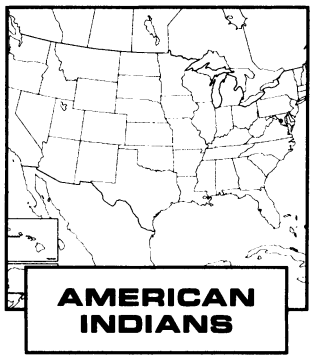
Cross-cultural Medicine
A Decade Later

- American Indians are an indigenous, heterogeneous population with over 500 recognized tribes, bands, or Alaskan Native villages
- Over half (54%) now live off reservations
- Rural to urban migration was given great impetus by World War II and the federal policies of the Eisenhower era



Health and Aging of Urban American Indians

B. JOSEA KRAMER, PhD, *Los Angeles, California*

Although half of the American Indian population resides off the reservation, mostly in the western states, research on the health of urban American Indians remains sparse. American Indians living in urban areas are not eligible for the federally mandated health care provided by the Indian Health Service and receive health care services in a variety of settings. This population is at high risk for many health problems, especially cardiovascular disease and diabetes mellitus. Social, cultural, and economic barriers that impede access to health care for this group, particularly for elders living in an urban setting, could be reduced if physicians improved their understanding of and communication with American Indian patients.

(Kramer BJ: Health and aging of urban American Indians, *In* Cross-cultural Medicine—A Decade Later [Special Issue]. West J Med 1992 Sep; 157:281-285)

Urban American Indians have been called the "invisible minority" because their conditions and needs are not generally recognized in comparison to those of other ethnic minority populations. For over a decade, more than half (54%) of American Indians have lived outside of reservation communities. In this article I review the health status of American Indians, including misperceptions that affect their access to health care; describe their migration to urban centers; report on general health findings of elderly urban Indians; discuss approaches to relating to American Indian patients; and examine in depth the population of older urban American Indians and their prospects for health care.

The term "American Indian" is used here to refer to the indigenous peoples of North America. This term is preferred, particularly by elders of this population, to the term "Native American," which under certain federal legislation includes native Hawaiians, Samoans, and other Pacific Islanders.

The American Indian population is extremely heterogeneous: There are nearly 300 federally recognized reservations; 500 recognized tribes, bands, or Alaskan Native villages; and an estimated 100 tribes that do not benefit from federally recognized status. There is little public understanding or awareness of this cultural diversity and of contemporary American Indian peoples and their concerns.[1] The public is most familiar with northern Plains cultures (for example, the Lakota), thanks to Hollywood movies such as *Dances With Wolves,* and with cultures that have become strongly identified with their arts in a commercial context, such as Navajo weaving, Pueblo pottery, or Kwakiutl carvings. Different geographic regions host widely diverse American Indian societies.

Today, 150 native languages continue to be used. Just as there is no single American Indian language, there is no single cultural tradition or style of dress. In urban areas, tribal differences may not be apparent because a pan-Indian identity unifies many community-wide activities. Distinct cultural values and traditions, however, continue to provide a positive source of ethnic identity. A stereotype of "the American Indian" is unwarranted.

History of Urban Migration

The massive migration of American Indians to urban settings has been ongoing since the beginning of this century. From 1920 to 1950 a slow but steady migration took place from poverty-stricken rural reservations to the cities, which offered greater employment opportunities.[2] Participation in the military and the defense industry during World War II speeded up this migration process, as did the federal policies of the Eisenhower era.[3,4] By 1977, 50% of all American Indians lived off the reservation. Now more than half of the entire American Indian population lives in the western states, with the greatest number in California cities.

The favorable climate and the expanding labor market of West Coast cities attracted American Indians from across the nation. This accounts for the great heterogeneity of American Indians in Los Angeles compared with the relatively homogeneous population in Midwestern cities such as Minneapolis. The Los Angeles City and County Native American Indian Commission estimates that it represents members of 200 tribes.

Relocation from small indigenous communities to large industrial centers has created and exacerbated social problems for a portion of the migrating population. Numerous studies focused almost exclusively on these problems.[5] Such social deviation was not universal among urban American Indians, however. Price noted an important difference between those American Indians who had been relocated to Los

From the Medical Anthropology Division, Department of Epidemiology and Biostatistics, University of California, San Francisco, and the County of Los Angeles Department of Community and Senior Citizens Services, Los Angeles, California.

