

ON THEIR OWN TERMS

ON THEIR OWN TERMS: HEALTH PERCEPTIONS OF URBAN NATIVE PEOPLE

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## ABSTRACT

Cultural differences between Native patients and non-Native health practitioners lead to misunderstanding and mis-communication in the clinical milieu. This applied anthropology study provides information which can lessen this problem. It is an investigation health perceptions, as described by a diverse group of Native people living in Hamilton, Ontario.

Four major themes emerged from open-ended questions covering a wide range of health topics. The first is the meaning which informants attribute to health, and how this contrasts with the traditional view and that expressed by non-Native people. The second is the role of a identity in creating and maintaining good health. The third is people's experience with mainstream health care practitioners and, in some cases, with traditional healers, and how differing styles of communication and guidance impinge on health promotion. The final theme involves people's feelings about freedom and control, and notes how the course of history as well as Native ethics affect their perception of "personal control". Some alternative ways to conceptualize health promotion strategies are offered. I also suggest a link between individual health, community well-being and community self-determination.

The study combines elements of interpretive and critical anthropology and psychological theory with descriptive data derived from questionnaires and unstructured interviews. I conclude with suggestions as to how the health of this population could be optimized by three approaches - that offered by mainstream health care providers, by Native community organizations, and by the society itself.

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## CHAPTER 1: INTRODUCTION

Significant changes are occurring in Canada in the recognition of the rights of Native people, and the endurance and viability of their traditions. For many centuries, Native culture was suppressed, and political decision-making power monopolized by well-meaning but paternalistic white men<sup>1</sup>, with their own narrow vision of what was right and good. As in the case of other colonized peoples, the health and general well-being of Native people in this country underwent a sharp decline in the years following contact, and despite the availability of modern medicine, Native health status continues to be a concern.

At the present time Native leaders, and the people themselves, are demanding and gradually reclaiming stewardship over their lives, and the decisions that affect their communities. One way they are doing this is by taking responsibility for better health care in many reserve and urban Native communities. The change is occurring slowly, however. At present, the vast majority of qualified health care professionals dealing with Native people<sup>2</sup>

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<sup>1</sup> The terms "white men" and "dominant society", are used here (as they frequently are in Native culture and publications) to refer to the non-Native people in general, i.e. those (primarily but not exclusively of Anglo-Saxon origin) who settled in Canada during the past several centuries, and who hold political and economic power.

<sup>2</sup> Speaking about "Native people" in Canada, I risk over-generalizing in describing peoples who are diverse in culture and environmental circumstances. In the relatively brief review of

(especially in non-reserve settings, where a significant portion of the Native population lives) are non-Native, and are relatively unfamiliar with Native ways. Increased availability of information which bridges the cultural gap between Native people and non-Native health care providers will support the trend toward better and more culturally-appropriate health care for Canada's first people. One purpose of this thesis is to provide such information.

During the research I spoke with a wide variety of Native people in the Hamilton area, about their perceptions of health issues. The themes which emerged included

- the holistic nature of health, as understood by Native people,
- the importance of identity for good health and for healing,
- the differences in styles of guidance and communication which often stand in the way of successful clinical encounters when one party is Native and the other non-Native,
- people's ambivalence about the idea of "control", and their thoughts about how one can best live a healthy life

Recognition of these ideas will help mainstream health care providers to better understand the needs of their Native patients, and thus not miss the opportunity to provide the best care possible.

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Native health issues which comprises this and the following chapter, it is a necessary means of documenting the currently published information. In the remainder of the study, the term "Native people" refers primarily to the people who took part in the research, and others in their social groups. These are, for the most part, people from Iroquois and Ojibwa nations, currently residing or working in Hamilton.

NATIVE HEALTH RESEARCH

Most of the current literature on the health of Native people in Canada comes from medical practitioners and other biological scientists working within the biomedical framework. Medical statistics indicate that Native people in Canada, when compared to other Canadians, are more likely to experience chronic health problems such as respiratory disease, diabetes, and alcoholism (Young 1988a; Frideres 1988b; Shah and Farkas 1985). They have a shorter life expectancy (Mao et al 1986), and are more likely to become sick or to die during infancy or early years (Evers and Rand 1982; Morrison et al 1986). The inquiring reader has access to information on the relative disadvantage (due to education level, employment status and economic circumstances) of the average Native person (Frideres 1988a), and the potential contribution of social factors to their health status (Waldram 1990a; Shah and Farkas 1985). A minor focus in the literature is the level of adherence of Natives to treatment or rehabilitation programs (Jenkins 1977; Young 1988b; Morgan and O'Connell 1987), and efforts to increase compliance.

With some notable exceptions (Brant 1990; Mala 1988; Aitken 1990; Castellano 1982, 1986) the majority of Native people have, in the past, remained silent in the academic discussion about their health. Despite efforts by several Canadian universities to increase Native enrolment in medical programs<sup>3</sup>, relatively few

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<sup>3</sup> An example is the Aboriginal Health Professions Program at the University of Toronto, which was established in 1986. This program recruits Native students into the mainstream health

Native people have so far chosen to pursue medical careers within the mainstream system.

In the Native community generally, a lack of confidence and trust of non-Natives and differing communication styles impede communication between the two groups. Cultural differences may cause research initiatives (as well as clinical communication between health care providers and Native patients) to be incomplete and fraught with misunderstandings.

#### EXPANDING THE FOCUS: THE IMPORTANCE OF CONTEXT AND MEANING

Unlike biomedical research which restricts itself to investigating biological universals and technological interventions in a relatively context-free environment, the hermeneutical paradigm de-emphasizes universal laws of nature and nosological categories. While not discounting the biological aspect of health and disease, it stresses the interpretation of meaning - an integral part of our communication and social interaction - as inseparable from the experience of human health and illness, and consequently as a necessary component of health studies. Moreover, the historical, social, and cultural contexts in which people experience health and illness (and in which they communicate information about these) are critical elements, which are integral to our understanding of the total health picture (Good 1977; Kleinman 1982; Van Shaik 1989). The formulation and communication of meanings, as evidenced in the

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professions, and provides advocacy, counselling and financial assistance during their educational involvement. The training includes a component on traditional healing, designed to enhance graduates' understanding, and ability to access this resource in Native communities.

social environment, must be understood if relevant and constructive interaction between patient and practitioner is to ensue.

This study adopts and goes beyond such an approach. It describes Native informants' perceptions about health and health care, using their own words and life histories to illustrate the themes which emerge. Furthermore, it utilizes these personal accounts to analyze their broader implications as to the health of the population.

Recently, some medical anthropologists have faulted the hermeneutic approach, in that it may be used as a vehicle for bringing patients more effectively under the hegemonic control of the biomedical establishment (Taussig 1980; Singer 1989). The continuing tendency to take the individual as the subject of investigations is seen as problematic (A. Young 1982:269; Frankenberg 1988:330). These commentators see the critical approach, in which the mechanisms of delivery of health care and the interests of the power-brokers (that is, the corporate and governmental decision-makers) is of primary concern, as more pertinent in understanding the forces which create health and ill health.

The present study, to some extent, melds the interpretive and critical perspectives, in that the health concerns of Native informants de-emphasize the health of the individual, and enlarge the perspective to include the individual in his/her relationship to others, to the community, and to the environment. In this, they are similar to the ideas of those who have gone beyond the reductionistic and "germ theory" (i.e. biomedical) view of human health

(Bolaria 1988:1-2), and the interpretive approach to patient management, and are promoting change in broader systems as a more comprehensive, and ultimately more practical way of improving human health.

The study involves, for the most part, Native people living in Hamilton, Ontario, a city of approximately 600,000 people, in which recent unofficial estimates place the Native population at approximately 8-9,000 (Cooke 1992). In Canada, the percentage of Natives living off reserves has increased from 16% in the mid-sixties to over 30% in 1980. Close to 80% of those living off reserve are in large metropolitan centres (Frideres 1988a: 207). Despite this fact, the great majority of Native health research involves populations living on-reserve, as health initiatives by Indian Health Services (a section of Medical Services Branch of the federal Department of Health and Welfare) have been restricted to reserve and northern populations.<sup>4</sup> Little recent information on urban Natives is available, with much of what is in print having been published in the 1970's and early 1980's (Ablon 1971; Nagler 1971; Brody 1972; Sorkin 1978; Johnston et al 1978; Hagey, 1983, 1984). The lack of research on the health of city-based Native

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<sup>4</sup> There is at present one urban health clinic, (Anishnawbe Health Toronto, a community health centre funded by the Ontario Ministry of Health) which is operated by Native people, with the primary purpose of providing urban-dwelling Natives with health care which is based on traditional values. Staff in this organization see their priority as treatment, not research, at the present time. They are working to establish a policy on potential future research projects, which will eliminate the exploitive and intrusive elements which they feel have characterized past research involving Native people. (Morrison, 1992)

people is viewed as a major problem by those dealing with this population (Farkas and Shah 1986; Shah and Farkas 1985).<sup>5</sup>

#### PURPOSE AND LAYOUT OF THE STUDY

The purpose of this research is to learn more about the health of urban Native people, and more specifically, to investigate their perceptions of their own health, and the factors which influence it in times of dynamic change. Chapter 2 provides background information, beginning with a brief historical outline of Native health. This is followed by a description of the present-day health status of Native people. The particular case of urban-based Natives, and the need for increased understanding of their special needs, concludes the chapter.

Chapter 3 is a description of the present study. I include a commentary on the development and potential utilization of the study, followed by a description of methodology, and of the population involved. My observations on the role of a non-Native researcher working within the Native community conclude the chapter.

Chapter 4 investigates how people think about health. It begins with informants' ideas about what it means to be healthy, and the time in their lives when they felt most healthy. In this discussion, I demonstrate how people's perceptions of the holistic

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<sup>5</sup> Publications on Native health have become more numerous in the past decade. A 10-year survey of Index Medicus shows that the majority of publications are those which deal with specific physical disorders experienced by Native people. Areas of recent attention include the need for recruitment and training of health care professionals of Native origin, the health effects of local resource development in northern communities, and the transfer of responsibility for health care to Native communities.

nature of health differ from those of many health care practitioners, and are an integral part of Native identity. A discussion of traditional ideas about health as described by an Iroquois herbologist, and by others in the Native community follows. The final section of the chapter is a discussion of some non-Native definitions of health, culled from international sources, and analysis of how these compare to the Native understanding described previously.

In commenting on what non-Native health care providers should understand about Native people, many respondents raised issues relating to "who they were" and "where they had been". In many informants' stories of healing, a newly-experienced positive identity as a Native person was cited as an integral part of the healing process. This personal transformation is the subject of Chapter 5; my analysis explores how Native identity impacts on health and health care.

Chapter 6 reports on respondents' ideas about the health of their families and their community, and their accounts of how they deal with health problems which arise. The chapter includes people's stories about their experiences with the mainstream health care system, in contrast to traditional healing experiences.

The association of "personal control" and good health has been highlighted in some health promotion literature (Wallston et al 1976; Peterson and Stunkard 1989). For a number of my informants, the idea of "control" elicits feelings of discomfiture, frustration or anger. Chapter 7 uses freedom and control as central concepts,

which integrate the various themes which have been discussed previously. The chapter details informants' antipathy to the idea of control, and in some cases even self-control. It goes on to describe people's perspectives on the oppression of their people, the ethic of non-intervention in traditional Native culture, and the implications of these for effective medical care. Some more culturally-appropriate ways of conceptualizing self-discipline conclude the chapter, along with ideas on how this might impinge upon people's feelings of self-efficacy and self-esteem.

Chapter 8 summarizes the major themes of the study, and uses these to make recommendations as to how health care for Native people in the city could be improved. The first section which deals with culturally-appropriate health care, and is directed at mainstream health care professionals; the second concerns health initiatives which are presently occurring within Native communities; the third section deals with structural changes which must occur if Native health is to be optimized.

The primary relevance of this study is in the social, or more specifically, the health field. As well as the dissemination of the thesis in the present form, it is my intention to submit an abridged version of the work for wider circulation in the health care community and in urban-based Native organizations, and to remain involved in health-promotion efforts in this area. Applied anthropologists today speak of the need to maintain responsibility to the communities in which work is carried out, and develop

research plans which will benefit those communities (see, for example, van Willigan 1986:xi; Paine 1985:1). The present study was undertaken with these principles of responsibility and reciprocity in mind.

I conducted this research during a time when Native concerns gained great prominence in Canada. The period spanned Elijah Harper's stand on the Meech Lake Accord, the Oka crisis, and the acknowledgement of Native peoples' rights to self-determination during Constitutional discussions. It was a time of optimism for those seeking and promoting change in relations between Native people and mainstream Canadian society. Based on the ideas expressed by my informants, I will argue that Native health at the individual level is linked to the general well-being of the larger Native community, that is, to improved social conditions and self-respect stemming from increased self-determination.<sup>6</sup> If this is so, the currents of change presently evident in the larger Native community in Canada, will in the long term, have a positive impact on the health status of urban Native people. These processes should be of interest to concerned health care professionals, as well as to Native people interested in promoting positive health beliefs and behaviour. It is the goal of the present study to begin to trace

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<sup>6</sup> Similarly, in a recent book on health of Native people (in particular, those in the Sioux Lookout Zone in Northern Ontario) Young (1988a:123-137) promotes the idea that community development and the achievement of political, economic and social power by Natives will do more than increased "medical services" in raising the health status of Native people.

the connections between these forces, as well as to contribute to the dialogue between the health care and the Native communities, and to increase the possibility of mutual understanding.

## CHAPTER 2: HISTORICAL AND CONTEMPORARY SETTING

The Native perception of health is a holistic one, in which not only the health of the individual, but also that of the community and the extended environment are woven into a multiplex pattern of well-being. When discussing health, many Native informants raised issues of identity, that is, of how Native people see themselves in relation to white people and the history of interaction between the two groups. A study of Native health today would be incomplete without some consideration of what has gone before.

This chapter gives an abbreviated history of Native health in Canada, with minor emphasis on Iroquois and Ojibwa groups of which the majority of subjects in the present studies are members. It places the subject of the health of the Native people living in Hamilton into the broader context of Native health concerns in Canada.<sup>1</sup>

### HEALTH DURING THE HISTORIC PERIOD

Existing records suggest that when European explorers and traders first encountered Native people, they were impressed by the

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<sup>1</sup> Of necessity, the source of information in the present chapter is material written in books and journals by non-Native people, i.e. by missionaries, doctors, government officials, historians, etc. It is a representation of the views of a selection of members of the dominant society on the subject of Native health. For more comprehensive treatment of the history of Native health, see Young (1988a), Graham-Cumming (1967).

good health and strong constitutions of the individuals they met (Young 1988a:33-34; Grant 1907:142; Lahontan 1970:418; Henry 1901:114). Although not free from disease, they were at least as healthy as the newcomers, whose own contemporary medicine was not able to cure many common ailments. A long tradition of indigenous medicine, which included herbal and spiritual healing, contributed to this state of good health. The European newcomers were impressed by the Native people's healing skills and knowledge, and in some cases, utilized them in relieving maladies for which they themselves had no cure (Vogel 1970; Henry 1901:118; Lafitau 1724:204-209).

With the arrival of increasing numbers of Europeans, however, the incidence of disease increased sharply. Epidemics such as measles, scarlet fever, diphtheria, chicken-pox, smallpox, typhus, typhoid, tuberculosis spread through many Native communities; Native people, most of whom had not previously acquired immunity through exposure to the diseases, suffered highly debilitating effects that were not seen in the European carriers (Young 1988a:36; Graham-Cumming 1967:145; Heagerty 1940:8). Epidemics resulted not only from the introduction of unfamiliar microorganisms, but from the facilitation of their spread due to fragmentation of the social fabric in Native communities (Herring 1991:2).

The dominant society strongly discouraged the practice of Indian medicine, seeing it as incompatible with the conversion to Christianity and, in later years, the assimilation which was seen by government officials as both desirable and inevitable. Although of

variable success in different areas, the suppression of this tradition decreased Natives' access to their primary source of healing and support, and resulted in deep schisms within some Native communities.

Tuberculosis became an overwhelming problem when Native people were displaced from their traditional territories, and situated on reserves. Crowding, inadequate housing, poor sanitation, and a lack of other basic facilities exacerbated their already-poor health status (Graham-Cumming 1967). During the years between World War I and World War II, physicians and administrators expressed doubts about "the very survival of the Indian race" (Young 1988a:40).

An additional factor in the persistence and gravity of tuberculosis was the placement of children in residential schools, where they lived for years in isolation from family members and from their traditional lifestyle. In the schools, nutrition for students was poor, conditions were crowded, and proper ventilation was lacking. The gravity of the situation was acknowledged by those in authority, but nonetheless, infected children were not segregated due to cost considerations (Graham-Cumming 1967: 133).

More destructive than the physical deficiencies of residential school life, however, were the cultural dislocation, loneliness and grief which the new situation caused. The rationale for the removal of children to residential schools throughout this period was not primarily for educational purposes, but to "civilize" them, convert them to Christianity, and to hasten their acculturation

(Barman, Hebert and McCaskill 1986:5-6). Native language, customs and spirituality were strictly forbidden, and students were shamed and punished for using the ways of their people (Haig-Brown 1988; Barman, Hebert and McCaskill 1986). Sexual abuse was not uncommon, and was endured by children who were removed from contact with family, and access to help from outside the school (Haig-Brown 1988). Some parents ("the strong ones", in the words of one professional woman who spoke to me during the study) hid their children from the Indian agent, and thus kept them out of school, in order to preserve the old ways.

The Indian agent was the representative of the Federal Government in Native communities, and held "an extraordinary range of administrative and discretionary powers" under the Indian Act of 1876 (Gibbins and Ponting 1986:22). The Indian Act, while presenting the illusion of Indian participation in decisions affecting their lives, actually exerted very tight control, and "extended the regulatory reach of the government into virtually every nook and cranny of Indian life (ibid:22).

Native people's political effectiveness was diminished further when traditional forms of government and spiritual practice were made illegal by the federal government. For example, on the Six Nations Reserve near Hamilton, the League of Six Nations, which had governed successfully for several centuries, was abolished as a legal form of government by a federal act in 1924, and replaced by an elected council (Price, 1979:161). The hereditary council continues to exist, however. It has remained a strong conservative

force, supporting the traditional and spiritual life of the community. The presence of two sources of political leadership causes deep and ongoing philosophical divisions within the community.

#### THE MODERN ERA

The Federal Government continues to exercise bureaucratic control on reserves under the Indian Act, although the impetus for change is strong. The elected band council makes by-laws, subject to the provisions of the Indian Act, but these must be sent to the Minister of Indian Affairs for approval before they can be instituted (Government of Canada, 1985). Despite official endorsement of self-sufficiency as an ideal for reserve management, tight control is exerted over band funds, and entrepreneurial activities are discouraged by legislative restrictions (Gibbins and Ponting 1986:29).

Today, signs of social malaise are clear. Accidents, poisonings and violence constitute a very significant proportion of reported causes of death in Native communities; in recent studies of Native groups in Canada, between 38% and 50% of deaths were of this nature (Young 1988a:54; Mao et al 1986: 265). Many of these incidents of violence and accidental injury are alcohol related (Jarvis and Boldt 1982:1345). Suicide is significantly more frequent in the Native population than among Canadians in general. For example, Young (1988a:57) notes that the risk of suicide is twice as great among Natives in northwestern Ontario as in the

general Canadian population, and that suicide "epidemics" occur at times in Native communities, especially among young people.

Although specific information on physical, sexual or emotional abuse within Native families is lacking, family violence is well-recognized in many Native communities (Warry 1991:213-214). Some Native health professionals describe the psychological problems manifested in such behaviours as instances of "internalized oppression". This refers to a process in which individuals internalize the collective experience of colonization, leading to feelings of powerlessness, low cultural esteem and poor self-image (ibid 215).

Contemporary Native people are also at a disadvantage where physical health is concerned. Although the incidence of tuberculosis and other infective diseases has declined significantly with the help of modern medicine, the prevalence of these diseases remains higher in the Native population than among the general population of Canada (Young 1988b:664; Mao et al 1986:265). Infant mortality has dropped sharply, but remains higher in the Native population. The most significant differences are in postneonatal mortality (i.e. deaths between 28 days and one year of age), where social, economic and environmental factors are relatively important (Morrison et al 1986:270).

The incidence of infectious and parasitic diseases has declined in recent decades, but remains a more prevalent cause of death in the Native population than among the general population. Respiratory problems also represent an elevated risk (Mao et al

1986). With the decrease in infectious disease, the occurrence of chronic diseases such as diabetes, cancer and hypertension has increased in Native populations in North America. Diabetes has become a serious concern in recent years; for example, in southwestern Ontario it was found to be seven times more prevalent in Natives (Evers et al 1987). The causes of diabetes may include both genetic and environmental factors, and the stresses imposed by acculturation (Hagey 1984; Szathmary and Ferrell 1990).

Coronary heart disease is the leading cause of death among Native people, as it is with the general population in Canada. The incidence of cancer is significantly lower in Native populations than in the general population of Canada, although there is increased risk of specific types of cancer, such as gallbladder and kidney. Young (1988b:665-666) cites environmental and genetic causal factors, and notes that the gap between Natives and non-Natives may narrow in the future, as the process of acculturation continues.

There is an increasing recognition today that while Western medicine has mitigated the effects of infectious disease and increased life expectancy, it has not succeeded in reaching many Native patients in a way that is culturally appropriate. Treatment for tuberculosis is readily available and potentially effective, and incidence has decreased significantly in the past several decades. Yet the rates of infection and re-activation in the Native population are several times that of the general population (Young 1988c:305). Some Native people remain mistrustful of the expertise

available in the dominant society, seeing medical intervention and potential institutionalization as coercive and undesirable (Jenkins 1977: 545; Atcheson 1987:93). Also, orthodox biomedical recommendations for the control and management of diseases such as diabetes do not conform well with Native lifestyles, and contacts with health professionals engender intimidation and frustration for Native patients (Hagey 1984:266).

#### THE MOVE TO URBAN CENTRES

As mentioned previously, a significant and increasing proportion of Native people in Canada live in large urban centres. Most Native people cite employment opportunities as their reason for moving to the city. The next most frequent reason (especially among younger respondents) is education (McCaskill 1981:82; Maidman 1981:30). However, the rate of unemployment is relatively high, and average income is low compared to the general population (Maidman 1981: 18-20). Reasons cited for this high rate of unemployment include lack of training, the need to attend to family responsibilities, and discrimination (Frideres 1988a:211).

In a recent Hamilton-based study of Native employment and training needs (Ball, Bonham and Sandy 1991:13-17) respondents cited discrimination as the most frequent cause of unemployment. Other factors included lack of education, substance abuse, low self esteem, insufficient transportation and child care, and inadequate awareness of job possibilities. Native people adapting to city life report stress stemming from many sources including the need to manage finances more carefully, concern about being on time,

transportation problems, non-Native understanding of Native behaviour, and diminished family closeness (Drew 1988:116).

Native people in the city tend not to integrate with the non-Native population. The typical Native person in the city turns to friends and family members or, in some cases, Native organizations for help. S/he interacts relatively infrequently with non-Native agencies and care givers. People's reluctance to use health care facilities has been attributed to socioeconomic circumstances (Waldram 1990a), lack of familiarity with health services provided in the city, communication and cultural differences (Shah and Farkas 1985). Native people may feel neglected in the clinical encounter with what they perceive as cold, uncaring and in some cases, overtly prejudiced practitioners.

An additional problem in the provision of adequate health care for urban Native people is a structural one. As already stated, the health care of Native people living on reserves is the responsibility of Indian Health Services, a branch of the federal government's Medical Services Branch, whereas health is a provincial responsibility for other Canadians. Off-reserve Native people do not fall clearly into either domain, which gives each level of government latitude to view health care for urban Natives as the responsibility of the other, in which case comprehensive health care for urban Native people suffers. Farkas and Shah (1986) note that jurisdictional confusion about responsibility for the health care of urban Natives has led to inertia on the part of different levels of government, and has prevented collaboration which could result in

better health care for both urban and reserve populations. There is a paucity of information on the health status of urban Natives. Health statistics are not kept according to ethnicity by most city health departments, and few studies have been done specifically involving Native people (ibid:276). However, those familiar with this population note that many of the same problems appear to occur in the urban Native population as those outlined above for those living on reserves (Brody 1971; Sorkin 1978; Shah & Farkas 1985).

