly. Housework was problematic for two of the elders, but it should be noted that one individual with an amputated leg still assisted with vacuuming and other housework.

HEALTH AND HEALTH PRACTICES

Perception of Health

Culture, not nature, defines health. Although every culture delineates what is normal and therefore healthy, health is rarely, if ever, viewed narrowly as only concern with the well-being of the physical body. Well-being refers to the subjective sense that a person is generally satisfied with life.[21] Elders in this study reported an average of 5.25 chronic health conditions each, the majority of which are associated with advanced age, such as high blood pressure, arthritis, dental disease, and cataracts and other age-related vision disorders. Despite the presence of these conditions and their sequelae (for example, leg amputation and retinopathy secondary to the circulatory disturbances caused by diabetes mellitus), all but one person perceived himself or herself to be healthy. From a phenomenological approach, perception is reality; thus, the overwhelming majority of elders in this study considered themselves to be healthy. The elders conceptualized well-being in terms of positive mental attitude and a variety of health-promoting behaviors and activities.

Health Promotion

When we asked the elders what they did to prevent illness or to promote health, the most frequent responses included diet (four), vitamin supplements (four), and exercise (five), with mall walking being particularly popular. All of the elders reported that they had physicians, and physical check-ups (including blood pressure monitoring) and following the prescribed medical regimen (for example, taking prescription medicines) were part of their health-promotion practices. Influenced by the growing availability of nonprescription complementary or alternative remedies, two elders indicated that they used glucosamine, chondroitin, and/or shark cartilage for arthritis. One elder was chided by another Indian for drinking diet beverages containing an artificial sweetener (for example, Equal or NutraSweet) containing the suspected carcinogen aspartame. The health-promoting activities reported by these elders are consistent with practices of the general US population of older adults.[22] Only one individual reported using traditional herbal medicines for health promotion.[23]

Access to Health Care

Most of these urban Indian elders report alternating between urban primary care physicians and reservation-based health services. There are several reasons why urban elders tend to have two health providers, one urban and the other located on the reservation. Despite the fact that the majority of American Indians live in urban areas, the Indian Health Service (IHS) allocates only two percent of its budget to urban Indian health programs.[24] No IHS services are available in the Rochester area. Many elders travel to their reservations periodically to obtain free medical services and health products, particularly prescription medicines, from the Indian Health Service. The IHS provides medical care as part of the ongoing treaty obligations of the US government to Indian people. Because of limited income, some Rochester Indian elders prefer to make quarterly or even monthly visits to reservations to renew their prescriptions rather than pay for medicines at urban pharmacies. Some elders utilize reservation-based clinics for screening tests for diabetes, hypertension, glaucoma, and related conditions rather than patronizing urban clinics or other health care practitioners. The elders often coordinate their reservation visits to coincide with prescription renewals and medical appointments.

For these urban Indian elders, access to affordable health care means a drive of two hours or more to a reservation and its IHS facility. Even then, problems arise with access to care. Changes in tribal governments, tribal policies, and tribal finances affect reservation clinics and their ability to provide health care to nonreservation residents. One elder told about going to her reservation to obtain prescription medicines through the IHS only to be told that she was not in their service area since she lived in the city. “One day we went to get a supply, you know, for our sugar medication and they said you couldn’t get it anymore. And I said, why? It made me very upset. And they said, we’re not in that area.” She was able to get her prescriptions filled at

another IHS clinic at another reservation, where "they help everybody. I mean from the other reservations." The second reservation had a better financed clinic because of that tribe's highly successful gaming operation.

Only one individual reported using an urban primary care physician exclusively. He also noted that he enjoyed excellent overall health and indicated that his former employer provided free annual physicals and very good health benefits. Given that most of this group of urban Indian elders held relatively low-paying jobs during their productive working years, only a few enjoy private insurance benefits in their retirement. The remainder rely on Medicare, Medicaid, and/or the Indian Health Service.

Negative physician attitudes concerning their needs also impacted individuals in our sample. One woman reported that two weeks before she had a bad fall, she had asked her physician for an emergency response system to summon help. As she related, "'Aw, you don't need one of those,' he said. So he found out I did," after she sustained injuries from the fall. She no longer sees this physician but instead receives health care from another primary care provider and a specialist. While this problem is not exclusive to Native peoples or to elders, it does exacerbate other problems with access to health care.