Reprint requests to B. Josea Kramer, PhD, 10834 Rose Ave, No. 14, Los Angeles, CA 90034.

Angeles by the Bureau of Indian Affairs and those who chose to live in southern California on their own initiative: The latter tended to be more successful.[6]

A difficult area of adjustment for some American Indians was getting health care in an urban setting. Eligibility for federally mandated health care provided by the Indian Health Service expires after 180 days of residence off the reservation,[7,8] and many American Indian migrants are unfamiliar with any other system of health care.[9] Recognizing this problem, the Indian Health Care Improvement Act of 1976 authorized the Indian Health Service to allocate funds for the establishment of health clinics by urban American Indian organizations. These urban Indian health clinics provide a health care option where many access barriers have been reduced through such practices as American Indian staffing, outreach by community health representatives, free transportation to the clinic, and educational programs. Although patient visits reached low levels in the late 1980s, in recent years both the amount of appropriations and the number of patient visits have increased. From 1989 to 1990, the levels of appropriations and workload increased more than 33%, with $13 million allocated for 570,000 patient visits (a return to the level of services provided in the early 1980s) for medical or dental treatment, community services, nutrition and health education, optometric services, mental health services, and substance abuse counseling.[10]

Some urban clinics have diversified their funding sources to become comprehensive ambulatory health care centers. It is not known to what extent urban American Indians seek health care from non-Indian providers. Anecdotal findings, based on health-related research in two California cities, indicate that a third of the contemporary urban American Indian population uses non-Indian services, such as employer-sponsored health maintenance organizations. Indian health clinics, however, may be attracting American Indians who have low incomes or are without health insurance.[11]

General Health Profile of Adult Urban American Indians

Data on the health of urban American Indians are extremely limited. Large-scale national surveys, such as the National Health and Nutrition Examination Surveys, do not separate data on urban American Indians from those on the general population. The Indian Health Service does not systematically collect data on diagnostic patient care, vital statistics, or population characteristics for urban American Indians except where this information is included with national-level data on reservation states.[11] The American Indian Health Care Association has recently attempted to collect morbidity and diagnostic data from those urban Indian health clinics that voluntarily record and submit such data; data from five participating clinics are available.[12]

The health profile of American Indians living on reservations is similar to that of the general US population: The leading chronic disease is hypertension, 40% of the population suffers from at least one chronic health condition (cardiovascular disease, cancer, emphysema, gallbladder disease, hypertension, rheumatism, arthritis, or diabetes mellitus), and rates of rheumatism and arthritis are comparable to those of the population at large. American Indians and Native Alaskans, however, are twice as likely to have diabetes mellitus as the general US population and 1.4 times as likely to have gallbladder disease.[13] Both urban clinics and reservation health facilities reported that diabetes and hypertension were among the ten leading diagnoses.[12]

The available research on urban American Indians is generally of smaller scope.[11,14-16] In published studies, the populations surveyed were somewhat homogeneous, and the samples consisted overwhelmingly of persons who reported low socioeconomic status. Therefore, the findings may relate to conditions of poverty at least as much as to ethnicity.

Urban American Indians are at high risk for both cardiovascular disease and diabetes mellitus. A study of health clinics in Oklahoma City, Oklahoma, and Wichita, Kansas, in 1983 and 1984 indicated that approximately half of the clinic visits were to obtain physical examinations or because of diabetes or hypertension for both men (52.04%) and women (48.56%).[11] A study in Minneapolis found health risk patterns consistent with high cardiovascular morbidity and mortality in its finding of high frequencies of obesity, diabetes, and cigarette use and of moderately elevated levels of blood pressure and serum cholesterol.[15] No sex-related differences among risk factors were found for American Indians.