In a health needs assessment of Manitoba Indians done in 1985 (Barnes 1985:58), respondents living in Winnipeg judged their health problems to be more serious than did those living in less acculturated communities. One possible reason put forward by researchers was that Natives moving to the city may assimilate the dominant society's health risks (such as increased use of fast foods and alcohol), before adopting the health beliefs and behaviours that are adaptive for non-Natives (for example, aerobics and jogging).

There have been some advances in recent years in providing culturally-appropriate health services to urban Natives. Anishnawbe Health Toronto, a community health clinic in the urban core of Toronto, is run by Native people. This centre and its satellite clinics provide culturally appropriate health care for urban Native people. Programs and services developed on the basis of traditional concepts and values. Biomedical treatment and traditional healing exist together, in a friendly, open environment.

Some health facilities in cities such as Winnipeg and Regina use cultural interpreters as liaison between Native patients and

health care personnel. This complex role may involve language translation, educating medical personnel about the linguistic or cultural perspective of Native patients, or explaining the biomedical perspective to Native patients. In some cases, an advocacy role for the patient within the hospital system is also included. (Kaufert & Koolage 1984; Baker et al 1987; O'Neil 1988).

Generalizations about "Native people" or "urban Native people" can be misleading as conditions vary significantly across this country. The health statistics for Native people cited in the foregoing sections of this chapter include populations living on isolated northern reserves which do not have ready access to medical services. Respondents in this study (many of whom are from the nearby Six Nations Reserve) have access to relatively comprehensive health services, on the reserve and in the city. Nonetheless, the above-mentioned problems recur, and were cited by many respondents in this study.

### CHAPTER 3: DESCRIPTION OF THE STUDY

#### GENESIS

The study grew from my interest in the link between culture and health, and a convergence of several factors involving Native people. My previous employment in a city hospital had brought me into contact with patients with varied cultural backgrounds, people with deeply-ingrained ideas about health events. It was clear that the ideas and priorities of the average patient and those of the average care giver differed in many ways. This often stemmed from dissimilar life experiences, including unequal socioeconomic and educational advantages. However, when care giver and patient were from different ethnic groups the gulf widened, causing misunderstandings which decreased the potential for optimal health care.

This was true of patients from the many cultures that comprise present-day Canadian society. However, Native people presented a special and particularly complex case. They had not chosen to emigrate to Canada in order to benefit from the advantages offered by the Canadian way of life. Rather, their way of life had been irretrievably altered due to the on-going influence of the dominant society. Despite the profound cultural disruption caused by the experience of colonization, the residential school era and the 1876 Indian Act, the Native value system and many traditional

practices had been maintained, and survive into the present on many reserves as well as in the urban setting.

According to Royce (1982:5) the presence of "others", who are in some way different, stimulates and moulds the perceptions of people in any mixed society, leading to the construction of symbols and stereotypes. These may be fixed or fluctuating, and operate on the "seductive middle ground between myth and reality". Working in the health care system, I was aware of the stereotype that Native people were uncommunicative, were not reliable in attending appointments, and often did not follow through on treatment recommendations (Halfe 1989:39; Hagey 1984:226). When (in my work as vocational counsellor for people with medical disabilities) I dealt with Native people, I sensed a barrier that existed between the client and me. The potential for open communication seemed hampered by differing expectations and communication styles. I wanted to understand more about the Native perspective, but the desire alone was not enough. My questions were relatively direct and specific, and brought only brief, guarded responses. I sensed that these clients had much to tell, but the setting did not lend itself to the telling. In the assessment situation, there was not the time or the opportunity to establish trust and understanding, so the encounters remained of minimal satisfaction to me and, presumably, to the client.

During this period, my part-time studies in anthropology had led to a greater appreciation of the importance of ethnocentricity in generating misunderstandings between people in multicultural

settings. Qualitative research offered a means of gaining a more comprehensive and grounded understanding of the way people in different groups think, attribute meaning, act and react in the complex social environments of daily life. Although anthropology is not an established discipline in the conventional health care setting, medical anthropology is a rapidly growing field, which offers a powerful means of expanding the knowledge (and, ideally, the sensitivity) of care givers, and thus enhancing the potential for effective care.

It was with this in mind that, during my subsequent enrolment in graduate studies in anthropology, I decided to undertake a study of the health perceptions of Native people. Having worked in the mainstream health care system, and now having the opportunity to spend time in ethnographic inquiry among city-dwelling Native people, I felt that I could help to "bridge the gap" between the two groups, by passing on to interested and concerned care givers insights that I gained.

My initial expectation was that the study would involve "health" in the conventional, Western sense of physical well-being. I soon learned that this narrow definition does not fit with my informants' ideas of what health means. The final product of the research, this thesis, speaks of health in its broadest sense: the health of people's psyche, their self-image, their relationship to the world and the creative force that is integral to their understanding of their lives.

There is growing recognition of the legitimacy of Native peoples' demands for a higher degree of self-determination, and more appropriate services. Healing is needed, and is beginning to occur. Constructive health initiatives generated from within as well as from outside of the Native community, make this a time at which there is the potential to eliminate (or at least lessen) the continued health disadvantage which Native people experience at present.

#### METHODOLOGY

The study began, not with a specific focused research question, but with a broad base of open-ended questions about health in the Native community. At the start, I spoke to various individuals (most frequently, but not necessarily, Native) with interest and/or experience in Native health. Beginning with one non-Native nurse and a Native employment researcher, I expanded my pool of informants by asking each for the names of other potential contacts. This process led to informal interviews with a wide range of individuals, including health care professionals in the mainstream system, traditional healers, employees in Native organizations, and lay people. Some were seen only once, and others became key informants who offered on-going insights. A total of 23 people were involved in this initial phase, which continued through the period of collection and analysis of questionnaire data.

Data gathering spanned the period between June 1990 and the summer of 1991, with the major portion being done during the first summer. Due to the early availability of a research assistant, a

Native summer student, Mr. Patrick Orgar, a questionnaire (see Appendix B) was constructed, pre-tested and finalized at the start of the summer of 1990. It includes open-ended questions about a wide range of health issues: respondents' ideas about the nature of "health", memories of significant health and illness events, experiences with or ideas about the mainstream health care system and traditional medicine, ideas about prevalent health problems in their communities and how they might be alleviated.

I was given permission to use several city organizations as research settings. The first was the Hamilton Regional Indian Centre, a Friendship Centre which offers a program of cultural, recreational, educational and social activities, and provides a base for urban and migrating Native people. Patrick or I would sit in the Drop-In Room of that facility, with a sign that briefly explained the research and requested volunteers to complete the questionnaire. I had been cautioned by two Native informants, one of whom had himself been involved in data collection, that Native people do not come readily to be "researched", and that this indirect approach is advisable, and most culturally-appropriate. The process of finding volunteers was a slow one. Patrick and I initiated conversations with individuals (both staff and visitors), and gradually introduced the subject of the research. If people agreed to participate, we would read each question, and record the responses verbatim in a response booklet. For the most part, people did not appear uncomfortable with this procedure. Ample time was allowed, and elaboration was requested in some cases. Several

respondents preferred to fill in the questionnaire independently. After they had completed it, the researcher read through the responses, and as necessary requested additional clarification.

Our experience soliciting respondents for the questionnaire fell somewhere between the negative extreme described by Dosman (1972: 10-11) and the ready acceptance of such methodology described by Waldram (1989:104-105; 1990:581).<sup>1</sup> Some days brought little or no success, due in part to the lack of potential respondents during the summer period, but also to some individuals' reluctance to participate. Often, it was older people who declined the request to participate, and it was suggested by some informants that the older generation is less accustomed to talking to non-Natives, and less trustful of them. A few people who had themselves completed the questionnaire acted as intermediaries, sending others to me, or contacting family members to arrange an appointment.

On one occasion, an informant arranged for me to interview her elderly relatives, and when calling to set this up, told them with a smile "Don't shoot her - she's white!" I was to learn, during the course of the research, that humour is an important part of Native communication. Sometimes laughter gave relief after a particularly difficult or serious communication; other times it

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<sup>1</sup> Dosman, after work which involved Native people in Saskatoon, reported that "Indians are unanimous in their rejection of surveys, whether conducted by whites or Indians". On the other hand, Waldram's non-Native interviewers, using the questionnaire format in a walk-in clinic and a Friendship Inn in the same city, encountered few refusals, and met with generally positive reactions. In the latter study, clinical staff, who had previously established rapport with patients, approached potential respondents, to ask whether they would participate.

served as a bridge, a bond between people. Aitken (1990:29-32) notes that in Native culture humour is used unselfconsciously, in a gentle, often self-deprecatory way, and in many instances serves a healing function.

Over the course of the summer, I began to make contacts in two additional research locations. The Native Women's Centre, a temporary shelter for women, which is staffed by Native women, houses women in distress, regardless of their origin. The Wesley Centre is an inner-city facility operated by Wesley Urban Ministries. The centre offers free lunch and snacks during the day, along with other "survival-level" services. It is visited regularly by a variety of indigent people, both Native and non-Native.

When the administration of the questionnaire yielded particularly productive results, I asked respondents for further meetings. These people, most of whom became key informants, showed a thoughtful approach, had a keen interest in health matters, or had particularly informative or representative personal histories.

In succeeding months, my on-going presence at social events led to the opportunity to talk to people informally, away from the "research" situation. In some cases, this established a link which would have been unlikely otherwise. It helped me gain a greater understanding of Native ways, and perhaps a greater measure of acceptance in the eyes of some who had been uncomfortable with me.

During this period, I became involved in other activities within the Native community. The Hamilton Regional Indian Centre holds monthly Traditional Teachings evenings, which were the source

of much valuable information on traditional ideas about health, as well as other areas of Native culture. My involvement in the Canadian Alliance in Solidarity with Native People led to a different set of contacts and discussions. I was also invited to attend an in-service meeting of a clinical team at a local hospital, where non-Native care givers were trying to gain a fuller understanding of cultural issues in the case of a Native patient. At this meeting I met two Native health care professionals, both of whom agreed to share their perspectives with me.

One additional experience, which has increased my familiarity with and comprehension of the Native community, has been my involvement with the Native Women's Circle at the Hamilton Regional Indian Centre. I became acquainted with several members of this group during the initial stages of my research, and began attending meetings several months later. Group activities include crafts, guest speakers, discussion/problem-solving groups, and field trips. I include no information stemming from the actual discussion groups, due to the confidentiality required as a feature of attendance; however, my friendship with the women who regularly attended these meetings helped me formulate and clarify the themes of the study. At one meeting, where I was the "guest speaker", I presented preliminary findings from the study. This generated discussion, which supplemented and expanded the emerging themes.

To date, I have given some preliminary feedback in two health care settings, and to one group of Native women. It is my hope that the study will prove of use to both the Native and the

non-Native community. In the former case, it will provide some reflections and insights from an "outsider" to those who contributed their ideas and their wisdom, and aided in the development and implementation of the study. I hope, also, that it may help at some point in the formulation of new health initiatives. For the non-Native community, the study will provide mainstream health care providers and planners with a relatively "close-up view" of Native people who are their patients, who speak so honestly of their lives and their perception of the world.

#### THE STUDY POPULATION

The data which is the basis for this study includes both informal conversations with key informants and questionnaire data gathered from 45 respondents in the various Hamilton organizations mentioned previously.

The 45 questionnaire respondents included both staff members and people who dropped in to the research settings. They all identified themselves as Native, with the exception of one young white man who had been raised in a Native foster home. Age range of respondents was from 17 to 94, with the majority being between 30 and 49 (for demographic information see Appendix A.) Sixty percent of the respondents were men. Men outnumbered women in the various settings. Sometimes the women who were there were accompanied by small children, and thus less available for the concentrated period of time necessary to do the questionnaire (approximately one hour). Many of the women who did respond were staff or volunteers in the organizations in which the research was carried out.

Almost a third of respondents had lived in Hamilton for more than 10 years. The remainder varied in time spent in the urban setting, with some being new arrivals. The majority were from the various nations of the Iroquois Confederacy; the next most frequent group were Ojibwa.

Forty percent of respondents were single, 20% were married, 20% divorced, 9% separated and 13% widowed. Native people have frequently lived in extended family groups in the past, but this was not the case with the study population. Female respondents were more likely than males to be married or divorced. Most lived in houses with one or two other people (including children). The majority of male respondents were single, and living alone in an apartment in the central core of Hamilton. One informant, commenting on people's living patterns, felt that extended family groups are not the norm today, possibly due to financial considerations and the fact that during their school years young people come to expect that they will support themselves and be independent.

Slightly over half the respondents reported having grade 9-11 education, with 15% having grade 8 or less. Approximately 7% had completed high school, 15% had some community college or university, and 11% had completed a college or university program. The proportion of respondents at the lowest education level was approximately the same as that of the general Canadian population, and smaller than that for the Native population as reported in the Canadian census. Study respondents were more likely to have incomplete high school education than were either of the other two

population groups, and were less likely to have graduated from a college or university program. (See Appendix A, Table 2 for specific data on education.)

Only thirty-eight percent of respondents were employed (24% full-time; 9% part-time; 7% on a temporary basis), 7% were retired, and 58% were unemployed. The proportion of employed people in the study population was smaller than in the larger Native population of Canada (46.7%). To some extent, this may be related to the nature of the organizations in which the questionnaires were administered, which provided help to new residents of the city, and social support to a range of other individuals.

Income level of informants was generally low (Appendix A), with the largest group (29%) reporting annual household income in the \$10-\$19,000 range. One third of respondents did not report income range. Further information on employment and income status of the study population, as compared with other Native people and other Canadians, is contained in Figures 2 and 3 of Appendix A.

The largest group (42%) described their spiritual orientation as Christian, while 24% followed the Longhouse tradition.<sup>2</sup> Seven percent of respondents reported following both Christian and traditional spiritual practices. Two individuals reported other non-traditional forms of belief. Twenty percent of respondents

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<sup>2</sup> The Longhouse religion combines moral and ethical precepts, healing ritual, calendrical rites (Speck 1982:87; Parker 1913:5-13). Based on the teachings of Seneca prophet Handsome Lake (1735-1815), it has been credited as a strong anti-acculturative force in the lives of its Iroquois followers on the Six Nations Reserve (Shimony 1961:12-14).

reported having no religious affiliation or spiritual beliefs.

The respondents who completed the questionnaire do not comprise a random sample of Hamilton's Native people. The method of data collection in this study, was based on availability, and provided two main groups of respondents. Approximately 1/4 were persons working in or associated with Native organizations in the city, that is, a relatively "elite" group (Dosman, 1972). Most of the remainder were persons seeking service from these organizations, and included, for example, unemployed people who were in need of assistance, and street people. Native people in Canada, when compared to the total population, are less likely to be employed, less likely to have graduated from high school or to have post-secondary education. The average person who participated in this study is less likely than either group to have a job, or to have completed secondary or post-secondary education.

Efforts to reach other Native people in the community, i.e. those who were living self-sufficiently or with their major contact being extended family groups, were only marginally successful. Notices requesting participation, posted at the Hamilton Regional Indian Centre and in the Centre's newsletter, brought no response from more "mainstream" groups. Nor did an interview on a local Native radio program. Some questionnaire respondents referred me to other potential candidates, but most, while willing to answer for themselves, did not wish to make referrals to other people. The population is therefore not fully representative of Native people in the city. This problem is, however, mitigated by the wide range of

individuals spoken to in an unstructured way, and key informants who are familiar with the larger population of native people in the area.

As well as providing consultations during the research process, several Native people were among those who agreed to review the written text of this study, in whole or in part, when it was approaching conclusion. Their valued comments on the content of the study and its presentation were used in revisions for the final draft.

#### THE NON-NATIVE RESEARCHER IN THE NATIVE COMMUNITY

One of the realities for a non-Native person contemplating research in a Native community is that, in light of the history and the current climate of Native-white relations, their presence will not always be appreciated. At the start of the research process, I was aware of the opinion (of some Natives) that the typical white researcher is self-serving in his/her research projects, and is not sensitive to Native needs and sensibilities. Another factor was the number of people wanting to work in the Native community. Twice I had been asked a riddle about the number of people in the average Native family (the answer always includes "the anthropologist".) Five times during the research there were other non-Native researchers working on student or community projects in the settings I was frequenting.

When deciding to proceed with the research plan I had laid out, I consulted one trusted Native informant, to determine her judgment of the appropriateness of a non-Native doing research in

the Native community. She considered the question, then answered that if there was any hesitation on her part it was because she could not protect me from the difficulties I would encounter with some people in the Native community who did not like anthropologists. However, she felt that "if you know inside that you want to do something, you should take the risk and do it".

Another of my initial contacts had counselled me to "just be honest" about what I was doing, and why I was doing it. I had learned that the negative stereotype of whites held by some Native people was that they were materialistic, overbearing and not to be trusted, and throughout the research undertook to earn the trust of informants. Given my student lifestyle, materialism was not a major issue. I did however have a car, so when possible offered my driving services in an attempt to balance, to some extent, my debt to friends and informants for their information and counsel.

The process of finding key informants was occasionally difficult. Several times, potential key informants refused to be interviewed or avoided the interview by indirect means, such as repeatedly deferring appointments or simply not showing up. The latter may have been the result of the individual's not wanting to be part of the research. However, it is also a manner of behaviour which is not inappropriate in Native culture. Missing an appointment is not, in itself, rude, and if one later remembers and calls to reschedule, this is a sign of recognition of the importance of the event. One informant noted, as well, that procrastination can be viewed as a form of "time management", in that those tasks that

are unimportant (or do not require immediate attention) will be eliminated. These rules of behaviour, being different from those in the dominant culture, may lead to misunderstandings in the clinical (or in other inter-cultural) situations.

Some of what I have described, such as the need to adopt a position of cultural relativism and avoid culturally-inappropriate behaviour, is the case in any anthropological endeavour. The anthropologist in a contemporary Native community must, at least at the outset, deal as well with the complexities inherent in Native-white relations, the result of our respective histories and the interaction of dominant and dominated societies. One woman voiced the thought, rather ruefully, that "the only way I can deal with what had happened to Native people in the past was to think that they (the white people) must have thought they were doing what was for the best". Although it was clear that a few informants had a great deal of antagonism for "white people", the greater number were kind and open, and spoke of "good white people" they knew.

Although the research was done at a time of great debate and unrest in Native-white relations, my conversations with informants did not, for the most part, involve current events. People at meetings or workshops I attended sometimes spoke of their anger and sadness at the abuses experienced by Native people, but expression of these things was not something which occurred frequently in one-to-one situations.

This study is the result of a decision to do research among a group that is not always easily accessible to the research

process. Although there were some difficulties during its implementation, they were not frequent, nor were they insurmountable. Many people quickly agreed to participate, others after some initial hesitancy. The process of becoming acquainted with a wide range of Native people was an interesting and satisfying one.

CHAPTER 4: THE MEANING OF "HEALTH"

Chapter 2 reviewed data on the state of relative disadvantage of the average Native person in Canada, and the serious health problems which lead to a shortened life expectancy and decreased functional capacity. One cannot fully appreciate people's view of the health problems they experience without an understanding of how they conceptualize "health", or what well-being entails.

"Health", on the one hand, and "health problems" or "sickness", on the other, are opposite ends of a continuum which Antonovsky (1987:3) suggests as an effective way to conceptualize the subtle and multiple degrees of health.

Premature Death		Complete Well-being
<--Disease or--> Illness	Doubtful Middle Ground	<--No Disease or--> Illness <sup>1</sup>
----- Disability/Symptoms/Signs (Treatment model)	----- Awareness/Education/Growth (Wellness model)	

The treatment model, the focus of biomedical practice, deals with only half of the continuum. The wellness model expands the scope of health concerns to promote a more generalized well-being of

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<sup>1</sup> Following Kleinman (1980), "disease" is considered a pathological state or abnormality in the structure and/or function of physical body, as recognized by the biomedical model. "Illness" refers to people's perception and experience of certain socially disvalued states, including (but not limited to) disease. "Sickness" is an inclusive term which includes disease and/or illness.

the individual (Sarafino 1990:5). Based on systems theory<sup>2</sup>, the model de-emphasizes the strictly "medical" role in health promotion, and moves toward a broader definition. This is consistent with the World Health Organization's definition of health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (WHO 1958).

"Health" is an abstract concept. As such, there is the danger that it will become reified, that is, that people (including health care providers) will hold a fixed and immutable idea of what health "is", and be unable to match their interpretations of its reality to those of their patients. When this occurs, meaningful communication about how to optimize health is unlikely. The primary aim of the present chapter is to seek an understanding of health, as it is conceptualized by contemporary urban Native people. The chapter begins with consideration of the word "health", that is, the roots of the English word, as well as the meaning in ancient Greek, and in the Cayuga language. I then describe respondents' ideas about what health is, and their accounts of the time in their lives when they felt most healthy. The traditional Native view of health, as recounted by elders today, follows. Some models derived in studies in other Western countries will also be used for purposes of analysis and comparison.

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<sup>2</sup> In which the individual person is considered one element in a network of inter-related systems of successively greater complexity, including, for example, cells, various organs in the individual's body, the family, the community in which one lives, society (von Bertalanffy 1968; Engel 1977).

In Ancient Greek, there are two distinct words for health, (hygeia and euexia), which suggest "living well", and "good habit of body" respectively. The English word "health" literally means "wholeness", and comes from "hal" in Old English, and "heil" in Old High German (Kass 1981:15). These words, which connote self-sufficiency, independence and the function and activity of the whole, are more similar to the forms of health described by Native people than are standard biomedical definitions. Modern medicine, while generating significant advances in health care, has narrowed the understanding of "health", and de-emphasized the broader well-being of the people<sup>3</sup>.

The word for health in the Cayuga language is ada<sup>?</sup>gai<sup>?</sup>:deh<sup>?</sup>fra<sup>?</sup>. It conveys the idea of not being sick, and of well-being in the broadest sense. This includes the person's mental and spiritual state, and the sense of being at peace with yourself. The greeting "sgę:ng" means "you're well", and depending on the intonation given, conveys the message as a question, or a statement such as "I'm glad you're well". Again, the idea of "peace" is evident - in the Great

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<sup>3</sup> In contrast to the ancient idea of holistic health, and the work of a small but growing number of researchers utilizing the biopsychosocial model (e.g. Engel 1977; Antonovsky 1988), standard biomedical practice today separates mind and body, and categorizes health problems as "physical" or "mental". This Cartesian dualism is the legacy of the sixteenth century thinker, Rene Descartes, whose ideas were influential during the rise of scientific thinking in Europe. Descartes regarded the body as an automatically operating machine, which was created by God, and in which dwelt the soul. It was the soul which synthesized the thinking substance (Castiglione 1941: 503-506).

Law of the Iroquois Confederacy, "sge:nq̄" means "peace" (Henry 1991).

Today, relatively few Native people in this area speak their ancestral languages<sup>4</sup>, but the ideas which are part of their cultural heritage have not been eradicated. The following section involves the ideas of respondents, that is, contemporary urban Native people in Hamilton.

#### URBAN NATIVE PEOPLE'S IDEAS ABOUT HEALTH: VIEWS OF THE RESPONDENTS

Respondents who completed the questionnaire vary widely in background and traditional focus. Some were born and raised in the city by Native parents, some were raised in non-Native foster or adoptive homes, some lived at various times on reserve and in cities, some live at Six Nations, and commute to the city for work or other activities. Varying degrees of interest in Native tradition is expressed by different respondents.

#### Health and Freedom

I asked respondents to describe the time in their lives when they felt most healthy, and what "health" meant to them.<sup>5</sup> For many, an important part of health was a feeling of freedom from restraints, and the ability to do as they pleased. Their responses suggested that they valued the sense of psychological well-being which freedom brought.

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<sup>4</sup> To counter the decline in Native language knowledge and usage, Native language classes are now being established in reserve settings and in some urban Native organizations.

<sup>5</sup> Data in this and the following chapters comes from both questionnaires and interviews. Quantitative information from the former source is given in Appendix B.

"I felt healthiest in my early 20's. Feeling able to do anything I wanted to do without having anything (pause)... with things coming out exactly the way I wanted it. With that, I'd be satisfied."  
(Cree male, age 40)

"When I was 15 I felt good. Could do anything I wanted. Anything -social-wise, mentally, emotionally - I was able - where people should be!"  
(Ojibwa male age 21).

