PROVIDING CULTURALLY COMPETENT DIABETIC CARE

TO THE PASQUA YAQUI

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ABSTRACT

Type II diabetes is epidemic among Native American tribes of the United States. It is important for nurses to have authentic knowledge about the traditional healing beliefs and practices of the tribes they come in contact with. In this report, literature from the fields of nursing, medicine, anthropology, and history is reviewed and synthesized for information regarding traditional healing beliefs and practices of the Pasqua Yaqui tribe of Southeastern Arizona. The information is then organized according to the Purnell Model for Cultural Competence within the domains of spirituality, family roles and organization, and health care practices. The report concludes with specific recommendations for the culturally competent nursing care of Yaqui clients with diabetes.
CHAPTER 1: INTRODUCTION

A note on terminology:
This is a report on the ethnohealth beliefs of a particular tribe among America’s original inhabitants. Many expressions have been used to identify these people. The author prefers the term “Native Americans” as it is technically accurate while duly acknowledging these peoples as the original inhabitants of this land.

A word is also appropriate regarding the particular tribe in question. The Pasqua Yaqui were given their name by the Spanish (Pasqua means Easter, while the term Yaqui comes the river that was their ancestral home, which the Spanish called the Rio Yaqui). The word Yaqui is sometimes also spelled Hiaki. The name they use for themselves is the Yoeme. The author will use the terms Yaqui and Pasqua Yaqui as they are probably more familiar to the majority of readers.

The reader should also understand that the term “diabetes” as it is used in this report refers only to Type II diabetes, also known as adult-onset diabetes and non-insulin dependent diabetes (NIDDM). This is because the cause of Type I diabetes, also known as juvenile-onset diabetes and insulin dependent diabetes (IDDM,) is caused by an autoimmune reaction. On the other hand, Type II diabetes has been shown to be both caused and perpetuated by lifestyle choices, and the focus of this report is to understand ways in which nurses can promote healthy lifestyles for their Native American clients within the context of traditional health related beliefs and practices.

The United States is a collage of subpopulations, people of various races and ethnicities, with each individual creating a unique pattern of identification with historical and cultural ties. Every individual will seek measures of health preservation and restoration in the course of his or her life. It is the unique privilege and responsibility of nursing to provide this care in ways that are personally and culturally meaningful and satisfying to the client. Yet this is an incredibly complex challenge, which cannot be answered without the acquisition of useful cultural knowledge.

Within the general society, there are certain populations that are considered vulnerable due to their relatively marginalized social standing or potential for exploitation, including children, pregnant women, the poor, minorities, AIDS victims, and those who have difficulty securing insurance because of preexisting conditions.
(American Nurses Association (ANA), 2004). These groups often experience disparities in care access and provision. The ANA has mandated that nursing as a profession advocate for these groups. Yet it is difficult for effective advocacy to occur when shared understandings do not exist because of vastly different worldviews between provider and client. One such group that virtually all nurses have come into contact with, yet only a few are truly knowledgeable about, are Native Americans.

Native American health issues have been the focus of study of many disciplines for some time now. In addition to nursing, these disciplines include medicine, sociology, epidemiology, and anthropology. Yet the great majority of these studies have a focus on the quantification of incidence and prevalence, the objective measurement of symptoms, or the response to treatment regimens. The problem is that in spite of this ongoing quest for quantifiable knowledge, the prevalence of diabetes and other preventable illness in this highly vulnerable population continues to increase exponentially. Without an adequate perspective on the ethnocultural meanings of health and illness among native peoples, and its resulting influence on the beliefs and practices of the people, the provision of culturally meaningful and relevant care is simply not possible. Thus the ascending spiral of illness and suffering can only continue.

It is of primary importance that the reader understands that every distinct Indian tribe and Nation has its own unique set of cultural knowledge and is in an equally unique position regarding the willingness and ability of its members to adapt or assimilate into mainstream American culture. It is important for nursing to develop the knowledge base regarding native ethnocultural practices and beliefs and the ways in which they affect the
provision and receipt of health care. Only in this way can culturally competent care be delivered to this population. Too easily and too often, generalizations based on misperceptions masquerade, even among the well intentioned, as genuine cultural knowledge. Nurses need both general and specific cultural knowledge in order to partner effectively with their clients (Purnell & Paulanka, 2003).