Treating American Indian Patients

No single approach to health care can respond to all the cultural and linguistic variations among American Indians. Furthermore, specific cultural values persist to varying extents for Indians living in an urban area. Typical attitudes of urban American Indian patients toward Western medicine range from indifference by traditionalists, through acceptance by bicultural people who expect scientific medical treatment, to rejection by pantraditionalists seeking to redefine an Indian identity in an urban setting.[17] Despite this variation, some general considerations (although developed, for the most part, to serve more traditional clients) may be of value to orient health care professionals.

American Indians perceive various barriers to obtaining social and health care services. Some of these barriers are based on mutual misinterpretations of cultural norms and etiquette. Elders in particular have encountered blatant racism and also have suffered the pernicious effects of stereotyping. Added to this are their cultural perceptions that many mainstream attitudes are intolerably rude, such as getting right down to business; addressing strangers in loud, confident tones; and frequently interrupting speakers. These attitudes increase social distance and decrease confidence in non-Indian professionals. Older American Indians report that they fear non-Indian health professionals, do not expect to be treated fairly by them, and anticipate adverse contact experiences.[18]

Among urban American Indians, there are two main criteria for selecting a physician: The clinician was either an American Indian—and thus shared unspoken assumptions about health and behaviors based on ethnicity[19]—or a non-Indian who treated the patient with respect and understanding. Therefore, health care professionals should be particularly aware of the need to establish a relationship conducive to treatment.

On a first visit, American Indian patients may test the friendliness and sincerity of a physician. It is not unusual for American Indians to express either passivity or hostility in uncomfortable new situations.[20] American Indian patients may withhold important information until an appropriate atmosphere and trusting relationship have been established. As

Everett Rhoades, director of the Indian Health Service, explains,

> This may require more than one visit and may tax the patience of a busy physician. Even in the face of hostility, a calm, accepting, nonjudgmental manner will almost always be of value.[20(p59)]

A successful therapeutic relationship with an American Indian patient, as with any other patient, requires the physician to establish an interest in the patient's well-being. Significant differences in etiquette between the non-Indian physician and the American Indian patient may inhibit the process, however. For instance, many American Indians expect that the initial visit should begin with the formality of a brief, light handshake, "often little more than a touch."[17,20] This is not the firm business handshake that, while commonplace among non-Indians, is a sign of aggressiveness among American Indians. Further, American Indians consider staring and excessive eye contact not only rude but an invasion of privacy or dignity.[17,20] On the contrary, non-Indians associate eye contact with frankness and equate avoiding eye contact with furtiveness. Responding to a patient's cues on etiquette is one way that health care professionals can avoid misunderstandings.

Until American Indian patients feel comfortable, physicians "should be prepared to be very indirect in asking questions."[20(p59)] Rhoades comments that questions about the use of traditional medicine may be asked directly if the physician uses a nonjudgmental attitude: "Have you been seen by an Indian doctor?" The term "medicine man" should not be used.

Urban American Indian patients may see no conflict between using Western medicine and traditional medicine.[21] Traditional American Indian medicine is holistic and wellness oriented.[17,22,23] It focuses on behaviors and life-styles through which harmony can be achieved in the physical, mental, spiritual, and personal aspects of one's role in the family, community, and environment. Traditional Indian healing practices may substantially reduce patients' stress.

Using the approach of nonjudgmental acceptance, physicians can probe for specific information about the presenting issues and the ways in which an American Indian patient perceives the disease course and treatment. Manson recommends a "mini-ethnography" approach to taking a patient's history—treating illness as distinct from disease, thus recognizing that the patient and physician may have different ways of approaching health (S. M. Manson, "Older Ethnic Minorities and Health Care: Accommodating Cultural Diversity in Clinical Practice," unpublished data, 1992). Illness is a patient's experience of the symptoms, how those symptoms affect the patient and his or her social networks, how those symptoms are understood and responded to, and the complaints brought to the attention of the physician. Disease is the "recasting of illness within a biomedical model," providing the illness with a diagnosis, interpretation, and treatment.

