American Indian, Alaska Native, and Canadian Aboriginal Two-Spirit/LGBT Elderly

7

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Abstract

The purpose of this chapter is to discuss the status of older two-spirit American Indian, Alaska Native, and Canadian Aboriginal two-spirit LGBT elders. Information is presented on traditional values and behaviors, two-spirit tradition and roles of elders in tribal communities, service utilization by two-spirit elders, systems of service delivery, and policy implications. The authors acknowledge the heterogeneity of these groups and do not presume uniformity across groups. Similarity, the term LGBT is used as the modern roughly equivalent of the Native term two-spirit. A brief background of two-spirit is included to provide the reader with an understanding of the history and significance of self-identity that is implicit in how two-spirit persons refer to themselves.

Keywords

American Indian · Alaska Native · Canadian Aboriginal two-spirit · LGBT elderly

Overview

Understanding the implication of health status, aging, disability, and other sociocultural and economic factors for two-spirit American Indian and Alaska Native (AIAN) and Aboriginal Peoples (AP) elders is important to investigate because little research has been done to address the extent to which disparities affect them. However, throughout the literature, historical trauma has profoundly shaped distinctive conditions of health risk and resilience of AIANs and AP, and two-spirit persons are considered to be at even greater risk for adverse health outcomes than other Natives (Fieland et al. 2007; Ristock et al. 2011). Although urban AIANs and First Nations face many of the same conditions as other urban poor, they tend to have less social support and a long history of circular migration and residential

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D.A. Harley and P.B. Teaster (eds.), *Handbook of LGBT Elders*,
DOI 10.1007/978-3-319-03623-6_7

mobility (i.e., regular travel between urban settings and reservations (Rhoades et al. 2005). Weaver (2012) suggests that cyclical migration is problematic, "particularly at times of illness, [it] can complicate accurate epidemiological information" (p. 477). Similar to many ethnic minority groups, AIANs and First Nations are typically overrepresented in the lower socioeconomic status; however, the reader is cautioned not to assume that all AIANs and First Nations are poor or destitute. As with any group of people, there diversity exists across demographic characteristics.

The purpose of this chapter is to discuss the status of older two-spirit AIANs and APs of Canada. Information is presented on the status of AIANs and APs, traditional values and behaviors, traditions and roles of two-spirit elders in tribal communities, service utilization by two-spirit elders, and systems of service delivery. Discussion of policy and implications for future directions are also presented. The authors acknowledge the heterogeneity of AIANs and APs in North America and do not presume to refer to the diversity of the people of tribal nations or indigenous peoples of Canada in a collectivist way. However, space prohibits discussion of each tribal nation or indigenous peoples, and so general information is presented, with specific reference to select groups. Although the term LGBT is used throughout this book to reference lesbian, gay, bisexual, and transgender persons, the term two-spirit is the preferred term of traditional American Indians and Aboriginal LGBT persons. LGBT is the modern equivalent of the Native term two-spirit (Fieland et al. 2007). Therefore, throughout this chapter, these two terms will be used interchangeably. A brief discussion of the background of two-spirit is included to explain the history and significance of self-identity implicit in how AIAN and AP two-spirit persons refer to themselves.

Learning Objectives

By the end of the chapter, the reader should be able to:

1. Identify the role of historical oppression of AIAN and AP populations.
2. Understand the traditions of two-spirit person in North American Indian culture.
3. Identify traditions and roles of elders in North American Indian culture.
4. Understand barriers to health care of North American Indians.
5. Identify health practices and disparities of North American two-spirit elders.
6. Identify policy issues and concerns affecting North American Indian two-spirit elders.

Introduction

American Indians represent a diverse population consisting of 565 tribes, including indigenous peoples of Alaska and Hawaii and more than 300 reservations that serve as indigenous homelands and seats of tribal governments (Ogunwold 2006). American Indians and Alaska Natives (AIAN) maintain a unique status as sovereign nations. As indigenous cultures, American Indians reside primarily in the West, with approximately 34 % living on-reservations and 57 % living in metropolitan areas. Urban American Indians experience significant social, health, and economic problems while having access to substantially fewer Native-specific resources than their reservation-based counterparts (Weaver 2012). American Indians (AI) comprise less than one percent of the US population, a figure the same for persons age 65 and over (Administration on Aging [AOA] 2012). The low numbers of AIs result in a relatively invisible status, which make them highly susceptible to stereotypes (Bureau of Indian Affairs 2011). The history of American Indians is complex and one of disenfranchisement and distrust of European Americans and the government. According to Walters et al. (2001), over the past century "American Indians have endured a succession of traumatic assaults on their cultural and physical well-being, and continue to disproportionately experience violence and trauma" (p. 134).

The "Aboriginal Peoples" (AP) refer to a collective name for the original peoples of North America and their descendants. Throughout this chapter, the terms Aboriginal Peoples and First Nations are used interchangeably. There are more than 50 distinct groupings among First Nations alone, with several dialects within Inuktitut. The Metis people speak a variety of First Nations languages such as Cree, Ojibwa, or Chipewyan, as well as Michif (Report of the Royal Commission on Aboriginal Peoples 1996). About 1.4 million people in Canada identify themselves as an Aboriginal person, 60.8 % of which have First Nations single identity (i.e., 45.5 % as registered or treaty Indian, 15.3 % as not a Registered or Treaty Indian), 32.3 % as Metis single identity, 4.2 % as Inuit single identity, 0.8 % as multiple Aboriginal identities, and 1.9 % as aboriginal identities not included elsewhere. The Aboriginal population increased by 20.1 % between 2006 and 2011, compared with 5.2 % for the non-Aboriginal population. The largest numbers of Aboriginal people live in Ontario and the Western provinces (Manitobe, Saskatchewan, Alberta, and British Columbia) (National Household Survey 2013). Winnipeg is home to the largest urban Aboriginal population in Canada (Ristock et al. 2011). The use of the terms Indian and Eskimo in Canada is considered pejorative. A glossary of terms for Canadian First Nations is provided in Table 7.1.

Historical trauma, the universal experience of colonization, is a shared history for two-spirit persons both within and across the heterogeneity of the tribes in North America. Ristock et al. (2011) stress that it is impossible to consider the health and well-being of Aboriginal two-spirit people without taking into account the historical impacts of colonization and its contemporary effects that interacts with socio-demographic vulnerabilities to negatively affect them. The experience of two-spirit person/LGBT is one of the dual oppressions—heterosexism from Native peoples and racism from LGBT persons (Fieland et al. 2007). Dual oppression puts two-spirit persons at compounded risk for discrimination and violent victimization (Brotman et al. 2002). Given that there is such limited research on older two-spirit persons/LGBT, information may be gleaned from studies on the general population of older Native peoples and younger two-spirit persons.

Status of AIANs and First Nations of Canada

American Indians differ in their degree of acculturation. In part, American Indians' acculturation is muddy because what actually constitutes an Indian is unclear and controversial. This controversy is heightened by several factors, for example, in the USA: (a) the United States Census relies on self-report of racial identity, (b) Congress has formulated a legal definition in which an individual must have an Indian blood quantum of at least 25 %, and (c) some tribes have developed their own criteria and specify either tribal enrollment or blood quantum levels (Sue and Sue 2013). Garret and Pichette (2000) identify levels of cultural orientation to explain the degree to which AIANs identify with native culture (see Table 7.2). In addition, urban dwellers do not have access to tribal governmental services and political decision-makers or to public housing as their counterparts on-reservations. Urban American Indians may find it difficult to exercise their rights as citizens of Native Nations and may be disenfranchised and lose their voice in tribal governance (Weaver 2012).