Nowhere is the need for authentic cultural knowledge greater than in the management of preventable chronic disease. Native Americans today are beset by a host of largely interrelated long-term threats to their health, including obesity, coronary heart disease, hypertension, and diabetes. The management of such illnesses requires a close therapeutic relationship between client and provider. Within this relationship the nurse must provide expert coaching and guidance through effective and personal lines of communication. But the deep understandings this communication requires cannot develop in the absence of authentic cultural knowledge. This report aims to use the Purnell Model for Cultural Competence to assess the literature and extract information that is relevant for the provision of culturally competent care to Yaqui clients with diabetes.
CHAPTER 2: SCOPE OF THE PROBLEM

It would be difficult to overstate the profound impact diabetes has had on the Native American population. This impact can be demonstrated by quantifiable morbidity and mortality figures. Hospitalizations due to diabetic ketoacidosis (DKA), hypoglycemic events, insulin shock, blindness, renal failure, lower-extremity amputation (LEA), and cardiovascular disease are some of the grim prospects facing the individual diagnosed with diabetes. But the impact also consists of the disruption in the lives of affected individuals and their families as well as the more pervasive social disintegration that is occurring as a result.

It is common knowledge that diabetes is epidemic among native peoples at this point in history. Native Americans are roughly three times more likely to acquire diabetes than Caucasians (Centers for Disease Control, 1998). Type II diabetes is by far the more prevalent of the different types diagnosed. This has previously been known as adult-onset diabetes, but is now being seen in children as young as 12 in the general population of the United States (Ramchandani, 2004) as well as on the Yaqui reservation (F. Molina, personal communication, March 2003).

Acton, Burrows, Moore, Querec, Geiss, and Engeigau (2002) found that in virtually every category of age and gender, there was an exponential increase in prevalence of Type II Diabetes in Native Americans between 1990 and 1998. The increases in prevalence were most notable in adolescents and young men. The prevalence of Type II diabetes among Native Americans aged 19 years and younger is 4.5 per 1,000.
This is in stark contrast to the prevalence rate among all U.S. citizens of 1.7 per 1,000 for the same age group (Centers for Disease Control, 2004).

Finally, while there were 22.3 diabetes-related deaths per 100,000 residents among all racial groups in Arizona in 2002, among Native Americans that figure was 80.8, almost four times higher (AZ Dept. of Health Services, 2003). These figures already exceed the Healthy People 2010 targets and are increasing annually.

The Clinical Problem in the Context of Native American Culture

The harm that diabetes is inflicting on native peoples is not limited to the physical symptoms experienced by individuals. The damage inflicted on an individual's body is reflective of the harm caused on the social body of families, communities, tribes, and the entire Native American population. Tribal resources, including those of the Indian Health Service, are facing serious difficulties in trying to meet the burgeoning need.

Since diabetes is a chronic disease with multiple and holistic implications for personal, family, and community life, there will be of necessity a variety of ways in which diabetes can be perceived by someone afflicted by it. Add to this a cultural perspective that may differ significantly from mainstream beliefs and it is easy to see that a client may have ways of conceiving of this disease that are quite unknown to the practitioner. This can in turn lead to problems in teaching, the receiving of information, and the carrying out of a therapeutic plan.

Since Madeleine Leininger (1991) first published her Theory of Culture Care Diversity and Universality, nurses have come to understand the relevance of culture and health belief systems to client care. Understanding the ways in which a client perceives
health and illness allows nurses to tailor treatment plans more congruently to a client's personal belief system and lifestyle. When treatment plans cannot be easily altered to conform to a particular belief, explanations can be given that are more meaningful to the client. Thus the likelihood of successful outcomes, from both provider and client perspectives, can be increased.
CHAPTER 3: SIGNIFICANCE OF THE REPORT

While much has been written on Native American beliefs and practices, some of this information is becoming outdated or applies to tribes other than the Yaqui, which may limit generalizability. Native American culture is in transition, and the knowledge base requires continual updating in order to remain relevant. The value of this report is that the literature is assessed and synthesized for specific information that nurses can use to provide culturally competent care to Yaqui clients with diabetes. This report can serve as a convenient reference for nurses to learn about Yaqui healing beliefs and practices and ways in which that knowledge can be used in the provision of care.
CHAPTER 4: THEORETICAL OVERVIEW

The Purnell Model for Cultural Competence “provides a comprehensive, systematic, and concise framework for learning and understanding culture (Purnell & Paulanka, 2003, p.8). According to the authors, the purposes of the model are to:

1) Provide a framework for all health-care providers to learn concepts and characteristics of culture
2) Define circumstances that affect a person’s cultural worldview in the context of historical perspectives
3) Provide a model that links the most central relationships of culture
4) Interrelate characteristics of culture to promote congruence and to facilitate the delivery of consciously sensitive and competent health care
5) Provide a framework that reflects human characteristics such as motivation, intentionality, and meaning
6) Provide a structure for analyzing cultural data
7) View the individual, family, or group within their unique ethnocultural environment (Purnell & Paulanka, 2003, p.8).

The metaparadigm concepts of the model include the concepts of person, family, community, and global society. These represent all possible levels of human social organization. All people simultaneously exist within each of these levels, and need to be assessed by health care providers accordingly. As the Yaqui do not have a significant global distribution, this report will focus on the levels of community, family, and person. The model also includes the metaparadigm concept of health, defined by Purnell &
Paulanka as “a state of wellness as defined by people within their ethnocultural group” (p.10).