The health care professional can use the mini-ethnography approach to establish an empathic rapport while trying to understand the presenting complaints from the patient's point of view. By asking follow-up questions to the patient's description of the illness and how it affects aspects of everyday life, the physician can gain insight into the patient's world, develop more effective strategies for clinical care, and encourage greater compliance with treatment. Because "American Indian beliefs and attitudes about health and illness are often in direct conflict with the Anglo society,"[17(p251)] using the mini-ethnographic approach can overcome potential cross-cultural misunderstandings. Not only does this approach advance both clinical goals (Manson, unpublished data, 1992) and professional development,[17] but learning about other cultures through this method of inquiry can be a rewarding personal experience.

Urban American Indian Elders

Access to Services

American Indians who migrated to urban centers in the post-World War II era are now reaching retirement age. Of 353 elders in Los Angeles who were asked, 81% reported that they did not plan to return to natal reservations.[24-26] In fact, increasing age is associated with a greater commitment to remain in the city.[27] Some health care[28] and social service[29] professionals, however, erroneously thinking that few older American Indians live in our nation's cities, have either turned away clients or failed to plan services for this population.

Even at middle age, American Indians have been found to suffer physical, emotional, and social impairments characteristic of the general US population aged 65 or older.[30] On reservations persons appeared to be old at 45 years of age, and in urban areas American Indians appeared old by age 55. The greater need for services for the aged has been recognized by the federal government's Administration on Aging, but the age for service eligibility has been lowered only for tribal contractors on reservations. In urban areas, service eligibility is based exclusively on chronologic age.

American Indians are less likely than non-Indians to define aging by chronology. The American Indian community, both on and off reservations, uses social role functioning (for example, grandparenting) and decline in physical activities to define who is considered an elder.[31] In Los Angeles, the median age for both men and women who were considered elders by the community was 58 years.[24]

In urban areas, poverty characterizes the lives of approximately a third of older American Indians, although there are no substantial differences in the labor participation and employment of whites and urban American Indians aged 65 and older.[32] About half of urban American Indians aged 75 or older live with family members. These families are three times as likely as their white counterparts to live in poverty. Generalizations about family support systems must be tempered by the knowledge that, if living in poverty, their resources are scarce and irregular.

Health Profile

Information on urban elders' health was collected in surveys conducted through the auspices of American Indian organizations in Phoenix, Arizona[26]; Los Angeles[24]; and a national multisite survey.[30] Findings are consistent across sites. Although responding with generally positive self-assessments on their health, most elders suffered from one or more health problems at the time of their interview (Table 1).[24,29,30] American Indian elders living in Los Angeles rated health care as their primary concern and top priority for service.[24] Compared with American Indians aged 45 and older living on reservations,[30] the elders in Los Angeles reported higher rates of problems with eyesight (65.9% reported having this problem), hypertension (30.7%), diabetes mellitus (19.8%), asthma (8.1%), stroke (4.9%), speech

TABLE 1.—*Diseases or Specific Symptoms Reported by American Indians Aged 45 and Older*

Health Problem	Los Angeles (n=283), %*	National (n=712), %†	Health Problem	Los Angeles (n=283), %*	National (n=712), %†	Health Problem	Los Angeles (n=283), %*	National (n=712), %†
Eyesight	65.9	54.6	Headaches	11.0	28.5	Speech problems	4.6	1.4
Arthritis/rheumatism	36.4	42.6	Depression	11.0	NA	Prostate	4.0‡	NA
Dental problems	33.2	NA	Stomach problems	10.2	NA	Goiter	3.9	NA
Hypertension	30.7	19.3	Chest pains	8.5	NA	Swallowing	3.9	NA
Joint pains	29.3	NA	Asthma	8.1	4.3	Other ailments	3.9	16.4
Back pains	29.3	NA	Loneliness	7.8	NA	Paralysis	3.5	5.7
Sadness/grieving	22.4	NA	Atherosclerosis	7.4	NA	Trembling	3.5	NA
Hearing problems	21.0	44.4	Skin problems	7.4	NA	Liver problems	3.5	1.6
Foot care problems	20.5	NA	Urinary or bladder problems	7.1	NA	Kidney stones	3.2	8.9
Diabetes mellitus	19.8	12.5	Coughing	6.7	NA	Mental illness	3.2	7.9
Sleep problems	17.0	30.4	Infections	6.2	NA	Amputation	2.8	1.2
Heart problems	14.8	16.1	Osteoporosis	5.7	NA	Elimination problems	2.5	NA
Breathing problems	13.1	34.0	Dizziness	5.7	NA	Cancer	2.5	1.1
Allergies	12.0	NA	Stroke	4.9	3.2	Tuberculosis	2.1	5.0
Swollen ankles	11.3	NA				Gallstones	0.4	NA

