

American Indians and Alaska Natives and Diabetes

Diabetes mellitus poses a significant public health challenge for the US. Some 800,000 cases are diagnosed each year, and changing demographic patterns in the US are expected to increase the number of people at risk for diabetes and who eventually develop the disease. Diabetes is a chronic disease that usually manifests as one of two major types. In type 1, which occurs mainly in children and adolescents, the body does not produce insulin, and insulin administration is required to sustain life. In type 2, which usually occurs in adults over 30 years of age, the body becomes unable to use its own limited supply of insulin effectively. (US DHHS, 2000).

Adult-onset diabetes also has **strong physiologic ties to cardiovascular disease (CVD)**. The majority of patients with diabetes mellitus die of complications of CVD rather than of causes associated directly with glucose control. (US DHHS, 2003).

Diabetes is a major clinical and public health challenge among certain racial and ethnic groups in which both the number of new cases of diabetes and the risk of associated complications are great. Vulnerable and high-risk populations include Asian Americans and Pacific Islanders, elderly persons, and economically disadvantaged persons. Factors that account for this chronic disease epidemic include behavioral elements (e.g., increased fat consumption, decreased physical activity, obesity), demographic changes (aging, increased growth of at-risk populations), genetics, cultural and community traditions, and socioeconomic status. The level of patient knowledge and empowerment has a great impact on the disease burden associated with diabetes. (US DHHS, 2000).

Overweight and Obesity

Overweight and obesity are major contributors to many preventable causes of death. On average, higher body weights are associated with higher death rates. Those who are overweight or obese have a substantially higher risk of developing high blood pressure, high cholesterol, type 2 diabetes, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances and breathing problems, and certain types of cancer. (US DHHS, 2000).

- **Incidence and Mortality**
- **Complications**
- **Traditional Health Beliefs and Practices**
- **Risk Factors and Challenges**
- **Strengths and Protective Factors**
- **Adherence Factors**
- **Diet**
- **Complementary and Alternative Medicine**
- **Service Interventions**
- **References and Resources**

Adherence Factors

Questions to Promote Adherence

- Do you have any questions about what I explained?
- Do you understand what I am recommending?
- Is there anything that would make it difficult to follow my recommendations?
- Is there anything that you think should be changed?

(MSH, 2003b).

Providers should:

- Acknowledge bias.
- Value diversity and difference.
- Look for cultural strengths.
- Recognize the interaction of race, culture, and gender.
- Know that culture is important to the clinical encounter.

(MSH, 2003b).

Communication: Verbal and Nonverbal

- **Handshake.** A firm handshake in Anglo-American culture is a symbol of strong character, but in some American Indian groups, a limp hand is culturally appropriate and is a symbol of humility and respect. (HRSA, 2003b).

Recommendation

To enhance provider-patient communication, build culturally competent care elements into clinical practice guidelines. For example, use the mnemonics BATHE, ETHNIC, and ADHERE. (HRSA, 2003d).

- **English language.** More than 1 in 20 American Indians and Alaska Natives lives in a household in which no adolescent or adult speaks English “very well.” (Smedley et al., 2003).
- Some American Indians and Alaska Natives exhibit a **style of communication that is reserved** and may be interpreted as unfriendly. Many American Indian and Alaska Native people also exercise caution in personal communications with others. Information or problems may not be readily shared.

Recommendation

Do not interpret a failure to volunteer information as an indication that nothing is wrong. An American Indian or Alaska Native patient is more likely to share information if you have developed trust. (Oropeza, 2002).

- **Slow down.** American Indian languages have some of the longest pause times compared with other languages, especially English. Silence is valued, and long periods of silence between speakers is common. (Hendrix, 2002).