There are twelve domains of information categorized by Purnell. These are: 1) Overview, inhabited localities, and topography, 2) Communication, 3) Family roles and organization, 4) Workforce issues, 5) Biocultural ecology, 6) High-risk behaviors, 7) Nutrition, 8) Pregnancy and childbearing practices, 9) Death rituals, 10) Spirituality, 11) Health care practices, and 12) Health-care practitioners. (See figure A). For truly in-depth knowledge of an individual or society, it would of course be necessary over the course of time to acquire information from each of these categories to gain a true understanding of that individual or society. However, as Purnell and other researchers have demonstrated, selected domains can be extracted and focused upon a certain topic for the purpose of acquiring specific information. This is what will occur in the course of this report. All the same, as each of the domains are interconnected to all others, inevitably additional information will be gleaned which will serve the greater understanding.

The following three domains were chosen for utilization by the author on the basis that they possess the greatest relevance for health care professionals working with Yaquis with diabetes:

1) **Spirituality.** The importance of spirituality in all cultures is that it can have an overriding influence on virtually every other aspect of life. Spirituality includes all behaviors that give meaning to life and provide strength to the individual (Purnell & Paulanka, 2003, p.32). Important aspects of spirituality include
dominant religion and use of prayer, the meaning of life and individual sources of strength, and spiritual beliefs and health care practices.

2) **Family roles and organization.** This cultural domain affects all other domains and defines relationships among insiders and outsiders (Purnell & Paulanka, 2003, p.18). Family structure within the context of community structure influences roles, priorities, and behavioral norms. Important aspects of family life include head of household and gender roles, prescriptive, restrictive, and taboo behaviors for children and adolescents, and family goals and priorities.

3) **Health care practices.** All cultures possess ways of maintaining health as well as ways of preventing illness or alternatively, coping with it. These ways can show a remarkable degree of variety and have roots in traditional, magico-religious, and biomedical beliefs. Important elements of health care practice include health-seeking beliefs and behaviors, beliefs on the individual responsibility for health management, folk practices, and cultural responses to health and illness such as the expression of pain and perception of the sick role. Disparity in access to and quality of health care is one of the defining realities of vulnerable populations.

These three domains will provide the theoretical framework for examining the literature and organizing information that will assist nurses and other health care providers in delivering culturally competent care.

The last concept of the model is cultural competence. Purnell & Paulanka assert that the acquisition of cultural competence proceeds through the phases of unconscious incompetence, conscious incompetence, and conscious competence to the final and
desirable state of unconscious competence, in which the provider, through education and experience, intuitively provides culturally competent care to members of a given population. This process, according to the authors, is nonlinear, meaning that it does not proceed smoothly or predictably from one phase to the next.

Assumptions

The following assumptions provide support for the use of the Purnell model in this report.

1. Cultural values and beliefs affect the way individuals respond to health and illness.
2. The acquisition of expertise in ethnohealth issues requires both quantitative and qualitative knowledge and methods of study.
3. The provision of culturally competent care is not possible without both general and specific cultural knowledge of the target population.
4. Policy makers and individual caregivers who understand their clients' cultural values, beliefs, and practices are better positioned to provide care that is congruent with the client’s cultural beliefs and practices.
CHAPTER 5: YAQUI HISTORY AND CULTURE

Yaquis were living in the area from the Yaqui River, in the Yaqui River Valley near Guaymas, Sonora, Mexico, to the Gila River in Southeast Arizona since 552 A.D. Conflict between the Yaqui and the Spanish, who moved into the area looking for slaves and silver, began in 1533. For generations the Yaqui people continued to fight the Spanish, and then the Mexicans (after they won their independence from Spain). During this time, the Yaqui asked the Jesuits to enter Yaqui villages to do missionary work and economic development. Most of the 60,000 Yaquis settled into eight sacred towns or "pueblos" and built churches. In 1897, a peace treaty was signed at Ortiz, Sonora between the Yaqui people and the Mexican government. In 1939, Mexican President Cardenas granted the Yaqui tribe official recognition and title to their land.

In the United States, the last battle with the U.S. Cavalry took place on January 8, 1918, at Arivaca. On September 18, 1978, the Pascua Yaqui Tribe of Arizona gained Federal recognition as a “created tribe”. In 1994, the Federal government upgraded their status to that of a “historic tribe” (from Sandoval, 2001. See Appendix for the complete history).

In 2003, the Pasqua Yaqui Tribe had 13,148 enrolled members (AZ Dept of Commerce, 2004). There is one tribally owned health care clinic on the reservation, as well as a traditional healer named Dolores Flores. People also go to clinics and hospitals in Tucson for care (AZ Dept of Commerce, 2004).