Activities of Daily Living

We asked this group of elders about their ability to perform the routine activities of daily living, such as bathing, dressing, toileting, transferring, eating, and moving. The majority reported they could function independently, with a few needing some help in one or more categories. Similarly, we asked the elders about their ability to perform instrumental activities of daily living such as those required for telephoning, managing finances, shopping, transportation, meal preparation, and housework. Given the age of our sample (sixty-five to eighty-four) and the nature of their chronic conditions (strokes, amputation secondary to diabetes mellitus), it is not surprising that four of the elders reported needing some help with shopping and transportation or total assistance with transportation and housework. These needs do not differ from those in the general population at the same age and with similar health conditions.[25]

FAMILY, COMMUNITY, CULTURE, AND HEALTH

These elders in Rochester consider themselves relatively healthy, and they are indeed able to carry out most of the normal activities of daily life. Many of the elders mention healthy habits that they try to keep, including good diet, exercise, and regular medical care. In addition, these elders enjoy a strong extended family network, maintain their involvement in community activities, and remain connected to their cultural heritage. All these factors contribute to a positive attitude about health and well-being,[26] despite some serious and life-threatening illnesses that individuals in this group of elders have experienced.

Family

When asked about their family and social support networks, the elders reported a wide range of persons living nearby or with them, including spouses, adult children, grandchildren, siblings, in-laws, and other relatives. Two also mentioned pets. Only two of the women live in extended (three-generation) households, with children and grandchildren. The three men live with only their spouses, and one of the women lives with her daughter. Two of the women live alone but see their children or grandchildren daily.

Six of the elders still have living siblings, and most of them see or speak to their brothers and sisters by telephone frequently. Those with siblings in Rochester see them weekly, and those with siblings on the nearest reservations (Allegany and Cattaraugus in New York State, and Six Nations in Ontario, all within a two-hour drive of Rochester) see them at least monthly. Even those elders whose siblings are more distant (Florida, California) still manage to get together at least once or twice a year.

All of the elders have children, many of whom live in the Rochester area. Those children and the grandchildren are in frequent, usually daily, contact with the elders. Children often perform vital tasks for their parents, including doing grocery shopping, providing transportation to doctors and to social activities, and maintaining houses and yards.

Community

Rochester is the home of these elders and has been for many years. Three of them have lived in Rochester for their entire lives, one came as a child, and the other four have been in the area for between thirty-one and fifty-five years. Three of them were born in the city, one was born in a small town in southern New York, one was born in an urban area in Canada, one was born near a reservation, and only two were actually born on reservations. These elders consider themselves part of the Rochester urban Indian community and have been active in community organizations and activities. All of them belong now or have belonged to one or more community groups, particularly the Native American Cultural Center (a social service organization) and O'gisto (a Native women's group). Five of the elders have served on the board of the Cultural Center, and most of the women have participated in O'gisto. In addition, several have been involved in local Indian education programs in the public schools, both as staff and as resource persons. All these elders participate in Iroquois socials hosted by various Rochester urban Indian groups, which include potluck dinners and traditional Iroquois social dancing. Socials are the most important, well-attended cultural events in the Rochester Native community. Many of the elders also volunteered at powwows held in Rochester in the early 1990s, and all of them attended the powwows. The community makes it a point to reach out to the elders, recognizing their contributions over the years. A list of elders, who were part of the Native American Cultural Center, appeared in the organization's newsletter, with a reminder that community members should call or visit these individuals.[27]

All the elders in our sample know each other, as well as knowing most of the Native population in Rochester. They socialize with each other and provide a support network for each other. At one elder's home a list of names was posted near the telephone. It included every elder in our sample, all of the elders initially contacted about participating, and several others who were living in local nursing homes. Another elder replied to our question about whom she counted as her close relatives with the answer, "my friends who are Indian." During our interview with another elder, she made sure that we were aware of all the elders who had recently moved away from Rochester to return to their home reservations or to live with family members. One elder spoke about helping another community member to make the difficult decision to have a diabetes-related amputation and how good he felt about being able to be supportive of her in a time of need.

Several of the elders have been recognized by the Rochester urban Indian community for their activities. The men were all asked to be part of the veterans color guard at the powwows. One of the women was honored by a Native American student group at a local college. Other women have been singled out at an event recognizing New York State Native women. The Rochester community publicly acknowledges the ongoing contributions of the elders, bringing them into the forefront, where they are praised and feted.