Create an Atmosphere of Open Communication

Perhaps the most important thing a provider can do to ensure that a patient adheres to recommended treatment is to create an atmosphere of open communication. The patient needs to trust that the provider is acting in his or her best interests. The patient needs to understand the purpose of the treatment and be confident that the provider has used good judgment in recommending it. What many providers overlook is that the patient needs to be able to tell the provider when he or she does not understand something about the recommended treatment—most importantly, when the treatment conflicts with the patient's beliefs or lifestyle. Cultural factors may interfere with the provider's ability to understand what the patient means or needs. (MSH, 2003b).

Communicate Effectively

- Listen to **how the client describes** his or her condition.
- Learn to **ask questions appropriately**.
- Learn to **observe nonverbal behavior**.
- Ask the client for **his or her views**.
- Know when to involve **family members**.
- Know when to use **interpreters**.

(MSH, 2003b).

- **How to refer to American Indians.** Although there is no agreement about appropriate labels, when speaking generally of American Indians rather than of a specific nation, using the word *people* (Indian people, Native people, indigenous people, First Nation people) may be most appropriate. When speaking of a specific nation such as Lakota, Onondaga, or Nez Perce, use of these specific labels is generally preferable to a broader term. (Weaver, 1998).

Recommendation

When working with a specific client, ask about that client's preferred terms. Doing so communicates respect. (Weaver, 1998).

Keys to Communicating with American Indian Patients

1. **Greet** your patient warmly, smile, shake hands, and be friendly. The return handshake may feel softer or gentler than what you are used to.
2. **Eye contact** is expected at first greeting, but prolonged eye contact may be considered disrespectful.
3. **Do not appear to be in a hurry.** Your patient may have traveled a great distance at great expense to see you. If you spend only a brief amount of time, your patient may get a negative impression of the value of the visit.
4. During the visit, **avoid medical terms that may not be understood.** Do not speak “down” to your patient, however.
5. When you have finished speaking, **give your patient time to reflect** on what you have said. Do not be afraid of silence.
6. Your patient may not understand what you mean if you ask him or her to identify a specific location of pain. Rather than asking, “Where is the pain?” **ask the patient to point to the area of most intense pain.**
7. Patients may wish to perform certain **tribal healing ceremonies**, such as smudging (see the Complementary and Alternative Medicine section), even in the hospital. Try to accommodate these practices.
8. Great respect is given to the elderly. **Treat the elderly with kindness and respect** and do not appear to criticize or scold them.
9. Poverty, distance from the medical facility, and taboos against dying in the home may put a strain on the family of a patient who needs long-term or terminal care. **Discuss different care options with the family** and decide together what option is most appropriate.
10. The **extended family** plays an important role in health care decision-making. Several family members may accompany a patient when he or she arrives to be admitted to the hospital. Try to make accommodations so that family members can be close to the patient’s room or close to the hospital.
11. Work with your patients and their families to determine how best to remember to **take medications at prescribed times or return for appointments** when needed.
12. Indian culture discourages competitive behavior and encourages giving, sharing, and cooperation. **Generosity and doing things for others** are regarded highly.

(Adapted from Diversity Resources, Inc., 2001).

Communicating with Elders

- **Listening is valued over talking** by most older American Indians. Calmness and humility are valued over speed and self-assertion. (Hendrix, 2002).
- Elders frequently complain that **English speakers “talk too fast.”** (Hendrix, 2002).
- **Interrupting a person who is speaking is considered extremely rude**, especially if that person is an elder. (Hendrix, 2002).
- **Nonverbal communication.** A distance of several feet is the usual comfort zone. Body movements are minimal. Except for a handshake, touch is not usually acceptable. (Hendrix, 2002).

Suggestions

- Avoid the “invisible elder” syndrome and ask for the elder’s help in understanding the current situation and in planning the components of care to show respect for the elder’s experience.
- Adapt questions to the patient’s age and acculturation level. Slow down when communicating with an Indian elder, especially during initial encounters and when explaining treatments, medications, or health care decisions.
- Frame questions carefully to convey the message of caring rather than idle curiosity about the patient’s culture or cultural practices. (Hendrix, 2002).