NA = not assessed

*From Weibel-Orlando and Kramer[24] and Kramer.[29] †From National Indian Council on Aging.[30] ‡For this item, n = 135.

problems (4.6%), liver problems (3.5%), amputation (2.8%), and cancer (2.5%). Although no comparable data were collected by the National Indian Council on Aging, a high frequency of dental problems was noted in Los Angeles; these were the third most frequently identified health problem.

Although most of the elders living in Los Angeles reported no impairments in either activities of daily living (such as bathing or eating) or instrumental activities of daily living (such as money management or preparing meals), those who were impaired tended to report multiple impairments.[29] The greatest number of impairments and the strongest correlation with age related to instrumental activities of daily living, especially the ability to use a telephone, handle finances independently, and prepare meals. Increasing age was also associated with limitations in activities of daily living, with the strongest correlations found in bathing, transfer, and mobility. The larger sample of American Indian elders residing in Los Angeles reported levels of impairments greater than those reported in the smaller samples collected by the National Indian Council on Aging from several urban sites (Table 2).[29,33]

In Los Angeles nuclear households were common, but frail elderly persons typically lived in multigenerational households.[29] Often unmarried children or grandchildren accepted the role of care giver. Thus, the family support system is an essential component of treatment compliance. Just as health beliefs vary culturally, the expression of care giving may also vary. In contrast to non-Indian family care givers, American Indians may feel less anger and guilt toward dependent elders.[34] The preferred coping strategy is passive forbearance. This is not fatalism but rather an embracing acceptance of the reality of aging relatives.

In most urban areas with large American Indian populations, access to community-based long-term care support services is limited at best.[35] Urban American Indians are typically underserved by the federally funded network of services for the aging.[29] The gap in services is caused by a combination of factors, including allocation of services based on an economy of scale that penalizes small populations, access barriers, and lack of policy initiative. Urban elders were also found to be more disadvantaged than their on-reservation peers in receiving critical information about access to psychological and supportive services from their attending physicians.[36]

Prospects for Health Care

The number of American Indians living to old age (65 years or older) is increasing. The elderly comprise the fastest-growing segment of the US population,[37] and the number of American Indian elders is projected to double by the year 2000.[38,39] Increasingly this older population, with its high burden of chronic diseases, will be coming to the attention of physicians in a variety of settings.

TABLE 2.—*Impairments in Functional Status Reported by American Indians Aged 45 and Older*

Impaired Activity	Los Angeles (n=294), %*	Other Urban Areas (n=96), %†‡
Activities of daily living		
Bathing	7.7	4.2
Dressing	5.9	2.2
Toileting	4.9	NA
Transfer	8.1	1.1
Feeding	2.4	2.1
Mobility	13.1	7.4
Instrumental activities of daily living		
Telephone	5.4	7.4
Finances	7.2	2.2
Shopping	19.0	11.9
Transportation	19.2	10.8
Meals	15.2	5.4
Housework	19.7	20.4

NA = not assessed

*From Kramer.[29]
†The sample population was surveyed by the National Indian Council on Aging in the following cities: Pittsburgh, Pa; Tulsa, Okla; Denver, Colo; Minneapolis, Minn; and Tacoma, Wash.
‡From American Indian Health Care Association.[33]

American Indians living in urban environments face the same health care dilemma as other Americans.[40] Those lacking adequate health insurance and financial resources will find the availability of health care services limited by their ability to pay. Poverty and cultural patterns contribute to the

vulnerability of many urban American Indian elders. These elders are usually unwilling to "endure the gauntlet of waiting rooms and clinics" and find welfare clinics a humiliating experience, one to be avoided.[28,41] Elders are not adept at cutting through "white tape." The high costs of health care and medication make these items a low priority for those living at poverty level.[42] Elders have the lifelong experience of being turned away from public clinics whose staff incorrectly insist that the Indian Health Service is the sole agency responsible for their care.[28,43] In recent years, the Social Security Administration has targeted outreach projects to assist ethnic minorities to receive supplemental income assistance. It is hoped that greater access to Social Security, Medicare, and Medicaid will also improve access to adequate health care.