"Being able to get up in the morning, and do what you want to do. Taking a long walk if you want to. Being happy with yourself." (Oneida male, 30's)

For some, this appeared to mean freedom from any constraints; for others it took on a more functional sense, involving the freedom to pursue a chosen lifestyle, such as raising a family, or working.

"Being able to be active and do what you like. To take care of my daily needs and family." (Cayuga female, 20's)

"Being able to get up every morning, and being able to live your own life. Not to feel sickness. Being able to work, play, and enjoy the activities that life has to offer." (Cree male, age 40's)

The theme of freedom and self-determination, an important one in Native people's discussions of health, is the major focus of chapter 7.

### Harmony and Balance

Several respondents spoke of health as involving a combination of physical, mental and spiritual well-being.

Health means "a good state of mind. Physical, mental and spiritual in tune, together. If one is missing, you're not up to par." (Ojibwa female, age 31).

"It's kind of a broad question - do you mean mental health, spiritual health or physical health? Health means to me when you can connect all those

three areas and put them into harmony with one another - that's health!" (Chippewa male, age 38)

"Looking after yourself. Looking after yourself emotionally, mentally, physically, Keeping them in balance - balance with your lifestyle. That's about it." (Ojibwa male, age 21)

Because this idea of balancing these various elements was so prevalent, I asked a group of informants how they had achieved this understanding. Responses differed, depending on the individual's history. One woman spoke of her early life, when care givers such as her grandmother would ask questions about the broader picture when physical ailments were noted.

"I remember when I had a physical ailment, my grandparents would ask me if there was something bothering me. If it was something that I was worried about. So I think that was where it started. Because it wasn't just focused on the physical part of it - you know, like the symptoms...they were asking me if there was something I was worried about. The emotional part of it, and the physical part." (Cayuga female, 30's)

Another respondent, who spent most of her early years in a non-Native foster home, arrived at her current understanding more recently.

"Well, I was never brought up spiritually...at all. But when I quit drinking and went into the program, and ended up learning about spirituality, and trying to follow - just trying to follow the way other people were teaching me...and it seems to be working out ok. When I'm right spiritually, I'm right physically, and I'm right mentally. When I'm not right spiritually, forget it!" (Tuscarora female, 40's)

The program that she speaks of is Alcoholics Anonymous. It was through her involvement with this organization that she first became conscious of her spirituality, and

"when I started learning about Native culture, I realized that that was how Native people had been living all along - it was great! When I became more involved with my culture, I just kept following it. This is the biggest part of my life today."

A young man gave an example of how he was able to achieve the necessary balance in one difficult life situation, stressing the importance of stepping back to gain perspective on one's situation.

"I lost...got out of touch with myself. I had headaches for two weeks, and finally realized what was what. I was stressed right out. I went to the manager and explained the problem, and ended up taking a couple of days off... sitting back, stepping out of the situation for a few days. And I realized its not such a big problem. It's a stress management kind of thing that might throw me out of balance - my spirituality out of balance. A lot of the balance stems from spirituality - that seems to be the dominant factor." (Seneca male, 20's)

When respondents spoke of balance and harmony, it was the larger context of their lives to which they referred. Health is a part of this frame of reference. Physical symptomatology may or may not be a part of this; spirituality frequently is an integral part.

#### Health and Alcohol Use

Problems related to alcohol and drug usage are frequently a factor in hospital admissions due to disease, accidents or incidents of violence, as well as death of individuals at an early age (Jarvis and Boldt 1982:1345-52; Young 1988a:57; Mao et al 1986:265).<sup>6</sup> My respondents were very cognizant of the adverse effects of alcohol in the Native community, and often in their own lives. Some had

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<sup>6</sup> For discussion of alcohol use in the Native population, see also Lurie (1979); Westermeyer (1979b).

experienced such problems in the past and had overcome them; others had on-going health problems relating to alcohol. The following are descriptions of "what health means" given by two individuals who were clearly on the lower portion of the wellness continuum.

"I got no feeling...for health. If I should die right now, I don't care. I mean it. I don't care if God takes me. I go home, I pay for that apartment (and it's \$375), and I never stay there for four days. I don't like staying by myself. I stay for one night by myself, and then I phone my friend up - my boyfriend. I don't like to stay alone."  
(Oneida female, age 42)

Health means "not to be sick in the morning. Getting up an alcoholic. There's a bottle of wine that picks you up - but you're shaking. Get a bottle of wine, drink it - feel all yourself together again. Does you til the next night."  
(Oneida male, 40's)

The lack of health, balance and robustness is starkly evident in these people's descriptions of their lives. In contrast, one young man describes in enthusiastic terms his newfound sense of well-being, which came with sobriety.

"[My most healthy time is] recently - the present day. Because I quit alcohol. I quit drinking. I'll be six months sober on February 10. "Health" means feeling good about yourself. Appearance looks good, you have a feeling of control. It's more your mind than anything else. You just look at things differently, have a greater understanding of yourself. Being content, and at peace with yourself - that's what I've got." (Ojibway male, age 29).

#### Optimal Health Experience

When people were asked to describe "the time in their life when they felt most healthy", the most frequent theme (especially

for male respondents) was that their feeling of optimal health was at a time when they were very active physically.

"[I felt most healthy] at age 27. I pitched ball for 25 years. I even pitched against my own father. I used to run to work every day - 5 miles! But I didn't run home, I went to the hotel instead. Took a taxi home. I worked in a foundry in general maintenance - there you do everything, got to fix things really fast." (Mohawk male, age 40's).

The experience of robust health can include periods in their lives when people work hard at physical labour, or when they are involved in organized sports or fitness activities.

"That would have to be when I was in a Group Home. Because I did a lot of exercise, sports. Hockey, football, and a lot of outings - [We got] a lot of counselling." (Ojibwa male, age 20's)

"That would have to be in '75 when I was doing a jump course. To be a paratrooper. Because we had to go through three weeks of hard physical training, and I just felt good." (Chippewa male, age 38)

For most people, this level of activity stems from life situations, and not from personally-planned "fitness programs". In several cases, however, a conscious decision to adopt a healthy lifestyle led to behavior change.

"When I was 19 I worked out and ate well (including roughage). I was on a health kick, not eating starchy foods -conscious of my self and my body. Unfortunately, it wore off. I read "Fit For Life" and that brought my awareness up. I had a lot of energy, and I carried through some. Now I work out, but not with weights." (Ojibwa Female, age 31)

Many people describe themselves as "healthy", although in some cases they go on to describe quite significant health problems. As in T.K. Young's (1982) study in Northern Ontario, a functional view of health is evident; if they are able to carry on their normal

lives despite physical abnormalities, health is not defined as a problem. This is also consistent with findings in two studies (Cornwell 1984:124; Eyles and Donovan 1990:36) involving British working class informants, who de-emphasized health problems, and did not want to be seen as "moaners". The theme of "not liking to complain" recurred among Native informants when they were later asked to describe themselves as patients.

A significant number of respondents report that the present is their "most healthy time", this being for various reasons, including cessation of substance abuse, newfound religious faith, involvement in social programs:

"Now. I've been in custody for five months. I don't smoke drugs or drink for the time being. I used to do a little". (Ojibwa male, age 17, involved in community service program).

"Presently - I feel fine. I was smoking a lot in my younger days; more than tobacco! Because I quit "substance". I'm more active these days. (Seneca male, age 21)

"Right now. For the last 3-1/2 years, since I've become a born-again Christian. I have more purpose to live." (Ojibwa female, age 30's).

#### Health and the Maternal Role

A common theme in female respondents' reports is that their maternal role is related to perceptions of good health. In Native tradition, the bearing, nurturing and teaching of children is a highly valued role for women, one which is expected as part of each woman's life (Aitken 1990:18-19). The majority of female respondents have children, and several cite pregnancy and their children's early years as their most healthy time.

Being pregnant was a healthy time - eating right, proper sleep and plenty of exercise." (Cayuga female, 20's)

"After I had my children. I had two boys and two girls, all eighteen months apart. I think back now - I had to be on my toes to keep up with them, and enjoyed every minute of it. Now my oldest is 33 years old." (Cree female, 50's).

In some cases, it was the very fact of pregnancy which engendered a sense of purpose, contentment and fulfillment.

When I was pregnant - both times. I had a few problems, like varicose veins, but for the most part I felt fantastic. I really liked it. My skin texture was different, and I felt really really good - emotionally and spiritually. I felt more aware of my purpose - aware of nature - it was like a euphoria and fantasy. To me it was great. It's such a wonder - that that should happen to me!" (Cayuga female, age 30's).

Women are seen as having been given the "gift of creation", and the role of first teacher for children (Aitken 1990:18). Being pregnant is considered natural (Farkas et al 1989:79), and not as the "medical event", that it is sometimes interpreted to be in biomedical education and practice (as described, for instance in Klass 1987:323; Reissman 1989:195).

#### TRADITIONAL NATIVE HEALTH PERSPECTIVES

Native culture has, until recent times, been transmitted by oral tradition. Beliefs were passed down from generation to generation, in the form of legends, ceremonies, dances, stories, and thus, the written record is incomplete. Existing written records from historical times are the product of missionaries, settlers and traders, and their veracity and accuracy must be judged accordingly. Although much has been lost in the past century, due to government

efforts at assimilation, popular knowledge has not been eradicated. Many of the old ideas have survived, and have been gaining increased acceptance and prominence during the past two decades. Elders from many parts of North America are sharing the knowledge they have been given.

Lee Brown, a Native teacher living in Western Canada, travels widely and works toward maintaining and further developing Native traditional approaches to healing and other areas of life for contemporary Native people. He describes health as follows:

"Health is being balanced in the physical, mental, emotional and spiritual areas of life. Freedom from disease is not health. A person who has a major illness, but who is working with that illness to learn its lessons is more healthy than the person who now has no illness, but is not learning and moving towards greater purpose in life.

Moving toward the unique gift the Creator has hidden within each one of us is health. It is process and journey, not an event or a stop along the way. Movement toward one's gift produces four inter-related conditions: a sense of purpose, a sense of the meaning of life, a sense of direction, and a sense of connectedness with all things (Brown 1990).

Janice Longboat, is a Native herbologist from the Cayuga tribe. She is respected in the community for her knowledge of traditional health, and is called upon frequently to speak to groups seeking such knowledge. The following description is based on a presentation on traditional Native ideas on health which she gave at the Hamilton Regional Indian Centre.

Spirituality is the key to healing, as it is understood in Indian tradition. Contrary to practice in the biomedical health care milieu, Native tradition teaches that it is very difficult to start healing the physical body without tending to the whole

person and the whole environment. Balance and harmony are integral parts of health, i.e. balance among the various parts of the whole, these being the physical body, the mind, the spirit and the emotions.

Food, rest, exercise, elimination and proper breathing may be considered "natural doctors". In the old days, elders taught that good health requires care in what you eat, with completion of a circular pattern being best - e.g. eating foods that grew high up (nuts, berries, apples) in the morning, foods that grew at ground level (squash, etc.) at noon, and those that grew below the ground (potatoes, carrots, other root vegetables) at night.

Rest was seen as important, as nighttime is the healing time. Ceremonies done at night help one to let go of the day's stress. It was seen as important to exercise every day. Walking allowed the legs (which are a form of natural pump) to get things going, and also aided in gaining mental balance, working out the day's events, and feelings.

Elimination was seen as another of the natural doctors, with cleansing and purging practices been used as preventative health measures. Proper breathing was considered important, as it is good for physical and spiritual growth.

The importance of the mind in the balance of health is in that every thought creates our future, either by conscious or sub-conscious means. When we have a clear mind, its power can be directed positively, and improved health can result.

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<sup>7</sup> Lake (1991:29) notes that dreams are integral to the traditional Native way of seeking spiritual guidance and truth. Both dreams during the night (when carefully recalled and interpreted), and visions or meditation entered into in a deliberate manner, provide a means of getting in touch with the unconscious part of the mind, which is influenced by ancient and natural symbols, creative imagination, instinct and intuition. Many study participants spoke of their interest in dreams. Discussion and analysis of dreams within the family setting is a common occurrence. For an account of dreams as a source of psychoanalytic understanding among seventeenth century Iroquois, see Wallace (1958).

Emotions are different to the mind, just as crying is different to thinking. If the two have become separated, the connection can be restored and strengthened with ceremonies, songs, humour, stories, music. Prayer can also create balance and harmony, with tobacco used as an intermediary to carry the prayer to the Great spirit.

The spirit is an inner guiding force, which when we listen, tells us what to do and when to do it. We must slow down enough to hear within. All healing begins with the spirit. The body is a vessel that holds the spirit, the mind and the emotions (Longboat 1990).

These are examples of contemporary teachings about traditional health, as explained in workshops within the Native community, and in books which have been published recently by Native teachers. Many of the old ideas, as discussed by elders and teachers today, are echoed in the responses of urban-dwelling respondents in this study. The ideas of respondents are also, of course, influenced by those encountered in the wider social context - from health practitioners, social acquaintances, the media. In the next section, we consider some ideas about which are expressed in studies involving non-Native people, and how they are reflected in the view of Native informants.

#### CROSS-CULTURAL THEMES IN HEALTH STUDIES

In a study of health perceptions among Americans (primarily middle-class women) Crawford (1984) discerns a set of themes which fall into two major categories, reflecting fundamental American cultural values. In the first, health is seen as relating to self-control, denial and will-power, and as the result of intentional action. This is exemplified by the need to diet, exercise, refrain from smoking. The "control" theme bears a strong relationship to

the dominant American value of mastery of oneself and one's environment. Crawford notes that the American ideal of independence is reflected in the individual disciplined approach to health.

The second group of Crawford's respondents regard health as a release, a form of disengagement from imposed or internalized controls. Respondents stating this view tend to feel that "you can make yourself sick by worrying too much," especially in a world already full of externally-imposed stressors. In their minds, health involves the pursuit of well-being, contentment and enjoyment. It is a form of psychological health rather than that of a strictly physiological nature. The external threats to one's physical well-being are taken as "givens"; the important thing is to remain free from worry.

In a study carried out in France in the 1960's (Herzlich 1973), people's perceptions of health cover themes which range relatively widely, and which recur in different parts of the world. The first of these was "Health in a vacuum", Herzlich's term for the absence of illness and body-awareness. This theme reflects, to some extent, an awareness of the "disability" portion of the health continuum, which is the focus of biomedical practice.

The second theme, "Reserve of Health", was characterized by constitutional robustness and strength which enabled the individual to resist attacks, fatigue and illness. "Reserve of Health" is an important part of health culture in France, where disease is typically viewed as a failure of internal defenses (Payer 1990:40).

The third and most frequent response, "Equilibrium", is illustrated by the following quote. "When I am enjoying good health, I feel well, and there's a sense of equilibrium when I feel that everything is going well, and difficulties appear quite insignificant". There is a sense of harmony here, and an ability to deal with the world in a positive manner (Herzlich 1973: 55-60).

Although there are elements of all of the above themes evident in the responses of Native people, I believe that those characterized by "Release" and "Equilibrium" are those which resonate most closely with the ideas expressed by my informants. For them, balance is an important metaphor, which facilitates the understanding of the natural world, and their own lives. Balance of mental, physical, and spiritual elements of life is required for a healthy lifestyle, and this concept is emphasized in much of the current health promotion effort coming from within the Native community.<sup>8</sup> The understanding of some Native informants reflects what they have learned within their own families, or from contemporary teachers of traditional understandings - that balance of the various aspects of life, including physical, mental, spiritual and emotional, will create equilibrium, well-being, and the capacity to live in accordance with one's inner sense of purpose.

The issues of "control" and "release" were prominent in the responses of informants. Some respondents spoke of exercise (in vocational or social programs, and sometimes in physical fitness

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<sup>8</sup> Balance is a concept which recurs in many world health traditions, including the ancient Greek (Castiglione 1941:136, 160-162) and Chinese (ibid:100-101).

activities such as jogging) as generating strength and feelings of healthiness and self-control. More frequently, however, it was a feeling of freedom, of being able to do whatever you wished with no barriers, which was associated with health.

The power of thought can be wasted on negative emotions, according to traditional teachings. Alternatively, it can be used constructively, in the quest for health, balance, and fulfillment of one's life purpose. This will not involve an absence of barriers, but rather the will to overcome difficulties, the discipline to learn from life experience. My informants' sense of power, control or discipline is not achieved in the direct way that is mandated by North American culture, but more often through a sense of spirituality or oneness with the world which is consistent with the values inherent in their culture. I believe that this represents an important difference between the understandings of the Native and mainstream communities, and is an element which should be emphasized in health promotion and health care efforts. These ideas will be dealt with more comprehensively in Chapter 7.

A sense of robust good health was suggested in the responses of those who spoke of their physically active lifestyles - the mother who was too busy and too happy to be sick while raising her four children; the elder who recalled with pride his days working in pipeline construction, where the schedule called for 10-12 hours a day, five days a week. The absence of illness or impairment which could prevent normal performance in daily life, and the fulfillment

of one's chosen goals is an element here. It is a reflection of the functional aspect of health in the minds of these people.

HEALTH: A SUBTLE MIX

Native informants' idea of health differs from the mainstream view in several significant ways. They do not see health as merely an absence of disease; nor does health involve doctors. It involves a good life, the freedom to live as you wish, the ability to get up and greet the day knowing that it is going to be a good one, to maintain a sense of balance between the various aspects of life.

Many people who work toward the ideal of health in a manner that is consistent with traditional thinking report that their identity as Native people changes, and becomes more positive. The manner in which informants speak of their Native identity is the subject of the next chapter.

## CHAPTER 5: NATIVE IDENTITY, SPIRITUALITY AND HEALTH

When respondents were asked what non-Native health care workers should know about Native people, the most frequent response cited a need for understanding their background. People spoke of oppression, grief, and dysfunctional family life. In conversations through the course of the research, informants spoke of their increasingly positive identification with Native culture. [The traditional Native understanding of health as recounted in the previous chapter - a holistic concept, a balance of spiritual, mental, physical and emotional well-being - remains central for many Native people. Consideration of this understanding, especially the emotional and spiritual aspects of health, suggests a link between identity and health. A positive self-image and valuation of Native ways is seen by some (e.g. Westermeyer 1979a) as a step toward enhanced possibilities for health.]

This chapter deals with the ideas expressed by informants about their lives and their identity as Native people. I begin on a theoretical note with the ideas of Royce, who cites "power, perception and purpose" as a framework for the analysis of ethnic identity (1982:3). I then explore the elements of Native identity which become evident through the life histories of informants. Some are stories of changing self-perceptions in this era of cultural renewal and politicization of Native needs. Others are stories of

healing - people sharing their pain and the wisdom gained by experience, and the spiritual strength gained in what one informant described as the reintegration of the spirit and the physical self.

It is the ability to deal with the problems of the past, and to fashion an identity which recognizes and utilizes the strengths inherent in Native ways, which is the healing force that has changed many informants' lives.

#### POWER, PERCEPTION AND PURPOSE

Royce (1982:3) cites power, perception and purpose, as factors which can be used to analyze cultural identity.<sup>1</sup> She argues that power (which derives from material or ideological resources) allows those in the dominant groups to impose their own definitions of reality, and to assume that the status quo is a "natural state of affairs". Those holding power (and this includes the more subtle manifestations of power, such as that held by health professionals) need not attend to fine distinctions and complexities in the life situations of those individuals or groups in subordinate positions. Hence, they may categorize behaviour in relatively simplistic, black-and-white terms. Further, Royce suggests that those in dominated groups must learn to see the fine shadings of meaning in their own situations and those who hold power over them. They may

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<sup>1</sup> Although ideas found in the literature of ethnic identity are useful in the analysis of the identity of Native peoples, this does not imply that the latter are considered "one more case" in a multi-ethnic society. The situation of Native people is substantially different from groups of other national origins, due to the respective experiences of these groups within the context of Canadian history, and Native peoples' identities as distinct nations within this country.

show resistance in obvious or subtle ways, and may use the fact of their subordination as a weapon in the battle for change (ibid:4)

Perception, in Royce's analysis, is the perception of both self and others held by members of a group. Utilizing the ideas of Barth (1969) who said that ethnic boundaries and the presence of other groups are prerequisites to the formation of ethnic identity, she notes that the presence of "others" stimulates and moulds ethnic identity, or sense of group character (ibid:7). This group identity may be, in part, imposed from without, by those who would segregate people who they deem "inferior". [It is also generated from within, by those who would strengthen group cohesiveness in order to achieve common goals. Symbols of ethnic identity may include manner of dress, dietary customs and life philosophy. Identity may be constant or may fluctuate. It may be based on reality, myth, or some combination of the two, in which facts are interwoven with culturally constructed and psychologically coherent (and, I suggest, politically astute) interpretations in such a way as to lend strong credence to the potent images created.]

Royce asserts that ethnic identity is a phenomenon which is "powerful both at the affective level, where it touches us in ways mysterious and frequently unconscious, and at the level of strategy, where we consciously manipulate it" (ibid:1). She sees it as one of many identities which can be consciously or unconsciously manipulated.

The element of purpose (which is relatively easy to isolate in the contexts of colonialism, nationalism, immigration, but which

is also a factor, conscious or unconscious, in the day-to-day behaviour of individuals and groups) is the third in Royce's analysis. [The purpose for emphasizing ethnic identity include "getting ahead", attributing blame, or healing the self and the community.]

#### THE COURSE OF HISTORY AS A DETERMINANT OF HEALTH

When respondents spoke of the need for an appreciation of the background and lives of Native people, this sometimes involved greater sensitivity to the past, and awareness of the historical processes that had led to their current state of disadvantage. These people noted that Native people have suffered due to the oppression experienced at the hands of the "other",<sup>2</sup> the white man, who in the process of colonization, held power over their lives. This power inequality continues into the present. It may contribute to the tendency of some to trivialize the situation in which Native people find themselves.

The following are responses to the question "What do you think would be the most important thing for non-Native doctors, nurses and health care workers to understand about Native people?"

"[They should understand the] emotional trauma. Doctors don't look at that. They put it, like, 'You did this to yourself'. They got to look at where the person's coming from, where he's living, what his background's like. [They should think about] why they give up so easily. Cause everything's been stripped away from them." (Ojibwa male, age 21).

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<sup>2</sup> Contrary to the standard anthropological use of the term "the other" (which specifies people not from the dominant society), it is used here to reflect the perspective of informants.

"They should grow up to be one [an Indian], and they would understand more. [They should] study the history - what ails them." (Oneida male, age 40).

"Actually, the hardest thing to understand about Native people is that fact that when the Whiteman first came, they broke their pride. Like when I broke the horses - the horse has a lot of pride - I feel bad doing that. But its the same. When you break a horse's pride, you can do anything with them. They broke the pride of Indians. They fed them firewater. They came in and broke the pride of people who had lived in peace for thousands of years. The ones that had pride, they killed. The others they put on reservations. My opinion of the Whiteman at that time is not that high." (Mohawk male, age 19)

This latter respondent is a young man, whose responses reflect much of the bitterness which is a feature of many young, politicized Native people today. Not obviously Native in appearance, he described himself as a half-breed, the son of a Native father and non-Native mother. He lived on and off reserve during his childhood, and is now 19 years old, unemployed, and living alone in Hamilton. He spoke of his desire to get back into school to upgrade his grade 10 education, and of his earlier problems in school, not wanting to "have things forced down his throat". He is angry, and describes himself as having a history of violent behaviour. He has learned, through the power of Zen, to control his temper and use it only for self-defense. He blames the dominant society for the problems experienced by Native people, but feels that the solution for him and others like him is self-discipline. He notes that this can lead to one's being "sound in mind and body", and thus "able to do anything you want to and not having a mental block that'll make it difficult to complete the task at hand."

THE INTERCONNECTEDNESS OF ALL LIVING THINGS

Some respondents regard the present condition of the world, with social and political unrest and environmental pollution, as determinants of their health and sense of well-being. Traditionally, Native people consider themselves part of nature, and not a separate entity. This world view differs from that of the dominant society, in which human beings are seen as superior to other living things, and able to direct the natural world to their own advantage. Native people see themselves as part of a larger whole, which includes the entire universe, and all the living things that share this environment.] One woman expressed her connectedness thus:

"The holistic idea - smoke, air, water, Mother Earth. Even if something doesn't affect you directly (like things that happen to my grandparents, or ex-husband) - it's unclear how, but it does affect you. The Mohawk thing - I've been dreaming about it. I talked to the children. It affects you personally, on a psychological level. And earthquakes, or floods, in other parts of the world - I can feel it!" (Cayuga female, age 30's, interviewed during Oka standoff).