For non-Yaquis it may be difficult to fully grasp the blend of ancient Yaqui beliefs and the religion taught to them by Jesuit priests in the 1500s, but they successfully
melded the two into a unique belief system that includes their beloved deer dancer. The Yaqui may be best known for the Deer Dance, an ancient religious ceremony in which the highly trained male dancer wears a headdress depicting a deer's head and whose steps imitate the movements of a deer. It is during the Easter season that the deer dancer is most prominent, participating in ceremonies that depict events of this holy period (Pasqua Yaqui Tribe, 2001, Yaqui Culture, paras. 1-3).

Flowers are important to the Yaquis' daily lives and ceremonies. They combine the ancient belief that the deer dancer is from a flower-filled spiritual world of natural beauty with the belief that Christ's grace is symbolized by flowers that grew from blood that fell from Jesus' wounds during the crucifixion. Flowers are believed to be powerful weapons against evil and are a prevailing symbol seen in elaborately embroidered floral designs on traditional Yaqui clothing (Pasqua Yaqui Tribe, 2001, Yaqui Culture, para. 4).

The family remains the basic social unit in Yaqui life. The kinship system regards age and gender more highly than formal biological relationships. For example, people about the same age are called cousin; elders separated by one generation are aunts and uncles, nieces and nephews. Ritual kinship is also important. To accept the role of godparents implies an actual obligation to care for another’s children in case of their incapacitation. This and other mutual family assistance constitutes relationships that are generally maintained for life (De Vera, 1998, p. 47). These traditions have roots in both Yaqui and Spanish social history.
CHAPTER 6: TRADITIONAL YAQUI HEALING BELIEFS AND PRACTICES

Traditional Yaquis believe that health is conferred by a state of harmonious balance between the individual and nature. Disease can result from an imbalance in this relationship, as punishment for sin, or from supernatural forces. Medicine men / herbalists, known by the Yaqui name of hitevi or by the Spanish curandero can administer herbal medication, perform purification ceremonies to restore balance, or utilize dreams to discover the nature and source of a hex, or evil spell, placed upon the patient. Diet and massage are also frequently used as curatives in traditional practice (De Vera, 2003, p.40).

Spiritual power is known to the Yaqui as seataka. This is the power utilized by traditional healers to cure. But seataka goes far beyond that. All humans are said to possess seataka. So are certain animals, plants, and rocks. However, only a very few people, animals, and places are said to possess it in abundance. Among humans, these include healers and great leaders. In nature, the deer, a central figure in Yaqui culture and religion, is said to possess great seataka. And very remote and wild desert places possess such great seataka that a person remaining in these places for too long would be overwhelmed by its power and become insane (Shutler, 1977, pp. 186-188).

The patient may also utilize prayer to God, Jesus, Mary, the Saints, animal and plant spirits, or deceased ancestors for relief from disease. Frequently a manda or promesa (promise) is made, obligating the supplicant to perform a service, sometimes for life, to the deity in return for a cure (Shutler, 1997, p. 195).
Western medicine made its debut into Yaqui healing culture through the Spaniards, whose theory of disease causation was founded on the Hippocratic doctrine of the four humors, blood, phlegm, and black and yellow bile (Shutler, 1977, p.17). This has since been replaced with modern Western medicine. Modern Yaquis may make use of traditional methods, modern Western medicine, or, very frequently, a combination of both.
CHAPTER 7: LITERATURE REVIEW: TYPE II DIABETES AMONG NATIVE AMERICANS

While literature of this type remains somewhat limited, a few researchers have still done much to draw out authentic and specific cultural knowledge in the context of nursing theory through ethnographic and phenomenological methods. Even so, Purnell & Paulanka (2003, p.xxii) point out quite rightly that "there continues to be a paucity of literature on specific ethnocultural groups", including Native Americans. This deficit in nursing's knowledge base is most apparent in the lack of research done on the subjective meaning of illness to Native Americans. Compounding this problem is the fact that each individual tribe has its own distinctive cultural knowledge that is quite foreign to most non-native providers.

Diabetes has not always been a problem for Native Americans. Felipe Molina, (personal conversation, March 2003) relates that before Anglos were seen in the American West, there was no diabetes among the Yaqui and it was not unheard of for people to live to be 100 years old. In the 1940’s, it was still a rare condition among Native Americans (Parker, 1994, p.5). It was in the 1970’s that diabetes began to present a threat to the health of the Native American community (Huttlinger, 1995, p.10). Since then its prevalence has continued to increase exponentially until reaching its current epidemic proportions. The coming of the Anglos initiated major changes in the Native Americans’ way of life. This included altering a diet that was largely plant-based to one based on highly processed carbohydrates and a decrease in levels of activity as the people moved from a hunter-gatherer society to one in which unemployment and a sedentary
lifestyle is the norm. Coupled with this was the loss of the communal social and healing practices that kept the people in balance within themselves and with nature, thus becoming unhealthy by their own culturally based definition. These events occurred much too fast for biological adaptation to keep pace. Seen in this light, the diabetes epidemic is not at all hard to understand, and can in fact be seen as almost inevitable.