Culture

Despite the fact that none of these elders have lived in their reservation communities for decades, they are all aware of their cultural heritage and take pride in it. They can discuss their tribal histories and the history of the Six Nations of the Iroquois, and many maintain close ties to their nations, visiting relatives, attending celebrations, and voting in tribal elections. Three of the elders specifically mentioned the importance of relatives living on reservations as a significant component of their support system and indicated that they regularly see these individuals or talk with them by telephone. Even one of the women who demurred that she was "not familiar with the customs of the Native Americans" since she did not grow up on a reservation can still read some of her native language and considers her reservation her home, where she plans to retire. One of the men noted that he tried to "look like" an Indian, just to remind people that Native Americans are still around. Several of the women have been active in preserving and presenting aspects of their cultures through storytelling, singing, and crafts such as beadwork.

Perhaps more germane to this study of health and well-being, several elders indicated that they knew other Indian people who used traditional medicine or had heard about various practices from their parents or grandparents.[28] The term *traditional medicine* refers to those time-honored healing practices that include the use of herbs, rituals, ceremonies, and other activities that restore or contribute to health. One elder was adamant that "on the reservation some believe and practice witchcraft. No traditional healing is practiced in the urban setting." The majority of the elders, however, said that traditional medicine is simply more prevalent on reservations than in cities.

In some instances the elders indicated they had used traditional medicine in childhood but were not currently using it. One of the women related, "My dad's father was somewhat of a doctor, too. He cured my father of asthma, which I wish he was here today to help me along. . . . I was probably in high school before I ever saw a white doctor. All the rest was from grandpa and grandma."

Another elder noted that he has healing powers that he has used in the past. "I have helped people out in different ways and different times. My hands you know sometimes they have healing in them you know. So I have helped people. I don't practice it though. I wouldn't accept money for it. But people say they have been helped by it."

Several of the elders noted that they did not use traditional healing themselves but were knowledgeable about where one might go to obtain it and indicated that they have Indian friends who use herbal medicine. One woman said, "They have Indian medicine but I, I don't take it. I don't like the taste of it. I did take it before. It's, you know, like twigs and you brew 'em up. Tastes terrible. And then you drink it. Cleans you out." One of the men noted, "I never knew where to go before but now I do. If I wanted to [use traditional medicine], I could, but I don't want to." He went on to provide the name of an urban herbalist.

One of the elders does try to use herbs for healing "every chance I get." She related the following incident about a visit to a white doctor. "He give me some of his pills, and he said, 'Well,' he says, 'I don't s'pose you'll take this, you'll probably go home and steep up some of those herbs!' He was just disgusted. He spoke it in sort of a derogatory way."

CONCLUSIONS

Despite the presence of chronic illnesses and advancing age, all these elders manage to function relatively independently in their own homes, and the majority (all but the eldest, at age eighty-four) consider themselves to be healthy. The diseases and disorders that afflict these elders mirror those reported for other elder American Indians. The most serious and potentially life-threatening conditions include cardiovascular disease and diabetes mellitus. Vision problems, dental disease, and arthritis contribute to their inability to perform activities of daily living and instrumental activities of daily living. Transportation and shopping were problematic for those who no longer drive or drive only short distances.

Through active engagement with their families and in local Indian organizations and social activities sponsored by these organizations, urban Indian elders retain their connections to their heritage. Although the use of traditional medicine for health promotion and disease prevention is limited in this urban setting, these elders are aware of traditional healing practices and can draw on them as part of their cultural repertoire. We believe that these ties to family, community, and culture help these urban Indian elders to maintain their overall perception of health and well-being. With the very limited scope of this study it is not possible to draw any definite conclusions. Our data support the

same interconnectedness of health and community activity suggested by Weibel-Orlando and the importance of social variables in subjective well-being indicated by Blandford and Chappell in their studies of urban Indian elders.[29]

This study expands the limited research conducted to date with urban Indian elders, but more work needs to be done. Given that our sample included only individuals from the Mohawk and Seneca nations, future studies of urban Indian elders need to include additional tribes. Recognizing that there are regional differences in populations, there needs to be more broadly based geographic representation in the future. For example, Rochester is located in a relatively affluent section of the Finger Lakes region of upstate New York, which has consistently enjoyed low unemployment and high average household income levels. Other studies might also begin to explore gender differences and their influence on the well-being of urban Indian elders. Last, future research needs to include a longitudinal study to examine the overall health of urban Indian elders as they grow increasingly older. Will connections to family, community, and culture continue to sustain these elders and help them to enjoy a high level of well-being with advancing age?[30]