The sense is of being one part of the natural world in which a multitude of forces are acting and interacting, and affecting the well-being of individuals. This may take the form of psychological, spiritual and physical health, and may be related to environmental concerns.

"It's too late now. If they don't do nothing now, there will be no water to drink in 20 years. My grandchildren won't have it. I read about it - the lakes in the north are dead from air pollution, sewage and factories. My grandchildren won't have anything. We used to dig and get clear water - we'd move from bush to bush, dig a hole, and get water. At first it would be brown, then it would run clear." (Mohawk male, age 47)

[This respondent exemplifies a group of urban-dwelling Native respondents, in that he was born in a small town in Ontario, and moved a lot during his childhood, throughout Canada, living in both rural and urban settings. He had worked in a variety of jobs, including trucker, structural steelworker, welder and bouncer. At the time of the interview, he had been resident in Hamilton for two years, and was on a disability pension, due to a back injury. He retains strong emotional ties with the land. His description of what "health" means relates the overall health of present and future generations to the well-being of the larger environment.]

The idea of the oneness of the world, and of world consciousness, are described by a researcher who worked with Rolling Thunder, a Native healer in the American southwest.

"He had called the earth an organism...Rolling Thunder had somehow gone from streams to veins of flowing blood. Somehow the sand, soil, plants, rivers, streams and air were a body. I do not recall the words, but he managed to present a number of impressions instantaneously, giving rise to new perceptions in me: this earth a body, a gigantic body of a conscious, struggling living being. The body belongs to an individual with an identity and a purpose. That being exists here now. We have to be within it - like cells." (Boyd, 1974:49-50).

Many Native people regard the dominant society's idea that technology can conquer nature and make it the servant of humankind, as a form of oppression, and a demonstration of the truth that they do not understand the natural order. The present state of the environment gives testament to this. Humans cannot make laws or systems to control nature or people's inner nature or consciousness.

Rolling Thunder sees healing as a spiritual concern, which includes the ability to look into and understand one's inner nature, to respect and enhance it (ibid:40). This is an idea which is currently being echoed by non-Natives in the New Age movement, who see a growing spiritual awareness among people as a healing force in the contemporary world (Simmons 1990; White 1990).

#### THE SYNTHESIS OF CULTURAL IDENTITY

[Ethnic identity is one of a shifting pattern of identities which a person assumes. Barth (1969:9-10) notes that ethnic boundaries persist despite the fact that there is a flow of personnel across them. The following case study illustrates how this can occur. It demonstrates how identification with a cultural group can change, based on experiences and perceptions which occur naturally during the course of one's life.]

Tom<sup>3</sup>, a separated male in his 30's, who has lived in the city for several brief periods during the past three years, was born in British Columbia. He lived in a small town in that province during his childhood, in a succession of non-Native foster homes. He wears his black hair long, in the style of many Native men; his friends in the drop-in centre where we spoke included both Natives and non-Natives. Tom agreed readily to complete the questionnaire, but spoke in a quiet, hesitant manner, and stated that he "isn't really into the Indian way - I lost it." Tom is, however, being introduced to local Native organizations by a new friend. Bob is a

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<sup>3</sup> For purposes of confidentiality, fictitious names are used for the informants in this and the remaining chapters.

30-year-old male, who is white, but identifies strongly with Native culture. He reports having been raised in a Native foster home. Bob wears Native jewellery and t-shirts with Native rights slogans prominently displayed. He left his family to join the military, but remains in frequent contact with his foster mother, and has recently started to "learn about his Native heritage" again, and to "tell people about the fact that we were here first." Tom and Bob, with their varying experiences and interests, demonstrate how cultural identity can be experienced in an individual's life. [A person's cultural affiliation is not static. It evolves over time, depending on life circumstances and values, contacts with people from other groups, and the goals to which one aspires.]

The values and behaviour of people vary greatly between individuals and across time. This diversity will, perhaps, be heightened in a group in which profound social change is occurring, as it is the Native population. Many factors, including the political demands of Native leaders, the recognition of past injustices, the flowering of Native productions in the arts, and increased coverage of Native issues in the media, are contributing to recognition of the viability and strength of Native culture. This change is occurring slowly, however. The legacy of past oppression has continued to have a marked effect on many people's consciousness.

A negative form of identity manipulation is the tendency for members of a disadvantaged group to "pass", when possible, as

members of the majority group (Royce 1982:5-6). One respondent, a young Christian woman from a Northern Ontario community, answered bluntly when asked whether she felt that her Indian identity had ever influenced the quality of care that she had received.

"My doctor is not aware that I am a North American Indian. I have not mentioned to any health care providers that I am North American Indian, as I feel I would be prejudiced against. I probably would not receive the care I do. I can pass for Caucasian - white - and use this to my advantage."

Despite this presumed advantage, the woman is not happy with the care she has received from the health care system, finding it cold and impersonal. She defines health as "having energy and generally feeling good", but is not experiencing this at the present time. She has migraine headaches and is discontented with life in what she considers a polluted city environment. One might infer that her lack of pride in her own Native identity is a contributing factor to her present malaise, and to her distrust of "the other".

Westermeyer (1979a:196) describes identity problems among a group of Native psychiatric patients, noting negative or ambivalent feelings regarding their Native identity. Several had been raised in non-Native foster homes, or by Native parents who sought to distance themselves from the Native community. He suggests that remedial measures are necessary for cases such as these. This might include individuals being encouraged to become involved in Native culture, history, language and family life workshops. Other suggestions are association with positive Native role models, as well as the involvement of support workers from within the Native community in order to help keep troubled Native families intact.

re: healing?

Many individuals who were dislocated from their Native roots through adoption into non-Native homes, are now seeking knowledge of and experience with Native culture. Others who previously sought to "pass" as non-Native to gain social advantage or avoid discrimination describe becoming more overt in the expression of their Native identity. In some cases, this begins with the arrival of children, and a desire on the part of the parents to instill the new generation with pride in their heritage. In a culture where emotional and spiritual well-being are understood as part of health, the self-acceptance which is linked to such move is necessary if one is to live well.

healing?

A professional woman, the daughter of a Native mother and a white father, began proceedings to gain legal Indian status under Bill C-31<sup>4</sup> after the arrival of her children. Her own appearance is not obviously Native, and her grandfather hoped that she could "pass" for white, and thus avoid the racism which many Native people experienced. For this reason, he had advised her to marry outside of the Native community. As with other Native women I spoke to, this mother was now motivated to promote a positive Native identity in her children, and to provide good role models for them.

A hypothetical people who lived with no knowledge of the existence of other groups would lack a sense of ethnic identity; we

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<sup>4</sup> Previous to 1985, Section 12(1)(b) of the Indian Act specified that any Indian woman who married a non-Indian lost her Indian status for herself and her children. This sexual discrimination was eliminated in 1985, when Bill C-31 entitled the above-mentioned category of women, and their offspring, to apply to have legal status as an Indian reinstated (Government of Canada 1985)

need ethnic boundaries with other groups in order to recognize our own characteristics (Barth 1969:10). [Most Native people living on reserves will have had some contact with non-Natives, and will have formulated a sense of their own identity in relation to these people. They may have experienced racism. They learn, through contact, through media exposure and through conversations with others in their social group what "others" think of "Indians". However, their everyday lives do not necessarily involve close or on-going contact with non-Natives. Upon arrival in an urban setting ethnic identity may be thrown into sharper focus, although social contact, for some, is primarily with other Natives.]

Although those from the dominant culture may see Native people as part of the multicultural mosaic, the situation of Native people is different from other minorities. They have not chosen to leave their country or their cultural heritage in order to "seek a better life in Canada". For most, the move to the city is not based on a recognition that the urban life or the mainstream culture is "better". As previously noted, the majority of Native people who move from reserve to city cite employment, and lack of adequate housing, and other opportunities on reserves, as their reason for migrating (McCaskill 1981; Maidman 1981; Frideres 1988a). Some parents encourage their children to get an education, and to leave the reserve in order to avoid the problems which reserve life often involves. The next sections illustrate themes which recurred in the informants' rationale for leaving the reserve and taking up city life.

urban

### A Break with Tradition

This is the life history told to me by Peggy, who describes herself as atypical in the Native community. She is outspoken and openly ambitious. Many of her friends are non-Native.

Peggy was raised on a reserve in southern Ontario. Her father, an unemployed welder, had a big garden, and hunted and fished to supplement the family's diet. One of their regular meals was soup made from bones they were given by the butcher. Peggy describes her father as a good cook, and a binge drinker. She notes that he was a smart man, with limited education, and an interest in theology. He had lived in the city during his early life, but moved his family back to the reserve to avoid the prejudice that he encountered.

Peggy feels that her mother was oppressed, both by the conservative thinking of the time, and her Christian vows to marry "for better or for worse". She had been raised in an abusive, alcoholic family, and remained in her troubled marriage, financially dependent on her alcoholic husband.

Peggy recalls names like "dirty Indian" being hurled at her by neighbourhood children when she visited her grandmother in the city. Although life on the reserve protected them from such abuse, and provided support from friends and family, it also involved poverty and hardship. Peggy's father lived to regret the decision to move back. He urged her to get an education and to leave the reserve, which she did.

Peggy's early experience with "the other" was not a positive one, and she has continued to be aware of racism during her adult life. She has professional training in a technological area, and was employed part-time by a private firm until recently. She preferred the freedom of part-time work, although her job paid just above the welfare level. Peggy lost her job, and describes complex reasons for this, which include racial discrimination. At present, she is investigating the possibilities for training in the social service field. She is active in a voluntary capacity in the community. Peggy is a single mother, and is relatively strict with her young son. She dismisses non-directive parenting as lax and ineffective.

Brant (1983:31; 1990:535) describes the ethic of non-interference as a rule of correct social behaviour in Native culture. In pre-contact times, harmonious interpersonal relations, and suppression of conflict was necessary for individual and group survival among aboriginal people living in close-knit groups. One means of avoiding conflict was to respect individual independence, and avoid coercion of any kind. This included relationships between parents and children, in which the child was accorded a high degree of personal autonomy.<sup>5</sup> Brant notes that this type of freedom was not detrimental to the child's well-being on the trapline, where the environment itself set many limits. He contrasts this with life in the city, where many forces may pull upon the child. Brant notes that many successful Native people have a parent who broke the ethic of non-interference by criticizing and praising their children in a way that could be considered "deviant" in Native tradition. (1983:50). Peggy's child-rearing practices might be described in this way.

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<sup>5</sup> Some (e.g. Loucks and Timothy 1981:13-14) link the inability to set guidelines (associated with the breakdown of the extended family, and the consequent lack of parenting skills) with the residential school experience. Children who traditionally would have learned how to be a successful adult by example were removed from their families. They were required to live in conditions in which their behaviour was strictly controlled by severe and often destructive means. They were left with no acceptable models of culturally or psychologically appropriate parenting from whom to learn. The parents of many of my respondents, had lived at home while going to reserve schools, where discipline was harsh and Native ways discouraged. One exception is Nora, whose story is told in Chapter 7.

Peggy feels that children learn more about being free by having limits. Although she does not ascribe to the traditional non-interventionist philosophy of child-rearing, her philosophy is traditional in that she values giving decision-making responsibility to children at an early age. Peggy is bi-cultural in her orientation, having developed her own blend of the traditions.

Peggy is an active member of a Christian church in the city, and is involved in social causes, aimed at promoting justice and enhancing inter-cultural understanding and communication. Her family has a history of religious involvement. Her grandmother was a Sunday school teacher in a Christian church. Peggy feels that her grandmother shunned Native culture, but was not able to totally suppress her Native ways. She used to perform certain traditional ceremonies if she felt there were bad feelings around, or ill health in the family. She was not, however, willing to talk about this to family members.

She also used to have a traditional dream or vision, when someone was about to die, so could foretell the event. Peggy and her siblings continue to believe in their dreams as a way of understanding life, and foretelling future events. Peggy feels that intuition is dismissed too readily by the mainstream society.

Peggy describes "a confusion between Native and non-Native culture" in her family, stemming from the fact that traditional Native spirituality was considered "heathen". She feels that Christianity has had a negative effect on her people's perception of themselves, but that there is positive goodness in Christian beliefs. She cites Christian teachings regarding love, forgiveness and peace, and faith in the future, in this regard. She is tentative about Native spiritual practices, accepting some, and not ready to accept others. She does not want to judge others, but wants the freedom to decide what is best for her.

Florence's story: a more traditional focus

Whereas Peggy sees herself as atypical, in many ways her values and actions reflect her Native culture. Many of her ideas parallel those of Florence, a woman who has lived in Hamilton for more than 15 years, but who retains a somewhat more traditional focus.

Florence was raised on the reserve, in a home with no running water. She and her siblings worked hard at home, doing household chores. She did not go out much, as her father felt that his children would encounter abuse if they strayed far from home. Her father was an affectionate man, with lots of time for his children and grandchildren, but after a work-related injury left him disabled, he "just gave up". Florence covered for her father when he drank at home during the day, and for her mother when she, too, drank. She did not have many friends, as she didn't want other kids to see what was going on at home. Some of Florence's cousins were removed from their parents' care and put in foster homes, but this didn't happen in her home. Florence quit school at 17, and lived for several years in the U.S., where she worked in a factory. Upon her return to Ontario, she took up similar work. She never married, but had three children with a man who became abusive during the time they were together. After the birth of her youngest child, Florence decided to leave, and moved to the city. Her parents supported this decision, and her father told her "You have one job in the world, and that's to raise those kids".

Florence became involved in the Native community in the city. At first she received social assistance, and worked on a voluntary basis. She now works shifts, and her kids say that she is away from home too much. She feels that it is better to be out doing something constructive than home drinking. Her children are now in their teens. She talks to them a lot. When they encounter problems in school or in making life decisions she tries to guide them into responsible behaviour, and to set a good example.

Florence used to drink and smoke. Although she never neglected the things she had to do, she decided to stop drinking for the sake of her children. This occurred when the children became teenagers, and were more aware of her behaviour. She does not feel that she can tell her children what they should do, but wants to set a good example for them. She has also stopped smoking, and is beginning to eat less, in order to lose weight.

Florence thinks that the thought "How do I look to other people" is one which helps people change. She feels that with all the present demands for Native self-government, "how other people view Indians" is an increasingly important concern. She has seen the negative stereotype of Indians reflected ironically in her own people's perceptions: "Maybe we should go out and get drunk - we're Indians, after all!"

Florence is settled permanently in the city. She believes in the Longhouse faith, although she doesn't often go to the reserve to the ceremonies. Recently, she has been sharing her beliefs with a relatively new acquaintance, a young woman, who was raised a Christian but is currently seeking a clearer understanding of spiritual matters.

Health and identity are linked at many levels in the lives of Florence and Peggy. Their early years, in loving but problematic family situations, have been shaped by poverty, alcoholism, the sense of being viewed in a discriminatory way by "the other". For both women, the maternal role is very important, and they seek a better life for their children. Part of this involved building a positive sense of self, overcoming the stigmatized Native identity which history and colonized status brought about. For many, this process includes a strong spiritual awareness, a source of strength which can generate and reinforce constructive life change.

### THE ROLE OF SPIRITUALITY

A sense of spirituality is apparent in the answers of many respondents. One elder, when speaking of the value he placed on spirituality, commented that he didn't care if people were Christian or Longhouse people, as long as they believed in something. Most people did. Only eleven of the forty-five respondents reported no religious or spiritual affiliation. The remainder reported association with various Christian denominations, traditional Native spirituality, or a combination of the two (Appendix A). Several informants reported that, as they began to seek more knowledge about traditional culture during their adult years, they grew away from their Christian belief, and accepted Native spiritual ideas. Spirituality, in the Native understanding, does not involve weekly religious practice. It is an awareness of the Creator, and of the gift of the spirit of life which connects you to all living things. This makes possible self-acceptance, the freedom to live and to have a strong sense of purpose (Aitken 1990:35).

Many respondents, both Longhouse people and Christians, spoke of the possibility of healing which derived from spiritual well-being. The most frequent cause of health problems in the Native community cited by respondents was alcohol abuse, with its physical, social and spiritual concomitants. Because the lives of so many people had been affected by alcoholism, either their own or among their families, many of the accounts of health and healing involved recovery from alcohol problems. Two of these follow, in

the life histories of Henry and Carl, both of whom speak of spiritual healing in their lives.

A Story of Healing in the Christian Context

Henry, a quiet man in his 40's, tells of his life which until a year ago involved living on the streets in a state of alcohol-induced squalor, fighting with other drunks, and coming close to death from liver disease. In spite of this lifestyle, Henry always retained a sense of spirituality. During his teenage years (before the above-mentioned problems began), he had what he describes as a near-death experience, when he was very ill with Infectious Hepatitis.

"I went through this long tunnel - it was like the twilight zone tunnel. And there was this little light, and it got bigger, and next thing you know, I was standing outside of it. And all I could smell was flowers, nice green grass, and blue water and swans in the stream, and...it was like Paradise.

And I looked across the little wooden bridge, and I seen all my relatives that had died before. They're all waving to me. I thought - Wow! It kind of clicked in to me - I must have died! So I started to go across the bridge. And there was someone standing there, but I couldn't see their face. I seen their hand go up, and they said "Stop!" I said I wanted to stay, and they said "No you can't. You have something to do. You have to go back."

Henry tells of being swept back through the tunnel, and finding his mother crying over him, because the doctor said he had died. This occurred when he was 16. The years that followed were difficult ones. Henry's younger brother was killed in a car accident on a night when Henry had been left in charge of him, and had

acceded to his demands to "go out for a little while". This caused Henry much remorse, and long-standing feelings of guilt.

Profound grief is a sadly common occurrence in the Native community. Many people have first-hand experience with accidental death or suicide, and bear the emotional scars which such events create (Long 1983). In Henry's case, the feelings precipitated a pattern of heavy drinking, which continued for many years.

"So I started drinking. Every time I'd get feeling like that, out comes the bottle, or two, three. And I didn't buy just one little six pack, or something like that. I'd get a few cases of beer, and a forty-ouncer or two. I quit school, and went to work. Quit my job. At last count I'd had over 300 jobs. I'd work for a week, or two weeks, then I'd quit."

This continued during the years that Henry married, and fathered several children. Eventually it led to insurmountable problems with his wife, and unemployment for Henry. His wife and children moved out of the house, taking their belongings. Henry reports driving to the beer store and the liquor store, and filling his truck. A binge lasting four days ensued, of which Henry remembers nothing. Some time later, he spoke to his wife, and agreed to vacate the house, so that she and the children could return. For the next fifteen years Henry lived life on the streets. He slept in alley ways, and ate in soup kitchens. He describes himself as having "a big beard, a dirty face, and scrappy, raggedy pants, dirty pants...and booze breath, and staggering or fighting or swearing". Nonetheless, he retained some sense of religious conviction.

"I used to pray. The others would be sitting there, and would all be drinking, and I would pray, or be singing to myself, or I'd be reading those tracts they have at church. Or I'd stop by a church on the way some Sunday morning...I used to go up to the door, and I'd listen to the sermon, rather than go in. They didn't want to see an old street bum walk into the church."

The story of Henry's recovery begins about a year ago. Shortly after his fortieth birthday, he became very ill. "The same kind of feeling like I had when I was a kid - tired, and turning yellow. I started blowing up." He was admitted to the hospital, and remained there for several weeks.

"I guess the doctors told my parents that...there was nothing they could do, it was over. They didn't tell me that. They were going to try some new kind of drug on me, and if that don't work, it's over - get ready for the worst."

At some point during this period, a minister from the reserve, whom Henry didn't know very well, came to visit.

"He sat and talked to me for a little while, and asked me about what I intended to do. I just told him all about...the drinking, and wishing all the time that I could change. And just before I knew, he was going out. So I says, "Well, no matter what happens, I'm not afraid, and the sooner something happens, the better".

Well, I knew he was praying, in the church. And the congregation prayed, my mother said. And all of a sudden, I was feeling good. Good! That's when the doctor asked me if I'd like to go home. And something strange came over me - like, "Wait a minute, now, I'm supposed to be sick! I don't feel sick. I have my strength back. That's strange! I'm not worried about where I'm going, now. I have nowhere to go, really. Well, I don't have no money. But I don't have a worry in the world, not a care or worry in the world. Nothing! Just brand new. I remembered, that's what I always prayed for...a chance. Here's my chance - to start with nothing again".

I prayed to get better. Not just here (pointed to his head), but here, too (his heart). Not just...not physically, but mentally, I wanted to get better, and spiritually."

Henry feels that there is a reason why he is living today, and why his life evolved as it did. It explains the message from his relatives during the near-death experience in his teenage years. He is part of a gospel group, and tells people about his life experience.

"Like maybe it was...to be able to tell people. Like, I'm not a talker, I'm not a speech person. But I can get up and tell an audience my story. Before, I could get up and play music, but now I can't be shy about it. People ask me how I can do it..."You were a mouse before!" And I says "Well, that was what I prayed for - a chance - and I'd do anything to change. And this is part of me...doing anything!" Maybe that was why I was spared. Its the only reason I can figure. To keep on going, and maybe help somebody else some day, who is in same position."

In Henry's life, healing came at a time when he came into closer touch with his own spirituality. Although drug treatment may have affected his state of physical health, it was the spiritual context which had the profound and on-going effect on his life. The spiritual contact he experienced with his ancestors during the near death experience took on new significance, and he became aware of his inner strength and the purpose he perceived in his life's course. Although the context is Christian, Henry's story is consistent with elements of Native tradition - the supernatural experiences which led to increased insight and conviction. Many Native healers speak of visions as an intrinsic part of their learning experience (Lake 1991:16-27).

Healing as Experienced by a Longhouse Man

The next story of healing is told by Carl, a young Longhouse man. Carl describes his early years, when a dysfunctional family life led to feelings of isolation and despair.

"I always was on my own. Growing up as a child, I was always - I was the only person that I could rely on. Always! Like my parents were never there for me. If they ever were, it was in a negative sense. Mom was pretty mean to us. I think she was pretty incapable of showing her feelings properly. There was a lot of abuse in the family - physically and emotionally and, you know, verbally.

Carl began drinking at age 12, and using drugs when he was 13. He feels that he was a full-blown alcoholic by age 14. His recollection of the next few years is hazy. He had a few friends, but maintained emotional barriers around himself. During this period, he did, however, become very close to his cousin, who shared many of the same problems.

"He was very much on his own. His parents were never there for him, either. He grew up by himself, and I don't know, I guess that somehow once we were both old enough to recognize each other, we just got along. And we both just started to really relate to each other in a lot of ways. You know, like, we found out that we could trust another person, so that we had built a very strong relationship between us."

Their lives were very troubled, though, with thoughts and feelings "racing around in a mass of confusion". It was a great shock to Carl when his cousin took his own life.

"He couldn't live no longer, leading such a...a destructive life. So he decided to leave. He committed suicide. And, uh, that hurt me in a lot of ways. Number one, just the pain that he would

do that. But there was actually a breach of trust there, too - that he never brought that to me, his feelings or anything."

Once again, guilt and remorse were an integral part of the complex emotions experienced in the wake of tragedy.

"There was one thing that I had a hard time forgiving myself for. And that was - that day, that he passed away, he had been looking for me in the morning. He came to the bus stop. And he was asking where I was. He wanted to talk to me."

Carl had gone to the dentist that morning, and he resisted the urge to visit his cousin on his way from his dentist appointment to school. Later, he profoundly regretted that decision.

"I just couldn't forgive myself for...for not being there. I had a real hard time dealing with that. For a very long time after that, I thought that that was my only answer, too. To stop all the pain - to stop all the hurt. Because that's all I really wanted to do, at that point in my life, was to stop it."

Carl became closer to his sister during this time, but remained anxious and disturbed, feeling unable to trust himself, or to be alone. In order to sort out his thoughts and feelings, he went to his grandmother, who is known in the community for her ability to look into the future.

"She did it in her sleep. She'll sleep with a personal article of yours, and, the way it was taught to me, she actually goes to the other side and is actually there, and brings back the knowledge."