Decision-making

Recommendation

Address the individual’s health problems in the context of his or her family. In many cultures, an individual’s health problems are considered the family’s problems, and it would be improper and disrespectful to exclude family members from medical interactions. Family members can provide valuable information about the patient’s diet, health behavior, daily activities, and types of alternative medications used. Their involvement in a treatment plan may be vital to the patient’s ability to adhere to the recommended treatment. Families may decide what the patient eats, when he or she takes medication, whether he or she exercises, and when he or she seeks medical attention. (MSH, 2003b).

A culturally competent provider discusses with the patient the patterns of decision-making in his or her family. Understanding and respecting the complex and often delicate interactions that exist between family members enable providers to use the patient’s family as a valuable resource, rather than seeing it as an intrusion into the provider-patient relationship. Working with the family often means working with the extended family (aunts, uncles, grandparents, etc.). (MSH, 2003b).

- **Family often extends** beyond the sphere of the traditional nuclear family. Because health care decision-making may include members of the extended family and the community, providers should consider familial influence on treatment decisions. (HRSA, 2003b).

- **Wisdom of elders.** The presence of elders is critical to the provision of culturally competent services. Elders can provide specific advice and emotional support and can guide the approach to counseling or other forms of intervention and prevention from an American Indian and Alaska Native perspective. (MSH, 2003).

Diet

Encouraging Adherence to Recommended Dietary Changes

Getting a patient to change his or her diet is difficult under ordinary circumstances, but cultural factors can complicate a patient's ability to adhere to recommended changes. Diet is so closely related to culture that failure to incorporate a patient's dietary customs is a recipe for noncompliance. Many cultures follow food guidelines based on religious beliefs. Some cultures have strict beliefs about the kinds of food a woman can eat during pregnancy or after giving birth.

Ask the patient about any dietary restrictions. Get a sense of the patient's usual diet and the way foods are prepared at home. Show interest, respect, and understanding for the patient as an individual and as part of a cultural tradition, and you will be rewarded with information about dietary beliefs and traditions that will help you find suitable and appropriate ways to get the patient to make the dietary changes you propose. (MSH, 2003b).

Historical Distrust

- **Past injustices** may cause American Indian and Alaska Native patients to distrust their providers. (HRSA, 2003b).
- **Suspicion and mistrust** are natural outcomes and important survival skills for people who have experienced genocide. Practitioners and program planners who seek to work with American Indian people must realize that their helping interventions may be viewed in this context. (Weaver, 1998).

Suggestion

Patience, perseverance, and working with clients around concrete issues are ways that social workers (and health care providers) can begin to establish trusting relationships with American Indian clients. (Good Tracks, 1973).

Interpretations of Disease and Disability

- Physicians have many ideas about disability. For example, most doctors believe that treatment should include intervention and that biological anomalies should be corrected. However, **some cultures believe that the "disability" is spiritual rather than physical or that the "disability" itself is a blessing** or reward for ancestral tribulations. (HRSA, 2003b).
- Western physicians are well indoctrinated about the dangers of "invisible" diseases such as hypertension and high cholesterol, but people in other cultures may not be as willing to intervene **when there are no symptoms**. (HRSA, 2003b).

References and Resources

Association of American Indian Physicians. (2001). *Yakama tribal WIC program and Washington State Department of Health WIC Program*. Oklahoma City, OK: Association of American Indian Physicians.

Centers for Disease Control and Prevention (CDC). (1999). Trends in diabetes prevalence among American Indian and Alaska Native children, adolescents, and young adults, 1990–1998. <http://www.cdc.gov/diabetes/pubs/pdf/aian.pdf>. Cited September 12, 2003.

Centers for Disease Control and Prevention (CDC). (2002). Diabetes projects. <http://www.cdc.gov/diabetes/projects/cda2.htm>. Cited September 12, 2003.