Summary

Although little has been reported about urban American Indian populations, the sparse literature suggests a population at risk, especially for cardiovascular disease and diabetes. The number of American Indians living in cities has increased dramatically since World War II, and currently more than half of the total American Indian population lives in our nation's cities and towns. Urban American Indians use a variety of health care settings, although most studies have concentrated on clinics serving a low-income clientele. An increasing number of older urban American Indians, typically with high rates of chronic diseases, will be seeking medical care in urban areas in the coming years. Social, cultural, and economic barriers continue to impede access to health care services. Health care professionals can take an active role in reducing the perceived barriers when treating American Indian patients.

REFERENCES

1. US Commission on Civil Rights: Indian Tribes: A Continuing Quest for Survival. Washington, DC, Government Printing Office, 1981

2. Neils EM: Reservation to City—Department of Geography research paper 131. Chicago, Ill, University of Chicago, 1971

3. Gibson AR: The American Indian: Prehistory to the Present. Lexington, Mass, DC Heath, 1980

4. Sorkin A: The Urban American Indian. Lexington, Mass, DC Heath, 1978

5. Thornton R, Sandefeur DG, Grasmick HG: The Urbanization of American Indians: A Critical Bibliography—Newberry Library Center. Bloomington, Ind, Indiana University Press, 1982

6. Price J: The migration and adaptation of American Indians in Los Angeles. Hum Organiz 1969; 27:168-175

7. Smith EM: Health care for Native Americans: Who will pay? Health Aff (Millwood) 1987; 6:123-128

8. Stuart P, Rathbone-McCuan E: Indian elderly in the United States, *In* Rathbone-McCuan E, Havens B (Eds): North American Elders: United States and Canadian Perspectives. New York, NY, Greenwood Press, 1988, pp 235-253

9. Urban Indians pose unique health problems. Am Med News, Sep 28, 1984, p 19

10. Public Health Service, Indian Health Service: Trends in Indian Health. US Dept of Health and Human Services (DHHS), Washington, DC, 1991

11. Taylor T: Health problems and use of services at two urban American Indian clinics. Public Health Rep 1988; 103:88-95

12. Johnson KM: National Uniform Aggregate Epidemiological Statistical Data and Analysis Report. St Paul, Minn, American Indian Health Care Assoc, 1989

13. Johnson AE, Taylor AK: Prevalence of Chronic Diseases: A Summary of Data from the Survey of American Indians and Alaskan Natives. National Medical Expenditure Survey Data Summary 3, publication No. 91-0031. Washington, DC, US DHHS, Agency for Health Care Policy and Research, 1991

14. Hsu JSJ, Williams SD: Injury prevention awareness in an urban Native American population. Am J Public Health 1991; 81:1466-1468

15. Gillum RF, Gillum BS, Smith N: Cardiovascular risk factors among urban American Indians: Blood pressure, serum lipids, smoking, diabetes, health knowledge, and behavior. Am Heart J 1984; 107:765-776

16. Johnston FE, McKigney JI, Hopwood S, Smelker J: Physical growth and development of urban Native Americans: A study of urbanization and its implications for nutritional status. Am J Clin Nutr 1978; 31:1017-1027

17. Primeaux M, Henderson G: American Indian patient care, *In* Henderson G, Primeaux M (Eds): Transcultural Health Care. Menlo Park, Calif, Addison-Wesley, pp 239-254

18. National Indian Council on Aging: Access, a Demonstration Project Entitlement Program for Indian Elders. Albuquerque, NM, NICOA, 1982

19. DeGeynt W: Health behavior and health needs of urban Indians in Minneapolis. Health Services Rep 1973; 88:360-366

20. Rhoades ER: Profile of American Indians and Alaska Natives, *In* Minority Aging—Essential Curricula Content for Selected Health and Allied Health Professions. Washington, DC, US DHHS publication HRS-P-DV 90-4, 1990, pp 45-64