When we went back for the reading, she was very scared for me. It was almost like a fork in the road. If I continue in my ways, it's very dark, and bad, and gloomy, and the dark gloomy road comes to an end. Whatever was going to happen was very fast, and very violent. And it was just going to happen, Bang! Like a fast moving train, coming to a dead end, or something like that. And if I

was...not of a strong mind or spirit, it was going to be the end...I wasn't going to be able to make it through that."

Carl realized at this point that he wanted a different type of life, not one controlled by drugs and alcohol. He hoped for a future, and to do something with his life. He asked his grandmother what to do in order to achieve this, and she told him that he must purify himself, to regain the connection between his body (which he had abused for years) and his spirit. This involved a ceremony, which he carried out on his own for three days.

"Very early in the morning, before anyone else is up - four or five in the morning. It's supposed to be before the spirits retire. I would have to make this tea the night before, and let it sit overnight.

Each morning I drank this tea. I would have to go through, and drink a very large amount of water. Like, I'm talking pitchers - big pitchers - eight of them I think I drank. And it just had to be like, lukewarm. And I had to just keep drinking it, until the point that I was just so expanded from the water that it just had to go somewhere, and that forced it right back out. And what this tea was to do was that it was supposed to get inside your system and loosen all the impurities that you had put in there. And for each morning, I had to collect the solids - whatever came up. It was really weird, 'cause there was some unrecognizable stuff in there! That's supposed to be the actual physical evidence of the impurities that you're seeing."

On the fourth day, Carl had a feast, and buried the solids that he had collected, in order that the evil would be kept there, and would not return to him or to anyone else. He burned tobacco (which is a sacred substance, used for spiritual purposes), and thanked the Creator for giving him the chance to change his life. He acknowledged that now he was clean, he wanted to stay clean. During the

time that Carl was performing these ceremonies, he had experienced a visit from the spirits of his grandfather and his recently-deceased cousin, who told him that they would support him in this quest for change, and would be there for his guidance in the future.

These events happened several years ago. Carl changed very significantly after that. He continued to go out with the same friends, and although for a long time they tried to get him to drink and do drugs, he never had the desire to do so. He did not try to change them, but was there, and able to help them when they needed help. Some resented this, feeling that Carl thought he was better than them. He could not keep those friends, because they had no respect for him and what he had achieved. Other friends respected his decision, and they continued to go out together, talk, and get along well. Some of Carl's friends have stopped drinking since that time, and some have cut back. Others continue to drink and use drugs, and suffer the disruptive and debilitating consequences. Many of Carl's family members have undergone a healing process as well, and they are relating to one another and to the larger community in a more positive and constructive way.

Carl continues to seek self-understanding, and this has been a painful process. He is learning more about the traditions of his people (including healing traditions), continuing his own recovery, and promoting Native people's knowledge of their heritage. He is also willing to share information about his experience with others, in the interest of promoting healing and inter-cultural understanding. The reluctance of some to speak of Native spirituality, and

the effort of some Native leaders to change this, is dealt with more fully in the next chapter.

POSITIVE NATIVE IDENTITY AS NECESSARY FOR HEALTH

Until recently, real political power has been withheld from Native people, and even the spiritual power, so integral to the Native sense of self, has been scorned and illegitimized by those "others" who governed. It has not, however, been eliminated. While Native leaders are negotiating at the political level for self-determination, many Native people are using the traditions of their people in order to renew themselves, and to promote the positive identity necessary for healing.

Identity takes shape within a social context, and the opinions of others can influence it in both destructive and constructive ways. They may prevent change, in that it is difficult to leave the comfort of group identity, even if it is a hurtful one. They may also be a powerful force for positive change, in the case of persons motivated to show themselves responsible, and thus set a good example for children, for others seeking guidance, and for those who are weighing the implications of self-determination for Native people.

As well as changing inwardly, many people display overt signs of their Nativeness more readily today. It is evident in their dress, their hairstyles, and use of traditional symbols. One purpose is to diminish the negative sense of self, the legacy of treatment inflicted on their forbears during the course of history

of this country. Another is to acknowledge their place in society, their relationship with their God or Creator and with other living things. As evidenced in cases detailed in this chapter, each Native person achieves a unique bi- or multi-cultural blend in defining and redefining him- or herself.

People may move to the city to seek education or employment, or return to the reserve to avoid discrimination or to seek their roots and be with family members. In each case, they share opinions, form impressions and interact others in a social context. The biculturalism which results from these varying experiences is expressed in child-rearing practices, in one's interaction with others, and in one's ever-changing sense of self. Whether this is despairing and destructive, or a positive, healing force varies over time and with on-going experience. What seems crucial if healing is to occur, is that people seek their inner strength and spirituality in a way that is consistent with their own lives and the experience of their people.

One man, a former heavy drinker, spoke of his healing process, and his increasingly positive self-image, which changed from "Indian" to "Native person", then to "Ojibwa", and finally to "Anishnawbe". The latter is how his people think of themselves, on their own terms, and that is how it must be if they are to be healthy.

## CHAPTER 6: SEEKING HEALTH

Chapter 4 began with the observation that we must consider the multiple degrees of health and illness if we are to gain a comprehensive understanding of health issues. It dealt primarily with the positive end of the continuum, with people's ideas about the meaning of health. Now I turn to people's thoughts about those factors which interfere with their well-being, their assessment of the most common health problems in the Native community, and their ideas about how to alleviate these problems. I also examine people's impressions of their experience with both mainstream and traditional healers, and the reasons for their choice of healing systems.

### HEALTH PROBLEMS DEFINED BY RESPONDENTS

The majority of respondents described their own health, and that of other members of their household as "good". This was the case even when the presence of significant (and in some cases life-threatening) disease became evident in subsequent responses. This is similar to T.K. Young's study of a northern Ontario Native population, in which he distinguished the concepts of "clinical health" and "functional health" (1982:276). Eyles and Donovan (1990:37) see this pattern as an indication that health is valued, and ill health is "defined away" unless it significantly affects the individual's ability to function in their everyday capacity. In

their working class population, sickness is discounted and ignored, and health concerns become secondary to people's daily obligations.

Although my informants generally described themselves as healthy, they were not unaware of health problems in their own lives as well as those of their family members and others in their community. A mix of diagnostic, behavioral and environmental causes for ill health were cited. The most frequent was alcoholism, followed by poor diet, drug abuse, diabetes, and poor living conditions. Three (out of the 45) respondents felt that white people were to blame, in that they brought disease and alcoholism to the Indian; an equal number cited self-neglect as the major cause of health problems.

A variety of health promotion strategies were suggested. Many respondents thought workshops would be useful, in helping people gain self-understanding, learn better nutritional habits and living skills. The next most frequent suggestions were for people to stop drinking, and improve their diet.

#### THE ETHIC OF SHARING

The use of workshops and healing circles as a means of health promotion is consistent with the value placed on sharing by Native people. Sharing with others is an important behavioural norm in Native culture (Brant 1990:535). People do not hoard possessions, but share what they have with others in their community. This dates from pre-contact times, when group survival was more important than individual survival.

Perhaps more important than the sharing of material goods, is the sharing of information and wisdom. This is done in an unassuming and non-directive manner. One woman, who speaks frequently in public and is highly respected in the Native community, stated clearly at the start of a student seminar that she spoke not as an expert, or as the representative of any particular school of thought, but only on the basis her own experience.

Native people learn by example during their childhood, and example is used during adult years in healing as well as in other aspects of life. Workshops and traditional healing circles are being held in many places within the Native community (both in urban centres, and on reserves) at present. In these circles, people speak about their lives, about the problems they have encountered and how they dealt with these problems. They share their pain and find solace and support among their fellows. People's ability to profit from this sharing of knowledge grows slowly. The experience of seeing that others, much like themselves, have managed to leave destructive aspects of their lives (such as alcoholism and abusive behaviour) behind, and to rebuild in a steady quiet manner, is a valuable lesson about the possible.

One woman, who has experienced problems with alcohol, described her gradual recognition that a different way of life was possible for her. She had heard elders speak at workshops, telling of the abusive and alcohol-ridden lives that they had left behind. This had led to her realization that she could do this as well, and gradually she began to cut back on her alcohol consumption. At

first she was a "closet non-drinker", as she did not wish to make an issue of her decision. It was a private decision, which she was not ready to share. She was ashamed of drinking. However, she was also ashamed of quitting drinking, fearful of what people would think of her, seeing her as "feeling she was better than they were". She did stop, however, and the change has been a profound and lasting one. Speaking to others about herself remains very difficult, but is gradually becoming easier. It allows her a greater sense of self-acceptance, and gives a means of helping others understand their own lives.

People's ideas about health and sickness, and their health-related actions, are shaped by communication with others throughout the course of their lives. This takes many forms, such as verbal and non-verbal interaction with parents and other care givers, with other members of one's social and/or occupational group, and with healers of many types. It also includes exposure to information disseminated by the media or by organized health programs.<sup>1</sup> These social interactions contribute to a multi-faceted and unfolding concept of health, which each individual uses to interpret and respond to any given health situation.

I asked informants what shaped their health attitudes and health status. Each person ranked five factors: their own knowledge and experience, the knowledge and experience of others,

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<sup>1</sup> The healing process of one informant, who had felt extremely isolated in an abusive marital situation, began with a public service announcement on the radio, telling her where help was available.

the environment, heredity, and luck. The most frequent response was that one's own knowledge and experience was most important in determining health and, by inference, action devised to enhance health.

Table 1. The most important factor in determining health

Your own knowledge and experience	44%
Environment	25%
The knowledge and experience of other people	15%
Heredity	12%
Luck	5%

Some informants emphasized the importance of first hand experience, and cited episodes of ill health they or their family members had undergone, noting that "you haven't been through it, so you don't know - you have to take my word for it." Although people were not always liable to "take someone else's word for it" they learned by first hand experience and by observing the lives of others. The knowledge of elders was an important source of knowledge for some.

It is not surprising that the knowledge and experience of professionals was not a prominent feature. One young man reported that he read medical books and first aid books, and tried to cure his own health problems before calling the doctor. More typical is the respondent who said he had not experienced problems with doctors, but that was not surprising because he did not go to doctors. Chapter five dealt with the formation of identity in the presence of "the other", persons from other groups who serve as a basis for comparison. Many informants resist being "told what to

do", not only by their fellows, but especially, by non-Native professionals, those "others" whom they perceive as so different from themselves. If the physician's system of meanings differs markedly from the patients', then his/her disease categories become less convincing, and the remedies prescribed less likely to be accepted.<sup>2</sup>

Respondents also felt that the environment is important in determining health. The interconnectedness of humans and the larger environment was evident. In some cases, this referred to the cleanliness of air, water and living space. Others spoke of the interpersonal environment, and the need to be around people with a positive attitude, in order to live a healthy life. Health is seen as being generated from one's life experience, from the attitude and wisdom of others in the community, and not primarily on the basis of personal control or professional expertise. It is nurtured by one's ability to profit by experience (including mistakes), to create good and positive environments in which one's potential and that of one's children can flourish. But the individual must make the decision to do so independently. It cannot be forced by others, or prescribed by those in authority.

"Nobody's going to help them out. They will do it on their own. When they want help, they will do it on their own." (Mohawk female, 30's)

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<sup>2</sup> See also Warry (1992:9) for Native psychologist Dr. Ed Connors' remarks on culturally-coherent "prescriptions", as practiced both in psychiatry and in traditional medicine.

CONTACT WITH THE MAINSTREAM HEALTH CARE SYSTEM

Although people may prefer to rely on their own experience and inner strength, and popular knowledge culled from their social circle in handling everyday health situations, there is a point on the wellness-illness continuum where they can no longer function without outside help. This may result from the worsening of a chronic condition, from injuries sustained in accidents or fights, or from common illnesses experienced as part of family life. Although 77% of questionnaire respondents have a family doctor, many appeared not to visit doctors for minor ailments. For some, the only hospital experience was for childbirth or for traumatic injury.

There is considerable variation in informants' degree of comfort in dealing with the health care system, and likelihood of using it when problems arise. There is also much diversity in people's familiarity with and utilization of traditional Native healing practices. The individual's degree of bi-culturalism, and spiritual beliefs are probably the most influential factors. Some factors which may influence these include by age, educational history, area of origin, and length of residence in city, association with Native cultural groups. The relatively small numbers of informants in this study preclude clear definition of the effect of individual factors.

Respondents were asked if they felt that the fact that they were Indian had ever influenced the treatment or quality of care that they had received. Approximately one third felt that it had.

In some cases, this was due to their own reluctance to speak up; in others, instances of overt prejudice were recounted.

"As a child, we (my family) used to attend a hospital clinic, and non-Natives used derogatory remarks, such as "There's another bunch of wild Indians." Their manner was very cold. Therefore, we had no desire to return. Consequently, we weren't kept at the best level of health." (Tuscarora female, 40's)

"Yes. There's a lot of prejudism. Like they (excuse the language!) always go to the white person first, take care of them, then you're next." (Cayuga male, age 38)

"Yes, at times. I had to go to the Emergency Room for pains in my stomach and chest. The doctor on the floor that day, he was very rude. He said "What are you drinking?" His attitude was really bad. My father really gave it to him." (Seneca male, 20's)

Sixty-two percent of respondents reported no such problems, although in some cases, positive responses were vague or conditional.

"I don't think so. Then again, I can't really answer that question truthfully - I haven't been to many doctors. Doctors I have been to, I've never really had that problem." (Oneida male, 30's)

"No. Not between doctors and nurses. They treat us the same. They've got an oath to provide, you know." (Mohawk female, age 29)

"No. I've always been quite fortunate." (Cayuga female, 40's)

Most Native people do not like to complain, and are reticent in their contacts with non-Native health care providers.<sup>3</sup> The typical medical visit, in which the doctor's or nurse's questions

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<sup>3</sup> This non-complaining attitude may also contribute to the lack of negative reports regarding experiences with the mainstream health care system.

are relatively brief and direct, and the expectation is for a dispassionate and full accounting of one's problems, does not fit well with the indirect mode of communication which is the norm in Native culture (Hanson 1988:26; Hagey 1983:30). Because of this, Native patients may come away feeling unsatisfied.

One man in his 30's, who was hospitalized after having injured his leg in a motor vehicle accident, left the hospital without knowing how to care for his injuries. He feels that staff took it for granted that he knew how to take care of himself, that is, whether and for how long to wrap his ankles, to soak his foot, etc. This problem may have resulted from neglect. An alternative explanation is that misunderstandings resulted from differing communication styles. A non-Native individual may not be sensitive to the hidden question asked by a Native patient. An example cited by Hagey (1983:30) is that a statement such as "Mrs. Brown is having trouble with her eyesight" may be interpreted as "Is diabetes going to make me blind?" The care giver's lack of response may be misinterpreted, in turn, as an indication that she doesn't know the answer, or is implying "You poor man, you're going to go blind, and I can't help you, so I won't talk about it."

Direct and intrusive questions from health care personnel may be left unanswered, or answered at a later time. This is not inappropriate in Native culture. A Metis nurse from northern Ontario speaks of the need to show respect, and to ask questions in a non-invasive way. For example, she would ask "How is your family?" instead of the more direct "How many children do you have?"

or "Are you married?" In this way, the patient is given the opportunity to supply information about marital status and family, without the affront of invasive questions. A practitioner might, alternatively, introduce a subject of concern as follows "Some people living in the city have problems with getting enough exercise/eating balanced meals/taking their medication" in order to open the clinical exchange successfully.

This type of questioning requires more time, but, for many Native people, denotes caring. It was a patient, caring attitude which several respondents felt was missing in their contacts with health care providers.

"You have to understand people - Indians - Natives. Because we're not all bad. Because the first thing they look at you like that, and think you're bad because you are an Indian." (Cayuga male, age 38)

"Not so much with the younger ones, but with elders - a lot of those people have never been to doctors - they're used to taking care of themselves. Afraid doctors are going to hurt them. Have a little more patience, ease their minds some - maybe explain to them what they're going to do, and that the medicine they're going to give is not going to hurt them." (Mohawk female, 40's)

Several respondents noted that they are not assertive in seeking health-related information. They are reluctant to complain, or to "bother the doctor".

"We don't like to complain. [The doctor will say] "How are you doing?" [and we'll say] "Oh, I'm fine." And yet someone's going through a lot of pain. We'll go for one thing, and not mention other things. Don't want to bother the doctor. Don't realize the doctor is a service-provider, and we are going there for service."  
(Cayuga female, 30's)

Both the disease state, and the illness as experienced by the patient, may worsen in the wake of such a negative clinical encounter.

"Well, in my case, I was scared, and I had to get explained more in detail what's going to happen in the future. Native people are shy. A lot of times I don't explain in detail, because he's always in such a hurry." (Mohawk female, 50's)

"I feel most Native people are too quiet about their health. If asked by doctors or nurses, they'll answer. If not, they keep to themselves. I don't know why. To me, it's just that if not asked about it, they won't give out the information. [It's important] to find out what's going on with them, not just what they're in for. It could be something else that caused the problem." (Cayuga female, 30's)

This comment suggests the practitioner's need to appreciate the larger context of the patient's life, the holistic nature of his/her health.

"They should take time to see...a lot of Natives are shy, afraid, when talking to a white person. [They'll think] "What if I'm wrong?" [and be] afraid to ask "Should I do this or take this?" Afraid they'll think "What kind of person are you?"

One man, who had spoken to many groups during the course of his working years, commented that it had taken him years to be able to communicate confidently with non-Natives. He saw this as stemming from his early years, when his parents taught him to believe that "They (the white people) don't like us". In contrast, another informant, a woman in her 50's, remembered it being ingrained in her family members that they should be proud of their heritage.

"My father, he said to hold you head high. I always hold my head up, am proud of who I am. I never had anything to be ashamed of. I know a lot of people that are ashamed to be Indian. I always got...if I thought I was being neglected when I was in hospital, I let them know about it. I'd raise my voice."

Interviewer: "And were you neglected?"

"No - no way!" (Cree female, 50's)

The habit of asking for help, however, is not an easy one to acquire. Many Native people are reluctant to reach out for help. This is the case even when dealing with friends and family, but the problem is compounded with mainstream health care providers.

"Letting them know that you are down in the dumps, or you are sad, or need advice. Without [having them] thinking you're not too bright, or something..."

The disinclination to ask questions or seek help was linked by this informant and others to childhood experiences.

It depends on how you're brought up, too. If you're told when you're a kid, that when big people talk, you're not supposed to listen...you learn that when you grow up. And before you know it, you're not - you just don't think it's your business, so you don't ask questions. If you're supposed to know, then you'll know it. If you're supposed to know it, it'll be told to you." (Cayuga female, 40's)

"In Native communities when you ask questions, the people think that maybe they didn't explain it right to you, or that you're just too fidgety, or you're not paying attention." (Female, 20's)

In addition to the reluctance to ask questions, there is a tendency to respond slowly, with periods of silence being seen as normal. This, again, leads to misunderstandings and/or communication breakdown in the clinical encounter.

"Non-Natives tend to want the answer (clicked fingers) like that! My God, if somebody thinks for five minutes when they ask them a question! I don't have time to think, like with another Native person...I remember my mother sitting there and thinking before she'd answer. It's not that we're a slow people, it's just that we're... deliberate. We're deliberate in our answers and in our thinking." (Tuscarora female, 50's)

These differing communication styles can impede good health care, and cause Native patients to feel uncomfortable, or inadequately treated; they may lead to people discontinuing or avoiding treatment in what is perceived as a hostile or uncaring milieu (Hanson 1988:27). On the other hand, the clinicians who respect the patient, and who take the time to explain in detail and check for misunderstandings are remembered and appreciated.

"My pediatrician understands...he is great! He'll talk to you person to person. He'll talk to you where he knows you will understand. He says 'If you don't understand me, tell me.' He breaks it right down - he's great." (Ojibwa female, 30's)

The presence of culturally-sensitive communication will influence the Native person's determination of meaning in encounters with health professionals, and in their handling of health problems.

In recent years in Canada, there have been efforts to increase cross-cultural understanding in government services and the medical community. Multicultural workshops and publications promote culturally-appropriate treatment. However, progress is uneven. The majority of health care personnel are from mainstream culture, and entrenched biomedical routines and understandings are resistant to change. Generally, it is those with an already-existing interest in cultural issues who participate. In the present climate of economic

restraints and increased work demands, opportunities for such participation may be less available. Also, cultural sensitivity training is a minor part of the curricula of most medical schools, so graduating doctors begin their careers lacking a grounding in the issues which will so strongly effect their practice in indigenous and ethnic communities.<sup>4</sup>

#### USE OF TRADITIONAL MEDICINE

The problems created by the perception of "us" and "them" are not present in the same sense in the utilization of traditional medicine (or, in the case of some Christian respondents, take a different form). This section deals with respondents' ideas about traditional Indian medicine and its usage, including how they contrast it with the mainstream medical system, and decide which system to use for any given illness episode.

If Native people are unhappy or uneasy with the health care available in the mainstream system, an alternative is traditional Native medicine.<sup>5</sup> The practice of Native healing has survived into

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<sup>4</sup> However, one current initiative in Ontario is the "Educating Future Physicians of Ontario" (EFPO) Project, designed to modify medical education in order to more adequately prepare physicians to meet the diverse health care needs of today's society. One component of this project, which is being co-ordinated at McMaster University Medical School, is to assess health care needs and expectations of people in Ontario, and one of the specific groups being asked for input into this process are Native people.

<sup>5</sup> The terms "Native healing", and "Indian medicine" are used interchangeably here, and include a wide range of traditional practices including the use of natural remedies derived from plants and animals, ceremonies, counselling by an elder, and self-healing. Spirituality is an important element of healing, which is seen as neither specifically "religious" nor "medical", but rather as involving all aspects of one's life.

the present, despite past attempts by the dominant culture to eradicate it as a means of hastening the assimilation process. Although much has been lost, Native healing remains a viable choice for many Native people. It is more accessible on reserves, and Native people in the city who desire contact with a traditional healer or healing society generally return to the reserve for this purpose (Fuchs and Bashshur 1977; Waldram 1990b). As mentioned in Chapter 2, Anishnawbe Health in Toronto now offers a program of health care in which traditional healing is available alongside biomedical services.<sup>6</sup> More commonly, however, access to traditional Native healers is on an informal basis, through the knowledge of or contacts within the Native community.

Many Native people are reluctant to talk to Non-natives about Native healing. The reasons are complex. Some relate to the sacred and mysterious nature of this practice.

"Some things are not meant to be understood and especially dealing with the supernatural."

"I am [reluctant to talk about traditional healing]. Because there's certain things that I belong to that I can't talk even to another Native person about. It gives that mystery that's construed as "there's something wrong". There's certain things that we don't talk about in winter, summer, or at night."

Traditionally, there has been privacy, if not complete secrecy, about spiritual healing, and healing societies (Parker 1913; Speck 1982). This is changing with the changing times, and the acknowledged need for the two cultures to gain better communication and

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<sup>6</sup> The complexities of implementing a dual system such as this are considered and discussed by McCormick (1988:8-13).

understanding. Some Native leaders are becoming more public about Native spirituality (McGaa 1989:vii; Boyd 1974:viii), based on the belief that this will benefit humankind in an era when materialism and technology have shown themselves lacking the capacity to solve current problems, and when spirituality and cosmic/ecological awareness show promise and are gaining a wider acceptance as solutions for an ailing world.<sup>7</sup>

Another reason for some people's reluctance to speak of traditional medicine is self-protection.

"Some of them are [reluctant to talk about it]. Probably because they're so protective of their own ways. It depends on the individual - I think older people are reluctant to talk about it - because they were raised in a different era."

"It's private to them, their own. Don't let white society get a hold of something that they might destroy."

"Yeah - probably, because when people do talk about it - things that are really sacred like that - people that they tell say they're not going to do anything with it, but they do - put it in a book, and use it to make money. [Because they're] exploiting us, I guess. They did that with everything else, too - the ceremonies and the songs. There are some things that are just not supposed to be written about."

Regarding the appropriateness of the questions I was asking, this respondent said that they were acceptable, because of the generality

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<sup>7</sup> Some (e.g. Kehoe 1990:193-209) urge caution in accepting the authenticity of those self-proclaimed traditional healers (or "plastic medicine men") who are highly public in their assertion of special powers and who promote easily-digested pan-Indian ideologies, arguing that this may be for purposes of personal gain, and may be based on spurious claims of expertise.

of the discussion, and the fact that I wasn't asking for specific information about sacred rites.