The scope of this epidemic was demonstrated clearly by the Strong Heart study (Howard, Lee, Fabsitz, Robbin, Yeh, Cowan, & Welty, 1996). This was a landmark study both for the quantification of diabetes in the native population and its role as a risk factor for heart disease. It was not actually designed to study diabetes per se. Its purpose was to quantify coronary heart disease and its risk factors, including diabetes, among three geographically diverse groups of American Indians. The phase I examination (1989-1991) revealed very high prevalence rates of diabetes that ranged from 33 to 72% in men and women in the three centers (p.601-602). These figures demonstrate the rapidity with which diabetes is sweeping through the native population.

Mary Shutler in 1977 put forth a magnificent description of the traditional health beliefs and practices of the Yaqui living at Pasqua Pueblo, which was based on a previous doctoral dissertation for the University of Arizona Department of Anthropology. While this work was done outside of a nursing perspective or theoretical base, it is nevertheless a remarkably comprehensive and authoritative work. See the section on traditional Yaqui healing beliefs and practices for some of the information gleaned from this study.

In one important and original study, “Doing Battle”, Huttlinger (1992) highlighted the importance of metaphorical communication about diabetes among Navajos. In this
ethnographic study, Huttlinger analyzed interviews with 20 Navajo men and women with diabetes as well as utilizing participant observation. She found that when talking about diabetes, the Navajo frequently use metaphorical images having to do with war, by using expressions such as “doing battle” with diabetes, referring to amputations as “wounds”, expressing feelings of being “captives” of the disease and “losing the war” against diabetes. The author concluded that the Navajo saw diabetes itself as a metaphor for larger changes in lifestyle and traditions. The author further concluded that clinicians could improve communication with their clients by understanding these metaphorical relationships.

The previously discussed study was part of a larger one by the same author (“A Navajo Perspective of Diabetes”, 1995), in which Huttlinger interviewed and observed 33 adult Navajo diabetics over a three-year period. Huttlinger identified a conceptual framework that she termed the “emergent dimension” (p.13) that represented the unique dimension of thoughts and ideas the Navajo had regarding diabetes, which was interfering with their ability to cognitively arrange the concept of diabetes into their cultural domain of understanding. Huttlinger emphasized that diabetes needs to be considered a manifestation of intergenerational posttraumatic stress disorder. Her point is that diabetes, along with poverty, teen pregnancy, alcoholism, obesity, and other psychosocial and biological ills are manifestations of the catastrophic stress experienced by Native Americans since the arrival of the Anglos on the continent.

Parker (1994) described the lived experiences of Native Americans with diabetes in rural Oklahoma from a transcultural perspective. Ten adult Native Americans from
seven different tribes participated in this study. The author utilized non-structured interviews and observation to collect data. From this, six themes were identified: 1) reactions to diabetes, 2) responses to loss of health, 3) identification with others, 4) fear associated with the disease process, 5) peace related to the diagnosis of diabetes, and 6) grieving associated with the diagnosis of diabetes.

Hennessy (1999) in her study of the diabetic educational needs of family members, used five focus groups composed of Native Americans from five tribes in New Mexico and two tribes from Oklahoma who were caring for elders with diabetes at home. The content of diabetes education for these families, challenges faced by caregivers, and the need for support services were questioned. The families reported that anxiety about in-home care, coping with psychosocial issues, decision-making, and communication with other family members ranked among their greatest challenges. The caregivers emphasized that developing a routine was instrumental in successful in-home management of diabetes. The caregivers also asked that more education be directed toward caregiver issues, rather than being directed exclusively at patient requirements.

Most recently, de Vera (2003) offered an excellent description of the perspectives of four Yaqui people with diabetes regarding biomedical and traditional methods for healing foot ulcers. Madeleine Leininger’s Sunrise model (1991) provided the conceptual framework for the study. The author identified four cultural themes: 1) belief in God is expressed in prayers for healing, 2) the way to keep healthy is to take care of one’s self, 3) foot ulcer is a modern illness that takes time to heal, and 4) support is important to survive a difficult journey.
CHAPTER 8: SUMMARY OF STUDIES AND THEIR APPLICATION TO PRACTICE

At this point it is possible to summarize the literature presented in the context of the chosen domains of Purnell’s Model of Cultural Competence to explicate the relevant ethnocultural beliefs about diabetes among the Pasqua Yaqui.