In Canada, AP (including Inuit and Metis) are not afforded the same privileges as other Canadians. "In 1998, a United Nation Human Rights Committee ruled that the treatment of AP within Canada stood in violation of international law and was the most pressing human rights issue facing Canadians" (Meyer-Cook and Labelle 2003, p. 36). Both the historical and current treatments of AIAN and First Nations in North America are discriminatory and oppressive. The circumstances faced by AIANs and First Nations are similar to the challenges and oppression faced by more than three million indigenous people globally. The concerns for indigenous peoples globally culminated in the United Nations Declaration on the Rights of Indigenous Peoples ("the

Table 7.1 Glossary of terms for Canadian first nation(s)

First Nation(s)—term used as a substitution for *band* or Indian, referring to any of the numerous groups formally recognized by the Canadian government under the Indian Act of 1876.
First Nation people—generally applied to both status and non-status Indians. Is not a synonym for Aboriginal peoples because it does not include Inui or Metis
First peoples—a collective term used to describe the original peoples of Canada and their descendants. It is used less frequently than terms such as Aboriginal peoples and Native peoples
Indian—collectively describes all the Indigenous People in Canada who are not Inuit or Metis. Three categories apply to Indians in Canada: (a) Status Indians—people who are entitled to have their names included on the Indian Register. Only Status Indians are recognized as Indians under the Indian Act and are entitled to certain rights and benefits under the law; (b) Non-status Indians—people who consider themselves Indians or members of a First Nation but whom the Government of Canada does not recognize as Indians under the Indian Act and are not entitled to the same rights and benefits available to Status Indians; and (c) Treaty Indians—descendants of Indians who signed treaties with Canada and who have a contemporary connection with a treaty band
Inuit—Aboriginal People of Arctic Canada
Metis—the French word for people of mixed blood. The Constitution Act of 1982 recognizes Metis as one of the three Aboriginal Peoples
Native—a collective term to describe the descendants of the original peoples of North America
Native American—commonly used term in the USA to describe the descendants of the original peoples of North America. The term has not caught on in Canada because of the apparent reference to US citizenship. Native North American has been used to identify the original peoples of

Adapted from http://web.archieve.org/web/20100714021655/ http://www.aidp.bc.ca/terminology_of_native_aboriginal_metis.pdf

Table 7.2 Levels of cultural orientation

Traditional—the person may speak limited English and practice traditional tribal customs and methods of worship
Marginal—the person may be bilingual but has lost touch with his or her cultural heritage, yet is not fully accepted in mainstream society
Bicultural—the person is conversant with both sets of values and can communicate in a variety of contexts
Assimilates—the person embraces only the mainstream culture's values, behaviors, and expectations
Pantraditional—the person has been exposed to and adopted mainstream values but is making a conscious effort to return to the "old ways"

Adapted from Garrett and Pichette (2000)

Declaration"), which is a framework of rights for indigenous peoples for states. Each Nation that adopts the Declaration is independently responsible for enacting domestic legislation and polices that comply with Declaration standards (Rowland 2013), though the Declaration is not legally binding for Nations that adopt it.

Cultural determinants of AIAN resistance and resilience include identity, spirituality, and traditional health practices, the very aspects of Native culture targeted by colonial persecution (Walters and Simoni 2002). For two-spirit persons in Canada, the binary concept of gender conformity that prevailed in colonial days was contrary to that of gender variance. Canadian two-spirit persons who thought in more circular ways resulted in outlawing and discrediting of any processes that that could not easily be co-opted to advance a larger agenda of profit by Europeans (Meyer-Cook and Labelle 2003). In fact, for two-spirit persons, enculturation (the process by which individuals learn or re-immerse themselves in their cultural heritage, norms, and behaviors within a contemporary context) in the form of "retraditionalization" may be a powerful process because of the denigration of their formally elevated status in many tribal communities (Fieland et al. 2007). Meyer-Cook and Labelle

(2003) suggest that for two-spirit persons to achieve a sound identity, they need to simultaneously follow two tracks of identity formation: first as Native people or people of a minority group and second as people who are differently gendered.

As a population, health statistics for American Indians reveal significant adverse outcomes (Roubideaux et al. 2004). As compared to the general US population, American Indians have alcoholism mortality rates that are more than twice as high, significantly higher obesity and diabetes rates, injury-related deaths (e.g., homicides, motor vehicle crashes, suicides), disproportionate rates of depression, and deaths from injuries and violence account for 75 % of all deaths (Centers for Disease Control [CDC] 2007; U.S. Department of Health and Human Services 2007), lower earnings, lower educational level, and higher poverty rates, violence, and depression (CDC 2011). These factors are co-occurring, which means that AIANs are simultaneously at risk for all of them, creating a potentially severe network of social and psychological risks that affect their mental well-being (Native Vision Project 2012). Rates for older AIAN or two-spirit elders are not disaggregated among the data. The Alaska Department of Labor estimates that Alaska Natives (AN) account for about 7135 ANs over age 65 and 8040 between the ages of 55 and 64, with the most rapid increase in elders between 70 and 74, followed by those 85 and older. There is a higher prevalence of chronic illnesses such as cancer and heart and lung diseases, which can lead to a higher incidence of functional disability, and a corresponding need for long-term care (Branch 2005). Table 7.3 provides priority health needs as identified by Alaska Native elders.

Table 7.3 Priority health needs identified by Alaska Native elders

Personal care services
Comprehensive care and tracking of chronic illnesses
Medication issues
Elder abuse
Housing
Alzheimer's Disease and related disorders
Unintentional injuries (causes and prevention of falls)
Telemedicine
Elder and youth activities (sharing traditions and participating in intergenerational activities to support youth and community)
Palliative care
Traditional healing
Urban/rural differences (understand why elders are moving to town and the implications this has on service availability in urban and rural areas)

Adapted from Branch (2005)

Currently, older single-race AIAN adults account for 0.87 % of the total US population and multiple-race AIAN for 1.53 % of the US population (Ogunwole 2006). Compared to the general population, older AIANs are less educated, have a higher divorce rate (24.0 % vs. 19.9 %), and a higher percentage has never married (11 % compared to 6.5 % of the general population) (Tamborini 2007). Several factors contribute to the vulnerability of older AIANs: lower educational attainment, lower household income, greater poverty, less insurance coverage, and higher limited English proficiency. Furthermore, vulnerability might be affected by multiple contributing factors, not by a single factor (Kim et al. 2012). AIANs aged 62 and older self-reports of health status reveals that almost 46 % are in fair to poor health, compared with 33.6 % of the general population. AIANs have higher rates of work limitations at 34.3 %, compared to 15.2 for the general population (Dunaway-Knight et al. 2012). In addition, the percent of AIANs who will receive Social Security disability benefits at some point in their lives is higher than the general population (16.0 % vs. 10.8 %) (Social Security Administration 2011). Typically, the age at which a person is considered elderly in American society is 65; however, there is no such consensus among tribal nations. The Older Americans Act gives discretion to individual tribes to make this determination. The health status of AP of Canada, especially elders, is similar to that of AIANs and is substantially lower than that of average Canadians. Moreover, compared to other Canadians, AP have poorer social and economic

indicators, face critical housing shortages, higher rates of unemployment, lack of access to basic health services, and lower levels of education attainment (Lafontaine 2006).

First Nations elders, including Aboriginal, Metis, and Inuit seniors, have received limited attention by researchers because as a population, Aboriginals are younger than the non-Aboriginal population (Beatty and Berdahl 2011), and a lack of epidemiological data results in pan-Aboriginal (i.e., between assimilation and traditional) evidence and approximations (Lafontaine 2006). The dire straits of Aboriginal elders is summed up thusly: they "are among the most neglected social class because of their increasing multiple physical and mental health problems and increasingly poor socioeconomic supports have forced them into even more challenging and dependent situations at an age when they should expect to be well treated and taken care of properly by both their families and governments" (Beatty and Berdahl 2011, p. 1). Metis report poorer health status than the non-Aboriginal population (Janz et al. 2009; Wilson et al. 2011) and are more likely than First Nations elders to report fair to poor health (Wilson et al. 2010, 2011). One in five Metis has arthritis or rheumatism compared to one in ten in the general Canadian population. In addition, Metis have higher rates of high blood pressure, asthma, diabetes (30 % of men vs. 14 % of non-Aboriginal men; 32 % of women vs. 11 % of non-Aboriginal women), and heart problems. First Nation elders have higher rates of disability due to injury and/or chronic disease, with 58.5 % over age 60 compared to 46.5 % of Canadian seniors (Lafontaine 2006). Aboriginal elders are more likely than non-Aboriginal elders to report daily smoking and heavy drinking; however, one in two reports not drinking at all, with the majority either never smoking or having quit smoking (Turcotte and Schellenberg 2007).