Department of the Interior. (2002). Indian entities recognized and eligible to receive services from the United States Bureau of Indian affairs; Notice. *Federal Register*, Friday, July 12.

Diversity Resources, Inc. (2001). *Culture sensitive health care: American Indian*. Blacksburg, VA: Virginia Tech, Office of Multicultural Affairs, Diversity and Work/Life Resource Center. <http://www.multicultural.vt.edu/divresources/indian.html>. Cited July 8, 2003.

Fagot-Campagna, A., Burrows, N.R., and Williamson, D.F. (1999). The public health epidemiology of type 2 diabetes in children and adolescents: A case study of American Indian adolescents in the southwestern United States. *Clinica Chimica Acta* 286(1–2):81–95. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10511286&dopt=Abstract. Cited September 12, 2003.

Glanz, K. (2003). *Cancer in women of color monograph*. Bethesda, MD: US Department of Health and Human Services, National Cancer Institute. <http://cancercontrol.cancer.gov/womenofcolor/index.html>. Cited August 27, 2003.

Ghodes, D. (1995). Diabetes in North American Indians and Alaska Natives. In *Diabetes in America*, 2nd ed. NIH Publication No. 95-1468. Bethesda, MD: National Diabetes Data Group, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases. <http://diabetes.niddk.nih.gov/dm/pubs/america>. Cited August 27, 2003.

Good Tracks, J. (1973). Native American non-interference. *Social Work* 18(6):30–35.

Hendrix, L.R. (2002). *Health and health care of American Indian and Alaska Native elders*. Stanford, CA: Stanford University. <http://www.stanford.edu/group/ethnoger/americanindian.html>. Cited August 14, 2003.

Human Resource Services Administration (HRSA). (2003b). *Culture*. Module 3, in draft. Washington, DC: Bureau of Primary Health Care, Institute for Healthcare Improvement, Cultural Competence in the Clinical Care Model Project.

Human Resource Services Administration (HRSA). (2003c). *Complementary and alternative medicine: Issues in serving diverse populations*. Module 5, in draft. Washington, DC: Bureau of Primary Health Care, Institute for Healthcare Improvement, Cultural Competence in the Clinical Care Model Project.

Human Resource Services Administration (HRSA). (2003d). *Pharmacological treatment issues in diverse populations*. Module 6, in draft. Washington, DC: Bureau of Primary Health Care, Institute for Healthcare Improvement, Cultural Competence in the Clinical Care Model Project.

Indian Health Service. (2000). *Trends in Indian health 1998–1999*. Rockville, MD: US Department of Health and Human Services, Indian Health Service.
<http://www.ihs.gov/publicinfo/publications/trends98/trends98.asp>. Cited October 21, 2003.

Indian Health Service. (2001). Diabetes. <http://info.ihs.gov/Health/Health4.pdf>. Cited August 26, 2003.

Kittler, P.G., and Sucher, K.P. (1998). *Food and culture in America: A nutrition handbook*, 2nd ed. Belmont, CA: West/Wadsworth.

Management Sciences for Health (MSH). (2003a). The provider's guide to quality & culture. www.erc.msh.org. Cited July 31, 2003.

Management Sciences for Health (MSH). (2003b). Reducing health disparities in Asian American and Pacific Islander populations: An interactive virtual seminar for providers.

May, P.A., and Gossage, J.P. (2001). New data on the epidemiology of adult drinking and substance use among American Indians for the northern states: Male and female data on prevalence, patterns, and consequences. *Journal of the National Center for American Indian and Alaska Native Mental Health Research* 10(2):1–26.
[http://www.uchsc.edu/ai/ncaianmhr/journal/10\(2\).pdf](http://www.uchsc.edu/ai/ncaianmhr/journal/10(2).pdf). Cited August 22, 2003.

Minnesota Department of Health. (2001). *Health fact sheet*. November 19.