There is the feeling that mainstream society has taken much of value from Natives, and has exploited and spoiled it. This involves exploitation of the land itself, but also extends to potential abuse of Native beliefs. It is by remaining within the Native community that the spiritual and healing practices have survived the era of attempted assimilation.

Some respondents noted that white people are often disrespectful of Native customs and spiritual healing practices.

"Cause a lot of people don't believe in it, and think it's just bullshit. But it's like anything else - if you don't believe in it, it won't work. You've got to believe in it for it to happen."

Some people cited the potential of bad medicine (intentional harm caused by others invoking spiritual forces) as a reason why some Natives were reluctant to be open.

"It's something you leave in the closet, and leave it there. A lot of Indians are scared of it. I am, to a point, and I'm not. Some people are scared to talk about it, and some aren't. Everybody's time comes - when you're meant to die, you will die."

"People other than Native don't understand this medicine - the way it works. Medicine can be used both ways - for good and for bad. I think that's one of the main reasons that people don't want to tell other races about the medicine that they know about."

This reluctance is understandable, especially given the labelling of Native spiritual beliefs as pagan by Christian missionaries and teachers in the past. Today, the value of traditional healing is

gaining increased official recognition, including support by the World Health Organization (1978).

Traditional medicine and healing practices remain a significant part of the lives of many Native people living in the city. Slightly more than half of the people responding to the questionnaire have used Indian medicine at some point in their lives. The extent and nature of this use, however, varies greatly. There were some respondents whose mothers gave them Indian medicine as a child but who had not used it during their adult life, some who had begun only recently to investigate traditional practices and use traditional healing, and some were life-long users.

Most respondents have at least some knowledge of traditional medicine, and their answers suggest pride in the tradition. Often, the level of awareness seems limited, however, and there is regret that the old knowledge has been lost - discouraged by the dominant society, and also allowed to slip away. Many contemporary people's busy lives, departure from the reserve, or adherence to more mainstream lifestyles do not encourage utilization of the old ways.

The most frequent description of what traditional healing and Indian medicine is, mentioned not the more private ceremonial healing practices, but the use of herbs and roots for healing purposes.

"Like using different roots and herbs that you get from the earth, and making the different medicines. And probably the way its made. Like, a lot of times the person that makes it is gifted. They have to have a certain power within themselves to make it work. I guess you'd say like a medicine man." (Cayuga female, 40's)

"Well, you can heal some sores or cuts with some sorts of things. They pick some herbs, grind it into powder, and they pour it on the wound. Within three days its healing up real good." (Cree/Sioux male, age 23)

"We take things of nature and we cook it up, and everything like this, and we drink it. And it'll prolong life instead of hurting life. It will heal you instead of hurting you." (Mohawk male, age 48)

Approximately half of the respondents have used herbal remedies, for problems ranging from colds and fevers, cuts and burns, cold sores, rashes and other skin problems, to anxiety and diabetes. Reasons for their use included promoting generalized wellness, as well as dealing with disease. Often, this involves the use of teas.

"I had some this morning - ginseng tea<sup>8</sup>. You get a little package -it just keeps your system pure. It has a number of uses. I just like to have a cup of that every day - to feel good. It's not a drug, in the sense that a lot of people would see a drug. It just keeps your system pure, and will pep you up if you're feeling a little down." (Oneida male, 30's)

"Yes. I drink a lot of cedar tea, and bathe in cedar tea. Get it in the bush, up north. I try to bring it back. And I throw tobacco under there where you get that cedar." (Ojibwa female, age 48)<sup>9</sup>

Some informants know where and how to acquire the plants used for healing, and others wish they did.

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<sup>8</sup> The use of ginseng by Iroquois people in New France was noted by Lafitau (1724:xxxiii-xxxiv; [141-142] 88).

<sup>9</sup> Tobacco is an offering and a medium of communication, with which one gives thanks and shows respect for the Creator, who is the source of healing, and of the natural medicines. Indian tobacco is also taken to traditional healers when they are consulted. Sometimes a small amount of money is given, or some object which is of significance to the giver.

[I don't use it] "on a regular basis, just occasionally. Mostly for me, just the teas. I'd be using them all the time if I had access to what my grandmother made." (Ojibwa female, 30's)

One woman who has lived in the city for 14 years, noted that her aunt who lives on the reserve knows about medicines, and it is likely that she has chosen someone to pass her knowledge along to. The respondent herself grew up with traditional remedies that her mother and grandparents knew of, but this knowledge has not been passed along to her, and she has not sought it out.

The acquisition of herbal remedies may be through contact with a traditional healer, or direct knowledge of natural sources. Sometimes, also, they are obtained from health food stores.

[We use herbal remedies] "consistently. I can go to the health food store and get sassafras for my girls if I notice them hyper and nail biting. My kids are very aware of sweetgrass - we use it at home. They'll even ask." (Cayuga female, 30's)

#### The Need for a Correct Attitude

Traditional healing is also described as an attitude, which helps people maintain mental and physical balance.

"You have to have the right frame of mind. Being brought up with the belief that it works, that's half of it. Willingness to try it, and believe that it can help you. [I've used traditional healing] all my life. Things that anyone can do. Indian health practices are preventative, like tonics, used year round. Taking care of yourself - cleansing, fasting. Things we can do when we open our eyes in the morning. Gratitude, appreciation, asking for guidance. It effects your health. Mental health. You're more in tune with the spirit." (Cayuga female, 30's)

There is the belief that with the correct attitude, people can heal themselves, and not require contact with the Western medical system.

"One tends to think you can heal yourself with a positive attitude. Ignore the pain, and therefore there will be no pain. Being at one with the spirit." (Cayuga male, 20's)

"Traditional healing and Indian medicine means more to me than what doctors and nurses say. I don't like hospitals. [I] like using my own ways to heal myself." (Ojibwa man, 17)

People are brought up with the knowledge that you must believe, in order for the medicine to work. Most do not question this. Without the need to conceptualize this as a "placebo effect", Natives understand the power of belief at a practical level in their healing.

"Being brought up with the belief that it works, that's half of it. Willingness to try it, and belief that it can help you."

An important extension to this is the perception, voiced by an elder, that one must also believe in mainstream medicine in order for it to work. Similarly, Connors (in Warry 1992:8) states that metaphors of healing vary cross-culturally (the idea of balance, and the influence of guardian spirits in Native tradition; the unconscious mind in Western psychiatry) but successful treatment must be meaningful and comprehensible to the patient. Healing can only occur when treatment is consistent with the individual's belief system, or when the healer can explain it in a way that becomes meaningful to the patient. Failure to accomplish this is the source of much of the inadequacy of the European system when dealing with Native people.

When speaking of their understanding of healing, several informants mention the spiritual aspect of healing. Some feel that being in touch with the spirit means being in touch with your own inner strength and healing power.

You have to look within yourself to see the problems. When you are aware of this, you start healing spiritually. I believe if you heal spiritually and mentally, the physical doesn't take half as long to heal." (Tuscarora female, 50's)

"I think what it boils down to is just believing in yourself. I can remember that time when I got hurt. I was looking in the mirror, and thinking "Why am I like this? I'm not stupid or retarded like I'm acting. I can get better." And after that I got better. I think that was more psychological than anything. Because like some people believe in Jesus, and because of that belief, it does something to their body to make them get better. Some people just get better from faith. I'll tell you, after I saw that Medicine Man, I didn't even think of him - I just thought of myself. Maybe that's his way of doing things." (Ojibwa male, age 29)

Two key informants suggested that traditional people would be more likely to utilize Indian medicine as a preference, or to use it first, whereas Christians would use Western medicine. One significant finding, however, is that while Longhouse or other traditional people utilize Indian medicine with greater frequency, Christians are not necessarily averse to using it. All but one of the 12 people following Longhouse or other traditional beliefs had some experience with Native healing, and said that they knew healers. Seven of the 19 Christian respondents had used some form of traditional medicine, as had all three individuals who reported having a combination of Christian and traditional beliefs.

One Christian expressed a negative opinion of traditional healing, citing the spiritual aspect, and stating firmly that or "I don't believe in it; I believe in God!". Another Christian woman had begun to learn about Native spirituality, but voiced hesitancy about traditional medicine, as she had only been told about bad medicine during her childhood.

There is great confusion about spirituality evident in the responses of a small minority of informants, who have been brought up in Christian homes (often by parents who were educated in residential schools), but who do not identify closely with either tradition. The responses of one such person, a single man in his 40's, resident in Hamilton for 10 years, suggest anger and despair. He describes his home "in a barn, with the mice and cockroaches" in the north end of the city. He is unable to work, due to injuries sustained in an accident in which he and his brother were hit by a train while walking on the tracks, and his brother was killed. His more recent health problems include "getting up sick in the morning...getting up as an alcoholic", and a

"stomach problem...it lasts three weeks, won't go away. I don't know why. I think it's appendix, not sure."

When asked whether he has sought help with this latter problem, he responds

"No, I take Tums and all this shit. Pain won't go away. I'm too stubborn to go to a doctor. Because I'm an alcoholic. Won't go to the doctor."

He is a dishevelled, rough-spoken man, who (although he says his own doctor is "a good man") expresses great animosity for the majority

of white people, describing prejudice and abuse from people on the street, police, and hospital personnel. During his stay in the hospital

"it was boring. To many fuckin white people in there. I said "Can I take a piss?" and they wouldn't give me the piss can, because I was Indian. I rang the bell, and they said "What the hell do you want?" (white bitches!) because I was Indian. They had this piss can at the side of the bed, and I couldn't move because of the body cast - they practically threw it at me. They were prejudiced. They treat you like an asshole."

As his experience with the mainstream health care system has not been a positive one, the idea of traditional medicine would seem to present an alternative. When asked for his ideas about Indian medicine, he expressed great ambivalence and confusion, stemming perhaps from his history of having been raised in the Baptist church tradition.

"You mean witch doctor? I believe it's there (I know it's there), but have never seen it done. Everybody knows its there - my uncle was a witch medicine man. I believe in the Bible. I believe in both, but I believe in the Bible most. They say don't have no other God but thee. I believe in both - I don't know which way to go. I'm lost. I don't know if the Lord is mad at me. I believe in both. I believe in the happy hunting ground."

This man considers his health "poor", and is not benefitting from either traditional medicine or the care available in the mainstream health care system; he appears to be in some kind of spiritual "no man's land". One way of conceptualizing his problem is as a "spiritual illness", which Timpson et al (1988:7) note occurs in some Native people experiencing profound psychic distress in the acculturative context.

Most informants do not experience the type of extreme distress evident in this man's life. Many are able to strike a more easy balance between traditional and Christian beliefs, or to find comfort and spiritual strength in one or the other religious tradition. Some Christians incorporate traditional Native healing within their repertoire of practices for seeking health and well-being. Spiritual healing is also sought by some within the Christian context. One very elderly Christian woman spoke of a faith healing service which she had attended with her minister.

"If you don't have faith in it, it's not going to do you any good. It's spiritual. If you are a Christian, and believe the spiritualist will help you, he will help you. Oh I was so sick when I was in the sanatorium. And my minister took me there. He took me, and he said I want you to believe that this is going to help you. If you just make fun of it, that's not going to help" (Cayuga woman, 90's)

Spirituality and a strong belief system were stressed. To some, it matters little what form the spirituality takes. A traditional man, an elder in the community, commented that the only people he had problems with were those who "do not think about these things at all!" Of the 45 people surveyed, only seven report no form of spiritual belief. The small numbers preclude clear definition of the effect of this aspiritual orientation on health and health seeking.

As previously mentioned, many factors contribute to the choice of healing strategy, and there are no absolute predictors. Two traditional healers, both of whom were relatively elderly,

report having a family doctor whom they visit regularly. Examples given by one of these individuals suggest that if she has an ailment, she often uses her own medicine first, and goes to the doctor if this is unsuccessful. She feels that many people go to the doctor to have problems diagnosed, then come to her for a remedy. A young Longhouse woman sees problems with this.

"I think some of it [Native healing] is good, and some isn't. A lot of the older people will try to just heal themselves, using the medicine man. But it don't always work. And by the time they find a regular doctor, whatever's wrong with them will be worse, and they'll end up having to go to the hospital." (Seneca female, 20's)

Many people use both types of healing, as is common in other settings where traditional medicine is available alongside biomedical practice (Woods 1977; Kleinman 1982).

Respondents were asked how they would decide when to use traditional healers instead of Western medicine. Among those people who would discuss this, some said that traditional healers are the choice when other sources of help had not been successful, or there is an element of mystery about the ailment.

"You just know. It's something in the air. Something about it tells you who to go to, who to see. A doctor you go to for a sore throat, or stuff like that. Other weird things you go to a medicine man." (Cree/Sioux man, age 23)

"If we can't understand, and we have tried to understand and tried to do many ways, then we will go to the elder, and take medicine in order to help us, not to hurt us." (Mohawk man, age 48)

Traditional people may go more quickly an elder.

"We go to an elder first, and tell her what is really bothering us. Things in our life...like when my teenaged daughter couldn't sleep -something was keeping her awake. The elder would suggest that we should have someone go to the house and burn tobacco. Have to have a feast in our house to think of the dead. Every so often we have to have a feast in our house. Fix a tray of food for the dead - leave it overnight, and the next day give it away. [We did that] when my daughter couldn't sleep." (Cree woman, 50's)

Sometimes when medical attention proves unsatisfactory for quite disabling conditions, traditional healers are able to effect an improvement.

"That one time I got up, and I couldn't walk at all. Both my legs went, and my arm. This arm, I couldn't lift up at all, and this here hand, I couldn't move it. And I went up to the Emergency, and they said there's nothing wrong with you. But I said well, I can't move, I can't walk, and that. And they just put me in a wheelchair and sent me home. And said it'll be all right in a few days. And after that I went to the Reserve and got something. And I only used it for three days, and after that I was fine." (Woman, 20's)

Biomedical practice, with its continued separation of sickness into "physical" and "mental" categories, (and, in many cases, the devaluation of the psychological component) is at a disadvantage when trying to help those patients whose somatic problems are not clearly organic. The problem is exacerbated when the patient believes (as do many Native people) that health is a state of being in which mind, body and spirit are inextricably intertwined.

"If we are to be helpers in our own healing process...we need to understand sickness, we need to understand the spiritual health as well as the physical ailment and the psychological symptoms that accompany disease. And all of those factors

are linked and work together. So often, when someone is sick, I think that it might be psychosomatic, it might just be imagined. Yet the experience is very real to the person. In the tradition of our time, we were told that if you have something like that, you can call upon the spirits to help you. If it is a psychosomatic or a mental thing, the spirits will help you get through the agony of the disease, and you will not have to become physically sick and get a "physical" doctor to help you." (Aitken 1990:21)

Contrast the visit of the above-mentioned patient to an Emergency Room, where time is at a premium, and where physical findings are the focus, with the visit to a traditional healer.

"If you're going to meet with the medicine people, you'll go to them, and they'll help you with the physical things, right? But they'll also counsel you - they'll do things to counsel you. With my family doctor, (I wouldn't say he's a pill pusher, but...) if I have an appointment, and go for something physical, but I tell him I want to talk about something, I have to schedule another appointment.

Now, at my doctor's office, they don't put a priority on that. There's a two- or three- or maybe a four-week wait, for me to talk to somebody. Why can't he talk to me then? He won't talk to me! But if you go to a medicine person, they'll talk to you. Right then and there, or the next day. And they'll spend the time that you need, too. They don't say "Well, sorry, there's a bunch of patients out there." You know, it's so different. [At the doctor's office] it's really more for physical, isn't it?" (Cayuga woman, 30's)

For problems that people perceive as having a clear-cut physical basis, the family doctor generally offers the treatment of choice.

"I go to a doctor in the city for something really major - something wrong with my insides - my heart, or something. The other times - for other little things, I'd go to a traditional healer." (Ojibwa man, 20's)

"I think that for sickness like cancer, the white doctors know more about that. I think medicine men are more into kind of surface healing - like if you've got a sore or if something's wrong with your blood - you'd drink stuff. But for surgery - if you need surgery, you'd go to a regular doctor."  
(Ojibwa woman, 48)

In a study of illness perceptions in an Ojibwa community (Garro 1990:431), people describe three categories of illness. The first is Anishinaabe Sickness, which occurs as a result of people's actions, and may be intentional or unintentional. It could take the form of culturally inappropriate behaviour (such as disregarding taboos), or could involve the intentional use of bad medicine. Anishinaabe Sickness includes such problems as "baby who fusses/cries all the time", "acting abnormally/crazy" etc. It is resistant to treatment by physicians, but amenable to traditional methods of healing. The second illness category is White Man's Sickness, which includes illnesses seen as having been introduced into North America by Europeans (such as cancer, hypertension, diabetes). These problems are commonly treated by physicians. The third category, "Inapine", refers to ordinary illnesses, such as colds, and other respiratory ailments, stomachaches, etc. which are explained as resulting from observable events such as exposure to excessive cold or overeating.<sup>10</sup>

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<sup>10</sup> This may be contrasted with Cornwell's (1984:130) British informants, who also described three categories of illness. These were "normal illnesses" such as chickenpox, measles, infections, boils, flues, respiratory problems, "real illnesses" such as cancer, heart disease, epilepsy, diabetes, which were disabling and sometimes life threatening, and "health problems" which exist (e.g. relative to reproductive capacity, aging, etc.), but which were not

The mix of healing strategies which people use, whether it be for a disease as defined by the biomedical system or illness of a more holistic nature, is the result of the meaning they derive from their own experience and that of others.

#### THE QUEST FOR WELL-BEING

This chapter has dealt with respondents' experiences in seeking health, in moving through that intermediate area on the wellness continuum where organic, psychic and spiritual problems diminish their ability to live in the way they would choose. In conversations about significant health problems, people most frequently mention diabetes and alcoholism. They also see diet, drug use, and poor living conditions as major factors in decreasing well-being. People report that they manage health problems on the basis of their own experience, and wisdom gained from watching and listening to others in their families or social group. Consequently, workshops are seen as a practical and culturally-appropriate route to improvement.

People's experience with the mainstream health care system is contrasted with their perception of traditional healing in the latter part of the chapter. Many cultural differences which hinder effective clinical communication are illustrated by people's reports of how doctoring occurs in the two widely variant settings.

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amenable to treatment and not seen as "illness". The latter category includes arthritis, varicose veins, menopause.

In the remainder of the study, I turn to one important difference in the two systems of healing and communication - the issue of control; that is, how behavioral change is promoted, and guidance given and received.

## CHAPTER 7: THE CONCEPTS OF FREEDOM, CONTROL AND DISCIPLINE

In chapter 6, I noted that respondents cite improved diet, more exercise and abstinence from alcohol as means to improve their people's level of health. This is consistent with the thrust of many health promotion campaigns and medical programs, which recommend a disciplined approach to eating, drinking and exercise, and adherence to prescribed guidelines in the management of both acute and chronic disease.

This chapter deals with the people's ideas about freedom, control and self-discipline, and relates these to health and the health-seeking process. The chapter did not grow directly from the questionnaire data, as did the previous chapters, but from discussions and readings throughout the research process. A preliminary version of the questionnaire included a question about the connection of "self-control and health". A key informant, who was reviewing the form, suggested that I should word the question differently because the idea of control had very unpleasant connotations for many Native people. To her, it seemed like "a dirty word", and for many of her contemporaries, something which caused feelings of unease. An ensuing discussion indicated that this was related to her feelings about the history of oppression of Native people by the dominant society, coupled with the ethic of freedom and non-interference in traditional Native culture. In

subsequent conversations with other informants, introduction of the subject of personal or self-control often led to discussions of externally-imposed control.

In Native culture, personal independence and choice are highly valued. Freedom, the ability to "do what you want to do" recurred in many respondents' definitions of health. The valuation of freedom, along with the strong negative feelings associated with the controls exerted over Native communities by the dominant society in the past, may colour people's perception of prescribed medical regimes. The distinction between "control" and "discipline" is one which is important in understanding culturally-appropriate means of health promotion in the Native community.

The chapter begins with theoretical background on health and personal control. The next section deals with social context. The highly negative feelings generated in respondents by the pervasive controls exerted by the Canadian government in the past are part of this picture, as is the present impetus for Native self-determination. Discomfort at the idea of control may be one factor in the blurring of the distinction between "personal control" and "external control". Some more culturally-appropriate ways of giving guidance to others, and conceptualizing a disciplined and health-promoting lifestyle follow.

#### THEORIES OF PERSONAL CONTROL

Locus of control (Rotter 1966) is a measure of the degree to which an individual expects that s/he can generally affect the course of events in his/her life. Those scoring as "internals"

believe that their actions are, to a large extent, determinants of personal outcomes in their lives; "externals", on the other hand, are more likely to attribute outcomes to luck, fate, or powerful others. Specific locus of control measures have also been used to predict health behaviour (Wallston et al 1976). Research supports the hypothesis that locus of control may determine one's response to various forms of health programming - "internals" may respond better to a self-administered program, compared to "externals", who achieve greater success in group programs (ibid:584).

Evidence is mixed and somewhat inconclusive, but at least two studies suggest that Native people are more external in locus of control than are non-Natives, and that urban Native people more external than their reserve-dwelling counterparts (Halpin and Halpin 1981; Whitley 1980).

Bandura's (1982) theory of self-efficacy predicts that people's confidence in their own capability in any given endeavour will affect their behaviour, motivation, thought patterns and their emotional reactions in difficult situations. Self-efficacy feelings influence which actions are attempted, as well as how aroused a person becomes and how persistent s/he is in the event of difficulty. The accomplishments an individual experiences in actual performance of behaviours shape his/her sense of self-efficacy. Other sources of influence include observation of the effects achieved by others, persuasive communication from others, and physiological feedback (Bandura 1982; O'Leary 1985).

Bandura notes that people do not live as social isolates, and feelings of self-efficacy among individuals are related to the community's sense of collective efficacy in producing significant social change (ibid:143). One factor which undermines collective efficacy is the need to deal with the layers of bureaucratic structures which thwart effective social action. If we apply this line of reasoning to the case of Native people, it becomes obvious that this "bureaucracy factor" may be intensified by the federal/provincial jurisdictional confusion noted in chapter 2. More significant barriers to feelings of collective efficacy, however, would be the very experience of colonialism, the restrictions imposed by the Indian Act and by the controls exerted in educational settings in the past. It is not too great a leap to suggest that societal controls have helped generate a sense of personal inefficacy in many Native people, which can lead to a disinclination to take direct and persistent action in health and other areas of personal life. Bandura (ibid:144) notes that

"it is the internal barriers created by perceptions of collective inefficacy that are especially pernicious because they are more demoralizing and behaviourally self-debilitating than are external impediments." (ibid:144)

Following earlier theorists (White 1959; Rotter 1966; Bandura 1977; Janis 1983), Peterson and Stunkard (1989) have formulated a composite theory of personal control, which describes how individuals interact with the world. This involves confidence that they can effect actual outcomes, choose among them, cope with their consequences, and/or understand them. Peterson and Stunkard

suggest that individuals' ideas about personal control are an important factor in determining future behaviour. Feelings of personal control are desirable in a responsive environment, where they encourage intellectual, emotional, behavioral and physiological vigour. They are catalyzed by novel and challenging events. On the other hand, lack of personal control becomes salient in the face of overwhelming aversive events. A sense of personal control may be thwarted by failure and is encouraged by success (ibid:820).

Once again, the link between feelings of personal control and collective control is evident. In settings where people know they have the capacity to effect social change at a community or organizational level, they are more likely to respond in a positive way to health promotion initiatives at the personal level (ibid:824). An example is the relative success or failure of various health promotion programs (targetting, for instance, smoking, stress, obesity and hypertension) in work settings. Studies indicate that control is a critical ingredient here, and that labour and management philosophies regarding how much group efforts can improve conditions are important determinants of success (ibid:824).

#### THE LEGACY OF GOVERNMENT INTERVENTION

Native people have been prevented from exercising collective control in this country for many years, and they resent the rigid political controls which have been imposed on them by the dominant society. Feelings of powerlessness and cultural dislocation contribute to health problems such as teenage solvent abuse, suicide

and family violence, and there is a clear link between individual and community health (Warry 1991:223).