NOTES

1. B. Josea Kramer, "American Indian Aging," *Journal of Cross-Cultural Gerontology* 6 (1991): 205–17; also see Deborah D. Jackson and Elizabeth E. Chapleski, "Not Traditional, Not Assimilated: Elderly American Indians and the Notion of 'Cohort,'" *Journal of Cross-Cultural Gerontology* 15 (2000): 229–59, for a discussion of age differences among urban Indians in Michigan. Several recent studies of the urbanization of American Indians have added significantly to our understanding of this important aspect of contemporary Indian life; see Joan Weibel-Orlando, *Indian Country, L.A.: Maintaining Ethnic Community in Complex Society*, rev. ed. (Urbana: University of Illinois Press, 1999); Donald L. Fixico, *The Urban Indian Experience in America* (Albuquerque: University of New Mexico Press, 2000); Susan Lobo and Kurt Peters, eds., *American Indians and the Urban Experience* (Walnut Creek, CA: Altamira Press, 2001); and the special issue of *American Indian Culture and Research Journal* 22, no. 4 (1998) on urban Indians, also edited by Lobo and Peters.

2. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of sixty-one states (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. Available at the WHO website, www.who.int (accessed 7 July 2002).

3. Joan Weibel-Orlando, "Elders and Elderlies: Well-Being in Indian Old Age," *American Indian Culture and Research Journal* 13, nos. 3 and 4 (1989): 149–70; Audrey A. Blandford and Neena L. Chappell, "Subjective Well-Being among Native and Non-Native Elderly Persons: Do Differences Exist?" *Canadian Journal on Aging* 9, no. 4 (1990): 386–99.

4. Laura L. Carstensen, "The Second Half of Life: Studying the Strengths of Older Americans," *Chronicle of Higher Education*, 4 October 1996, B3.

5. See Martin C. Mahoney and Arthur M. Michalek, "Health Status of American Indians/Alaska Natives: General Patterns of Mortality," *Family Medicine* 30, no. 3

(1998): 190–95, for a general overview of Indian health trends; for specific overviews of Indian elders' health see Paul Rousseau, "Native-American Elders: Health Care Status," *Clinics in Geriatric Medicine* 11, no. 1 (1995): 83–95; and N. Burton Attico, "Wellness and the Elderly," *IHS Primary Care Provider* 21, no. 5 (1996): 55–62.

6. National Indian Council on Aging, *American Indian Elderly: A National Profile* (Albuquerque, NM: NICOA, 1981), 3.

7. R. C. Saravanabhavan and Catherine A. Marshall, "The Older Native American Indian with Disabilities: Implications for Providers of Health Care and Human Services," *Journal of Multicultural Counseling and Development* 22, no. 4 (1994): 182–94.

8. US Census Bureau, 2000 Census, Monroe County, New York, by Census Tract, http://factfinder.census.gov/servlet/ThematicMapFramesetServlet?_bm=y&-geo_id=05000 (accessed 10 March 2005).

9. US Census Bureau, 2000 Census, Monroe County, New York, Table P12C. Sex by Age (American Indian and Alaska Native Alone), http://factfinder.census.gov/servlet/DTSubjectShowTablesServlet?_ts=128435912787 (accessed 10 March 2005).

10. The Rochester Indian community is discussed briefly in one study on urban mixed bloods; see Susan Applegate Krouse, "Kinship and Identity: Mixed Bloods in Urban Indian Communities," *American Indian Culture and Research Journal* 23, no. 2 (1999): 73–89; see also Susan Applegate Krouse, "Traditional Iroquois Socials: Maintaining Identity in the City," *American Indian Quarterly* 25, no. 3 (2001): 400–408.

11. Jose Cuellar, *Aging and Health: American Indian/Alaska Native* (Stanford, CA: Stanford Geriatric Education Center, 1990), noted the lack of research on Indian elders in 1990; that gap has not been significantly lessened in the last decade. Rousseau, "Native-American Elders," and Attico, "Wellness and the Elderly," voiced similar concerns.