21. Waldram JB: Access to traditional medicine in a western Canadian city. Med Anthropol 1990; 12:325-348

22. Garrett JT: Indian health values, beliefs and practices, *In* Minority Aging—Essential Curricula Content for Selected Health and Allied Health Professions. Washington, DC, US DHHS publication HRS-P-DV 90-4, 1990, pp 179-191

23. Joe J, Gallerito C, Pino J: Cultural health traditions: American Indian perspectives, *In* Branch MF, Paxton PP (Eds): Providing Safe Nursing Care for Ethnic People of Color. New York, NY, Appleton-Century-Crofts, 1976, pp 81-98

24. Weibel-Orlando J, Kramer BJ: The Urban American Indian Elders Outreach Project—Final Report of Administration on Aging demonstration project 90AMO1273. Los Angeles, Calif, County of Los Angeles Dept of Community and Senior Citizens Services, 1989

25. Dukepoo FC: The Elder American Indian. San Diego, Calif, Campanile Press, 1980

26. Eck RD, St Louis RD: Research Results Concerning Economic and Social Problems of the Elderly Urban Indian in Phoenix, Arizona. Phoenix, Ariz, Nutritional and Coordinated Services for the Elderly Project, 1972

27. Kramer BJ: Study of Urban American Indian Aging. Presented at American Society on Aging annual meeting, Washington, DC, 1989

28. National Indian Council on Aging: Indian Elderly and Entitlement Programs. Albuquerque, NM, NICOA, 1981

29. Kramer BJ: Urban American Indian aging. Cross-Cult Gerontol 1991; 6:205-217

30. National Indian Council on Aging: American Indian Elderly: A National Profile. Albuquerque, NM, NICOA/Cordova, 1981

31. Weibel-Orlando J: Elders and elderlies: Well-being in old age. Am Indian Cult Res J 1989; 13:75-84

32. Manson SM: Older American Indians: Status and issues in housing and health, *In* Aging and Old Age in Diverse Populations. Presented at Minority Affairs Initiative empowerment conferences. Washington, DC, American Association of Retired Persons, 1990, pp 41-51

33. An Evaluation of the Availability of Services Provided to American Indians/Alaskan Native Elderly. St Paul, Minn, American Indian Health Care Association, 1990

34. Strong C: Stress and caring for elderly relatives: Interpretations and coping strategies in an American Indian and white sample. Gerontologist 1984; 24:251-256

35. Kramer BJ, Polisar D, Hyde JC: Study of Urban American Indian Aging—Final Report—AR0118. Washington, DC, Administration on Aging, 1990

36. Manson SM, Murray CM, Cain LD: Ethnicity, aging and support services: An evolving methodological strategy. J Minority Aging 1981; 6:11-37

37. Lockery S: Care in the minority family. Generations 1985; 9:27-29

38. Baker FM, Kamikawa LM, Espino DS, Manson SM: Rehabilitation in ethnic minority elderly, *In* Brody SJ, Pawlson LG (Eds): Aging and Rehabilitation II: The State of the Practice. New York, NY, Springer, 1990, pp 186-207

39. A Portrait of an Older Minority. Washington, DC, American Association of Retired Persons, 1988

40. John R: The state of research on American Indian elders' health, income security, and social support networks, *In* Minority Elders: Longevity, Economics and Health. Washington, DC, Gerontological Society of America, 1991, pp 38-50

41. Lyon JP: The Indian Elder: A Forgotten American—Final Report of the 1st National Indian Council on Aging Conference, Phoenix, Ariz, June 1976. Washington, DC, National Tribal Chairmen's Assoc, 1978, pp 72-74

42. American Indian Physicians' Association: Physical and mental health of elderly American Indians, *In* The Continuum of Life: Health Concerns of Indian Elderly—Final Report of the 2nd Annual Conference on Aging, Billings, Mont, August 1978. Albuquerque, NM, Natl Indian Council on Aging, 1978, pp 123-154

43. Stedman RW: Shadows of the Indian: Stereotypes in American Culture. Norman, Okla, University of Oklahoma Press, 1982