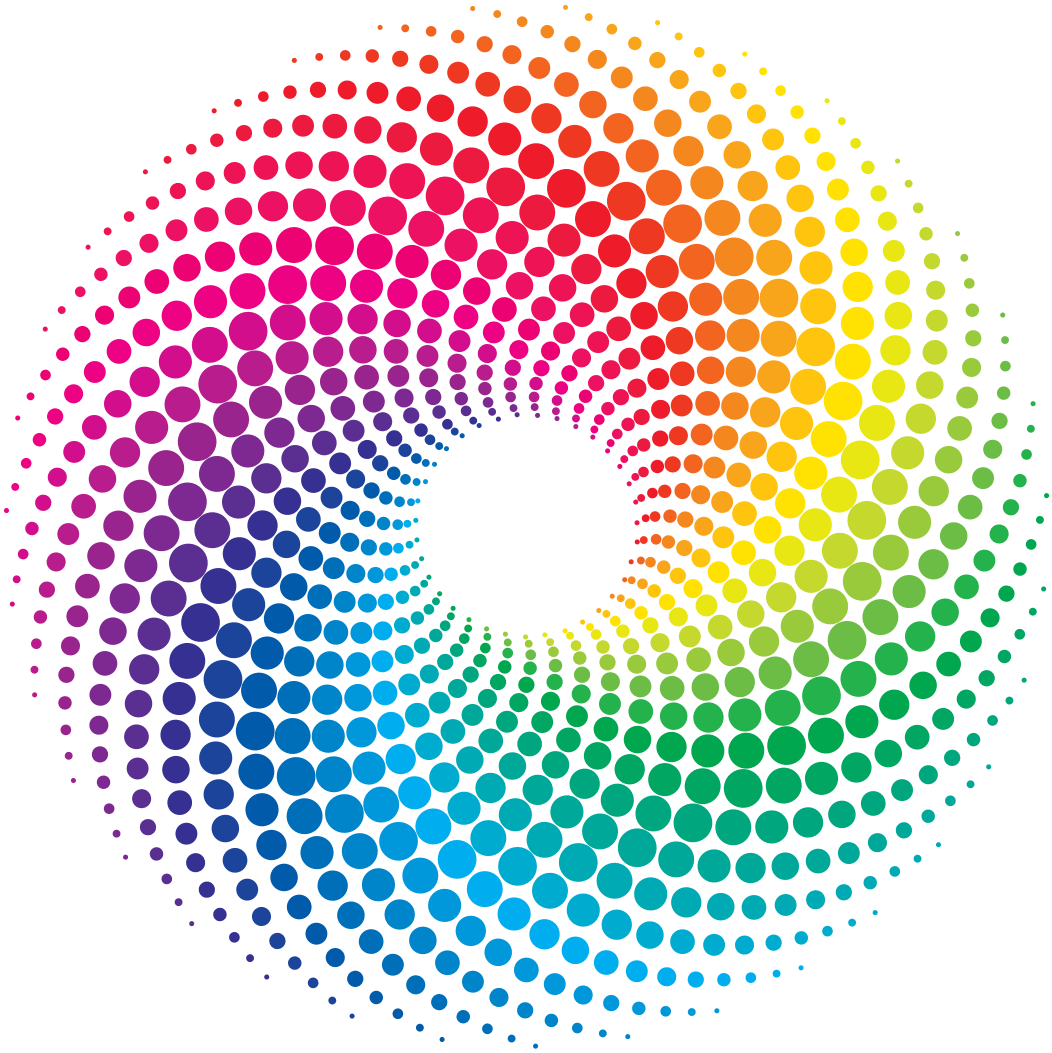
Journal of Case Management

CARE MANAGEMENT JOURNALS

The Journal of Long Term Home Health Care



SPRINGER PUBLISHING COMPANY

www.springerpub.com/cmj

Introduction to the Special Issue

J. Neil Henderson, PhD
American Indian Diabetes Prevention Center
College of Public Health, University of Oklahoma Health Sciences Center

This special issue provides a window into a national quest to reduce health disparities. The American Indian Diabetes Prevention Center (AIDPC) is funded by the National Institute on Minority Health and Health Disparities at the National Institutes of Health. The AIDPC is located at the University of Oklahoma Health Sciences Center, College of Public Health, in Oklahoma City, Oklahoma. Health disparity reduction of diabetes among American Indian people is the AIDPC's main purpose. Findings from the AIDPC investigators and tribal collaborators will serve as a resource to American Indian people and the nation as a whole.