12. Recent publications from this study include Elizabeth E. Chapleski and Jeffrey W. Dwyer, "The Effects of On- and Off-Reservation Residence on In-Home Service Use among Great Lakes American Indians," *Journal of Rural Health* 11, no. 3 (1995): 204–16; Elizabeth E. Chapleski, Peter A. Lichtenberg, Jeffrey W. Dwyer, Lise M. Youngblade, and Pao F. Tsai, "Morbidity and Comorbidity among Great Lakes American Indians: Predictors of Functional Ability," *Gerontologist* 37, no. 5 (1997): 588–97; Elizabeth E. Chapleski, James K. Lamphere, Richard Kaczynski, Peter A. Lichtenberg, and Jeffrey W. Dwyer, "Structure of a Depression Measure among American Indian Elders: Confirmatory Factor Analysis of the CES-D Scale," *Research on Aging* 19, no. 4 (1997): 462–85.

13. Kramer, "American Indian Aging."

14. Weibel-Orlando, "Elders and Elderlies"; B. Josea Kramer and Judith C. Barker, "Homelessness among Older American Indians, Los Angeles, 1987–1989," *Human Organization* 55, no. 4 (1996): 396–408.

15. Catherine A. Marshall, Marilyn J. Johnson, William E. Martin Jr., R. C. Saravanabhavan, and Barbara Bradford, "The Rehabilitation Needs of American Indians with Disabilities in an Urban Setting," *Journal of Rehabilitation* 58, no. 2 (1992): 13–21.

16. Chapleski and Dwyer, "Effects of On- and Off-Reservation Residence"; Chapleski et al., "Morbidity and Comorbidity"; Chapleski et al., "Structure of a Depression Measure."

17. Randy A. John, *Social Integration of an Elderly Native American Population* (New York: Garland, 1995), 93.

18. Weibel-Orlando, "Elders and Elderlies," 166.

19. Blandford and Chappell, "Subjective Well-Being," 392–97.

20. For a discussion of the problems with limited data on urban Indian elders and the appropriateness of convenience sampling for this population see B. Josea Kramer, "The Health Status of Urban Indian Elders," *IHS Primary Care Provider* 24, no. 5 (1999): 69–73, esp. 71–72.

21. See M. M. Leininger, *Transcultural Nursing: Concepts, Theories, Research, and Practices* (New York: McGraw-Hill, 1995), 106, for a discussion of health, culture, and well-being and the following definition: "Health refers to a state of well-being that is culturally defined, valued, and practiced, and which reflects the ability of individuals (or groups) to perform their daily role activities in culturally expressed, beneficial, and patterned lifeways."

22. Administration on Aging, Dept. of Health and Human Services, "Health and Health Care," in *A Profile of Older Americans: 2003*, http://www.aoa.dhhs.gov/prof/statistics/profile/2003/14.asp (accessed 10 March 2005).

23. By comparison, a study of three elderly ethnic minority groups in California reported that 11 percent of African Americans, 20 percent of Latinos, and 35 percent of Filipino Americans used complementary or alternative healing to manage chronic illnesses. See Gay Becker, Yewoubdar Beyene, Edwina M. Newsom, and Denise V. Rodgers, "Knowledge and Care of Chronic Illness in Three Ethnic Minority Groups," *Family Medicine* 30, no. 3 (1998): 173–78.

24. Mahoney and Michalek, "Health Status of American Indians/Alaska Natives," 190–91.

25. Administration on Aging, *Profile of Older Americans: 1999*, 13–16.

26. Weibel-Orlando, "Elders and Elderlies," 166; Blandford and Chappell, "Subjective Well-Being," 392.

27. "Remembering Our Elders," *Native American Cultural Center Dependency Education for Native Youth* newsletter (summer 1995): 5.

28. See Anne M. Marbella, Mickey C. Harris, Sabina Diehr, Gerald Ignace, and Georgianna Ignace, "Use of Native American Healers among Native American Patients in an Urban Native American Health Center," *Archives of Family Medicine* 7, no. 2 (1998): 182–85, for a discussion of the use of alternative forms of treatment by urban American Indians in Milwaukee, Wisconsin.

29. Weibel-Orlando, "Elders and Elderlies," 166; Blandford and Chappell, "Subjective Well-being," 392.

30. Since our research was completed, several of the elders in our study have passed on. They were remembered by the Rochester Indian community not only at funeral and memorial services but in the newsletter of the Native American Cultural Center (NACC) and by contributions in their names to the NACC Memorial Scholarship Fund.