**Spirituality**

To begin with, spirituality figures importantly into how people with diabetes view their condition and their resulting life roles. The Navajo participants in Huttlinger’s (1995) study could not clearly define a cause for diabetes in their own terms and often believed it arose from supernatural sources. Others see it as an “Anglo disease”, and so prefer Western medicine in its treatment (p.12). Nurses engaging in any sort of diabetic teaching should determine at the outset the client’s conception or definition of what diabetes is.

The traditional Native American concept of health and illness, including that of the Yaqui, is that health is the result of a harmonious and balanced relationship between an individual and nature. Mind, body, and spirit are the components of that balance. Disease results from an imbalance of these forces. Treatment, therefore, is directed at the restoration of that balance. Traditional Yaqui healing practices based on spirituality include the use of seataka (healing energy that comes through the healer through the use of ceremony, dream interpretation, and herbal medicines) and prayer.

The literature shows that spirituality provides a source of strength and support for people with diabetes. All the participants in de Vera’s (2003, p.44) study believed that “prayers were the best help in healing”. Shutler (1977, p.193) described the use of prayer...
as “the constant accompaniment to every phase of curing”, demonstrating the importance of prayer in the daily life of the Yaqui. Healers will pray for the curing of their patients. The patients themselves are also enjoined to pray for a cure, as are their friends and relatives.

Nurses can certainly encourage their clients to participate in spiritual activities in whatever way the individual client chooses to practice them. In assessment, sources of spiritual support and methods of practice need to be determined. In planning and implementation, the concept of balance can be easily utilized when constructing diabetic care plans. A proper diabetic diet contains a balance of food types. A balance of exercise and rest will help to stabilize blood glucose levels and promote weight loss. And a balanced emotional outlook will reduce stress and its disruptive effects on the hypothalamic-pituitary-adrenal (HPA) axis, promoting immune function and weight loss.

Family roles and organization

Diabetes not only affects individuals, but families, communities, and entire societies as well. This effect can be especially felt among the Yaqui, as theirs is such a family oriented society.

De Vera (2003, p.42) noted that support is important for Yaquis with diabetes. One category that emerged from her data was family support. This support could come from immediate, extended, or ritual family members. Difficulties were also noted when there was lack of family support and understanding. Hennessy (1999, p.748) noted that in practice "the objective of addressing diabetes care needs as a family-focused effort is
typically not achieved”. Due to the strong lifestyle component of diabetes, it is clear that this is not an acceptable situation.

It is therefore of utmost importance for nurses to bring the family into the plan of care. In assessment, the provider needs to enumerate the immediate, extended, and ritual family members and determine the quality of those relationships, weak or strong, supportive or confrontational. In planning and implementation, it is absolutely essential that family members are included in educational sessions, especially those who will be doing the cooking or providing other care.

Hennessy (1999) found that the caregivers were usually female and provided assistance not only with direct care such as foot care, glucose monitoring, wound care, prosthetics, in-home dialysis, and medication administration, but also the myriad of daily living tasks such as cooking, cleaning, bathing, shopping, and going to doctors (p.749). The caregivers identified three major challenges in caring for elders with diabetes: 1) anxiety, 2) dealing with difficult psychosocial issues such as depression and noncompliance, and 3) decision-making and communication with other family members (p.750).

Family members identified three strategies for finding the personal strength to successfully manage the elders’ diabetes: 1) developing efficient caregiving routines, 2) mastering care techniques, and 3) coordinating other family assistance (pp.751-752). The first two of these are related, as better technique will promote efficiency as well as decrease anxiety. The provider who has made a thorough assessment of the client’s
family situation will be better able to promote family cohesiveness and sharing of tasks, leading to improved home care for the client.

Parker (1994, p.9) noted that many people had multiple siblings who had been diagnosed with diabetes. Husbands and wives also frequently share the diagnosis. Sometimes, family traditions interfere with adherence to diabetic meal plans, as one of Parker’s participants (p.10) explains: “Sometimes, our traditions win and we do not care for that moment. We feast with our loved ones and friends”. Another participant said about a family reunion “‘We cannot turn down food at gatherings like this’ as she looked over tables filled with fried foods” (p.11). Nurses teaching dietary interventions to Yaqui people need to reach an understanding with them about how they plan to approach this particular challenge.

Health care practices

An important consideration in the provision of nursing care is determining an individual’s preference for and use of traditional native beliefs and practices as opposed to, or in conjunction with, a willingness to accept Western medical care. The literature clearly shows that providers cannot assume any specific preference based solely on race or tribal affiliation. It is not surprising that the Yaqui blending of native and Christian religions finds expression in a blending of health beliefs and practices. In fact, many Yaqui routinely make use of both native and Western practices. Because reliance upon traditional Native healing practices will vary among individuals, each client must in the end decide how to incorporate the new information (diagnosis of diabetes coupled with possibilities of utilizing Western medical practices) into their traditional cultural
inheritance. As one participant in Parker’s study (1994, p.10) put it, “Among our paraphernalia, we have added something new … a glucometer”. Here we see a metaphor for the blending of the old with the new. This is consistent with Huttlinger’s (1995) ‘emergent dimension’, in which Native Americans seek to cognitively integrate the concept of diabetes into their cultural framework.