Today, although the residential school era has ended and progress is being made with respect to the recognition of Native culture and inherent rights, there is residual anger, alienation and confusion in the Native population. There are significant schisms in Native communities, based on differing spiritual beliefs, political orientations, and acceptance of the values promoted by mainstream culture. One idea that is voiced repeatedly, however, is the Native people have suffered under the controls and the foreign values imposed on them by others, and wish to have their right to personal and societal self-determination respected.

"I think you can trace a lot of the problems, like health problems, or alcohol problems, or anything in the communities today, and find it's because of the colonial attitude that's inflicted on the communities, where you have people who have ideas of how they should live their lives, and then have these foreign values coming in, and making you do...you know, you have to do this and this and this. I think that the breakdown is just evidence, too, that it's a culture clash, and that these things are happening because Native people aren't living the way that they're supposed to..like the way that the Creator told them to live. And that when you have foreign ideas, that's why people are getting sick...because spiritually, they're sick, so that's going to trigger everything else." (Metis female, 20's)

It is perhaps unremarkable, given the history of skewed power relations between Native people and the dominant society, that the idea of control has become a source of conflict in the minds of many Natives. This does not mean, however, that culturally-appropriate means of achieving a disciplined lifestyle are lacking.

Some alternative ways of doing so are presented later in this chapter.

#### FREEDOM, CONTROL AND HEALTH

The link between "control" and "health" is an integrating factor in much of the discussion which was generated by initial research findings. It is related to people's views about holistic and spiritual well-being. Without the means to choose one's own path, the individual (or the community) cannot achieve the spiritual, self-affirming sense of well-being which is necessary for health. People's ideas about control, however, are a source of inter-cultural misunderstanding, in that they differ significantly from the ideas of members of the dominant society.

Both "self-control" (Aitken 1990:16), and "controlling your own mind" (Woods 1992) are valued parts of the Native tradition. However, the idea of undergoing control or interference from others is aversive, as a result of both tribal behavioral ethics and more recent coercive intervention, by government and educators, into the lives of Native people.

In my conversations with some Native informants, however, the distinction between self-control and external control seemed blurred by the overwhelming negative connotations of the idea of "control". Discussions of personal control as a means of health enhancement tended to become discussions of history and being controlled by the dominant society. One man noted that "even the sound of the word control" evoked feelings of frustration and anger in him. A sense of having been controlled and oppressed seemed an

integral and profoundly negative part of the Native identity of many informants, which became linked to the on-going presence of life problems.

Whereas some psychologists (e.g. Seligman 1975) cite "learned helplessness" or "acculturative stress" to explain mental health problems evident in the Native community, Native psychologists conceptualize the problem as "internalized oppression". This is a process by which people convert the collective experience of colonization into an inner, personal loss, with the feelings of powerlessness, low cultural esteem and poor self-image being the result (Warry 1991:215).

Rinehart (1991:8) notes the bidirectional connection between powerlessness in the health care situation and the related concepts of fear, anger, decreased self-esteem, ineffective coping, self-care deficits, non-compliance and prolonged grief. Empowerment (whether by emotional, cultural, physical, intellectual or spiritual means) creates positive feelings such as self-esteem, serenity and better coping skills, which in turn increase one's feelings of empowerment.

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My informants who had made major and lasting changes in their personal lives and gained a sense of empowerment described a process in which insight or intuition preceded their commitment to change. This was sometimes, as in the cases of Henry and Carl detailed in Chapter 5, based on a very significant spiritual

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<sup>1</sup> Although Rinehart speaks of personal power at the individual level, it does not seem unreasonable to apply these principles to collective power achieved in the political arena.

experience. For others, the turning point was the gradual realization that others had changed, and they could change. One man described being "sick and tired of being sick and tired". All such cases of healing and change involved some element of spirituality, which enabled people to focus on who they were and what they could become. It allowed them to utilize the healing force which they understood as part of the natural order.

Some variations on how people perceive this healing force, this way of actualizing one's potential, are discussed next.

#### DIFFERING COMMUNICATION AND GUIDANCE IN THE TWO CULTURES

As mentioned in Chapter 6, cultural differences impede communication between many Native patients and non-Native health practitioners. Differing expectations about the need for following clinical recommendations may also cause difficulties. Many clinicians communicate to patients in a highly directive manner, and regard Native patients as non-compliant<sup>2</sup> if they disregard programs instituted. Native patients, on the other hand, while not resisting openly maintain the right to determine their own behaviour. In the contact with a traditional healer or with elders, there are no "doctor's orders". There is discussion of options, and what the end result of various choices may be. People are encouraged to heed their own good judgment, to draw upon that self-knowledge that can enhance healing and responsible behaviour.

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<sup>2</sup> The very use of the word "compliant" denotes a judgmental physician-centred perspective. See Conrad (1987:219) for a discussion of how patients with chronic diseases such as epilepsy regulate their own medication as a means of gaining a sense of personal control over their condition.

The Ethic of Non-Interference

As noted in chapter 6, the Native ethic of non-interference promotes respect for each individual's personal independence. Tolerance is a virtue, and one does not tell another person what to do, or use coercion of any kind. This extends to parent-child interactions, in that children are allowed a high degree of decision making power.

One example is drawn from family life, as described by informants. In many families, children have the option to eat whenever they want to, and in whatever circumstance. One respondent noted that children who ask if they could have something to eat would be told "What are you asking for? Go in there and eat it!" This comes from

"the way we're raised. I know I got my eating habits because we were allowed to eat as much as we wanted. And, you know, pretty well whenever we wanted. Whenever we were hungry, we would go to the cupboard and eat...I've found out now that that's not a good way to bring up your kids. They should be eating, like, not as much. Three meals a day, but, you know, to cut down on their meals and that. That's why there's so many big Indians!"  
(Cayuga female, 40's)

Natural consequences may, however, be seen as a more appropriate deterrent to overeating than parentally-imposed controls.

"I'll just wait and see if they will overeat...it may be something they really like, and they'll be sick. Then I can say "Oh - I told you! I knew you were going to be sick!" So they can just realize that the choice they made to overeat, or to overindulge...they're paying for it."

Q: "And do they learn?"

A: Well, maybe they're a bit more careful. I hope so, anyway!"

These women are cognizant of ideas about diet being promoted in current public health programs, and follow them with varying degrees of care. When people do begin to eat in a more careful balanced way, it is often due to a health scare, or the wish to set a good example for the younger generation.

Some respondents' parents had attended residential school and experienced the harsh controls of that era for extended periods during their youth. Nora, a woman in her 30's describes the situation when she was growing up. Her father had gone to a residential school, and his actions when he had children of his own suggested great ambivalence about rules and regulations, seemingly the result of differing expectations in the two cultures. He made many rules for the household, but did not enforce them. Nora believes that her father's need to make rules stemmed from his residential school experience, but the enforcement of the rules was not appropriate within their Indian way of life, and therefore his rules were not carried out. She described the freedom she and her siblings were accorded during their childhood. Whenever she grew tired of being with her own family, she would get on a bus and go to the reserve, approximately 200 kilometres away. Her extended family would phone her parents in Toronto and let them know of her presence. No disruption resulted from an event such as this; it was accepted as a reasonable thing for her to do.

Nora works in a professional capacity today. When we spoke of the issue of control, she noted that control is simply not

important in her life - she does not plan ahead, but carries out her work by attending to issues as they arise. If she has the feeling that she has forgotten something, she does not sit down and try to think it out, but rather is confident that if it is important, she will remember it. She realizes that planning is valued in non-Native culture, and in professional circles, but has been successful in her career by working in what appears to be a relatively intuitive fashion.

Another informant, Lorraine, grew up in a family which was atypical in that harsh behavioural controls were harsh and strictly applied. One of Lorraine's parents had gone to residential school, and the other had elementary education in a non-residential school<sup>3</sup>. Both were Christians, and strict disciplinarians. No child was allowed to talk at the supper table. A 9 o'clock curfew was strictly enforced; for every minute a child was late, they lost an hour's future freedom. Although the parents were very strict, their own lives did not reflect the standards they set for their family. They sent the children to Sunday school, but were not regular church-goers themselves; often they drank on the weekends instead. Lorraine notes that as the family grew up the harsh discipline eased somewhat, but significant tensions still exist among family members, and there is much healing to be done.

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<sup>3</sup> Although extreme controls in the residential schools are often linked with contemporary attitudes, several respondents noted that harsh controls and punishments were also experienced by those attending reserve schools. One example is children being beaten for speaking their own language.

As in any group, ideas about appropriate behaviour vary. Peggy, whose story is told in Chapter 5, is strongly in favour of planning her life, and keeping charge of her child's activities. She finds that having a plan is necessary for her own sense of security and independence. She states her opinion bluntly. She feels that many Native people don't worry about the next day, and that people who think that control is bad for their children may just be rationalizing their own neglectfulness. However, she, too, is uneasy about the word "control". This woman had been told that she controls her child too much, and that he always had to ask permission to do things. Despite this, she feels that "children learn more about being free by having limits". This is the way she was raised, with the value of education and self-sufficiency being stressed.

In his discussion of the "control" and "release" themes which were described in chapter 4, Crawford (1984:97) notes that people interweave these ideas in various personalized ways. Either of them can be interpreted as an acceptance or rejection of the dominant ideology. The control ethic may lead one (1) to work hard and be healthy/rich/successful, or (2) to work hard and achieve the empowerment necessary to defy those in positions of established authority. On the other hand, the release ethic may (1) result in an attitude of "eat, drink and be merry, because stress and control can do you in", or (2) may cause a steadfast resolve to not be ruled by the culturally-mandated need to indulge.

Giving Guidance

The ethic of non-interference does not mean that guidance is lacking. A concerned person can intervene in a destructive situation, and talk to the participants, laying out the possible courses of action and probable outcomes. When done in a respectful and non-coercive manner, this is not inappropriate. Carl, whose story of healing is described in Chapter 5, states his regret that nobody intervened in this way during his problem years.

"Although knowledge was gained by the authorities around me (teachers or principals or parents or what have you) that I was involved in these bad habits, no one ever stepped in there - properly stepped in, and said "look what you're doing to yourself". Now and then I got a good beating, you know. But to properly administer the knowledge of right or wrong..."

Interviewer: "And how could they do that?"

"I think, just to sit down in a comfortable environment, and say (not a lecture, mind you) but to talk to me. Just say "Look what you're doing to yourself! Look what you're missing out!""

Frances, the mother of two teenagers, talks to them about the results of drinking and smoking. She has experienced the damage that these things can cause, herself, and prays that her children will not follow in her footsteps. In Native communities, children are shown, rather than told what to do. Frances tries to set a good example now, but does not tell her children what they must or must not do. Although this has been difficult at times, she hopes that by talking openly, they will be able to weigh the options and make wise decisions.

Small children, too, are treated as thinking people. A mother notes that clinicians should, but often do not, respect the child.

"They need to talk on an equal level. [It's] no good otherwise. We may be talking about my child - don't talk to me, talk to him! I've always talked to my kids. Not just "I'm your mother, so do this!"

(Cayuga female, 40's)

A Native elder notes that "we guide, we suggest. We don't tell you what to do. That's how Native spirituality works. Everything I tell you is common sense - things that you already know" (Woods 1992).

#### BETTY'S EXPERIENCE WITH DIABETES

Betty is a woman in her 30's, who was diagnosed as having diabetes two years ago. She was given a diet sheet, but does not follow it closely, due to the cost of some of the recommended foods. She was advised to eat frequently, using small portions of various foods. She finds it easier to just cut out certain things, however. She usually skips breakfast, and sometimes lunch, although she knows that this is not a good practice for diabetics.

Despite these difficulties, however, Betty feels that her diabetes is under control. She is not on medication. She knows when she is going to have a bad day because when she wakes up her hand is swollen when she makes a fist. Her doctor gave her a computerized machine to test her blood sugar, and advised her to use it twice a day. Betty has never taken it out of the box. It requires pricking your finger with a needle, and she doesn't like the idea of doing this. Also, she is afraid of what she might find out. She doesn't want the disease to control her life.

Betty worries about her vision. She asked her doctor about it, and was told she was fine. Betty finds her doctor quite patronizing. She has not been to see him for a year. Sometimes she picks up tips on health and child-rearing from the television.

Betty has not told her kids or her mother that she has diabetes, because she doesn't want to worry them. Her mother also has diabetes, but seldom talks directly to her about this or any other physical problems. Neither woman feels that they have time to be sick.

Although Betty has not told her mother that she has diabetes, she passes along information she has gained about the condition. For instance, she tells her about the value of certain foods. Betty feels that if she can understand the rationale for a health routine, she is more likely to follow it. She does not ask questions easily, however. She does not want to look stupid, asking questions about things that maybe she should know already.

Betty's story illustrates themes we have dealt with previously, including the reluctance to actively seek out information, the need for independent decisionmaking. Betty does not want diabetes to disrupt her lifestyle, or to "control her". She feels that one way some people gain a sense of control over their health is to go to the doctor right away when they have problems, but this is not her way. Although she is very disciplined in some aspects of her daily life, she does not follow all the instructions she is given by health practitioners. She prefers to maintain a sense of personal independence by resisting the type of close self-regulation recommended by her physician. However, she is more likely to follow medical guidelines when the reasoning behind the instructions is made explicit, and makes sense to her. What Betty cites as prerequisite for health-promoting behaviour could be described as intellectual empowerment.

SOME ALTERNATIVE CONCEPTS FOR LIFE AND HEALTH MANAGEMENT

One informant, discussing the aversive nature of the concept of control, suggested a subtle distinction, that is, that "self-discipline" is a more culturally-appropriate concept than is "self-control". Whereas "self-control" implies a reining in, a disallowing of freedom and pleasure, "self-discipline" suggests marshalling one's energies to accomplish a goal. It is a positive impetus, as compared to a restraint.

A 19-year-old male respondent, the son of a Mohawk father and a non-Native mother, described his understanding of self-discipline as an important component of being healthy.

"Being of sound mind and body. Being able to do anything you want to and not having a mental block that'll make it difficult to complete the task at hand. Self-discipline has a lot to do with health - mental and physical.

Some Native leaders teach that volition, "that force which helps us make decisions and then act to carry out those decisions" (Bopp et al 1984:14-15) is a means of developing mental, physical, emotional and spiritual elements of one's nature.

One young man, while rejecting "self-control" as a useful way to conceptualize a healthy lifestyle, saw himself as working to "maintain" those aspects of his life that were important to him.

"It's just trying to maintain that balance. There's a word difference there - to "control" it, or to "maintain" it. And personally, I feel you can't control it. Because there's so many things, in life and in the world about you, that you can't control. You may think you can, but then that's your mind out of your spirit.

Because you can't control people, you know. But you can maintain - you can maintain relationships, and whatever. You can work on that."

He notes that the idea of controlling one's environment, as emphasized in the dominant culture, is one which seems ill-founded, unrealistic, and perhaps destructive.

"I think there's too many people, in non-Native societies, who have developed that idea, that there's a need to have that control. Like, that's why you come across so many people who are control freaks. And everything has to be so organized, and so defined, and if it isn't, the whole world's going to die. You know, everything has to be in control. And, like, where they can't say "well, it's out of my hands. I can't do anything about it!"

Life for Native people in North America prior to European contact involved the need to respond in an adaptive manner to fluctuations in natural conditions. However, unlike the European belief that humans can master the environment and control nature, Native people saw, and continue to see themselves as a part of nature. The idea of controlling nature and the environment is something which is alien to many Native people. Nature is not something to be controlled; nature is a teacher, a giver of life, and the Creator's plan.

#### CONCLUSION

This chapter has included several lines of thought related to control and health among Native people. The first, culled from the psychological literature, relates feelings of personal control and self-efficacy to good health. It is noted that a person's belief that they can effect outcomes in their lives not only

predicts but also determines future behaviour. It is well-established in literature (dealing with individuals from mainstream society) that feelings of personal control are related to good health (Peterson and Stunkard 1989:822).

Rappaport (1977:101) observes that control "is one of the few variables in the social sciences that may be shown to have a consistent relationship which ties research across levels of analysis". When people experience collective control, it is more likely that they will benefit from health promotion efforts (Peterson and Stunkard 1989:824). Minority groups, including Native people, have not had collective control for many years. The all-pervasive controls which the 1876 Indian Act gave the Canadian Government (and its representative in Native communities, the Indian agent) over the lives of Native people have left feelings of bitterness which colour the perceptions of many of my respondents when the subject of control is raised. The distinction between control and self-control may be blurred by the overwhelmingly aversive nature of the general subject. How can self-control be relevant if externally-imposed controls pervade the fabric of one's life? A more appropriate way of conceptualizing the route to a healthy lifestyle is required.

Native culture provides such alternatives. The ideas of volition and self-discipline allow one to marshal one's energies to accomplish a goal, to set one's life in order, while avoiding the negative (disallowing, or "reining-in") connotations of "control". Also, while interference in the lives of others is culturally-

inappropriate, calm intervention and guidance can be offered. People often benefit by observing the good example of others, and teach their children by example. These are some of the ideas being promoted by Native leaders as a means to alleviate the problems which exist in urban and reserve communities today.

## CHAPTER 8: CONCLUSIONS

The goal of this thesis has been to seek an understanding of urban Native people's views of health and how to be healthy, and to make this available to those of all backgrounds who wish to work toward more culturally-appropriate health service for this group. I have investigated a wide range of health issues, as reported and discussed by a group of urban Native people, who vary widely in degree of biculturalism, in health status, and use of the health care system and/or traditional medicine. The ideas expressed by these people are both complex and diverse, a reminder of the hazards of generalizing too broadly about "urban Native people". Nonetheless, I believe that the themes which have been discussed can be accepted as a reflection of the health perceptions which are common among this group. Consideration of these can help shape health care initiatives coming from both mainstream health care practitioners and planners, and those within the Native community, in order to better meet the needs of Native people in the city.

This chapter will summarize the major findings of the research, and make recommendations on how mainstream practitioners can optimize their care of Native patients. Also, because health initiatives originating within the Native communities are an important element in the health picture of Native people, I will include some ideas about potential programming which are based on

informants' observations. Finally, I will touch upon broader societal changes which are necessary for the betterment of Native health.

#### SUMMARY OF STUDY FINDINGS

In order to address the issue of ill health, one must know what the ideal of health means to the people in question. This is the central premise of the current analysis. The auxiliary themes, such as Native identity, ideas about authority and control, and people's thoughts about improving their health status stem from this.

Although many practitioners in mainstream medical facilities view health in a relatively narrow physiological sense, that is, as the absence of organic pathology, this is not the case with Native informants. Many of the latter group see the physical component as only a small part of health, which encompasses a much broader range of life - the physical, mental, spiritual and emotional spheres of well-being. It is the spiritual realm which traditional teachers see as the most basic wellspring of well-being, and some informants echo this understanding. A sense of being active, being in balance, and an awareness of one's purpose and direction evoke feelings of good health.

For women, this might involve childbearing or raising children. Both the sense of purpose in being a mother, and the act of raising children could engender feelings of well-being. Under these circumstances, women might adopt a more healthy lifestyle, or become more motivated to set a good example for children.

Health, for some respondents, includes a high level of physical activity, generally stemming from a lifestyle which involves physical work or training programs. Personally-planned physical fitness or exercise programs, while not entirely absent from informants' reports, were not common. In one young man's case, the martial arts was a route to greater spiritual and physical well-being.

Although most informants describe the doctors and nurses from non-Native culture in relatively positive terms, further discussion indicates that there are significant obstacles to good clinical communication, and hence effective care. The short time frame, and the relatively high degree of directiveness in clinical encounters are problems. These are in contrast to the approach of traditional healers. Because individual independence and decision-making are highly valued in Native culture, those who go to traditional healers receive guidance but not orders. They speak of the broader context of their lives, and understand that health relates not only to the physical body, but also to the mental, spiritual and emotional aspects of life.

In light of Native-white relations, the identity of many Native people has been a stigmatized one. Nonetheless, informants' perception of themselves and their people has evolved and continues to evolve in a positive direction. Healing is occurring. In many cases, this involves a spiritual awakening, in either the Longhouse tradition or a Christian context. For many, however, the path to healing remains ahead, and is a long difficult one.

Informants describe the most common factor associated with health problems in their community as alcoholism (Appendix B). The lives of many have been touched by problems associated with alcoholism, and recovery from alcohol problems is a common theme in stories of healing. This may derive from the determination to set a positive example for others (including the younger generation, and those from outside the community), or from observing the example of others who have overcome similar problems. It may also be the result of the insight which occurs in moments of dissolution and despair, or a profound personal awakening catalyzed by specific spiritual experience. In many accounts of healing there is an element of spirituality present; people speak of seeking self-understanding and using their inner resources in the process of healing.

The next most frequently reported causes of health problems are diet, drug abuse, self-neglect, diabetes and poor living conditions. Informants regard workshops as one potential component in the solution of these problems, as people are able to benefit from the sharing of ideas and learning from the experience of others. In keeping with the cultural aversion to imposed control, however, it was noted that the will to alter one's pattern of behaviour cannot be forced and must be achieved independently. When people are ready to change, they will change.

Many Native people are reluctant to speak up, to ask for help. This problem may be exacerbated when they are dealing with a white person, whose expectations are different from their own, and

from whom they have come to expect communication which seems rushed, directive and uncaring. The practitioner who expresses caring and concern, who takes the time to let communication unfold naturally, who encourages the patient to ask questions if s/he does not understand something, and who respects the patient's capacity for independent choice will be appreciated. By behaving in this manner, the practitioner steps back from his/her position of power and control, and provides the opportunity for more egalitarian interaction with the patient. This respect for the patient and their independence, makes it more likely that the doctor's questions will be answered, and health prescriptions followed.

The issue of control was not directly addressed in the questionnaire, but emerged as a recurring theme in the responses of diverse individuals, and was part of discussions. It appears that most people raised in Native homes do not arrive at a sense of "control" (i.e. self-control or personal control) in the direct way that is the norm in mainstream culture. Although self-control has been a valued part of life in traditional Native society, another part of the Native understanding is that it is counterproductive for people to be "control freaks" or attempt to control others/the environment/the natural world of which they are a part. However, as part of that world they have rich inner resources and when they live a balanced life and heed their intuition, they can better deal with day-to-day problems and accomplish those goals which give their lives meaning. It is by this relatively indirect route that many achieve a sense of purpose and self-discipline.

The imposition of harsh controls and limits by the dominant society in post-contact times (and especially during the residential school era) caused confusion between Native and non-Native values for many, and made even the idea of "self-control" a troubling one for some. In families which have been touched by the residential school experience, the imposition of controls are sometimes erratic, or harsh. Far more often, however, direct control of children and other family members is considered inappropriate. Brant (1990:535) characterizes the parent who sets strict limits and who guides a child's life in a direct manner as "deviant" within Native culture. The more culturally-acceptable manner of guiding others and shaping behaviour is for options to be discussed, and examples to be set.

A sense of personal independence and choice has been limited in the lives of Native people in the past century, due to the controls exerted by educators, Indian agents and other authorities appointed by the dominant society. Greater collective control at the political level, although now apparently within reach, remains an unfulfilled goal. According to Peterson and Stunkard (1989:824) feelings of personal control and self-efficacy at the individual level are related to collective control. If and when Native people as a group achieve a higher degree of self-determination, it follows that there should be an increase in feelings of efficacy and competence at the individual level. As personal control is related to health status, this should have a positive long-term effect on the health of the Native population.

RECOMMENDATIONS BASED ON THIS STUDYMainstream Health Care Practitioners

Perhaps the first thing that health care practitioners should note is the difference in communication styles of Native and non-Native patients. Among Native people, silence is an acceptable part of social interaction, and is not a cause for concern. The fact that people may speak in what seems like a slow, deliberate fashion should not be viewed as pathological in any sense, as the expectation is for thoughtful unrushed consideration of questions. Time must be allowed if meaningful communication is to occur.

Because many Native people are reluctant to complain, and in some cases fear looking foolish if they ask questions, they may leave the clinical encounter having given or received inadequate information. Encouragement to ask about anything they don't understand, or to speak of any other problems they are experiencing is one way of lessening this problem. If the practitioner broadens the discussion beyond the physical problem in evidence, and inquires about the more general life situation, this will allow for easier flow of information and indicate caring and concern. This is important, as some Native people have been raised with the idea that "white people don't like us", and differences in communication and style can perpetuate this idea unnecessarily.