Similar to research findings in minority groups in the USA, Beatty and Berdahl (2011) identify social and economic status as the two most important determinants of health among Aboriginal elders. The prevalence of low income is higher among Aboriginal elders than non-Aboriginal elders, and Aboriginal elders are often less able to pay for private or co-funded services. Economic differences are more pronounced among First Nations who come from reservations and cannot fulfill the residency requirements and are placed at the end of long waiting lists. With the increase in the number of people receiving homecare among those without alternative income to supplement higher costs, health care beyond post-acute care is unaffordable and inaccessible to Aboriginal elders. A related issue is the underutilization of services by Aboriginal elders in cities and on-reservations. Barriers to service utilization include culture, language, affordability, jurisdiction, and problems navigating the health services system, barriers exacerbated by limited knowledge of and access to policymakers and service providers. Although some policies have helped improve competency skills and communications between service providers and minority elders, limited efforts have been made to address institutional structures, racism in gerontological settings, and access to care facilities for Aboriginal elders (Beatty and Berdahl 2011). Table 7.4 identifies health and service needs of First Nations Canadian elders.

Among other problems, Aboriginal elders encounter educational and literacy barriers, poor housing conditions, homelessness in urban areas, and elder abuse. In Canada, housing on reservations is among the poorest in the country, which means that many elders with disabilities

Table 7.4 Priority health needs of first nation elders

Culturally responsive programming and employment in healthcare systems
Coordinated elderly care funding initiative for Aboriginal caregivers
Aboriginal long-term care facilities in the major prairie cities
An integrated, coordinated, and holistic healthcare system
First Nations long-term care facilities on reservations
Palliative, respite and after hour care services
Access to all health benefits

Adapted from Beatty and Berdahl (2011)

and chronic conditions live in overcrowded and deficient homes (Health Canada 2009). Currently, federal funding policies do not allow for building of long-term care facilities on reservations (Beatty and Berdhal 2011). As a vulnerable population, medically compromised and dependent Aboriginal elders are often targets of abuse (Podneik 2008). Elder abuse occurs most frequently as physical, psychological/emotional, financial abuse, and neglect whether the elder is at home or in semi-private and public institutions. Often, elders' and families' preferences for self-determination of care are disregarded. Aboriginal elders living in Toronto identified major issues facing them including, social isolation, lack of transportation services, lack of assisted living services, lack of family peer support, lack of senior housing, poor proximity to housing services, lack of activities programming, lack of physical fitness resources, and lack of alcohol and drug abuse counseling (McCaskill et al. 2011).

Traditional Values and Behaviors

Indigenous peoples have an identity that is rooted in a particular land of origin. Cultural identity is intimately connected with and defined by traditional territories. Indigenous cultural beliefs and values (e.g., harmony, respect, generosity, courage, wisdom, humility, honesty) and spiritual practices (e.g., natural world) are inextricably linked to the land. Even when Native Peoples are displaced from their territories, with ethnic mixing, and sporadic contact with tribal homelands, the tie to core indigenous values persists (Hendry 2003; Weaver 2012). For AIAN and First Nations, family or tribe is of fundamental importance because it provides a sense of belonging and security, an extension of the tribe (Sue and Sue 2013). This sense demonstrates the persistence and resilience of the community despite change (Weaver 2012). Different families and tribes have their own cultural assets. The cultural values and behaviors presented in the remainder of this section are generalizations and their applicability should be assessed for particular clients or patients and their families. The authors acknowledge distinctiveness within and between indigenous persons in the USA and Canada, and the intent is not to obscure such distinctiveness.

Native Peoples traditionally have respected the unique individual differences (*personal differences*) among people. This respect is demonstrated through staying out of the affairs of others and expressing personal opinions only when asked. An expectation is that this courtesy will be returned. Another traditional behavior is *quietness*. The act of silence serves multiple purposes in Native life. Historically, silence contributed to survival. When angry or uncomfortable, many Native Peoples remain silent. Silence is a deeply embedded form of Native interpersonal etiquette, and Patience is a closely related value to silence. *Patience* is based on the belief that all things unfold in time. The practice of patience demonstrates respect for individuals, facilitates group consensus, and permits "the second thought" (deliberation) (http://www.nwindian.evergreen.edu/cirriculum/ValuesBehaviors.prf). In traditional Native Peoples' life, *work* is always directed toward a distinct purpose and is taken on when it needs to be done. Work is linked to accumulating only that which is needed, which reflects the nonmaterialistic orientation of many Native Peoples. *Mutualism*, as a value, attitude, and behavior, permeates everything in the traditional Native social fabric. It promotes a sense of belonging and solidarity with group members cooperating to gain group security and consensus. The traditional manner in which most Native Peoples prefer to communicate is affective (*nonverbal orientation*) rather than verbal. That is, they prefer listening rather than speaking. Talk, like work, must have a purpose, and talking for talking's sake is rarely practiced. Words have a primordial power, and when there is a reason for their expression, it is generally done carefully. Closely linked to nonverbal orientation are the highly developed and valued skills of *seeing* and *listening*. Hearing, observing, and

memorizing were highly developed skills because all aspects of Native culture were transferred orally through storytelling (http://www.nwindian.evergreen.edu/curriculum/ValuesBehaviors.pdf).

For Native Peoples, traditionally life unfolds when it is time. *Time orientation* is flexible and generally not structured into compartments. Similarly, Native Peoples have an *orientation to the present* and to immediate tasks at hand. What is occurring in the present takes precedence over vague future rewards. Emphasis is placed on *being-rather-than-becoming* (however, this value has shifted significantly over the past five decades toward a more futuristic approach). Both time orientation and orientation to the present tie into the Native value of *practicality*, with a focus on approaches that are concrete and experiential. At the core of traditional Native culture is a *holistic orientation* in which every aspect of life is based on an integrated orientation to the whole. A holistic perspective is essential in Native culture and is seen in aspects ranging from healing to social organization. Likewise, *spirituality* is integrated into every part of the sociocultural fabric of traditional Native Peoples' life. Spirituality is considered a natural component of everything. Lastly, *caution* is exercised in unfamiliar personal encounters and situations. Caution is manifested as quiet behavior and placidity. In many cases, being cautious is the result of fear of how their thoughts and behavior will be perceived by those with who they are unfamiliar or in a new situation with which they have no experience (http://www.nwindian.evergreen.edu/curriculum/ValuesBehaviors.pdf).

AIAN and Aboriginal or First Nations of Canada have distinct tribal values, beliefs, and behaviors; however, as Native Peoples of North America, these groups share some common cultural practices. The extent to which two-spirit persons incorporate some or all of these practices into life is dependent upon their level of acculturation, assimilation, or pantraditional experience. The following section describes two-spirit persons of North America.

Two-Spirit People of Indigenous North America

For traditional American Indians, the terms gender roles and sexual orientation are false conceptualizations because AIANs never analyzed human sexuality in such dichotomous and categorical ways. Rather, a continuum of human sexuality and gender behavior is appropriate for different people. That is, people do what they do best (Pope 2012). From a community perspective, the major focus was on the fulfillment of social or ceremonial roles and responsibilities as a more important defining feature of gender than sexual behavior or identity (Fieland et al. 2007). American Indians have always held intersex, androgynous people, feminine males, and masculine females in high esteem. Gender is viewed as biological, whereas gender status is more culturally defined. Thus, one's gender status may be either man (masculine), woman (feminine), or not-man/not-woman. In this model, not-man is not the same as woman, and not-woman is not the same as man. Clearly, by definition women are not men; however, other social groups within a society may consist of males whose gender status is that of not-men but who are also defined as not-women. These multiple genders are part of gender role construction in American Indian societies, and service providers for such cultures must be cognizant of this contextual ambiguity (Pope 2012).