As previously mentioned, Shutler (1977) and de Vera (2003) found that traditional Yaqui healing practices include the use of seataka, prayer, massage, medicines, diet, and exercise. The first three have been shown to have, at the very least, positive effects on the HPA axis and emotional well-being. This is in addition to any benefits of a supernatural nature that can be gained. The last three of these are mainstays of Western medical care for diabetes. By referencing suggested medical interventions as appropriate to the traditional Yaqui way of life, nurses can increase the likelihood of reaching a mutually agreed upon plan of care.

A major challenge to the successful management of diabetes among Native peoples is the disparity in access to care that so many of them experience. This is due largely to a combination of the rural environment in which most Native Americans live, low socioeconomic status, and limitations in resources of the formal health care system. This often results in the inability to obtain care in a timely manner or the abandonment of care plans by clients for lack of resources. These are very difficult issues for providers to address on an individual basis. Nurses need to work within their professional organizations to help shape public policy in ways that are more favorable to vulnerable populations.
Of course, the best way to manage diabetes is to prevent it altogether. As Purnell & Paulanka (2003) state, “All cultures possess ways of maintaining health as well as ways of preventing illness” (p.29). De Vera (2003, p.44) relates that the Yaqui seek to “live a healthy life”, and that self-responsibility is a desirable value within the culture. Similarly, the Navajo seek to walk in the Blessing Way. Both of these expressions are indicative of the lifeway based on a harmonious relationship between the individual and nature, resulting in the spiritual, emotional, and physical health the Native population enjoyed in past generations. In assessment, nurses should inquire about their clients’ beliefs in personal responsibility for health maintenance. Does the client believe that he or she is responsible for preventing or controlling diabetes? Or is their attitude more fatalistic in believing it is caused or controlled by outside, perhaps supernatural forces? In planning and assessment, nurses can help clients to see that their attitudes and actions can make a difference in the quality of their own lives. Self-responsibility and good self-care can be encouraged as appropriate to the traditional Yaqui way of life, which will show awareness of and respect for the Yaqui cultural inheritance.
CHAPTER 9: FUTURE DIRECTIONS

Few studies have been conducted with the Pasqua Yaqui to ascertain the effect of their unique cultural beliefs and practices on the care provided by practitioners of Western medicine. There is plenty of scope left for further inquiry into their cultural beliefs as they impact a variety of other physical and psychosocial diseases that affect their population. In particular, qualitative nursing studies that incorporate anthropological methods such as interviews and participant observation would be very helpful in bringing out the emic, or insider, point of view.
CHAPTER 10: CONCLUSION

This report has examined the literature in the context of Purnell’s Model of Cultural Competence to organize the literature within the domains of spirituality, health beliefs and practices, and family roles and organization. The relevant aspects of the literature have then been synthesized within these domains so that nurses can use the information to provide culturally competent and appropriate care to their Yaqui clients with diabetes.
Appendix A

History of the Pasqua Yaqui

This is the history of the Yaqui as told by Ernesto Quiroga Sandoval, Historian, Pascua Yaqui Tribe (2004).

The Yaquis were well accustomed to the many parts of North America. By 552 AD, Yaquis were living in family groups along the Yaqui River (Yoem Vatwe) [also known as the Rio Yaqui, in the Yaqui River Valley near Guaymas, Son., Mex.] north to the Gila River, where they gathered wild desert foods, hunted game and cultivated corn, beans, and squash. Yaquis traded native foods, furs, shells, salt, and other goods with many indigenous groups of central North America. Among these groups are the Shoshone, the Comanche, the Pueblos, the Pimas, the Aztecs, and the Toltec. Yaquis roamed extensively in pre-Columbian times and sometimes settled among other native groups like the Zunis.

By 1414, the Yaquis were organized into autonomous, yet unified, cultural and military groups.

In 1533, the Yaquis saw the first white men: a Spanish military expedition searching for slaves. The Spanish who initiated warfare were soundly defeated, but took thousands of Yaqui lives. Between 1608 and 1610 the Spanish repeatedly attacked the Yaqui people. The Yaquis proved they could raise a fighting force of 7,000 within a few hours to successfully defend Yaqui land and cultural integrity.