Respect for the patient, whether child, adult, or elder, is important in the clinical encounter. In Native culture, people interact in an egalitarian, non-authoritarian manner, and individuals' capacity to make decisions about their lives is respected.

When guidance is offered, this takes the form of suggestion, discussion of how to achieve the ends that one chooses, and not directives or "doctor's orders". It is the former type of relatively indirect guidance and support which will provide the best health care and counselling for Native patients.

Because health involves physical, mental and spiritual well-being for many Native people, there are health problems that mainstream practitioners will be unfamiliar with, or unable to deal with directly, and contact with persons within the Native community will be required. Communication with urban Native organizations such as those within the Ontario Federation of Indian Friendship Centres<sup>1</sup>, or with the health clinic at a nearby reserve, can provide such contact. Because people vary considerably with regard to religious beliefs, the matter of Native healers must be handled with sensitivity. In cases where it is desired, however, this is an option that may bring healing which mainstream practitioners cannot provide, and this should be facilitated.

Native spirituality may involve visions or other supernatural events, which may appear unusual or strange to the mainstream health care provider. It is important to note that such experiences are not pathological within Native culture, and that treatment of

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<sup>1</sup>In Hamilton, the Hamilton Regional Indian Centre is such a member.

them as such by non-Native doctors can lead to serious instances of misdiagnosis and mistreatment, and should be avoided.<sup>2</sup>

If health care for Native people is offered in a manner in which some cross-cultural understanding is evinced, then they will be more likely to benefit by that which Western medicine has to offer. The strengths inherent in traditional healing should be acknowledged, as well, and this regarded as an appropriate and life-sustaining option for those who wish to incorporate it into their lives.

One additional issue is that of access to health facilities and health knowledge. Many Native people do not go to doctors very readily. It appears that making health services available in locations where the people are, e.g. in gathering places frequented by potential patients<sup>3</sup>, and by making services culturally-appropriate and accessible (e.g. by requiring no pre-arranged appointment), utilization rates may increase.

Many Native people avoid interaction with mainstream health care providers due to the aforementioned cultural differences, and

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<sup>2</sup>Cultural differences also make the use of psychological tests such as the Minnesota Multiphasic Personality Inventory (MMPI), standardized on non-Native people, subject to misinterpretation or "gratuitously pathologizing" (Hoffman, Dana and Bolton 1985). Their use is therefore suspect at best, and inappropriate in the vast majority of cases, that is, where the psychologist does not possess acute awareness of Native culture (Pollack and Shore 1980; Greene 1987).

<sup>3</sup> An example of such an initiative is that Anishnawbe Health Toronto has established satellite clinics in several locations in the downtown core of Toronto.

differing beliefs about health and illness. Health practitioners, by becoming more sensitized to cultural issues, can better provide one necessary component of health care. However, it is from within the Native community itself that the most meaningful change will come. It is from the Native community that and from which culturally-based programming can be generated.

#### The Native Community

Health initiatives now being generated from within the Native community will shape the future health profile of Native people. To a great extent, my comments endorse what is already happening as a result of these efforts. I offer general suggestions, based on the ideas expressed by informants during the course of my research.

The first suggestion echoes one in the previous section. If increased access to health information is seen as important for people who do not go readily to doctors or hospitals, then there are several methods which could be considered. One way of accomplishing this would be making information and/or services available in locations which are frequented by the target population. Public service announcements on local radio and television could also serve this purpose. These could be used to give health information and publicity for health fairs or workshops.

Educational workshops are endorsed by many as a good way of stimulating discussion and learning about health. In workshops, information can be offered in a non-threatening milieu, ideas put

forward, and alternatives discussed. People experiencing ill health can learn from others who have undergone similar problem, and can profit from the example of others who have developed sound health maintenance strategies. An element of "biomedical cultural sensitivity training", designed to help people understand at a conscious level how to cope most effectively with mainstream health practitioners in the clinical situation, could be incorporated into workshops.

Initiatives to promote a positive Native identity deserve on-going support. Exposure to positive Native role models and elders who are familiar with Native traditions afford opportunities for learning. Some urban Natives first become conscious of their heritage (or the strengths inherent in Native culture) through their association with organizations such as the Friendship Centre. Efforts to promote the accessibility of organizations such as this will engender a stronger sense of pride and community cohesion.

The continued development of educational curricula which present the Native perspective of history and life philosophy will also help. I believe that if the schools and youth programs promote knowledge of the "best of both worlds" - techniques and wisdom available in both societies, then young people will be in a position to create their own personalized identity and to adopt those ideas which fit with their perception of their own needs and goals.

The fact that spirituality and spiritual guidance are important elements of health for many Native people leads to the

idea that these could be associated with existing biomedical programs, and incorporated into a more holistic model of health services. Although some traditional healers will no doubt wish to remain independent, models of cooperation and collaboration (Waldram 1990:343; McCormick 1988) with sympathetic biomedical practitioners can be considered. The provision of space for, or at least the facilitation of contact with, traditional healers (and perhaps, also, ministers from the appropriate Christian churches) could be considered as a part of health service. This would provide the social and spiritual support necessary for total health.

Contemporary interpretations of traditional ideas about health are being incorporated into programs developed to educate people about and provide solutions for common health problems. Living a balanced lifestyle, utilizing Longboat's "natural doctors" (as described on page 42-43 of this study) in order to live well, finding and following the life path which is most desirable and appropriate for your individual development are ideas which can be adapted to the management of health problems.

### Society

The third, and most difficult set of changes must come from society as a whole, and the legislators and policy makers who initiate change in society. Innovations at the societal level do not usually occur quickly or easily, but must be fought for, and promoted by people of foresight and good will. Fairweather (1972:7) notes that

power -

"it appears axiomatic that an invention is acceptable to a society in direct proportion to the degree that the innovation does not require a change in the roles or social organization of that society."

If the inequalities of the past, which have contributed to the present state of ill health of Native people, are to be altered, structural change must be considered.

Power (both political and economic) allows a person or a people to impose their own definitions on those over others in less powerful positions. This has led to a faulty conceptualization of the needs of Native people on the part of policy-makers, and hence to inadequate and inappropriate health services. Awareness of the negative repercussions of this "power effect", however, allows for the development of new possibilities for social change. Once we expand our view of what is right and proper, and acknowledge the validity and the strength in alternative viewpoints, the possibility of more appropriate health care in Native communities is greatly enhanced.

I would recommend that those policymakers adopt a broader definition of health, one that is more congruent with Native people's understanding. Bureaucratic obstacles which impede holistic health initiatives<sup>†</sup> should be eradicated. Although mental

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<sup>†</sup> An example of such an obstacle is the difficulty establishing permanent funding for Anishnawbe Health Toronto's Street Patrol. This program, which tends to the survival needs of street people in the downtown core, was developed by the centre after careful consideration of the health needs of the community, and is consistent with the centre's holistic model of health. Because it was seen

health is a pressing problem for many Natives, persons experiencing mental health problems are sent to mainstream health facilities, where culturally-appropriate treatment is not available. Mental health care which is consistent with cultural norms, and which incorporates holistic principles, should be a mainstay of health promotion for Native people.

At the time of writing, ongoing negotiations are being carried out in order that the Canadian constitution be amended to the satisfaction of the diverse national and regional interest groups in this country. The inherent right of Native people to self-government has been acknowledged by politicians from across Canada. It is unclear at this point how this will be put into practice in the coming decades. Most of the negotiations with Native leaders have dealt with self-government for reserve populations. The quest for self-determination by the substantial and growing communities of Natives people in urban settings presents a particular set of problems (including provisions for the delivery of health care to urban Natives). These are addressed in a discussion paper prepared for the Native Council of Canada (Wherrett and Brown 1992).

Many promises have been made to Native people in the past, with disappointing results. Canada now has the opportunity to make

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as a service which did not fall within the purview of a Community Health Clinic, however, funding of the program has been an on-going concern (Johnston 1992).

structural changes which lessen the damage, and to earn the reputation for reason and justice to which is aspires in the international forum.

### CONCLUSION

Native people are seeking self-determination at both the political level and in their personal lives. In chapter 7, I spoke of "internalized oppression" as one way to conceptualize the hurtful and immobilizing feelings experienced by many contemporary Native people. The experience of internalized oppression is one which some Native leaders are now counteracting with the caution that blaming others can prolong a destructive sense of rage and impotence, whereas accepting some responsibility for the course of events is a necessary step in gaining confidence which is required in order to make positive change. Seeking and accepting responsibility for future events is a challenge which Native people now face, and which I believe will provide greatly enhanced potential for their holistic well-being.

My own perceptions on Native health have been influenced by the fact that, during the course of the research, I attended several meetings at which elders or teachers from within the Native community presented their understanding of traditional ideas about health. While not all contemporary Native people are interested in pursuing the "old knowledge" (and the numbers involved in my study preclude a definitive statement in this regard), it is my belief that for many, the traditional teachings echo at a conscious level

implicit understandings which pervade the lives of many people. These transcend the narrow frame of reference of the biomedical model, and access sources of ancient wisdom which have been lost by those pursuing the current model of scientific practice. These are potent sources of healing, especially for the social ills which are so prevalent among Native people.

Many Native people are gaining a greater sense of pride is moving away from some of the ideas imposed on their ancestors by the dominant society, and utilizing modern versions of traditional ideas. Each individual comes into contact with ideas from different cultures during the course of their life, and adopts those elements of the bicultural (or multicultural) lifestyle which fit with their understanding of who they want to be, and what they want to show the world.

I submit that empowerment of Native people, and acknowledgment of the strengths of Native culture will enhance health in the broad holistic sense. This should improve the health status of the people, for whom social problems continue to be a major contributing factor in the broader health picture. Native culture and spirituality are helping an increasing number of Native people reclaim and celebrate a positive sense of self.

If the impetus for Native self-determination is successful, and if the theory that collective empowerment enhances personal empowerment (and therefore health status) is correct, then the

longterm future health of Native people should improve substantially. The societal change which is now in progress will provide fertile ground for research efforts investigating the links between societal self-determination, individual empowerment and health status in the Native community. The theoretical base is very incomplete at present. Longitudinal studies of the relative health of communities in which variations of community control<sup>5</sup>, would be of great value.

Native people seek power in a manner which is substantially different to that mandated by mainstream society, and therefore frequently misunderstood. Although they are seeking it directly at a societal level, through the political process, they also maintain their right to live in accordance with their own understandings. This involves consideration of and attention to the spiritual, physical, mental and emotional spheres of existence. The acknowledged right to build their institutions in accordance with such cultural precepts will strengthen their sense of the collective efficacy, something which has been lacking during the long period when they lived with rules and restrictions imposed from without. Culturally-appropriate resources have been conspicuous by their absence in the lives of many Natives who have lived under a

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<sup>5</sup> This includes the Health Program Transfer currently being offered by the Medical Services Branch, as well as the more comprehensive changes which may result from current negotiations for self-government on the part of Native communities.

system imposed by those whose understanding differed in many basic ways from their own. Now when self-determination for Native people is within their grasp, it is possible that this error of the past will be corrected.

APPENDIX A.

DEMOGRAPHIC INFORMATION: Questionnaire Respondents  
(Number of respondents, and percentage to nearest percentage point)

- 1) Sex: Males 27 (60%)  
Females 18 (40%)
- 2) Age Range: Under 18 1 (2%)  
18-21 5 (11%)  
22-29 6 (13%)  
30-39 14 (31%)  
40-49 14 (31%)  
50-59 2 (4%)  
60-69 0 -  
70 and over 3 (7%)
- 3) Marital Status: Single 18 (40%)  
Married 9 (20%)  
Separated 4 (9%)  
Divorced 9 (20%)  
Widowed 5 (11%)
- 4) Residence
- a) Location: Hamilton Central 15 (33%)  
Hamilton East 11 (24%)  
Six Nations Reserve 5 (11%)  
Hamilton Mountain 4 (9%)  
Hamilton North 3 (7%)  
Hamilton South 2 (4%)  
Stoney Creek 1 (2%)  
Hamilton West 1 (2%)  
Ontario - other 1 (2%)  
Unknown 2 (4%)
- ("Hamilton Central" is defined here was the city's central core, between Main and Barton Streets, and Queen and Wellington Streets)
- b) Type: House 22 (49%)  
Apartment 14 (31%)  
Room 4 (9%)  
Other (streets, hostel, rehab centre) 5 (11%)

c) Number of other people (including children) respondent lives with:

Lives alone	13	(29%)
One other person	5	(11%)
Two other people	10	(20%)
Three " "	7	(15%)
Four " "	2	(4%)
Five " "	5	(11%)
Ten - thirty (in hostel, rehab centre)	3	(7%)

d) How long respondent has lived in the city

Less than six months	6	(13%)
6-12 months	2	(4%)
1-3 years	8	(18%)
4-10 years	8	(18%)
More than 10 years	14	(31%)
Doesn't live in city	6	(13%)
Unknown	1	(2%)

5) Early Years

a) Where respondent was born:

Hamilton, Burlington	10	(20%)
Six Nations Reserve	10	(20%)
Hagersville, Brantford	2	(4%)
Toronto, London, Galt	4	(9%)
Northern Ontario	9	(20%)
Southwest Ontario	5	(11%)
Saskatchewan	2	(4%)
British Columbia	1	(2%)
Unknown	2	(4%)

b) Where respondent spent childhood

Hamilton	6	(13%)
Six Nations Reserve	7	(15%)
Other Ontario Reserves	3	(7%)
Ontario, Other (non-reserve)	13	(29%)
Moved about	3	(7%)
Saskatchewan, B.C.	2	(4%)
Part reserve, part non-reserve	2	(4%)
Unknown	9	(20%)

## 6) Aboriginal Status

Status Indians		38	(84%)
Metis		3	(7%)
Seeking Status		1	(2%)
Non-Native (raised by Native family)		1	(2%)
Unknown		2	(4%)

7) Nation	Six Nations (total)	25	(55%)
	Cayuga	10	
	Mohawk	8	
	Oneida	5	
	Seneca	1	
	Tuscarora	1	
	Ojibway	11	(24%)
	Cree, Cree/Ojibway, Cree/Sioux	4	(9%)
	Other	3	(7%)

## 8) Languages spoken:

English only	23	(51%)
English plus some Aboriginal language(s)	16	(35%)
English plus some other language(s)	6	(13%)

## 9) Religious/spiritual belief

Christian	19	(42%)
United Church	4	
Anglican	3	
Baptist	3	
Pentacostal	2	
Presbyterian	1	
Born Again Christian	1	
Roman Catholic	1	
Family of God	1	
Unspecified	3	
Traditional Native Spiritual Belief	12	(26%)
Longhouse	11	
Other Native tradition	1	
Both Christian and traditional	3	(7%)
Nothing	9	(20%)
Other	2	(4%)

## 10) Formal Education

Grade 1-7	3	(7%)
Grade 8	4	(9%)
Grades 9-11	23	(51%)
Grades 12-13	3	(7%)
Some Community College/University	7	(15%)
Community College/University Diploma	5	(11%)

## 11) Employment

Full time	11	(24%)
Part time	4	(9%)
Temporary	2	(4%)
Unemployed	26	(58%)
Retired	2	(4%)

## 12) Annual Household Income

Less than \$10,000	7	(15%)
\$10-19,000	13	(29%)
\$20-29,000	3	(7%)
\$30-39,000	3	(7%)
\$40,00 or more	4	(9%)
Unknown	15	(33%)

**TABLE 2: HIGHEST EDUCATIONAL LEVEL ACHIEVED; COMPARISON OF STUDY GROUP, NORTH AMERICAN INDIANS (AS PER 1986 CANADIAN CENSUS), TOTAL POPULATION OF CANADA (AS PER 1986 CANADIAN CENSUS)<sup>1</sup>**

Highest Education Achieved	Study Population	North American Indians	Total Population of Canada
Less than Gr. 9	15.6%	24.4%	17.3%
Partial High School	51.1%	33.9%	27.1%
High School Graduation	6.6%	8.4%	12.8%
Trades Certif.	Unknown	2.4%	3.1%
Partial college or university	15.6%	15.0%	15.7%
College or university Graduation	11.1%	16.0%	24.1%

<sup>1</sup> Data on Native people based on Canadian Census figures must be interpreted with caution. Many Native people in Canada have boycotted the Census in recent years, as a means of demonstrating their separate nationhood. Thus population figures are under-estimates, and social indicators are inexact.

**TABLE 3.** EMPLOYMENT STATUS: COMPARISON OF STUDY GROUP, NORTH AMERICAN INDIAN POPULATION (AS PER 1986 CANADIAN CENSUS), AND TOTAL POPULATION OF CANADA (AS PER 1986 CANADIAN CENSUS)

<u>Employment Status</u>	<u>Study Population</u>	<u>North American Indians</u>	<u>Total Population of Canada</u>
Employed	37.8%	46.7%	59.7%
Unemployed or not in labor force	62.2%	53.2%	40.4%

**TABLE 4.** ANNUAL INCOME: COMPARISON OF STUDY GROUP, NORTH AMERICAN INDIAN POPULATION (AS PER 1986 CANADIAN CENSUS), AND TOTAL POPULATION OF CANADA (AS PER 1986 CANADIAN CENSUS)

	<u>Study Population (per household, 1990)</u>	<u>North American Indians (per individual, age 15 and over, 1986)</u>	<u>Total Canadian Population (per individual, age 15 and over, 1986)</u>
Less than \$10,000	23.3%	53.8%	38.9%
\$10-19,000	43.3%	22.9%	24.9%
\$20-29,000	10.0%	12.7%	16.8%
\$30,000 and over	23.3%	10.4%	

APPENDIX B: RESPONSES TO NATIVE HEALTH CARE SURVEYMOST MEMORABLE HEALTH EXPERIENCES

1) Can you describe to me the time in your life when you felt most healthy?

- when involved in physical fitness, sports, activity (10)
- at present (8)
- felt I could do anything/any job (4)
- when I was pregnant (3)
- when my children were small (3)
- when I quit drinking (3)

2) In general, what does "health" mean to you?

- you can do what you want to do (7)
- combination of mental and physical (6)
- combination of mental, physical and spiritual (5)
- not experiencing any sickness (4)
- feeling good (4)
- balance in your life (3)
- get up and greet the morning (3)
- happiness (3)
- experience no barriers (3)
- look after yourself (3)

3) Have you ever had a serious health problem?

- no (10)
- alcohol-related (5)
- motor vehicle accident (3)
- diabetes/"sugar" (3)
- cancer (3)
- back injury (2)
- appendix (2)
- work-related accident (2)
- injured in Viet Nam (2)

4) Does any particular illness experience stand out in your mind from the past? Would you tell me about it?

- no (8)
- alcohol-related (7)
- hepatitis (3)
- cancer (3)

GENERAL HEALTH STATUS - HOUSEHOLD.

- 1) How would you describe your own health at the present time?
  - (a) Excellent (6)
  - (b) Good (23)
  - (c) Fair (9)
  - (d) Poor (3)
  
- 2) How would you describe the general health of those in your household?
  - (a) Excellent (6)
  - (b) Good (17)
  - (c) Fair (3)
  - (d) Poor (2)
  
- 3) Do you smoke?
  - (a) Daily (28)
  - (b) Occasionally (3)
  - (c) Not at all (14)
  
- 5) Has drinking or drug use ever caused upset either within your family/home life or at work?  
  
  - Yes (27)
  - No (13)
  
- 6) What are the most common health problems in your household.  
  
  - colds (10)
  - flu (4)
  - headaches (4)
  - heart problems (4)
  - alcohol problems (4)
  
- 7) If you could make some suggestions to improve the health of your household members, what would these be?  
  
  - diet (14)
  - exercise (8)
  - quit drinking (6)
  - quit smoking (5)
  - take care of self (2)
  - get counselling (2)
  - better housing needed (2)

EXPERIENCES WITH HEALTH CARE SYSTEM

1) (This question can be altered somewhat if hospital experience was discussed in previous section). Have you ever been a patient in a hospital?

- (a) Yes (44)
- (b) No (1)

1a) If you have, could you tell me why you were in the hospital?

- childbirth (10)
- motor vehicle accident (3)
- fractures (3)
- surgery (3)
- shot or stabbed (2)
- alcohol-related (2)

1b) Could you tell me what the experience of being in hospital was like?

- good experience (7)
- doctors and nurses good (5)
- lonesome (4)
- boring (4)
- ok (4)
- didn't like (3)
- scared (3)
- bad food (2)
- confining (2)
- experienced prejudice (2)
- I was rowdy/kicked out (2)
- wanted to be home (2)

2) How do you think health service or hospital procedures could be improved?

- need more staff (8)
- get to patient faster (8)
- more caring/people-oriented (7)
- system is good (6)
- too rushed (3)

3) Do you have a family doctor? Do you go to a health clinic?

- family doctor (30)
- health clinic (1)
- both (5)
- neither (7)

3a) How would you describe your doctor's understanding of Native people and their health needs?

- pretty good understanding (7)
- doesn't go by race/nationality (5)
- none/don't know (4)
- good (3)
- too rushed (3)
- not much understanding (2)
- prejudiced (2)

3b) What do you think would be the most important thing for non-Native doctors, nurses and health care workers to understand about Native people?

- understand their background/trauma (7)
- Native people are shy/don't complain (5)
- should treat them the same as others (5)
- Native people like to use their own medicine (4)
- alcohol abuse (2)
- should love their patients (2)

3) Do you feel that the fact that you are Indian has ever influenced the treatment or quality of care that you have received?

- no (25)
- no, but others have (2)
- yes 11)

3a) If you do, can you tell me what you mean by this?

- treat you second rate/go to white people first (3)
- afraid to speak up (3)
- staff were rude or prejudiced (4)

#### USE OF TRADITIONAL HEALING

1) Can you explain to me what traditional healing and Indian medicine means to you?

- use of herbs/roots (7)
- no idea (7)
- attitude/belief that it helps (3)
- spiritual, mental, physical (2)
- in tune with nature (2)
- in touch with the spirit (2)
- can heal yourself (2)
- it works (2)
- ceremonies (2)
- it's a gift (2)
- Mum used it (2)
- don't believe in it (2)

2) Do you know of spiritual healers or medicine men/women in your community?

- yes (22)
- no (15)
- know of (3)

3) Have you used Indian medicines or been part of traditional healing practices? If so, for what kind of problems?

- yes (19)
- no (20)

4) Do you think that Native people are reluctant to talk about traditional healing practices?

- yes (29)
- depends who you are (3)
- no (4)

If they are, why is this so?

- taboo (3)
- white people don't understand (3)
- it's private (3)
- white people might destroy/exploit (3)
- white people might ridicule (3)
- don't trust white people (2)
- more dependent on white culture now (2)
- sacred (2)

5) Do you or your family members ever use herbal remedies for health problems or just to stay healthy? (a) Yes (b) No

- no (18)
- yes (23)

6) Do you or your family members talk about, or analyze your dreams? Could you tell me a little about how and why you do this?

- yes (24)
- no (13)
- mention of prophesy from dreams (10)

GENERAL HEALTH OF COMMUNITY

1) What would you say are the main reasons for health problems in the Native community?

- alcohol (17)
- diet (10)
- drugs (6)
- self-neglect (5)
- diabetes (4)
- living conditions (4)
- white people's influence (3)
- heart problems (3)
- lack of money (3)
- pollution (2)
- smoking (2)
- shy with doctors/white people (2)
- distance from health care (2)

2) If you could make some suggestions to improve the health of your community, what would these be?

- education (7) (education re: diet: 3)
- stop drinking (6)
- diet (4)
- more activities (3)
- it's up to the individual (3)
- better housing (3)
- help when drinking (3)

3) Please tell me how important you think that each of the following are in determining whether you are healthy. Which is the most important, the next most important, etc.

Most important factor:

- Your own knowledge and experience (17 respondents)
- The knowledge and experience of other people (6)
- Your environment (10)
- Heredity (5)
- Luck (2)

4) Please tell me how important you think that each of these are in determining how well you recover from illnesses.

Most important factor:

- Your own knowledge and experience (16 respondents)
- The knowledge and experience of other people (7)
- Your environment (11)
- Heredity (3)
- Luck (2)

5) What do you feel about life in the city, generally?

- love it (2)
- like it (3)
- prefer reserve/country/farm (6)
- ambivalent (4)
- not bad (1)
- hate it (1)

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