Instead of seeing two-spirit persons as transsexuals who attempt to make themselves "the opposite sex," it is more accurate to understand them as individuals who take on a gender that is different from both women and men. In essence, two-spirits "will do at least some women's work and mix together much of the behavior, dress, and social roles of women and men" (Williams 1986, p. 344). Early on the term "berdaches" was used before the term two-spirit. Berdaches refer to that scared person accepted in the native world who is said to be both female and male (two-spirited) and believed to have mystical powers (Warren 1998). The term two-spirit originated in Winnipeg,

Canada, in 1990 during the third annual Intertribal Native American First Nation Gay and Lesbian conference. Two-spirit was originally chosen to distance Native First Nations people from non-Native as well as from the words "berdache" and "gay" (http://www.rainbowresourcecentre.org). In 1991, the term berdache was replaced with the word two-spirit because of various negative connotations (e.g., male slaves or prostitutes) (see Williams 1986 for additional information). According to Laframboise and Anhorn (2008), the term two-spirit is preferred because it emerged from Native American people, whereas the term berdache was imposed upon Native People by the colonial explorers. Table 7.5 contains various terms that have been used to describe two-spirit American Indians. One of the reasons that two-spirits received respect was out of fear because they were considered to be touched by the spirits and to have powers on the level of a shaman. Two-spirits were highly regarded as artisans, craftspeople, child-rearers, couples counselors, and tribal arbiters.

Two-spirits are considered to be a "third gender," and female two-spirits are considered to be a "fourth gender" (similar to the way that both female and male homosexuals are considered to be gay, while females are also considered to be lesbian) (http://androgyne.0catch.com/2spiritx.htm). Rather than emphasizing the homosexuality of two-spirits, American Indian focuses on their spiritual gifts (Williams 1986). Laframboise and Anhorn (2008) make a key distinction about terms regarding gender-variant people, indicating that two-spirit is different from sexual orientation because such words did not exist in Native languages. As terminology referring to LGBT persons has evolved over time, gender, which "is an obligatory grammatical category in the English/French and Latin languages"… and as a linguistic term "… has no connection with biological sex or social identity of an individual" (p. 2). The relevance of the issue is where gender intersects with the Native Peoples of North America because two-spirit does not refer to people with homosexual tendencies; rather, on different genders being manifested and not on sexual preferences or practices (Lafranmoise and Anhorn). See Discussion Box 7.1 for ways in which two-spirits are honored.

It is important to point out that the term two-spirited has multiple meanings within several different contexts. For example, Aboriginal people who identify as gay or lesbian use the term because it is more culturally relevant to their identities. Aboriginal people who are transgender might also use the term two-spirit, an umbrella term for Aboriginal persons who live between socially defined male and female gender roles (Balsam et al. 2004), or they may use terms of their own Aboriginal languages (Scheim et al. 2013). Elders within Aboriginal culture teach that two-spirited people have a special place in their communities. Aboriginal culture is recognized for balance and harmony, and no one element or force dominates the others. The term two-spirit originates from the First Nations'

Table 7.5 Two-spirit American Indian gender role and sexuality terms

Tribe	Term	Meaning
Crow	bote	Two-spirit
Kamia	warharmi	Hermaphrodite spirit
Lakota Sioux	winkte	Two-soul persons
Mohave	hwame	Female-bodied person who lives as a man
Navajo	nadleehe	"The change"
Omaha	mexoga	Homosexuality
Shoshoni	tainna wa'ippe	Man–woman/woman–man
Zuni	Ihamana	Man–woman

recognition of the traditions and sacredness of people who maintain a balance by housing both female and male spirits (Wahsquonaikezhik et al. 1976). Two-spirit persons are considered a vital and necessary part of the natural world and of the community as a whole because they possess an ability to see an issue from both perspectives and can understand and help solve problems that women and men may have individually or between each other (McLeod-Shabogesic 1995).

Discussion Box 7.1

Williams (1986) describes American Indian traditionalists as seeing a person's basic character as a reflection of their spirit and emphasize it as being most important. Rather than seeing two-spirit persons as transsexuals who try to make themselves into the "opposite sex," it is more accurate to understand them as individuals who take on a **gender** status that is different from both men and women. Since everything is thought to come from the spirit world, androgynous or transgender persons are seen as doubly blessed, having both the spirit of a man and the spirit of a woman. Thus, they are honored for having two spirits and are seen as more spiritually gifted than the typical masculine male or feminine female. Many American Indian religions often look to two-spirits as religious leaders and teachers. The emphasis of American Indians is not to force every person into one box, but to allow for the reality of diversity in gender and sexual identities.

Two-spirit persons are also respected by native societies because of practical concerns. That is, they could do both the work of men and of women. They were considered hard workers and artistically gifted of great value to their extended families and community. Two-sprit persons were believed to be economically beneficial as a relative to assist with raising children, taking care of the elderly, and serving as adoptive parents for homeless children.

Questions

How does the cultural view of American Indians about two-spirit persons differ from other culture's views?
What are the similarities between the value of two-spirit persons and LGBT persons in LGBT communities?
Do two-spirit persons share characteristics with other ethnic minority groups?

Not all AIAN or First Nations who are LGBT identify as two-spirited. Those who choose to use the term two-spirit do so to reflect their sexual and gender identity and its connectedness with spirituality and traditional worldviews (Walters et al. 2006). At times, First Nation LGBT persons may choose to use the word lesbian or gay in order to be understood in Western culture. C. Thomas Edwards (1998) is cited in *We Are Part of a Tradition* and explains that American Indians do not buy into homophobia because it is a focus on sexual behavior rather than the intricate roles two-spirit persons play. In the context of gender, two-spirit people also associate with the term bi-gender, which involves having a separate male persona and a separate female one. Granted, these terms are not exactly alike; nevertheless, they are closely related in both experiences and representation of that person (http://www.rainbowresourcecentre.org). Laframboise and Anhorn (2008) suggest that it is the inner calling of contemporary two-spirited people that mix their understanding of sexuality with the perception that homosexuality was well accepted in pre-colonization instead of recognizing that these homosexual behaviors were accepted under the role of gender identity. Thus, "the modern movement of reclaiming Two-Spirit Traditions incorporates sexual orientation and sexual identity" (p. 3).

Ristock et al. (2011) interviewed Aboriginal two-spirit/LGBT persons ages 19–61 regarding migration, mobility, and health and found that

most moved from First Nations communities and/or small or rural towns to metropolitan areas because doing so allowed them to find a personal identity either with their sexuality and/or gender identity and/or Aboriginal identity. Other reasons for the move were to explore the anonymity that a big city can offer when it comes to exploring the "gay lifestyle," finding others like them, for gender reassignment, and to begin a healing journey from incest and violence, they may have encountered as children. Those not actively involved in the LGBT community felt an affirmation of their identity just knowing that a large LGBT community in the city existed. Some distinction was made by two-spirit persons about the importance of having their own space because of the domination in the LGBT community by White people. A culturally specific space also allowed a place to have ceremonies.