Nevertheless, the Yaquis preferred peace. They asked the Jesuits to enter Yaqui villages to do missionary work and economic development. Most of the 60,000 Yaquis settled into eight sacred towns or "pueblos" and built churches: La Navidad del Senor de Vikam, Santa Rosa de Vahkom, La Asuncion de Nuestra Senora de Rahum, Espiritu Santo (Ko'okoim), Santa Barbara de Wiwisim, San Ignacio de Torim, San Miguel de Veenem, and La Santisima Trinidad de Potam.

Silver was discovered in the Yaqui River Valley around 1684. The Spanish, who treasured the silver stone, began moving into the area, began taking sacred Yaqui land, and treated the Yaqui people disrespectfully.

In 1740, the Yaqui allied with the neighboring Mayo tribe to force the Spanish out of the God-given Indian lands. For the next 190 years, the Yaqui people continued to fight the Spanish, and then the Mexicans (after they won their independence from Spain). Juan Banderas was one Yaqui leader who tried to unite the Mayo, Opata, and Pima tribes with the Yaqui tribe in attempt to force the Mexicans out of Indian country. He was caught with an Opata chief in 1833 and was executed.

By this time, the Yaqui people had suffered greatly. Many Yaquis left the Rio Yaqui area to fight in the Vakatettew Mountains; others relocated to Yaqui communities in Arizona. Many more died in battles or were executed. In 1868, 600 Yaqui men, women, and children were captured near Vahkom Pueblo by Mexican state and federal troops. Their arms (bows and arrows and rifles) were taken, and 450 were locked in a church. During the night, the church was shelled. 120 of the people inside were
massacred. But still, the Yaquis continued to believe in and fight for the right to land, autonomy, and freedom from harassment.

The Mexican government tried various tactics to defeat the Yaquis. Many were killed. Mexican troops would occupy Yaqui pueblos to keep watch over them. Yaquis were also deported to work as slaves in many distant areas of Mexico, as Yucatan, Oaxaca, Vera Cruz, Mexico City, and Guadalajara. The deportation of Yaquis extended past the borders of Mexico to include Bolivia, the islands of the Caribbean, and the United States.

The Yaquis continued to resist subjugation. By 1887, the Mayo tribe had stopped fighting. Smallpox disease had killed off many members of the Yaqui tribe so that only 4,000 Yaquis remained in the Rio Yaqui area. There were yet Yaqui who continued to battle the Mexicans. These were led by Cajeme, meaning "He Who Does Not Drink", and Juan Maldonado, who was also called Tetabiakte, "Rolling Stone". The Yaquis in Arizona sent guns and supplies to help the battle.

Significant Yaqui relocation occurred from the United States to Sonora and from Sonora to the United States during the 1880s. In 1897, a peace treaty was signed at Ortiz, Sonora between the Yaqui people and the Mexican government. But, after two years, war and deportation of Yaquis continued.

Yaqui families lived in the Gila and Santa Cruz River valleys since time immemorial. Around the turn of the century, these families, encouraged by farmers, politicians, and internal preferences, began moving into larger communities. Guadalupe took early form in 1880. Old Pascua Village was established in 1903. The Sonoran Governor Izabal had a policy to arrest and deport both peaceful and rebel Yaquis. This forced Yaquis to relocate to the Arizona communities and to join old family groups already in residence. Many Yaqui families moved to escape the violence of the 1910-1920 Mexican Revolution.

In 1916, Mexico had a constitutional governor named Adolpho de la Huerta, who was one-quarter Yaqui. He made the first attempts to restore Yaqui land and stop the bloodshed. But, the next president, Alvaro Obregon, changed the policy, and the Yaqui-Mexican wars continued.

The last Indian battle with the U.S. Cavalry happened on January 8, 1918, at Arivaca. Troop E of the Tenth Cavalry, intercepted a group of American Yaquis on their way to render aid to Yaquis of Sonora, who were in the midst of unrelenting war. The Yaquis fought their last major battle at Cerro del Gallo (Hill of the Rooster) in 1927. They were defeated physically, and Mexican garrisons were established in all Yaqui pueblos and villages. But, even now, Yaquis say that morally, they are still undefeated.

In 1939, Mexican President Cardenas changed the attitude about the Yaquis. He granted the Yaqui tribe official recognition and title to their land.

The autonomous Arizona villages became larger, and by 1952, were surrounded by urban communities. In 1964, with the aid of Congressman Morris K. Udall, the Pasqua Yaquis were recipients of 202 acres of desert land where Indian identity and sovereignty can be asserted and maintained.

On September 18, 1978, the Pascua Yaqui Tribe of Arizona became federally recognized: the Pascua Pueblo of the Pascua Yaqui Indian Reservation officially came
"into being". The Pascua Yaquis have a status similar to other Indian tribes of the United States. This status makes the Yaqui eligible for specific services due to trust responsibility that the United States offers Native American peoples who have suffered land loss.
References