Assembled in this special issue is the output of several health scientists from distinct disciplines engaged in research aimed at the amelioration of diabetes disease burden among American Indian people. Topics include health beliefs and chronic disease management behaviors of mothers with children with diabetes, survey results showing personal adaptations to diabetes as variably enacted by gender, and a study of pressure variance across the diabetic foot which is at high risk of tissue injury leading to cascades toward amputations. Furthermore, the organizational culture of the AIDPC is examined as critical to providing an environment in which multiple ideas and professional perspectives are valued and converted into new ways of seeing the manifold problems of one chronic disease, diabetes. Although each report is a discrete research topic, they share the subject of diabetes and coping as a health disparity problem among American Indian people. Stitching together these research findings into a single coherent whole is probably beyond the scope of this special issue. However, imposing buildings are built of many individual bricks held in place by a common mortar. For the AIDPC projects, that mortar is the dignity of all humanity, especially under the duress of chronic disease.

Dignity perhaps is the *best* mark of well-being and quality of life, yet, where we work, scientific research codes health status mainly in physical terms. In addition, mental health, that most neglected aspect of health research and practice, is categorized into clusters of behaviors with labels that sometimes obscure rather than clarify. Even in the presence of physical and mental pathology, self-worth, self-esteem, and other tropes for dignity exert a powerful effect on well-being. For example, Dressler, Balieiro, and Dos Santos (1997) and Dressler and Bindon (2000) have shown in a cross-national sample of rural, poor, African Americans and African Brazilians that arterial blood pressure is normal among those who held the self-perception that their social position in their community was appropriate, fitting, and consonant with their own and community expectations of social status. Multiple regression analyses of income, education, other medical/physical conditions, access to medical care, and so forth, were not the most important factors associated with normal blood pressure in a population with an excess prevalence of hypertension.

Think about it: physical health created by a psychosocial perception or *feeling* that "I've done just fine with my life," and "I can comport myself with dignity." The social determinants of health have an effect because they "biologize" (cf. Singer, 2009) cultural, social, and psychological phenomena into composite health and disease through the persistent activation (or not) of the hypothalamic-pituitary-adrenal cortex stress response (HPA axis; Jackson, Knight, & Rafferty, 2010). Living life with at least a modicum of dignity is protective of body, mind, and soul. Is our "metric" wrong? Should the national quest for health equity be measured in terms different than numbers of pathologies and dollar bills? Is it time for a new starting point to rethink the meaning of "health disparities" in real-world settings and in real time? Goal attainment strategies would certainly be different if "dignity" were the goal and typical health status was a secondary outcome.

Avoiding an "either–or" logic trap, can we see the research of the AIDPC and work at similar centers doing both: raising health status *and* dignity? I think we should all examine our research

Dignity perhaps is the best mark of well-being and quality of life, yet, where we work, scientific research codes health status mainly in physical terms.

http://dx.doi.org/10.1891/1521-0987.15.4.158

and look for signs that in addition to better glycemic control, our participants also gain a significant measure of dignity.

REFERENCES

Dressler, W., Balieiro, M., & Dos Santos, J. (1997). The cultural construction of social support in Brazil: Associations with health outcomes. *Culture, Medicine and Psychiatry*, *21*, 303–335.

Dressler, W., & Bindon, J. (2000). The health consequences of cultural consonance: Cultural dimensions of lifestyle, social support, and arterial blood pressure in an African American community. *American Anthropologist*, *102*, 244–260.

Jackson, J., Knight, K., & Rafferty, J. (2010). Race and unhealthy behaviors: Chronic stress, the HPA axis, and physical and mental health disparities over the life course. *American Journal of Public Health*, *100*, 933–939.

Singer, M. (2009) *Introduction to syndemics: A critical systems approach to public and community health*. San Francisco, CA: Jossey-Bass.

Dr. J. Neil Henderson is Professor of Medical Anthropology in the Department of Health Promotion Sciences and Director of the American Indian Diabetes Prevention Center in the College of Public Health, at the University of Oklahoma Health Sciences Center in Oklahoma City. He is Oklahoma Choctaw. Dr. Henderson's research investigates biocultural development and course of chronic diseases in non-majority populations. Dr. Henderson was named Edith K. Gaylord Presidential Professor in 2014, received the *Leadership in Prevention for Native Americans, 2006*, and the *Award of Achievement* by the University of Oklahoma, College of Public Health.

Acknowledgments. Research reported in this publication was supported by the National Institute on Minority Health and Health Disparities of the National Institutes of Health under Award Number P20MD000528, and in collaboration with the Choctaw Nation of Oklahoma and the Chickasaw Nation. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health or the Choctaw Nation of Oklahoma or the Chickasaw Nation.

Correspondence regarding this article should be directed to J. Neil Henderson, PhD, American Indian Diabetes Prevention Center, College of Public Health, University of Oklahoma Health Sciences Center, College of Public Health, 801 NE 13th St., Office 450, Oklahoma City, OK 73150. E-mail: Neil-Henderson@ouhsc.edu