AIAN, Aboriginal Peoples of Canada, and Two-Spirit Elders Physical and Mental Health

Individually and collectively, AIANs and AP have worse health outcomes than other ethnic minority groups and non-Hispanic Whites (NHWs). Health disparities and chronic health conditions exist with marked variation across Indian Health Service (IHS) areas and within tribes in the USA (Wright 2009) and likewise for indigenous elders in Canada (Beatty and Berdahl 2011). The disparities are especially problematic for low-income elders in indigenous communities. Older AIANs and AP have greater numbers of chronic conditions, higher rates of disease comorbidity, and higher rates of disability than do other populations of elders (Beatty and Berdahl 2011; Satter et al. 2010). Although research has focused on the physical health status of older AIANs and AP, studies pertaining to their access to healthcare service are sparse, and their mental health status has been less often documented (Kim et al. 2012). Research suggests that older AIANs experience greater emotional and/or mental health problems compared to their peers of other racial and ethnic groups (Kim et al. 2011; Satter et al. 2010). Arguably, the impact of structural oppression including homophobia, heterosexism, and racism is likely to play a role in the physical and mental health of Aboriginal two-spirit/LGBT persons (Canadian Rainbow Health Coalition 2004; Taylor and Ristock 2011; Ristock et al. 2011). In response to the limited research on healthcare access and service, Kim et al. (2012) examined older AIANs' physical and mental health status and related healthcare use in comparison with NHWs and found that older AIANs reported poorer physical and mental health than NHWs, were less likely to see a medical doctor and to have a usual source of medical care, and were more likely to delay getting needed medical care and report difficulty understanding the doctor at their last visit. However, this study did not indicate if any of the participants were two-spirit persons.

Two-spirit persons do not have more propensity or pathology of mental illness than the general population. However, their prolonged exposure to hostile or intolerant environments can cause significant stress on LGBT persons, and having to manage stigma has far-reaching effects on their health status (Brotman et al. 2003). Although information in this section is presented on the health status of AIANs and AP with reference to two-spirit elders as applicable, the authors agree with the position of Scheim et al. (2013) that AIAN and "Aboriginal gender-diverse peoples' experiences and health statuses cannot be understood by simply summing together what is known from research on broader (AIAN), Aboriginal, or gender-diverse populations. Nevertheless, health inequities documented in studies using one or the other of these identity categories provide an important context for understanding the well-being of (AIAN) and Aboriginal gender-diverse peoples" (p. 109). Scheim et al. (2013) conducted a study to describe barriers to well-being in a sample of Aboriginal gender-diverse peoples in Ontario, Canada (see Research Box 7.1).

Research Box 7.1

Scheim, A. I., Jackson, R., James, L., Dopler, T.S., Pyne, J., & Bauer, G.R. (2013). Barriers to well-being for Aboriginal gender-diverse people: Results from the Trans PULSE Project in Ontario, Canada. *Ethnicity and Inequalities in Health and Social Care, 6*(4), 108–120.

Objective: Despite health inequities experienced by Aboriginal and transgender communities, little research has explored the well-being of Aboriginal trans people. The purpose of this study is to describe barriers to well-being in a sample of Aboriginal gender-diverse people in Ontario, Canada.

Method: Of the 433 participant in the Trans PULSE Project survey, the 32 who self-identified as First Nation, Metis, or Inuit were included in the analysis. Because of the small sample size, unweighted frequencies and proportions were calculated.

Results: The participants were almost evenly split between male-to-female and female-to-male gender spectra. The majority was under age 35, almost half were living in poverty, live in metropolitan Toronto, and none were living on a reservation. Many were homeless or unstably housed, most had experienced some form of violence due to transphobia, including physical and/or sexual violence, and lifetime suicidality was high. Most had a regular family doctor but had unmet healthcare needs. Many were unable to obtain services including shelters, hormone therapy, trans-related surgery, trans-related mental health, sexual health, and addictions. However, needs were met for general health services, emergency care, and HIV or sexually transmitted infections testing. Some had seen an Elder for mental health support and a range of family and community support for gender identity and expression were indicated.

Conclusion: Action is needed to address the social determinants of health among Aboriginal gender-diverse people. Using principles of self-determination, there is a need to increase access to health and community supports, including integration of traditional culture and healing practices. Larger study samples and qualitative research are required.

Questions

1. What implications do these findings have for including gender-diverse Elders as part of comprehensive planning healthcare services?
2. What are the limitations of this study?
3. What other research methodology and design would you recommend for this study?

Cancer is the leading cause of death for AIAN females (breast) and the third leading cause of death for males (prostate) (Paltoo and Chu 2004). Of all races, AIAN women have the lowest rates of mammogram screening (Ward et al. 2004), the youngest mean age (age 54) for breast cancer diagnosis of all racial groups (age 56–62) (Li et al. 2003) and the lowest survival rates. Ward et al. (2004) found that for all cancers combined, AIANs have lower mortality rates than the general US population, but have disproportionately lower 5-year survival rates than Whites. Of all ethnic minority groups in the USA, AIAN men have the highest rates of chronic disease (e.g., obesity, cardiovascular disease, hypertension, high cholesterol, diabetes, and smoking), and women have the highest rates of obesity, cardiovascular disease, smoking, and diabetes, and the second highest rates of hypertension and high cholesterol after African American women

(Centers for Disease Control [CDC] 2003). Again, it is supposition that older two-spirit persons are counted among these numbers.

Overall, AP has poorer health than other Canadians. The long-term health conditions that affect First Nations adults living on-reservations tend to be the same as those affecting other Canadians except for diabetes, which is more prevalent among First Nations population. Approximately, 60 % of the Aboriginal population living off-reservations has chronic conditions compared to 49.6 % of the non-Aboriginal population (Tjepkema 2002). AP living off-reservations tend to have lower prevalence of long-term conditions than those living on-reservations, with the exception for diabetes, but these rates are still typically higher than they are for other Canadian adults except for the Inuit (Galabuzi 2004). Furthermore, Aboriginal adults living off-reservations are much more likely to be obese than non-Aboriginal adults in Canada, but those living on-reservations have even higher obesity levels (Reading and Wien 2009; Tjepkema 2002). In each geographic region (urban, rural, territories) (see Table 7.6 for a list of Canada provinces and territories), the Aboriginal population living off-reservations reported higher levels of fair to poor health than their non-Aboriginal counterpart in that region and percentage did not vary significantly between regions (Tjepkema 2002). The First Nations Centre (2007) indicates a significant difference in morbidity and chronic conditions for off- and on-reservation First Nations populations. For example, high blood pressure for off-reservation AP is 12 % versus 20.4 % for on-reservation, diabetes is 8.3 % for off- and 19.7 % for on-reservation, asthma is 12.5 % for off- and 9.7 % for on-reservation, and heart problem is 10.3 % for off- and 7.6 % for on-reservation. The higher rates of asthma and heart problems among off-reservation Aboriginal populations may suggest a function of lifestyle and environmental circumstances.

Table 7.6 Canada provinces and territories

Alberta
British Columbia
Manitoba
New Brunswick
Newfoundland and Labrador
Northwest Territory
Nova Scotia
Nunavut
Ontario
Prince Edward Island
Quebec
Yukon Territory

Aboriginal adults living off-reservations are almost twice as likely to experience a major depressive disorder compared to other Canadians (Canada Mortgage and Housing Corporation 2004). In fact, it is suspected that the rate of depression may be underdiagnosed within the Aboriginal population. Mental health consequences among AP are linked to "persistent socioeconomic inequities, intergenerational trauma, and colonial and neo-colonial processes including racialization and discrimination have taken a serious toll on the mental health of AP as reflected in alarming rates of suicide, depressions, substance abuse, and violence" (Browne et al. 2009, p. 19). Although research on Aboriginal Peoples' mental health is sparse, the First Nations Centre (2007) indicates that some evidence exists that mental health is better for Aboriginal populations living off-reservation than their on-reservation counterparts. This more favorable outcome may be credited to off-reservation AP having access to a relatively greater number of mental health services available in urban areas (Place 2012).