Mutha, S., Allen, A., and Welch, M. (2002). *Toward culturally competent care: A toolbox for teaching communication strategies*. San Francisco: University of California, Center for the Health Professions.

National Diabetes Education Program. (1999). The diabetes epidemic among American Indians and Alaska Natives. <http://ndep.nih.gov/materials/mediakits/am-ind/diabetesamind.pdf>. Cited August 27, 2003.

National Diabetes Information Clearinghouse (NDIC). (2002). *Diabetes in American Indians and Alaska Natives*. NIH Publication No. 02-4567. Bethesda, MD: National Institute of Diabetes and Digestive and Kidney Diseases.
<http://diabetes.niddk.nih.gov/dm/pubs/americanindian/index.htm>. Cited August 26, 2003.

National Heart, Lung, and Blood Institute. (2001). *Strong heart study data book: A report to American Indian communities*. NIH Publication No. 01-3285.

http://www.nhlbi.nih.gov/resources/docs/shs_db.pdf. Cited August 26, 2003.

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). (2002). Diabetes prevention study benefits American Indian participants.

<http://www.niddk.nih.gov/welcome/releases/02-06-2002.htm>. Cited August 26, 2003.

National Women's Health Information Center. (2003). Health information for minority women: American Indian/Alaska Native women: Diabetes.

<http://www.4woman.gov/minority/index.cfm?page=181>. Cited August 26, 2003.

Native American Diabetes Project. (2003). Strong in body and spirit.

<http://www.laplaza.org/health/dwc/nadp/index.htm>. Cited August 27, 2003.

Noe, T., Fleming, C., and Manson, S. (2003). Healthy nations: Reducing substance abuse in American Indian and Alaska Native communities. *Journal of Psychoactive Drugs* 35(1):15–25.

<http://www.uchsc.edu/ai/hni/>. Cited August 25, 2003.

Office of Minority Health. (2002). National forum on health disparity issues for American Indians and Alaska Natives, September 22–26.

http://www.omhrc.gov/omh/tribal%20colleges/2pgtcu/plans_tcu_002.htm. Cited February 13, 2003.

Oropeza, L. (2002). *Clinician's guide: Working with Native Americans living with HIV*.

Oakland, CA: National Native American AIDS Prevention Center (NNAAPC).

<http://ewebs.realtimesites.net/ds-Southwestern/sout-j-1/ImagesCust/970037646-10-01-2002-10-56-57e.pdf>. Cited August 25, 2003.

Rainbow Nations. (2003). Smudging. <http://www.rainbownations.com/>. Cited September 12, 2003.

Robinson, B.A. (2002). *Native American spirituality*. Ontario, CA: Consultants on Religious

Tolerance. <http://www.religioustolerance.org/nataspir.htm>. Cited July 14, 2003.

Sage, G.P. (2001). Worldview, identity, and prevention in American Indian communities. In Trimble, J.E., and Beauvais, F. (eds.). *Health promotion and substance abuse prevention among American Indian and Alaska Native communities: Issues in cultural competence*. DHHS Publication No. SMA 99-3440. Washington, DC: US Department of Health and Human Services, pp. 67–80.

Smedley, B.D., Stith, A.Y., and Nelson, A.R. (eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press, Institute of Medicine.

US Department of Health and Human Services (US DHHS). (2000). *Healthy people 2010: Understanding and improving health*, 2nd ed. Washington, DC: US Government Printing Office. <http://www.bphc.hrsa.gov/quality/HealthyPeople2010.htm>. Cited August 26, 2003.

US Department of Health and Human Services (US DHHS). (2003). Demographics and health disparities. Draft curriculum module 2 for Cultural Competence in the Clinical Care Model Project. Washington, DC: Health Resources and Services Administration, Bureau of Primary Health Care.

Weaver, H.N. (1998). Indigenous people in a multicultural society: Unique issues for human services. *Social Work* 43(3).