Rosenberg et al. (2009) report that in every age cohort, AP are more likely than non-Aboriginal people to indicate "poor/fair" health. Although chronic conditions increase with age, AP are more likely to report more chronic conditions than the comparable non-Aboriginal population. The prevalence rates of specific chronic conditions for elderly AP exceed that of non-Aboriginal people with the only exception being cancer. One possible explanation for this exception is that the lumping together of all cancers more than likely masks a number of critical differences between AP and

Table 7.7 Elderly Aboriginal peoples prevalence of specific conditions

Condition	Population	% age 65–74	% age 75+
Diabetes	Aboriginal	26	23
	Non-Aboriginal	13	13
Arthritis	Aboriginal	56	54
	Non-Aboriginal	40	47
Cancer	Aboriginal	9	5
	Non-Aboriginal	5	7
Stroke	Aboriginal	7	18
	Non-Aboriginal	3	7
Heart Disease	Aboriginal	23	36
	Non-Aboriginal	18	26
Stomach problems	Aboriginal	18	15
	Non-Aboriginal	4	5
Asthma	Aboriginal	13	11
	Non-Aboriginal	7	7
Chronic Bronchitis	Aboriginal	8	11
	Non-Aboriginal	5	6
Emphysema	Aboriginal	13	13
	Non-Aboriginal	3	4

Adapted from Rosenberg et al. (2009)

their non-Aboriginal counterparts. See Table 7.7 for prevalence of specific conditions. Presumably, elderly two-sprit Nations are included in these data. Ristock et al. (2011) found that the health concerns of Aboriginal two-spirit/LGBT persons included HIV, hepatitis C, weight issues, cancer, and diabetes. Unfortunately, no distinction of these concerns was reported based on age.

Service Utilization by Two-Spirited Elders

In a study of sexual orientation bias experiences and service needs of LGBT two-spirited American Indians, Walters et al. (2001) found that high rates of American Indians had experienced bias from the general public, ranging from 43 to 79 %. Types of biases they experienced include verbal insults, threat of attack, chased or followed, spat upon, object thrown, physical assault, assaulted with a weapon, and sexual assault. The attitudes of service providers toward AIAN were more positive than in the general population. Service providers indicated a high level of comfort working with American Indian two-spirit persons, and over 90 % of service providers indicated that they had LGBT friends and LGBT friends who are American Indian. The attitudes of service providers were consistently positive for specific subgroups of LGBT persons. However, service providers indicated a limited understanding of terminology associated with transgender, followed by homo-negativity and concepts of "passing," heterosexism, gender identity, homophobia, and sexual orientation. Research on service utilization by Aboriginal two-spirit persons in Canada is limited to nonexistent.

The problems identified facing American Indian LGBT or two-spirited ranged from HIV/AIDS epidemic to problems raising children (Walters et al. 2001) (see Table 7.8). Similar to other LGBT persons, AIAN two-spirit persons face many barriers to service utilization. Of the

Table 7.8 Problems facing American Indian two-spirit community

HIV/AIDS epidemic
Substance abuse
Homophobia in the American Indian community
Shunned by American Indian community
Homelessness
Trauma
Conflict with kin network/elders
Racism from non-American Indian LGBT
Conflict with religion
Suicide
Anti-gay violence
Conflict with Native traditions
Problems of raising children

Adapted from Walters et al. (2001)

thirteen barriers identified by Walters et al. and rated as moderate or great, nine were ranked above 50 % as a barrier (see Table 7.9). The results of the focus group study identified five main barriers for American Indian LGBT persons in accessing services: invisibility, discrimination, trauma, identity, and program planning. Walters et al. suggest that invisibility in the LGBT community stems forms the colonization process and the entrenched stereotypes that exist within the non-American Indian imagination that makes it difficult for two-spirit persons to identify each other for social support. In the American Indian community, invisibility is manifest as the failure to consider being LGBT as a possibility or "Native reality," which fuels homophobia within the heterosexual American Indian community. Furthermore, disclosure of one's identity as part of visibility is determined by cultural values, in which elders dictates the parameters regarding acceptable behavior. That is, it is not that the person is gay that the elder is responding to but it is how the person is behaving (Walters et al. 2001). Discrimination refers to dealing with racism in the LGBT community and homophobia in the American Indian community. A point of distinction was made between two-spirit persons on-reservations versus urban-born LGBT Indians. For those on-reservations who are required to leave because of publicly disclosing their sexual orientation, it is harder to do because of a lack of transportation, whereas urban-born two-spirit persons are able to be more open with their identity because they might be able to blend in some ways. Dealing with historical and cumulative trauma, including anti-gay violence, domestic violence, and mental and emotional abuse are the serious concerns of two-spirit persons. In addition, they fear being re-traumatized by insensitive or "homo-ignorant" service providers, including American Indians.

Table 7.9 Barriers to services utilization by two-spirit persons

Financial resources
Specialized programming for Native two-spirit persons
Fear of what Native community members might think
Fear of being "outed"
Stigma related being LGBT
Professionals' knowledge of Native two = spirit issues
Attitudes of Native two-spirit clients/family toward services
Staff support by non-Native LGBT agencies
Two-spirits' ability to locate services
Staff attitudes toward Native two-spirit persons
Transportation
Physical accessibility/location of services

Adapted from Walters et al. (2001)

A critical issue for AIAN two-spirit persons is identity, or the task of integrating a healthy, positive identity both as an AIAN and as a two-spirited person. Many AIANs have lost the social and spiritual context of whom they are and are always in crisis mode in trying to hold onto traditions while dealing with the LGBT identity. Service providers find it difficult to assist two-spirit persons when struggling to develop an integrated identity because of the historical diversity in terms of tribal acceptance of two-spirit persons and the LGBT person's search for a place and identity in relation to his or her own specific tribal nation. In addition, tribal acceptance is the conflict between AIAN Christian belief systems and acceptance of two-spirit/LGBT (Pope 2012; Walters et al.

2001). Two-spirit persons declare that spirituality is extremely important in their lives and may respond to spiritual conflict with adoption of an inclusive approach to their spirituality that comprises traditional tribal, pan-Indian, and Christian influences (Balsam et al. 2004; Fieland et al. 2007).

A final theme from the focus groups was program planning, which identified four key areas. The first is the need for community-based discussion to identify culturally relevant and meaningful ways to discuss sex, sexuality, gender identity, and LGBT issues. Second was the importance of contextualizing anti-gay violence and more general two-spirited experience within the context of AIAN experience of the colonization, the historical trauma, and the cumulative effect of anti-gay victimization and resulting trauma. The third area is in-service training for all staff regardless of sexual orientation. Finally, there is a need to develop programs that focus on health and mental health issues and to create safe space for two-spirit persons, especially youths.

Another possible explanation of underutilization of services by AIAN elders is that the location of services may be a barrier. A quote from Rose Jerue in 1989, an Alaska Native elder, provides insight about the importance of elders wanting to be close to home. According to Jerue, "elders need to be near the river where they were raised" (cited in Branch 2005, p. 1). AIANs and First Nations elders do not have long-term care facilities in their communities and when requiring institutional care are often placed in facilities located great distances away. The detrimental effects of being removed from their communities may include culturally inappropriate care, language barriers, isolation from family and friends, loss of community affiliation, and loss of their social role as an elder (Lafontaine 2006).

A key issue for elderly AP is gaining access to services because generally, more services, more specialized services, and better access to them is in urban areas than in rural areas. However, access to services in urban areas does not imply more culturally sensitivity to the needs of elderly AP (Rosenberg et al. 2009). The Canadian Community Health Survey (CCHS) and Aboriginal Peoples Survey (APS) asked three questions related to health utilization about whether in the past 12 months individuals visited a (a) physician, (b) eye doctor, and (c) nurse. The most notable difference in healthcare utilization by Aboriginal elders was a higher rate of nurse visits than non-Aboriginals, which may be due to the increased likelihood that rural and health centers on reservations are staffed by full-time nurses than physicians.

Aboriginal elders face a variety of unique issues and obstacles in the provision of healthcare services. Higher rates of Aboriginal elders are monolingual Aboriginal language-speaking, which complicates the interface between them and their largely non-Aboriginal healthcare providers. Other issues include cultural differences related to aging, medical treatment, traditional care-giving roles, the power structure inherent in Western medicine, exclusion of Aboriginal worldviews, and end-of-life (Rosenberg et al. 2009). According to Rosenberg et al., "Western medical practices are often viewed by AP as dehumanizing as they separate older AP from their communities and involve an individual-style decision making that can run contrary to traditional Aboriginal belief systems" (p. 17). These anxieties are particularly amplified for those who are monolingual and hold strongly to traditional views of health and healing. The informal caregiving is important in Aboriginal communities. Similar to AIANs and other ethnic minority groups in the USA, traditional care within Aboriginal communities is gender dependent, with women family members typically being the primary caregivers. In fact, Aboriginal households tend to have stronger gender parity in residential family size and structure, fewer women living alone, and fewer Aboriginal elders living with only their partner (Rosenberg et al. 2009).

AP, regardless of age, who move to urban areas in order to access medical services often face additional barriers, including a lack of financial and transportation support, suitable housing near medical services, type of services available, and isolation from their social support network in their home communities. The urban

Aboriginal population is fairly mobile and movement occurs both between rural and urban areas, and within urban settings (Place 2012). Access to services is only part of the equation for better health outcomes. Others are appropriateness of services and being culturally safe, to which merely living in urban areas does not overcome barriers (Adelson 2005). AP, especially Inuit and First Nations desire access to traditional healing practices, and as age and strength of Aboriginal identity increases, so does the perceived importance of access to this kind of healthcare. In fact, the *Urban Aboriginal Peoples Survey* (UAP) reveals that 72 % of Aboriginal residents in urban areas consider access to traditional healing practices to be more important than mainstream health, only 30 % have "very easy" access to them (Environics Institute 2010, p. 116). Just over half of AP in urban areas utilizes city-based Aboriginal services and organizations. Of those, Inuit (71 %) are most likely to use city-based Aboriginal services and organizations followed by off-reservation First Nations (59 %) and Metis people (48 %). Services are more likely to be accessed by those aged 45 and older and those who are of lower socioeconomic status (Environics Institute 2010).

Similar to AIANs, AP living off-reservations do not have access to the range of federally provided health services that First Nations living on-reservations and Inuit living in their communities (Place 2012). Eligibility for specific federal government programs and services for AP depends on a number of factors, including status (i.e., status vs. non-status Indians), residency, treaty, and provincial and federal legislation (Browne et al. 2009). According to Lavoie et al. (2008), every scenario of status, residency, and so forth results in a different set of benefits and services, and ambiguity of eligibility, which, eventually, leads to gaps and inconsistencies.

One other important consideration in addressing access to services for AP is the distinct issues related to women. Women make up over half of the urban Aboriginal population. Although women tend to live longer than men, they have more instances of health-related issues and are more frequent users of the healthcare system, are more likely to have low incomes, and may have been victims of violence, which is a major determinant of health and requires its own treatment (Browne et al. 2009; Native Women's Association of Canada 2007).

Systems of Service Delivery for Two-Spirited Elders

In healthcare and mental health programming, there is a need provide a cultural network that integrates the AIANs' indigenous community into treatment plans along with prevention and early intervention services (Native Vision Project 2012). Many AIANs ascribe to traditional health practices that are grounded in an indigenous worldview, which emphasizes harmony and balance. Traditional Native health practices (e.g., sweat lodge, pipe ceremony, Sun Dance, Native American Church) are ways of coping with disease and responding to adversity. Both Indians in urban areas and on reservations use traditional healing practices in conjunction with Western medicine, with traditional practices to treat the underlying cause (e.g., violation of a cultural taboo) and Western medicine to treat the symptoms (Fieland et al. 2007). Thin Elk's (2011) model combines a holistic approach with indigenous (e.g., talking circles, healers, seasonal ceremonies, and sweat lodge purification ceremonies) and mainstream approaches (e.g., one-on-one counseling) to wellness and healing. However, two-spirit persons may not be open about their identity or all their health practices because of discriminatory experiences in the American healthcare system and heterosexist attitudes among traditional healers. Among older urban AIAN patients in primary care, maltreatment and neglect are relatively common (Grant and Brown 2003).

One area of concern is the diagnosis of mental health functioning of AIANs. AIANs may conceptualize mental health differently and express emotional distress in ways that are inconsistent with the diagnostic criteria of the *Diagnostic and Statistical Manual* (DSM). For example, AIANs

may express distress as ghost sickness and heartbreak syndrome. Thus, the question becomes how to elicit, understand, and incorporate such expressions of distress and responding within the assessment and treatment process of the *DSM* (Grant and Brown 2003). The most recent edition of the *DSM* contains an updated version of the Outline for Cultural Formulation (OCF), which calls for systematic assessment five categories and the Cultural Formulation Interview (CFI), which is a set of 16 questions that may be used to obtain information during a mental health assessment about the impact of culture on key aspects of an individual's clinical presentation and care (American Psychiatric Association [APA] 2013).

Although federal and state funders of behavioral health services overwhelmingly require use of evidence-based practices (EBP), of which the "gold standard" of Western-based EBP does not reflect American Indian communities with regard to cultural, linguistic, and geographical differences in prevention and early intervention, Native American cultural practices (i.e., practice-based evidence) have been increasingly used in effective service delivery (Native Vision Project 2012). There is a distinction between evidence-based practice (EBP), which is scientifically tested and validates, and practice-based evidence or community-defined evidence (CDE), which is a validated practice, which is accepted by the AIAN community but not empirically proven. EBPs are particularly challenging because they have not been tested in AIAN communities; therefore, they have not been culturally validated. Government funders mandated that behavioral health providers observe the same EBP standards in health care (Nebelkopf et al. 2011). Neblkopf et al contend that this mandate brings into question, how can Western science reconcile with indigenous knowledge to operationalize AIANs and First Nations' core values to demonstrate EBP? The suggestion is to use CDE to identify cultural adaptations to EBPs (Martinez 2011).

One approach of service delivery that has produced successful outcomes with AIANs is the Holistic System of Care (HSOC). The HSOC is a community-focused intervention that provides behavioral health care, promotes health, and prevents disease. The HSOC integrates mental health and substance abuse services with medical, dental, and HIV services and provides support for the entire family. The approach links prevention, treatment, and recovery and is based on a community strategic planning process that honors Native culture and relationships while allowing for integration of Western (EBPs) treatment modalities. The HSOC acknowledges the diversity of traditional healing beliefs among the different tribes and respects each tribe's practice of traditional medicine. This approach deals with the whole person. The emphasis is on self-help, empowerment, and building a healthy community (Native Vision Project 2012).

Although substantial fragmentation exists in many Native communities, some communities (e.g., Native community in Chicago and Portland, Oregon) have developed a strong network of human services to meet the varied needs of community members (Weaver 2012). In Canada, practices have been implemented for First Nations and Inuit elders. The First Nations and Inuit Home and Community Care (FNIACC) program has been instrumental in facilitating the development of essential programs within 606 First Nations reserves and communities and 53 Inuit communities across Canada (Cyr and Ootoova 2010). FNIHCC consists of eight regions across Canada that engage in collaborative partnerships that create sustainable change in communities and jurisdictions.

Policy Issues

Currently, health services in the USA are delivered through a system of interlocking programs made up of the IHS, tribal programs, and urban programs. The structure involves interrelationships between the federal government, tribal governments, and urban Indian groups. The IHS structure consists of three levels: headquarters, area offices, and service units including hospitals, health centers, health stations, and clinics (Tosatto et al. 2006). The IHS is based on the

medical model and as such, one of the major problems is that the majority of funding goes into direct medical care (e.g., hospital and clinical care) with limited dollars available for prevention. Other challenges include a lack of resources and technical knowledge: most tribes do not have departments of public health, which "is a major contributor to the negative health disparities existing among Indian people today, on and off reservations" (Allison et al. 2007, p. 299). Another crucial problem associated with the IHS structure is the inability to bill and collect adequately for all of the services it provides.

Exponentially, Native American tribes are assuming more control of their own healthcare delivery systems and making decisions to create or plan their own departments of public health (Allison et al. 2007). Allison et al. propose three public health organizational delivery models to meet the public health needs of small, medium, and large American Indian tribes. The models become larger and more complex in the progression along the continuum. Basically, these models create an organizational structure in which services and functions are handled by specific departments and are designed with the premise that tribal governments are direct care providers. The models build on existing services provided through IHS.

In Canada, one of the greatest challenges for urban Aboriginal seniors in the healthcare system is the issue of jurisdiction, specifically for Inuit and status Indians peoples. Both Inuit and status Indian peoples face jurisdictional challenges, because while provinces and territories provide healthcare services, the federal government is responsible to pay for status Indian and Inuit health care. Although Metis and non-status peoples are declared as Aboriginal under the Constitution Act of 1982, they are not recognized as a federal responsibility. The result is that Metis and non-status Indian peoples receive the same provincial benefits as all other Canadians (Beatty and Berdahl 2011). The political jurisdiction and administrative barriers between federal, provincial, and regional authorities cause ongoing jurisdictional disputes in health regarding the provision of health services to AP (Beatty and Berdahl 2011; Cameron 2003). From a policy perspective, it is important to recognize that the off-reservation and urban Aboriginal populations in Canada are not distinct from the on-reservation and rural. They are interconnected in terms of mobility, culture, and politics (Graham and Peters 2002). AP are highly mobile between rural/reservations and urban areas, and within urban communities ("churn factor"), which has implications for policy (Place 2012).

The current policy frameworks in Canada for AP are hampered by fragmented services, judicial boundaries, and insufficient funding, which is especially challenging for elders. Understanding how two-spirit persons fit into the mix of things is still unclear. Beatty and Berdahl (2011) suggest that Canada look to Sweden, Denmark, and Iceland for alternative ways of thinking about options for elderly care in Canada. In Sweden, elderly care policy focuses on ensuring the elderly economic security, adequate housing, and good services and care. Iceland uses a model that consists of a mix of family and state involvement. Elderly care in Denmark is largely state funded. These three models contain several key components to reconcile the fragmentation of services for AP. First, they support a public push for governments to take more responsibility for long-term care with increased support for families as a means of empowering personal control among the elderly and their families. Second, they suggest more holistic Aboriginal eldercare models in Canada. Third, they advocate for inclusion of culture, community, and mixed systems. Finally, they promote community involvement as integral to proper health care (Beatty and Berdahl 2011). Presumably, specific attention is to be given to two-spirit elders in the redesign of policies and procedures.

The future brings new challenges and continuation of existing ones for development of interventions for AIANs and First Nations. One of the most substantial challenges is EBP. Since EBP is grounded in the supposition that the most effective practices are demonstrated through carefully controlled scientific experiments, which assess the causal efficacy of these practices, Nebelkopf et al. (2011) question the efficacy of EBP for

measuring practices of indigenous peoples of North America. Nevertheless, a consensus in the literature is that two-spirit persons of North America and especially elders are among, if not, the most marginalized people of all in their respective country or region.

Summary

AIAN and Aboriginal elderly people are among the most vulnerable and marginalized people of North America, and two-spirits elderly are even more so. Both in the USA and Canada, these groups are recognized as disadvantaged status because of poor socioeconomic conditions on reservations and in communities, both urban and rural. Two-spirit persons among AIANs and AP of Canada are further marginalized in their communities and within the LGBT community. A combination of social and economic exclusion, barriers to health services access, ignoring culturally specific coping mechanism, ageism, and the effects of colonization converge to relegate two-spirit elders to a status of unimportance, and far worse, to that of invisibility.

Learning Exercises

Self-check Questions

1. To what extent do urban American Indians have rights as citizens to tribal government on reservations?
2. How is enculturation an empowering process for two-spirit persons?
3. How does historical trauma shape the health risk factors for Native Peoples?
4. Compared to the general population, what types of health issues are significantly higher among AIANs?
5. Among First Nations of Canada, which group has poorer health status? What health issues do they have?

Field-Based Experiential Assignments

1. Interview an AIAN or First Nations elderly LGBT persons to understand how he or she defines two-spirit identity.
2. Establish an interdisciplinary team of professionals and develop processes and procedures to work with two-spirit LGBT elders in urban areas and rural settings.
3. Construct an interdisciplinary, cross-cultural conference to address the psychological, social, health, housing, economic, education, and life-care plans of two-spirit LGBT elders. Be sure to: (a) purpose of the conference, (b) goals and objectives, (c) identify topics to be covered, (b) expert speakers, and (e) other relevant components.

Multiple Choice Questions

1. Which of the following is how American Indians analyze human sexuality?
   (a) Dichotomously and categorically
   (b) Continuum of human sexuality
   (c) Physical appearance
   (d) Biologically
2. How do American Indians define gender and gender status?
   (a) Majority and minority
   (b) Biological and ambiguous
   (c) Rite of passage
   (d) Biological and cultural
3. How are two-spirit persons viewed in First Nations' culture?
   (a) Transsexuals
   (b) People who try to make themselves the opposite sex
   (c) Individuals who take on a gender that is different from both women and men
   (d) Individuals who take on one gender identity prior to puberty, then another gender to signify adulthood
4. Why do Aboriginal Peoples view Western medical practices as dehumanizing?
   (a) They separate older Aboriginal peoples from their communities

(b) They involve individual-style decision making that can run contrary to traditional Aboriginal belief systems
(c) They exclude Aboriginal worldview
(d) All of the above
(e) None of the Above

5. Which of the following is true of two-spirit persons on reservations who are asked to leave because of publicly disclosing their sexual orientation?
   (a) Lack of transportation make it harder for them to leave
   (b) They are able to blend in some ways
   (c) It is easier for them to integrate a positive, healthy identity
   (d) Service providers' attitudes are more positive
6. Which of the following service provider is a higher rate of usage among rural Aboriginal elders than non-Aboriginal elders?
   (a) Physician
   (b) Specialist
   (c) Nurse
   (d) Eye doctor
7. Why is the diagnosis of mental health functioning of Native Peoples a concern with the way diagnostic criteria are defined in the Diagnostic and Statistical Manual?
   (a) The language of the DSM is difficult to translate into many Native languages.
   (b) Native Peoples conceptualize mental health differently and express emotions that are inconsistent with DSM diagnostic criteria.
   (c) As a sovereign nation Native Peoples are not obligated to follow the same diagnostic criteria of the DSM.
   (d) The prevalence of indigenous people is not statically significant to meet DSM diagnostic criteria.
8. With the disclosure of one's sexual identity in the American Indian community, who dictates the parameters regarding acceptable behavior?
   (a) Parents
   (b) Peer group
   (c) Elders
   (d) Tribal law
9. Which of the following is prohibited by federal policies for Aboriginal elderly in Canada?
   (a) Building of long-term care facilities on reservations
   (b) Staffing healthcare facilities with nurses in rural communities
   (c) Renting of subsidized housing
   (d) Providing healthcare services both on- and off-reservation
10. Where did the term two-spirit originate?
   (a) USA
   (b) Australia
   (c) England
   (d) Canada

Key

1—b
2—d
3—c
4—d
5—a
6—c
7—b
8—c
9—a
10—d

Resources

Indigenous Health—Australia, Canada, Aotearoa, New Zealand, and the USA—Laying claim to a future that embraces health for us all: www.who.int/healthsystems/topic/financing/healthreport/Ihno22.pdf.

NativeOut: www.nativeout.com.

The Provincial Health Services Authority of BC (training modules on Indigenous cultural competency): http://www.culturalcompetency.ca/.

Toronto-based organizations: http://www.2spirits.com/.

Tribal Equity Toolkit 2.0: Tribal Resolutions and Codes to Support Two Spirit and LBGT

Justice in Indian Country: http://graduate.lclark.edu/live/files/15810-tribal-equity-toolkit-20.

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